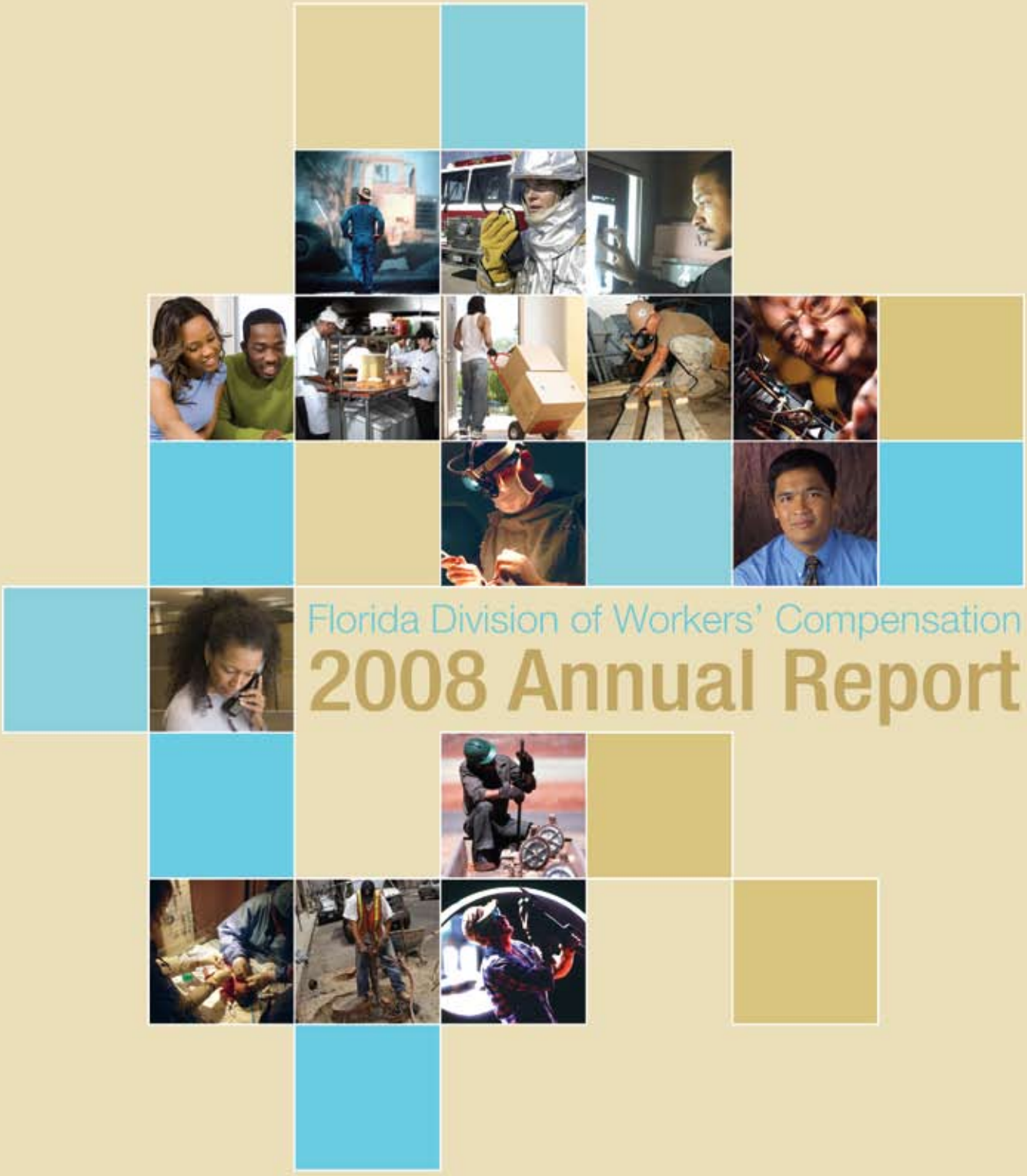

Florida Division of Workers' Compensation

2008 Annual Report

ALEX SINK
CHIEF FINANCIAL OFFICER
STATE OF FLORIDA

Florida Department of Financial Services

REPRESENTING

ALEX SINK

CHIEF FINANCIAL OFFICER
STATE OF FLORIDA

September 15, 2008

Dear Governor Crist, President Pruitt, and Speaker Rubio:

It is my honor and privilege to present the 2008 Division of Workers' Compensation Annual Report as required by s. 440.59, Florida Statutes.

During our sixth year as an integral part of the Department of Financial Services, we continued to implement programs and processes that are necessary to administer Florida's workers' compensation system. These initiatives are driven by the Division's organizational philosophy to continually seek opportunities to enhance the self-execution of the workers' compensation system and to assist injured workers, employers, health care providers and insurers in complying with their statutory obligations.

In addition, this Annual Report highlights our Bureau of Monitoring and Audit and its activities during the past year. Holding insurers accountable for meeting their statutory and regulatory claims handling performance standards is the primary responsibility of the Bureau. In fulfilling this responsibility, the Bureau uses various enforcement tools and claims monitoring processes that have allowed the Bureau of Monitoring and Audit to increase the sophistication and comprehensiveness of its audits. These audits focus on ensuring that injured workers receive the benefits that are due to them under the law. We are especially proud of the Bureau's success in improving insurer performance over the past few years, as evidenced by the significant increase in insurer compliance with statutory requirements.

The Division will continue to meet its regulatory responsibilities in the most cost effective and efficient means possible and we will strive to improve Florida's workers' compensation system so all of its stakeholders benefit from it.

We welcome any suggestions and comments with regard to this report and the performance of the Division.

Sincerely,

Tanner Holloman
Director

ALEX SINK
CHIEF FINANCIAL OFFICER
STATE OF FLORIDA
Florida Department of Financial Services

Division of Workers' Compensation 2008 Annual Report

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THE MISSION

The mission of the Department of Financial Services is to safeguard the people of Florida and the State's assets through financial accountability, education and advocacy, fire safety and enforcement.

The Division's mission, focus and accomplishments during FY 2007-2008 have contributed to the Department's mission in many significant ways.

Financial Accountability:

The Bureau of Monitoring and Audit

- Monitored the financial strength of individually self-insured employers to ensure they have the ability to pay all current and future workers' compensation liabilities.

The Bureau of Compliance

- Created a Internet-based online penalty payment service to allow employers that have been assessed a penalty to submit payments electronically.

- Developed a process to identify exemption applications and penalty payments that were returned to the Division for insufficient funds. During FY 2007-2008, 674 of these payments were identified. Notices of Intent to Revoke and Orders to Reinstate Stop-Work Orders were sent to those entities. Monitored and tracked employer accounts until secured funds were received and verified.

- Referred 628 delinquent employer accounts for submission to the Department's contracted collection agency and collected $149,706 from those referred accounts.

The Bureau of Data Quality and Collection

- Collected 100% of all medical bills and Proof of Coverage filings in electronic format consisting of over 4.3 million medical bills and 689,118 Proof of Coverage filings. This electronic collection permits the Division to use a seamless business process to hold employers and insurers accountable for providing statutorily mandated benefits to injured workers. The electronic collection of these data precluded the need for claims handler promulgation and mailing of paper documents and for data entry of this information by the Division.

The Office of Special Disability Trust Fund (SDTF)

- Saved $12,445,273 for Florida's employers by auditing for payment 2,105 Reimbursement Requests; approved $79,533,646 of the $91,978,919 requested.

- Audited and returned 1,731 Reimbursement Requests for correction because the Reimbursement Requests submitted included benefits that were not properly documented or were otherwise ineligible for reimbursement.

- Eliminated the historical backlog of approved Reimbursement Requests awaiting payment, which, on December 31, 2001, exceeded 15,500 Reimbursement Requests valued at more than $535 million. The SDTF is now paying all available approved Reimbursement Requests as they are approved and cleared for payment.

- Disbursed more than $137 million in audited and approved reimbursements to insurers which included amounts carried over as approved Reimbursement Requests awaiting payment from prior fiscal years and approved Reimbursement Requests from FY 2007-2008.

The Assessments Unit

- Calculated the imputed premiums and applicable Workers' Compensation Administration Trust Fund and Special Disability Trust Fund assessments for more than 400 self-insurers.

- Reconciled insurance company premiums reported to the Division against those premiums reported to the Office of Insurance Regulation and the National Association of Insurance Commissioners by the insurance company, pursuant to law, in order to validate the accurate payment of assessments and reveal any overpayments or underpayments by the companies.

Education and Advocacy:

The Bureau of Compliance

- Obtained licensure for fifteen investigators, including District Supervisors, to teach continuing education courses on workers' compensation coverage and compliance requirements to contractors licensed through the Department of Business and Professional Regulation.

- Created new informational bulletins and revised existing educational brochures regarding workers' compensation coverage and exemption requirements.

- Provided education and outreach workshops for insurers, employers, contractors and other stakeholders regarding workers' compensation coverage and compliance requirements.

The Bureau of Employee Assistance and Ombudsman Office (EAO)

- Telephoned 26,140 injured workers with lost-time claims to provide benefit information, address questions or concerns about the workers' compensation system, and advise them of services available through EAO, including the availability of a toll-free telephone line for assistance from EAO.

- Served as an ongoing resource for injured workers who have benefit concerns and contacted insurers to facilitate injured workers' receipt of statutorily required medical treatment and indemnity payments.

- Assigned Ombudsmen to assist injured workers in navigating the workers' compensation system, aiding in the resolution of complex disputes and when appropriate, and explaining the procedure for filing Petitions for Benefits.

- Conducted thirty-two educational workshops for system stakeholders about injured worker benefits and responsibilities.

- Reviewed insurer denials for appropriateness and intervened with insurers to assist injured workers in obtaining benefits to which they were entitled.

- Served as an educational resource for employers with questions about statutory requirements for workers' compensation coverage and the qualifying criteria for and obtaining an exemption.

The Office of Medical Services and Bureau of Employee Assistance and Ombudsman Office

- Worked jointly to resolve complaints on behalf of injured workers who were inappropriately billed by medical providers for medical treatment.

The Bureau of Data Quality and Collection

- Conducted two 2-day training classes for claims-handling entities on the new Release 3 Claims EDI format. One hundred seventy-five individuals attended the training.

The Bureau of Monitoring and Audit
The Bureau of Employee Assistance and Ombudsman Office
The Bureau of Data Quality and Collection
The Office of Medical Services

- Provided education and outreach programs for insurers, third-party administrators, medical providers, employers, and contractors regarding the various technological, process and regulatory improvements initiated by the Division.

Enforcement:

The Bureau of Monitoring and Audit

- Monitored the performance of insurers and third-party administrators through the Centralized Performance System (CPS) to ensure the accuracy and timeliness of workers' compensation benefit payments to injured workers. Evaluated and assessed insurer performance for timeliness of initial indemnity benefit payments to injured workers and medical bill payments to providers, in addition to timely filing of First Reports of Injury or Illness and medical bills.

- Reviewed data from 62,178 First Reports of Injury or Illness and assessed penalties in the amount of $1,720,441 due to late payments and $1,971,500 due to late filings.

- Reviewed more than four million medical bills for compliance with timely payment and filing requirements. Assessed penalties in the amount of $456,650 due to late payments and $2,225,615 due to late filings.

- Monitored and audited claim payments and claims-handling practices of workers' compensation insurers, self-insurers, self-insurance funds, and claims-handling entities. Verified the timeliness and accuracy of indemnity and medical payments, the filing of required Division forms, the mailing of required Division notices to injured workers and the accuracy of data electronically reported to the Division through on-site audits.

- Conducted 23 on-site audits, reviewed 3,201 claim files and reviewed 2,209 First Reports of Injury or Illness. Underpayments in the amount of $168,552 were identified and paid to injured workers and penalties and interest payable to injured workers were assessed in the amount of $116,850.

- Audited self-insured employer reporting and classification of payroll information to determine proper assessments for the Workers' Compensation Administration Trust Fund, the Special Disability Trust Fund, and Florida Self-Insurance Guaranty Association. The Self-Insurance Section conducted eight payroll audits and reviewed 21,000 payroll records of self-insured employers. The audits resulted in the identification of $5,448,557 in underreported payroll dollars and $658,853 in underreported premium dollars for assessment purposes.

- Ensured the accuracy and timeliness of permanent total benefit payments and permanent total supplemental benefit payments to injured workers. Worked collaboratively with SDTF to identify $1,136,665 in permanent total benefit underpayments, penalties and interest due to injured workers from the insurer.

The Bureau of Compliance

- Conducted 27,674 on-site investigations of employer worksites to determine employer compliance.
- Issued 2,518 Stop-Work Orders and assessed $48,547,961 in fines against non-compliant employers.
- Investigated 1,331 referrals alleging employer non-compliance.
- Adopted a new administrative rule to implement procedures to permit contractors to fulfill their requirements and obligations associated with obtaining evidence that subcontractors engaged by them possess workers' compensation insurance or that corporate officers of the subcontractors have been issued a Certificate of Election to Be Exempt by the Department.

All of the above activities and accomplishments also focus specifically on the Division of Workers' Compensation mission:

To actively ensure the self-execution of the workers' compensation system through educating and informing all stakeholders in the system of their rights and responsibilities, compiling and monitoring system data, and holding parties accountable for meeting their obligations.

Spotlight on ACCOUNTABILITY and ENFORCEMENT

The Role of the Bureau of Monitoring and Audit

The Bureau of Monitoring and Audit is responsible for ensuring that injured workers are appropriately compensated in accordance with Chapter 440, F.S. Greater insurer accountability and increased claims-handling standards were key components of the workers' compensation reform in 2003. This reform also provided the Bureau of Monitoring and Audit with a greater opportunity to ensure that workers' compensation system stakeholders meet their obligations under Chapter 440, F.S., and monitor the self-executing aspect of the workers' compensation system.

The Bureau's key challenges became to even more effectively monitor and audit the timely and accurate payment of benefits to injured workers, ensure the timely filing and payment of medical bills and the timely and accurate filing of required forms, ensure accurate payroll reporting for self-insured employers, and monitor the financial strength of self-insured employers and their ability to pay future and outstanding claims to injured workers. The Bureau assesses monetary penalties on, and requires corrective action plans from, insurers whose audit findings reveal significant statutory violations. The Bureau has also been very successful in its enforcement and education efforts, not the least of which is, evaluating millions of medical bills and indemnity payments for accuracy and timeliness.

To accomplish its responsibility for accountability and enforcement, the Bureau is organized into four major sections: Audit Section, Penalty Section, Permanent Total Section, and Self-Insurance Section.

Audit Section

The Audit Section conducts audits of regulated entities including insurers, self-insurers and claims-handling entities to identify:

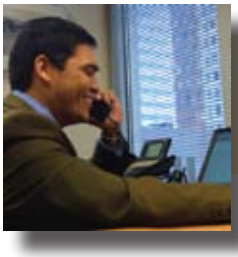
In 1981, a thirty-one year old employee of a trucking company was injured at work and severed tendons in his arm and hand. Once it was determined that the injured worker would not be able to return to work due to the loss of use of his arm and hand, permanent total and permanent total supplemental benefits were initiated. Years passed and benefits continued.

The injured worker's claim file was audited and it was determined that the insurer was paying $82.93 per week less than it should have paid. The auditor determined that the insurer had underpaid the injured worker from January 13, 1990 through September 28, 2007 by taking an incorrect social security offset. On March 14, 2008, the injured worker received $188,721.45 in underpayments, penalties and interest from the insurer.

1) inappropriate claims-handling practices, 2) patterns and practices of unreasonable delay in claims-handling, 3) untimely and inaccurate payment of benefits to injured workers, 4) untimely filing and payment of medical bills, 5) untimely and inaccurate filing of required reports, and 6) non-compliance with Orders of Judges of Compensation Claims. By performing these audits, the Bureau enforces the laws that govern the items noted above, identifies trends and practices in the industry that result in delays or failure to provide appropriate and timely benefits to injured workers and offers training and education to workers' compensation system stakeholders.

Since medical benefits make up over 60% of workers' compensation costs, the Audit Section is increasing the medical component of its audits by conducting a medical data review audit prior to the on-site audit. This pre-audit review consists of the examination of specific medical payment histories on claims provided by the insurer compared to the data reported

to the Division. This permits the Division to identify reporting errors and inaccuracies. In addition, the Audit Section has expanded its validation of the accuracy and filing of medical data with the Division. The Audit Section reviews and examines: 1) timeliness of the provision of medical authorizations, 2) accuracy in the payment of medical bills to health care providers, 3) insurer processes of returning incomplete medical bills, and 4) accuracy and compliance with administrative rule requirements for information contained in Explanation of Bill Review (EOBR) forms.



During FY 2007-2008, the Audit Section:

- Audited 3,201 insurer claim files and completed 23 on-site insurer audits. The insurer claim file contains all records, medical reports and benefit information relative to a particular injured worker's accident.

- Reviewed 25,988 indemnity payments for accuracy and timeliness and identified 325 claim files with underpayments totaling $285,402. The identification of these underpayments resulted in the additional payment of $168,552 in indemnity benefits and $116,850 in penalties and interest to injured workers.

- Verified that 94.36% of the required informational brochures and employee notification letters were mailed timely to injured workers pursuant to s. 440.185, F.S.

- Verified the accuracy and/or timeliness of 8,444 claim forms required to be filed with the Division.

- Reviewed 6,496 medical bills for filing and accuracy in data submitted to the Division.

- Assessed 19 penalties for pattern and practice violations to 13 insurers for failure to meet statutory claims-handling requirements in Chapter 440, F.S. The penalties are categorized as follows:

  Seven penalties for failure to report accurate medical data to the Division;

  Seven penalties for failure to timely file a Claim Cost Report Form (DWC-13) with the Division;

  Three penalties for failure to mail the Important Workers' Compensation Information for Florida's Workers (DWC-60) or the Informacion Importante De Seguro De Indemnizacion Por Accidentes De Trabajadores de la Florida (DWC-61) or the informational employee notification letter to injured workers;

  One penalty for failure to report accurate data on the First Report of Injury or Illness Form (DWC-1) filed with the Division; and

  One penalty for improper claims adjusting by the employer with the knowledge of the insurer.

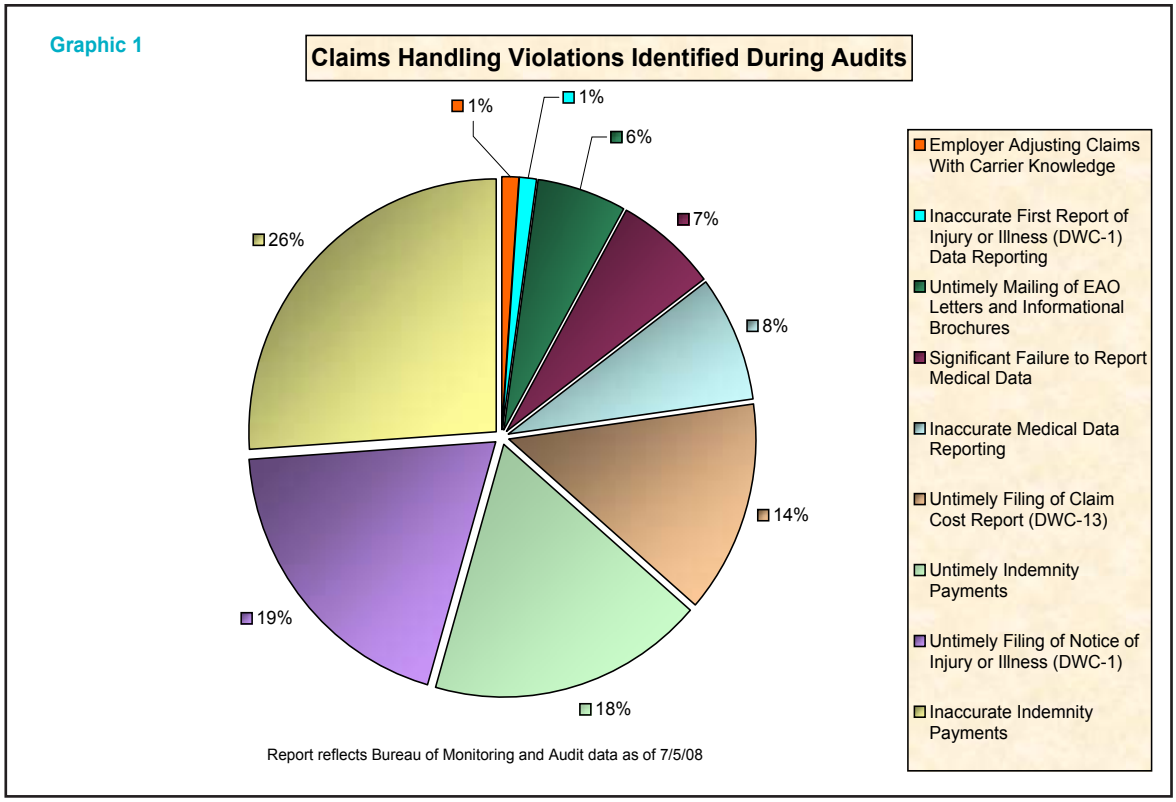
- Assessed $231,200 in penalties as follows:

  $139,000 for untimely indemnity payment performance that fell below the 95% required standard;

  $44,700 for untimely filing of the First Report of Injury or Illness Form (DWC-1); and

  $47,500 for 19 pattern and practice violations.

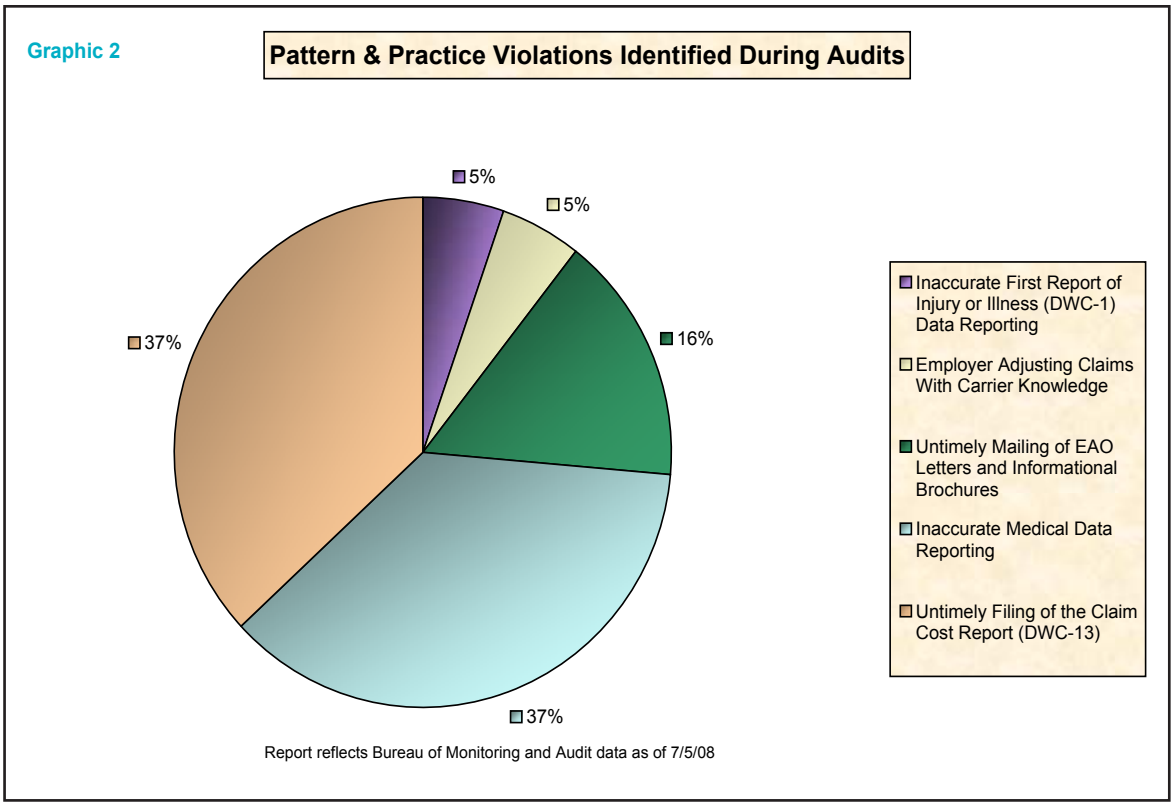
Graphic 1



Graphic 1 *above* illustrates the claims-handling violations found during on-site audits conducted during FY 2007-2008.

Graphic 2 *below* illustrates the distribution of pattern and practice violations identified during audits conducted during FY 2007-2008.

Graphic 2



Penalty Section

The Penalty Section is responsible for evaluating and assessing insurer performance regarding the timely payment of initial indemnity benefits and medical bills, and the timely filing of the First Report of Injury or Illness Form (DWC-1) and medical bills.

The Division has developed and implemented an interactive Internet-based system that allows insurers to access and respond to their performance information in real-time. The Centralized Performance System (CPS) provides essential performance information and industry trends that enable both the Division and insurers to monitor claim performance issues. The CPS system has two modules that monitor and evaluate an insurer's medical and indemnity performance.

The CPS system is the key component used to identify which insurers and claims-handling entities may require further monitoring. As a result of this additional monitoring, the Division may initiate an investigation or examination.

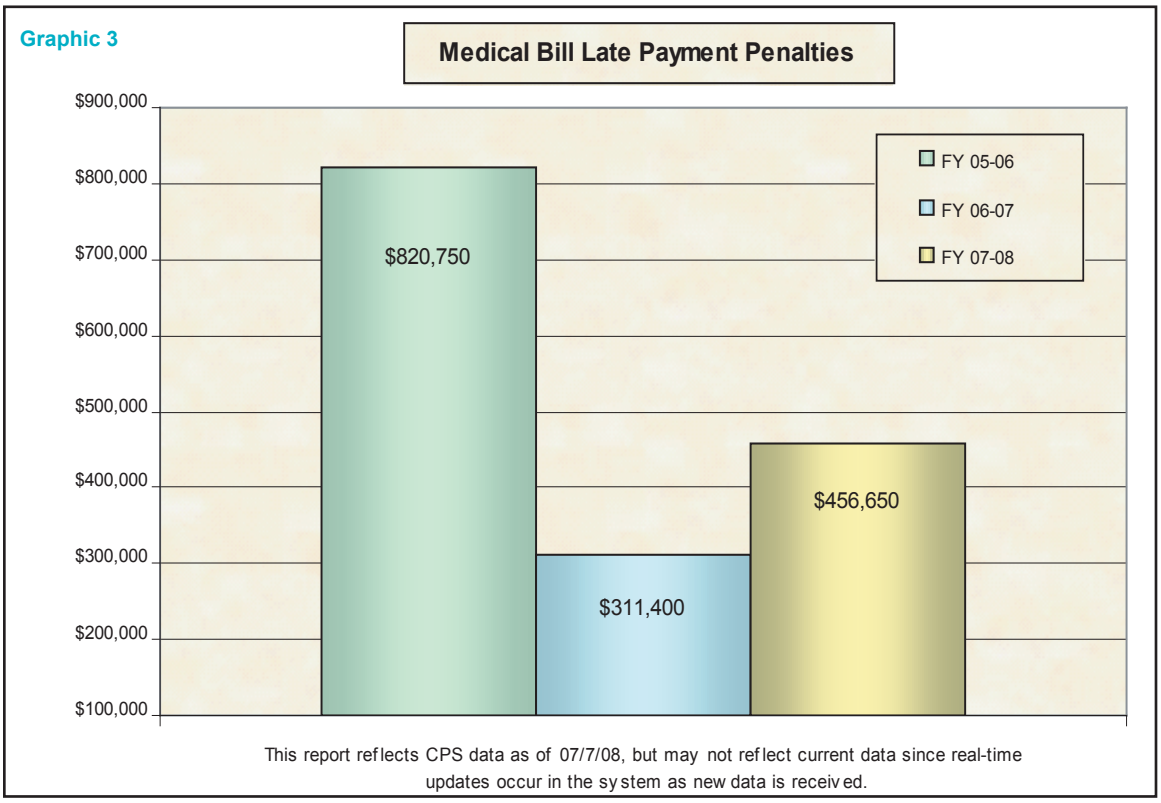
Prior to CPS, the Division manually reviewed medical bills to determine timeliness of payments by conducting on-site examinations of insurers. During FY 2003-2004, the Bureau of Monitoring and Audit reviewed 69,215 medical bills. The number of bill reviews under CPS increased dramatically to more than 3.7 million medical bills with the implementation of CPS during FY 2004-2005.

During FY 2007-2008, the Penalty Section:

- Evaluated 4,359,092 medical bills (received from approximately 900 insurers) for timely payment and filing. Insurers are required to disallow, deny or pay properly filed medical bills within 45 days of receipt of the bill. Insurer timely performance for medical bill payment was: 98.67% for Health Care Provider Claim Forms (DWC-9); 98.71% for Statements of Charges for Drugs and Medical Supplies Forms (DWC-10); 97.74% for Dental Claim Forms (DWC-11); and 97.88% for Hospital Billing Forms (DWC-90).

- Evaluated 62,178 First Report of Injury or Illness Forms (DWC-1) for timely filing and payment of compensation by both employers and insurers. Timely payment performance was 93.30%. Timely filing performance was 90.70%.

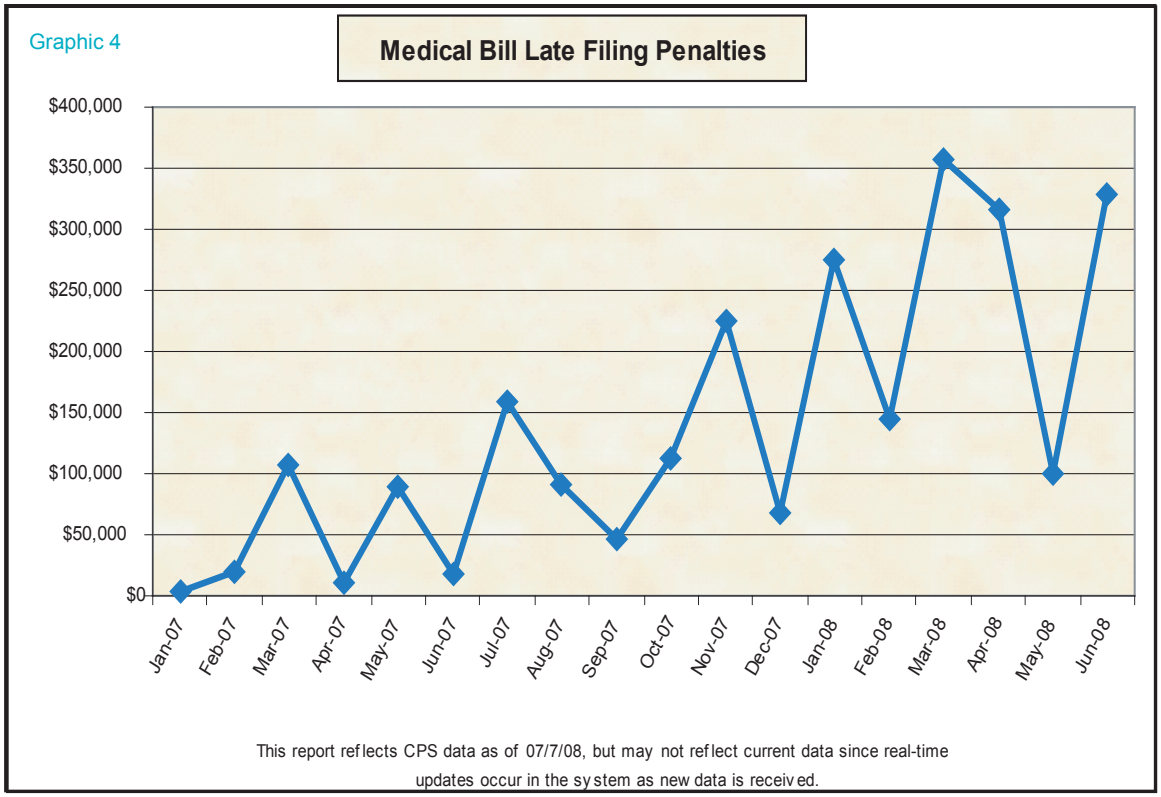
Graphic 3



Graphic 3 *above* illustrates the penalties assessed for late payment of medical bills for the past three fiscal years.

Graphic 4 *below* illustrates monthly medical bill filing penalties assessed during FY 2007-2008.

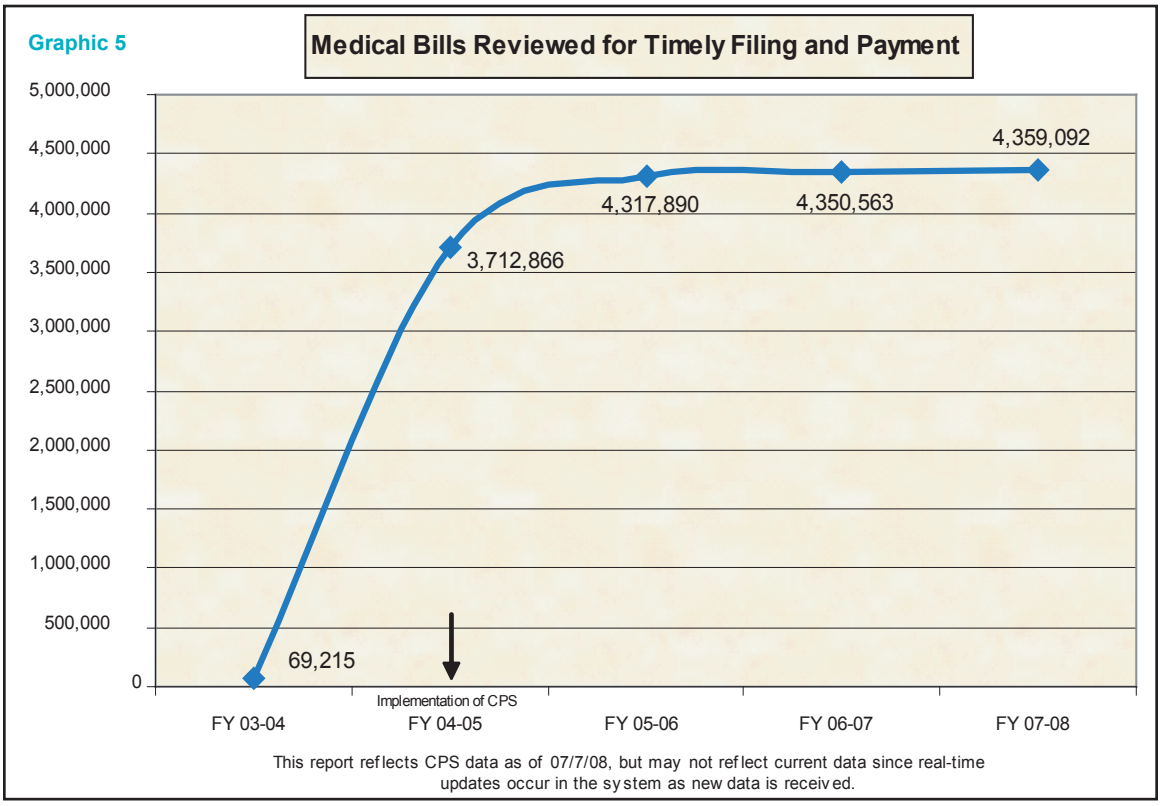
Graphic 4



In November 2004, the CPS medical module began electronically evaluating monthly performance for the timely filing and payment of medical bills in accordance with Rule 69L-7.602, F.A.C., and s. 440.20(6)(b), F.S. Medical bills must be paid, disallowed or denied within 45 calendar days of the date the bill is received. Medical bills must be filed with the Division within 45 calendar days of the date the bill is paid, disallowed or denied. Monthly bill payment information is reviewed and payment and filing performance penalties are assessed. The CPS system also tracks penalty payments, communication between the Division and regulated entities, and proof of payment by the insurers.

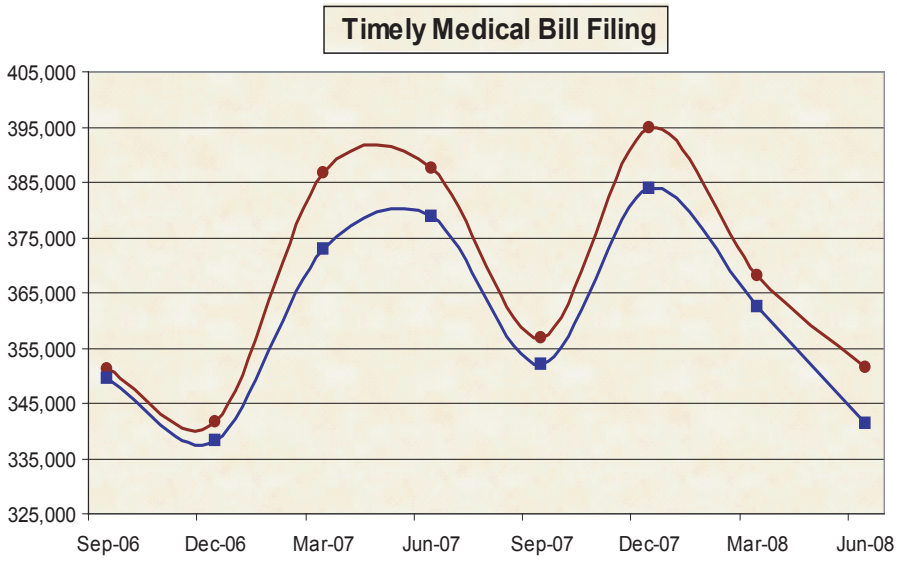
Graphic 5 *below* illustrates the increase in the volume of bills reviewed over time.

Graphic 5



Graphic 6 *below* compares the total number of medical bills filed to the total number of medical bills filed timely during the last two fiscal years.

Graphic 6

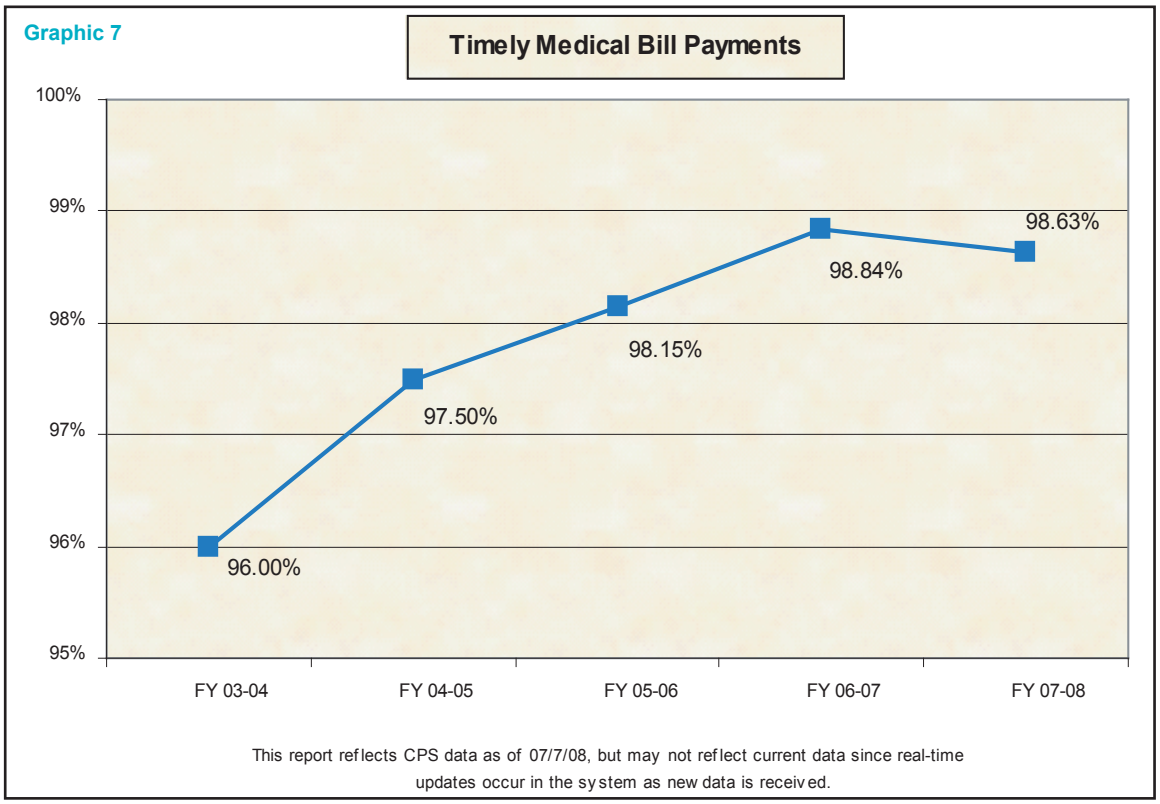


	Sep-06	Dec-06	Mar-07	Jun-07	Sep-07	Dec-07	Mar-08	Jun-08
Total Number of Bills Filed	351,072	341,684	386,671	387,673	356,913	394,990	367,965	351,427
Compliance Percentage	99.59%	99.01%	96.42%	97.73%	98.60%	97.17%	98.49%	97.14%
Total Number of Bills Filed Timely	349,645	338,317	372,841	378,860	351,908	383,814	362,412	341,363

This report reflects CPS data as of 07/7/08, but may not reflect current data since real-time updates occur in the system as new data is received.

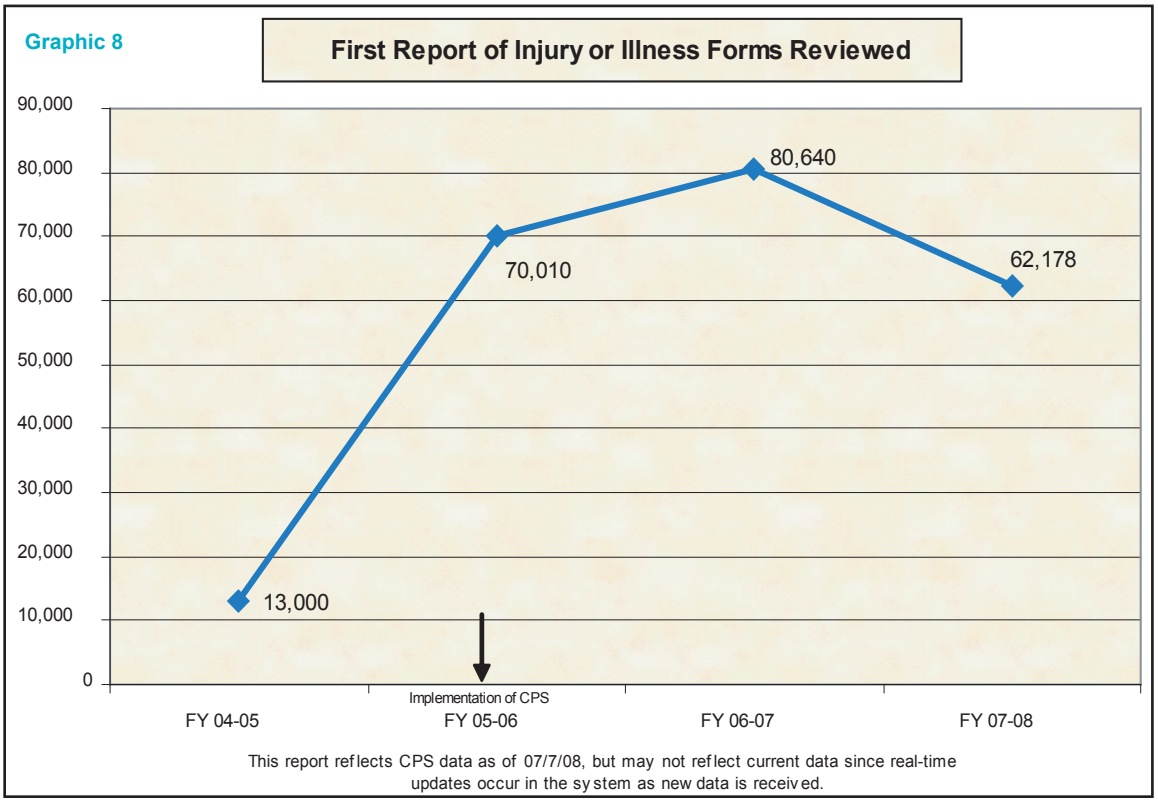
During FY 2003-2004 under the manual evaluation process, the performance for timely medical bill payment was 96%. However, this performance percentage was based on an evaluation of 69,215 medical bills. The implementation of CPS has allowed the Division to monitor 100% of industry performance for medical bill payments filed with the Division. This additional focus and access may have been the impetus for the increase in timely medical bill payment to more than 98% for each year since the implementation of the CPS System. Graphic 7 shows timely medical bill payment performance.

Graphic 7



The indemnity module of CPS was implemented during June 2005. This module allows the electronic evaluation of the First Report of Injury or Illness Forms (DWC-1) for timely filing and payment of the initial indemnity benefit. Prior to the implementation of this module, the Division was only able to manually review approximately 17% (13,000) of all filed DWC-1 forms. Subsequent to the implementation of this module, the Division began reviewing 100% of all DWC-1 forms submitted to the Division.

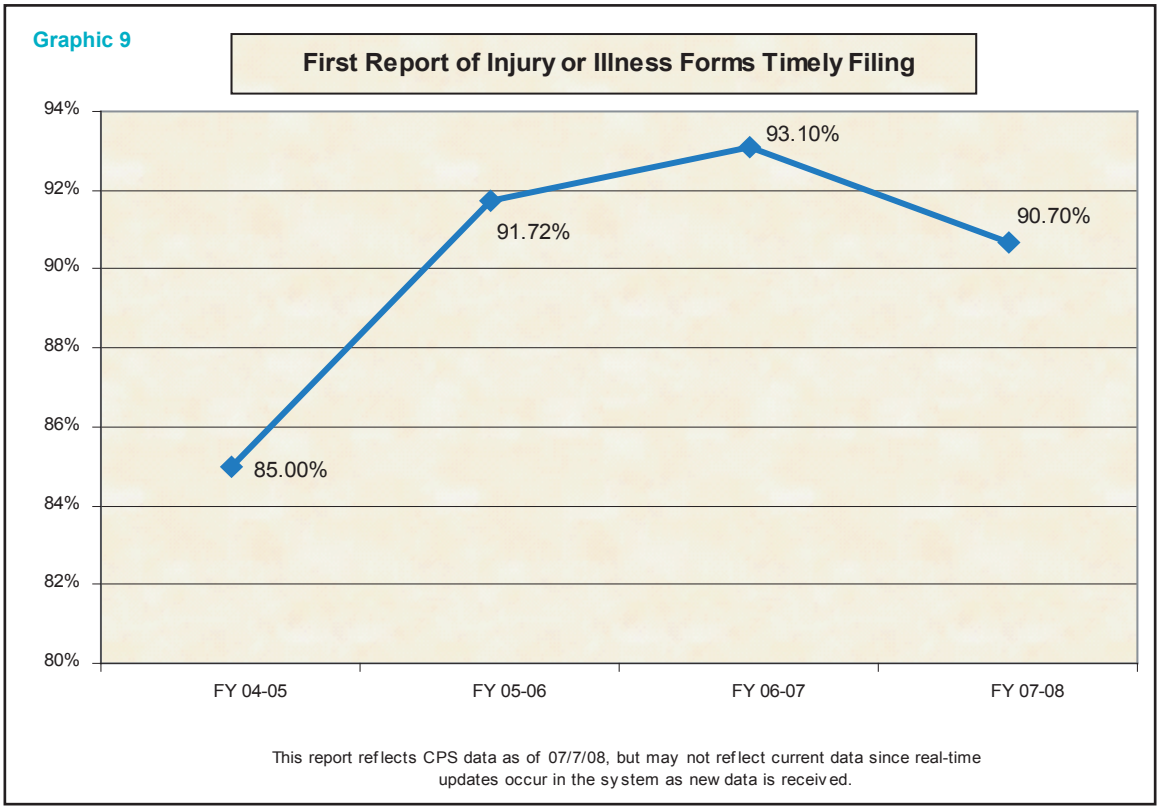
Graphic 8



Graphic 8 illustrates the changes in the volume of First Report of Injury or Illness Forms (DWC-1) reviewed.

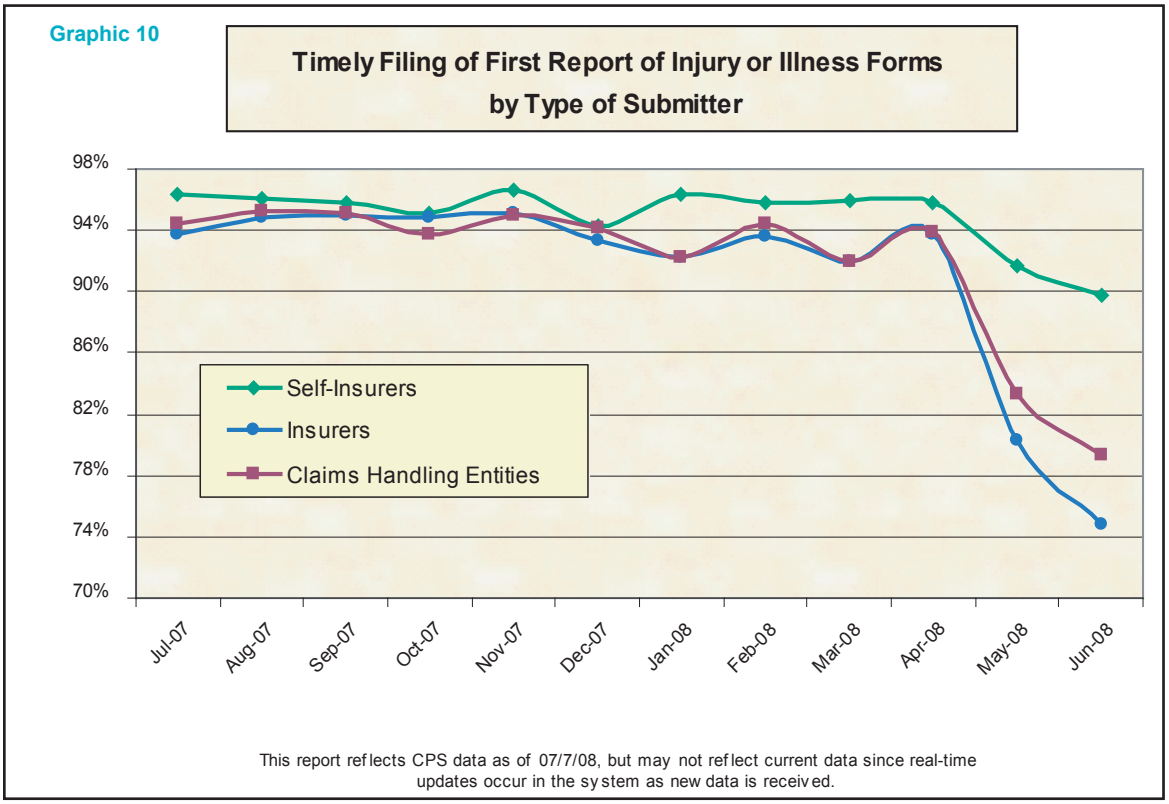
Timely filing of First Report of Injury or Illness Forms (DWC-1) increased from 85% of those reviewed in FY 2004-2005 to 91.72% during FY 2005-2006 and further increased to 93.10% during FY 2006-2007. The filings fell slightly in FY 2007-2008 to 90.70% as shown in Graphic 9 *below.* It is believed that the reduction in timely filings in FY 2007-2008 is due to the Non-Reported Claims Data Project undertaken by the Division in FY 2007-2008, which is discussed later in this report.

Graphic 9



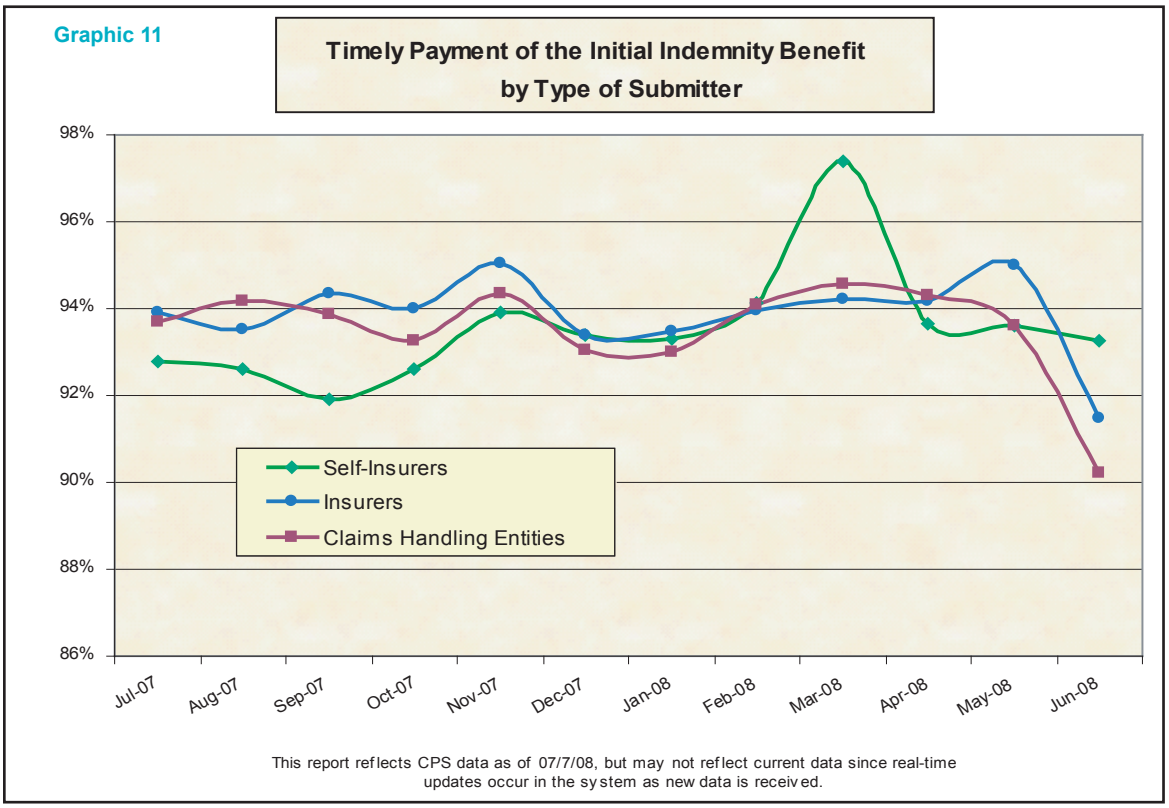
Graphics 10 and 11 *below* illustrate timely filing of First Report of Injury or Illness Forms (DWC-1) and initial payment of indemnity benefits among the top 20 self-insurers, insurers, and claims-handling entities for FY 2007-2008.

Graphic 10



This report reflects CPS data as of 07/7/08, but may not reflect current data since real-time updates occur in the system as new data is received.

Graphic 11

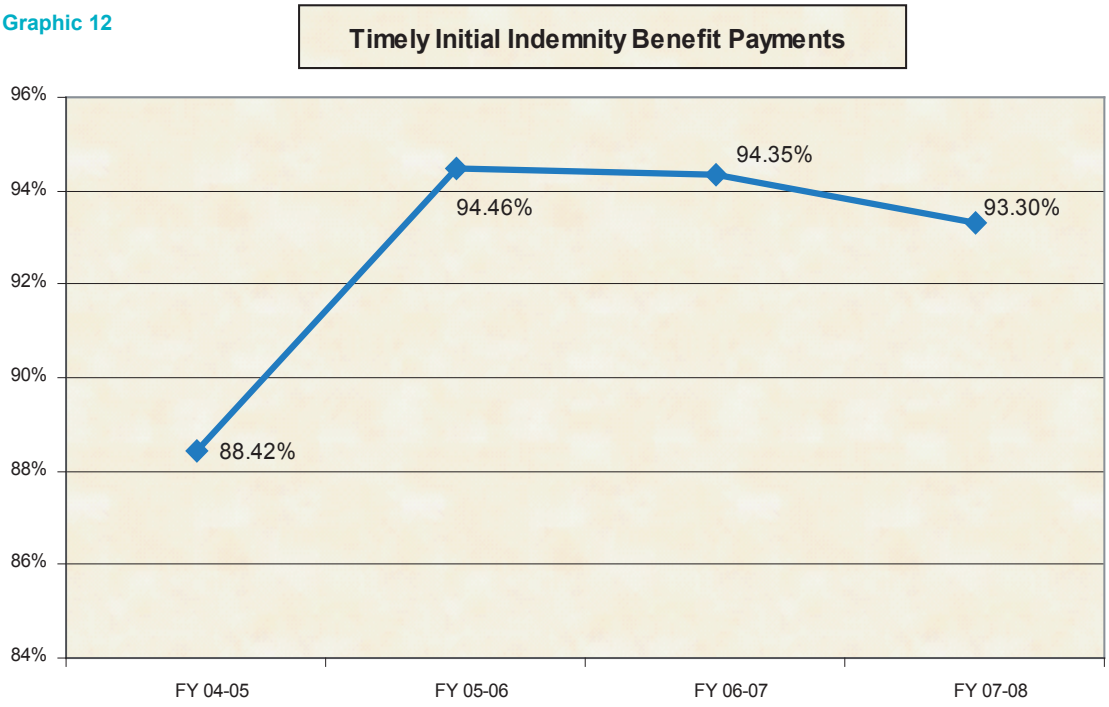


This report reflects CPS data as of 07/7/08, but may not reflect current data since real-time updates occur in the system as new data is received.

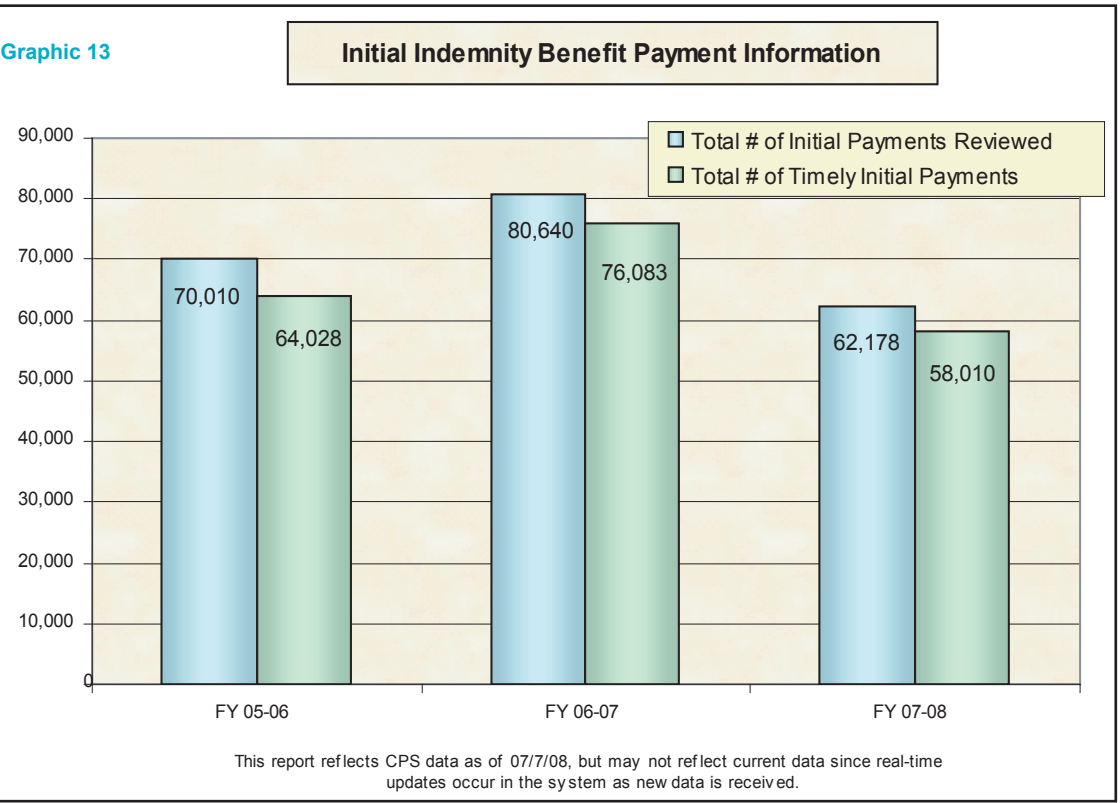
Insurer timely payment of initial indemnity benefits increased from 88.42% in FY 2004-2005 to 93.30% in FY 2007-2008. Graphic 12 *below* illustrates insurer performance for timely payment of initial indemnity benefits over time.

Graphic 13 *below* illustrates the number of initial indemnity payments reviewed and total number that were paid timely during the last three years.

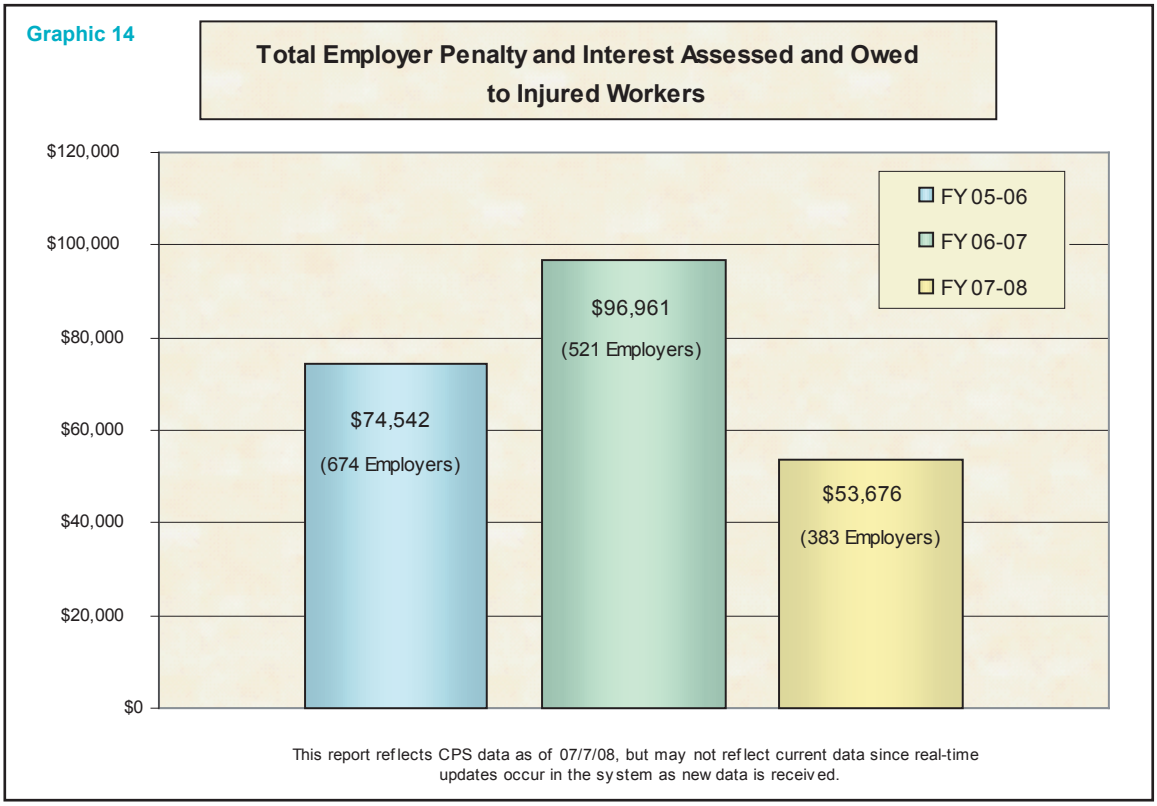
Graphic 12



Graphic 13



Graphic 14



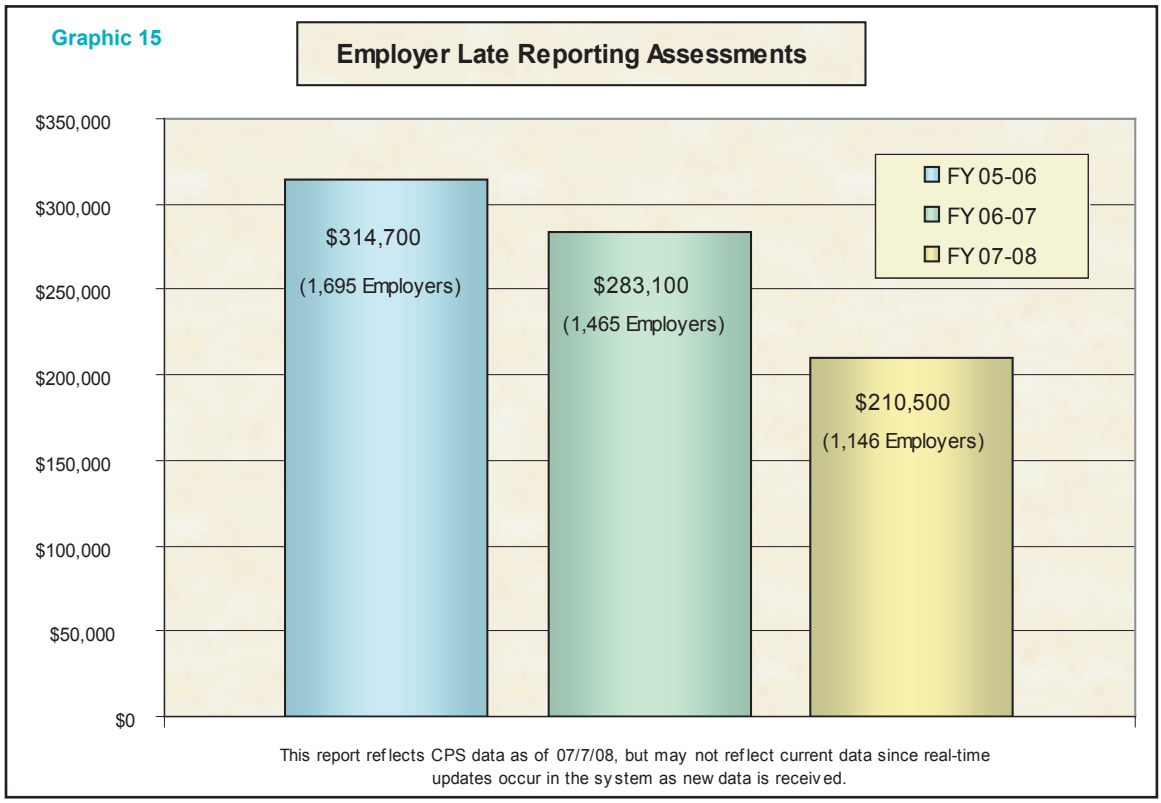
Through the CPS system, the Division is able to evaluate employer timely reporting of the First Report of Injury or Illness Form (DWC-1) and assess penalties and interest payable to injured workers and late reporting penalties payable to the Division. Graphic 14 *above* illustrates the employers' penalty and interest assessments payable to injured workers during the last three fiscal years for late initial indemnity benefit payments. These penalty assessments decreased significantly during FY 2007-2008. This trend may continue as employers become better educated and more knowledgeable about their obligations to injured workers and their stakeholder role in the workers' compensation system.

The indemnity module of the CPS System automatically reviews and evaluates the First Report of Injury Forms (DWC-1) for timely filing and payment of the initial indemnity benefit payment pursuant to Rules 69L-3.004(2)(a) and 69L-3.0045, F.A.C., and ss. 440.20(2)(a) and 440.20(6)(a), F.S. An employer must report an injury to the insurer within seven calendar days of knowledge of the injury. In turn, the insurer/claims-handling entity must report an accident to the Division either within 14 calendar days from the date the insurer/claims-handling entity had knowledge of the injury (for a straight lost-time claim), or within six calendar days from the insurer/claim-handling entity's knowledge of the eighth day of disability (for claims that begin as medical only and later become lost-time).

If insurers violate the statutory timely filing requirements regarding First Report of Injury or Illness Forms (DWC-1), administrative penalties are assessed. Utilizing CPS in FY 2005-2006, the Division began reviewing 100% of filed First Report of Injury or Illness Forms (DWC-1) which resulted in the assessment of administrative penalties totaling $1,693,800 in FY 2005-2006 and $1,971,500 in FY 2007-2008. The reason for the increase in late filing penalties during FY 2007-2008 may be due to the Non-Reported Claims Data Project undertaken by the Division in FY 2007-2008, which is discussed later in this report.

An insurer/claims-handling entity must either pay the first installment of indemnity benefits within 14 calendar days of the date first reported or within six calendar days from the eighth day of disability (for cases that begin as medical only and become lost-time claims) in order to avoid a penalty assessment of 20% of the benefits due, plus interest.

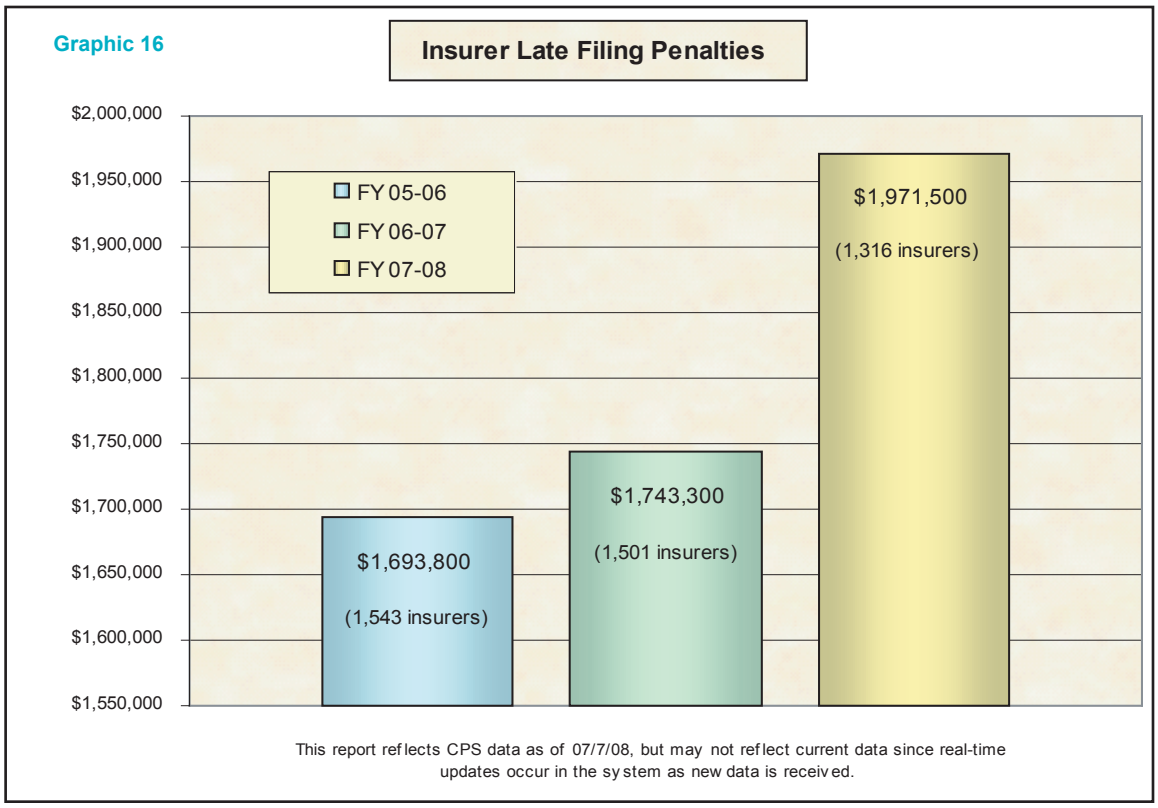
Graphic 15



Graphic 15 *above* illustrates penalties assessed against employers for late reporting of the injury to the insurer for the last three fiscal years.

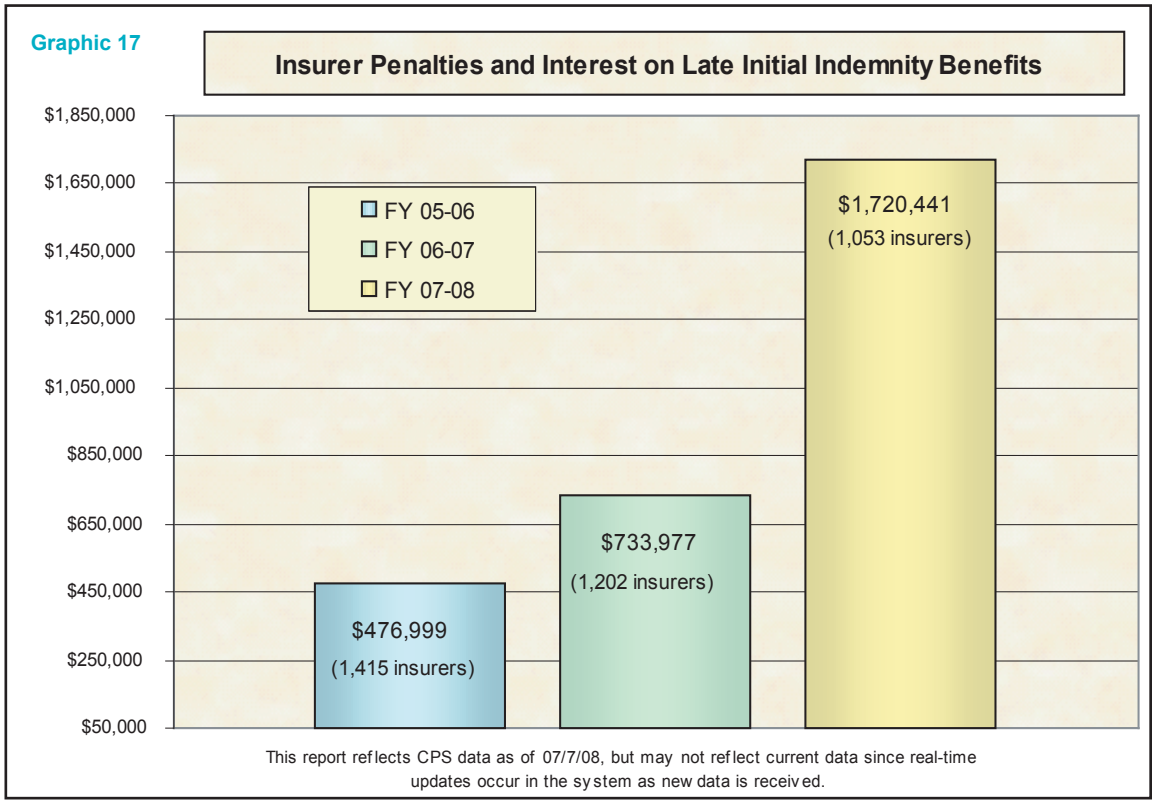
Graphic 16 *below* illustrates the total amount of penalties assessed and number of insurers assessed for late filing penalties payable to the Division during the last three fiscal years.

Graphic 16



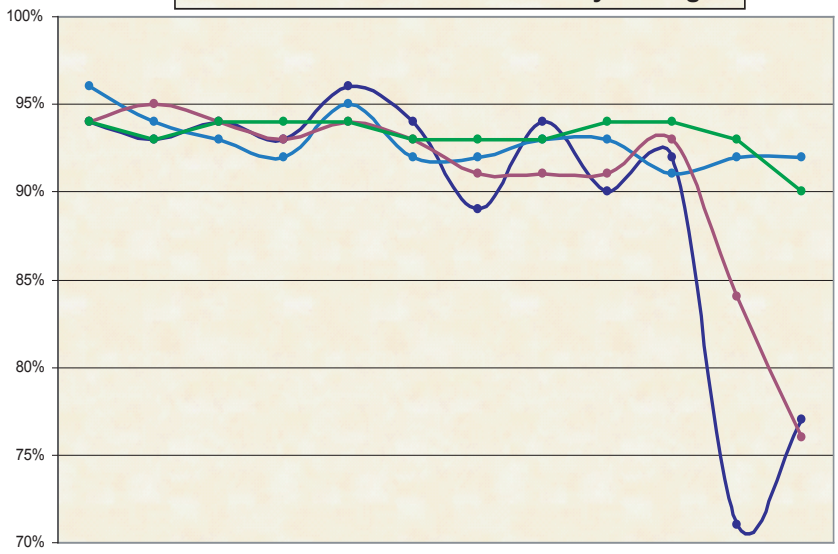
The review of the First Report of Injury or Illness Forms (DWC-1) for late initial payment of the indemnity benefits resulted in penalty and interest payments to injured workers of $476,999 for FY 2005-2006, which increased to $1,720,441 in FY 2007-2008. Graphic 17 *below* illustrates the penalties and interest assessed to insurers during the last three fiscal years.

Graphic 17



The CPS System enables the Division and insurer/claim-handling entities to monitor their performance on a monthly basis with regard to timely reporting of First Report of Injury or Illness Forms (DWC-1) and timely payment of all initial indemnity benefits to injured workers. The CPS system also permits insurers/claims-handling entities to compare their performance to the composite performance of others, as illustrated in Graphic 18. The significant decrease in timely filing of First Report of Injury or Illness Forms (DWC-1) during May and June 2008 is believed to be due to the Division's receipt of late filed DWC-1 forms requested as a result of increased scrutiny through the Non-Reported Claims Data Project discussed in detail later in this report.

Graphic 18



	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
XYZ Timely Filing of the DWC-1	94%	93%	94%	93%	96%	94%	89%	94%	90%	92%	71%	77%
XYZ Timely Initial Payment	96%	94%	93%	92%	95%	92%	92%	93%	93%	91%	92%	92%
Industry Timely Filing of the DWC-1	94%	95%	94%	93%	94%	93%	91%	91%	91%	93%	84%	76%
Industry Timely Initial Payment	94%	93%	94%	94%	94%	93%	93%	93%	94%	94%	93%	90%

This report reflects CPS data as of 7/7/08, but may not reflect current data since real-time updates occur in the system as new data is received.

Permanent Total Section

The Permanent Total (PT) Section is responsible for ensuring the accuracy and timeliness of permanent total benefit payments and permanent total supplemental benefit payments to injured workers pursuant to ss. 440.15(1)(a), 440.15(1)(f)1, 440.20, 440.525, F.S., and Rules 69L-3.0194 and 69L-3.0195, F.A.C. The PT Section ensures the accuracy and timeliness of payments to the injured worker by auditing the claims data submitted by insurers on Division required forms.

In accordance with s. 440.15(1)(f)(1), F.S., the Division is responsible for permanent total supplemental benefit payments to permanently and totally disabled workers who were injured prior to July 1, 1984. During FY 2007-2008, the PT Section approved and processed permanent total supplemental benefit payments on 1,870 permanent total claims totaling $20,275,368. The PT Section also monitors all claims eligible for supplemental benefits to ensure payments are suspended, reduced or cancelled based on statutory amendments, case law or changes in the status of the claim and determines the correct amount of the social security offset, supplemental benefits, and permanent total benefits.

While auditing a Reimbursement Request, SDTF staff discovered that an injured fireman who had fallen in August of 1982 and injured his back was being paid an incorrect weekly compensation rate of $75.18. The SDTF staff referred this claim to the PT Section who conducted an audit of the claim data and confirmed the insurer's error. The insurer had incorrectly deducted the social security offset after this permanently and totally disabled worker reached the age of 62 in October of 1991. Staff contacted the insurer regarding the underpayment and a check in the amount of $141,492 for underpayment, penalties and interest was paid by the insurer to the injured worker on July 31, 2007.

In an effort to help resolve disputes between injured workers and insurers, the PT Section participates in hearings, depositions, and mediations. Additionally, the PT Section staff is responsible for performing desk-audits and on-site field audits of insurers and self-insurers. When a request for assistance or a Petition for Benefits is received, the PT Section staff review the claim file documentation to determine the appropriate benefits and payment amounts that may be due and owing the injured worker.

The PT Section is also responsible for verifying that permanent total supplemental benefits are paid only to injured workers who are legally eligible for those benefits. This verification is accomplished using many resources, including: the in-state death list provided by the Department of Health, Bureau of Vital Statistics; the out-of-state death list provided by a private vendor; the Department of Corrections inmate records; the Judges of Compensation claims data; and Employee Earning Report Forms (DWC-19).

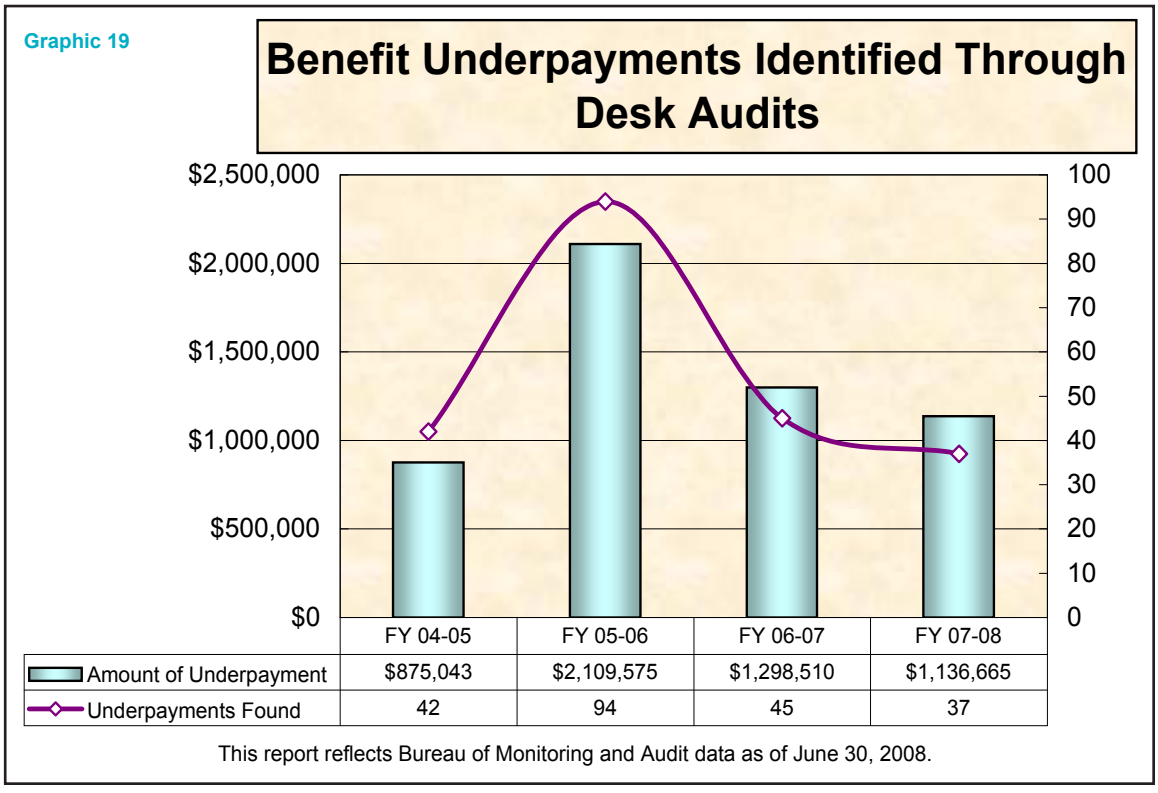
The PT Section and SDTF work collaboratively to ensure that permanently and totally disabled workers receive the appropriate amount of benefit payments. When SDTF staff note payment discrepancies while processing Reimbursement Requests, they refer those discrepancies to the PT Section for audit and analysis and resolution of any underpayments.

During FY 2007-2008 the Permanent Total Section:

- Audited more than 19,000 claim documents filed with the Division to determine if permanent total and permanent total supplemental benefits were paid correctly;
- Determined that permanently totally disabled workers had been underpaid and were due an additional $1,136,665 in underpayments, penalties and interest;
- Determined and authorized payment of $20,275,368 on 1,870 claims eligible for PT supplemental benefits.

Graphic 19 *below* illustrates the permanent total benefit underpayments identified during the last four fiscal years. The total amount of underpayments includes penalties and interest which are paid directly to injured workers. During FY 2007-2008, audits identified 37 claims with underpayments of more than $1.1 million.

Graphic 19

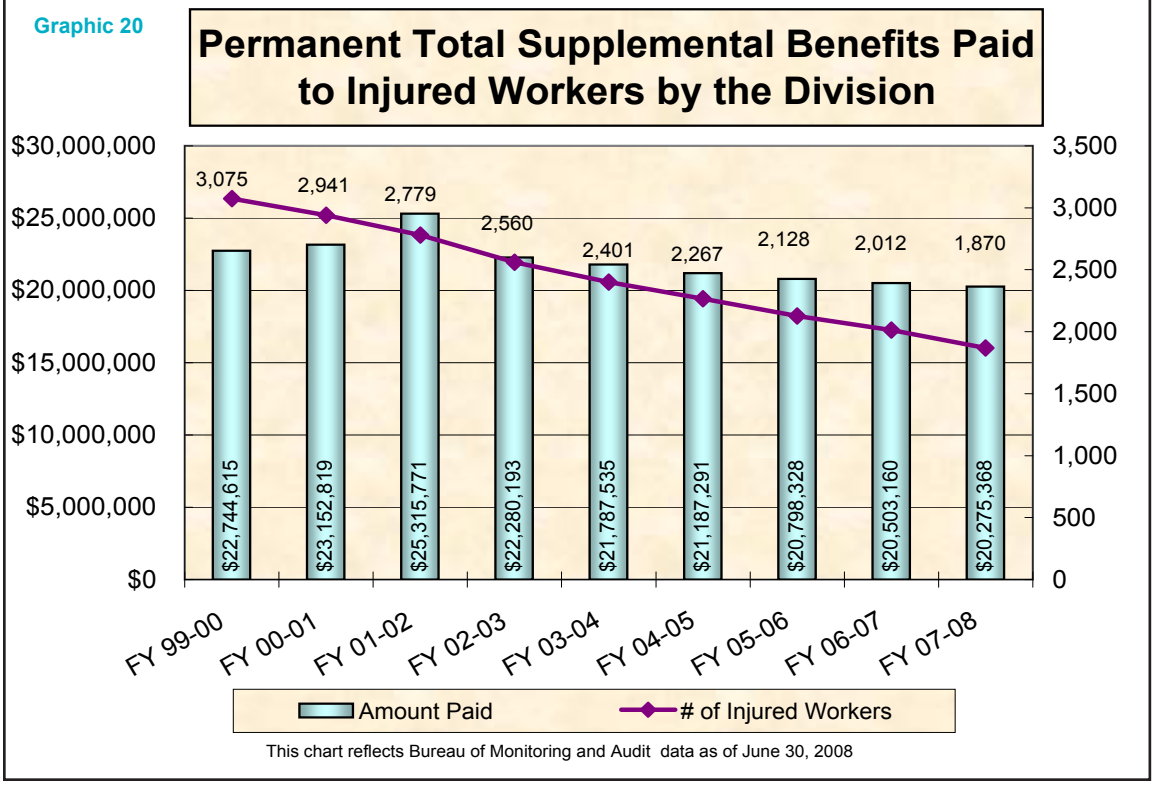


	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Amount of Underpayment	$875,043	$2,109,575	$1,298,510	$1,136,665
Underpayments Found	42	94	45	37

This report reflects Bureau of Monitoring and Audit data as of June 30, 2008.

Graphic 20 *below* illustrates the decrease over time in Division paid PT supplemental benefits. Insurers became responsible for the payment of permanent total supplemental benefits for all dates of accident after July 1, 1984. The number of claims for which payments are made by the Division are decreasing at a rate of approximately 135 claims annually due to claimant deaths, settlements and other factors.

Graphic 20



This chart reflects Bureau of Monitoring and Audit data as of June 30, 2008

Self-Insurance Section

The Self-Insurance Section is responsible for approving the self-insurance programs of non-governmental entities, governmental entities and public utilities that have been authorized by the Division to fund their workers' compensation liabilities under s. 440.38, F.S.

The staff monitors and analyzes the financial stability of individual self-insurers to ensure they have the financial strength and ability to pay their current and future workers' compensation liabilities. This Section works cooperatively with the Florida Self-Insurers Guaranty Association to grant self-insurance privileges and adjust security deposits when appropriate, and reviews Division required forms regarding payroll information, loss data, outstanding liabilities and financial information.

The Self-Insurance Section approves the applications of service companies that wish to provide adjusting, safety and rehabilitation services on behalf of self-insurers. This Section also audits reporting and classification of payroll information for self-insurers so that the proper assessments can be determined for the Workers' Compensation Administration Trust Fund, the Special Disability Trust Fund, and by the Florida Self-Insurers Guaranty Association, Inc.

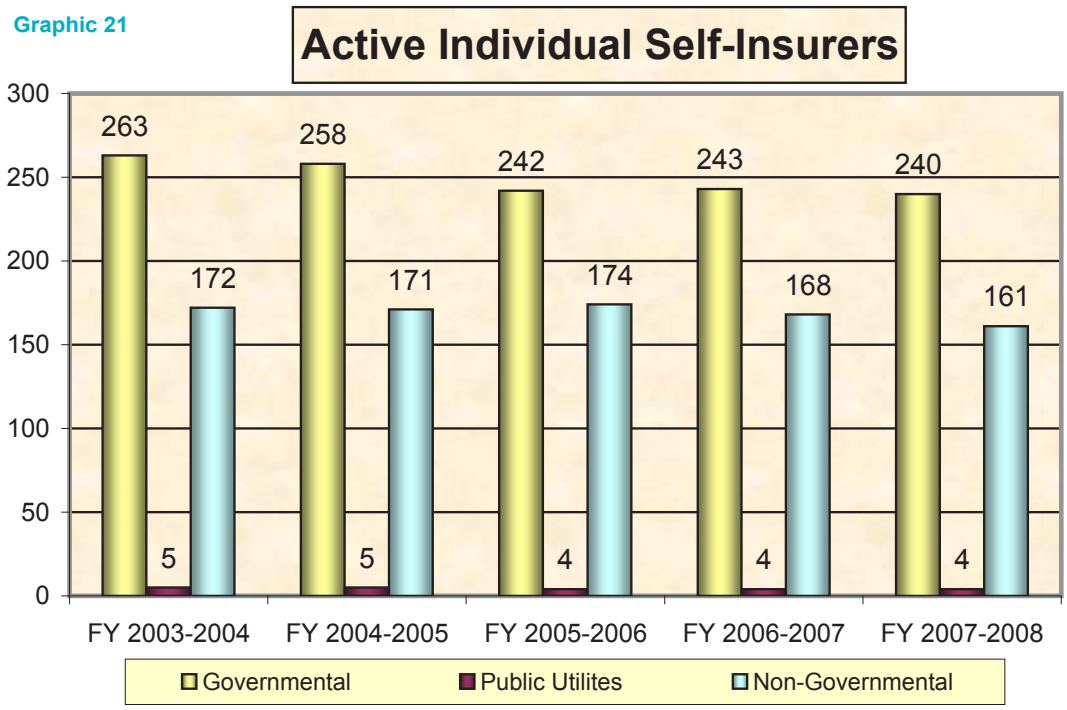
In addition to the above, loss experience and payroll data are collected by the Division from all self-insurers in order to promulgate experience modification factors. The experience modification factors are used to calculate each self-insurer's assessment which must be paid to the Special Disability Trust Fund and the Workers' Compensation Administration Trust Fund.

During FY 2007-2008, the Self-Insurance Section:

- Promulgated 404 experience modifications for active self-insurers;
- Re-certified 68 service companies to continue providing claims adjusting services to self-insurers in the State of Florida; and
- Audited 21,000 payroll records which resulted in the reporting of an additional $5,448,557 in payroll dollars and an additional $658,853 in premium dollars which are used to calculate self-insurers' assessments for the Workers' Compensation Administration Trust Fund and the Special Disability Trust Fund.

Graphic 21 *below* illustrates the changes in the number of active self-insurers from FY 2003-2004 through FY 2007-2008.

Graphic 21



This chart reflects Bureau of Monitoring and Audit data as of June 30, 2008.

The Bureau of Monitoring and Audit continues to evaluate new methodologies for auditing the performance of employers and insurers. The Bureau also continuously educates system participants on the workers' compensation system and their responsibilities. As the Bureau holds stakeholders more accountable for adhering to their statutory obligations, injured workers receive their benefits in a more accurate and timely manner.

Bureau of Compliance

The Bureau of Compliance is responsible for ensuring that employers comply with Chapter 440, F.S., requirements to obtain appropriate workers' compensation insurance coverage for their employees. Ensuring that employers purchase workers' compensation insurance levels the economic playing field for all employers, adds premium dollars to the system that were previously evaded due to non-compliance, provides coverage for employees that were previously without coverage due to non-compliance and ensures that covered employees with work-related injuries receive all statutorily required benefits.

The Bureau accomplishes its mission through:

- Enforcement investigations,
- Management of the exemption process, and
- Education of employers.

The Bureau conducts on-site investigations of worksites to determine employer compliance and issues Stop-Work Orders and assesses penalties against employers found not to be in compliance. The Bureau also reviews applications from individuals seeking to utilize the exemption provisions of the Workers' Compensation Law and issues exemptions to those who qualify. The Bureau participates in employer conferences and workshops to educate employers about workers' compensation coverage requirements.

New Initiatives during FY 2007-2008

Online Penalty Payment Service

The Division implemented an Online Penalty Payment Service for employers that have been issued a Stop-Work Order or Order of Penalty Assessment. This service is free to employers and allows them to use an Internet based system to pay their penalty payment in full or submit monthly periodic payments that are required in their Periodic Payment Agreement. The Penalty Payment Service is convenient, simple to set up and easy to use. The Online Penalty Payment Service can be accessed from the Division's home page at www.myfloridacfo.com/WC/. In addition, the Division created an Employer Instructional Manual, which contains general information about the Online Penalty Payment Service and step-by-step instructions on how to set up an online payment account. The Instructional Manual is provided to employers that have been issued a Stop-Work Order or Order of Penalty Assessment. In addition, employers can view and download the Instructional Manual from the Division's Internet homepage. As of June 2008, 21% of penalty payments received were paid using the online payment system.

Employer Education Outreach Campaign

In an effort to expand its emphasis on educating employers, employees and stakeholders about Florida's workers' compensation coverage requirements, the Bureau modified and enhanced its Education Outreach Campaign. The Education Outreach Campaign focuses on helping employers understand their statutory obligations under the Workers' Compensation Law. Fifteen investigative staff members, including district supervisors, obtained licensure to teach continuing education courses about coverage and compliance requirements to construction contractors licensed through the Department of Business and Professional Regulation. As of June 2008, 978 licensed contractors had attended continuing education courses taught by the Division. General education workshops will begin in October 2008 and will be held quarterly in 11 cities throughout the state.

The Education Outreach Campaign includes the development of revised employer and employee informational brochures that can be used as a continuing reference on a variety of workers' compensation issues. Exemption Renewal Notices are mailed to current exemption holders at least 60 days prior to the expiration date of their Certificate of Election to be Exempt and now include an information page containing general workers' compensation information

and exemption eligibility requirements. The information page sent out with Exemption Renewal Notices educates exemption holders on coverage requirements and provides current information related to the submission and issuance of exemptions. Workers' compensation information links will be placed on the websites of state agencies, employer trade associations and construction industry-related organizations to develop an effective partnership with regulatory agencies and the business community to further ensure compliance with the Workers' Compensation Law.

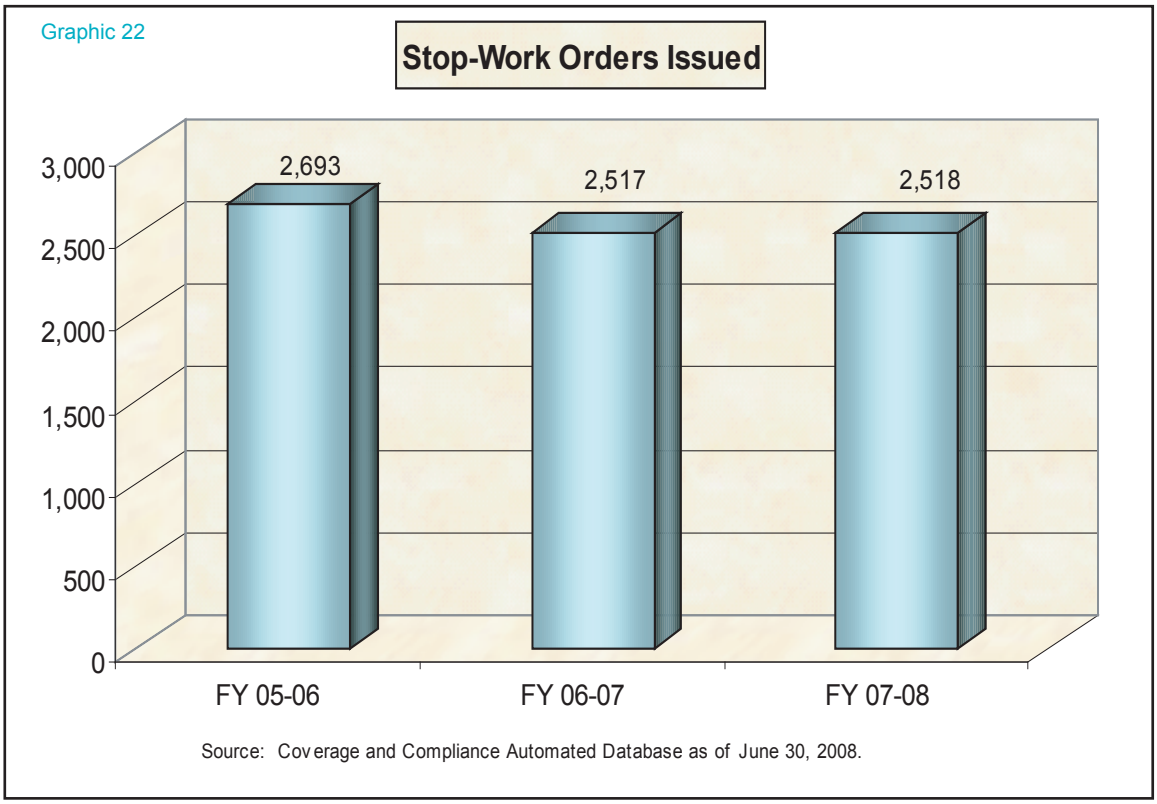
Penalty Calculation Administration Program

The Bureau developed and implemented a Penalty Calculation Administration Program staffed with 14 Penalty Calculator positions. Penalty Calculators are responsible for reviewing and analyzing employer business records and calculating statutory penalties for non-compliance violations. The Penalty Calculators attended a four-day training course that provided a comprehensive review of the investigative and enforcement processes. The training focused on reviewing and analyzing employer business and payroll records and the process of calculating penalties. The Penalty Calculation Administration Program streamlines the calculation of an accurate and complete employer payroll and provides internal controls to ensure that no one individual can control the calculation of penalties, the receiving of penalty payments, the manual input of penalty payment information, and the logging and transmitting of payments.

Through its enforcement and investigative efforts in FY 2007-2008, the Bureau:

- Issued 2,518 Stop-Work Orders as illustrated by Graphic 22 *below.* Stop-Work Orders are issued based upon a determination that an employer has failed to comply with the coverage requirements of Chapter 440, F.S. Stop-Work Orders require the employer to cease business operations until the Division issues an Order Releasing the Stop-Work Order.

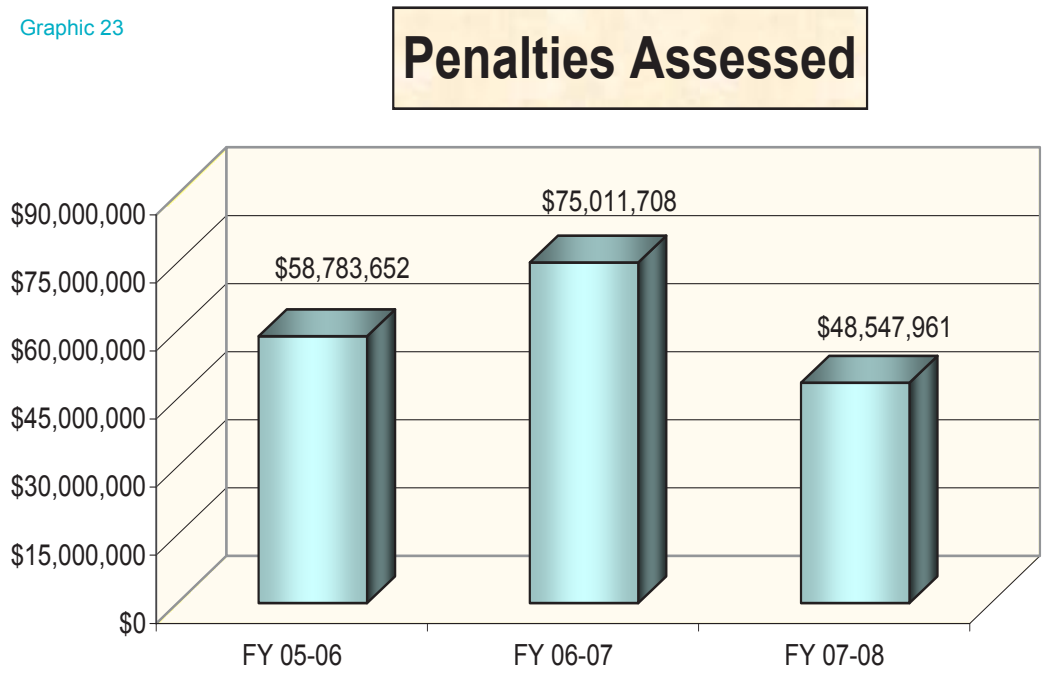
Graphic 22



Source: Coverage and Compliance Automated Database as of June 30, 2008.

- Assessed $48,547,961 in penalties, as illustrated by Graphic 23 *below*. Assessed penalties are equal to 1.5 times what the employer would have paid in workers' compensation insurance premiums for all periods of non-compliance during the preceding three-year period or $1,000, whichever is greater. Shorter periods of non-compliance, smaller numbers of employees not covered by workers' compensation insurance and smaller amounts of gross payroll paid by employers may have contributed to the decrease in assessed penalties during FY 2007-2008.

Graphic 23

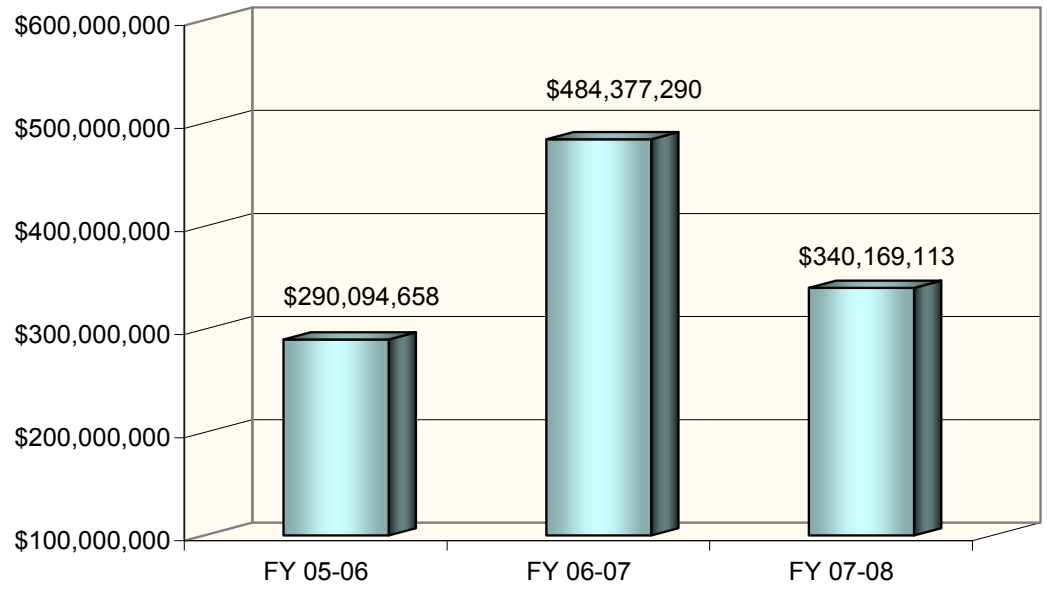


Source: Coverage and Compliance Automated Database as of June 30, 2008.

- Identified $340,169,113 in unreported Total Gross Payroll (used in penalty calculations), as illustrated in Graphic 24. Gross Payroll represents the actual payroll that the employer paid during all periods of non-compliance during the preceding three-year period. The gross payroll is used to calculate penalties pursuant to s. 440. 107(d)(1) F.S. The decrease in payroll parallels the decrease in assessed penalties.

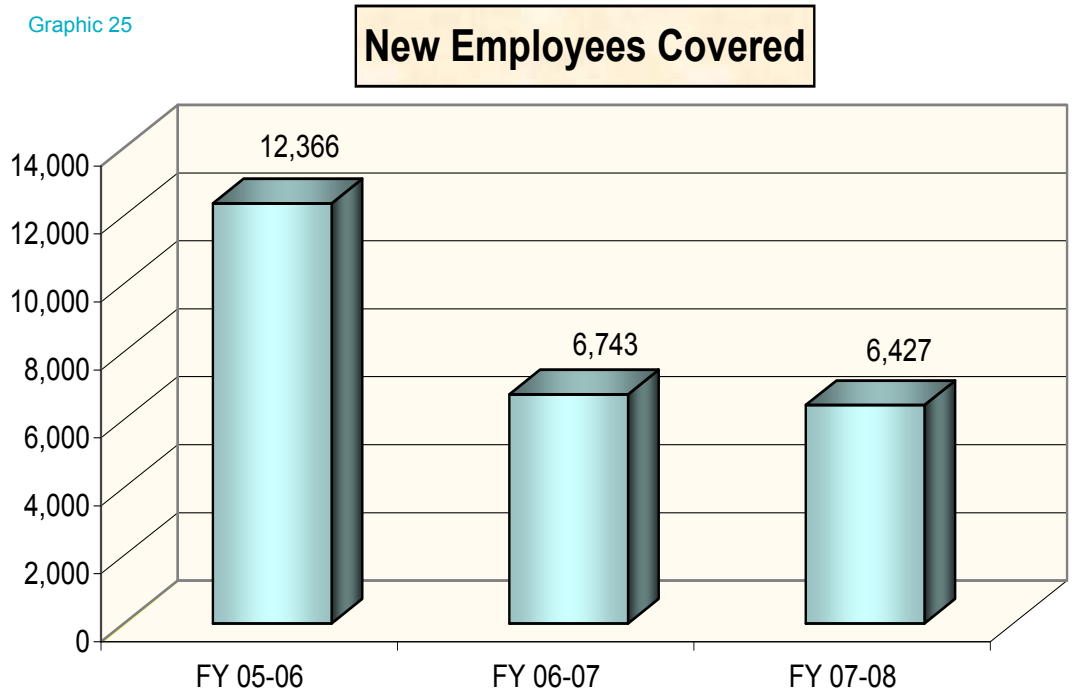
- Caused 6,427 new employees to be covered under the Workers' Compensation Law. The decrease in the number of new employees covered illustrated in Graphic 25 may be a result of an increase in the number of employees covered by workers' compensation insurance. Stricter statutory guidelines and penalties may have provided the impetus for additional employers to obtain the required coverage.

Graphic 24



Source: Coverage and Compliance Automated Database as of June 30, 2008.

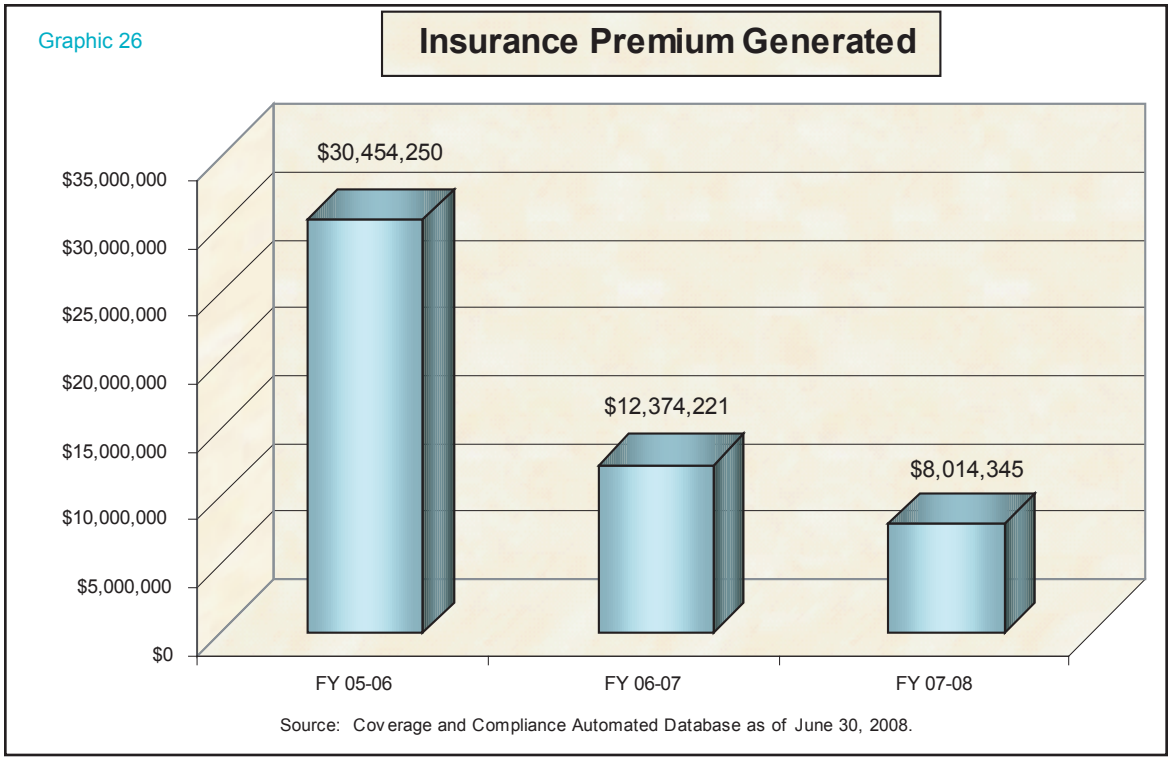
Graphic 25



Source: Coverage and Compliance Automated Database as of June 30, 2008.

- Caused $8,014,345 to be added to the premium base that had been previously evaded as shown in Graphic 26. During the last five years, workers' compensation rates have decreased on average by 51%. This rate reduction also resulted in a corresponding reduction in workers' compensation insurance premiums.

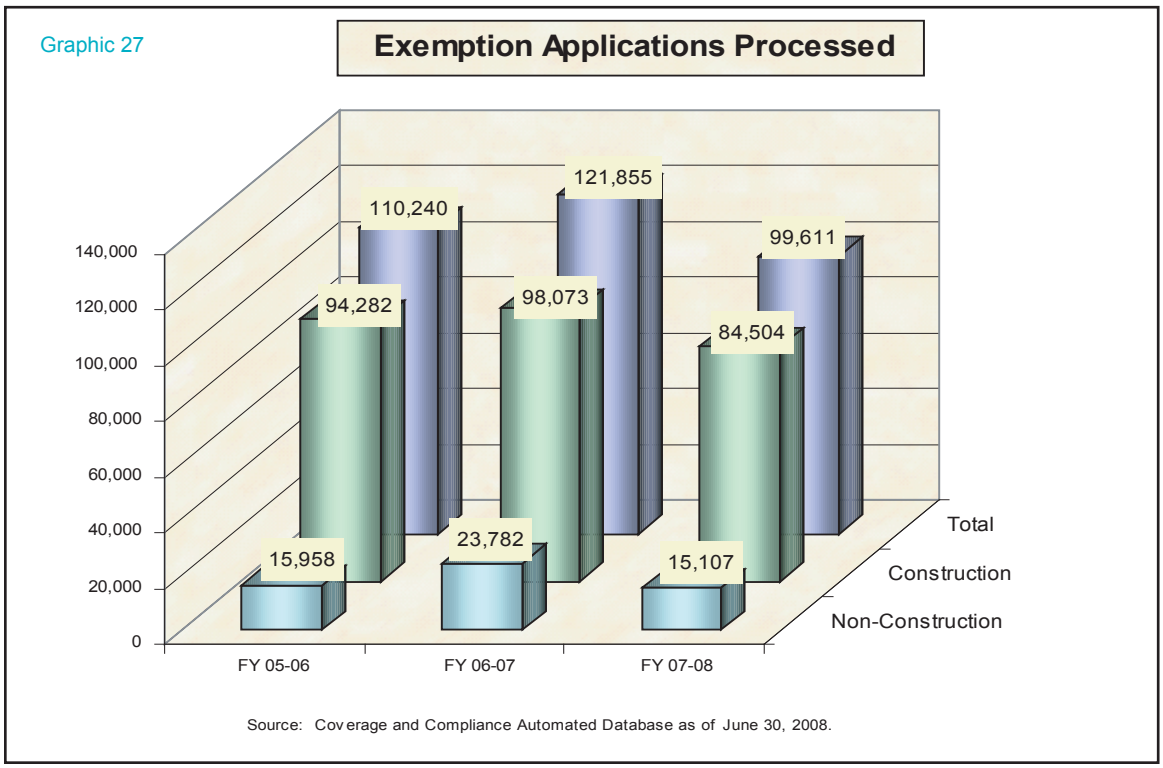
Graphic 26



Source: Coverage and Compliance Automated Database as of June 30, 2008.

- Processed 84,504 construction industry exemption applications and 15,107 non-construction industry applications, as illustrated by Graphic 27 *below*.

Graphic 27

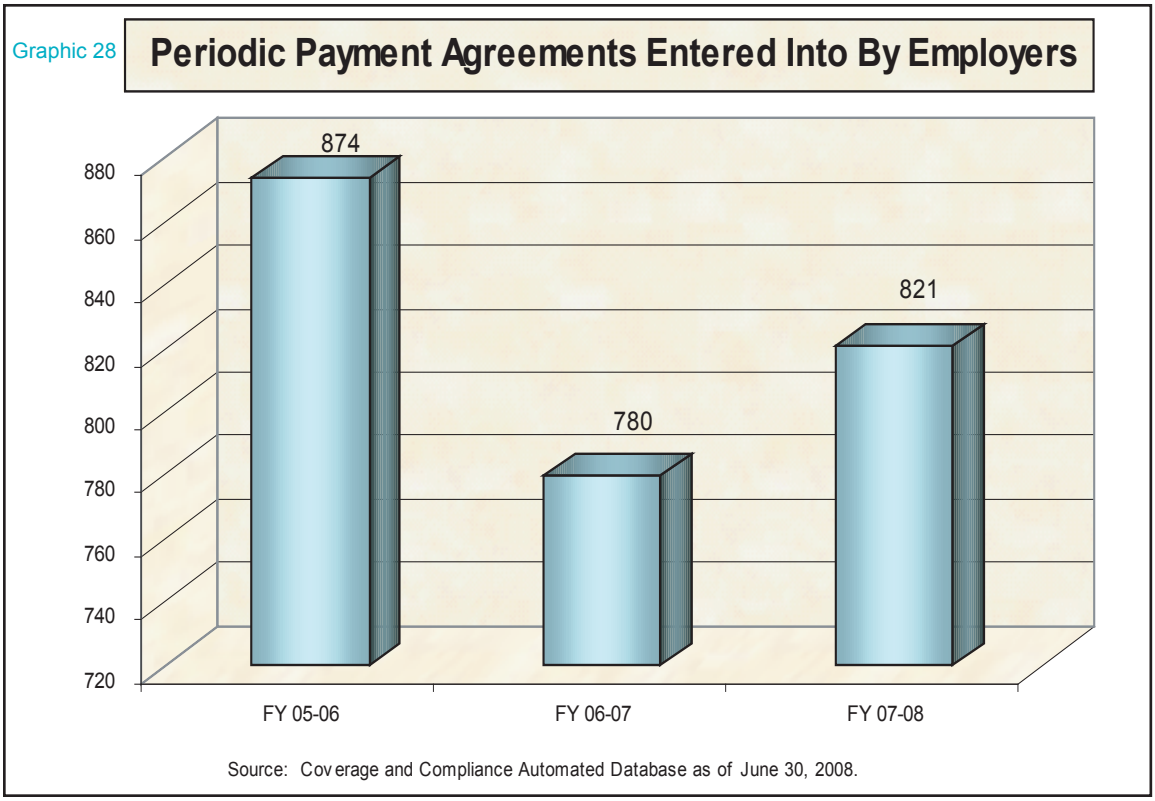


Source: Coverage and Compliance Automated Database as of June 30, 2008.

Effective July 1, 2004, s. 440.107(7)(a), F.S., was amended to authorize the Division of Workers' Compensation to conditionally release an employer from a Stop-Work Order upon a finding that the employer has complied with the coverage requirements of Chapter 440, F.S., and has agreed to remit periodic payments of the penalty pursuant to a payment agreement schedule. An employer is required to make an initial down payment that equals at least 10% of

the total assessed penalty or $1,000, whichever is greater. Pursuant to Rule 69L-6.025, F.A.C., an employer may elect to make 12, 24, 36, 48, or 60 equal monthly payments to pay the remaining penalty. The number of periodic payment agreements entered into by an employer that has been conditionally released from a Stop-Work Order is illustrated in Graphic 28 *below*.

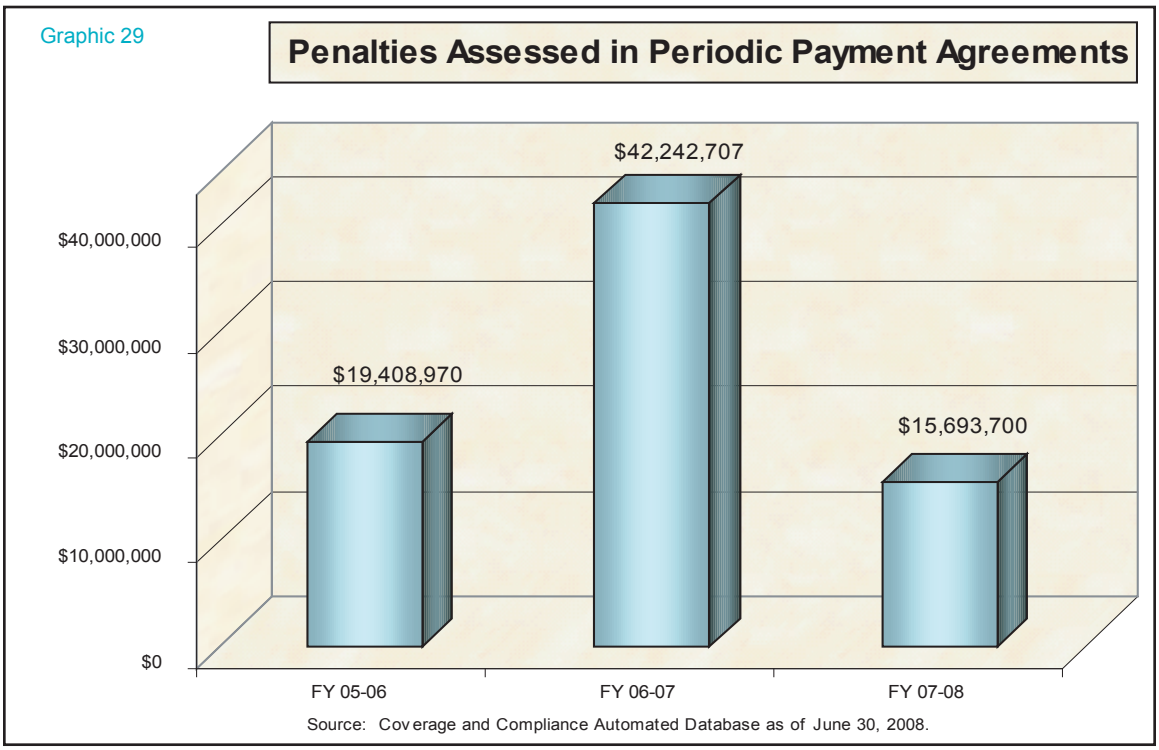
Graphic 28



Source: Coverage and Compliance Automated Database as of June 30, 2008.

- Graphic 29 illustrates the total amount of penalties assessed against employers who entered into periodic payment agreements. Although the total amount of penalties assessed has decreased, the total number of employers who entered into periodic payment agreements increased from FY 2006-2007 to FY 2007-2008.

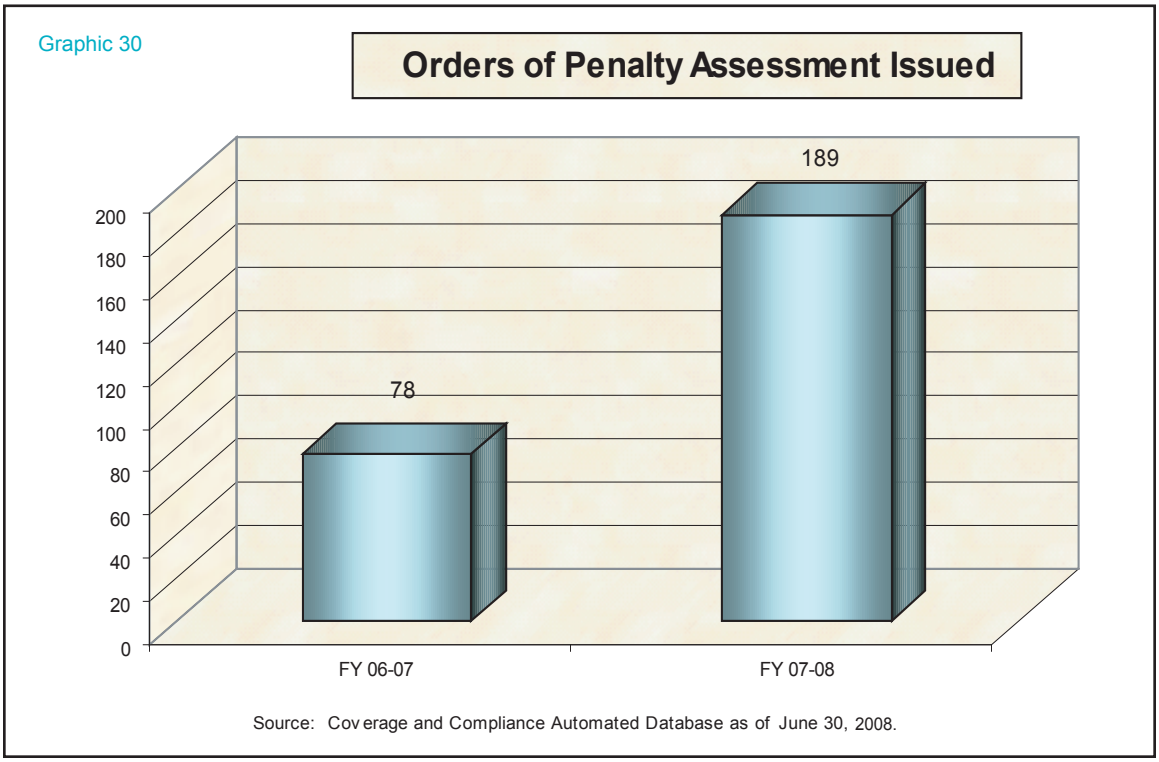
Graphic 29



Effective March 15, 2006, Rule 69L-6.030, F.A.C., pursuant to s. 440.107(7)(a),F.S., authorized the Division of Workers' Compensation to assess a penalty against an employer who is failing to secure the payment of workers' compensation on the date the investigation commences, but comes into compliance prior to the issuance of a Stop-Work Order.

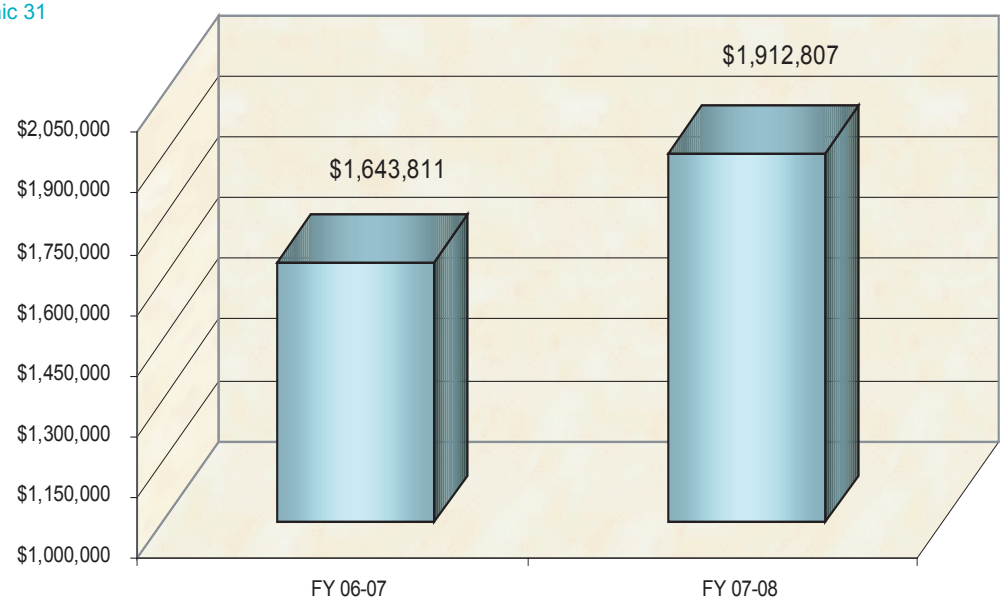
The next four graphics pertain to Orders of Penalty Assessments for cases where the employer obtained coverage which made the issuance of a Stop-Work Order unnecessary. During FY 2007-2008, 189 employers were issued an Order of Penalty Assessment, as illustrated in Graphic 30 with assessed penalties totaling $1,912,807, as illustrated in Graphic 31. Graphic 32 illustrates the total number of new employees covered and the amount of insurance premium generated is illustrated in Graphic 33.

Graphic 30



Total Penalties Resulting From Orders of Penalty Assessment

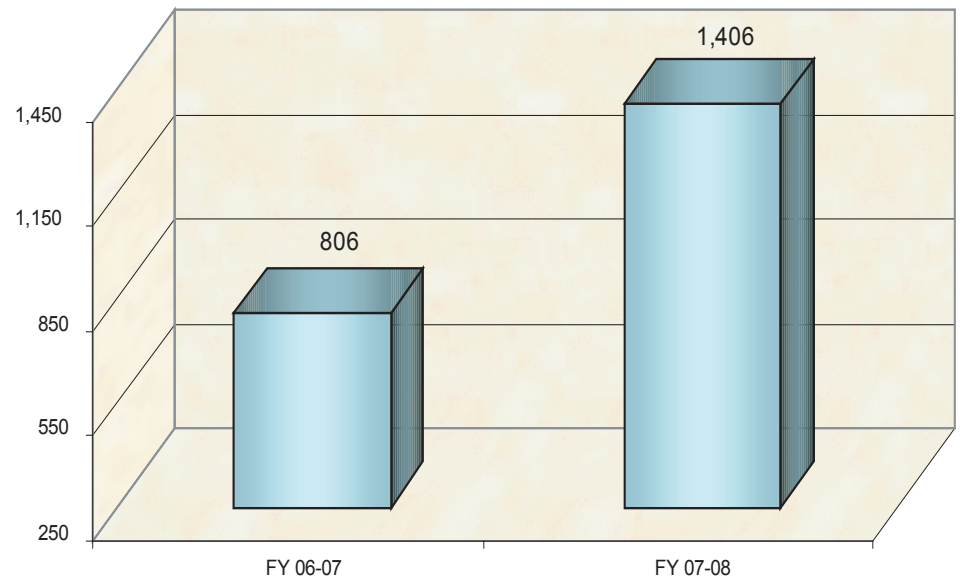
Graphic 31



Source: Coverage and Compliance Automated Database as of June 30, 2008.

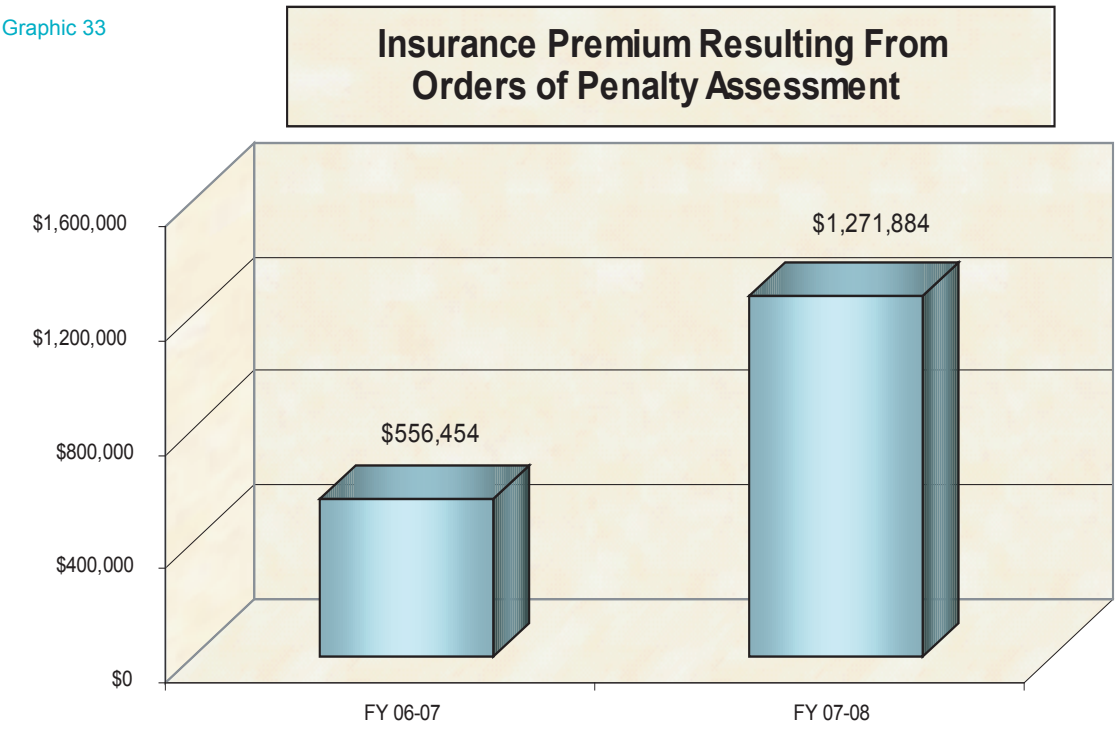
New Employees Covered Based Upon Orders of Penalty Assessment

Graphic 32



Source: Coverage and Compliance Automated Database as of June 30, 2008.

Graphic 33



Source: Coverage and Compliance Automated Database as of June 30, 2008.

Administrative Rule Changes

The Bureau of Compliance adopted the following new Florida Administrative Code rules in order to clarify and interpret some of the various enforcement and compliance provisions in Chapter 440, F.S.

69L-6.027: Penalty Calculation Worksheet: Revises the penalty language and penalty calculation process used on the Penalty Calculation Worksheet (Form DFS-1595) to harmonize the penalty language to conform to language used in related forms and provide a more equitable means of calculating penalties related to underreporting violations.

69L-6.032: Contractor Requirements For Obtaining Evidence That Subcontractors Possess Workers' Compensation Insurance or Otherwise Comply with Chapter 440, F.S. Provides guidelines and establishes procedures whereby contractors may fulfill the requirements and obligations associated with obtaining evidence that subcontractors engaged by them possess workers' compensation insurance or that corporate officers of the subcontractors have been issued a Certificate of Election to Be Exempt by the Division.

69L-6.035: Definition of Payroll Establishes criteria to be utilized in the determination of an accurate and complete employer payroll for penalty calculation purposes under s. 440.107(7)(d)1, F.S.

Case Summaries

The following case summaries taken from actual FY 2007-2008 cases are examples of the types of investigations conducted by the Bureau of Compliance in their enforcement efforts.

Case One: Based on a public complaint, the Bureau commenced an investigation on a framing company that was paying its workers through an employee leasing company. The investigation revealed that four employees were not reported on the employee leasing payroll and the other 11 employees had been paid additional cash payments that were not reported to the leasing company. A Stop-Work Order and Business Records Request were issued and served on the employer and a $75,984 non-compliance penalty was assessed. The employer came into compliance by adding all employees to the employee leasing payroll and reporting full payroll amounts for 15 employees.

Case Two: The Bureau received a tip regarding a company that was misclassifying the type of work being performed. During the site visit, three men were observed installing roofing shingles. The employer's workers' compensation policy listed classification codes for painting only. A Stop-Work Order for misrepresenting or concealing employee duties and a Business Records Request were issued and served on the employer. The employer provided business records that revealed the employer had been performing primarily roofing work during the past three years and the only class codes that were listed on the workers' compensation policy were painting. The penalty for non-compliance was assessed in the amount of $94,622. The employer came into compliance by reporting the proper class codes to the insurer, which generated $38,045 in premium dollars and by entering into a Periodic Payment Agreement to pay the penalty.

Case Three: The Bureau initiated an investigation based upon a public complaint alleging an employer with approximately 130 employees in 19 locations was operating without workers' compensation coverage. During the site visit, 15 employees were observed engaged in office clerical work. The owner of the company confirmed that there was no current workers' compensation coverage in place and that their previous workers' compensation policy had been cancelled three months before. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer. The business records provided for the period of non-compliance revealed a gross payroll of $1,163,405 for more than 100 full and part-time employees in 19 locations. The total penalty assessed was $10,732. The employer came into compliance by securing workers' compensation coverage which generated $19,546 in premium dollars and by entering into a Periodic Payment Agreement to pay the penalty.

Case Four: While conducting routine investigations, an investigator discovered a roofing company that was working in violation of the Workers' Compensation Law. The investigator observed three workers removing tile from a roof. The investigation revealed the employer had not reported the workers to its employee leasing company. The investigator issued and served a Stop-Work Order on the employer for failure to secure payment of workers' compensation coverage. The employer was assessed a penalty in excess of $112,000. The employer came into compliance by adding eighteen workers to its employee leasing agreement which generated $93,695 in premium dollars and by entering into a Periodic Payment Agreement to pay the penalty.

Case Five: The Bureau received a tip regarding a plastering business that might be working without workers' compensation coverage. A site visit was conducted during which the investigator observed six employees applying stucco to the exterior of a building. Information obtained on the job site indicated the employer had secured workers' compensation coverage through an employee leasing company. However, contact with the employee leasing company revealed that the employer's leasing contract had been inactive for two months. A Stop-Work Order and Business Records Request were issued and served on the employer. A penalty for non-compliance was assessed in the amount of $2,370. The employer came into compliance by adding ten employees to a new employee leasing contract, which generated $43,555 in premium dollars and by entering into a Periodic Payment Agreement to pay the penalty.

Case Six: Based on a public tip, the Bureau conducted an investigation of a commercial construction job site. The investigator observed eight workers performing carpentry work on the roof. The investigation revealed that the subcontractor did not have workers' compensation coverage and that all eight workers were undocumented employees who were being paid in cash. The contractor provided a Certificate of Insurance evidencing workers' compensation coverage through the Florida Workers' Compensation Joint Underwriting Association (FWCJUA). Contact with the FWCJUA revealed that there was no such coverage in effect for the contractor and that the Certificate of Insurance was fraudulent.

A Stop-Work Order and Business Records Request were issued and served on the contractor and subcontractor for failure to secure workers' compensation coverage. The subcontractor came into compliance and paid the assessed penalty in full. The contractor came into compliance by obtaining a workers' compensation policy through a licensed insurer and paying the assessed penalty in full. A referral was made to the Division of Insurance Fraud, Bureau of Workers' Compensation Fraud, resulting in the arrest of the insurance agent for the issuance of a fraudulent Certificate of Insurance. The agent subsequently reimbursed the contractor approximately $58,000 for payments the contractor made to the insurance agent for payment of workers' compensation coverage.

Case Seven: In response to a public lead, a site visit was conducted and nine employees were observed framing a new residential structure. The investigation revealed the employer had elected to be exempt from obtaining workers' compensation coverage for himself, but had failed to secure workers' compensation coverage for his employees. A Stop-Work Order and Business Records Request were issued and served on the employer for failure to secure workers' compensation coverage. The business records provided by the employer revealed a two-year period of non-compliance and a penalty was assessed in the amount of $45,816. The employer came into compliance by adding ten employees to a new employee leasing contract which generated $35,000 in premium dollars and by entering into a Periodic Payment Agreement to pay the penalty.

Case Eight: Based on a public complaint, the Bureau commenced an investigation against an art dealer-retailer. Upon making initial contact with the business and observing approximately six employees working, the investigator determined the employer did not have worker's compensation insurance. The investigation revealed that the employer had been conducting business without proper workers' compensation coverage since June 2006. A Stop-Work Order and Business Records Request were issued and served on the employer for failure to secure workers' compensation coverage.

The business records provided reflected a gross payroll of over $600,000 during the period of non-compliance. The employer was assessed a penalty in the amount of $11,659 and came into compliance by obtaining a workers' compensation policy covering seven employees which generated $3,273 in premium dollars and by entering into a Periodic Payment Agreement to pay the penalty.

Case Nine: While conducting routine investigations, an investigator visited a commercial construction site and observed a crew of eight workers doing concrete flooring work. The investigation revealed the employer had obtained workers' compensation coverage through an employee leasing company. However, only three employees were being paid through the leasing company. A Stop-Work Order was issued and served on the employer for failure to secure workers' compensation coverage.

A subsequent investigation determined the employer continued to conduct business operations in violation of the Stop-Work Order for 23 days resulting in an additional assessed penalty of $1,000 per day. A referral for working in violation of the Stop-Work Order was submitted to the Division of Insurance Fraud, Bureau of Workers' Compensation Fraud. The employer's total penalty was assessed in the amount of $42,106. The employer came into compliance by adding the employees to the leasing contract and increasing the annual gross payroll to $126,660, which generated $23,320 in premium dollars.

Case Ten: The Bureau commenced an investigation upon an employer based upon a public tip alleging an employer might be working without workers' compensation coverage. A Business Records Request was issued and served on the employer to determine if the employer was working in violation of the Workers' Compensation Law. The business records revealed the employer was working without workers' compensation coverage on the date the investigation commenced, but had subsequently obtained a workers' compensation policy prior to the issuance of a Stop-Work Order.

Further, the business records revealed that the employer had worked without workers' compensation coverage for approximately one year. In addition, the records reflected payments had been made to uninsured subcontractors during the period of non-compliance. A penalty was assessed against the employer in the amount of $114,682. The employer secured workers' compensation coverage for 47 employees which generated $130,499 in premium dollars.

BUREAU OF DATA QUALITY AND COLLECTION

The Bureau of Data Quality and Collection (DQC) is responsible for collecting workers' compensation claims, medical, and proof of coverage data; ensuring data quality; organizing data to provide real-time feedback to data submitters; and maintaining accurate and readily accessible information for all workers' compensation stakeholders. As the central information collection point, DQC is the information hub that facilitates the distribution of data to other parts of the Division for their usage.

DQC accomplishes its mission by:

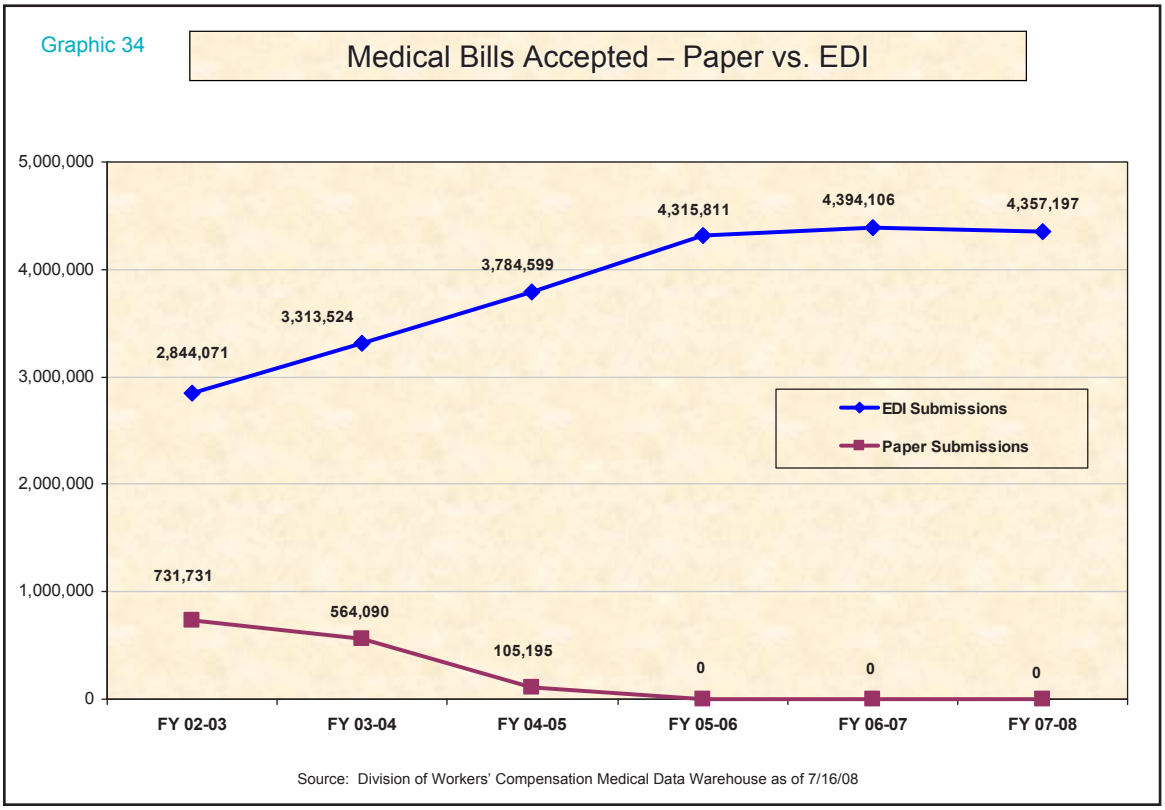
- Collecting, organizing, analyzing, and ensuring the quality of information submitted to the Division concerning injured workers' claim filings, medical services billings and employers' proof of coverage.
- Establishing and implementing administrative rules, requirements, and processes for electronic reporting of the First Report of Injury or Illness (DWC-1) forms, Claim Cost Report (DWC-13) forms, Notice of Denial (DWC-12) forms, and Subsequent Report of Injury and Proof of Coverage forms, using national Electronic Data Interchange (EDI) standardized file formats.
- Establishing and implementing requirements and processes for electronic reporting of medical services using Florida's model EDI standardized file formats.
- Training, facilitating and supervising the transition process as workers' compensation stakeholders convert from paper to electronic submission of required reports.
- Providing performance feedback to submitters on medical EDI submissions to allow submitters to review current performance on a monthly basis and a performance comparison with all other submitters.
- Facilitating electronic workflow distribution throughout the Division, including providing collected and accepted information to the Bureaus of Monitoring and Audit, Compliance and EAO and Ombudsman for determination of the submitters' compliance with statutory requirements.
- Providing "real time" filing results to insurer representatives for claims related forms via the web based EDI warehouse.
- Serving as repository for workers' compensation records that are archived using electronic imaging technology.
- Processing and complying with public records and subpoena requests.

FY 2007-2008 Accomplishments

- Received 4,374,444 medical records from physicians, hospitals, ambulatory surgical centers, pharmacies, and dentists that previously would have been promulgated, printed and mailed as hard copy documents. One hundred percent of all received medical reports have been filed electronically with the Division since FY 2005-2006. The total number of records stored in the Medical Data Warehouse was over 42 million medical records as of June 30, 2008.
- Received, accepted and processed 692,693 Proof of Coverage (POC) transactions. One hundred percent of all filed POC transactions were submitted electronically.
- Received and processed a combined total of 116,087 electronic First Report of Injury or Illiness (DWC-1) forms and Claim Cost Report (DWC-13) forms.
- Received and processed a combined total of 369,695 paper First Report of Injury or Illiness (DWC-1) forms, Claim Cost Report (DWC-13) forms and Notice of Action/ Change (DWC-4) forms.
- Received and processed 3,912 subpoenas for record production and 3,674 public records requests.
- Imaged and electronically archived 918,712 pages relating to both workers' compensation claims and workers' compensation coverage.

The Division received, accepted and processed more than 4.3 million medical bills during FY 2007-2008. Graphic 34 *below* illustrates the change over time in the volume of medical bills submitted in electronic and paper formats.

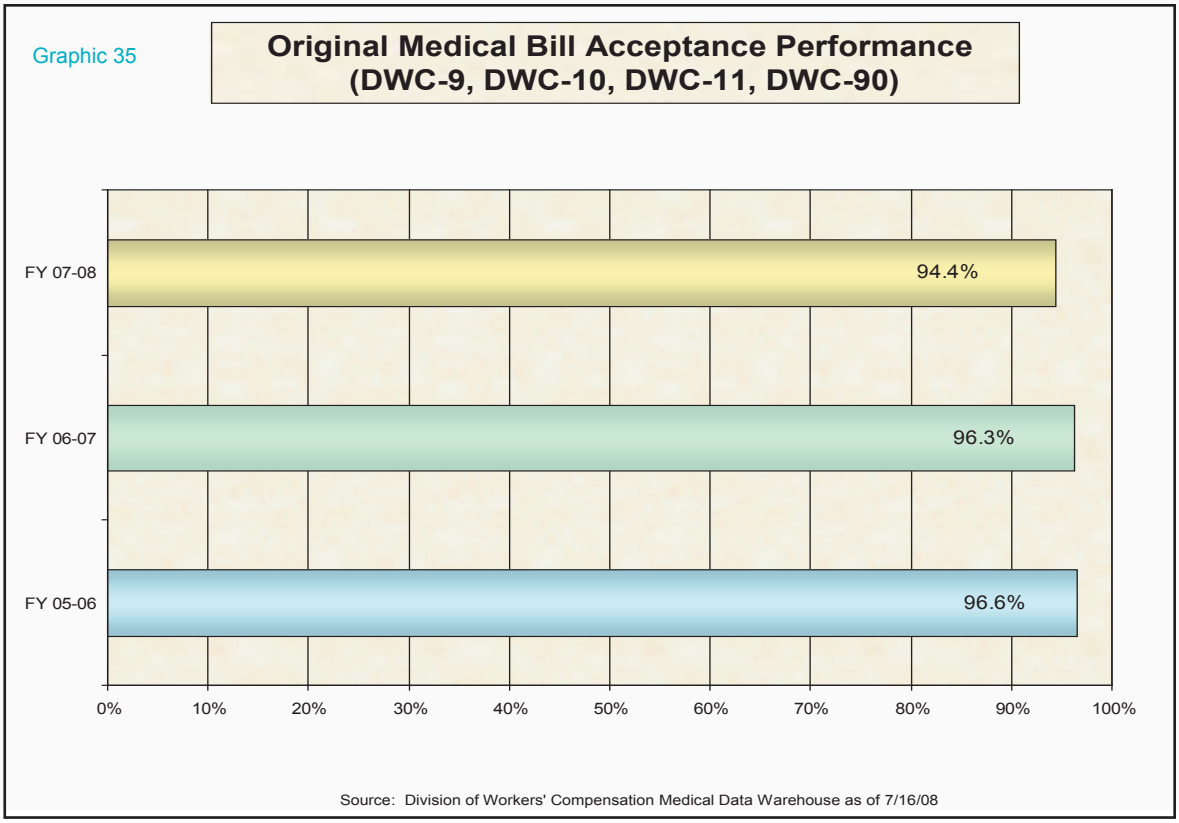
Graphic 34



Source: Division of Workers' Compensation Medical Data Warehouse as of 7/16/08

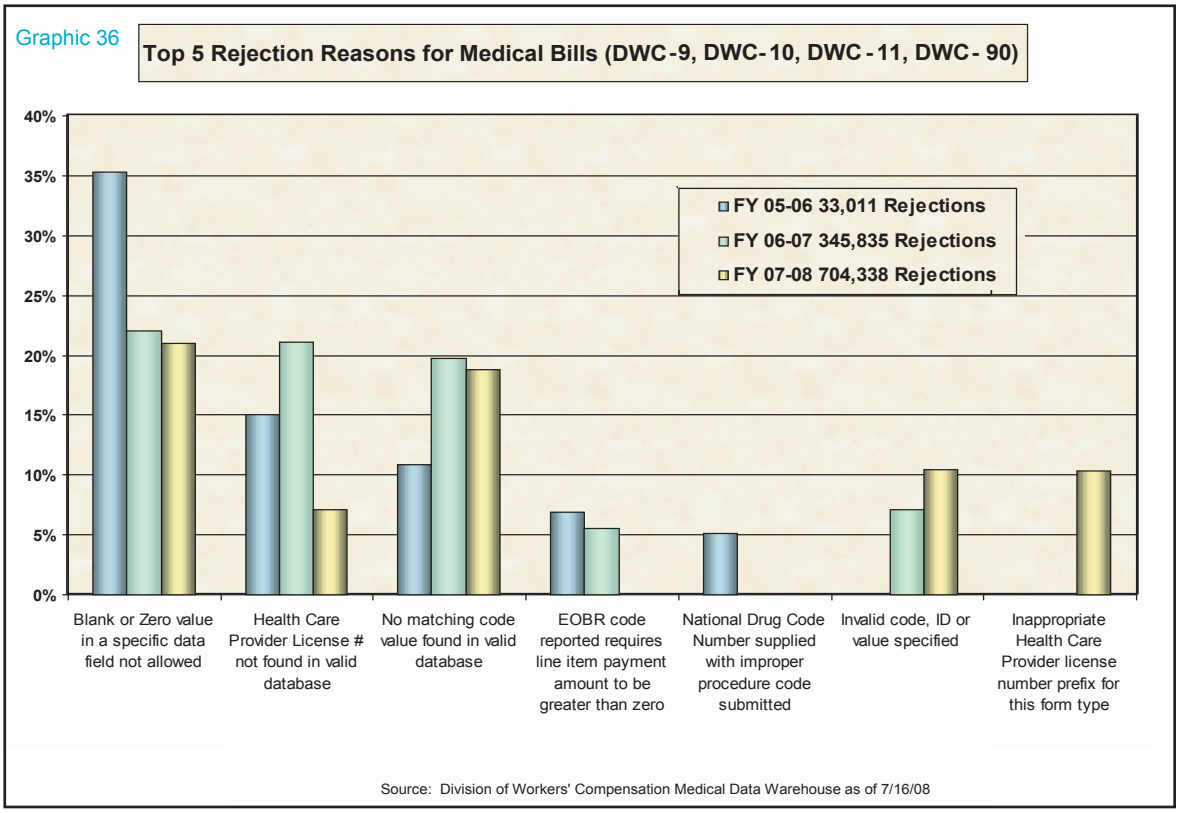
Each medical bill record submitted to the Division is required to meet specific minimum data requirements to ensure accuracy and completeness of the data. If a record is rejected, the submitter must successfully re-submit corrected data within 45 days of the date the bill was paid to meet administrative rule requirements. Graphic 35 depicts the submitters' performance as a whole for initial filing acceptance of medical forms. On-going analysis of medical data to determine submission quality levels has prompted the Bureau of Data Quality and Collection to develop additional, more sophisticated, edit mechanisms to improve the quality of medical data. Subsequently, as a result of adding additional, more complex quality edits to its medical data system, initial acceptance has slightly declined over the past three fiscal years.

Graphic 35



The Division generates monthly report cards for all EDI Medical Submitters that detail their respective reasons for initial bill rejection to educate insurer representatives and to improve the rate of initial acceptance of filed medical bills. The report card also compares the performance of each submitter to the performance of all submitters. Graphic 36 *below* depicts the top five reasons for medical bill record rejection over the last three fiscal years.

Graphic 36



Administrative Rules Amended in FY 2007-2008

69L-7.020: Florida Health Care Provider Reimbursement Manual, 2007 Edition.
This amendment updated the reimbursement manual for individual health care providers to implement new reimbursement rates authorized by the Three Member Panel and the latest editions of adopted reference materials. The amendment became effective October 18, 2007.

Non-Reported Claims Data Project

The Division performed an extensive analysis of its existing claims data to identify non-reported claims data that were required to be submitted to the Division, pursuant to s. 440.185, F.S., and Rule 69L-3, F.A.C. These data, which primarily include First Reports of Injury or Illness (DWC-1) or Claim Cost Reports (DWC-13), are needed to allow the Division to meet its obligations under ss. 440.51 and 440.59, F.S., and also to perform a comprehensive pre-reform and post-reform analysis to determine the impact of many of the reforms that were implemented as a result of the passage of Senate Bill 50-A in 2003. Insurers were provided with a detailed list of the non-reported claims data and have been submitting the requested information to the Division.

This project provided the Division with the opportunity to better educate insurers and claims-handling entities on how to accurately and timely comply with Division reporting requirements. The Division also added edits in its electronic data reporting systems that will improve the overall quality of claims data reported to the Division by insurers in the future.

Electronic Data Interchange (EDI) Update

The implementation of the electronic submission of all claim accident and indemnity benefit data using the national standard International Association of Industrial Accident Boards and Commissions (IAIABC) Claims EDI Release 3 format was a primary data focus during FY 2007-2008. The Division has been working extensively to design and implement EDI claims data since the early 1990s. By participating and assuming leadership roles in the Claims EDI efforts of the IAIABC, Florida has been instrumental in the preparation and implementation of this technologically complex undertaking. Through the EDI implementation, the Division has begun the evolution into a more efficient business environment, while simultaneously improving the quality and reliability of workers' compensation data.

Although the Division has been receiving EDI claims information using the IAIABC Release 1 EDI format since 1991 from a voluntary group of insurers, the new Release 3 format is a far more challenging and sophisticated program because of the cumulative and sequential nature of the report submissions.

The administrative rule regarding the electronic submission of claims data, Rule 69L-56, F.A.C., was amended on January 1, 2007 to mandate submission of claims data using the Release 3 format. The first insurer group began testing for the Primary Implementation in November 2007 and began implementation in March 2008.

The migration to EDI requires all stakeholders to add new terminology to discuss workers' compenstion cases. While the Division would prefer to employ plain language terms rather than acronyms, these are nationally standardized terms which will cross state lines in their use. Some of the most important new terms that have become colloquial terms of art in the workers' compensation community include the following acronyms:

- **FROI** - is the acronym for 'First Report of Injury' and the national standard nomenclature for the initial reporting of accident data, comprising two thirds of the information reported to the Division on its First Report of Injury or Illness, (DWC-1), Notice of Denial (DWC-12), and Aggregate Change in Claims Administration (DWC-49) forms.
- **JCN** – is the acronym for 'Jurisdiction Claim Number' and the national standard nomenclature for assigning a unique claim number by the Division following the reporting of a new claim.

- **MTC** – is the acronym for 'Maintenance Type Code' and the national standard nomenclature for representing the electronic submission of a particular claim "event", which equates to and often replaces a related claim form required by the Division.

- **SROI** - is the acronym for 'Subsequent Report of Injury' and the national standard nomenclature for reporting initial and cumulative payment information, suspensions, reinstatements and changes associated with the First Report of Injury or Illness (DWC-1 initial payment information), Claim Cost Report (DWC-13), Notice of Action/Change (DWC-4), and the Notice of Denial, (DWC-12).

Under the EDI program, insurers are held accountable, not just for timely filing of information, but also for the content of required reports. If an insurer attempts to report claim information which is incomplete or inaccurate, the report will be rejected. These errors are returned to the insurer on an "acknowledgement" transaction. Insurers are required to timely review all acknowledgement reports and will only be credited with timely filing when a rejected EDI transaction is corrected, resubmitted, and successfully passes all structural and quality edits within the filing timeframe required in Rule 69L-56, F.A.C.

To assist claim administrators in understanding this new complex reporting standard, the Division provided two detailed two-day EDI training classes in various locations throughout the state during FY 2007-2008 and another is scheduled in FY 2008-2009. Upon completion of the training, the Division will have trained approximately 500 members of the industry.

The Division is the first jurisdiction in the nation to create an EDI data warehouse for its trading partners. This data warehouse provides claim administrators with the ability to view their electronic transactions and acknowledgement outcomes via a secure Claims EDI Data Warehouse on the Internet. This warehouse provides next-day feedback of all transactions, allowing claim administrators to quickly identify errors to be corrected and avoid penalties.

The warehouse also provides resources such as a JCN list, Rejected but Not Resubmitted Successfully List, and individual company Report Cards.

As of July 1, 2008, 439 insurers out of approximately 875 active insurers had been approved and begun successfully submitting claim forms electronically in the Primary Claims EDI R3 Implementation. All insurers must be submitting all required information for the Primary Implementation via EDI by October 31, 2008. During FY 2007-2008, the Division received and accepted 126,716 EDI transactions.

In addition, there is a secondary implementation of electronic submission of Notices of Action/ Change (DWC-4) that will begin testing in November 2008 which is required to be completed by November 2009, under Rule 69L-56, F.A.C. Upon successful completion of this final implementation, the entire Claims EDI migration will be complete.

BUREAU OF EMPLOYEE ASSISTANCE AND OMBUDSMAN OFFICE

The Employee Assistance and Ombudsman (EAO) Office is responsible for facilitating the self-executing features of the Workers' Compensation Law by:

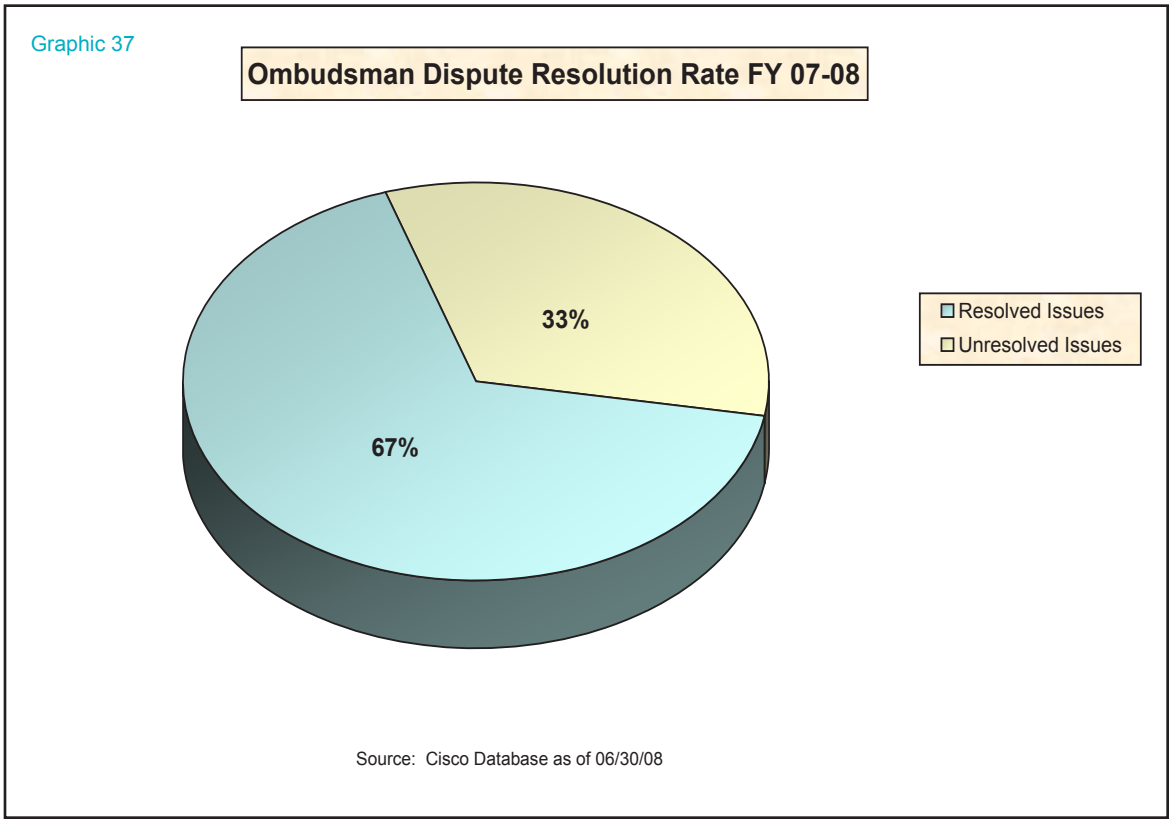
- Resolving disputes without undue expense, costly litigation or delay in the provision of benefits;
- Assisting system participants in fulfilling their statutory responsibilities;
- Educating and disseminating information to all system participants;
- Initiating contact with injured employees to discuss their rights and responsibilities and advising them of services available through the EAO; and
- Reviewing claims in which injured workers' benefits have been denied, stopped or suspended.

To effectively fulfill these charges, EAO utilizes a team structure. Each team is uniquely focused on meeting their statutory obligations. Through the team approach, EAO is initiating more contacts, educating more participants and providing comprehensive assistance to injured workers and other system stakeholders. In addition, the team approach results in enhanced data collection and analysis of the workers' compensation system.

Ombudsman Team

The Ombudsman Team assists injured workers in resolving complex and contentious disputes by conducting fact finding reviews, promoting open communication and advising parties of their statutory responsibilities. During FY 2007-2008, the Ombudsman Team resolved 1,081 disputes out of 1,608 disputes filed with the Division and prevented another 692 potential disputes by educating injured workers and providing them with in-depth case specific information. Graphic 37 *below* illustrates the resolution rate of the Ombudsman Team.

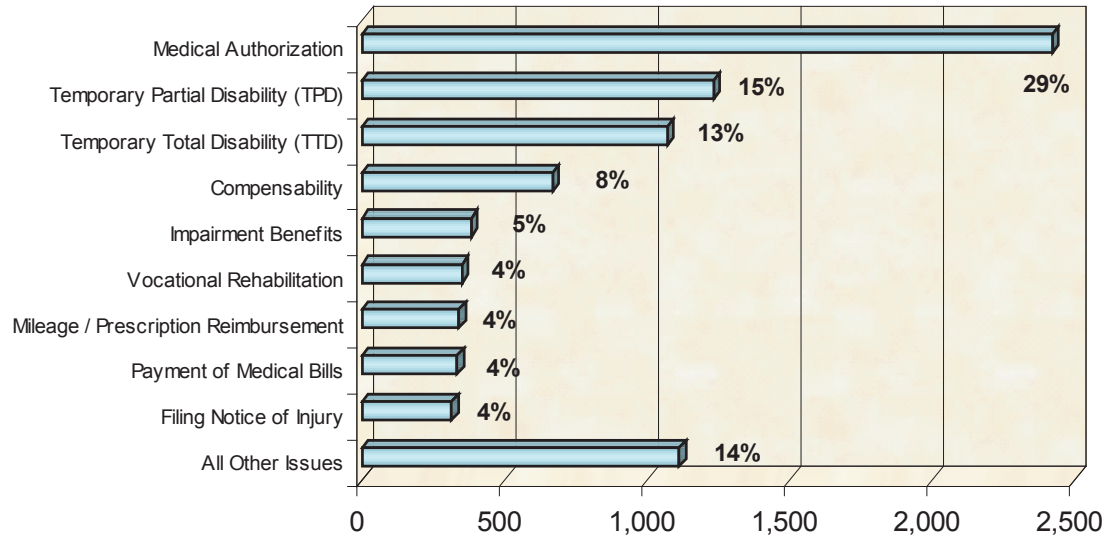
Graphic 37



Injured workers requested assistance or education with medical authorization issues more than any issue for which they requested assistance. Physical Therapy, Orthopedic Services, Surgery, MRI/Cat Scan and Pain Management are the medical authorization issues for which assistance is requested most frequently. Graphic 38 *below* illustrates the types of issues addressed by the Ombudsman and the Injured Worker Helpline Teams.

Injured Worker Issues Addressed by Ombudsman and Helpline Teams FY 07-08

Graphic 38



Source: Cisco Database as of 06/30/08

The Division continues to broaden its efforts to communicate with injured workers via email using the Department of Financial Services' website. This venue allows our ombudsman the opportunity to communicate in an interactive environment with injured workers as questions arise during the development of their claim. Electronic communications such as web inquiries are expected to become a significantly greater part of the workers' compensation education and assistance process. During FY 2007-2008, 1,263 responses were provided via email by the Ombudsman Team.

Early Intervention Team

The Early Intervention Team (EIT) proactively focuses on workers who have suffered serious injuries that may result in prolonged treatment and protracted recovery periods. By establishing and maintaining on-going communication with these injured workers, the team is able to communicate with insurers and facilitate the prompt provision of benefits throughout the life of the claim. During FY 2007-2008, the EIT added 401 new cases for continuous case management.

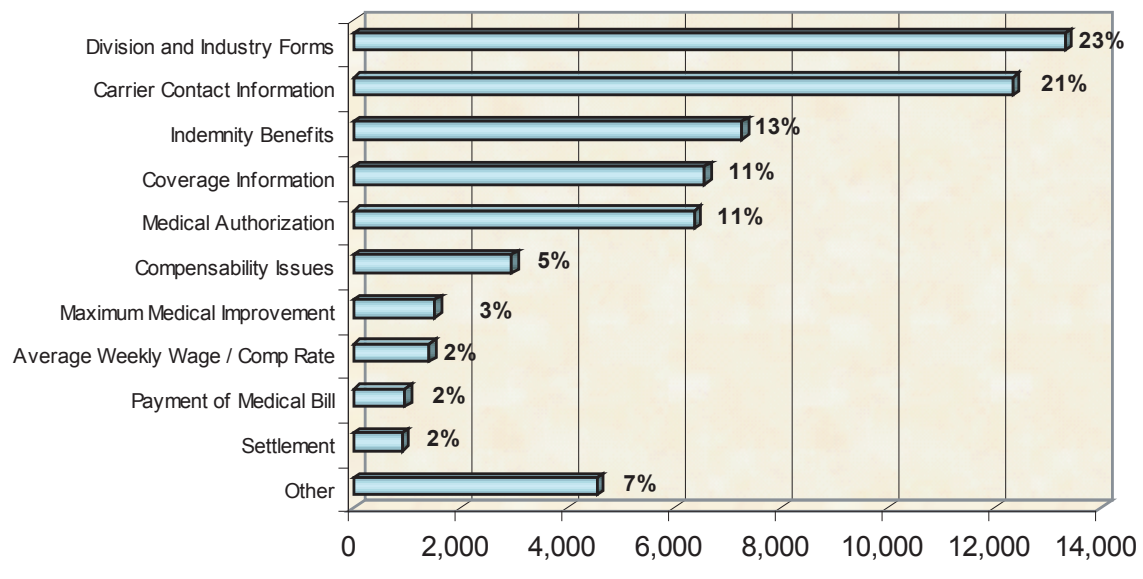
In addition, upon receipt of notice that a work related injury has resulted in death, the EIT immediately initiates contact with family members to advise that they may be eligible for benefits pursuant to the Workers' Compensation Law and offer assistance. During FY 2007-2008, the EIT managed 256 death claims, 231 of which occurred during FY 2007-2008.

Injured Worker Helpline Team

The Injured Worker Helpline Team assists system participants by educating them about their rights and responsibilities under the Workers' Compensation Law, in addition to resolving minor disputes. During FY 2007-2008, the team provided workers' compensation educational information and assistance by telephone to 77,116 system participants, including 9,154 Spanish-speaking callers.

Graphic 39 *below* illustrates the volume of educational inquiries addressed by the Injured Worker Helpline Team by topic.

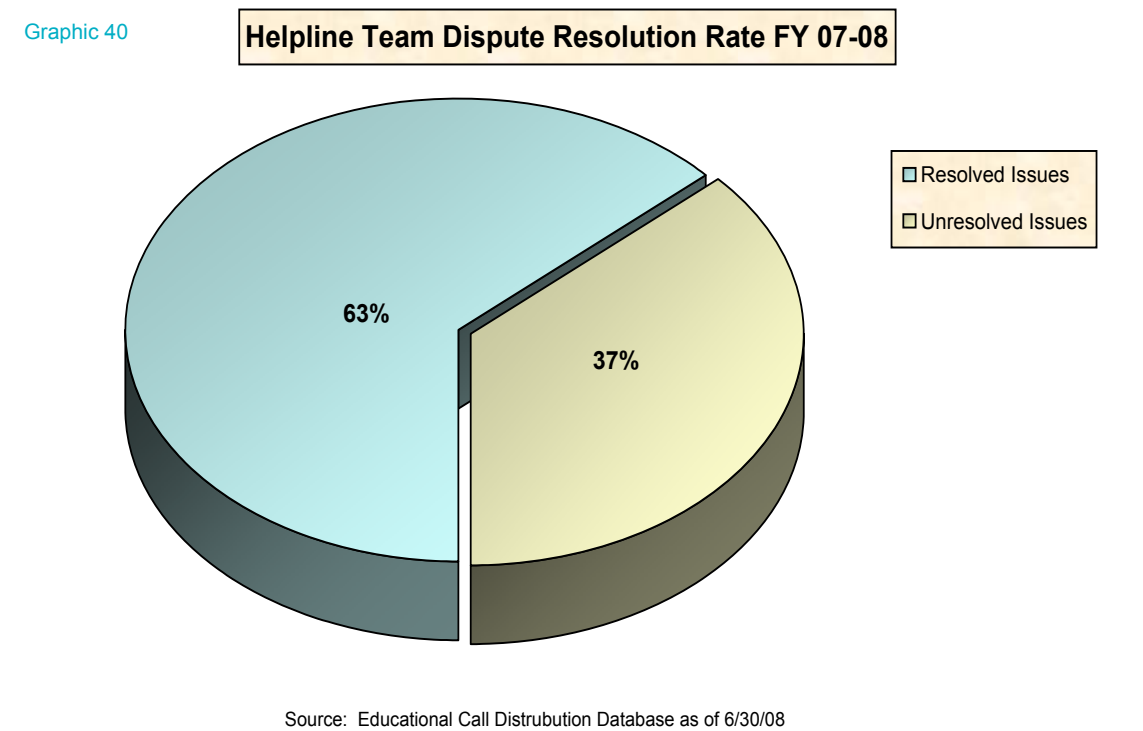
Graphic 39



Source: Educational Call Distrubution Database as of 6/30/08

During FY 2007-2008, the Helpline team resolved 1,515 disputes out of 2,389 disputes filed with the Division and prevented another 5,467 potential disputes by providing in-depth case specific information and education to injured workers. Graphic 40 *below* illustrates the dispute resolution rate by the Injured Worker Helpline Team on behalf of injured workers.

Graphic 40



Source: Educational Call Distrubution Database as of 6/30/08

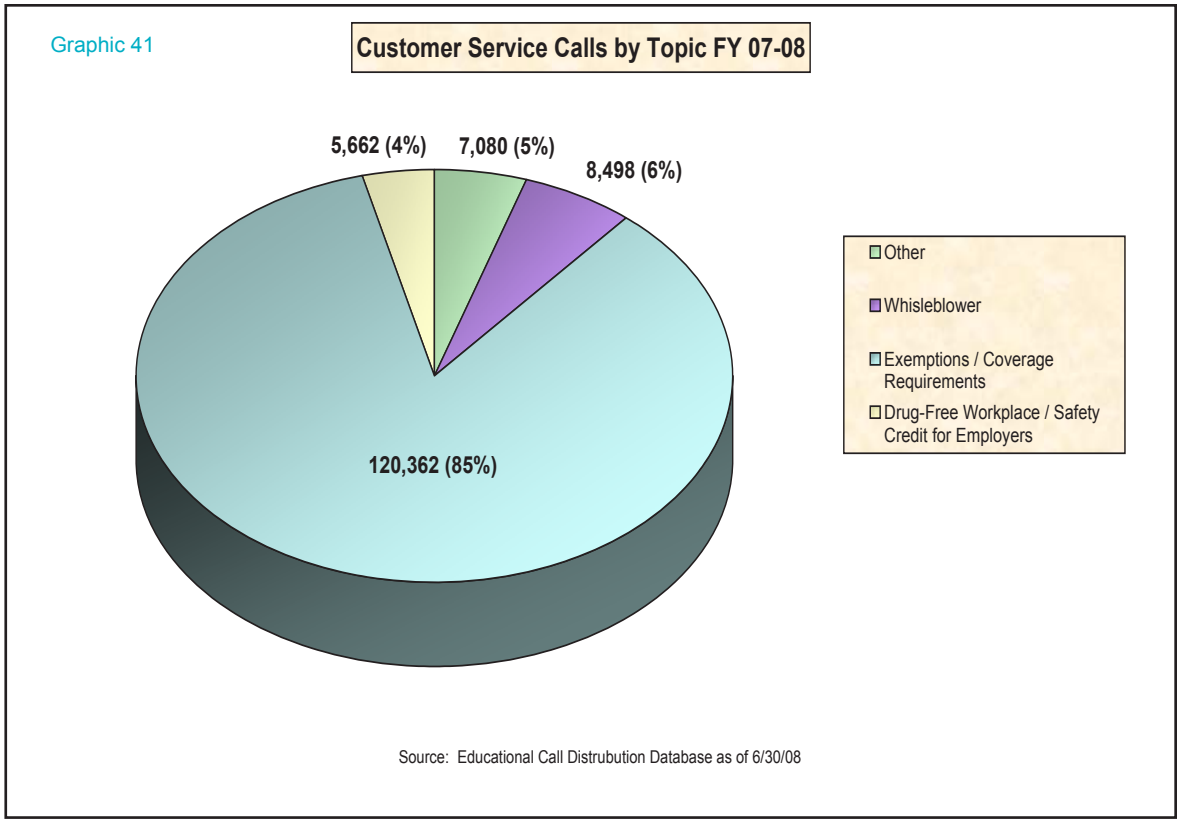
Customer Service Team

The Customer Service Team educates and assists employers with questions regarding workers' compensation coverage, exemptions from coverage and drug-free workplace and safety programs. The team also receives calls from persons reporting employer non-compliance on the Division's Whistleblower Hotline. When compliance violations are reported, the team refers those inquiries to the Bureau of Compliance for appropriate review. During FY 2007-2008, the call volume for the Customer Service Team was 141,602.

The Division continues to enhance the quality of service to its customers. During FY 2007-2008, the team implemented a call monitoring program that elevates the quality of service and accuracy of information by evaluating the information communicated and providing additional training to staff.

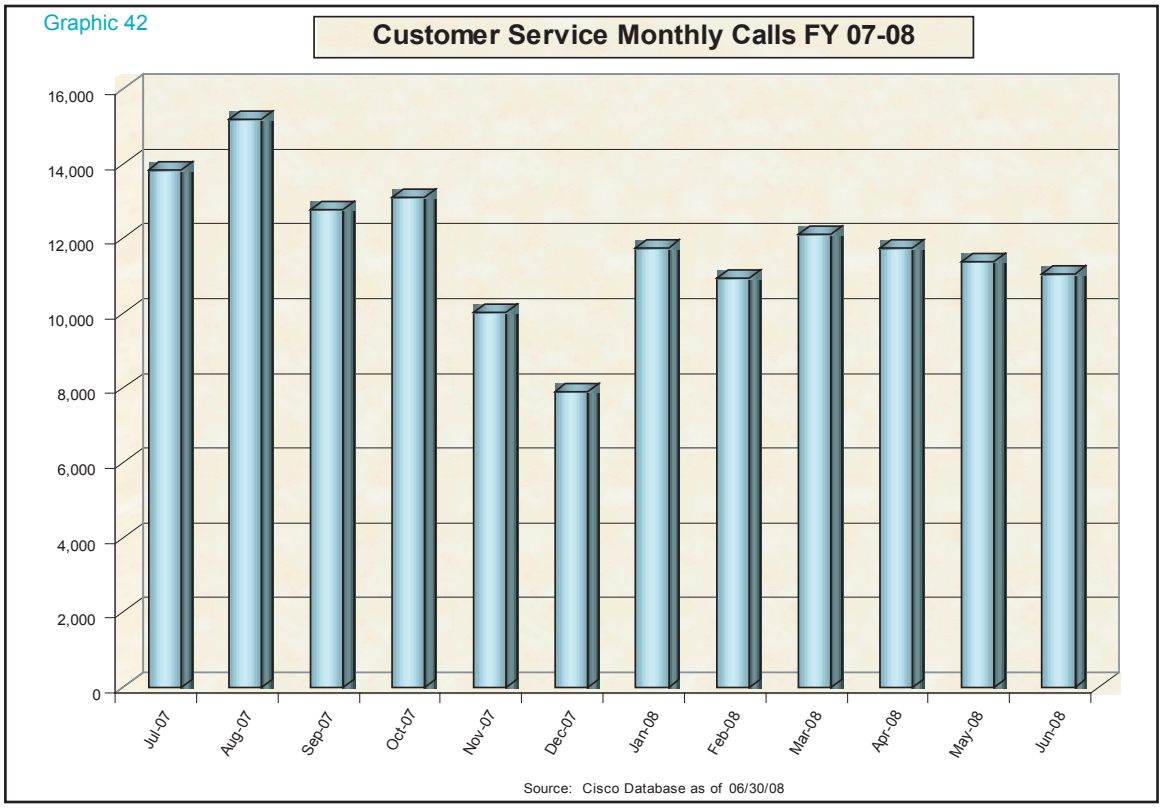
Graphic 41 *below* illustrates the volume of educational calls handled by the Customer Service Team by topic.

Graphic 41



Graphic 42 *below* shows the monthly call volume for the Customer Service Team.

Graphic 42



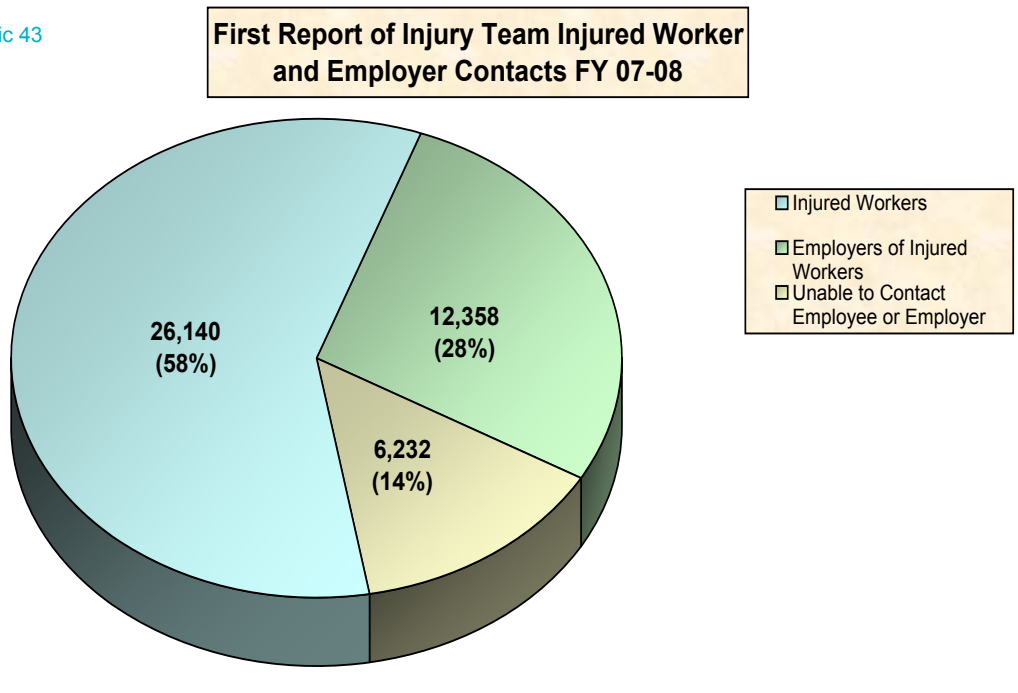
First Report of Injury Team

The First Report of Injury Team takes all steps necessary to educate recently injured workers and disseminates information to them. Utilizing Division data, the team identifies and targets injured workers whose injuries resulted in lost work time. Within two business days of the Division's receipt of a First Report of Injury or Illness, the team initiates contact with the injured worker to discuss his/her rights and responsibilities under the Workers' Compensation Law and advise him/her of EAO's services.

On a daily basis, the First Report of Injury Team's outreach efforts assist injured workers by clarifying their understanding of the workers' compensation system. Initial telephone contact with injured workers allows EAO staff the opportunity to answer questions about the workers' compensation system and immediately address their concerns about medical or indemnity benefits.

During FY 2007-2008, the team made personal telephone contact with 26,140 injured workers. When the team was unable to reach an injured worker, contact was attempted with the injured worker's employer. The team made personal telephone contact with 12,358 employers to inquire about the status of the injured worker's claim and to advise the employer about EAO's services. While EAO succeeded in contacting 86% of injured workers and employers, there were 6,232 cases where the team was unable to reach either party by telephone. Collectively, 44,730 letters were sent advising the injured worker of EAO's services.

Graphic 43

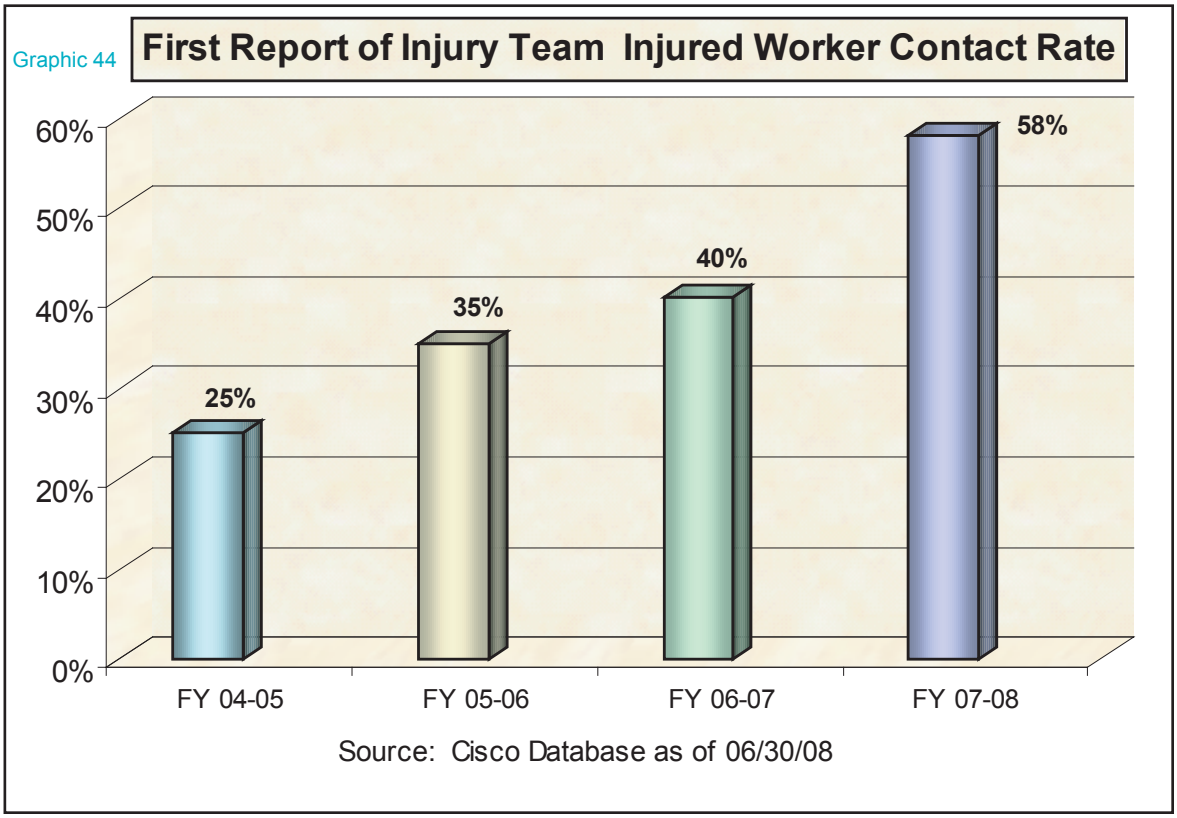


Source: Cisco Database as of 06/30/08

Graphic 43 *above* illustrates injured worker and employer contacts by the First Report of Injury Team.

Graphic 44 *below* illustrates the injured worker contact rate for the past four fiscal years. The First Report of Injury Team's increased contact success rate is attributed to EAO's enhanced team approach which was implemented in 2006.

Graphic 44



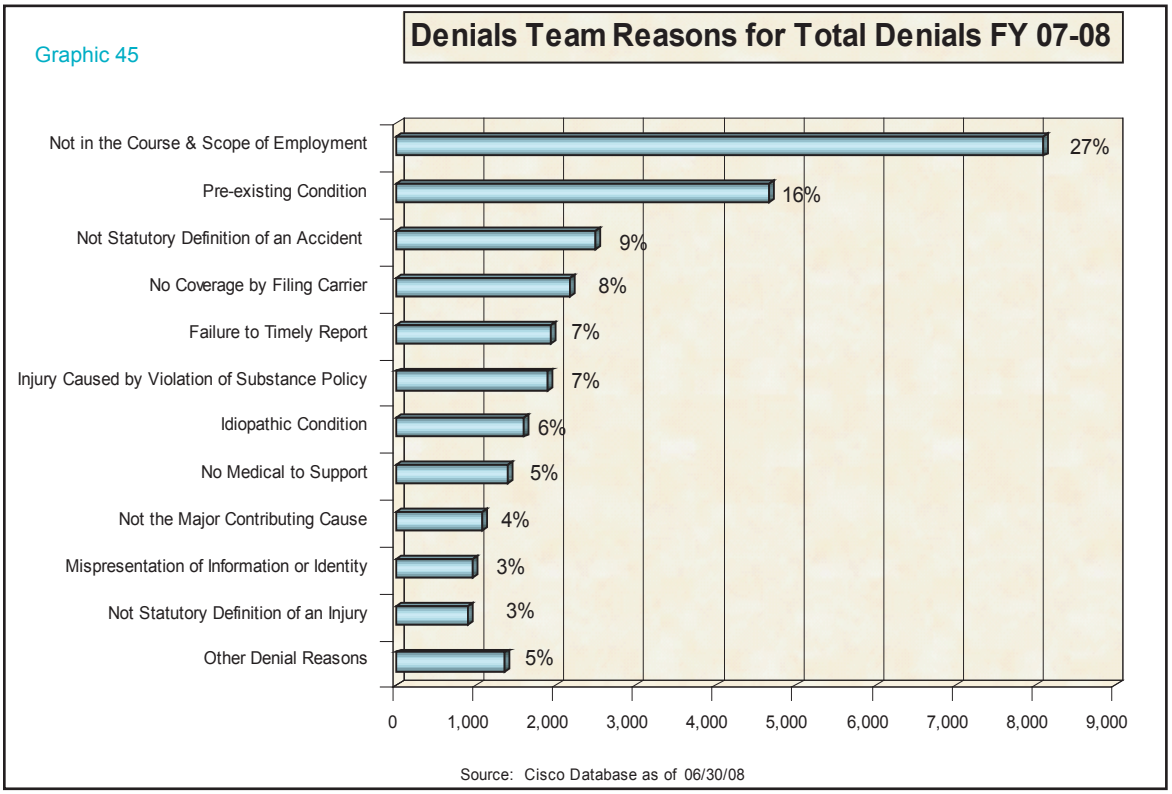
Source: Cisco Database as of 06/30/08

Denials Team

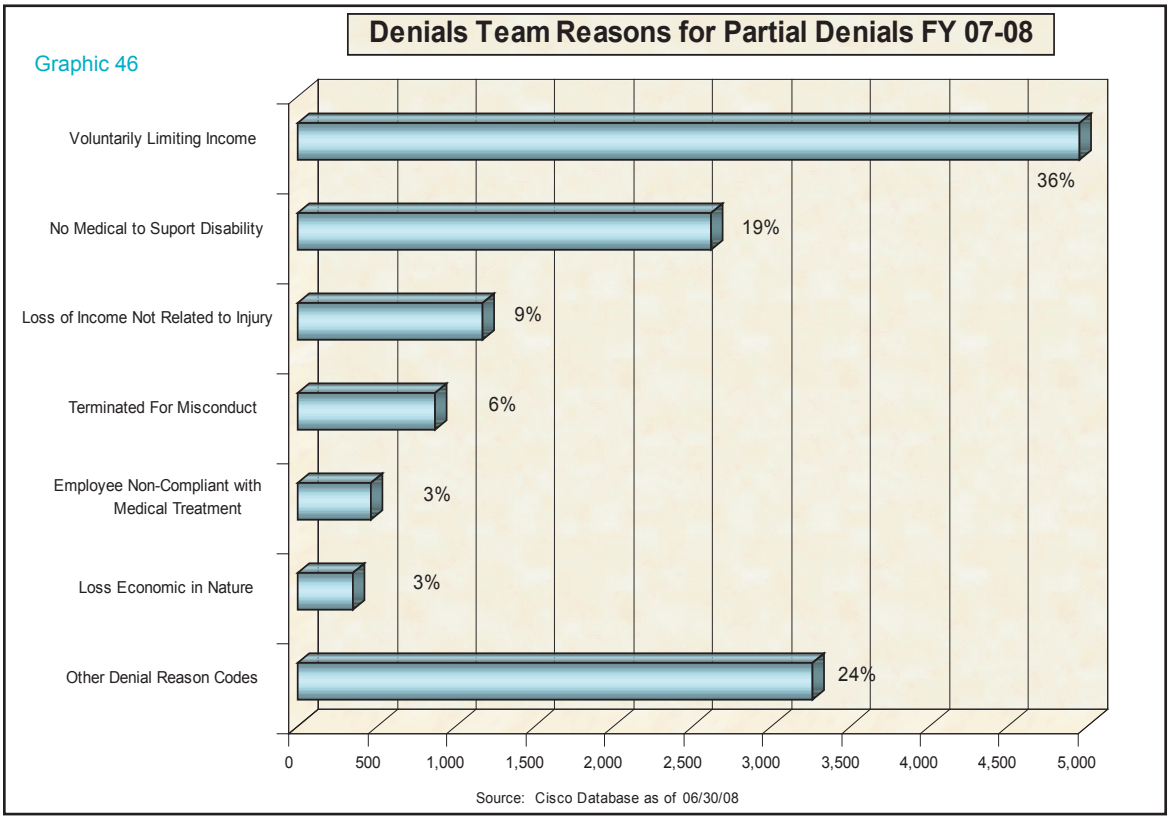
During FY 2007-2008, the Denials Team reviewed all 42,203 denied claims filed with the Division to ensure compliance with the Workers' Compensation Law. Team members contacted insurers for clarification regarding appropriateness, reasonableness, and specific details of the denial. This review permits the Division to monitor and analyze the denial trends of the industry.

Denied claims include total denials (both indemnity and medical benefits) and partial denials (for which a portion of the indemnity or medical benefits were denied). Graphics 45 and 46 *below* illustrate the reasons claims were totally or partially denied.

Graphic 45



Graphic 46



EAO Success Stories

The following success stories are a result of assistance and intervention provided by EAO staff during FY 2007-2008.

A 32-year-old pregnant customer service representative slipped and fell causing her to go into spontaneous labor. Surgery was required as well as post-operative treatment, including bed rest. She was unable to work for six weeks. The insurance carrier denied the claim saying that the fall was not the major contributing cause and that the pre-existing condition (pregnancy) was the cause for the surgery, treatment and bed rest. An EAO Denial Team Specialist questioned the denial and contacted the insurance adjuster to ask for documentation which would support the denial of benefits. The adjuster did not have any documentation, but agreed to contact the doctor. The doctor provided documentation that the fall was the major contributing cause, the adjuster rescinded the denial and began paying both medical and indemnity benefits. The mother and baby are currently doing fine.

A 47-year-old male electrician, who had been struck by a beam and thrown to the ground, was injured and diagnosed with a sprained back. The injured worker went to the EAO Tampa office seeking assistance and told an EAO Specialist that he had not received Impairment Benefits (IBs) after reaching Maximum Medical Improvement. The EAO Specialist requested payment documentation from the insurance carrier. The documentation indicated that the IBs had not been paid and the Specialist also discovered that there were other indemnity benefits that either had not been timely paid or were misclassified. EAO staff worked with the insurer to secure $1,973.88 in indemnity benefits, penalties and interest on behalf of the injured worker.

A 47-year-old male construction worker, who suffered a neck injury after being struck in the forehead with a pipe, called the EAO Hotline stating that his Temporary Total Disability check was late. An Injured Worker Helpline Team Member contacted the adjuster to check on the status of the payment. The adjuster acknowledged that the payment had not been made and agreed to send a check that day. One month later the injured worker called back and said he had not received a check since the one he had received after his first call to EAO. The Injured Worker Helpline Team Member called an adjusting supervisor to ask why there was an ongoing problem with this injured worker's receipt of timely payments. The supervisor issued a check that day and advised that she would speak with the adjuster about the requirement for making timely payments. The payments totaled $6,366 including penalties and interest. To date, the injured worker has not reported any additional late payments.

A 56-year-old female driver, who injured her knee while loading a truck, contacted EAO staff via e-mail requesting assistance because she wasn't receiving any indemnity benefits and had not received any assistance from her attorney. An Ombudsman contacted the adjuster and learned the insurer had just been notified of the worker's impairment rating and the adjuster agreed to immediately pay Impairment Benefits (IB). The Ombudsman questioned the adjuster on how much the IB check would be and how they had determined the amount because it did not match what the Ombudsman had calculated. After some discussion about how Impairment Benefits are calculated, the adjuster agreed with the Ombudsman's calculation and issued a check for $2,928.69, which was twice what the adjuster was originally going to pay.

OFFICE OF MEDICAL SERVICES

The Office of Medical Services (OMS) is responsible for certification of health care providers, certification of Expert Medical Advisers, determination of patterns and practices of overutilization and other health care provider violations under Chapter 440, F.S., and resolution of medical service reimbursement and utilization disputes. The OMS also collaborates with the Bureau of Data Quality and Collection to revise administrative rules for medical billing and reimbursement manuals for health care providers, hospitals, and ambulatory surgical centers.

The OMS has been managed under an Interagency Agreement between the Division and the Agency for Health Care Administration (AHCA) since November 2005. The Division has provided ongoing direction and supervision of fourteen full-time AHCA employees to fulfill statutory responsibilities and ensure appropriate outcomes for stakeholders through interagency cooperation. The two agencies have collaborated on proposed revisions to the certification rule and process and expedited the issuance of Final Orders ensuing from reimbursement disputes. The Division has augmented AHCA staff resources with three full-time Division positions to enhance customer satisfaction and fulfill statutory responsibilities. House Bill 5045 provided for a type two transfer of the OMS responsibilities from AHCA to the Division, effective July 1, 2008.

One of the new initiatives undertaken by the OMS during FY 2007-2008 was the recruitment of Expert Medical Advisors (EMAs) in nine specialty areas: Anesthesiology/Pain Management, Cardiovascular Disease, Infectious Disease, Neurology, Neurosurgery, Occupational Health, Orthopedics, Orthopedic Surgery and Psychiatry. The OMS created a recruitment brochure to target physicians in the nine specialty areas. The brochure was mailed to physicians currently certified as health care providers in the nine specialty areas to encourage participation in the EMA process. In addition, OMS created a dedicated EMA web page highlighting the need for additional EMAs and soliciting additional participation. The web page is accessible from the Division's home page: www.myfloridacfo.com/wc or www.myfloridacfo.com/wc/ema.html.

To further promote recruitment efforts, articles were developed to inform physicians about the need for EMAs, the services EMAs provide and the requirements to become an EMA. The OMS worked cooperatively with the following organizations to promote recruitment efforts: Florida Medical Association, Florida Osteopathic Medical Association, Florida Orthopaedic Society, Florida Society of Anesthesiologists, Florida Dental Association, Florida Podiatric Medical Association, Council of Florida Medical Society Executives and Department of Health, Medical Quality Assurance.

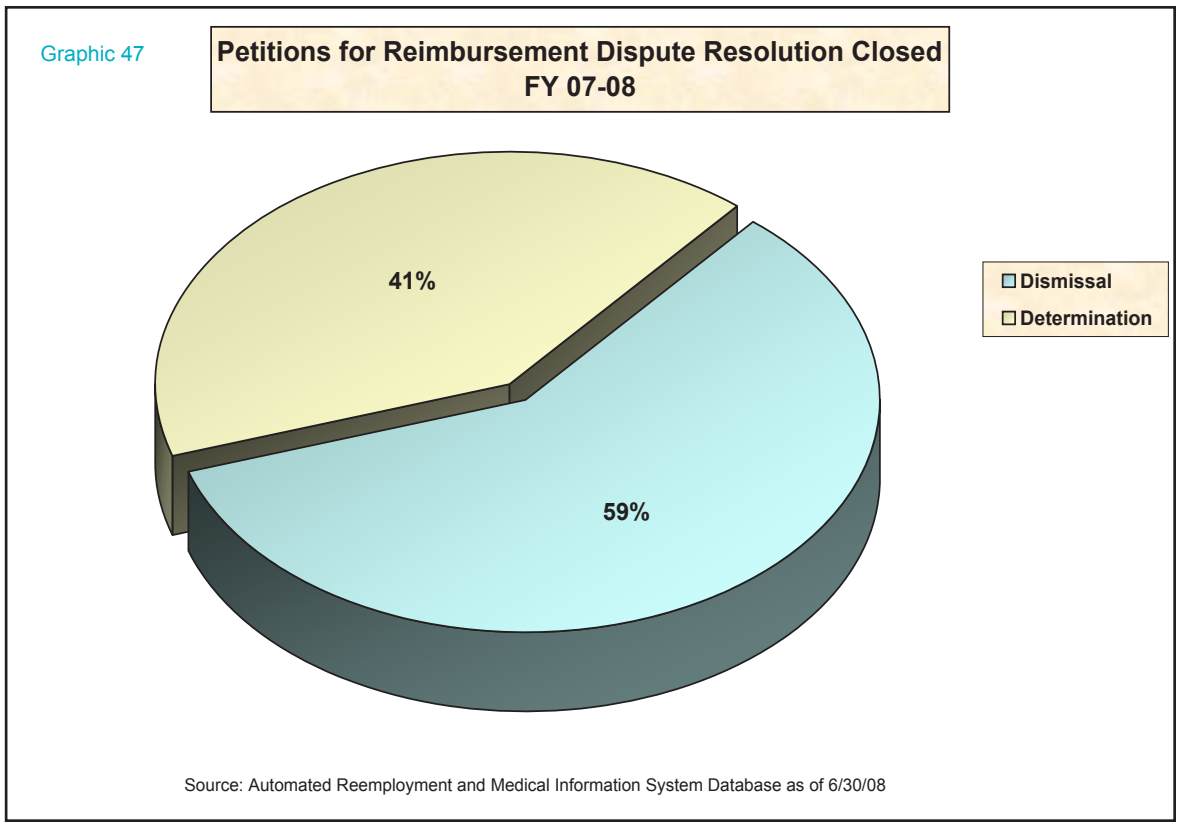
Certification renewal dates are monitored closely by the OMS so early notification can be provided to EMAs about certification renewal dates and the need for recertification. The OMS calls and emails physicians' offices to ensure the EMAs are aware of the renewal date and to offer information and assistance on the renewal process. In addition, to further promote EMA recruitment, the health care provider certification approval letter for newly certified health care providers was revised to include information about the EMA certification process.

During March 2007, the Three-Member Panel adopted a revision to the hospital, ambulatory surgical center and health care provider reimbursement manuals. The rule amendment was effective October 18, 2007. The revised hospital and ambulatory surgical center manuals contain a provision to limit reimbursement amounts for implants. The hospital implant charge carve out was implemented to determine whether the remaining inpatient charges would exceed the stop-loss provision or fall into the per diem reimbursement rate, promoting further cost containment.

The OMS has implemented significant process changes as a result of the revisions to Rule 59A-31, F.A.C., Resolution of Workers' Compensation Reimbursement Disputes. As a result, the OMS has been able to process an increasing number of disputes. These disputes are classified by provider type, decision type (Determination or Dismissal), and the reason for the decision.

Graphic 47 *below* illustrates the percent of Petitions for Resolution of Reimbursement Dispute closed during FY 2007-2008. Of the 1,921 petitions closed, 1,130 received a Dismissal and 791 received a Determination.

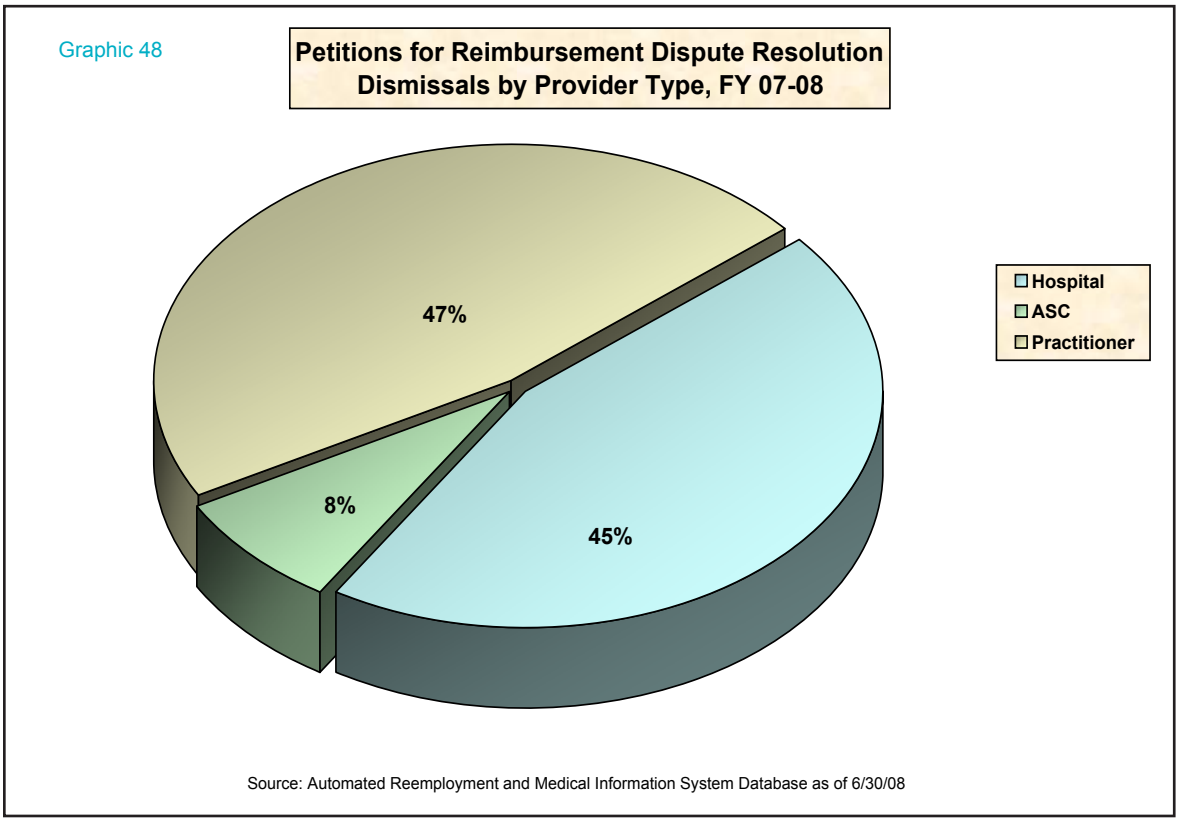
Graphic 47



Source: Automated Reemployment and Medical Information System Database as of 6/30/08

Graphic 48 *below* illustrates the percent of Petitions for Resolution of Reimbursement Dispute for which a Dismissal was issued during FY 2007-2008 by provider type. Of the 1,130 petitions that were dismissed, 509 were submitted by hospitals, 92 were submitted by ambulatory surgical centers (ASC) and 529 were submitted by Practitioners.

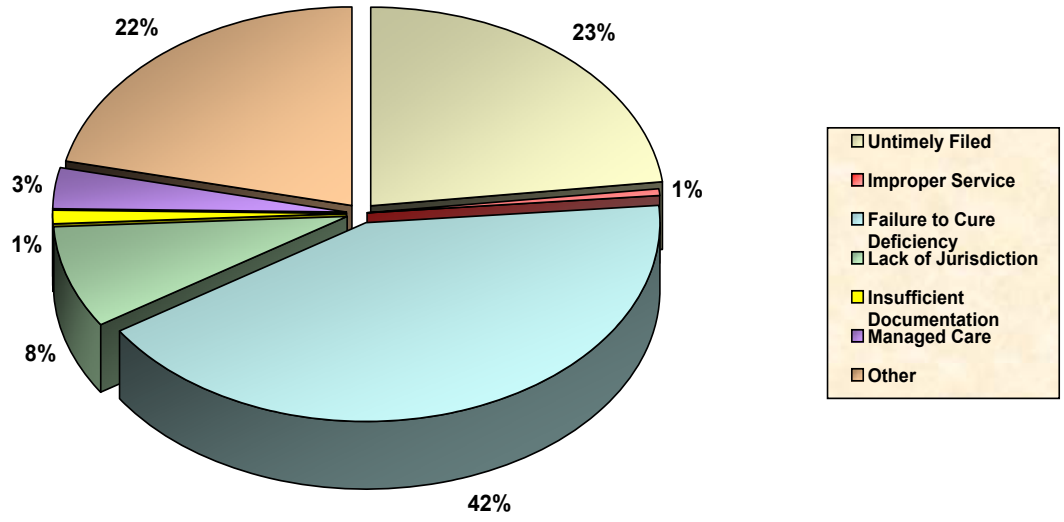
Graphic 48



Graphic 49 illustrates the percent of Petitions for Resolution of Reimbursement Dispute that was dismissed during FY 2007-2008 by reason for dismissal. A petition is untimely filed if it was submitted more than 30 days after receipt of the Explanation of Bill Review (EOBR). A petition must be served on the entity listed on the EOBR or it is dismissed for improper service. If an incomplete petition is received, the petitioner is sent a Notice of Deficiency and given 10 days to cure the deficiency. If not cured within 10 days, the petition is dismissed. Incomplete responses to a Notice of Deficiency are dismissed for insufficient documentation. If a petition received is not within OMS' jurisdiction, e.g., petitioner is not a health care provider or the claim is not covered by Florida's Workers' Compensation Law, the petition is dismissed for lack of jurisdiction. Services rendered under a managed care arrangement are not contestable under s. 440.13(7), F.S., and are dismissed. Finally, petitions may be dismissed under the "Other" category because of withdrawal by the petitioner, a settlement agreement, etc. Of the 1,130 petitions dismissed during FY 2007-2008, nine were dismissed for improper service; 15 for insufficient documentation; 35 for managed care; 92 for lack of jurisdiction; 243 for other reason; 259 for untimely filed; and 477 for failure to cure deficiency.

Graphic 49

Petitions for Reimbursement Dispute Resolution Dismissals by Reason, FY 07-08

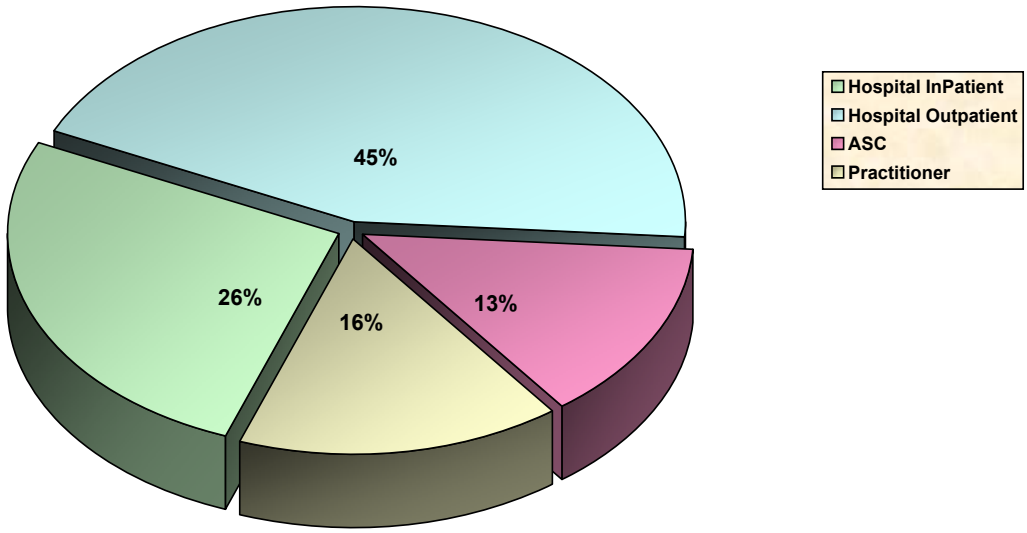


Source: Automated Reemployment and Medical Information System Database as of 6/30/08

Graphic 50 *below* illustrates the percent of Petitions for Resolution of Reimbursement Dispute for which a determination was issued during FY 2007-2008 by provider type. Of the 791 petitions filed for which a determination was issued, 71% were submitted by hospitals (which are further distinguished by outpatient and inpatient care), 13% by ASC's and 16% by practitioners.

Graphic 50

Petitions for Reimbursement Dispute Resolution Determinations by Provider Type, FY 07-08

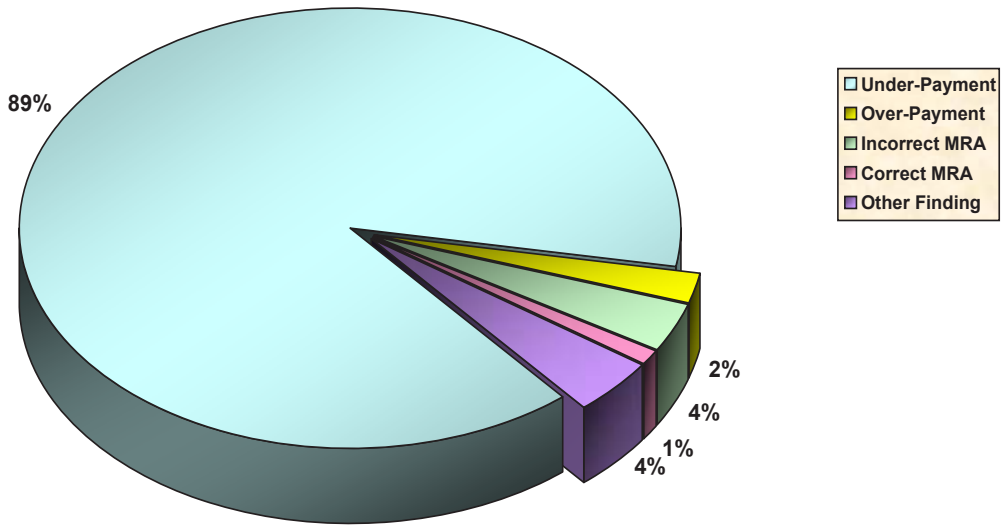


Source: Automated Reemployment and Medical Information System Database as of 6/30/08

Graphic 51 *below* illustrates the percent of Petitions for Resolution of Reimbursement Dispute for which a determination was issued during FY 2007-2008, by determination outcome. Of the 791 determinations issued, seven were for incorrect maximum reimbursement allowance (MRA) according to the appropriate reimbursement manual, 17 for overpayment, 29 for correct MRA, 34 for other reasons and 704 for underpayment.

Graphic 51

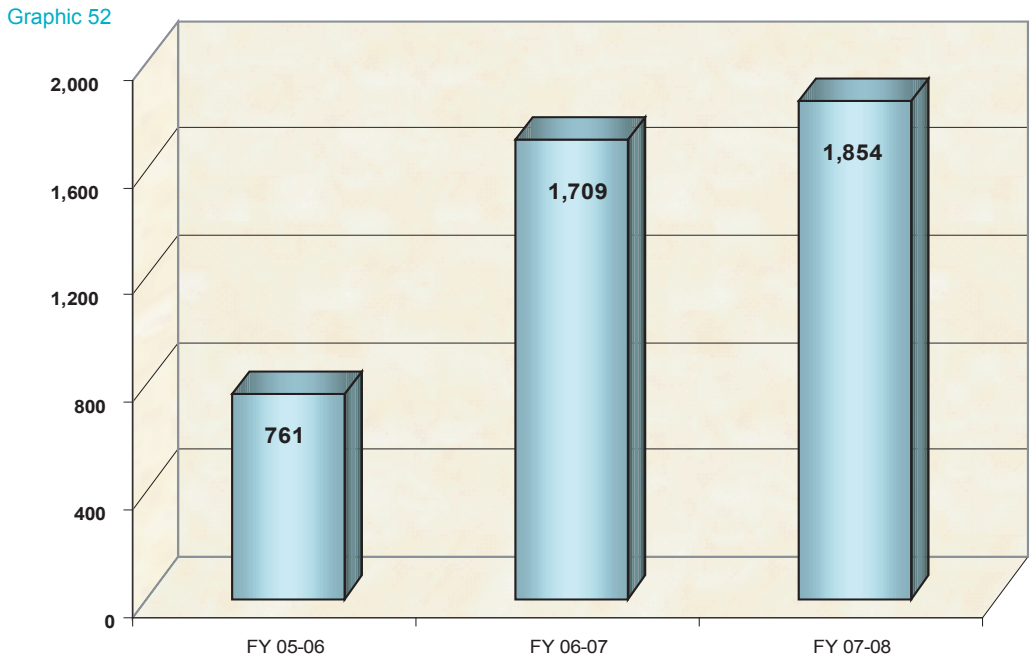
Petitions for Reimbursement Dispute Resolution Determinations by Outcome, FY 07-08



Source: Automated Reemployment and Medical Information System Database as of 6/30/08

Graphic 52 illustrates the number of Petitions for Resolution of Reimbursement Dispute received by OMS during the last three fiscal years. The number of petitions submitted has increased annually, resulting in a 144% increase from the number of petitions submitted in FY 2005-2006 to those submitted in FY 2007-2008.

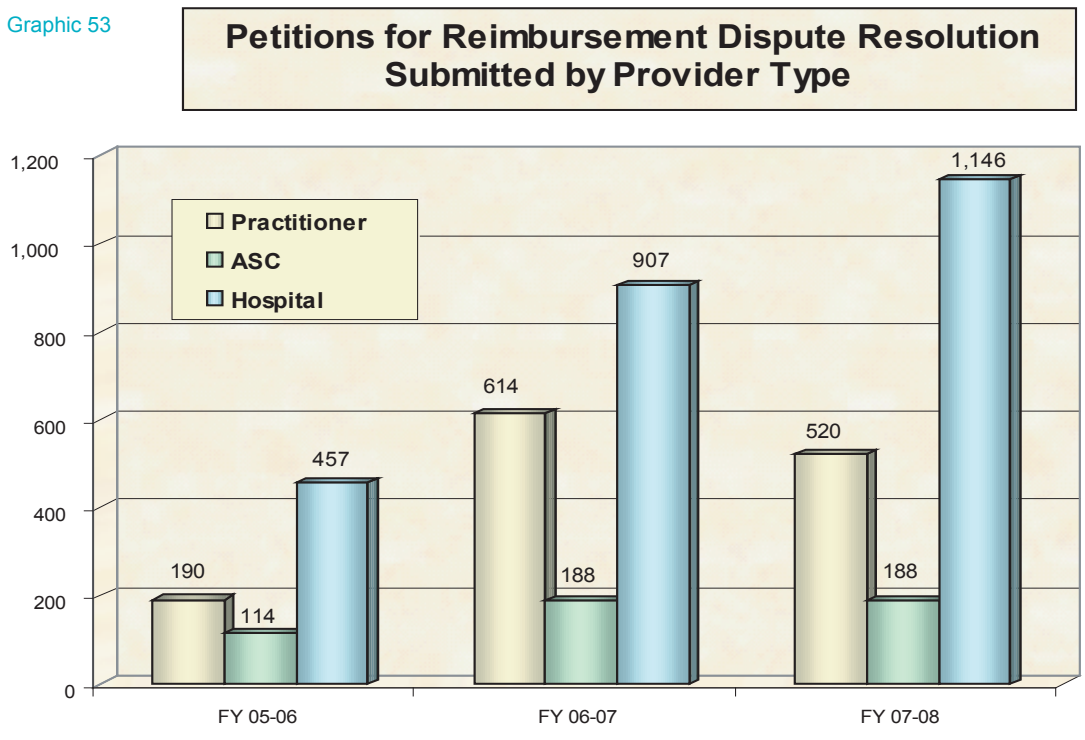
Graphic 52



Source: Automated Reemployment and Medical Information System Database as of 6/30/08

Graphic 53 *below* illustrates the number of Petitions for Resolution of Reimbursement Dispute received by OMS during the last three fiscal years by provider type. The number of petitions received from hospitals increased by 151% from FY 2005-2006 to FY 2007-2008. The number of hospital petitions submitted exceeds the combined number of petitions submitted by Ambulatory Surgical Centers and Practitioners during each of the three fiscal years cited.

Graphic 53



Source: Automated Reemployment and Medical Information System Database as of 6/30/08

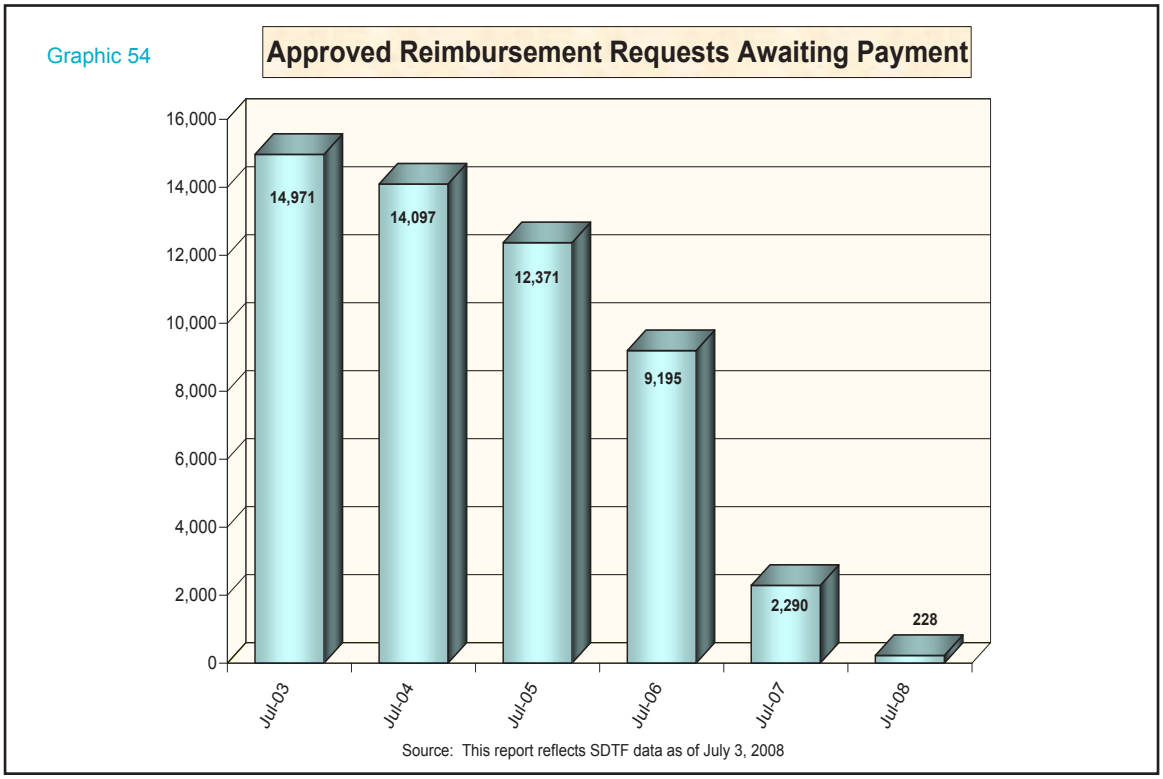
OFFICE OF SPECIAL DISABILITY TRUST FUND

The Special Disability Trust Fund (SDTF) was established in 1955 to encourage employers to hire people with pre-existing permanent impairments by reimbursing excess costs if new work-related injuries occur subsequent to hiring and result in an additional permanent impairment. The cost of the SDTF, including reimbursements to employers and claim administrators, is funded through assessments on workers' compensation premiums written by insurers and the amount of premium calculated by the Division for self-insured employers. The SDTF was "prospectively abolished" in 1997 and has transitioned to a "run-off" of eligible claims. However, assessments continue to be collected, by law, to fund the ongoing operation of the SDTF.

In the early 1990s, the SDTF began experiencing increased costs along with the rest of the workers' compensation system. If no restriction had been imposed, the SDTF assessment rate was expected to rise into the double digits. In 1994, the assessment rate for the SDTF was legislatively capped at 4.52% of net written workers' compensation premium. In 1997, the SDTF was prospectively abolished by limiting claims against the SDTF to dates of accident occurring on or before December 31, 1997. While employers and their insurers are not permitted to receive reimbursement for dates of accident occurring after December 31, 1997, they are still permitted to file new Notices of Claim and Proofs of Claim for accidents occurring on or before that date.

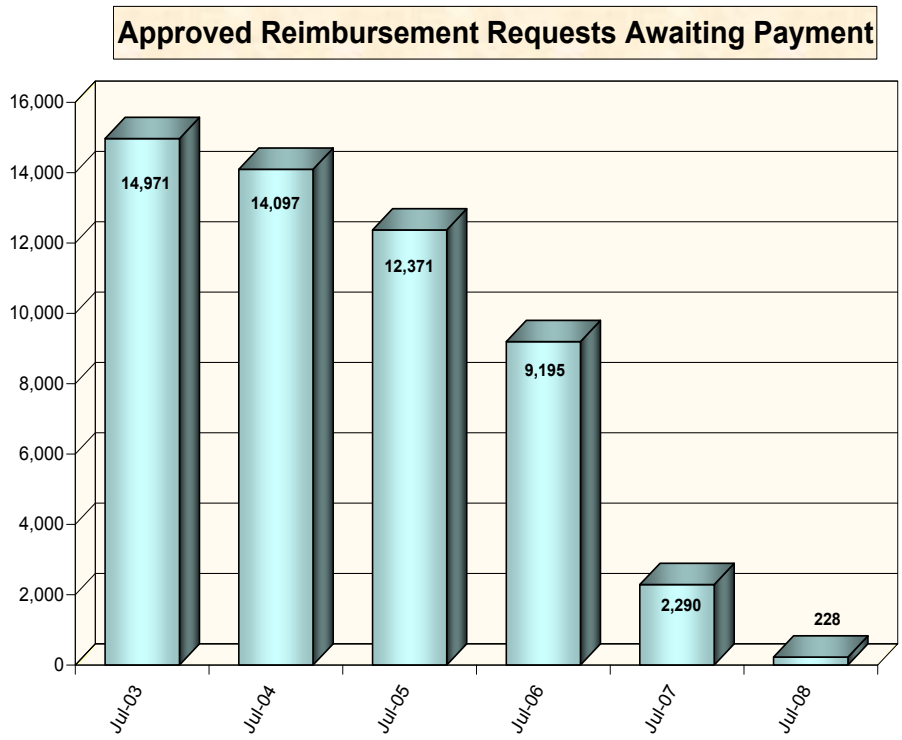
For several years, the value of approved Reimbursement Requests exceeded the revenue produced by the capped assessment. The result was a backlog of approved Reimbursement Requests awaiting payment. The backlog reached over 15,500 approved reimbursements and was valued in excess of $535 million by December 31, 2001. The wait time between filing a Reimbursement Request and receiving payment grew annually until FY 2004-2005 when the wait time on approved reimbursements reached its peak at almost forty-five months. By the end of that fiscal year, the trend had been reversed and the wait time began decreasing. As of March 2008, the SDTF eliminated the backlog of approved Reimbursement Requests awaiting payment. The SDTF is now paying reimbursements as the Reimbursement Requests are approved and cleared for payment. Graphics 54 and 55 illustrate the reduction in the backlog of approved reimbursements awaiting payment.

Graphic 54



Source: This report reflects SDTF data as of July 3, 2008

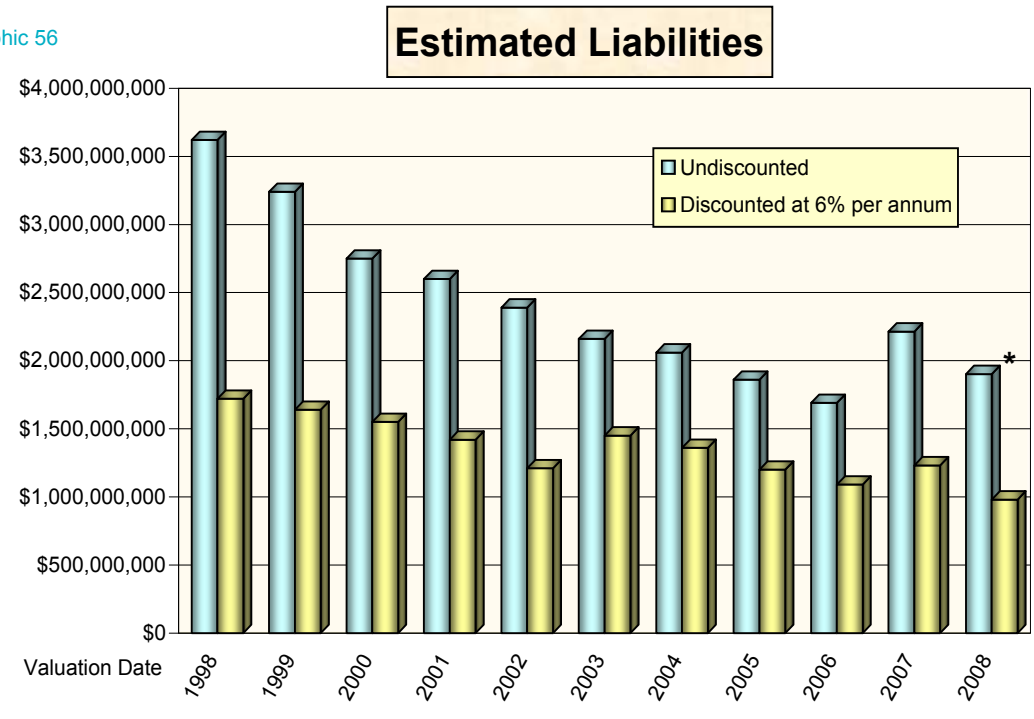
Graphic 55



Source: This report reflects SDTF data as of July 3, 2008

Immediately following the SDTF's prospective abolishment, the total unfunded, undiscounted future liability was estimated at $3.62 billion in 1998. As post reform claims experience developed, the SDTF's estimated unfunded undiscounted liability decreased. The most recent annual actuarial report, Actuarial Valuation of the Florida Department of Financial Services, Division of Workers' Compensation, Special Disability Trust Fund, Actuarial Analysis as of June 30, 2007, prepared by Pinnacle Actuarial Resources, Inc., places the unfunded undiscounted SDTF liability at about $2.214 billion. Graphic 56 *below* illustrates the change in the last ten SDTF liability valuations.

Graphic 56



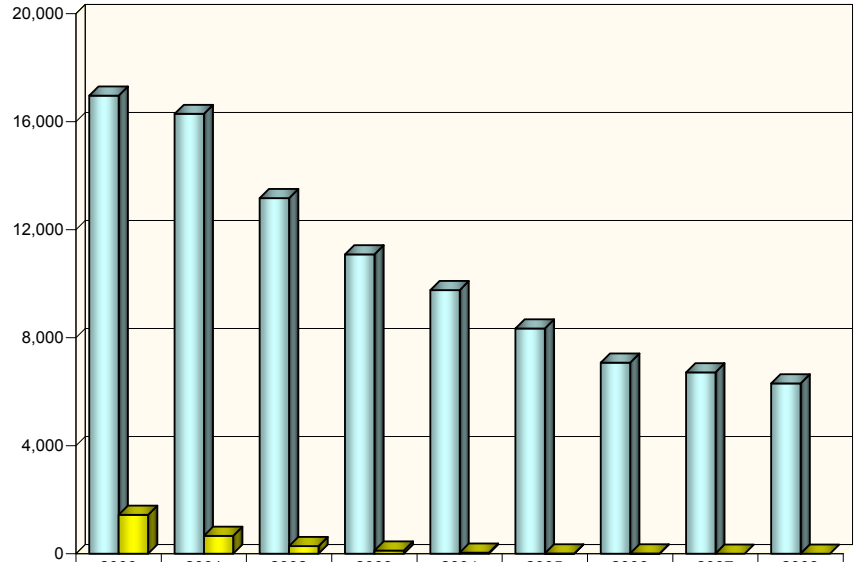
*2008 Estimated Liabilities are from advanced estimate in 2007.

Source: Annual Actuarial Reports supplied by various vendors and on file with the SDTF for the given valuation date.

The number of open claims was reduced from 16,961 at the end of FY 1999-2000 to 6,304 at the end of FY 2007-2008. The number of new Proofs of Claim being filed has become negligible in recent years with only five filed in FY 2007-2008. Graphic 57 *below* shows the reduction in open claims and Proofs of Claim filed over time.

Graphic 57

Open Claims at Fiscal Year End



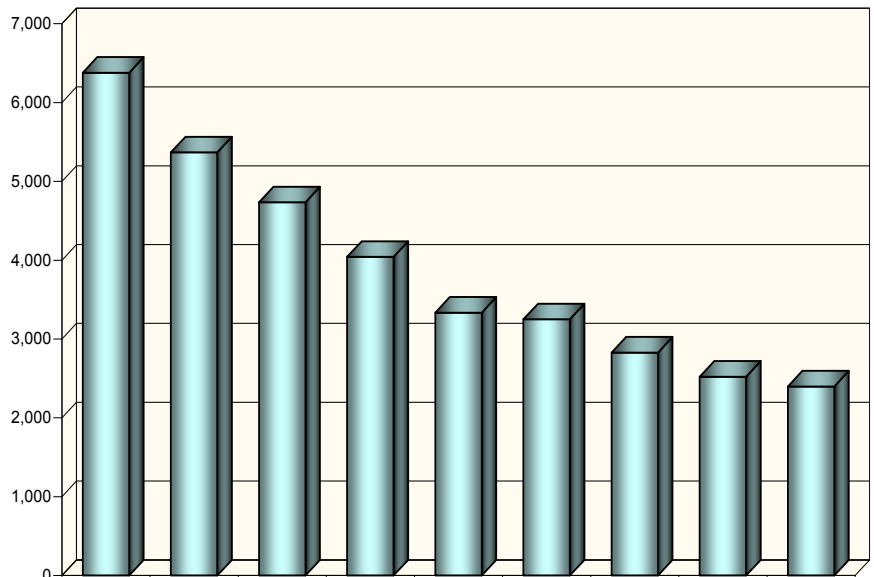
	2000	2001	2002	2003	2004	2005	2006	2007	2008
Number of Open Claims	16,961	16,286	13,171	11,088	9,761	8,342	7,073	6,714	6,304
Number of Proofs Filed	1,443	666	282	115	45	13	9	6	5

Source: This report reflects SDTF data as of July 3, 2008

The number of Reimbursement Requests filed per year has steadily declined since FY 1999-2000. Reimbursement Requests decreased from 6,738 filed during FY 1999-2000 to 2,398 filed during FY 2007-2008 resulting in a reduction of more than 62%. Graphic 58 *below* shows the reduction in Reimbursement Requests filed over time.

Graphic 58

Reimbursement Requests Filed by Fiscal Year



	2000	2001	2002	2003	2004	2005	2006	2007	2008
Number Filed	6,378	5,368	4,735	4,042	3,334	3,251	2,829	2,522	2,398

Source: This report reflects SDTF data as of July 3, 2008

During FY 2007-2008 the Special Disability Trust Fund analyzed the status of the fund, its claims and processes, to determine how to most efficiently and effectively conclude the SDTF's liabilities. This analysis resulted in the implementation of initiatives intended to advance the SDTF to the point that it will be primarily servicing active, open claim files, because the SDTF will have addressed the maximum number of previously lingering, unresolved claims.

The SDTF began pursuing the following initiatives during FY 2007-2008:

- **Claims that are open, but pending the receipt of additional information –** There are approximately 990 Proofs of Claim that are outstanding because they have been returned for additional information concerning the eligibility of the claim. Generally, these are claims that the SDTF anticipated could be perfected, but additional documentation would be needed to do so. The SDTF is working in conjunction with the Division of Legal Services, Workers' Compensation Section to review and take action on these files based upon the information already on file with the SDTF.
- **Data verification audits –** Concurrent with performing an initial audit of the Reimbursement Request, the SDTF also conducts a data verification audit. These data verification audits compare the information contained in the SDTF's electronic claims database with the information contained in the physical claim file. Any subsequent Data Verification Audit only covers the period since the prior Audit. The SDTF implemented data verification auditing during the last half of FY 2006-2007. It is expected that the majority of all open claim files will have undergone a Data Verification Audit within the first two years of the initiative. By the end of FY 2008-2009, these audits are expected to shift almost entirely to Subsequent Data Verification Audits. These audits enhance the accuracy of the valuation and estimate of SDTF liabilities contained in the annual independent actuarial report.
- **Reduction of the number of Reimbursement Requests awaiting an initial audit –** The SDTF has a large number of Reimbursement Requests filed, but pending initial audit. Audit wait time is now the primary driver of payment wait time, especially when the Reimbursement Request is approved upon initial audit. The number of Reimbursement Requests awaiting audit is expected to decrease to a negligible level during FY 2008-2009. This should occur due to additional resources being dedicated to auditing, the reduction in the complexity of Data Verification Audits over time, and the consistent decline in the number of Reimbursement Requests filed per year.

Consistent with the proactive initiatives described above and implemented during FY 2007-2008, the SDTF will expand these efforts in FY 2008-2009 with the implementation of an additional initiative:

- **Resolution of outstanding Reimbursement Requests pending correction by the employer/carrier –** The SDTF has approximately 500 audited Reimbursement Requests that are pending approval because the SDTF has returned them to the employer/carrier, or their representative, for correction. If these Reimbursement Requests are not perfected within five years of filing, they become barred by the statute of limitation. The SDTF will proactively pursue these outstanding Reimbursement Requests by advising the employer/carrier of the status of the claim, the required employer/carrier action, and the pending statute of limitation bar. The goal of this initiative is to encourage and assist the employer/carrier in resolving the maximum number of these Reimbursement Requests as possible before they are barred by law.

ASSESSMENTS AND FUNDING

The Division manages two trust funds: the Workers' Compensation Administration Trust Fund (WCATF) and the Special Disability Trust Fund (SDTF). Both funds are supported by annual assessments against workers' compensation insurance premiums, actual and estimated. For insurance companies, assessable mutuals, and self-insurance funds, assessments are based upon actual premiums; for individual self-insurers, assessments are based on the amount of premiums calculated by the Division.

The Workers' Compensation Administration Trust Fund

The Division, in accordance with s. 440.51, F.S., determines the funding level for the WCATF each year, based upon anticipated administrative expenses for the next calendar year. Assessments are calculated by prorating these administrative expenses among insurance companies, self-insurance funds, assessable mutual companies, and individual self-insurers. The estimated expenses include costs for the Division of Workers' Compensation (administrative costs and the payment of Permanent Total Disability Supplemental Benefits for eligible injured workers with dates of accident prior to July 1, 1984), administrative expenses for the Office of the Judges of Compensation Claims, and a portion of expenses for the Agency for Health Care Administration, the Department of Education, the Division of Insurance Fraud, and the Department of Business and Professional Regulation.

Effective July 1, 2001, the WCATF assessment period was changed from fiscal year to calendar year. At the same time, the Legislature expanded the assessable premium base and required insurers to pay the WCATF assessment on net premiums, including the deductible premium discount amount of the policy and the nondeductible premium amount. Concurrently, the maximum assessment rate was lowered from 4% to 2.75%. Since that time, the WCATF assessment rate has steadily decreased. It was reduced to 0.25% for calendar year 2008 and will remain at that level for calendar year 2009.

Graphic 59 *below* summarizes the WCATF assessment rates and total revenues generated from all sources for the past five fiscal years.

Graphic 59

Workers' Compensation Administration Trust Fund
Assessment Rates and Total Revenue

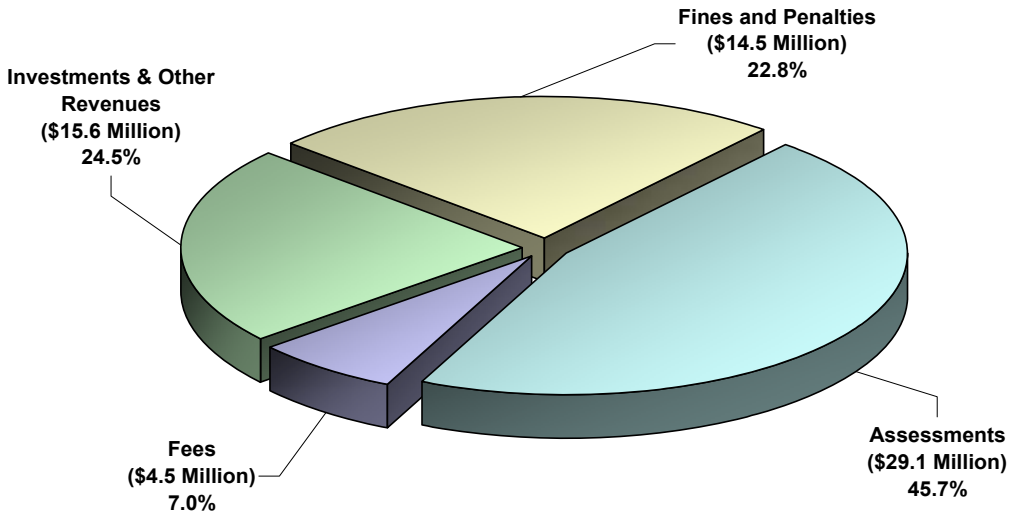
Fiscal Year	Assessment Rates*		Total Revenue
2003-2004	7/1 - 12/31 1/1 - 6/30	1.75% 1.50%	$146,447,288
2004-2005	7/1 - 12/31 1/1 - 6/30	1.50% 0.75%	$122,706,612
2005-2006	7/1 - 12/31 1/1 - 6/30	0.75% 0.60%	$97,209,027
2006-2007	7/1 - 12/31 1/1 - 6/30	0.60% 0.50%	$83,537,585
2007-2008	7/1 - 12/31 1/1 - 6/30	0.50% 0.25%	$63,563,336

*** The WCATF Assessment Rate is applied on a Calendar Year basis.**
Source - Department of Financial Services, Revenue Processing Unit and Division of Treasury, as of July 9, 2008.

Graphics 60 and 61 *below* illustrate the breakout of WCATF revenues and disbursements during Fiscal Year 2007-2008. Any excess of revenue over disbursements is applied toward estimated expenses for the subsequent calendar year, and included in the computation of that year's assessment rate.

Graphic 60

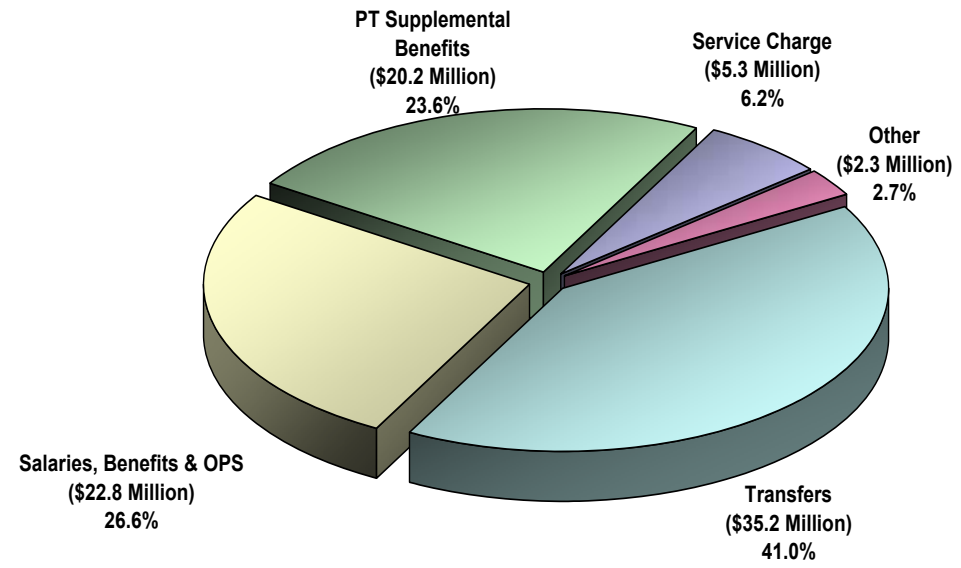
Fiscal Year 2007-2008
Workers' Compensation Administration Trust Fund Revenue



Source: Department of Financial Services, Revenue Processing Unit and Division of Treasury, as of 7/9/2008.

Graphic 61

Fiscal Year 2007-2008
Workers' Compensation Administration Trust Fund Disbursements



Source: Florida Accounting Information Resource Database as of 7/14/08

Special Disability Trust Fund Assessments

Graphic 62 *below* summarizes the assessment rates and total revenues generated from all sources by the SDTF for the past five fiscal years. The breakout of total revenues received between assessments and filing fees has not been provided, since assessment revenues have historically accounted for more than 99% of total revenue receipts.

Graphic 62

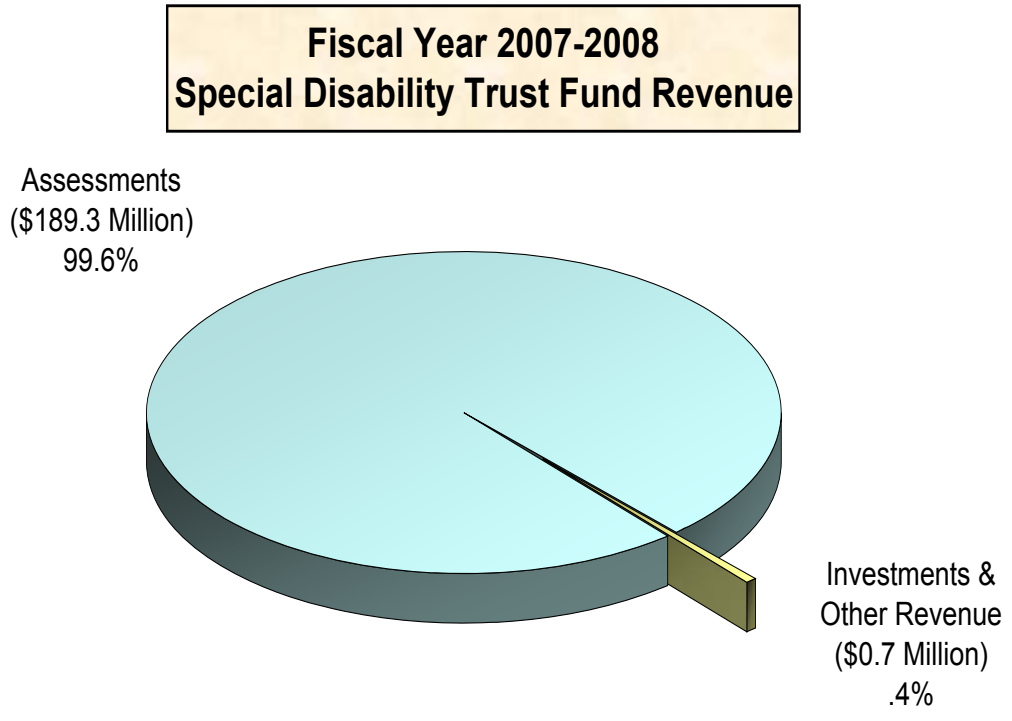
Special Disability Trust Fund Assessment Rates and Total Revenue

Fiscal Year	Assessment Rates	Total Revenue
2003-2004	4.52%	$200,261,453
2004-2005	4.52%	$227,066,908
2005-2006	4.52%	$250,779,908
2006-2007	4.52%	$246,115,970
2007-2008	4.52%	$190,033,167

Source - Department of Financial Services, Revenue Processing Unit and Division of Treasury, as of July 9, 2008.

Graphic 63 *below* illustrates the sources of SDTF revenue during FY 2007-2008.

Graphic 63

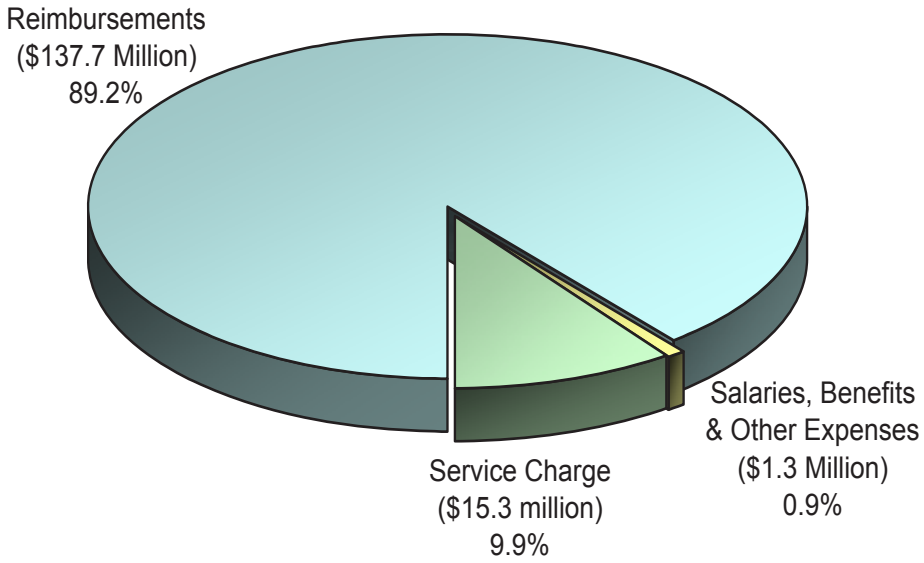


Source: Department of Financial Services, Revenue Processing Unit and Division of Treasury, as of 7/9/08.

Graphic 64 *below* illustrates the breakout of SDTF disbursements during FY 2007-2008. Almost nine out of every ten dollars (89.2%) disbursed by the SDTF were paid to insurers and self insurers for reimbursement of eligible claim costs.

Graphic 64

Fiscal Year 2007-2008
Special Disability Trust Fund Disbursements



Source: Florida Accounting Information Resource database as of 7/14/08

Lost-time Claims

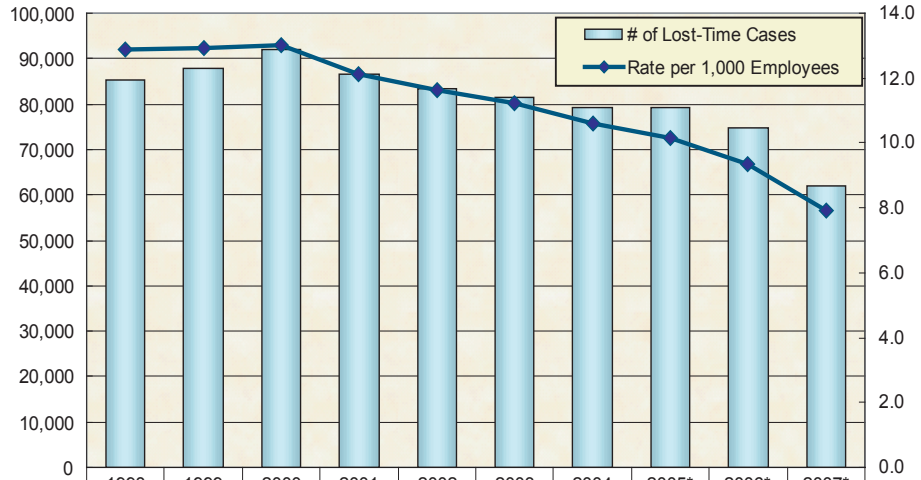
After an increase through 2000, lost-time injury frequency has steadily declined in each subsequent year. It is important to note that lost-time claim data for 2005 through 2007 are not fully mature (meaning that many accidents which occurred in those years may not have yet developed into lost-time claims) and too much emphasis should not be placed on the level of claims reported for those years.

Graphic 65 *below* provides the frequency of lost-time cases along with the rate of injury per 1,000 employees over the past ten years. This rate is determined by comparing the number of lost-time claims to the number of employees covered under the Unemployment Insurance Tax Law, (excluding federal government workers). An asterisk after the years 2005, 2006, and 2007 in many of the graphics throughout this report designates the immature aspect of the data pertaining to those injury years.

The trend showing a decreasing number of lost-time cases is consistent with the decreasing trend for the rate of injury. At its height in 2000, 13 lost-time cases occurred for every 1,000 employees. By 2004, this number had declined to 10.6, an 18.5% reduction.

Graphic 65

Lost-Time Cases and Lost-Time Case Rate



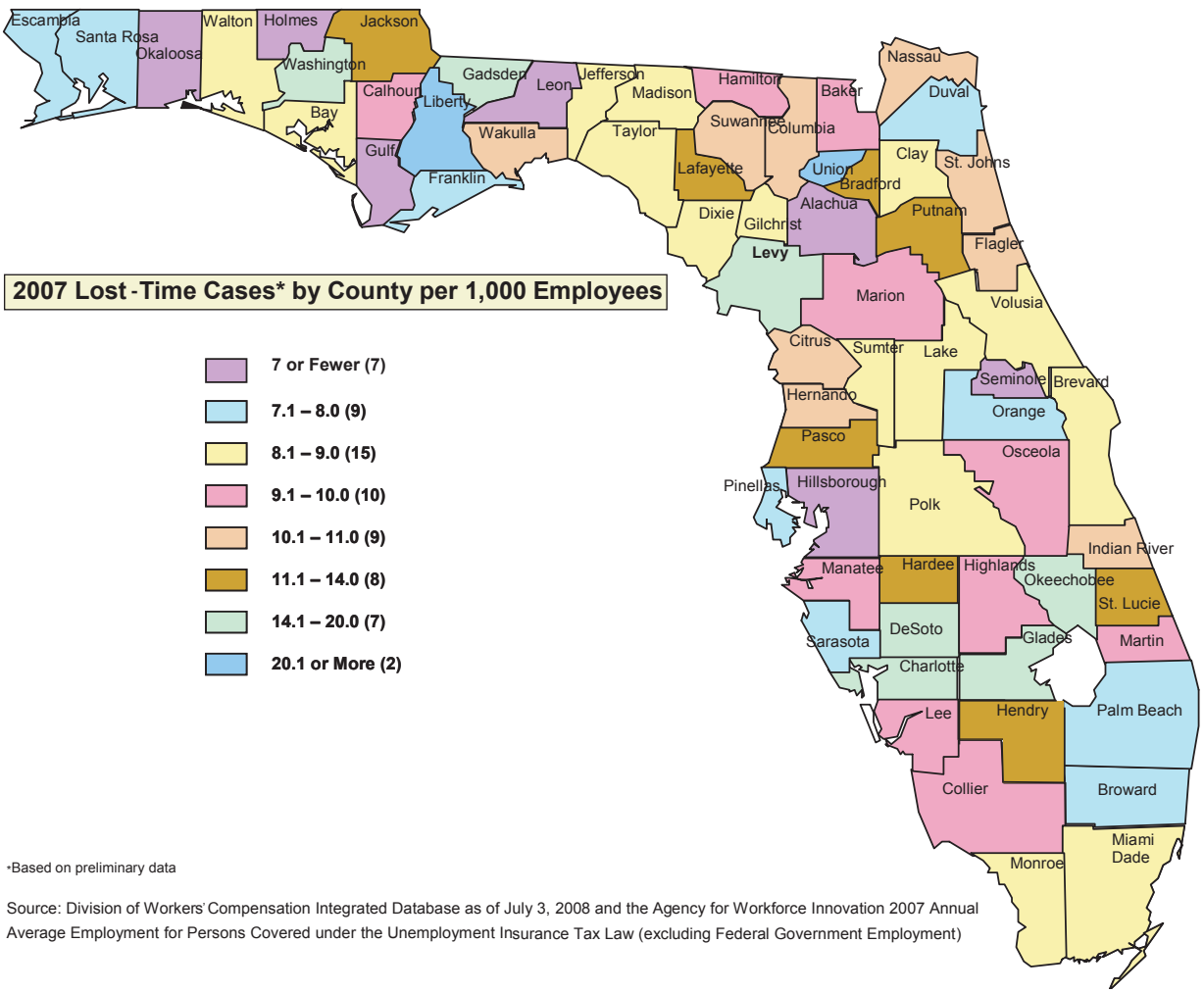
Injury Year	1998	1999	2000	2001	2002	2003	2004	2005*	2006*	2007*
# of Lost-Time Cases	85,294	87,989	92,102	86,649	83,486	81,518	79,338	79,203	74,674	62,023
Rate per 1,000 Employees	12.9	12.9	13.0	12.1	11.6	11.2	10.6	10.2	9.3	7.9

*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 3, 2008 and the Agency for Workplace Innovation Annual Average Employment for Persons Covered under the Unemployment Insurance Tax Law (excluding Federal Government employees)

During 2007, the rate of lost-time claims per 1,000 employees varied considerably throughout Florida, from a low of six in Leon and Okaloosa Counties to a high of 31.2 in Liberty County. The rate of lost-time claims by county is reflected in Graphic 66. Many of the counties in Florida with the largest concentrations of employment had lost-time rates below the rate for the state as a whole. Duval, Pinellas, Hillsborough, Orange, Palm Beach, and Broward Counties all demonstrate this pattern. Conversely, the two counties with the highest rates of lost-time injuries - Liberty and Union - have a comparatively small labor force. Four of the six counties with the lowest lost-time rates were in north Florida, though in general the geographic distribution of injury rates does not suggest any clear trends.

Graphic 66

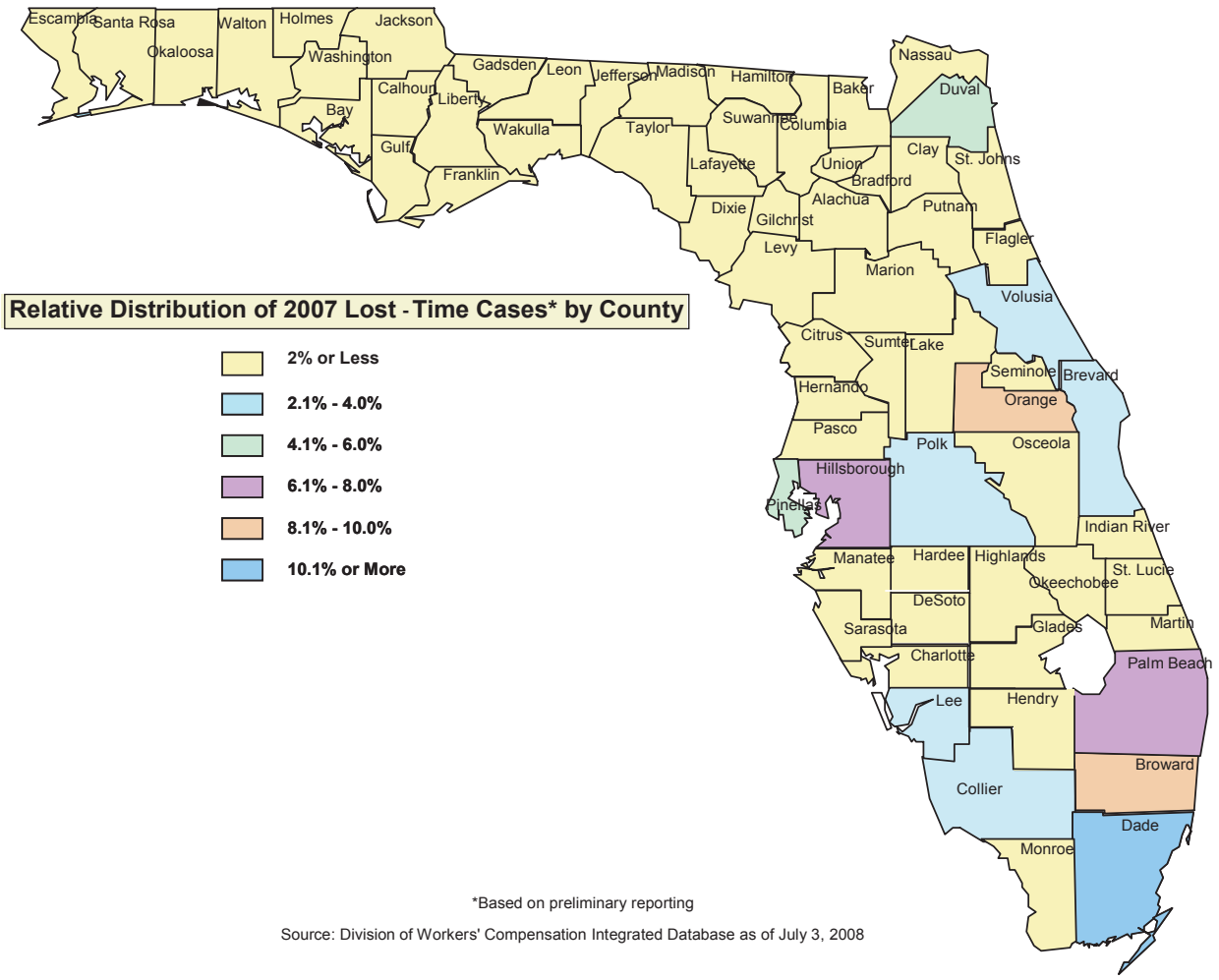


*Based on preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 3, 2008 and the Agency for Workforce Innovation 2007 Annual Average Employment for Persons Covered under the Unemployment Insurance Tax Law (excluding Federal Government Employment)

Graphic 67 displays the relative distribution of 2007 lost-time cases by county. This distribution is based on the number of cases in that county compared to the statewide case total. Counties with the largest population and workforce also reflect a concentration of lost-time cases. Miami-Dade County had the highest percentage of injuries. Of the 12 counties with the largest number of persons employed, only Seminole had a share of lost-time cases that mirrored the 55 less populous counties.

Graphic 67

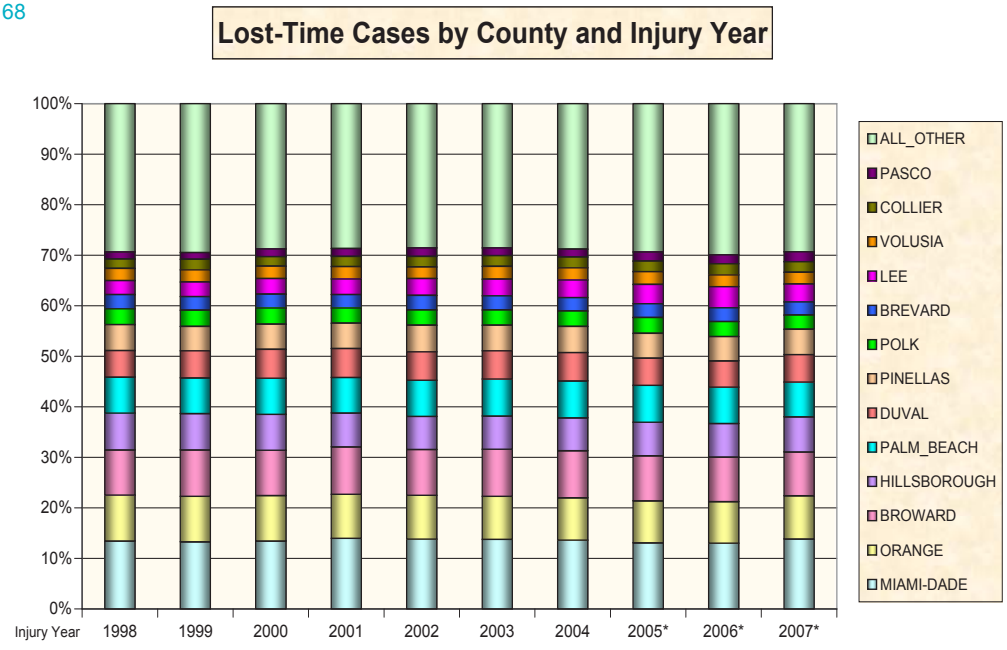


*Based on preliminary reporting

Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

The historical trend for the percentage of lost-time cases by county is provided in Graphic 68. County percent distributions over the decade have remained relatively stable. In each injury year, the three leading counties - Miami-Dade, Orange and Broward reported more lost-time cases than the combined 54 counties included in "All Other." The leading 13 counties accounted for 70% of the statewide total of lost-time cases each year.

Graphic 68

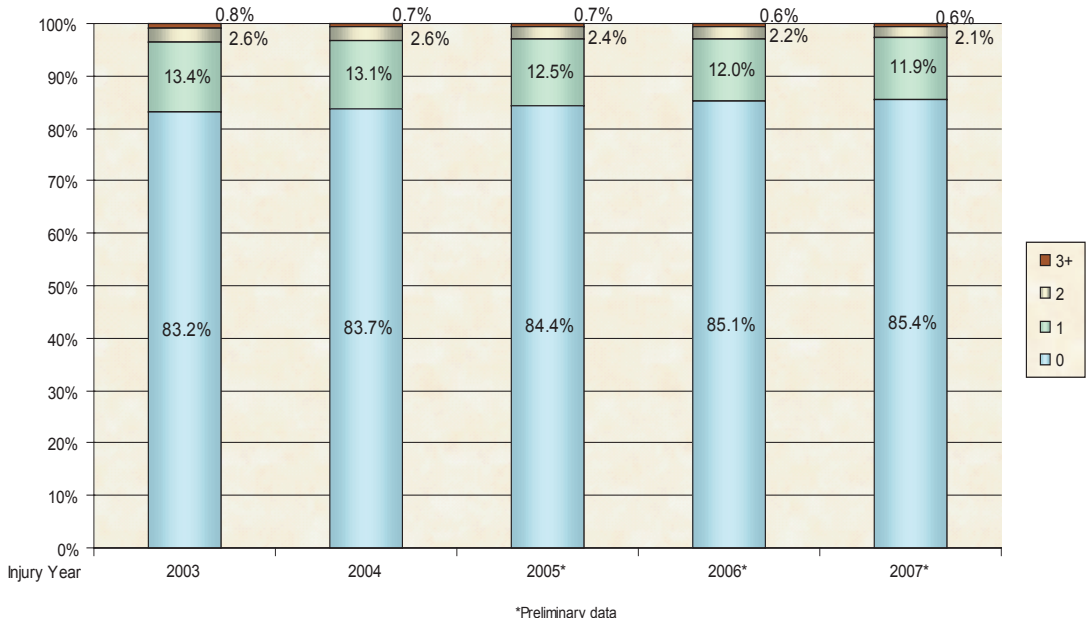


*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

A relatively small percentage of injured workers with lost-time claims have additional accidents resulting in one or more additional lost-time claims within the previous five years. Graphic 69 shows how many injured workers with lost-time claims from 2003 through 2007 also experienced a lost-time claim during the five-year period prior to that year. The data indicate that between 14.6% and 16.8% of the workers with lost-time claims had one or more prior lost-time claim during the prior five years. Less than 1% experienced three or more claims during the prior five years and only about 3% of injured workers in each injury year had two or more prior claims. The vast majority of injured workers, from 83.2% to 85.4%, did not sustain a lost-time injury during the preceding five year period.

Graphic 69

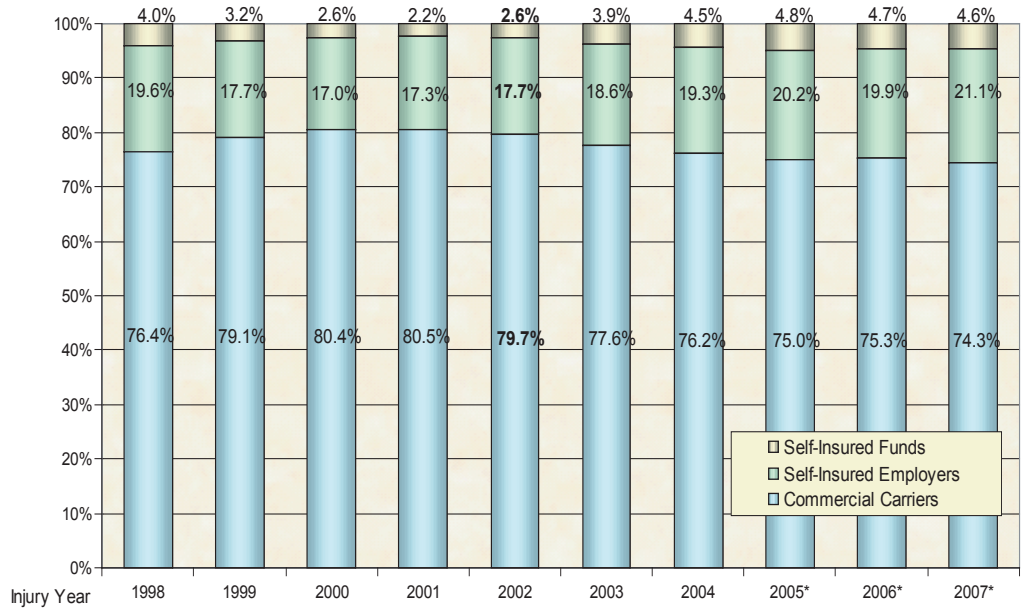


Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

Insurer Type

One potential indicator of changes in market share over time is the proportion of lost-time cases for which each insurer type is responsible. These numbers may be impacted by changes in injury rates by insurer type and/or reflective of the types of industry and industry injury rates for which each insurer type is responsible. After being relatively stable from 1999 through 2002, the market share of lost-time claims handled by individually self-insured employers has gradually risen from 2002 through 2007, increasing from 17% of the market share in 2000 to 21.1% in 2007. During that same period, group self-insured funds almost doubled their market share from 2.6% of the market to 4.6%. Graphic 70 displays the insurer types handling lost-time claims from 1998 through 2007. Commercial insurers are still the predominant insurer type, with their share of cases peaking at 80.5% in Injury Year 2001. The commercial insurer share of cases has annually declined somewhat since 2002 to 74.3% of lost-time cases in 2007.

Graphic 70



*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

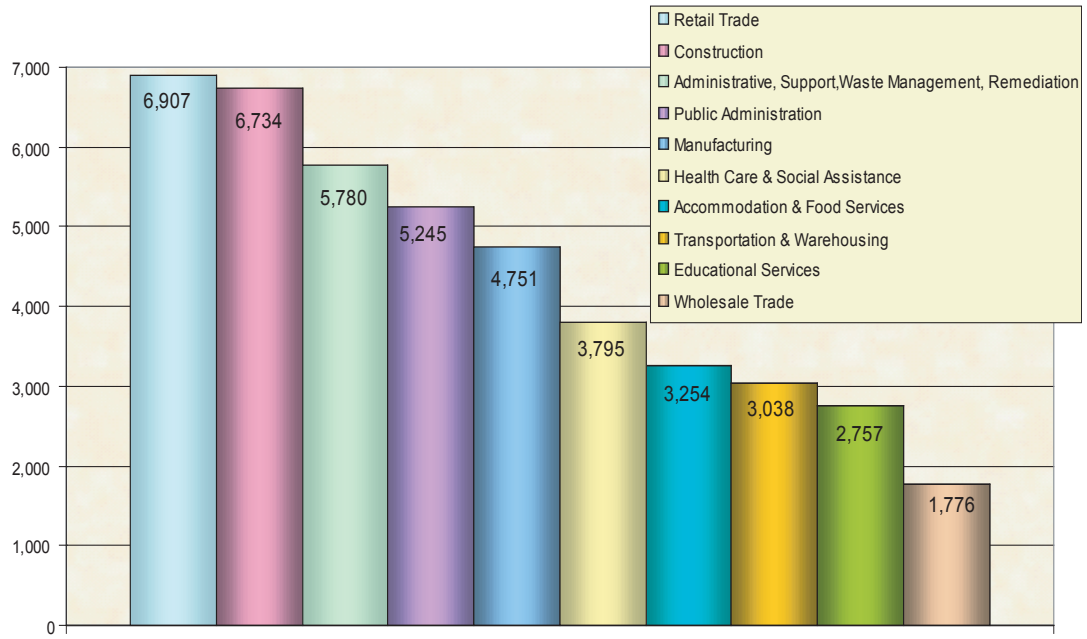
Industry Type

Graphic 71 provides the frequency of 2007 lost-time cases for the top ten industry classifications. The classification of industries began following the North American Industry Classification System (NAICS) in 2006 with prior years reported on the basis of the Standard Industrial Classification (SIC) system. Frequency counts are based on 84% reporting of the industry class code for 2007 lost-time cases.

Retail Trade and Construction classification totals are so close as to be considered a statistical tie for the leading industry classification among 2007 lost-time cases, with 6,907 and 6,734 cases, respectively. Administrative, Support, Waste Management, and Remediation; Public Administration; and Manufacturing complete the top five industrial classifications among 2007 lost-time cases. These top five classifications account for 57% of all cases with reported classification information, while the top ten industries account for 85% of the cases.

Graphic 71

Top Ten Industrial Classifications for 2007* Lost-Time Cases



*Preliminary

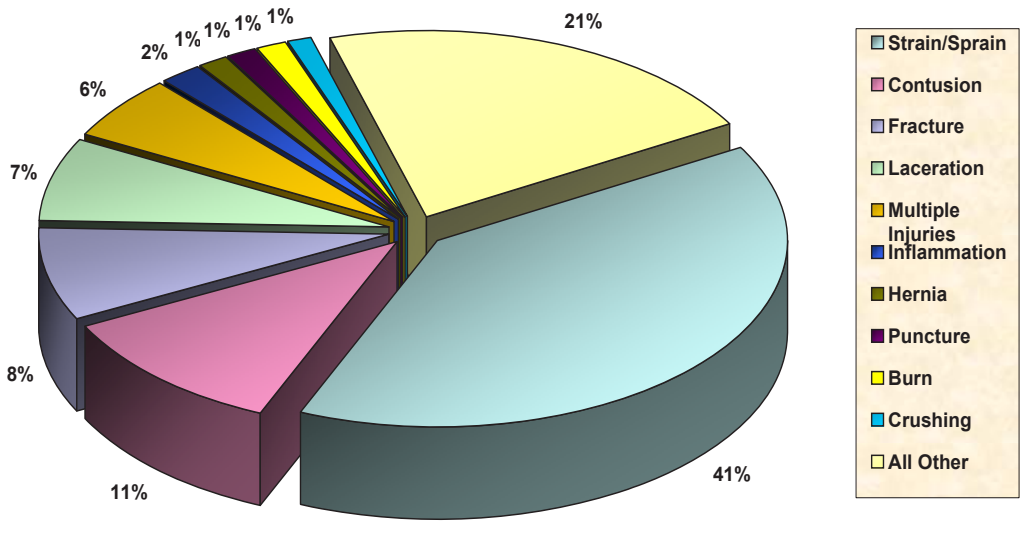
Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

NATURE, CAUSE, AND BODY LOCATION OF WORKPLACE INJURIES

Workplace injuries leading to lost-time claims fall into fairly consistent patterns by nature of injury. Graphic 72 *below* illustrates the distribution of 2007 lost-time cases by their underlying nature of injury. Together, Strain and Sprain account for 41% of the 2007 cases. Contusion (11%), Fracture (8%), and Laceration (7%) combine with Strain and Sprain to constitute over two-thirds of all 2007 lost-time cases. Most of the remaining cases involve Multiple Injuries (6%), followed by Inflammation (2%), Hernia (1%), Puncture (1%), Burn (1%) and Crushing (1%).

Graphic 72

2007* Lost-Time Cases by Nature of Injury

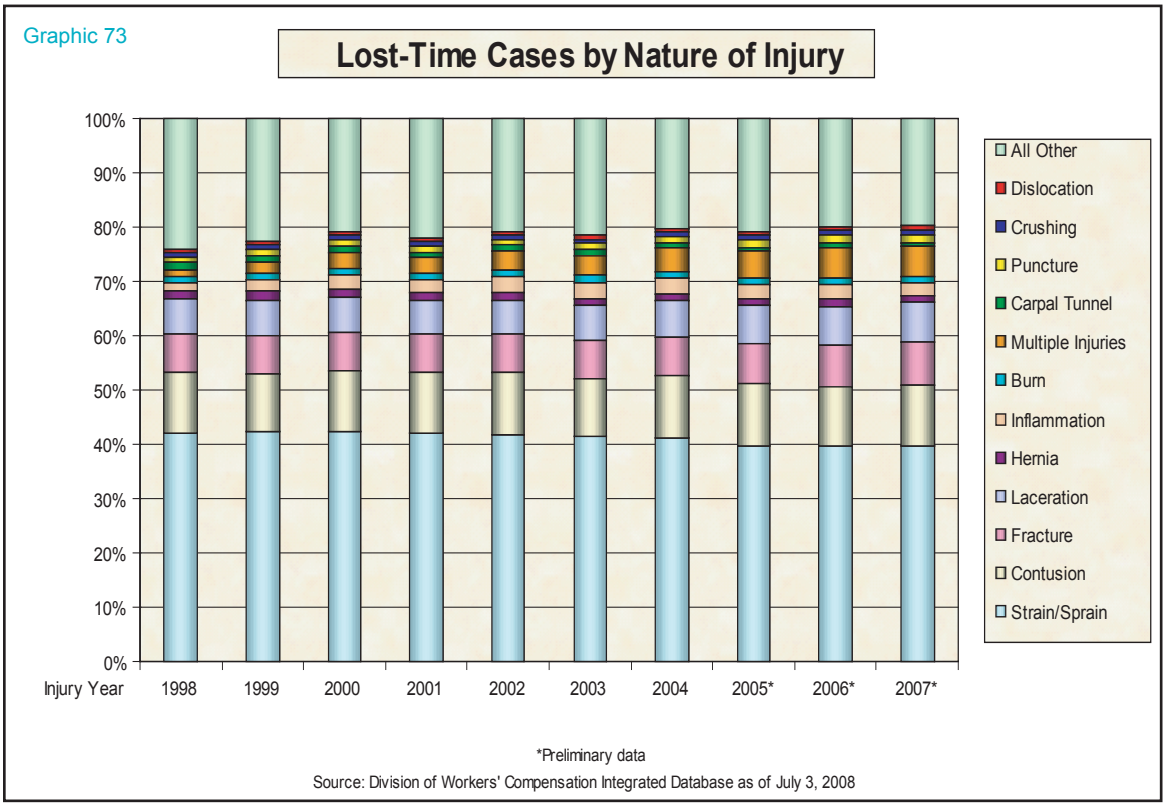


*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

Graphic 73 *below* shows changes to the nature of injury over the past decade. The relative distribution of injuries remains fairly constant throughout this period, with only Multiple Injuries showing a slight increase over time.

Graphic 73

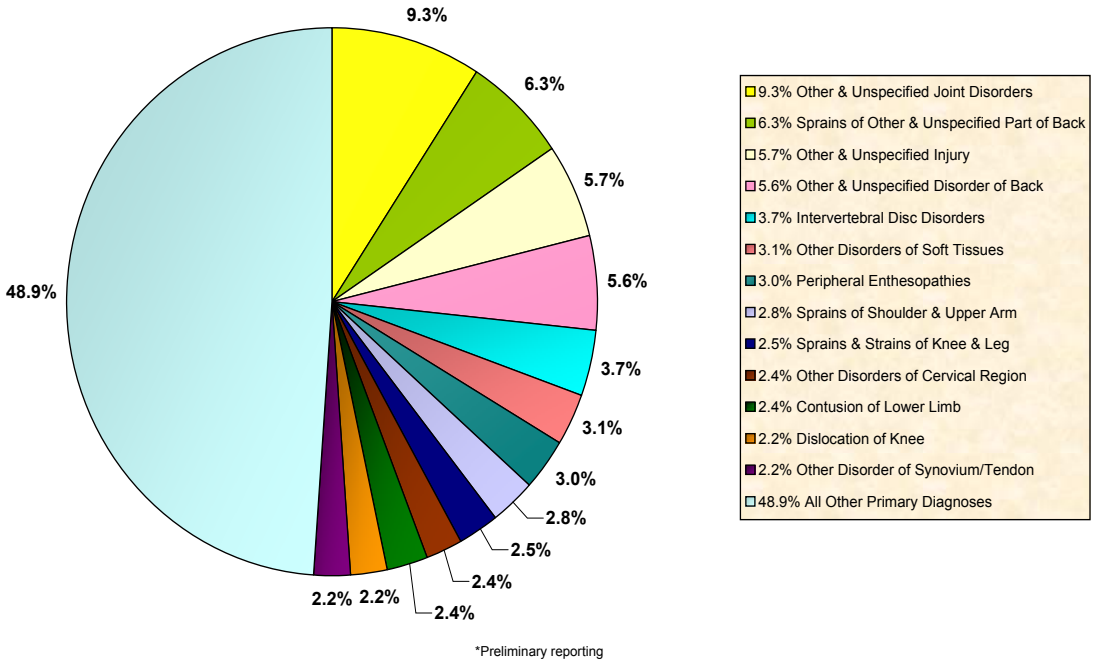


A medical perspective of the most frequent diagnoses assigned to lost-time injuries can be obtained by examining medical bills submitted to the Division. Each injured worker may generate multiple medical bills. Bills from health care providers (DWC-9) may include up to four diagnosis codes, while hospital bills (DWC-90) may include up to eight (since April 2007). However, instructions for completing medical bills require that when more than one diagnosis is identified and multiple ICD-9-CM codes are used, the code representing the primary diagnosis must be listed first. For purposes of analysis, all primary diagnosis codes from health care provider and hospital bill data were summarized into broader diagnosis code groups, and each group was counted only once per lost-time case receiving a diagnosis within a particular diagnosis code group.

The average number of distinct primary diagnosis code groups per lost-time case was 3.9 for 2006 and 3.8 for 2007. For injury year 2006, the primary diagnosis code from medical bills for all lost-time cases contained 812 different diagnosis code groups, which were reported 278,735 times. The 13 most frequent primary diagnosis code groups account for 51.1% of the total, with the remainder spread over 799 diagnosis groups. Ninety percent of the primary diagnosis code frequencies fell into the top 102 diagnosis groups, while 355 of the primary diagnosis groups had frequencies of ten or less. Graphic 74 shows the distribution of the top 13 diagnosis code groups for 2006 lost-time cases based on primary diagnosis codes reported.

Graphic 74

Leading Diagnosis Code Groups Billed to 2006* Lost-Time Injury Cases



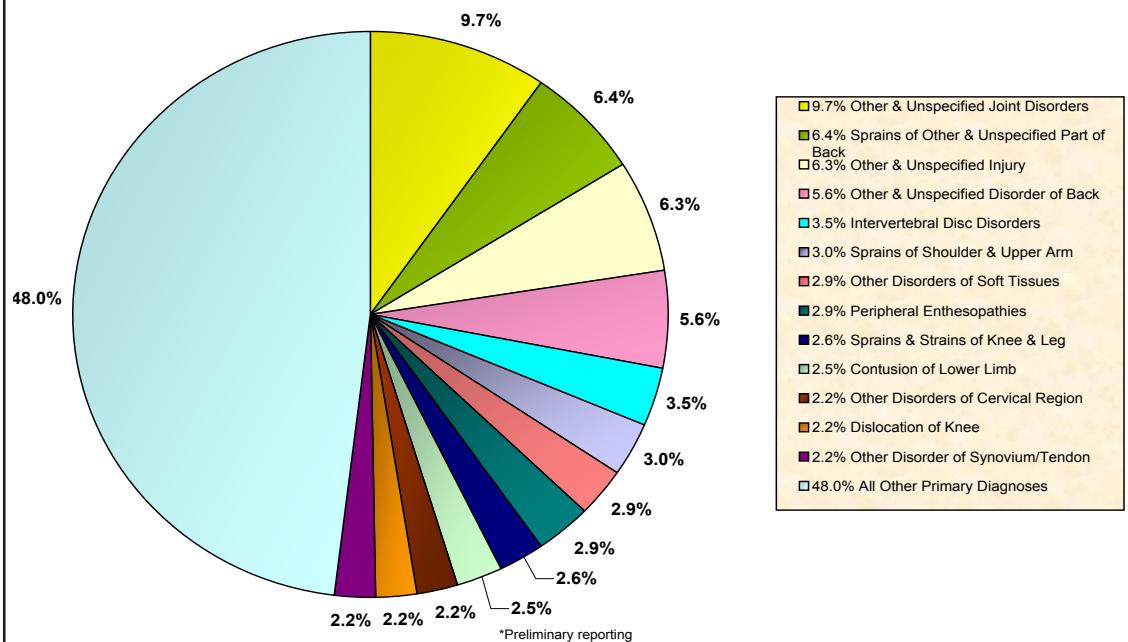
*Preliminary reporting

Source: Division of Workers' Compensation Medical Data Warehouse as of July 31, 2008

For injury year 2007, medical bills for all lost-time cases contained 788 different primary diagnosis code groups, which were reported 223,942 times. The 13 most frequent primary diagnosis code groups account for 52.0% of the total, with the remainder spread over 775 diagnosis groups. Graphic 75 *below* shows the distribution of the top 13 diagnosis code groups for 2007 lost-time cases based on primary diagnosis codes reported.

Graphic 75

Leading Diagnosis Code Groups Billed to 2007* Lost-Time Injury Cases



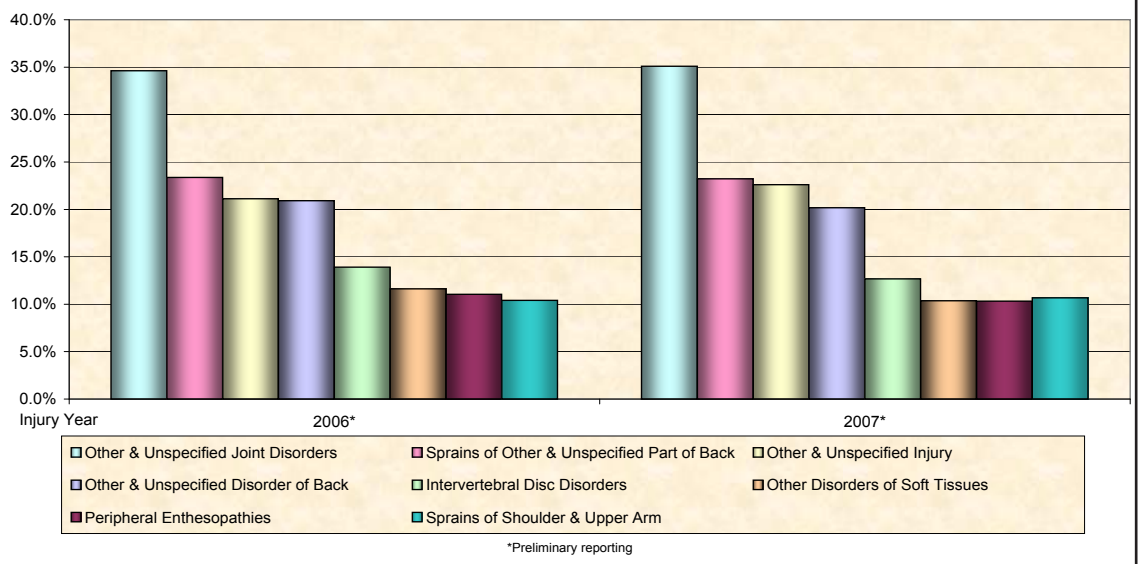
*Preliminary reporting

Source: Division of Workers' Compensation Medical Data Warehouse as of July 31, 2008

Another perspective shows the percent of lost-time cases with the most frequently assigned diagnosis code groups based on the primary diagnosis code reported. Certain diagnosis code groups have a high prevalence in lost-time cases. For injury years 2006 and 2007, Other and Unspecified Joint Disorders was assigned to 34.6% and 35.1% of lost-time cases, respectively. Sprains of Other and Unspecified Part of Back, the second most prevalent primary diagnosis code group for both 2006 and 2007, applied to 23.4% of lost-time cases in 2006 and 23.2% in 2007. In all, eight primary diagnosis code groups each applied to more than 10% of lost-time cases for both 2006 and 2007. These are shown in Graphic 76 *below*.

Graphic 76

Percent of Lost-Time Cases with Most Frequently Assigned Diagnosis Code Groups



*Preliminary reporting

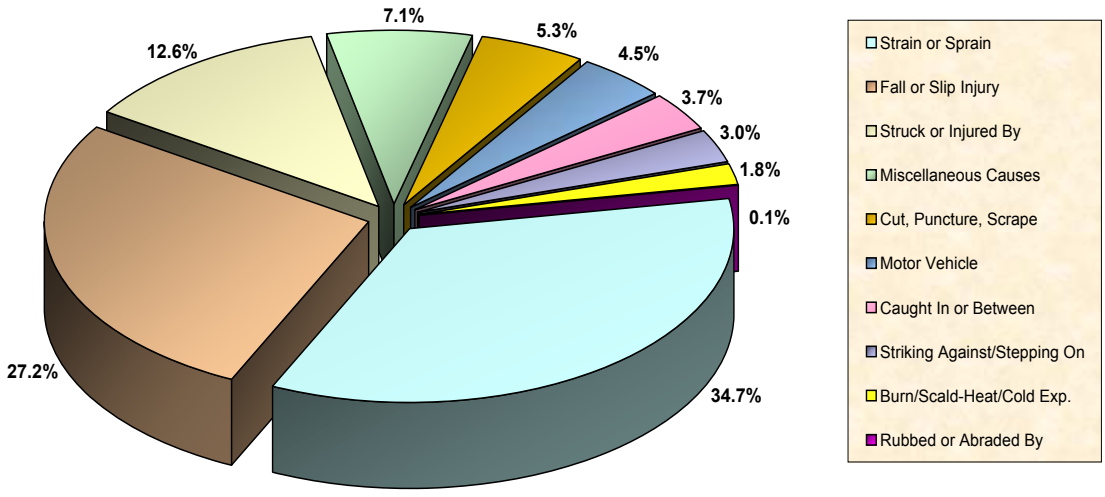
Source: Division of Workers' Compensation Medical Data Warehouse as of July 31, 2008

Cause of Injury

Strain or Sprain is the leading cause of injury (34.7%), and together with Fall or Slip (27.2%), accounts for nearly 62% of all 2007 lost-time cases. Adding Struck or Injured By (12.6%) raises the cumulative share of these causes to nearly three-fourths of the 2007 cases. Less frequent causes include Cut, Puncture, Scrape (5.3%), Motor Vehicle (4.5%), Caught In or Between (3.7%), Striking Against/Stepping on (3.0%), Burn/Scald-Heat/Cold Exposure (1.8%), and Rubbed or Abraded By (0.1%). Causes of Injury underlying 2007 lost-time cases are displayed in Graphic 77. The proportions of these causes have changed minimally over the past ten injury years, as shown by Graphic 78.

Graphic 77

Distribution of 2007* Lost-Time Cases by Cause of Injury

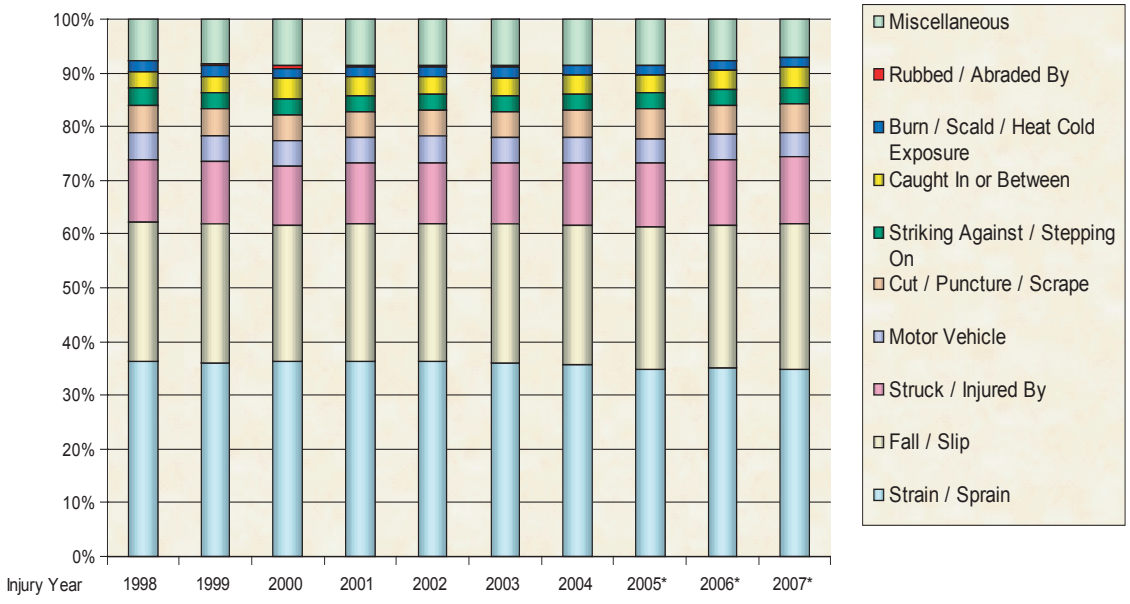


*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

Graphic 78

Lost-Time Cases by Cause of Injury



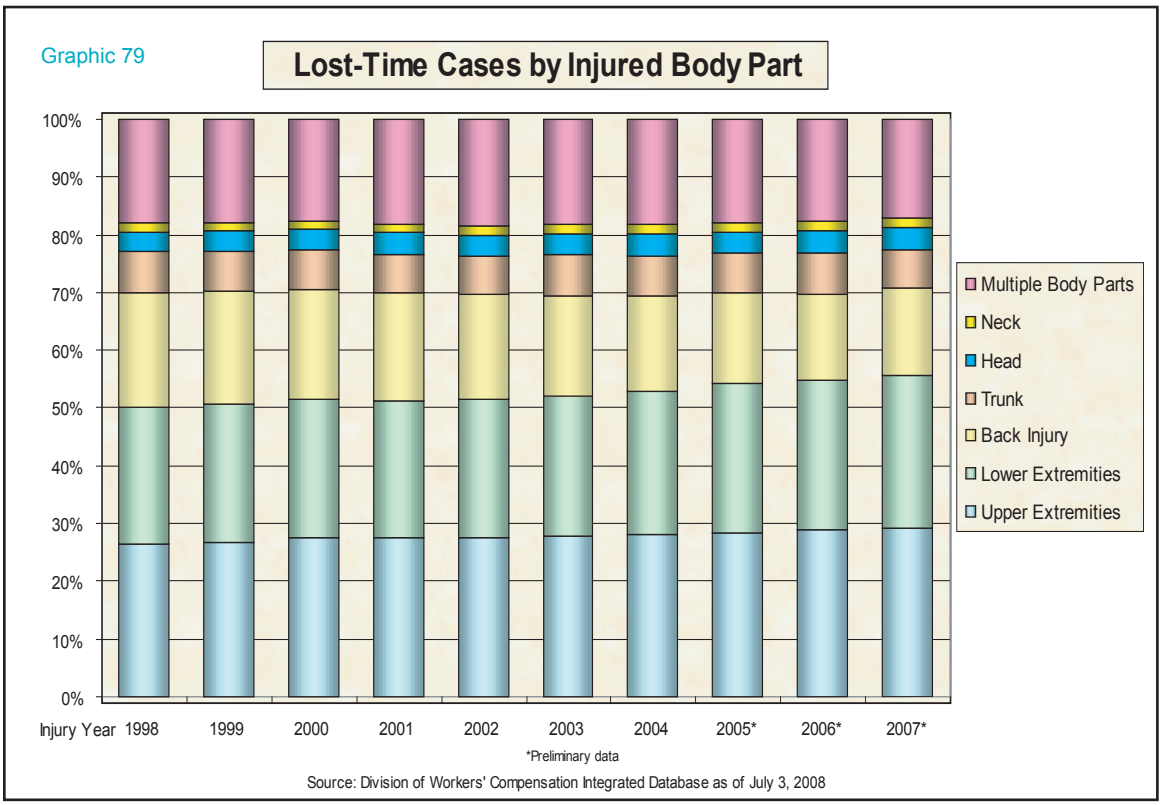
*Preliminary

Source: Division of Workers' Compensation Integrated Database as of July, 2008

Body Location of Injury

The relative distribution of lost-time cases by body part over the past ten years is shown in Graphic 79 *below.* It should be noted that the injured body part is reported on the First Report of Injury or Illness by the employer and may not necessarily reflect the body part injured according to the health care provider's diagnosis. During this 10-year period, a slight increase occurred over time in injuries to both Upper and Lower Extremities, while Back injuries show a notable decline. The proportions of other injured body parts remained relatively stable over the ten-year period from 1998 through 2007.

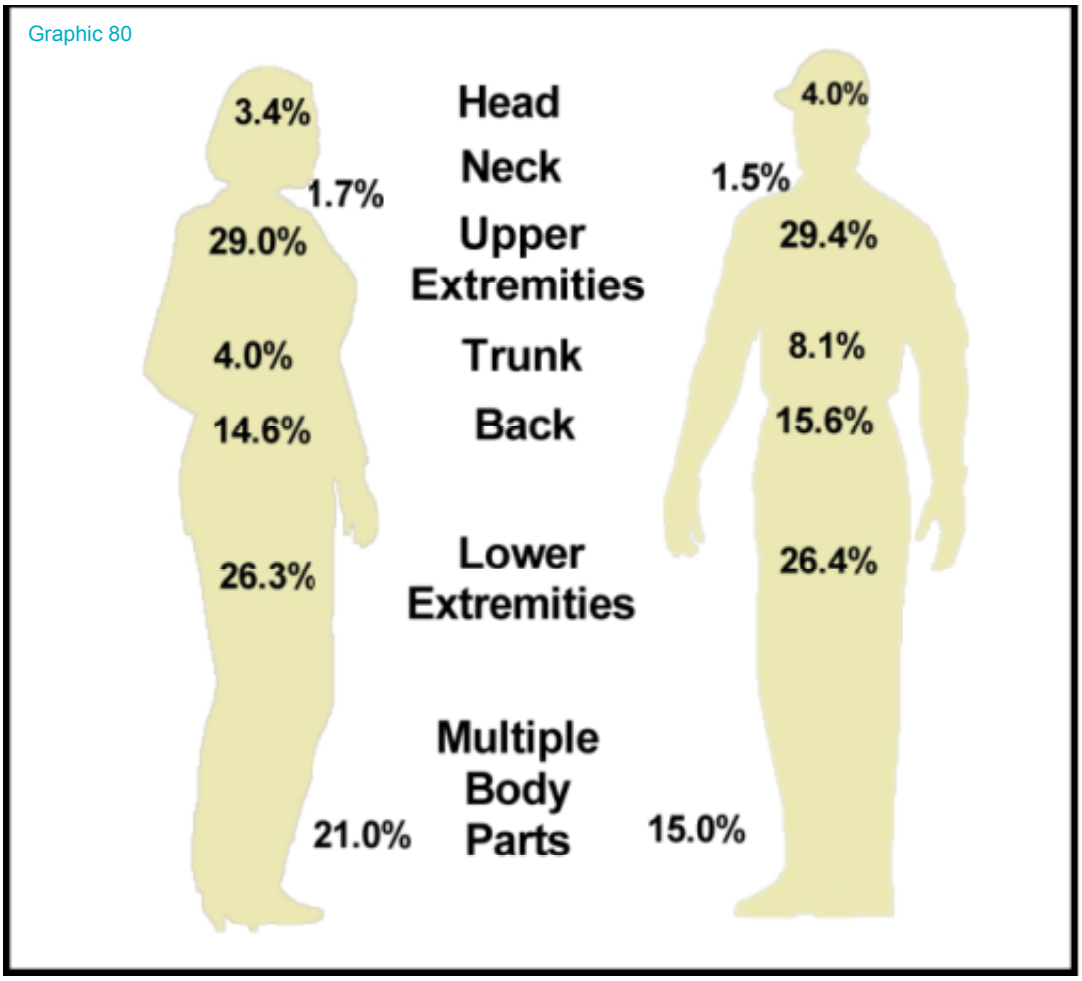
Graphic 79



Although men represent a two-to-one ratio in their frequency of lost-time cases, there are both similarities and differences noted in the body location of injury by gender. For both men and women, injuries to the Upper Extremities (29.4% and 29% respectively), Lower Extremities (26.4% and 26.3% respectively), Back (15.6% and 14.6% respectively), Head (4.0% and 3.4% respectively) and Neck (1.5% and 1.7% respectively), occur in very similar proportions and combine to represent 75% to 76.9% of all cases. The greatest differences between men and women occurred in injuries to the Trunk (8.1% for men vs. 4.0% for women) and injuries involving Multiple Body Parts (15% for men vs. 21% for women). Comparison of body location by gender for 2007 lost-time cases is illustrated below in Graphic 80.

Injury Body Location by Gender for 2007 Lost-Time Cases

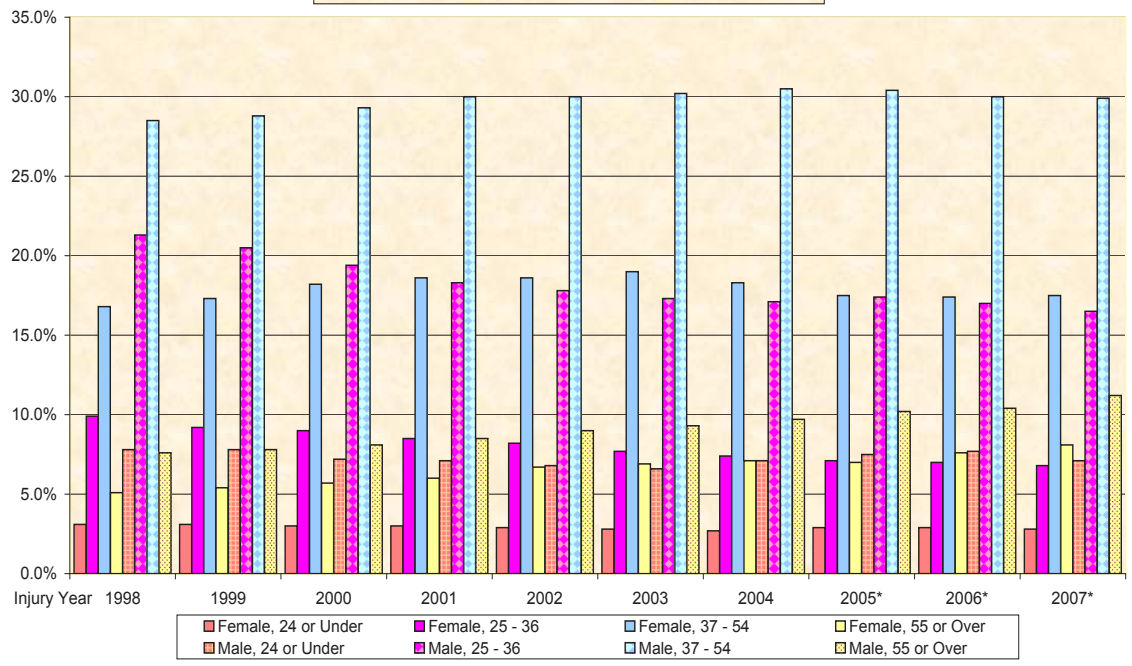
Graphic 80



If gender alone is considered, lost-time cases have steadily displayed a two-to-one ratio of men to women. Analysis that combines both gender and age provides additional information. Almost half of all lost-time cases (between 46.4% and 49.8%) during the last ten years involved men aged 25-54. However, that is consistent with the two-to-one ratio mentioned above with women aged 25-54 sustaining between 24.3% and 27.2% of the lost-time cases during that same ten-year period. Workers aged 24 or under have maintained the same proportion of lost-time injuries (9.4% to 10.9%) while approximating the same men to women two-to-one ratio. There has been a small but consistent increase in the representation of workers aged 55 or older, with men increasing from 7.6% to 11.2% of the total injuries and women increasing from 5.1% to 8.2%. For workers aged 55 or older, the ratio of men to women is substantially lower than the two-to-one ratio for all age groups combined. Overall, the median age of all workers with lost-time claims has steadily risen throughout the ten-year period, growing from 39 years of age in 1998 to 43 years of age in 2007. The composition of lost-time cases by combined age and gender groups over the past ten years is shown in Graphic 81.

Graphic 81

Lost-Time Cases by Age and Gender



*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

Benefits Paid[1]

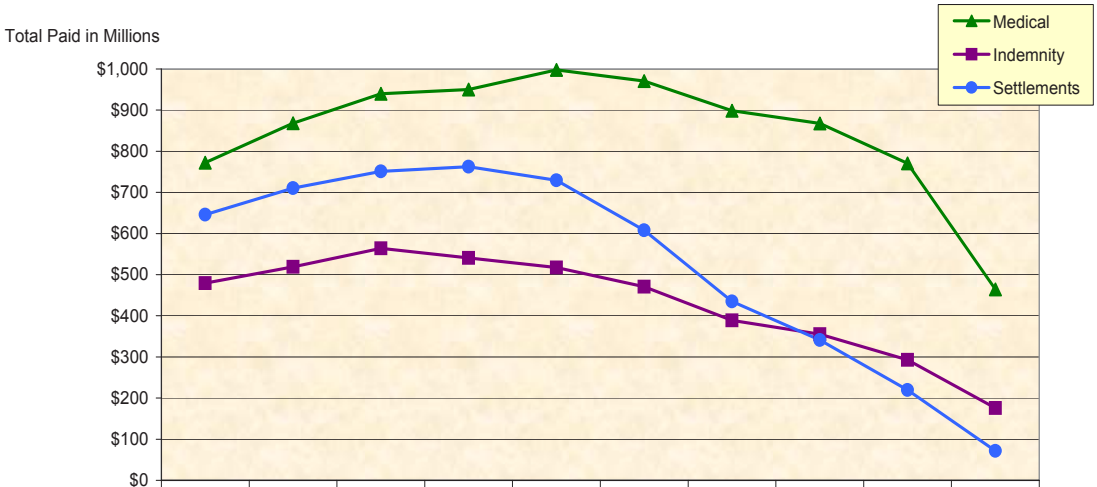
For all covered employees, the workers' compensation system provides all medically necessary remedial treatment, care, and attendance as the nature of the injury or the process of recovery may require. In addition, workers losing time from work due to their injury may receive indemnity benefits to replace a portion of wages lost due to the injury. Some injured workers may receive some or all medical and/or indemnity benefits in a lump-sum settlement of their claim.

Graphic 82 *below* shows total cumulative payment amounts for medical benefits, indemnity benefits and settlements by injury year over time. Only lost-time cases are included and dollar amounts were not adjusted for inflation. Because of their lack of development, injury years after 2004 should be regarded as preliminary.

Graphic 82 shows a downward trend after 2000 for indemnity benefits, 2001 for settlements, and 2002 for medical benefits. Total benefits paid peaked at $2.3 billion for the 2000 injury year and have steadily decreased to $1.7 billion for 2004. To the extent that 2004 injuries still include more open cases than 2001 injuries, some of the difference in their respective cumulative payment amounts will diminish over time. However, the decline in total payments is consistent with the decline in the total number of lost-time cases since 2000 and the decline in the average benefit payment per case after 2002. Average payment amounts for indemnity benefits and settlements declined annually beginning in 2002; payment amounts for medical benefits declined, beginning in 2003.

Graphic 82

Cumulative Medical, Indemnity and Settlement Costs for Lost-Time Cases by Injury Year



Injury Year	1998	1999	2000	2001	2002	2003	2004	2005*	2006*	2007*
Medical	$772.3	$868.0	$939.5	$950.1	$997.6	$970.8	$898.6	$867.5	$770.7	$464.2
Indemnity	$479.2	$519.0	$564.0	$540.5	$517.6	$470.9	$388.9	$355.4	$292.6	$175.5
Settlements	$646.1	$710.3	$751.2	$762.4	$729.3	$608.0	$434.8	$341.2	$219.5	$71.8

*Preliminary data

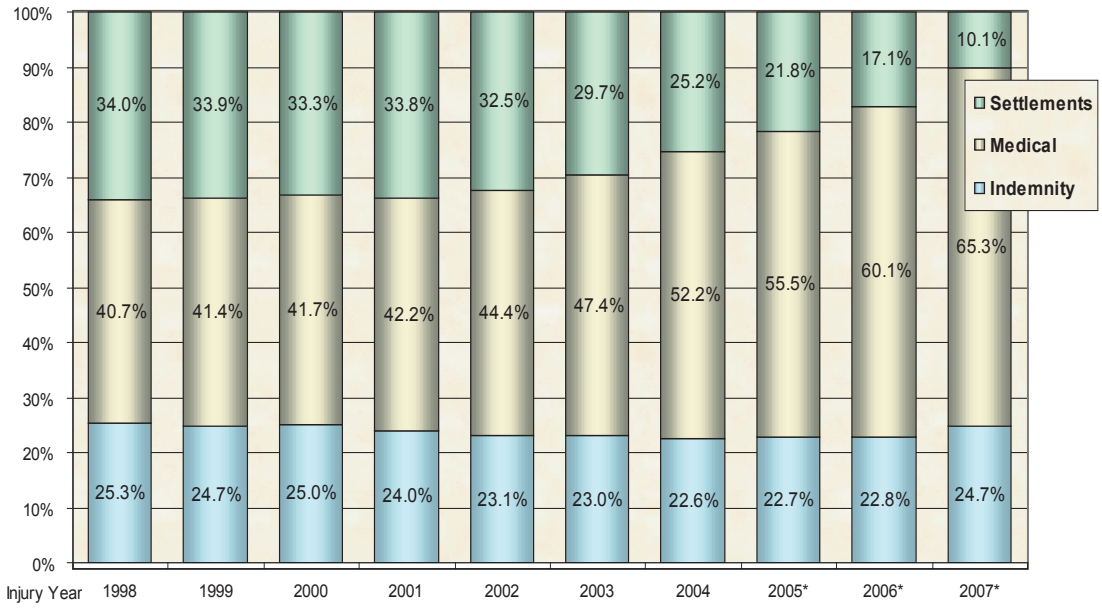
Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

[1] As a result of the extensive analysis performed for the non-reported claims data project undertaken by the Division in FY 2007-2008 and a reconciliation between databases, the Division began tracking and measuring historical claims data using a new method. This new method results in the more accurate reporting of historical trends. Consequently, readers will note differences in the reported system costs over time for medical, indemnity and settlement benefits. These differences are primarily due to more accurate reporting, not growth during the last fiscal year.

Graphic 82 above also displays the relative magnitude of the three payment categories, with medical benefits the most costly and indemnity benefits the least costly for injury years having mature data. This relative standing is further developed in Graphic 83 *below*. However, it should be noted that the proportionate shares of the payment categories change over time as the claims mature.

Graphic 83

Distribution of Indemnity, Medical, and Settlement Costs for Lost-Time Cases by Injury Year

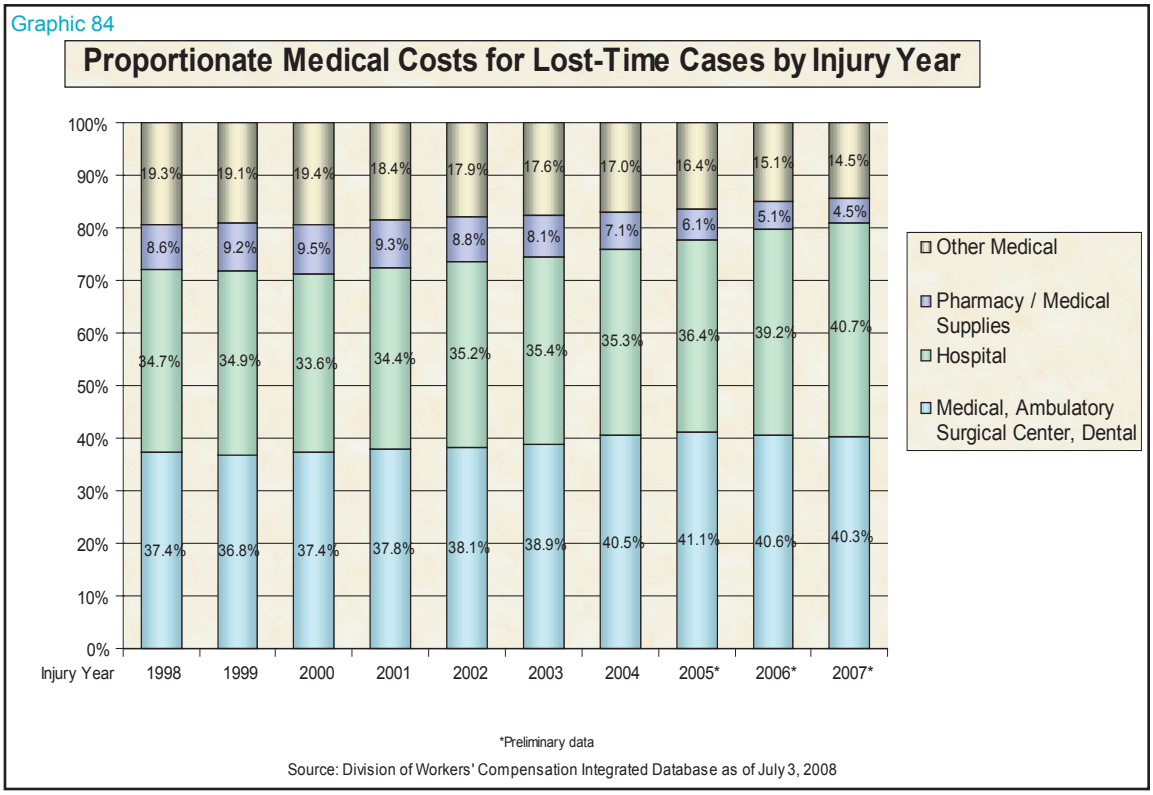


*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 3, 2008

Medical costs by category for lost-time cases are provided in Graphic 84 for injury years 1998 through 2007. The categories displayed are medical, ambulatory surgical center (ASC) and dental (combined), hospital, pharmacy, and several smaller categories grouped as "other" which includes medical transportation, home attendant care, skilled nursing care, rehabilitation, and miscellaneous medical. The results reported in Graphic 84 show an increase in the proportionate costs of medical/ASC/dental and hospital and a corresponding decrease in pharmacy and other through 2004. However, due to the long claims tail of workers' compensation cases, this is only a snapshot of these cases as of a point in time, and not suggested to be a reported trend. Medical/ASC/dental and hospital costs combined represent 72.1% of total medical costs for the 1998 injury year and 75.8% for 2004. "Other" medical cost shares declined modestly between injury years 1998 and 2004, as did pharmacy costs.

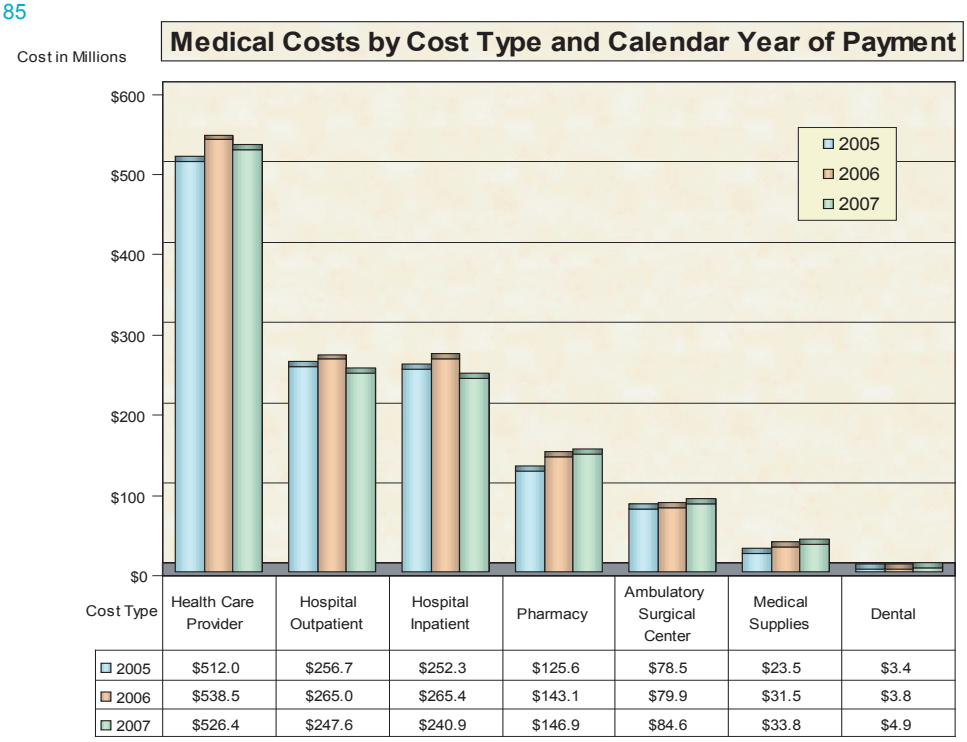
Graphic 84



The next graphic marks a transition in this section. All previous graphics pertain only to lost-time cases and utilize data reported by insurers and claims handlers. In the remainder of this section, the information reported differs in four respects. First, cost information was taken from medical data submitted by or on behalf of health care providers, dentists, hospitals, and pharmaceutical suppliers. Second, reported medical costs comprise benefits paid on both lost-time and medical only claims. Third, cost information is aggregated by calendar year of payment rather than injury year. Fourth, since some of the smaller medical cost categories reported for lost-time cases (such as home attendant care or medical transportation) are not reported by the providers listed above, "other" medical cost category expenditures are not included in the graphics that follow.

Graphic 85 displays total payments for seven medical cost categories during the past three calendar years. Payments to health care providers comprised the largest payment category, followed by hospital outpatient and hospital inpatient payments. Totaling more than $500 million each year, payments to health care providers were approximately equal to inpatient and outpatient hospital payments combined. Payments to health care providers and hospitals exceeded $1 billion dollars each year and total payments for all categories were consistently about $1.3 billion each year, with a very slight increase over the three-year period. Because of delayed carrier reporting of medical bills to the Division, payment amounts may increase somewhat over time.

Graphic 85

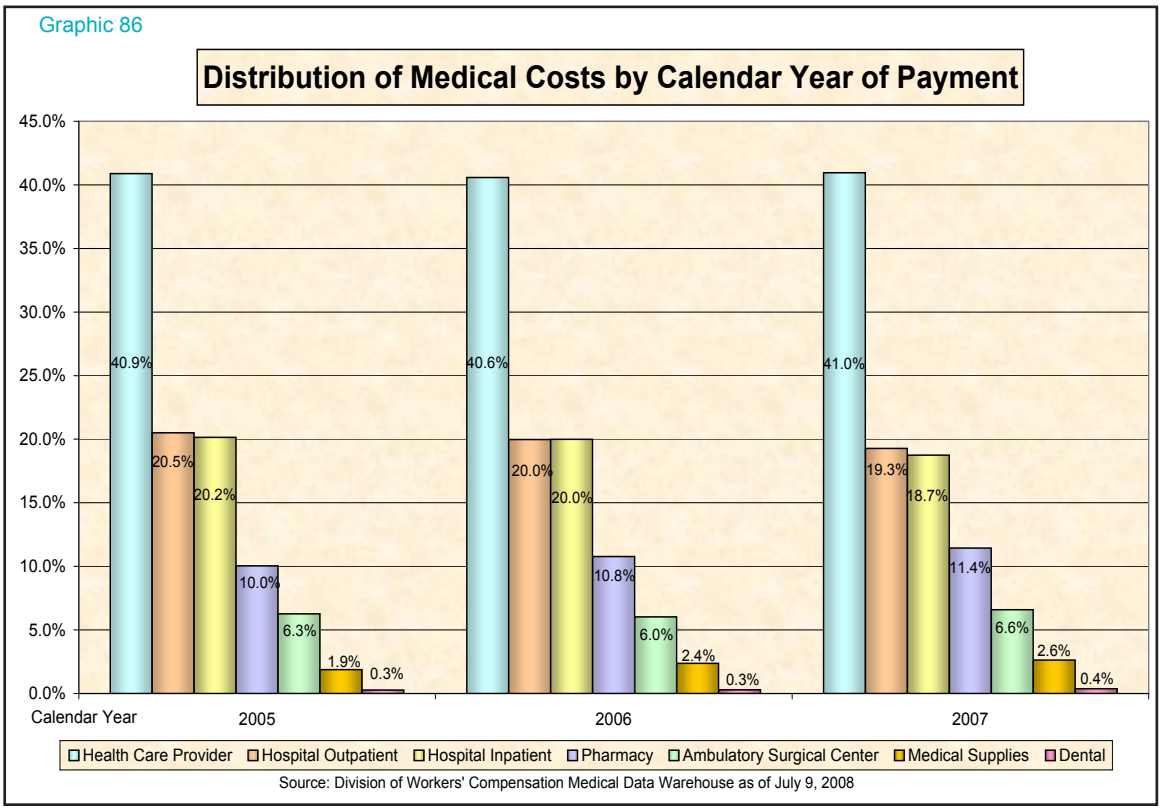


Cost Type	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Pharmacy	Ambulatory Surgical Center	Medical Supplies	Dental
2005	$512.0	$256.7	$252.3	$125.6	$78.5	$23.5	$3.4
2006	$538.5	$265.0	$265.4	$143.1	$79.9	$31.5	$3.8
2007	$526.4	$247.6	$240.9	$146.9	$84.6	$33.8	$4.9

Source: Division of Workers' Compensation Medical Data Warehouse as of July 9, 2008

Graphic 86 *below* shows the relative proportions of system-wide medical costs reported previously in Graphic 85. The dominance of health care provider, inpatient hospital, and outpatient hospital payments is evident. Pharmacy costs, which ranked a distant fourth among the cost types, increased only slightly over the three-year period. The three smallest cost types - ambulatory surgical centers, medical supplies, and dental services - comprise less than 10% of the total payments in each year. Dental services consistently represent less than one-half of one percent of total costs

Graphic 86



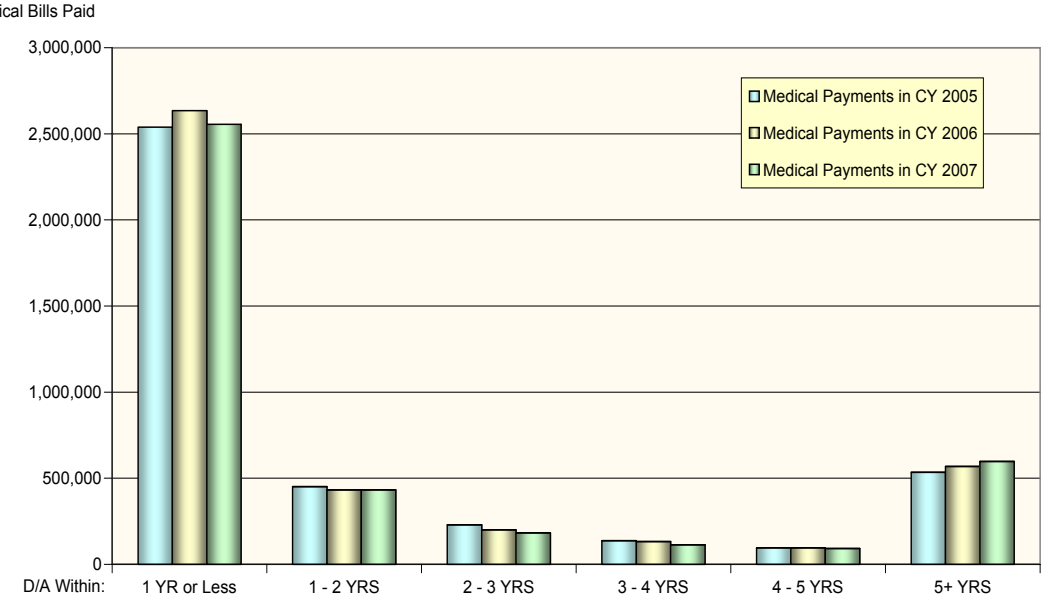
Source: Division of Workers' Compensation Medical Data Warehouse as of July 9, 2008

Graphic 87 *below* examines the relationship between the date medical bills are paid and the date of accident when you examine medical bills paid during the last three calendar years. During each year, nearly two-thirds of the medical bills paid during that year were for dates of accident occurring within one year of that payment. Another 10-11% of the costs were for accidents that occurred one to two years prior to the date the medical bill was paid.

In all, roughly three-quarters of the medical bills paid within the past three years were for dates of accident within two years of the date the medical bill was paid. However, 13% to 15% of the payments made stemmed from accidents that preceded the payment date by more than five years. This illustrates how protracted the medical portion of the claim tail can be and how older cases remain a substantial cost factor for many years.

Graphic 87

Correlation Between Medical Bill Payments and Date of Accident



CY Paid	1 Yr or Less	1 - 2 Years	2 - 3 Years	3 - 4 Years	4 - 5 Years	5+ Years
2005	63.7%	11.3%	5.8%	3.4%	2.4%	13.4%
2006	64.8%	10.6%	4.9%	3.3%	2.3%	14.0%
2007	64.3%	10.9%	4.6%	2.8%	2.3%	15.0%

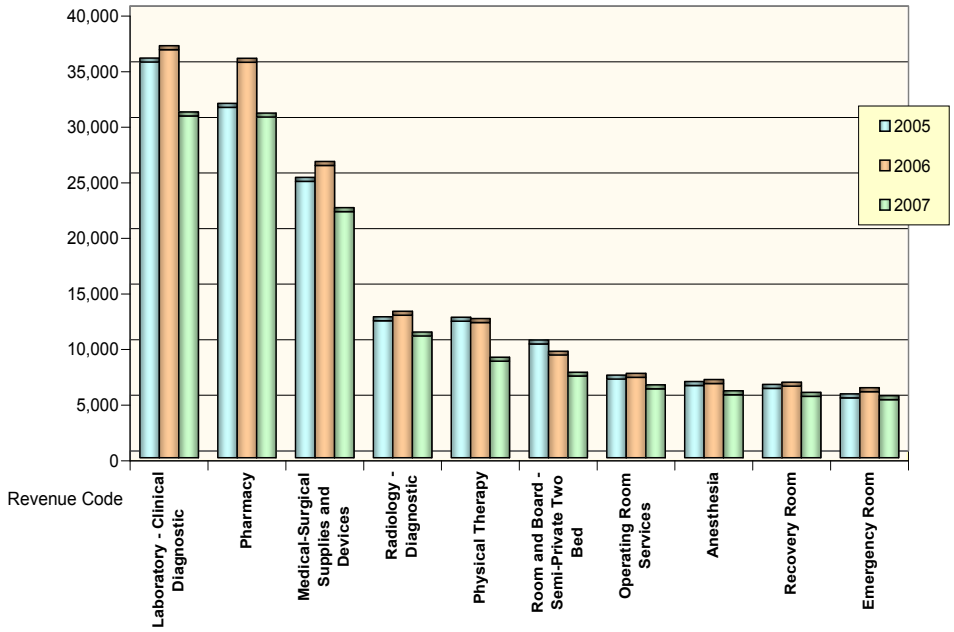
Source: Division of Workers' Compensation Medical Data Warehouse as of July 9, 2008

Graphics 88 and 89 display the top ten hospital revenue codes by frequency for bills paid during the last three calendar years. Graphic 88 illustrates inpatient codes, and Graphic 89 illustrates outpatient codes. For hospital inpatient codes, Laboratory-Clinical Diagnostic, Pharmacy, and Medical-Surgical Supplies & Devices occur with the greatest frequency during all three payment years. All revenue codes show a pattern of reduction in 2007 to the lowest level in the three-year period after an increase in 2006 for several of the most frequently occurring revenue codes. This may be due to the reduction in the number of lost-time cases.

Graphic 89, which displays the frequency of hospital outpatient revenue codes, has both similarities and differences with the distribution of hospital inpatient revenue codes. Like the inpatient codes, outpatient revenue codes (for bills paid in 2007), are at the lowest levels in the three-year period, with two exceptions. Treatment/Observation Room and Clinic codes are more frequent in 2007 than in either of the two preceding years. It is important to note that the relative volume of codes is considerably higher for outpatient than for inpatient codes.

Graphic 88

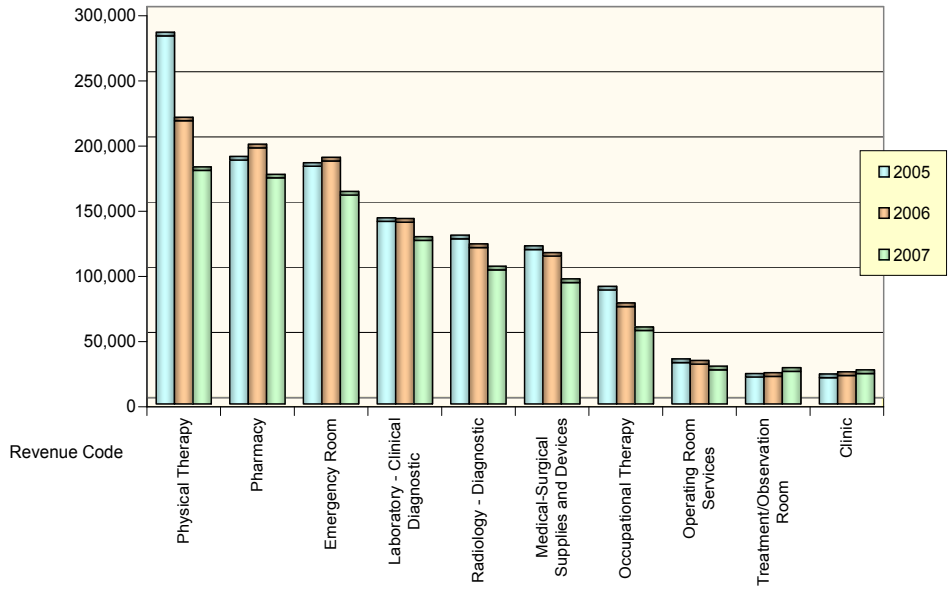
Billing Frequency of Hospital Inpatient Revenue Codes by Calendar Year of Payment



Source: Division of Workers' Compensation Medical Data Warehouse as of July 9, 2008

Graphic 89

Billing Frequency of Hospital Outpatient Revenue Codes by Calendar Year of Payment



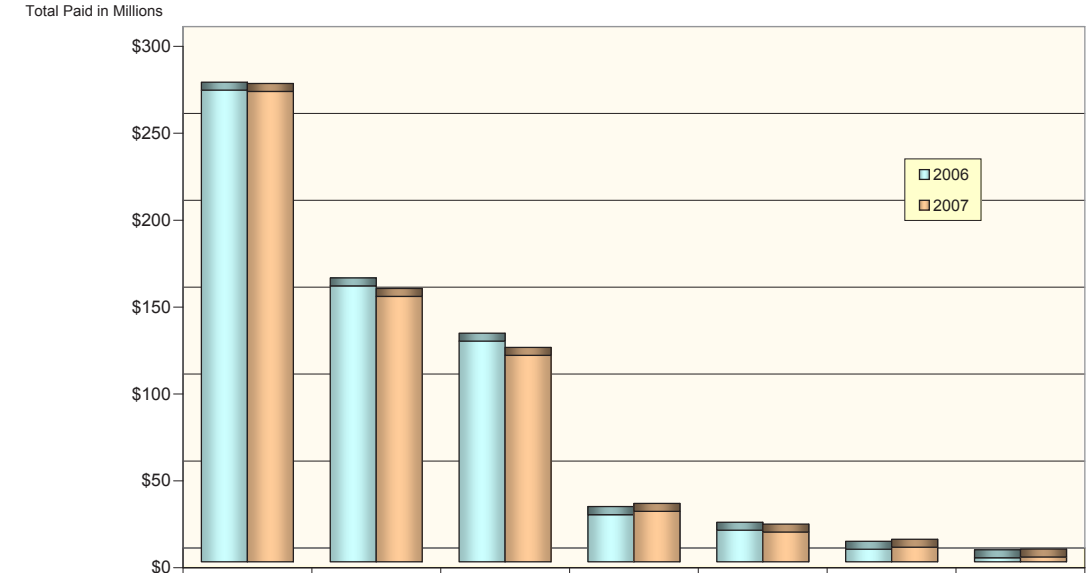
Source: Division of Workers' Compensation Medical Data Warehouse as of July 9, 2008

Graphic 90 *below* offers a different perspective on medical costs. Medical payments for injuries occurring in 2006 and 2007 are totaled by payment type for all payments made within six months of the injury date. Both lost-time and medical only cases are included. To further ensure similarity in the payment window of the two injury years, both years exclude payments reported to the Division after June 30 of the following year. The result of these analytic restrictions is to offer a basis for comparing medical payments for injury years 2006 versus 2007 that is not affected by their difference in age.

What the graphic shows is that payments for three of the four smaller cost types have increased for 2007 injury cases at six months beyond the injury date. Combined Dental, Medical Supplies, and Ambulatory Surgical Center costs are up by $3.5 million, or 9.6%. The larger cost categories, however, declined by a combined $16.2 million, over $14 million of which represents diminished hospital costs. Overall, medical costs for 2007 injuries at six months post-injury have fallen by $12.6 million, or 2.1%. Several additional years of data will have to be accumulated before any trend analysis can be observed to determine if this very preliminary data are the result of a decline in the number of lost-time claims, a reduction in the severity of the injuries and/or a shift in the type of treatment provided.

Graphic 90

Total Medical Payments Made within Six Months of Injury



Payment Category	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental
2006	$271.4	$158.8	$127.0	$27.2	$18.2	$7.2	$2.3
2007	$270.7	$152.7	$118.8	$29.0	$17.1	$8.5	$2.8

Source: Division of Workers' Compensation Medical Data Warehouse as of July 9, 2008

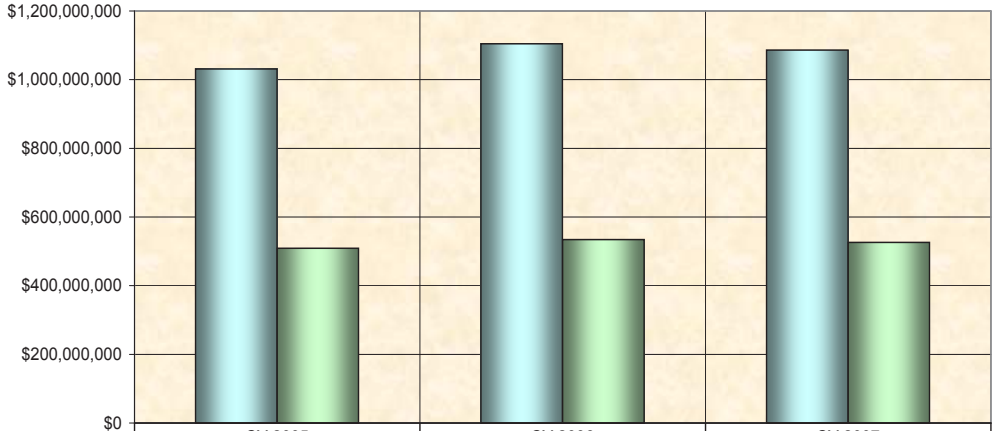
MEDICAL BILLING DATA

In a departure from last year's reporting of medical billing data, this year's medical costs are grouped by the calendar year paid rather than the fiscal year submitted to the Division. This change makes comparison between the present and the prior report problematic. Because there is a lag of several months between the time an insurer pays a medical bill when it is reported to the Division, it makes fiscal year reporting problematic. Reporting on a calendar year paid basis ensures that enough time has elapsed so that the Division has received the majority of bills paid during the calendar year. Secondly, there is some volatility in the submission dates themselves, which are often subject to change when a previously paid bill is adjusted and re-submitted.

Graphics 91 through 95 display medical payments during the last three calendar years for treatment regardless of the date of accident for both lost-time and medical only cases and include: health care provider services, outpatient hospital services, inpatient hospital services, ambulatory surgical center services, and dental services. Aggregate charge and payment data are provided, along with the average amounts charged and paid per bill for each category. Because of changes in data element requirements, complete pharmacy charge and payment data are only available for the most recent calendar year. Except for dental bills which are relatively small in number, the average amount charged per bill and average amount paid per bill have increased each year in every service category. However, in 2007, the number of bills paid/submitted declined for health care providers and hospital inpatient and outpatient services. It is far too early to determine if the decline is due to a smaller number of injuries, a reduction in the severity of injuries or reporting issues.

Graphic 91

Total Charges and Total Paid for Health Care Provider Services



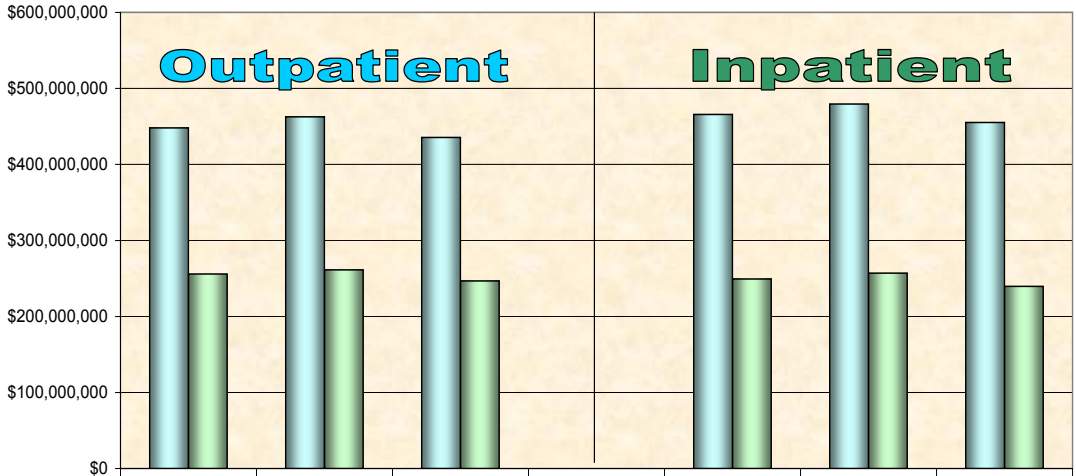
	CY 2005	CY 2006	CY 2007
Charges	$1,031,312,857	$1,104,463,052	$1,086,221,627
Paid	$508,855,876	$534,054,655	$526,077,983

Total Bills	2,786,938	2,809,04	2,751,360
Avg	$370.05	$393.18	$394.79
Avg Paid/Bill	$182.59	$190.12	$191.21

Source: Division of Workers' Compensation Medical Data Warehouse as of 7/16/2008

Graphic 92

Total Charges and Total Paid By Hospital Bill Type

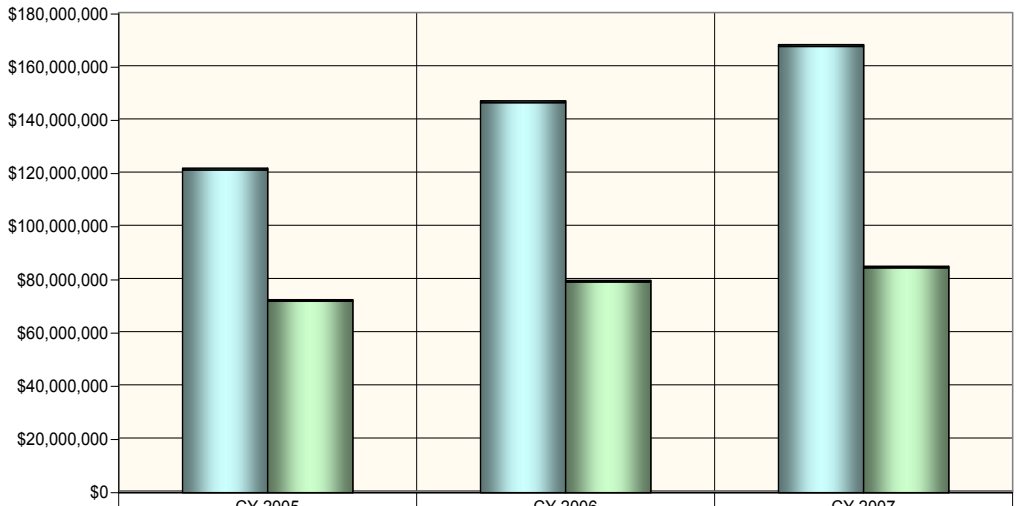


	CY 2005	CY 2006	CY 2007		CY 2005	CY 2006	CY 2007
Charges	$448,137,624	$462,607,041	$435,603,408		$465,690,762	$479,359,708	$455,156,691
Paid	$255,789,712	$261,216,427	$246,604,421		$249,222,946	$257,161,848	$239,670,113
Total Bills	249,890	234,802	206,516		13,623	12,967	10,959
Avg Chrg/Bill	$1,793.34	$1,970.20	$2,109.30		$34,184.16	$36,967.66	$41,532.68
Avg Paid/Bill	$1,023.61	$1,112.50	$1,194.12		$18.294.28	$19,832.02	$21,869.71

Source: Division of Workers' Compensation Medical Data Warehouse as of 7/16/2008

Graphic 93

Total Charges and Total Paid for Ambulatory Surgical Services

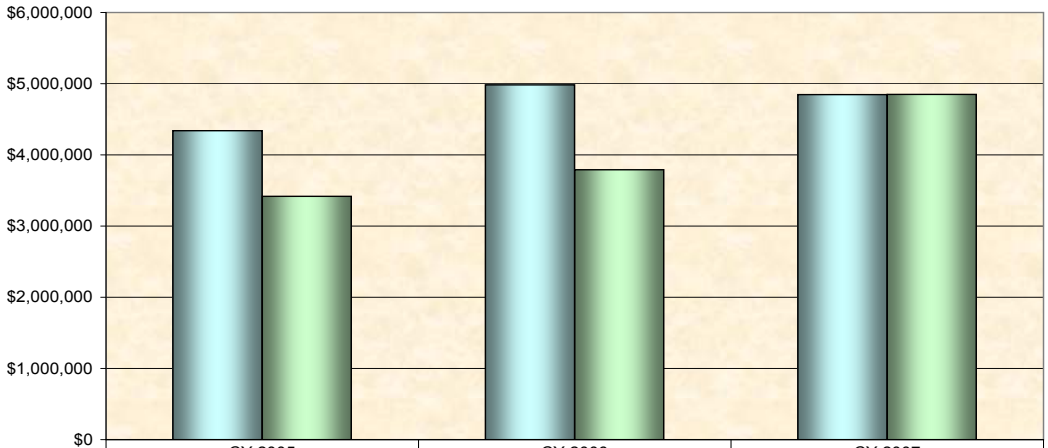


	CY 2005	CY 2006	CY 2007
Charges	$121,434,201	$146,745,347	$167,893,775
Paid	$71,987,012	$79,288,839	$84,592,687
Total Bills	25,661	27,065	27,383
Avg Chrg/Bill	$4.732.25	$5,421.96	$6,131.31
Avg Paid/Bill	$2,805.31	$2,929.57	$3,089.24

Source: Division of Workers' Compensation Medical Data Warehouse as of 7/16/2008

Graphic 94

Total Charges and Total Paid for Dental Services



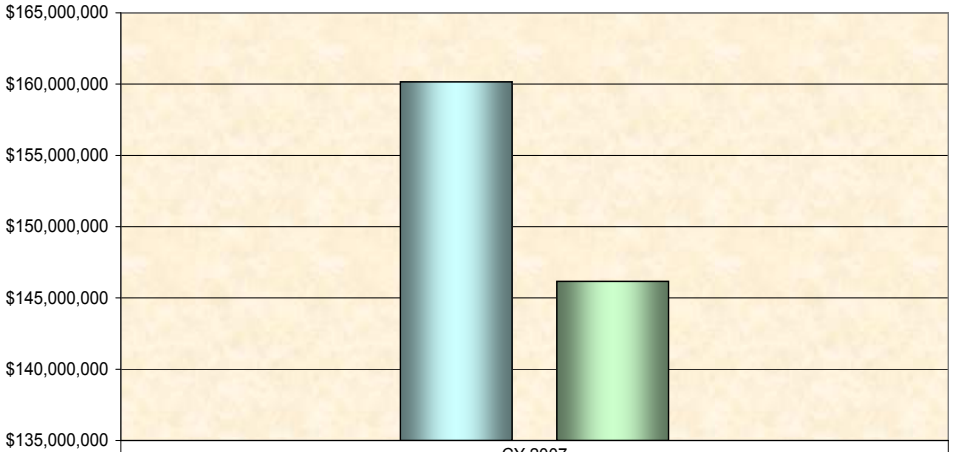
	CY 2005	CY 2006	CY 2007
Charges	$4,339,277	$4,982,144	$4,846,485
Paid	$3,416,543	$3,790,751	$4,849,957

Total Bills	3,897	4,426	4,964
Avg Chrg / Bill	$1,113.49	$1,125.65	$976.33
Avg Paid / Bill	$876.71	$856.47	$977.03

Source: Division of Workers' Compensation Medical Data Warehouse as of 7/16/2008

Graphic 95

Total Charges and Total Paid for Pharmacy-Only Bills



	CY 2007
Charges	$160,149,918
Paid	$146,154,852

Total Bills	847,508
Avg Chrg / Bill	$188.97
Avg Paid / Bill	$172.45

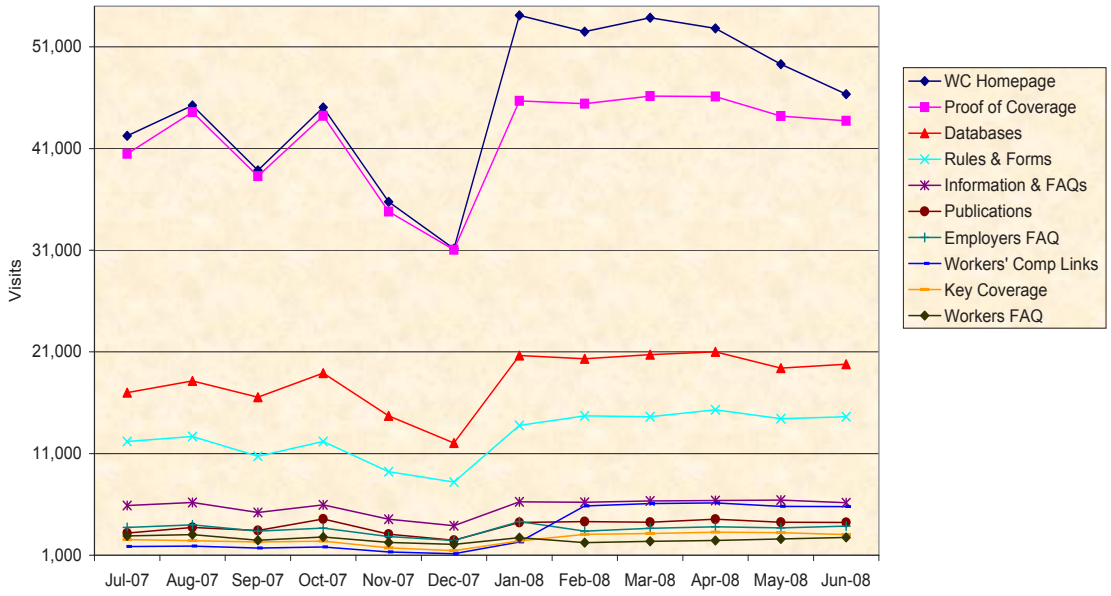
Source: Division of Workers' Compensation Medical Data Warehouse as of 7/16/2008

DIVISION OF WORKERS' COMPENSATION WEBSITE

The Division of Workers' Compensation Internet home page is located at: http://myfloridacfo.com/WC/index.htm and is designed to provide direct information access for all of the stakeholders in the workers' compensation system. During FY 2007- 2008, the Division's home page was visited 547,244 times. After the home page, the page visited most often was the Compliance Proof of Coverage database. Graphic 96 *below* illustrates the 10 most frequently visited pages on the Division's website.

Top 10 Most-Visited Division of Workers' Compensation Internet Pages FY 2007-2008

Graphic 96



The following is a list and description of pages within the Division's website, grouped by stakeholder. In addition, a description of databases, statutory and rule information and publications, along with the website addresses are provided.

Directory: This directory lists phone numbers and websites for each area of the Division and also provides phone numbers for other agencies peripherally related to workers' compensation.

Injured Workers:

1. **EAO Answer**. This allows injured workers to contact the Bureau of Employee Assistance and Ombudsman Office with questions, requests for assistance or complaints. It is located in the "Contact Us" link on the left side of the Division's home page or through the radio button on the right side at the "Broken Arm Poster."

2. **You Have Been Injured on the Job – What You Need to Know,** an online tutorial. This presentation may be accessed from the Division's home page under "News" for March, 2008.

3. **Injured Workers FAQ:** Click on "Information and FAQs" on the left side of the Division's home page and then click on "Injured Worker FAQ."

4. **Benefit Delivery Process**. This provides a flow chart of how benefit delivery is determined. Click on "Benefit Delivery Process" on the Division home page.

5. **Informational Brochure for Employees (English and Spanish).**

Employers/Contractors:

1. **Employer FAQs**: Click on "Information and FAQs" on the left side of the Division's home page.

2. **Key Coverage and Exemption Eligibility Requirements:** Click on "Information and FAQs" from the home page.

3. **Proof of Coverage Database**

4. **Claims Database Query Screen**

5. **Online Penalty Payment Service:** Click on the icon on the right side of the Division's home page.

6. **Construction Policy Tracking Database**

7. **Online Exemption Application:** Click on icon on the right side of the Division's home page.

8. **Stock Certificate template for Construction Exemption Applicants:** Click on icon on the right side of the Division's home page.

9. **Informational Brochure for Employers (English and Spanish).**

10. **Safety Information:** Click on "Information and FAQs" from the home page.

Insurers/Claims-Handling Entities:

1. **Claims Database**

2. **Centralized Performance System (CPS) Database Tutorial**

3. **Division EDI Claims Data Warehouse**

4. **Special Disability Trust Fund Rules for Reimbursement and Reimbursement Request Form**

Health Care Providers:

1. **Expert Medical Provider Recruitment:** Click on icon on the right side of the Division's home page.

2. **Florida Workers' Compensation Uniform Medical Treatment /Status Report Form, DWC-25 in Word Format savable as a Word template:** Click on "Rules and Forms" from the Division's home page, click on the tab "69L-7" and scroll down to the fourth link.

3. **Medical, Medical Provider, Managed Care Arrangement FAQs:** Click on "Information and FAQs" on the left side of the Division's home page and then "Medical, Medical Provider, Managed Care Arrangement FAQs."

4. **Health Care Provider Reimbursement Manual Menu:** This page permits access to the complete Florida Workers' Compensation Health Care Provider Reimbursement Manual as well as text files of the Schedule of Maximum Reimbursement Allowances and Reimbursement Manuals for Hospitals and Ambulatory Surgical Centers.

5. **Reimbursement Dispute Resolution Forms**

6. **Health Care Provider Directory**

Workers' Compensation Databases:

The following list identifies and describes the various databases that are maintained to provide interested parties with direct access to information that is routinely utilized by various stakeholders.

1. **The Insurer/Claim Administrator Database** contains addresses and contact information for claims administrators, self-insurers, and third party administrators approved to handle workers' compensation claims of injured workers in the State of Florida.

2. **Insurers licensed to do business in the State of Florida:** This link to the Office of Insurance Regulation provides names, business addresses, and identifying information for companies/entities doing business in Florida.

3. **The Proof of Coverage Database** provides information regarding workers' compensation coverage and exemptions from workers' compensation.

4. **The Download of Proof of Coverage Database** combines 11 tables that make up the Compliance Database and may be downloaded as one zip file, or individually.

5. **The Construction Policy Tracking Database** provides information to contractors and other interested parties regarding changes to workers' compensation coverage. These changes may include changes to the status of subcontractors' coverage or changes to any policy specified by a registered user. The system sends automatic electronic notification to the requestor concerning any changes to the status of the specified policy.

6. **The Non-Compliance Referral Form (Whistle-Blower):** is completed to report an employer someone suspects has failed to secure workers' compensation insurance coverage for all of its employees. Other options for reporting non-compliant employers are provided.

7. **The Provider Databases** provide daily updates of the most current listing of AHCA's medical provider lists (Health Care Providers and Expert Medical Advisors), and the Department of Education, Bureau of Rehabilitation and Reemployment Service's approved companies, facilities or providers lists to treat or provide vocational rehabilitation services to injured workers.

8. **The Claims Database** contains workers' compensation accident data on an individual claim basis. Information relating to personal, financial or health information has been redacted from the database in compliance with ss. 440.125 and 626.9651, F.S., and Rule 4-128, F.A.C.

9. **Statistical Reports Based on Claims Data** can be generated from the end-of-month claims file and may be requested based on a variety of search options. Output consists of aggregated data by year of injury for: the number of injuries, total benefits (including indemnity, medical, and settlement payments), and average benefits for each category.

10. **Workers' Compensation Policy Search Page:** Allows a user to obtain a customized downloadable list of employers in the State of Florida whose workers' compensation insurance policies are either due to expire within the month and year selected or become effective within the month and year selected.

11. **Employer Loss Run Report:** Allows a user to obtain an employer specific list of lost-time injuries reported to the Division of Workers' Compensation since 1990.

12. **The 8th Day of Disability for EDI Submitters Database** is one of the options authorized for EDI claim administrators to report the employee's 8th day of disability and knowledge of the 8th day of disability at the same time the electronic form equivalent of Form DWC-1 is required to be sent to the Division as specified in Rule 69L-24.0231, F.A.C.

13. **The Compliance Stop-Work Order Database** lists employers that have been issued a Stop-Work Order based upon a determination that an employer has failed to secure the payment of compensation.

14. **The Division Claims EDI Data Warehouse** contains workers' compensation records for which an EDI First Report of Injury (FROI), Subsequent Report of Injury (SROI), or Electronic Supplement to the First Report of Injury (8th Day of Disability information) has been electronically reported to the Division since October 1, 2000. Claims EDI Trading Partners have access to their EDI DWC-1, EDI DWC-13, and Electronic Supplement to the First Report filings and may view specific transactions/data elements in the manner and format received by the Division to aid in the reconciliation of filing errors. Also, Claims EDI Trading Partners have access to their monthly Claims EDI Report Cards and Rejected Records Not Resubmitted Successfully Reports, as well as proprietary Acknowledgement Reports produced in response to transmissions received/processed by the Division.

Florida Workers' Compensation Statutes:

Workers' Compensation Law, Chapter 440, Florida Statutes

Information and FAQs:

1. **Informational Memoranda/Bulletins**
2. **FAQs**

Rules and Forms

1. **Rule 69L of the Florida Administrative Code**
2. **Division Forms**

Publications and Manuals:

This page provides direct access to many reports issued over the last eight years on subjects pertinent to the business of the Division of Workers' Compensation including:

1. **Three Member Panel Reports**
2. **Joint Reports of the Bureau of Workers' Compensation Fraud and the Division of Workers' Compensation, Bureau of Compliance**
3. **Division Annual Reports**
4. **Medical Reimbursement Manuals**
5. **Annual Actuarial Estimation of SDTF Liabilities**
6. **Employer's Guide to a Drug-Free Workplace**

DIVISION OF WORKERS' COMPENSATION CONTACTS

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

Bureau of Employee Assistance:
850-413-1610
Greg Jenkins, Bureau Chief

Bureau of Compliance:
850-413-1609
Tasha Carter, Bureau Chief

Bureau of Monitoring and Audit:
850-413-1608
Robin Ippolito, Bureau Chief

Bureau of Data Quality and Collection:
850-413-1711
Don Davis, Bureau Chief

Office of Special Disability Trust Fund:
850-413-1604
Eric Lloyd, Manager

Assessments Unit
850-413-1603
Evelyn Vlasak, Assessment Coordinator

Office of Medical Services
850-413-1613
Anna Ohlson, Program Manager

Hotlines:

Reporting Deaths:	800-219-8953
Compliance Fraud Referral Hotline:	800-742-2214
Employee Assistance Office Hotline:	800-342-1741
Customer Service:	850-413-1601

Bureau of Compliance District Offices

District One Offices

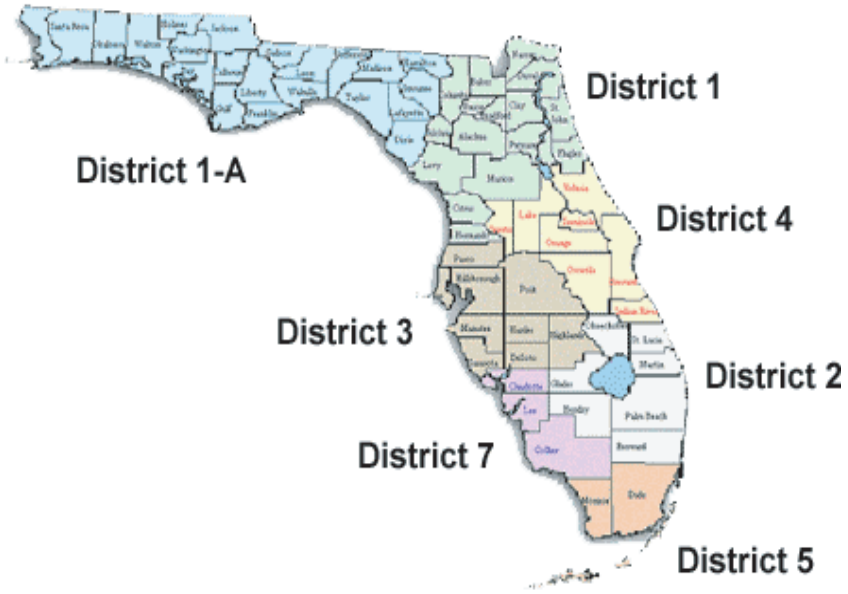
Robert Lambert (District Supervisor)

Jacksonville

Bureau of Compliance
921 N. Davis Street
Building B, Suite 250
Jacksonville, FL 32209
Tel 904-798-5806
Fax 904-353-2101

Ocala

Bureau of Compliance
1111 NE 25th Avenue, Suite 403
Ocala, FL 34470
Tel 352-401-5350
Fax 352-401-5344



St. Augustine

Bureau of Compliance
2200 A1A South
St. Augustine, FL 32080
Tel 904-461-2469
Fax 904-461-5087

District One-A Offices

Vacant (District Supervisor)

Tallahassee

Physical:
Bureau of Compliance
2012 Capital Circle SE
Hartman Building, Suite 106
Tallahassee, FL 32399-2161
Tel 850-413-1609
Fax 850-922-1028

Mailing:
Bureau of Compliance
200 East Gaines Street
Tallahassee, FL 32399-4228

Fort Walton Beach

Bureau of Compliance
Busby Center
105-A Lewis Street, Suite 104
Fort Walton Beach, FL 32547-3182
Tel 850-833-9019
Fax 850-833-7435

Panama City

Bureau of Compliance
2686 Chapman Drive
Panama City, FL 32405-4914
Tel 850-747-5425
Fax 850-747-5426

Pensacola

Bureau of Compliance
610 E. Burgess Road
Pensacola, FL 32504-6320
Tel 850-453-7804
Fax 850-484-5111

District Two Offices

Mark Carlin (District Supervisor)

Plantation

Bureau of Compliance
499 NW 70th Avenue, Suite 116
Plantation, FL 33317
Tel 954-321-2906
Fax 954-585-2657

West Palm Beach

Bureau of Compliance
3111 South Dixie Highway, Suite 123
West Palm Beach, FL 33405
Tel 561-837-5716
Fax 561-837-5416

District Three Offices

Deanna Mulaly (District Supervisor)

Port Richey, FL

Bureau of Compliance
6709 Ridge Road, Suite 102
Port Richey, FL 34668-6842
Tel 727-816-1967
Fax 727-816-1970

Tampa

Bureau of Compliance
1313 North Tampa Street, Suite 503
Tampa, FL 33602
Tel 813-221-6506
Fax 813-233-3742

Sarasota

Bureau of Compliance
5969 Cattlemen Lane
Sarasota, FL 34232
Tel 941-329-1120
Fax 941-378-6318

District Four Offices

Terence Phillips (District Supervisor)

Daytona Beach

Bureau of Compliance
135 Executive Circle, Suite 103
Daytona Beach, FL 32114
Tel 386-323-0906
Fax 386-226-7883

Orlando

Bureau of Compliance
400 W. Robinson Street
North Tower, Suite N512
Orlando, FL 32801-1756
Tel 407-835-4406
Fax 407-999-5570

Tavares

Bureau of Compliance
c/o Lake County Building Services Division
315 West Main Street, Suite 525
Tavares, FL 32778
Tel 352-343-9653 x 5577
Fax 352-343-9616

District Five Offices

Vacant (District Supervisor)

Miami

Bureau of Compliance
401 N.W. Second Avenue, Suite S-321
Miami, FL 33128-1740
Tel 305-536-0306
Fax 305-377-7239

District Seven Offices

Carol Porter (District Supervisor)

Fort Myers

Bureau of Compliance
4415 Metro Parkway, #300
Fort Myers, FL 33916
Tel 239-938-1840
Fax 239-938-1842

Bureau of Employee Assistance and Ombudsman District Offices

Northern Region Offices

Tallahassee

2012 Capital Circle SE
Hartman Building, Suite 301
Tallahassee, Fl 32399-4225
Tel 850-413-1610
Fax 850-410-0669, 850-922-8427

Pensacola

610 E. Burgess Rd
Pensacola, FL 32504
Tel 850-453-7805
Fax 850-484-5111

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921 N. Davis St., Bldg B, Suite 250
Jacksonville, FL 32309
Tel 904-798-5807
Fax 904-353-2102

Central Region Offices

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Oakbrook Professional Center
1111 NE 25th Ave, Suite 403
Ocala, FL 34470
Tel 352-401-5339
Fax 352-401-5344

Orlando

400 W. Robinson Street, Suite N-509
Orlando, FL 32801
Tel 407-835-4407
Fax 407-245-0891

Southwestern Region Office

Tampa

1313 North Tampa Street, Suite 503
Tampa, FL 33602
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Fax 813-233-3741

Southeastern Region Office - North

Plantation

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Plantation, FL 33317
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Fax 954-585-2657

Southeastern Region Office - South

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List of Graphics