


Florida Division of Workers' Compensation

2010 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, 2010

Dear Governor Crist, President Atwater and Speaker Cretul:

It is my honor and privilege to present the 2010 Division of Workers' Compensation Annual Report as required by Section 440.59, Florida Statutes.

We continue to develop new initiatives and refine our core business processes to more efficiently and effectively administer Florida's Workers' Compensation System. All of our initiatives are driven by the Division's 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. This year, the Division also elevated its focus on processes to protect its assets and avoid or minimize significant risk events by incorporating comprehensive internal controls.

One of our new initiatives is built upon one of our core processes through which the Bureau of Employee Assistance and Ombudsman Office contacts injured workers early in the life of a claim to provide educational information about the Workers' Compensation System, advise injured workers of their statutory responsibilities, and inform them of the Division's services. The new process consists of collecting some basic claim information from injured workers as part of our communication with them. That information is then used to measure injured worker satisfaction against Petitions for Benefits filed to make an early determination of what factors trigger litigation so we could share that information with insurers relative to their claims. This process will provide insurers with additional information so they can see how their claims-handling practices might impact litigation compared to the industry as a whole.

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

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CHIEF FINANCIAL OFFICER
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Division of Workers' Compensation

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THE MISSION

The mission of the Department of Financial Services (Department) 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 Fiscal Year 2009-2010 continued to contribute to the Department's mission in many significant ways.

Financial Accountability:

The Bureau of Monitoring and Audit

- Monitored the financial statements and reports of individual self-insurers to ensure they have the financial strength and ability to pay all current and future workers' compensation liabilities.

The Bureau of Compliance

- Referred 936 delinquent employer accounts to the Division of Accounting & Auditing for submission to the Department's contracted collection agency and collected $208,828 from those referred accounts.
- Identified 715 payments that were returned to the Division for insufficient funds and monitored and tracked employer accounts until secured funds were received and verified.
- Issued 111 Notices of Intent to Revoke to exemption-holders whose exemption application fee was returned for insufficient funds. Revoked 8 Certificates of Election to be Exempt for failure to submit secured funds.

The Office of Medical Services

- Resolved 2,474 petitions contesting insurer reimbursement for medical services to ensure that health care providers receive appropriate reimbursement for services rendered consistent with the Workers' Compensation Law.

The Office of Special Disability Trust Fund

- Saved $2,656,020 for Florida's employers by adjusting 1,130 Reimbursement Requests which were approved for payment after audit; Approved $41,411,806 for payment out of $44,067,826 requested.
- Reimbursed employers or their insurers $35,976,208 in audited and approved reimbursements from the current and prior fiscal years.
- Of the 2,564 Reimbursement Request audits performed, 1,342 were returned to the insurer for improper documentation or expenses unrelated to the Special Disability Trust Fund claim.

The Assessments Unit

- Calculated the imputed premiums and applicable Workers' Compensation Administration Trust Fund (WCATF) and Special Disability Trust Fund (SDTF) assessments for 472 individual self-insurers.
- Validated the accurate payment of insurance company assessments through the reconciliation of insurer premiums reported to the Office of Insurance Regulation and the National Association of Insurance Commissioners.

Education and Advocacy:

The Bureau of Compliance

- Conducted 85 education workshops for employers, contractors, and other stakeholders regarding workers' compensation coverage and compliance requirements. Educated 2,662 employers and stakeholders who attended the workshops.

The Bureau of Employee Assistance and Ombudsman Office

- Contacted 28,768 injured workers with lost-time claims to provide information about the Workers' Compensation System and to address questions or concerns about their claims and advise them of services available via telephone and the Division's website through the Bureau of Employee Assistance and Ombudsman Office (EAO).

- Assisted injured workers in navigating the Workers' Compensation System by aiding in the resolution of complex disputes, and when appropriate, explained the procedure for filing Petitions for Benefits.

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

- Resolved 362 injured worker complaints about improper billing for medical treatment by health care providers. The total charges for medical treatment improperly billed to injured workers was $486,618.

- Served as an educational resource for employers regarding the statutory requirements for workers' compensation coverage, the criteria for qualifying for an exemption, and the process for obtaining an exemption.

- Reviewed denied lost-time claims for appropriateness and intervened with insurers to assist injured workers in obtaining benefits to which they were entitled.

The Office of Data Quality and Collection

- Educated employees and employers via the Division's website on how to request protection and non-disclosure of personal information (e.g., home address and telephone number) for employees who are exempt from that disclosure under the provisions of the Public Records Law, s. 119.071(4)(d), F.S.

- Trained 353 claims-handling entity representatives on the Claims EDI Release 3 (R3) format which included: a two-day EDI overview training program and a two-day advanced training program in Tallahassee; a 3-hour introductory training program via Webinar from Tallahassee; and National and Florida EDI training at the Southern Association of Workers' Compensation Administrators' Convention.

- Provided ongoing training and education on Claims EDI R3 issues to claims-handling entities through informal teleconferences. Division staff also provided training and education in the form of monthly email advisories regarding program updates and through responses to an average of 2,369 emails per month that requested information and/or assistance on Claims EDI filing issues.

- Published revised training materials and "Helpful Resource" documents on the Division's website to assist claims-handling entities in their understanding and implementation of Claims EDI R3 program requirements.

- Generated customized reports for each medical EDI submitter that provided information about the submitter's errors that resulted in rejections. Sent reports listing outstanding Electronic Claim Cost Reports to Claims EDI trading partners. Enhanced the Claims EDI Data Warehouse to permit users to access error listings.

The Bureau of Monitoring and Audit, Bureau of Employee Assistance and Ombudsman Office, and Office of Medical Services

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

Enforcement:

The Bureau of Monitoring and Audit

- Examined permanent total and permanent total supplemental benefit payments to ensure timely and accurate payments to injured workers. Through the claims audits, and in cooperation with the Audit Section and SDTF, the Permanent Total Section (PT) identified $2,873,482 in permanent total benefit underpayments, penalties, and interest due from insurers to injured workers.

- Monitored and audited the claims-handling practices of workers' compensation insurers, self-insurers, self-insurance funds, and claims-handling entities through Division audits.

- Validated the accuracy of data electronically reported to the Division and verified the mailing of required Division notices to injured workers, the filing of required Division forms or their electronic equivalents, and the timeliness and accuracy of indemnity payments.

- Conducted 52 audits, during which 5,223 claim files and 2,655 First Reports of Injury or Illness were reviewed. As a result of these audits, underpayments, penalties, and interest for late payments of indemnity in the amount of

$319,312 were identified and paid to injured workers.

- Monitored and evaluated insurer performance for timely disposition and timely filing of medical bills through the Centralized Performance System (CPS).
- Monitored and evaluated the accuracy and timeliness of First Report of Injury or Illness Forms filed by employers, insurers, and third-party administrators through CPS.
- Reviewed the performance of employers, insurers, and third-party administrators for timeliness of initial indemnity benefit payments made to injured workers through CPS.
- Analyzed information from 52,768 First Reports of Injury or Illness for compliance with the Division's timely payment and timely filing standards. This analysis resulted in $616,816 assessed insurer penalties due to late payments and $1,208,775 in assessed insurer penalties due to late filings. Further analysis resulted in $18,232 assessed employer penalties due to late payments and $135,700 in assessed employer penalties due to late filing.
- Analyzed 4,070,533 medical bills for compliance with the Division's timely disposition and timely filing standards which resulted in $2,128,250 assessed penalties due to late dispositions and $751,995 assessed penalties due to late filings.
- Conducted self-insurer payroll and premium audits to ensure accurate assessments for the WCATF, SDTF, and the Florida Self-Insurers Guaranty Association. The Self-Insurance Section conducted 29 audits and reviewed 72,659 employee payroll records. As a result of the audits, $44,093,000 in underreported payroll was identified and $237,715 in under-reported premium was identified for assessment purposes.

The Bureau of Compliance

- Conducted 33,235 on-site investigations of employer worksites to determine employer compliance.
- Issued 2,214 Stop-Work Orders and assessed $49,786,917 in fines against non-compliant employers.
- Initiated revocation proceedings for 301 exemption holders determined to no longer meet exemption eligibility requirements.
- Investigated 2,294 referrals alleging employer non-compliance which resulted in 278 Stop-Work Orders being issued.
- Conducted 23 employer investigations for underreporting or concealing payroll and misclassifying employees. Caused $56,066 to be added to the premium base that was previously evaded.
- Permitted 7,068 contractors to register in the Construction Policy Tracking Database which allowed contractors to receive automatic email notification about changes to the workers' compensation coverage status for any contractors they use. Those 7,068 general contractors were able to monitor coverage on 32,486 contractor policies.

The Office of Data Quality and Collection

- Collected 97.8% of claim-related filings via the Claims EDI R3 format, representing a total of 485,492 electronic claim filings.
- Collected 100% of all medical bills and Proof of Coverage filings in electronic format consisting of 4,080,348 medical bill filings and 752,644 Proof of Coverage filings.

The Office of Medical Services

- Decertified a health care provider and barred the provider from future reimbursement on cases covered under the Workers' Compensation Law after a determination was made that the provider engaged in overutilization of medical services.

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

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

EARLY CONTACT WITH INJURED WORKERS: LITIGATION WARNING SIGNS?

When changes to the Workers' Compensation Law are debated, common ground among insurers, employers, injured workers, and claimants' attorneys is rarely achieved, which in the long term leads to a less than optimal Workers' Compensation System for all stakeholders. One reason for this lack of consensus is the general distrust among stakeholders about the information or data each group uses to defend their positions. Using non-empirical data or subjective, anecdotal information leads to poor policy-making, but more importantly, can hide the true problems and the potential solutions to those problems.

For the past several years, the Division has placed a great deal of emphasis on seeking new ways to gather workers' compensation data and subsequently use the data to more effectively administer the Workers' Compensation System while simultaneously exploring how the data could be used for the benefit of the system stakeholders. Two of the most frequently discussed issues relate to whether or not an injured worker believes that his or her claim is positively on track and whether or not there are key, early warning signs that would cause an injured worker to litigate a claim. With these issues in mind, the Bureau of Employee Assistance and Ombudsman Office expanded one of its existing, core business processes. EAO attempts to make contact with injured workers within two days of the Division's receipt of the First Report of Injury or Illness in order to provide educational information about the Workers' Compensation System, advise injured workers of their statutory responsibilities, and inform them of EAO's services. In late 2008, EAO started collecting some basic claim information from injured workers as part of their communication with them. EAO made contact with 23,679 injured workers in Calendar Year 2009. EAO's initial contact with an injured worker is usually made, on average, 19 days after the date of the injury.

The information collected by EAO during this first contact comes from responses to the following questions:

- Do you have the name and phone number of your insurance company?
- Has the insurance company provided you with any informational material regarding your workers' compensation claim?
- Are you receiving authorized medical care for your injury?
- As of today, do you think you have received adequate medical treatment for your injury?
- Have you returned to work?
- Have you been in contact with your employer since your date of injury?
- Have you received your first benefit check?

The purpose of asking these questions is to obtain information about three fundamental workers' compensation principles and their effect on the progression of the claim: communication among the injured worker, insurer, and employer; medical treatment; and return-to-work. Most experts would agree that if all three of these principles are positively aligned, the outcome of the claim will be positive for all parties.

EAO collects the responses to those questions, which are then cross-matched against the Division of Administrative Hearings database to determine if the injured worker filed a Petition for Benefits. The results of this cross-matching analysis confirmed some long-standing workers' compensation claim beliefs. Injured workers are less likely to file a Petition for Benefits:

- If they have received informational material from their insurance company about their workers' compensation claims. When asked if the insurance company had provided informational material regarding their workers' compensation claim, injured workers who answered negatively were more than one and one-half times more likely to file a Petition for Benefits. Insurers are required to send an informational brochure about the workers' compensation system and notification about services available by the Division to injured workers within three days of the insurer's knowledge of the injury. (23.5% versus 14.8%)

- If they are receiving adequate medical treatment for their injury. When asked if the injured workers thought they had received adequate medical care, those who answered negatively were more than twice as likely to file a Petition for Benefits. (31.9% versus 14.7%)

- If they have returned to work. Injured workers who had not returned to work were more than twice as likely to file a Petition for Benefits. (18.6% versus 8.6%)

- If the employer has been in contact with the injured worker since the date of injury. Those injured workers who had not been in touch with their employers were more than one and one-half times more likely to file a Petition for Benefits. (23.6% versus 15.1%)

Other highlights of the responses include:

- 98.7% of the injured workers knew the name and phone number of their insurance company.

- 90.3% had received informational material about their claim.

- 98% had received authorized medical care.

- 95.4% stated that they had received adequate medical treatment for their injury.

- For those injured workers who had returned to work at full duty, only 3.9% had filed a Petition for Benefits, while 18.6% of workers who had not returned to work had filed a Petition for Benefits.

- 97.5% of injured workers had been in contact with their employer since the date of their injury.

The data obtained can be aggregated based upon the responses for all injured workers or can be separated by insurer, so each insurer can compare their results to the overall industry. "The goals for this new initiative were to obtain first-hand feedback from injured workers about their claims, identify litigation drivers, and provide insurers with empirical information to assist them in seeking new opportunities to more effectively manage their claims so injured workers can receive their benefits without having to resort to litigation," explained Pam Macon, Bureau Chief of EAO. Macon added that, "In the upcoming fiscal year, we plan to follow-up with the injured workers 60-90 days after the date of injury. We will then compare those results with responses we received on average 19 days after the date of injury to see what, if any, new or different trends have emerged. We also plan to contact those injured workers who responded negatively about their medical treatment or who had not yet received their first benefit check to see how we can provide them with any assistance in order to reduce potential claim disputes in the future."

BUREAU OF EMPLOYEE ASSISTANCE AND OMBUDSMAN OFFICE

The Bureau of Employee Assistance and Ombudsman Office (EAO) was established pursuant to s. 440.191, F.S., to assist injured workers, employers, insurers, health care providers, and managed care arrangements in fulfilling their responsibilities under the Workers' Compensation Law. EAO is a resource for all employees who participate in the Workers' Compensation System and is responsible for educating employees and employers and distributing educational information to them. EAO assists injured workers by:

- Contacting injured workers within two days of receipt of the First Report of Injury or Illness to discuss their rights and responsibilities and advise them of services available through EAO;
- Educating and disseminating workers' compensation information to all system participants;
- Educating attorneys, insurers, third-party administrators, and health care providers to assist them in fulfilling their statutory responsibilities;
- Resolving disputes between injured workers and insurers without undue expense, costly litigation or delay in the provision of benefits;
- Analyzing claims in which injured workers' benefits have been denied to determine if benefits are properly denied and collect data to determine industry denial trends.

The Role of the Bureau of Employee Assistance and Ombudsman Office

In order to ensure that system participants are aware of the services they provide, EAO uses the Division's website, brochures, toll-free telephone lines, emails, and group presentations to communicate its role of education and advocacy. EAO also tracks stakeholders' verbal and written inquiries and feedback for use in developing educational programs and designing new methods of communicating frequently requested information. To effectively fulfill their mission, EAO utilizes a team structure. This approach allows each team to focus on a specific portion of EAO's statutory responsibilities. Furthermore, it allows the Division to collect more specific data about each of the team's processes, which permits a more comprehensive analysis of the workers' compensation system.

First Report of Injury Team

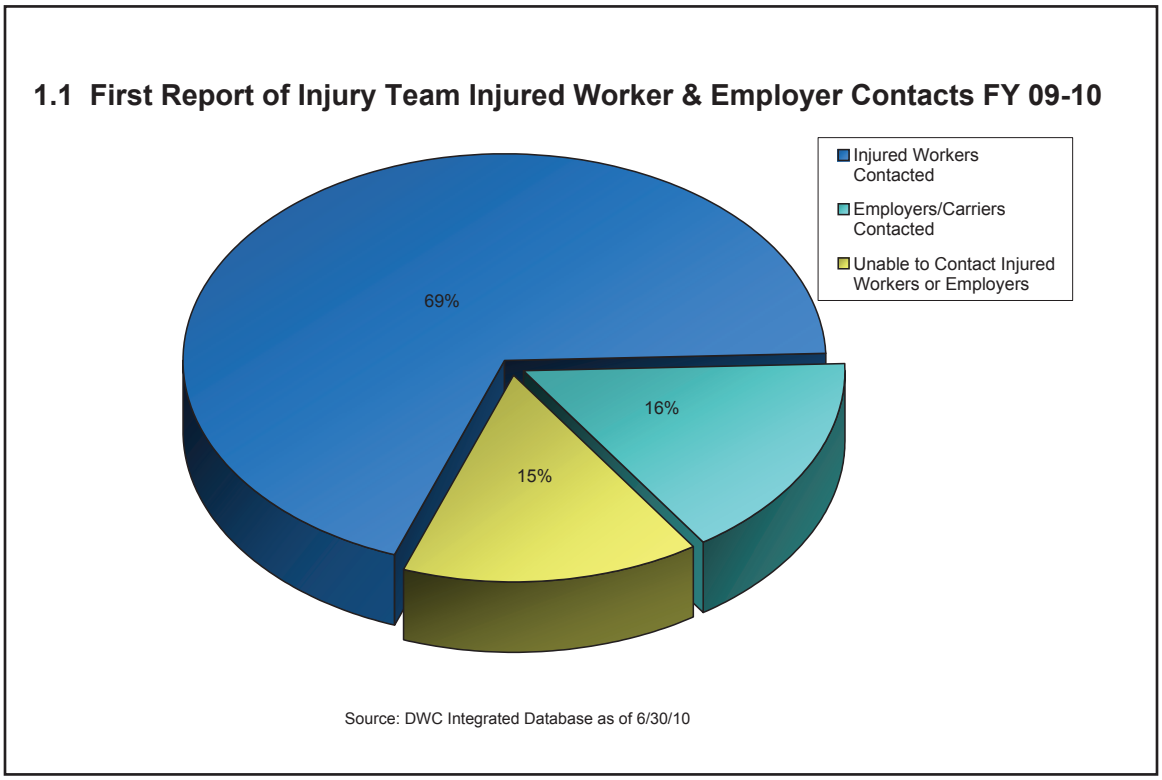
The primary focus of the First Report of Injury Team is to initiate telephone contact with injured workers within two days of the Division's receipt of the First Report of Injury or Illness. The Team's goal is to educate injured workers of their rights and responsibilities under Florida's Workers' Compensation Law and make them aware of services provided by EAO.

When conversing with injured workers, the Team asks specific questions about the handling of their claims to determine if they are experiencing any problems that can be immediately addressed. If there are concerns about medical or indemnity benefits, the Team refers injured workers to the appropriate team in EAO, who then contacts various parties to intervene on the injured worker's behalf to resolve the issues. After contacting injured workers, the Team mails follow-up information to injured workers about the services EAO provides and includes EAO's toll-free telephone number and identifies information available on the Division's website.

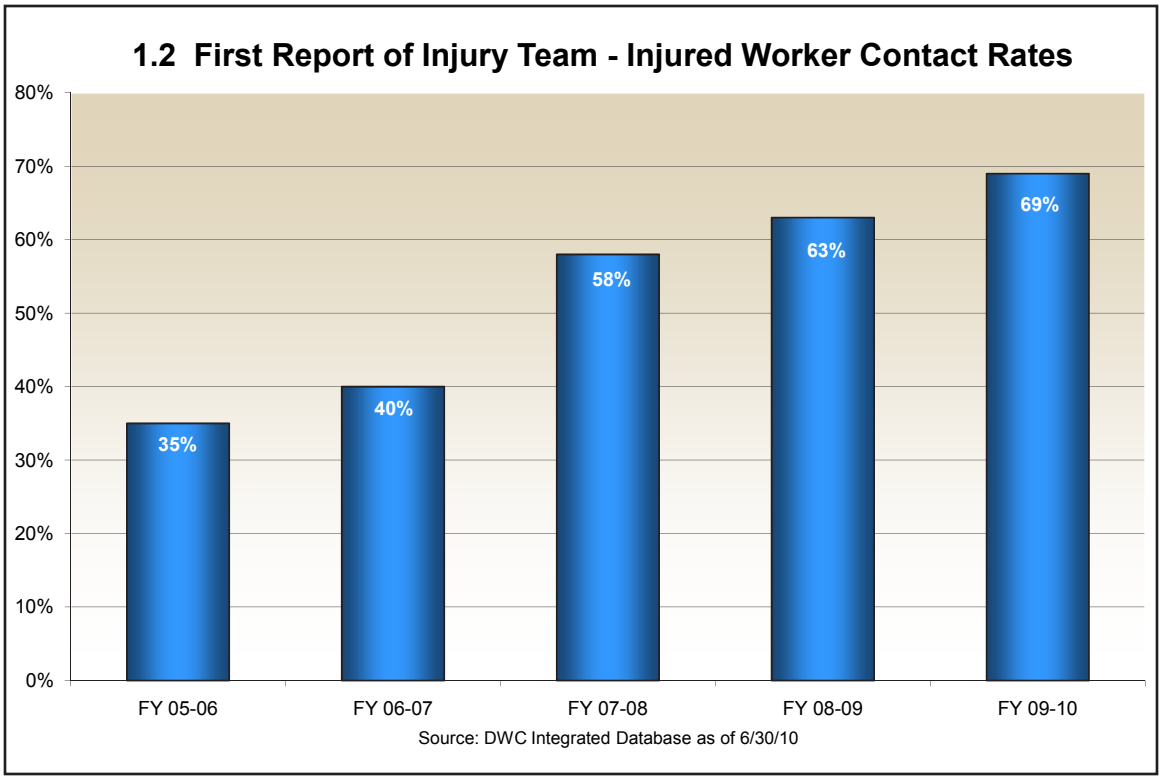
During FY 2009-2010, the First Report of Injury Team:

- Contacted 28,768 injured workers by telephone;
- Contacted 6,726 employers when the team was unable to reach injured workers to inquire about the status of injured workers' claims and to advise them of EAO's services;
- Mailed letters to 41,783 injured workers to advise them of EAO's services and offer assistance.

Graphic 1.1 illustrates injured worker and employer contacts by the First Report of Injury Team.



Graphic 1.2 illustrates that the rate at which the Bureau is successful in contacting injured workers has steadily increased over time. This increased contact success rate is attributed to EAO establishing a team dedicated to this function.



Injured Worker Helpline Team

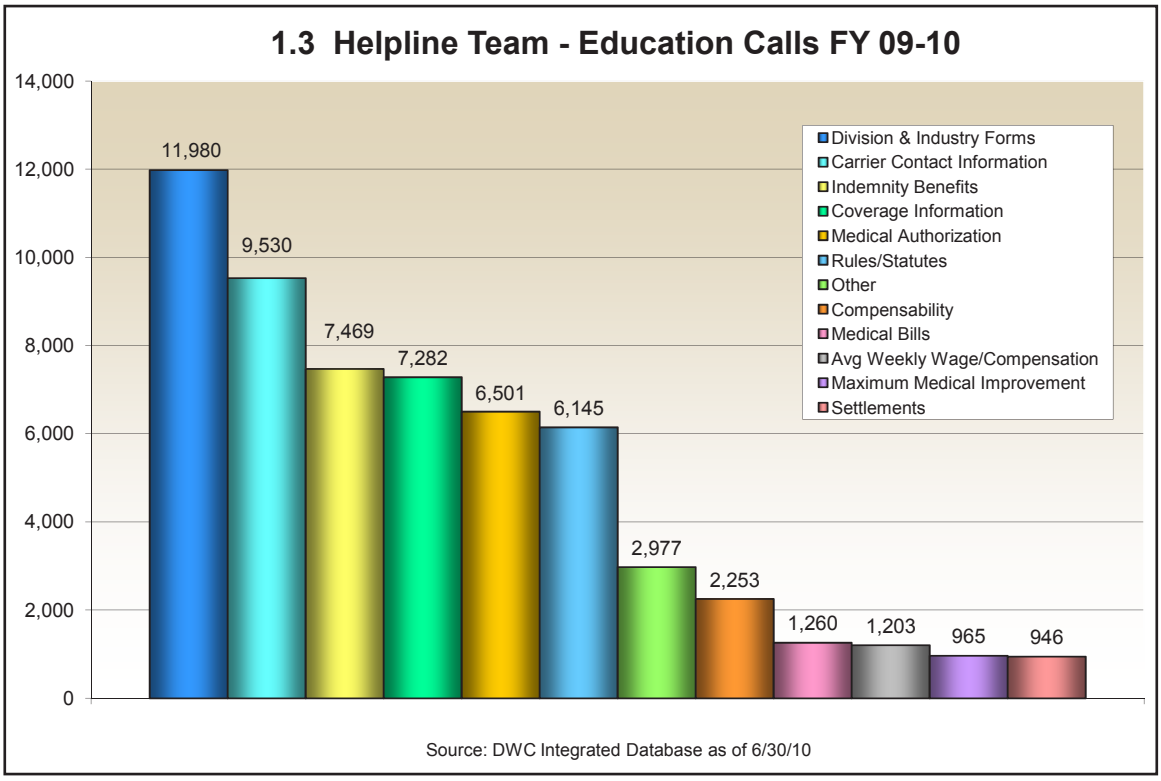
The Injured Worker Helpline Team's primary responsibility is to provide assistance to and educate people who call the Division's toll-free telephone line. The Team answers general questions about the Workers' Compensation System as well as specific inquiries posed by injured workers about their claims.

When injured workers communicate that they are having problems obtaining medical or indemnity benefits, the Team identifies disputed issues, researches injured workers' concerns, and contacts employers, carriers, attorneys, medical providers or other appropriate parties to facilitate resolution. Disputes that will require extensive investigation are referred to the Ombudsman Team. If injured workers' concerns are outside the jurisdiction of EAO, the Injured Worker Helpline Team refers callers to the appropriate Division office or external agency. Many callers request information that results in referrals to different public agencies such as the Agency for Workforce Innovation, Department of Education, and Social Security Administration.

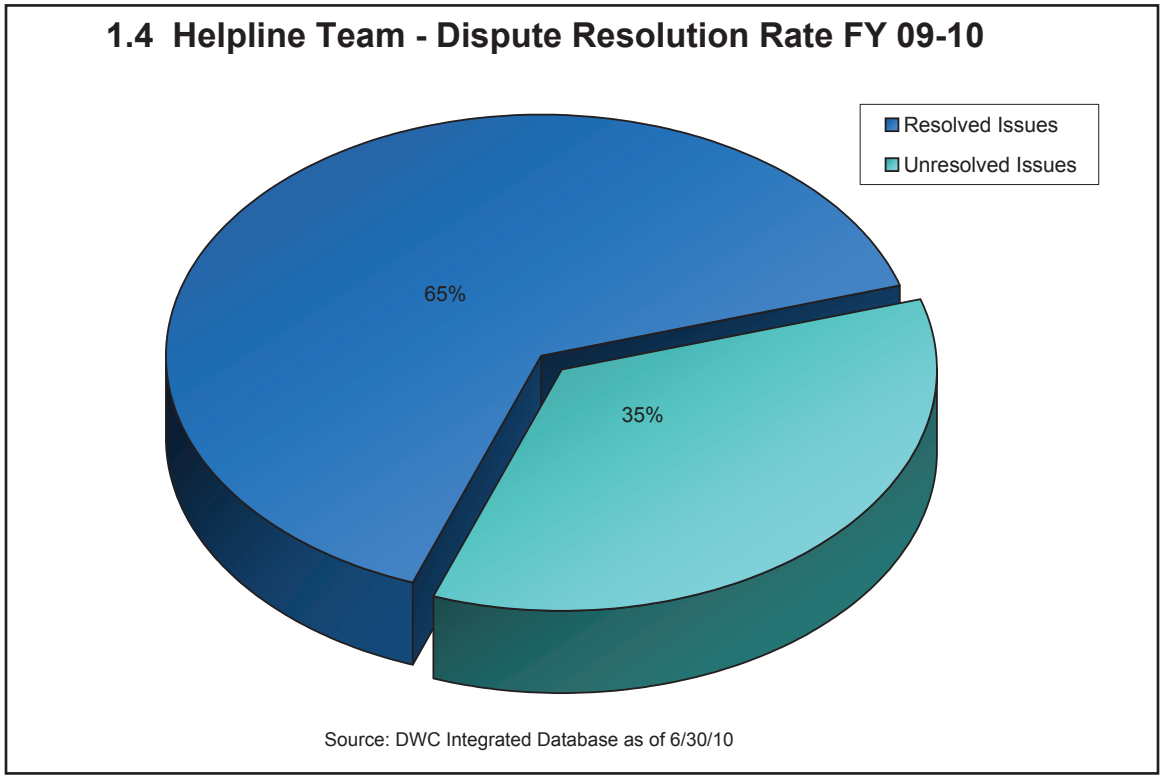
During FY 2009-2010, the Injured Worker Helpline Team:

- Provided workers' compensation educational information and assistance to 58,511 callers, including 6,620 Spanish-speaking callers;
- Resolved 646 disputes out of 999 disputes received.

Graphic 1.3 illustrates the volume of educational inquiries by topic addressed by the Injured Worker Helpline Team.



Graphic 1.4 illustrates the dispute resolution rate for the Injured Worker Helpline Team.



Ombudsman Team

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

The Team assists walk-in customers in eight offices around the State resolving disputes and providing workers' compensation information applicable to each injured worker's claim, including guidance on the Petition for Benefits process. The Team also assists injured workers referred from the Governor's Office, legislators, and other elected officials.

In addition to obtaining information and requesting assistance by telephone, system participants have direct access to an EAO Ombudsman via a dedicated email address for injured workers through the Division's website. Previously, only very minimal data was collected by the Ombudsman Team. A new initiative implemented in December 2009 allows the Team to capture data electronically about each email request, such as the types of concerns raised by the email and the topics for which education was needed. EAO is using this information to develop additional educational materials and modify training programs to incorporate additional issues or areas of concern. During the first six months of recording this data, the three most frequent issues inquired about were medical authorization, accident compensability, and indemnity benefits.

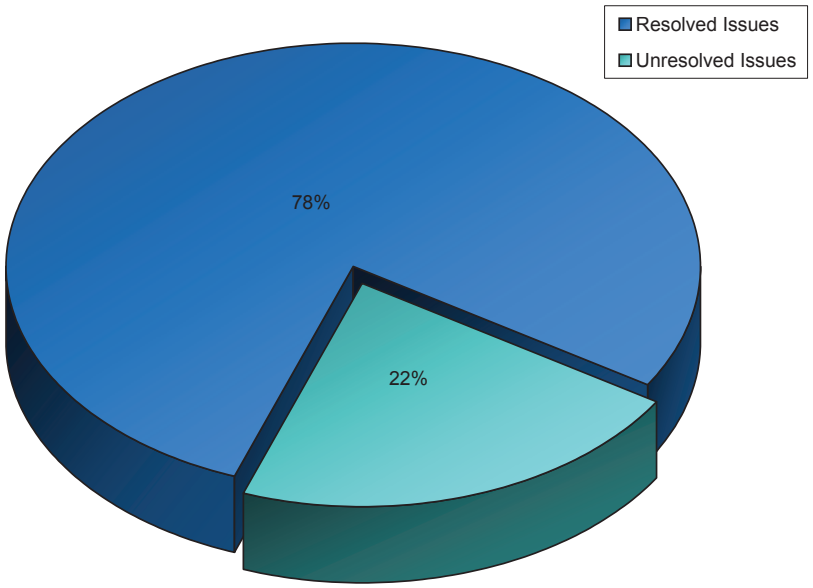
During FY 2009-2010, the Ombudsman Team:

- Resolved 1,125 disputes out of 1,437 disputes reported to the Division which included 362 disputes from injured workers regarding $486,618 of unpaid medical bills, 93% of which were successfully resolved;
- Prevented 2,730 potential disputes by educating injured workers and providing them with in-depth case specific information;
- Responded to 1,067 email inquiries from injured workers, employers, insurers, and health care providers about issues related to provisions in the Workers' Compensation Law and related administrative rules;
- In cooperation with the Injured Worker Helpline Team, secured $435,279 in indemnity benefits for injured workers and obtained 668 authorizations for medical treatment;

- Assisted 349 walk-in customers with questions and concerns about their workers' compensation claims;
- Assisted 200 injured workers with the Petition for Benefits process.

Graphic 1.5 illustrates the resolution rate for the Ombudsman Team for all of the issues addressed.

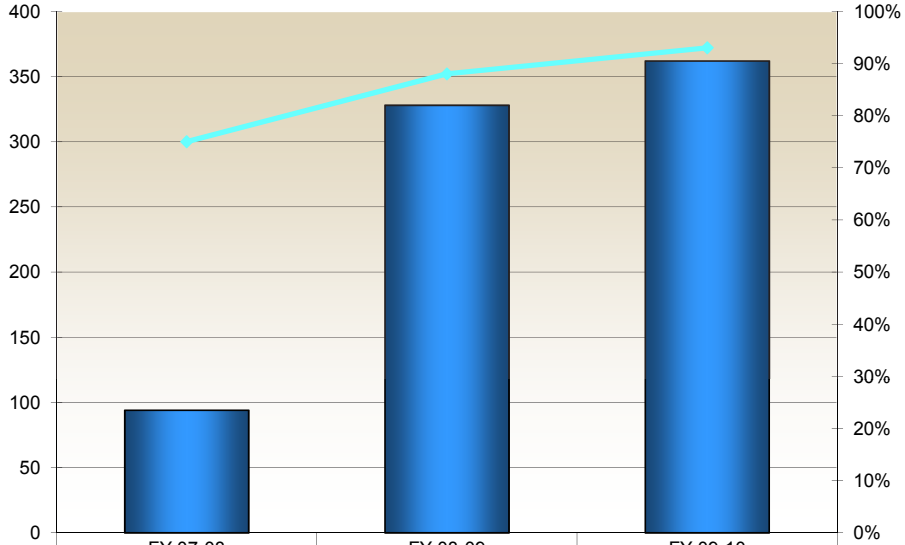
1.5 Ombudsman Dispute Resolution Rate FY 09-10



Source: DWC Integrated Database as of 6/30/10

Graphic 1.6 illustrates the number and percent of disputes resolved involving unpaid medical bills for the past 3 fiscal years.

1.6 Number and Percent of Unpaid Medical Bill Disputes Resolved

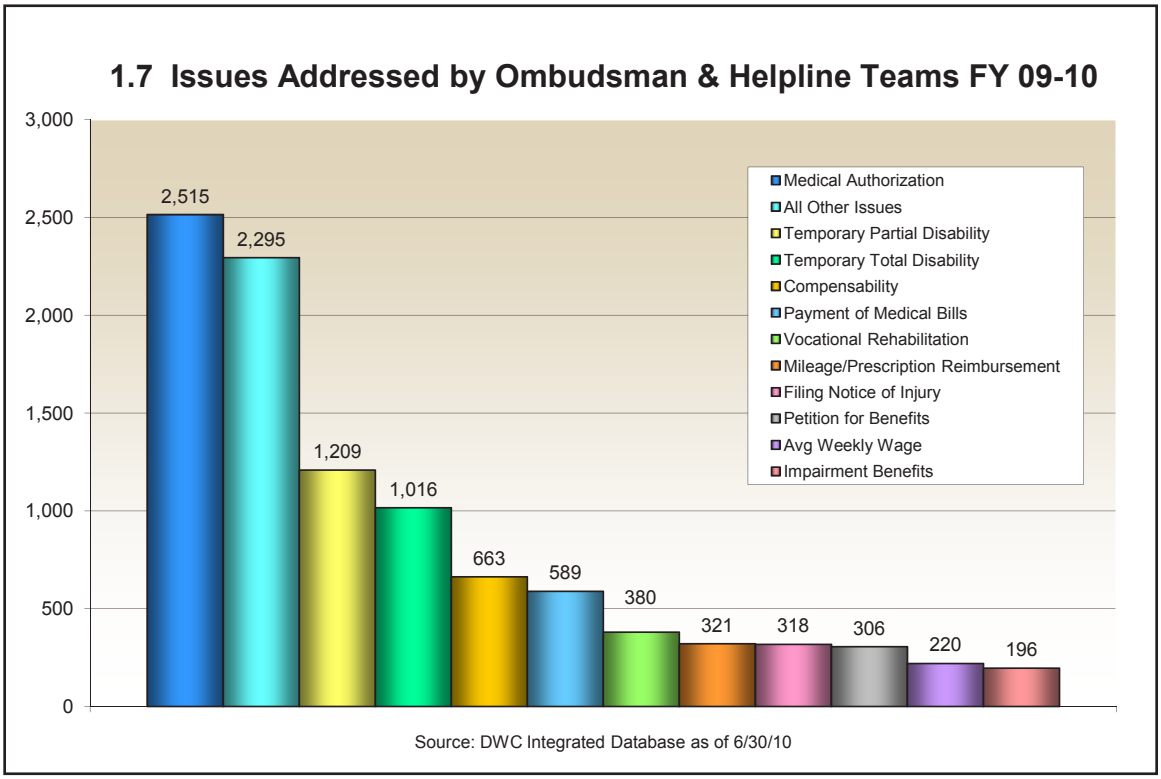


	FY 07-08	FY 08-09	FY 09-10
Number	94	328	362
Percent	75%	88%	93%

Source: DWC Integrated Database as of 6/30/10

Medical authorization is the most frequent issue that was addressed by the Ombudsman and Helpline Teams, accounting for 25% of all issues addressed. Requests for physical therapy, orthopedic services, surgery, MRI/CT scan, neurological services, and pain management are the medical authorization issues for which assistance or information was requested most frequently.

Graphic 1.7 illustrates the array of issues addressed by the Ombudsman and the Injured Worker Helpline Teams.



Early Intervention Team

The Early Intervention Team focuses on workers who have suffered serious injuries that could result in a prolonged recovery period. By establishing and maintaining on going communication with these injured workers, the Team is able to communicate with insurers to facilitate the prompt provision of benefits and avoid disputes throughout the life of the claim. Additionally, upon receipt of a notice that a work place death has occurred, the Team immediately reviews the case and if appropriate, makes contact with the family to advise them of their eligibility for dependent indemnity benefits, funeral expenses, and educational benefits.

During FY 2009-2010, the Early Intervention Team:

- Added 385 new cases for continual case management;
- Received and analyzed 310 First Reports of Injury or Illness which reported a death and contacted 132 families to provide information about dependent benefits.

Denials Team

The Denials Team reviews and analyzes 100% of denied claims filed with the Division to validate denial codes and permit data aggregation. A substantial amount of time is devoted to educating insurers on proper coding procedures. This data is then used to monitor the denial trends of the industry and is used by the Division to examine carrier practice outliers for denials. When suspected coding errors are identified in denials, specialists contact insurers for additional information or clarification to complete their reviews. The Team's review efforts and subsequent communication with insurers resulted in denials being rescinded in 74 cases during Fiscal Year 2009-2010. During September 2009, the Denials Team implemented a new initiative that expanded their review of denied claims by participating in on-site carrier audits with the Bureau of Monitoring and Audit.

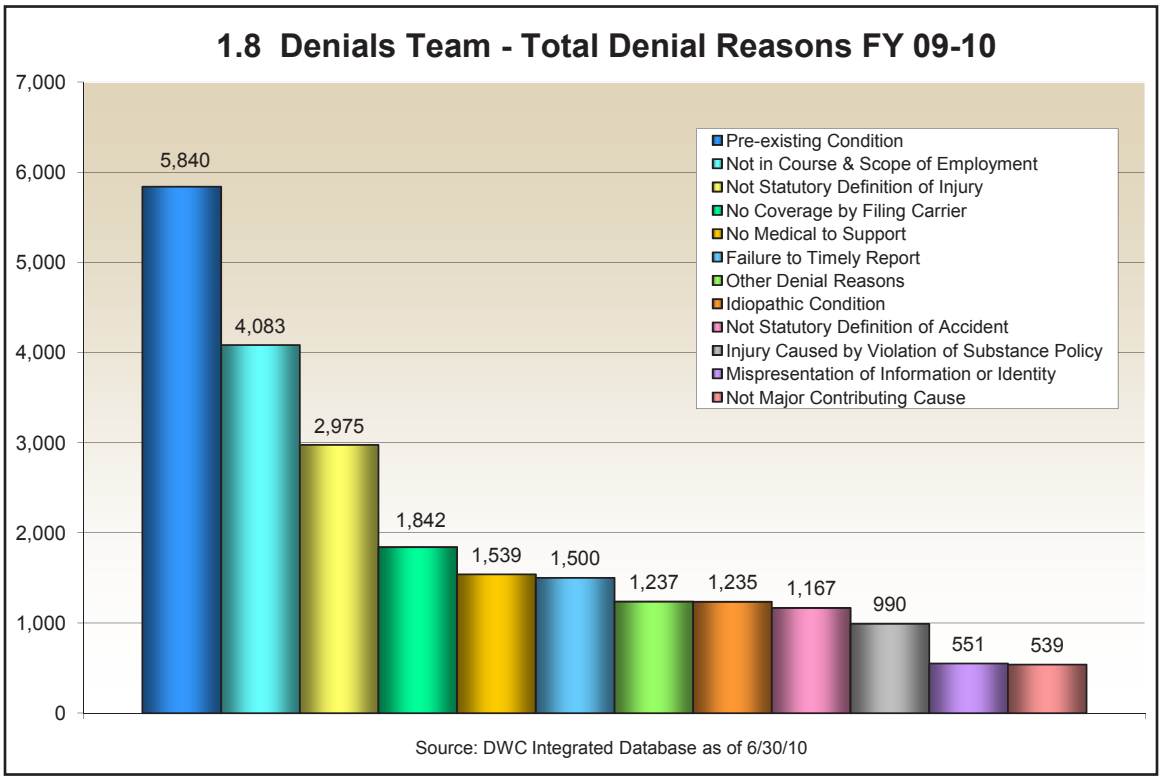
During FY 2009-2010, the Denials Team:

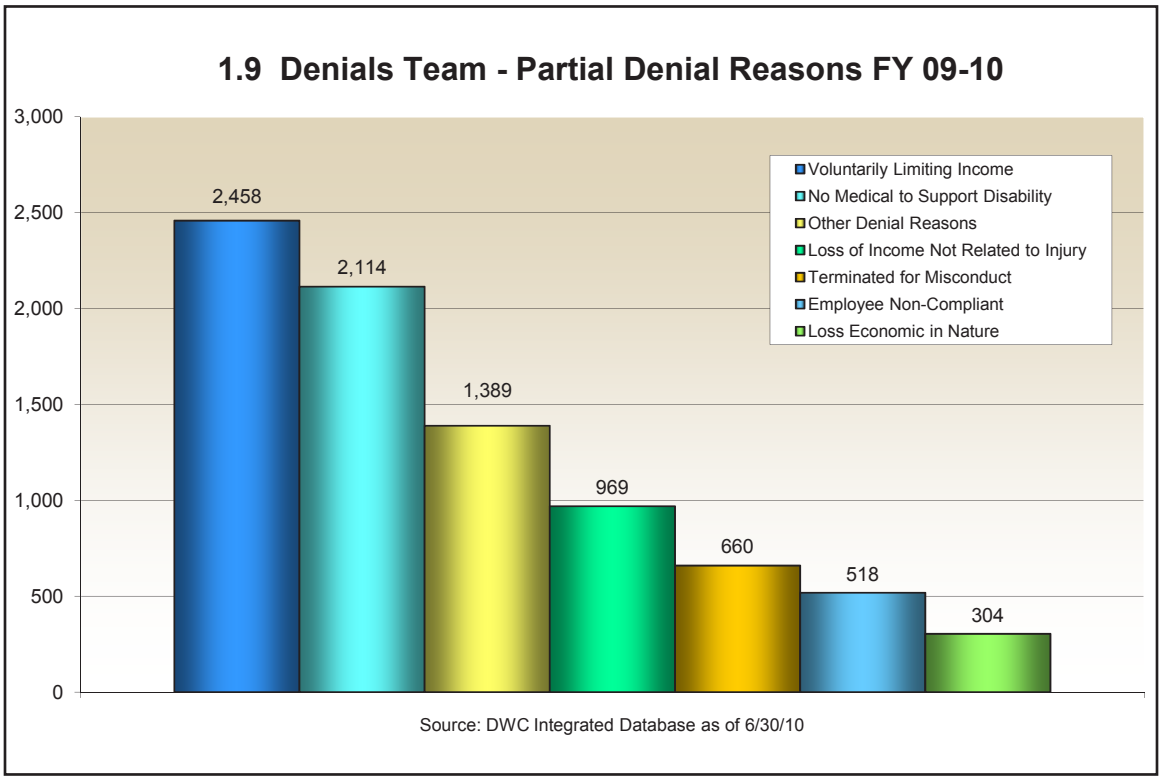
- Reviewed 23,498 total denials (in which both indemnity and medical benefits were denied)

and 8,412 partial denials (in which indemnity or medical benefits were denied);

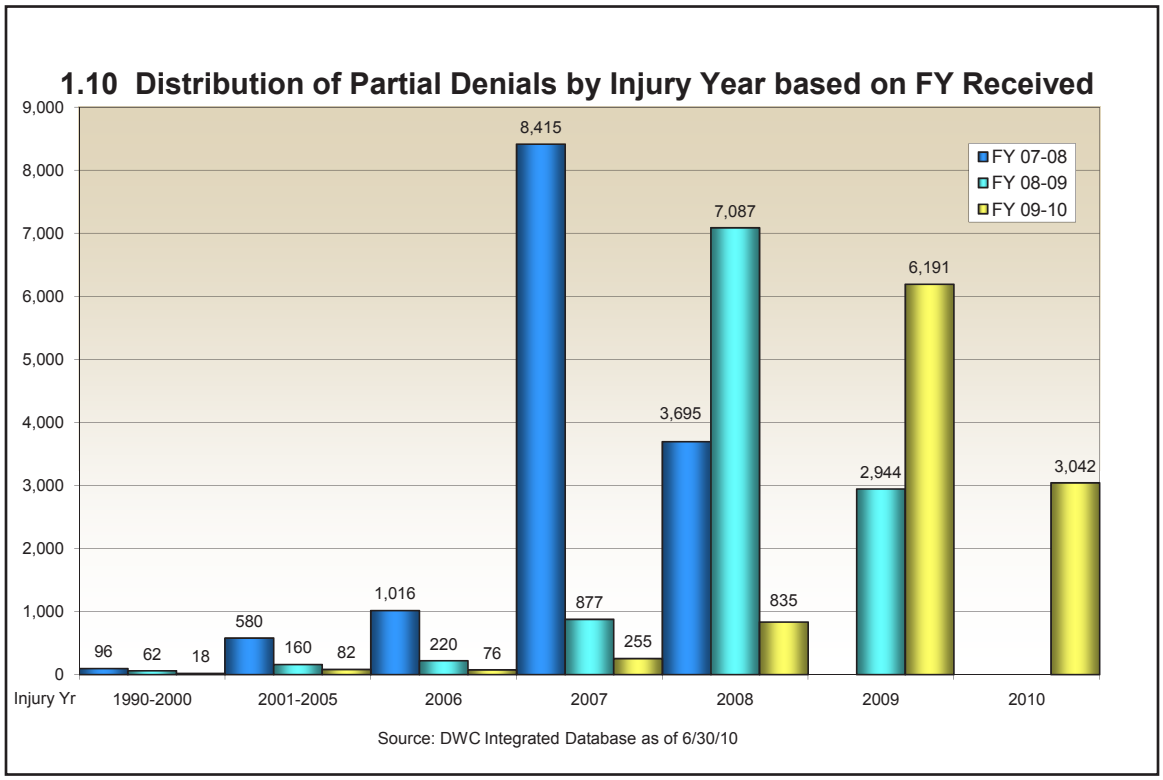
- Participated in 11 on-site carrier audits to review denials filed by the insurer which provide additional information to the Bureau of Monitoring and Audit about the denial practices of the insurer being audited.

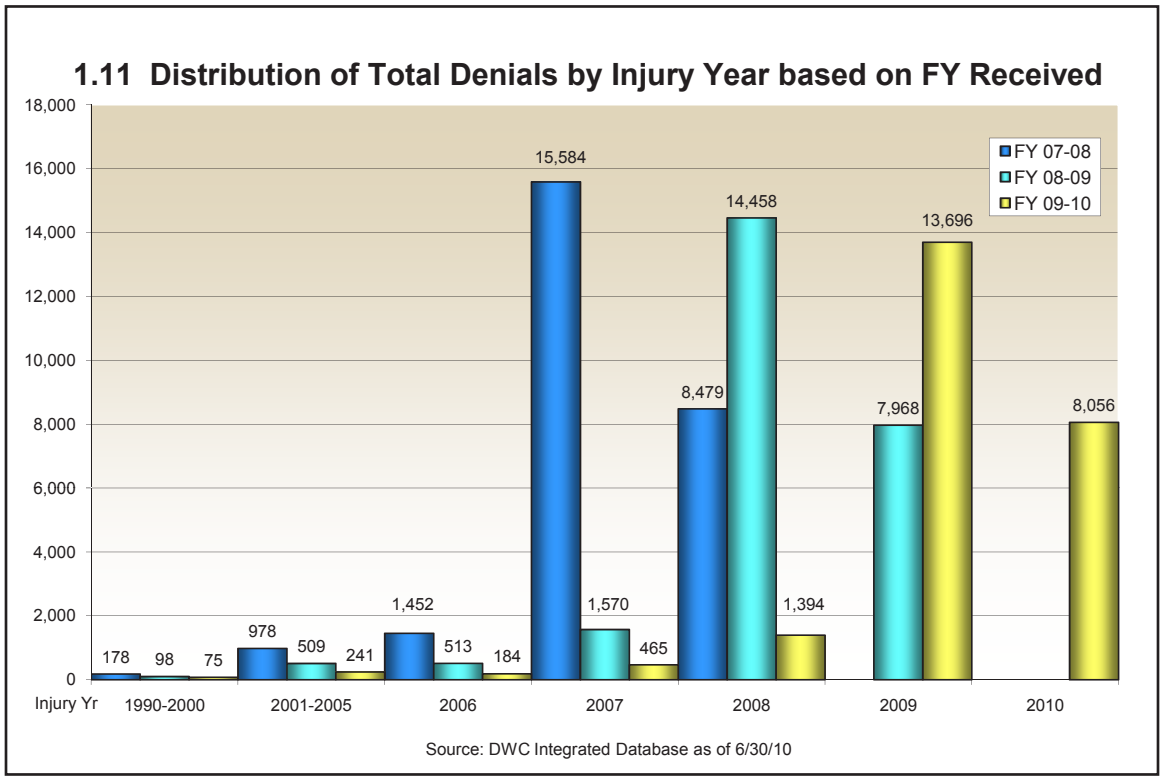
Graphic 1.8 and **Graphic 1.9** illustrate the reasons claims were totally or partially denied.





Graphic 1.10 and **Graphic 1.11** show the number of partial and total denials filed with the Division over time. Note that an insurer may file more than one denial on a single claim over the life of a claim and the denial may apply to claims filed within that injury year or during a prior injury year. As demonstrated by these graphics, most denials are filed regarding accidents that have occurred during the last four injury years.





Customer Service Team

The Customer Service Team assists and educates employers with inquiries regarding workers' compensation coverage and exemption from coverage. The Team also addresses inquiries regarding drug-free workplace and safety programs. Calls are referred throughout the Division that pertain to penalties, liens, and financial accountability. Further, the Team handles calls from persons reporting employer non-compliance. When a caller reports that an employer does not have workers' compensation coverage, the Team researches Division records to verify whether or not the employer has coverage or a valid exemption. If the employer does not have either, the information is referred to the Bureau of Compliance for further investigation and handling.

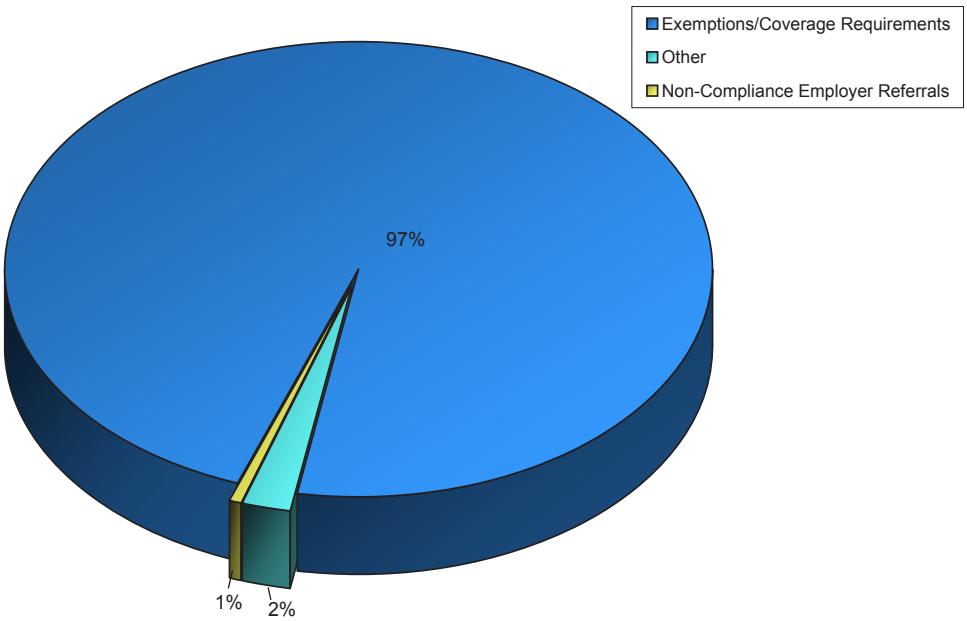
This Team also provides assistance by responding to inquiries relating to provider certification and statutory responsibilities. In addition, the Team responds to email requests via a dedicated email address for medical issue inquiries.

During FY 2009-2010, the Customer Service Team:

- Received and handled a volume of 108,787 calls, 558 of which were referred to the Bureau of Compliance for further investigation;
- Responded to 222 email inquiries submitted on medical issues.

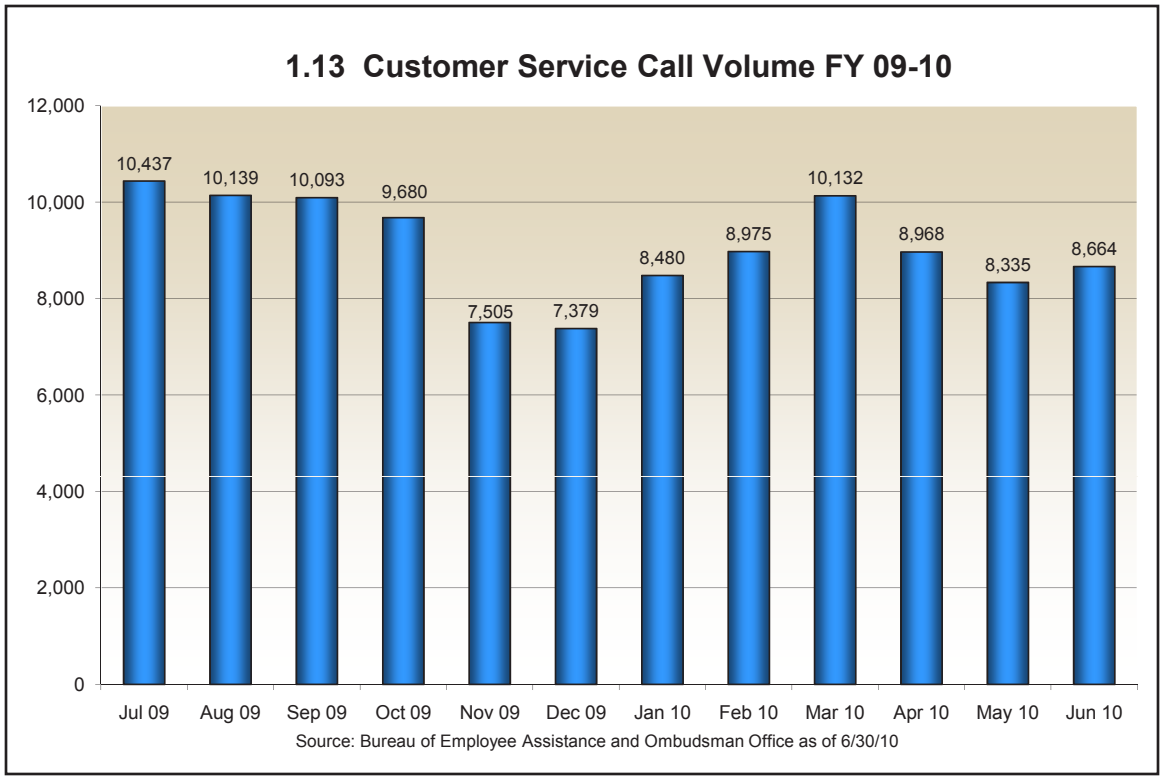
Graphic 1.12 illustrates the volume of educational calls handled by topic by the Customer Service Team.

1.12 Customer Service Calls FY 09-10



Source: Bureau of Employee Assistance and Ombudsman Office as of 6/30/10

Graphic 1.13 shows the monthly call volume for the Customer Service Team.



EAO SUCCESS STORIES

A 66-year old laborer with a shoulder injury contacted EAO and requested assistance because he had been advised he had exhausted his workers' compensation benefits. The injured worker was unemployed, but looking for work. The Ombudsman assigned to the case determined that he had reached maximum medical improvement in November 2009 with a 15% permanent impairment rating. The injured worker reported that he had been told by his adjuster that he would receive $6,943 in impairment income benefits. The Ombudsman determined that the amount quoted to the injured worker would only have been correct if the injured worker had returned to work earning his pre-injury wages. However, the employer did not have work available for the injured worker to return to work.

The Ombudsman contacted the adjuster and was told that the carrier's attorney had advised that the injured worker's benefits should be reduced by 50% because the unavailability of work for the injured worker was due to economic conditions, not his injury. The Ombudsman explained that the carrier's position was not supported by the Workers' Compensation Law since a reduction in impairment income benefits is only permitted if the injured worker returns to employment earning income equal to or greater than pre-injury wages. Based on EAO's intervention, the adjuster, after consulting with counsel, agreed to provide the injured worker with an additional $6,943 in Impairment Income Benefits.

A 67-year old construction laborer who had injured his ankle while working in April 2009 called EAO's helpline in February 2010 because he had not received a benefit check in eight months. The EAO Specialist determined that the injured worker had relocated, but had not informed the insurance company of his new address. The Specialist also determined that the injured worker had not seen the authorized workers' compensation physician in several months. The EAO Specialist coordinated a conference call between the Specialist, the adjuster, and the injured worker to establish communication between the injured worker and the insurer. The adjuster documented the injured worker's new address and authorized a local physician so the injured worker could obtain medical treatment in his city of residence.

The EAO Specialist also requested that the adjuster review the claim file to determine why the injured worker's benefit payments had ceased. As a result of EAO's intervention, the injured worker received $3,914 in past due benefits, which included penalties and interest.

A 32-year old cashier injured her wrist in November 2007 and received indemnity benefits for the days she missed from work due to her work-related injury. The injured worker subsequently reached maximum medical improvement and the treating physician assigned a 15% impairment rating. Even though the injured worker had retained an attorney to settle her claim, the injured worker contacted EAO in September 2009 because she had not received any impairment income benefits from the carrier. The EAO Specialist contacted the adjuster and advised that impairment benefits were past due to the injured worker because progression of a settlement did not eliminate their responsibility to pay impairment income benefits. As a result of EAO's intervention, the injured worker received impairment income benefits in the amount of $4,984.

A 49-year old teacher's aide sustained an injury to her right shoulder and right arm while cleaning a classroom in November 2009. The injured worker contacted EAO because she had missed 24 days from work and had not received any benefit payments. The carrier had denied indemnity benefits because they believed the injured worker's loss of income was not due to her work-related injury. After multiple attempts, the EAO specialist succeeded in reaching the claims adjuster and advised him the injured worker stated she routinely worked 30 hours a week which would qualify her for indemnity benefits. After EAO's intervention, the adjuster requested a wage statement from the employer to confirm the hours worked. This intervention resulted in the injured worker being paid $1,070 in indemnity benefits for missing four weeks from work due to her injury.

A 49-year old window washer who had suffered a serious work related neck injury contacted EAO's Injured Worker Helpline Team because she had not received any benefits for more than ten weeks. Although she had been released to return to light duty work by her doctor, the employer did not have work available within her restrictions. Her attorney had filed a Petition for Benefits for temporary partial disability benefits. The case was referred to an Ombudsman. The Ombudsman contacted the adjuster assigned to the claim. That adjuster advised that she was no longer responsible for the claim and referred the Ombudsman to a new adjuster. As a result of EAO's intervention, the new adjuster acknowledged that the injured worker had not been paid benefits due in over ten weeks. The adjuster agreed to overnight a $4,480 check to the injured worker for past due benefits and pay an additional $999 in penalties and interest.

A 26-year old laborer was injured while using a table saw at work in December 2009, which resulted in the amputation of the tips of three fingers. He was taken immediately to the emergency room and admitted for surgery. The injured worker's claim was subsequently denied because the insurance company determined that an employer/employee relationship did not exist on the date of the accident. The denied claim was filed with the Division and assigned to the EAO Denials Team for review. At the time of the review, 16 days had elapsed since the accident. The Denials Team found that an employee/employer relationship had existed for more than a year, including on the date of the accident. Accordingly, a Denials Team Specialist contacted the adjuster who refused to rescind the denial because there was no payroll documentation substantiating that the injured worker had an employer/employee relationship on the date of the accident.

The denial was referred to an Ombudsman for further investigation. The injured worker reported that the employer had failed to submit the hours he had worked on the date of his accident to the employee leasing company. This error was later corrected and the injured worker was issued a payroll check for hours worked prior to the accident. The payroll check confirmed the employer/employee relationship on the date of accident. The Ombudsman's intervention included contact with the claims adjuster, employee leasing company's attorney, claims manager, and the injured worker. One month after submitting the Notice of Denial, the adjuster contacted the Ombudsman and agreed to rescind the denial. As a result of EAO's assistance, the injured worker was paid $1,760 in indemnity benefits, medical treatment was authorized, and the medical treatment already rendered was paid.

BUREAU OF COMPLIANCE

The Bureau of Compliance is responsible for ensuring that employers comply with their statutory obligations to obtain appropriate workers' compensation insurance coverage for their employees. Ensuring that employers adhere to workers' compensation coverage requirements results in coverage for employees that were previously without coverage due to non-compliance, ensures that covered employees with work-related injuries receive all statutorily required benefits, levels the playing field for all employers who are bidding jobs, and adds premium dollars to the system that were previously evaded due to non-compliance. The Bureau accomplishes its mission through enforcement investigations, management of the exemption process, and education of employers.

The Bureau of Compliance conducts investigations to determine employer compliance and assesses penalties against employers who fail to meet their statutory obligations. The Bureau also reviews and processes applications from eligible employers seeking to utilize the exemption provisions of the Workers' Compensation Law. The Bureau participates in employer conferences and conducts workshops to educate employers, contractors, and other stakeholders about workers' compensation coverage and compliance requirements.

New Initiatives

Payment Receipting Activities

During Fiscal Year 2009-2010, the Bureau of Compliance began developing new revenue receipting automation processes to enable the Division to deposit payments more quickly, increase the Division's collection rate, and increase the Division's ability to safeguard its assets. These automated processes include expanding and developing new online payment services that will allow employers to pay assessed penalties and exemption application fees via the Internet. In addition, the Bureau will perform a daily electronic fiscal reconciliation, which will eliminate data entry errors and strengthen internal controls. The automation of these revenue receipting procedures will provide a faster, more efficient method of payment, reduce the number of payments that are returned to the Division for insufficient funds, and enable the financial recordkeeping system to more efficiently account for all revenue received within the Bureau.

Collection Activities

Another new initiative implemented during Fiscal Year 2009-2010 has assisted the Bureau in focusing efforts on increasing the Division's penalty collection rate. In accordance with s. 440.107(11), F.S., the Bureau began filing liens against employers to collect unpaid penalties associated with a Stop-Work Order or Order of Penalty Assessment. During this fiscal year, the Bureau filed liens against 831 employers. In addition, the Bureau, in conjunction with the Department of Financial Services' Division of Accounting and Auditing, has begun the selection process to secure a new debt collections vendor with sophisticated and comprehensive business processes for collecting unpaid penalties from non-compliant employers. Further, in Fiscal Year 2010-2011, the Bureau is going to begin accepting credit cards for payment of assessed penalties. The availability of this additional payment option will provide employers with increased payment flexibility. The Bureau anticipates the implementation of these new initiatives will lead to higher overall collection rates.

Proof of Coverage Database

The Division has numerous databases that provide access to information for all stakeholders in the Workers' Compensation System. The Bureau recognizes the importance of providing stakeholders with more information to assist them in fulfilling their rights and responsibilities under the Workers' Compensation Law. As a result, during Fiscal Year 2009-2010, the Bureau enhanced the Proof of Coverage Database and the Construction Policy Tracking Database to provide stakeholders with more tools to verify employer compliance.

The Proof of Coverage Database provides information regarding workers' compensation coverage and exemptions from workers' compensation. Data regarding workers' compensation insurance policies, endorsements, reinstatements, cancellations, non-renewals, and certificates of exemption can be accessed via the database. During Fiscal Year 2009-2010, the Bureau began the process to make information available in the database on the total number

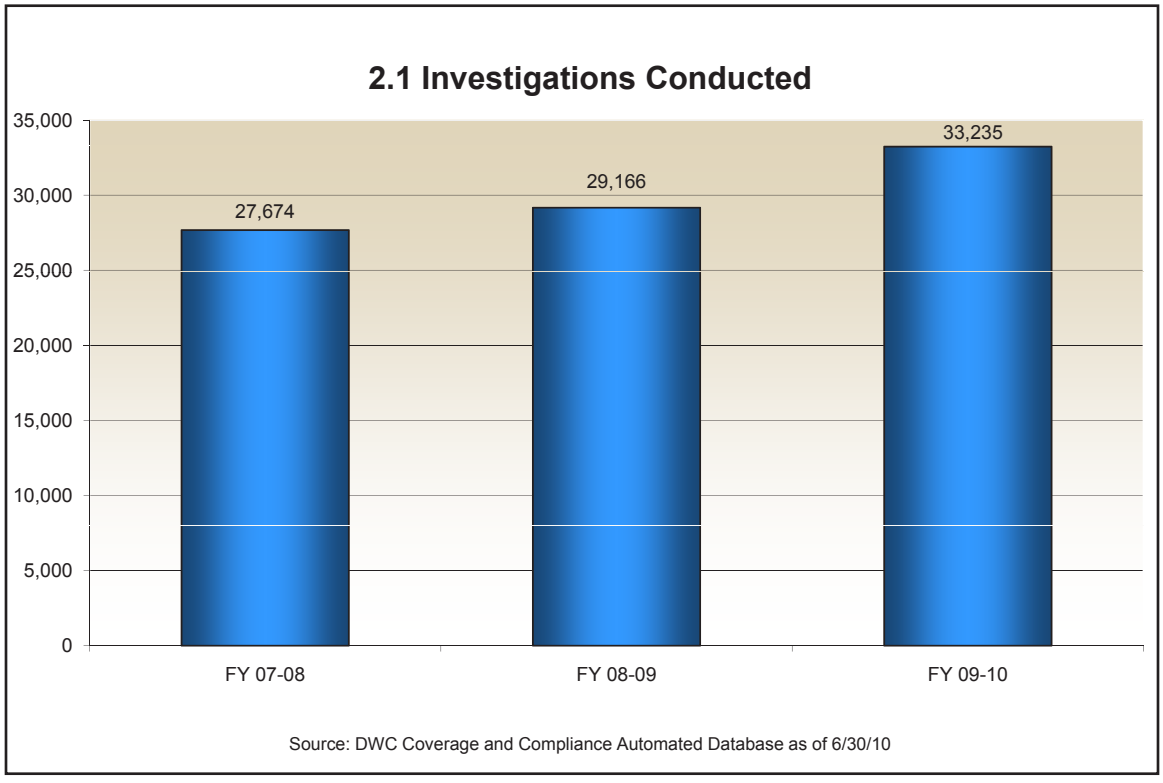
of employees for each employer as reported by the insurer according to the primary National Association of Industry System Classification Code of the insured entity. The availability of this information is beneficial to the Department, insurers, and employers in determining if an employer is underreporting or concealing payroll or misrepresenting employee duties and whether appropriate coverage has been obtained.

Construction Policy Tracking Database

The Construction Policy Tracking Database provides information to contractors and other stakeholders regarding changes to employers' workers' compensation coverage. The database is designed to send electronic notification to the requestor concerning any changes to the status of a specified policy. Changes may include endorsements, cancellations, or policy renewals. In addition to workers' compensation insurance, certificates of exemption from workers' compensation represent proof of compliance with the Workers' Compensation Law. Therefore, access to exemption information is vital when verifying employer compliance. Previously, requestors were only able to track policy information. During Fiscal Year 2009-2010, the Bureau began the process to enhance the database to allow requestors to track exemption records, including the renewal or revocation of certificates of exemption. The addition of this new tracking feature will create a more comprehensive database which will provide requestors with a useful tool to monitor all coverage and exemption changes.

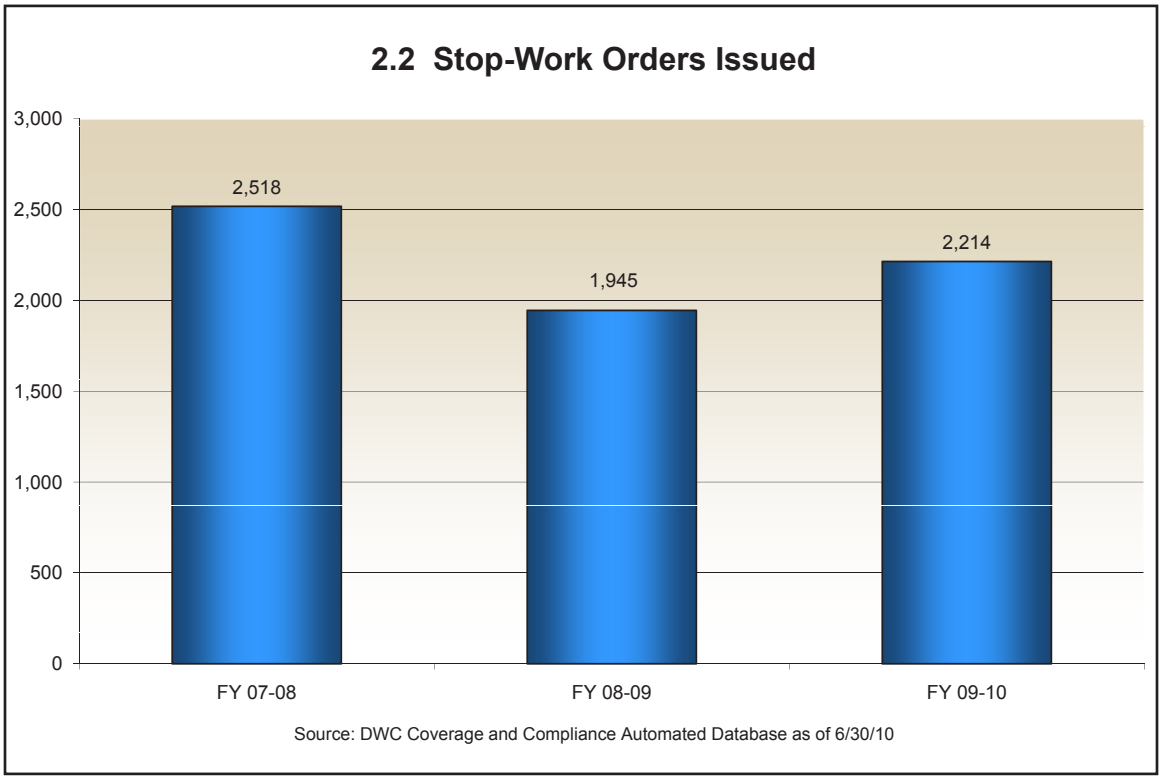
Through its enforcement and investigative efforts in Fiscal Year 2009-2010, the Bureau:

- Conducted 33,235 investigations. **Graphic 2.1** shows the total number of investigations conducted during the last three fiscal years. Investigations are physical, on-site inspections of an employer's job-site or business location to determine compliance with workers' compensation coverage requirements. Many of the enforcement actions taken by the Bureau originate from referrals and random work-site inspections. During Fiscal Year 2009-2010, the Bureau commenced 2,294 investigations in response to referrals from the public, employers, and employees alleging employer non-compliance.

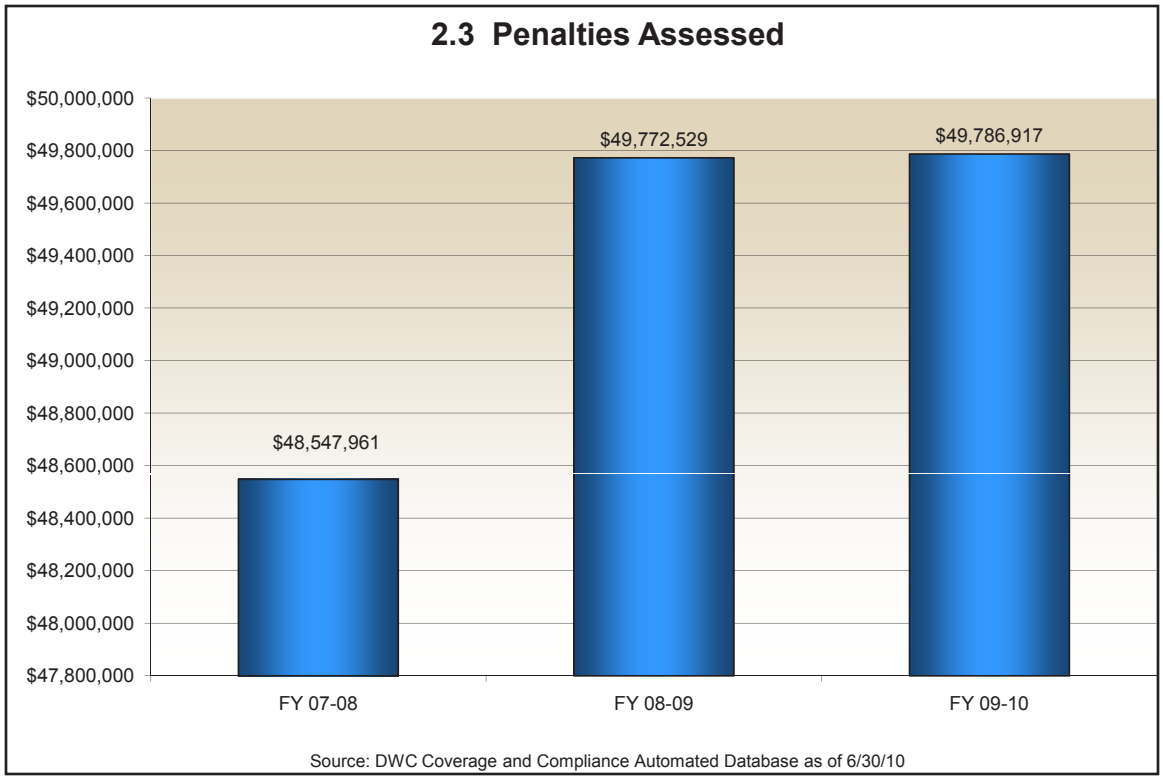


Source: DWC Coverage and Compliance Automated Database as of 6/30/10

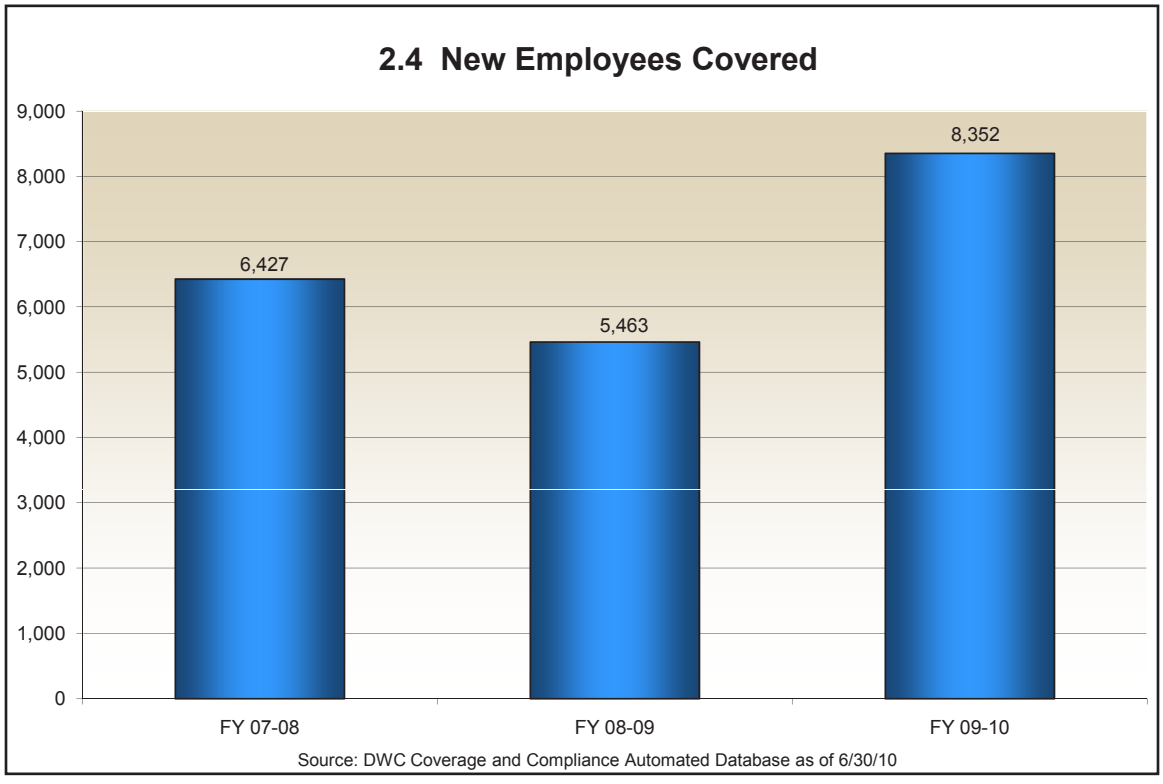
- Issued 2,214 Stop-Work Orders as illustrated by **Graphic 2.2**. Stop-Work Orders are issued for the following violations: failure to obtain workers' compensation insurance, materially understating or concealing payroll, materially misrepresenting or concealing employee duties to avoid paying the proper premium, materially concealing information pertinent to the calculation of an experience modification factor, and failure to produce business records in a timely manner. Stop-Work Orders require the employer to cease business operations and the order remains in effect until the Division issues an Order Releasing the Stop-Work Order;



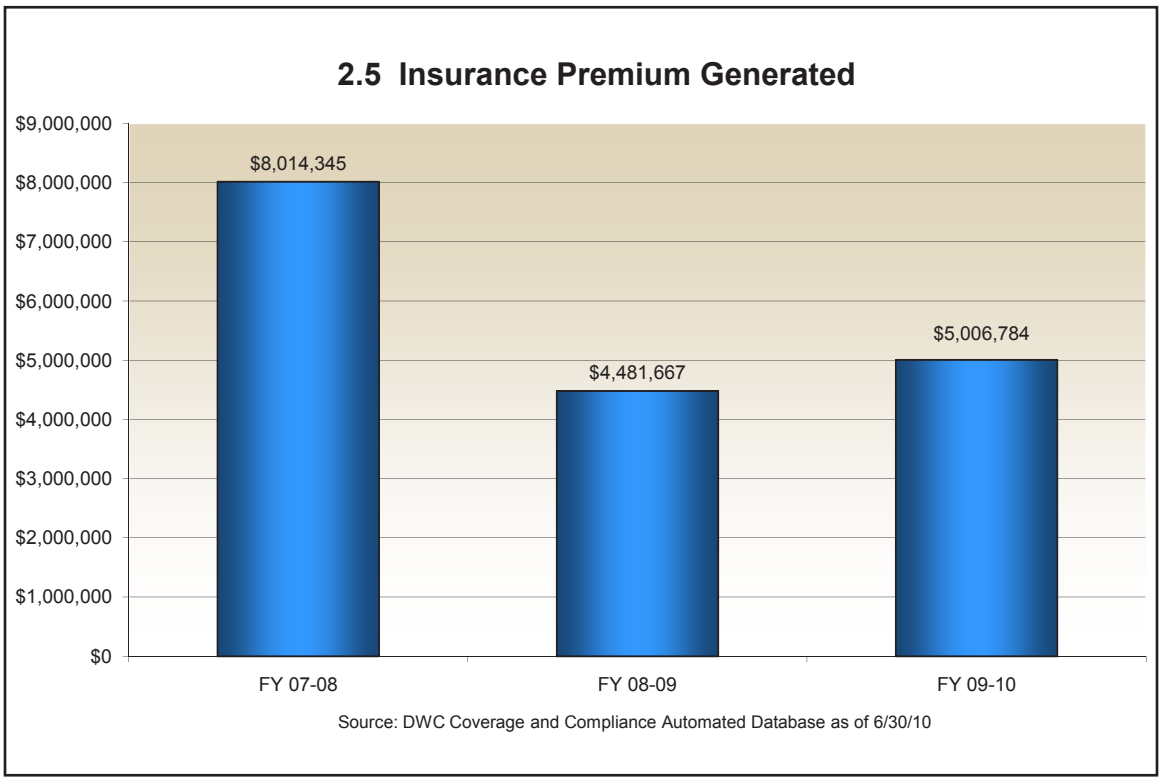
- Assessed $49,786,917 in penalties as illustrated by **Graphic 2.3**. An employer who has failed to adhere to the workers' compensation coverage requirements is assessed a penalty based upon the methodology required by the Workers' Compensation Law. Assessed penalties are equal to 1.5 times what the 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. Penalty amounts vary and are dependent on the employer's payroll, risk classification, and period of non-compliance;



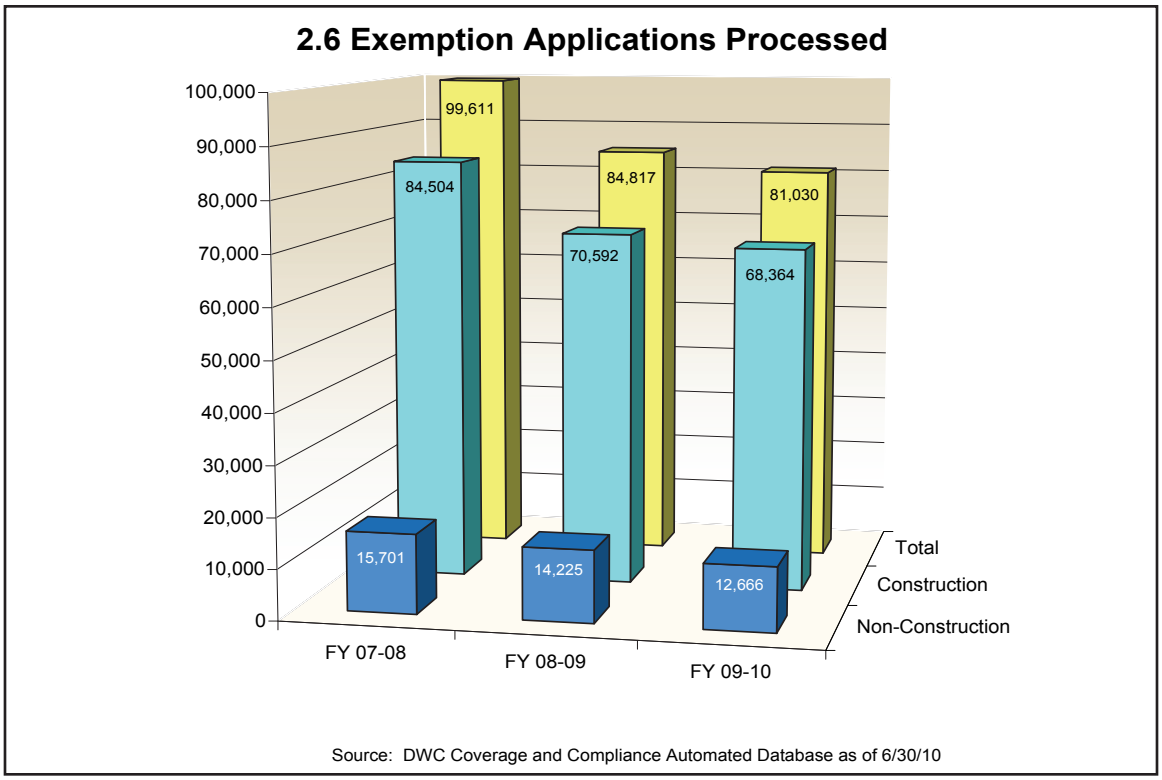
- Caused 8,352 new employees to be covered under the Workers' Compensation Law. **Graphic 2.4** shows the number of additional employees covered as a direct result of the Bureau's enforcement efforts;



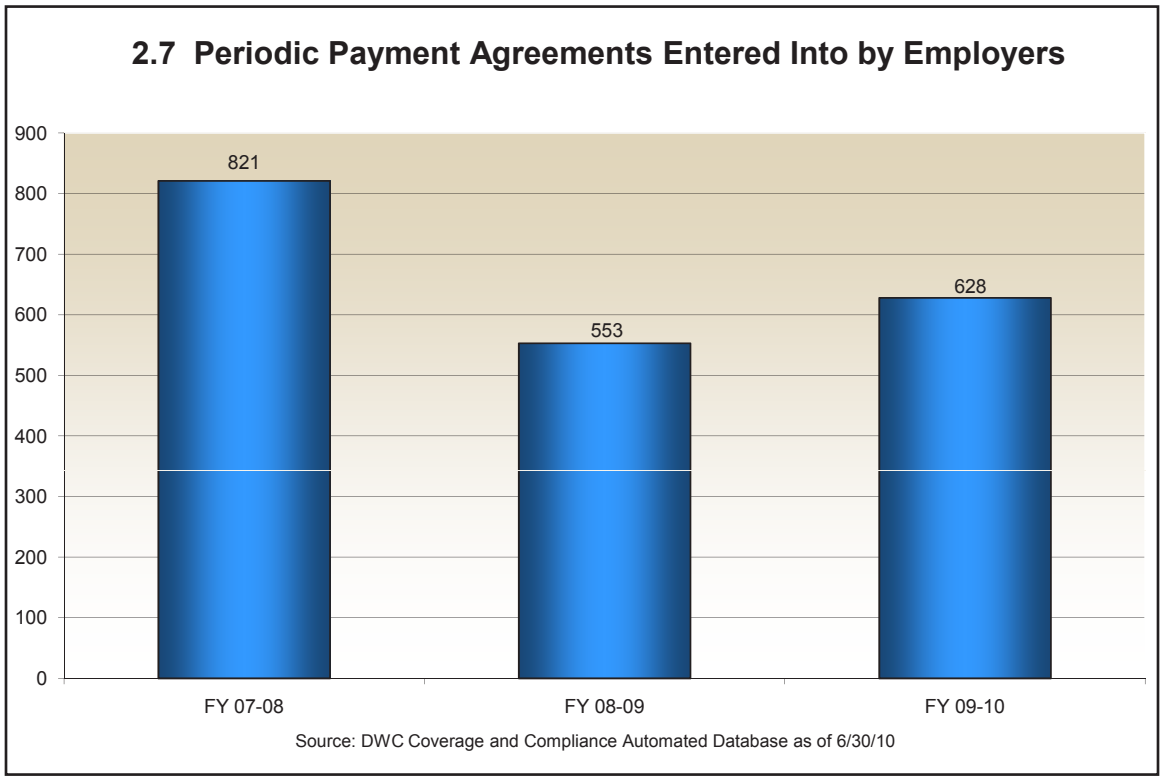
- Caused $5,006,784 to be added to the workers' compensation premium base that had been previously evaded as illustrated in **Graphic 2.5**. During the last six years, the workers' compensation rates have decreased, on average, by 64.7%. This rate reduction also resulted in a corresponding reduction in workers' compensation insurance premiums;



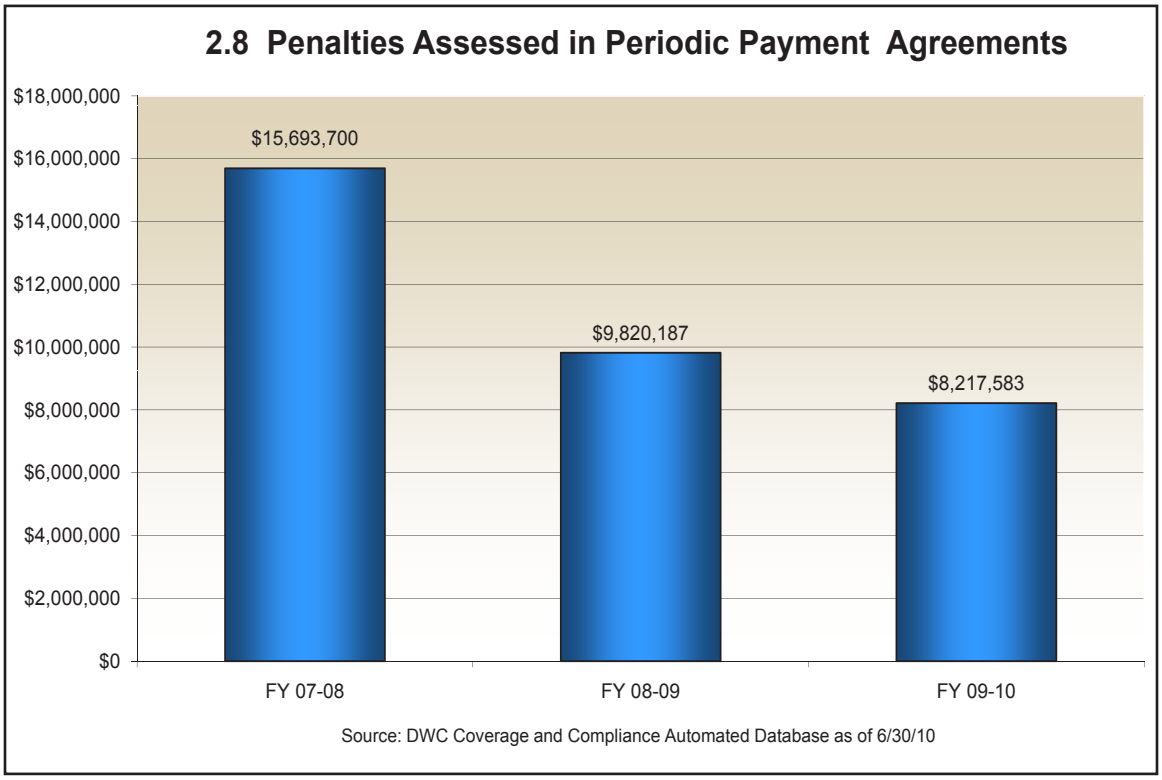
- Processed 68,364 construction industry exemption applications and 12,666 non-construction industry exemption applications as illustrated by **Graphic 2.6**. As of June 30, 2010, there were 1,135,685 active exemptions;



- Section 440.107(7)(a), F.S., authorizes the Division to conditionally release an employer from a Stop-Work Order when it is determined that the employer has complied with workers' compensation coverage requirements and has agreed to remit periodic penalty payments pursuant to a payment agreement schedule. An employer is required to make an initial down payment equal to at least 10% of the total assessed penalty or $1,000, whichever is greater. Under Rule 69L-6.025, F.A.C., an employer has to make 12, 24, 36, 48, or 60 equal monthly payments to pay the remaining penalty. **Graphic 2.7** shows the number of periodic payment agreements entered into by employers, which represents 28% of employers that were issued Stop-Work Orders and assessed a penalty during Fiscal Year 2009-2010;



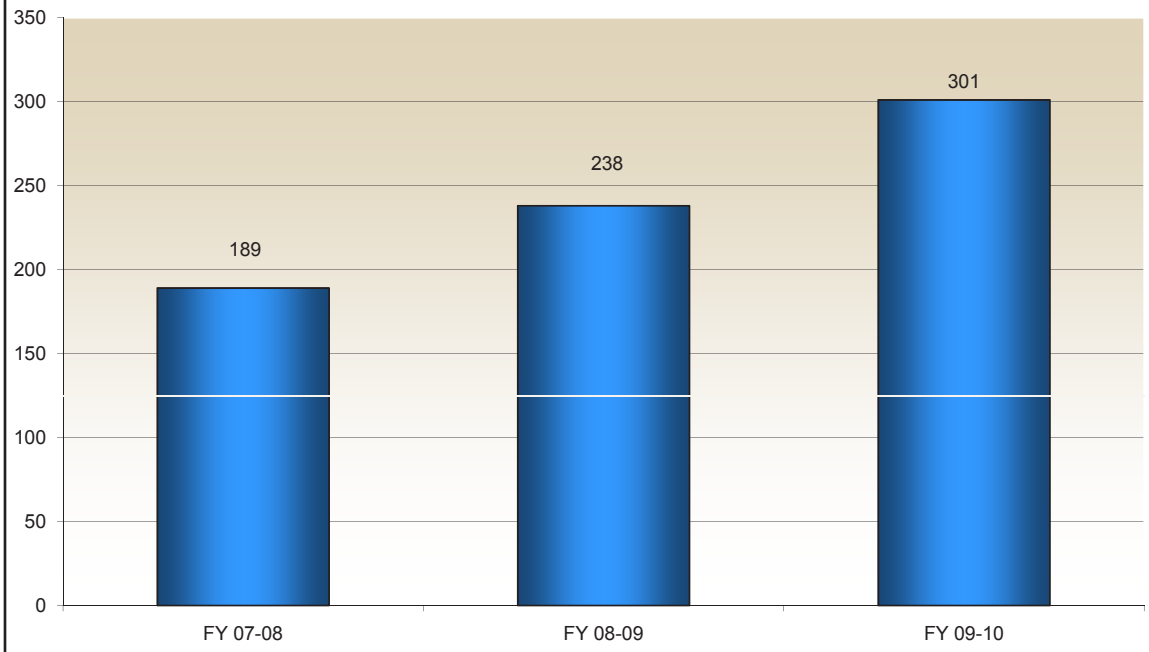
- **Graphic 2.8** illustrates the total penalties assessed against employers who entered into periodic payment agreements.



An employer who failed to secure the payment of workers' compensation on the date an investigation commences, but came into compliance prior to the issuance of a Stop-Work Order is assessed a penalty pursuant to an administrative rule.

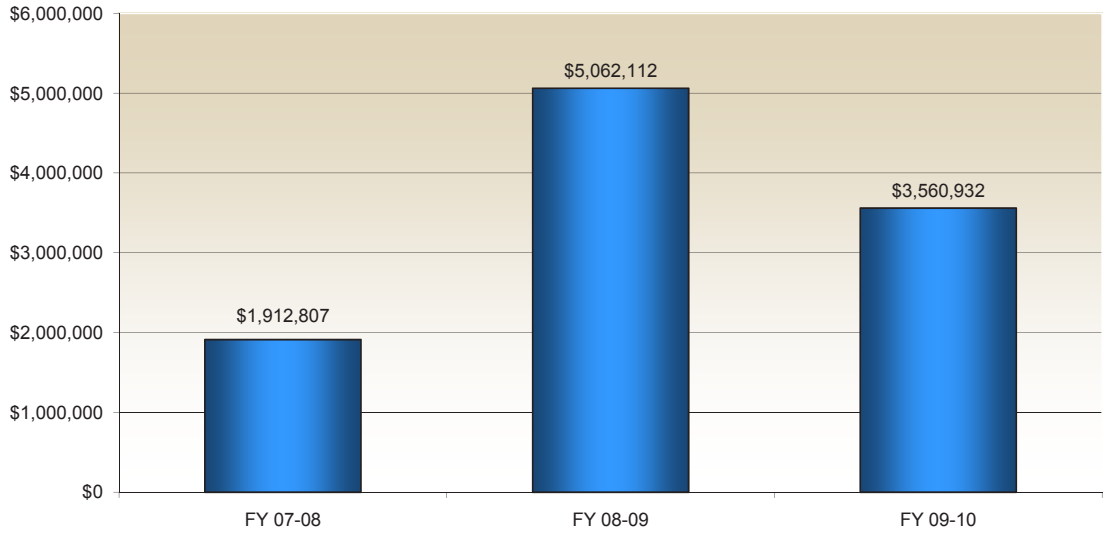
The next four graphics pertain to Orders of Penalty Assessments for cases when the employer obtained coverage subsequent to the commencement of an investigation, which made the issuance of a Stop-Work Order unnecessary. During FY 2009-2010, 301 employers were issued an Order of Penalty Assessment as illustrated in **Graphic 2.9** with assessed penalties totaling $3,560,932, as illustrated in **Graphic 2.10**. **Graphic 2.11** illustrates the total number of new employees covered. The amount of insurance premium generated is illustrated in **Graphic 2.12**.

2.9 Orders of Penalty Assessment Issued



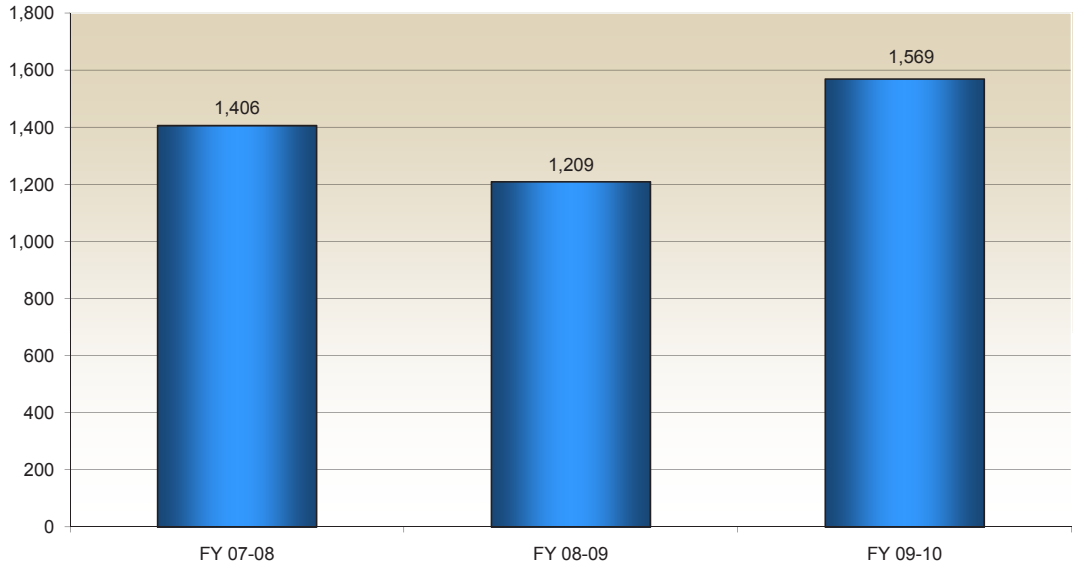
Source: DWC Coverage and Compliance Automated Database as of 6/30/10

2.10 Total Penalties Resulting from Orders of Penalty Assessment



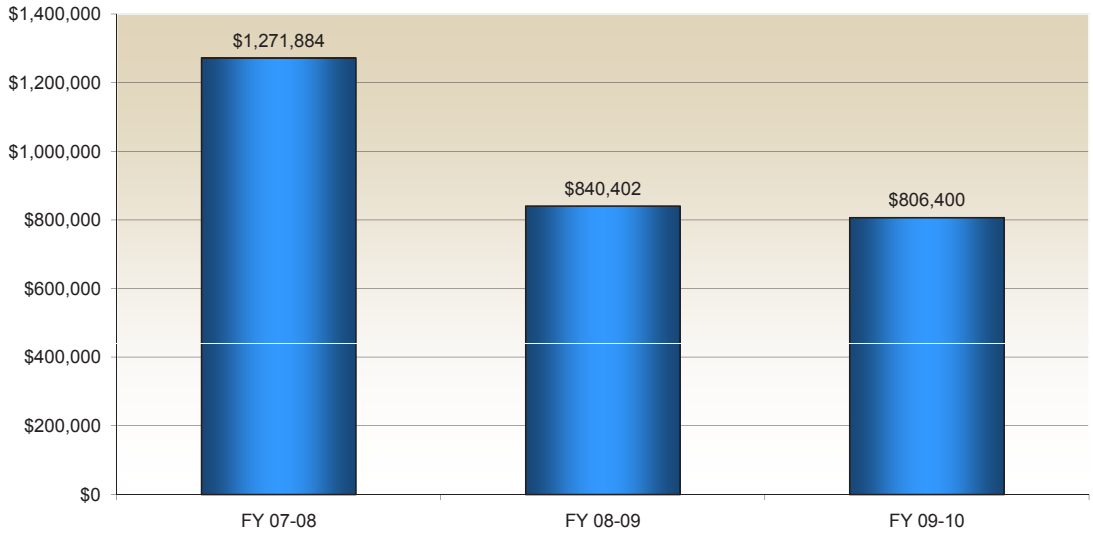
Source: DWC Coverage and Compliance Automated Database as of 6/30/10

2.11 New Employees Covered based upon Orders of Penalty Assessment



Source: DWC Coverage and Compliance Automated Database as of 6/30/10

2.12 Insurance Premium Resulting from Orders of Penalty Assessment



Source: DWC Coverage and Compliance Automated Database as of 6/30/10

Administrative Rule Changes

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

- 69L-6.028 - Procedures For Imputing Payroll and Penalty Calculations:

  The changes provide the Division with alternative means and methods by which it may calculate an employer's imputed payroll and penalty, clarifies the timeframe within which such imputation may occur, and defines non-compliance for purposes of the rule.

- 69L-6.025 - Conditional Release of Stop-Work Order and Periodic Payment Agreement:

  This amendment extends the payment agreement over a greater timeframe to those employers who have demonstrated ongoing compliance with the terms and conditions of the Division's periodic payment agreement. It also provides new language clarifying procedures regarding the conditional release of Stop-Work Orders and the reinstatement of Stop-Work Orders where employers have defaulted on penalty payment obligations.

BUREAU OF COMPLIANCE
SUCCESS STORIES

The Bureau received a tip alleging that a cabinet manufacturing and installation business in Palm Beach County was operating without workers' compensation insurance. A site visit was conducted and nine workers were observed manufacturing cabinets and performing trim carpentry work. An investigation revealed that the employer's workers' compensation coverage through an employee leasing company had been canceled one month earlier. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer.

The employer's business records revealed the employer had prior periods of non-compliance as far back as 2006. All periods of non-compliance were included in the penalty calculations and a $16,231 penalty was assessed. The employer came into compliance by purchasing a new workers' compensation policy, which covered 10 employees and generated $14,000 in premium and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

While conducting routine compliance investigations in Martin County with representatives from the Martin County Building Department, four workers were observed renovating a single family residence. 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 three of the four workers had not been reported on the employee leasing payroll. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer.

A review of the employer's business records revealed the business contracted with multiple uninsured subcontractors during the three prior years. The payroll for the uninsured subcontractors and all other periods of non-compliance were included in the penalty calculations and a $46,950 penalty was assessed. The employer came into compliance by adding the workers to the employee leasing contract, which generated $12,480 in premium and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

In response to a public referral alleging a roofing crew was working without workers' compensation coverage, an Investigator observed nine workers re-roofing a commercial building in Green Cove Springs. Information obtained on the job site indicated the employer had secured coverage through an employee leasing company. However, prior to the Investigator contacting the employee leasing company, the owner confessed he had misled the investigator and that none of the workers had been reported on the employee leasing payroll. The employer admitted to paying all of the workers directly. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer.

The employer's business records revealed numerous payments made directly to employees during the prior 20 months totaling over $98,000 in uninsured payroll. A $22,841 penalty was assessed. The employer came into compliance by adding the workers to the employee leasing contract, which generated $20,420 in premium and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released. This case was also referred to the Department of Business and Professional Regulation (DBPR) because workers' compensation coverage is a requirement to maintain licensure under the DBPR Construction Industry Licensing Board.

During a random site visit of a single family residence under construction in Ocala, two men were observed prepping a house for stucco application. The Investigator contacted the employer to determine compliance with workers' compensation coverage requirements. The employer advised he had coverage through an employee leasing company. Contact with the employee leasing company revealed that one of the workers had not been reported on the employee leasing payroll. In addition, further investigation revealed that only two of the three corporate officers had current exemptions. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer.

A review of the employer's business records identified 14 additional employees that were not covered by workers' compensation insurance. A $76,453 penalty was assessed. The employer came into compliance by reducing his number of employees, obtaining an exemption for the third corporate officer and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released. This case was also referred to the Division of Insurance Fraud because seven employees listed with the employee leasing company appeared to be using fraudulent social security numbers.

While conducting random investigations of job sites in Miami, an Investigator discovered a roofing company that had three employees working on a residential roof. An investigation revealed that the roofing company had originally obtained coverage through an employee leasing contract, but that contract had been terminated. The Investigator further determined that the employer had subsequently obtained another employee leasing contract, which had also been terminated for failure to comply with an audit. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer.

The employer's business records revealed prior periods of non-compliance and that the employer had hired multiple uninsured subcontractors. A $66,844 penalty was assessed. The employer came into compliance by entering into a new employee leasing contract, which generated $11,138 in premium and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

A public referral was received that alleged that a tree trimming company in Hernando County employed 20 workers and was operating without workers' compensation coverage. The employer advised that workers' compensation coverage was provided through an employee leasing company. Contact with the employee leasing company revealed that the employer's leasing agreement had been cancelled six weeks prior. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer. The employer's business records identified 12 uninsured employees and a $2,036 penalty was assessed. The employer came into compliance by entering into a new employee leasing agreement covering 13 employees, which generated $27,768 in premium and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

The Bureau received a tip alleging that a spa in Walton County was operating without workers' compensation coverage. The investigator observed four women working various jobs in the spa. All of the women indicated they were employees. The Investigator contacted the owner who advised that he did not have workers' compensation coverage. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer. Several days after service of the Stop-Work Order, it was determined that the spa was operating in violation of the Stop-Work Order. The owner was advised that an additional $1,000 penalty would be assessed for violating the Stop-Work Order. In addition, a referral was forwarded to the Division of Insurance Fraud.

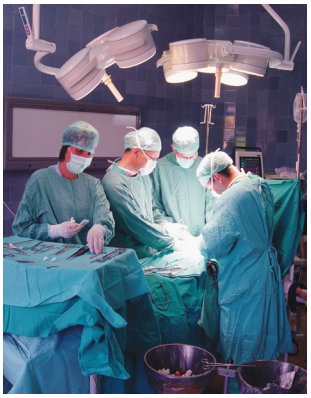
A $12,980 penalty was assessed, which included the additional penalty for working in violation of the Stop-Work Order. The employer came into compliance by purchasing a workers' compensation policy covering 12 employees, which generated $2,960 in premium and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

While conducting routine investigations in the Miami area, an Investigator entered a hair salon to determine compliance with workers' compensation coverage requirements. The investigator observed nine individuals working. Hair stylists and beauticians that work in hair salons are typically independent contractors. However, an investigation revealed that these individuals met the statutory definition of employees. In addition, the employer did not have workers' compensation coverage for the employees nor did any of the corporate officers have valid exemptions. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer. The employer's business records revealed that the employer had been operating without workers' compensation coverage for the prior three years. A $20,554 penalty was assessed. The employer came into compliance by purchasing a workers' compensation policy covering 11 employees, which generated $2,775 in premium and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

In response to a public complaint alleging a home health agency in St. Petersburg was operating without workers' compensation coverage, a site visit was conducted. The employer advised that approximately 200 independent contractors were employed to provide home healthcare services. A Business Records Request was served on the employer to determine compliance with workers' compensation coverage requirements. A review of the employer's business records revealed that a large number of individuals were independent contractors, but that other individuals met the statutory definition of an employee. The employer obtained coverage through an employee leasing company prior to the issuance of a Stop-Work Order. A subsequent Business Records Request was served on the employer for penalty calculation purposes. The employer was served an Order of Penalty Assessment for $9,063. The employer came into compliance by obtaining coverage through an employee leasing company for 11 employees, which generated $6,160 in premium.

While conducting routine investigations in Orlando, an Investigator entered a fast food restaurant to determine compliance with workers' compensation coverage requirements. The Investigator observed three individuals working. An investigation revealed that two of the three individuals were paid in cash and that the corporate officers did not have valid exemptions. The employer confirmed that the employees were not covered by workers' compensation insurance. A Stop-Work Order for failure to secure coverage and a Business Records Request were served to the employer.

The employer failed to provide the requested business records during the required timeframe; therefore, the employer's payroll was imputed, resulting in a $24,336 assessed penalty. Upon service of the Amended Order of Penalty Assessment, the employer provided the requested business records and the penalty was reduced to $7,559. The employer came into compliance by purchasing a workers' compensation policy covering four employees, which generated $1,224 in premium and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.



While conducting routine investigations in Orlando, an Investigator entered a pharmacy. The employer advised that he had eight employees and that he had workers' compensation coverage. The employer was unable to provide the Investigator with proof of coverage because that information was kept by his accountant. A Business Records Request was served on the employer to determine compliance with workers' compensation coverage requirements. The next day the employer contacted the Investigator and advised that he had been confused the previous day and failed to understand that the Investigator was attempting to obtain proof of workers' compensation coverage. In addition, the employer stated that all of his workers were independent contractors. He also stated that depending on which of those independent contractors he decided to keep in the future, he would treat them as regular employees and provide workers' compensation coverage at that time.

Upon review of the employer's business records, it was determined that the workers met the statutory definition of employees. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer. A $2,011 penalty was assessed. The employer came into compliance by purchasing a workers' compensation policy covering six employees, which generated $2,613 in premium and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

BUREAU OF MONITORING AND AUDIT

The Bureau of Monitoring and Audit is responsible for accountability and enforcement to ensure that claims-handling entities and insurers meet the requirements of Chapter 440, F.S. The Bureau's mission is to ensure the timely and accurate payment of benefits to injured workers, the timely filing and payment of medical bills, and the timely and accurate filing of required claims forms and electronic data. Audit processes permit staff to provide training to adjusters. Insurers that do not meet their statutory obligations are penalized according to Chapter 440, F.S., and administrative rules. The Bureau also verifies that self-insurers have sufficient resources to pay outstanding liabilities.

The Bureau's early intervention business processes allow the Bureau to promptly identify filing issues, data reporting errors, and benefit calculation issues. Insurers are notified when potential errors are identified, which allows prompt reconciliation and minimizes potential violations or penalties. In addition, they allow staff to provide training to adjusters on claims-handling best practices and the calculation of benefits, and to share their knowledge of rules, statutes, and case law.

Electronic data filing continues to greatly increase the scope of monitoring and auditing business processes in the Bureau. Staff can now promptly analyze all submissions to identify unacceptable claims-handling practices.

The core functions of the Bureau are divided into four key areas of responsibility.

Permanent Total Section

The Permanent Total (PT) Section is responsible for paying permanent total supplemental benefits to all permanently and totally disabled workers who were injured prior to July 1, 1984. Additionally, the PT Section verifies the accuracy and timeliness of permanent total and permanent total supplemental benefits due and paid by insurers to injured workers. The Section also monitors permanent total disability claims to ensure payments are suspended, reduced, or cancelled based on statutory amendments or case law and that benefit offsets are correctly applied.

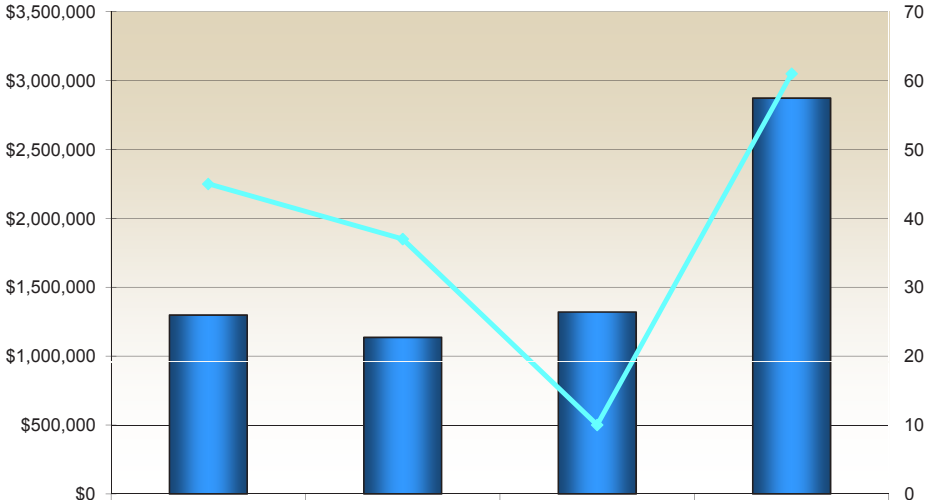
During Fiscal Year 2009-2010, the PT Section implemented a new initiative as part of the Division's electronic data business processes. The PT Section began conducting audits from electronic data transmissions rather than paper form filings. As a result, the PT Section has developed comprehensive, analytical query tools to increase its focus on those claims where information indicates improper compensation payments and untimely submission of data have occurred.

The PT Section identifies inaccurate benefit payments, notifies insurers of inaccuracies, and requests correction of any under or overpayments of benefits. The interaction with insurers is an opportunity to educate adjusters on how to properly calculate and pay permanent total benefits. If an underpayment is identified, the insurer is directed to issue an additional payment to the injured worker. In many cases, the miscalculation may have happened many years ago and not been subsequently corrected. The underpaid benefits, penalties, and interest are often a significant amount of money obtained for the injured worker. Conversely, the miscalculation of benefits can also result in an overpayment of benefits to injured workers. In those cases, the insurer is entitled to recoup the overpayment by as much as a 20% reduction in the injured worker's future payments.

By leveraging electronic data submissions and implementing new processes, the PT Section has been able to significantly increase its productivity. In Fiscal Year 2009-2010, the PT Section audited 31,176 claims transactions and obtained $2,873,482 in past due benefits, penalties, and interest for 61 injured workers, which is a 102% increase in the number of claims transactions analyzed and a 118% increase in benefits obtained for injured workers over the prior year. In addition, during Fiscal Year 2009-2010, the PT Section implemented a new initiative to contact insurers about delinquent electronic claim cost transactions, which resulted in reducing the number of pending delinquent claim cost transactions due to the Division from 6,100 transactions to 2,034, a decrease of 67%. These changes to data collection and analysis have allowed the Bureau to provide early and immediate intervention to correct inaccuracies and ensure that proper benefit payments are being provided to injured workers.

Graphic 3.1 shows the amount and number of underpayments by insurers identified through desk audits during the last four fiscal years.

3.1 Permanent Total Benefit Underpayments Identified Through Desk Audits



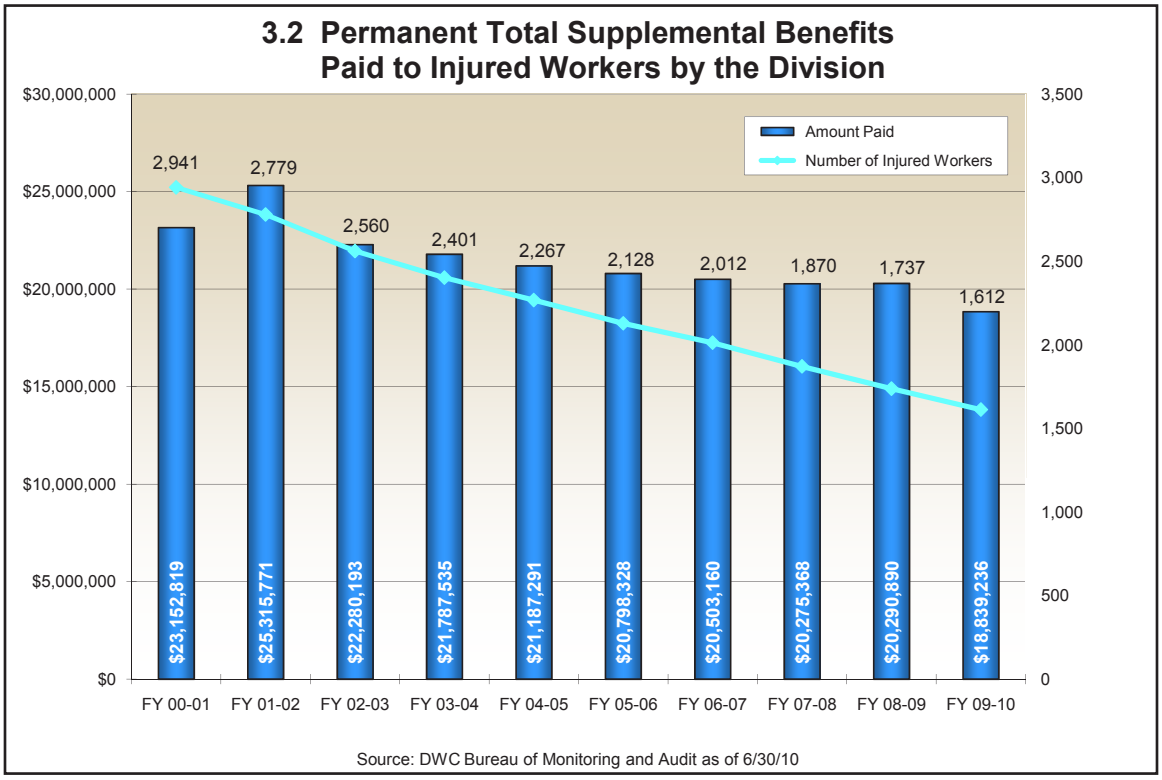
	FY 06-07	FY 07-08	FY 08-09	FY 09-10
Amount of Underpayments	$1,298,510	$1,136,665	$1,320,516	$2,873,482
Underpayments Found	45	37	10	61

Source: DWC Bureau of Monitoring and Audit as of 6/30/10

During Fiscal Year 2009-2010, the PT Section calculated, approved, and processed supplemental benefits for 1,612 claims, totaling $18,839,236. On a continuing basis, the PT Section verifies the eligibility of those injured workers' legal entitlement to supplemental benefits by reviewing the following resources:

- A monthly list of in-state deaths from the Department of Health, Bureau of Vital Statistics;
- A monthly list of deaths that occurred out-of-state that is provided by a private vendor;
- Department of Corrections' inmate records;
- Judges of Compensation Claims' data;
- Employee Earnings Reports;
- PT claims data submitted electronically by insurers.

Graphic 3.2 illustrates the permanent total supplemental benefits paid to injured workers by the Division over the past ten fiscal years.



Source: DWC Bureau of Monitoring and Audit as of 6/30/10

The PT Section also assists and provides education and dispute resolution assistance to injured workers and insurers about the computation of permanent total benefits, permanent total supplemental benefits, and any offsets which may apply. When permanent total benefit discrepancies are identified by SDTF, EAO, and the Audit Section, the PT Section collaborates with these units to determine the accuracy of benefits that are due to an injured worker.

During FY 2009-2010, the Permanent Total Section:

- Audited 31,176 electronic claims data transactions submitted by insurers to ensure that permanent total and permanent total supplemental benefits were paid correctly;
- Identified and advised insurers of underpayments to injured workers in the amount of $2,873,482;
- Identified and advised insurers of $525,660 in benefit overpayments to injured workers;
- Calculated and approved payment of $18,839,236 in permanent total supplemental benefits to 1,612 eligible PT claimants.

PERMANENT TOTAL SECTION SUCCESS STORIES

A 71-year old employee severely injured his back while repairing an elevator in 1987. Following back surgery, the injured worker was determined permanently and totally disabled on June 11, 1992. The PT Section conducted a quality review audit and determined that permanent total supplemental benefits had not been paid from June 11, 1992, through December 31, 2005. As a result of the PT Section's intervention, the carrier paid the injured worker $100,807 in past due benefits and an additional $150,006 in penalties and interest.

The PT Section investigated the claim of a worker injured in 1990, while employed with the Chamber of Commerce for a municipality. The injured worker was badly injured when knocked down by a child in a store while collecting Christmas items for needy children. The worker was 52 years old at the time of the injury and 57 when determined permanently and totally disabled. The PT Section found that the insurer discontinued the payment of supplemental benefits when the claimant reached age 62, which at first glance would appear to be correct. However, the PT Section discovered that the injured worker was not eligible for social security benefits which meant the permanent total supplemental benefits should not have been terminated. The PT Section contacted the insurer and provided documentation regarding their findings. The insurer issued a check to the injured worker for $93,620, which included monies for past due benefits, penalties, and interest.

During a desk audit, the PT Section discovered that an injured worker was not receiving permanent total supplemental benefits. The worker was injured in 1991 at age 61 and then accepted as permanently and totally disabled at age 63 in 1993. The PT Section examined the claim and determined that the insurer should have started paying permanent total supplemental benefits when the injured worker reached age 65. As a result of the PT Section's intervention, the insurer paid the injured worker $87,800 in past due benefits, $17,502 in penalties, and $72,225 in interest.

A 65-year old injured worker was referred to the PT Section by EAO. The injured worker, who severely injured her chest and shoulder while pushing a housekeeping cart in 1990, complained that her permanent total supplemental benefits had been terminated by the insurer because she was receiving social security benefits. The PT Section determined that as a widow, the injured worker was receiving social security survivor benefits. The PT Section researched case law and determined that an insurer is not permitted to offset social security survivor benefits. The PT Section's intervention resulted in the insurer reinstating the injured worker's $280.40 bi-weekly permanent total supplemental benefits for life.

The PT Section received a referral from the SDTF to review and analyze a potential underpayment of benefits. A 74-year old employee slipped and fell on a wet floor while at work and was seriously injured in August 1988. The insurer accepted the injured worker as permanently and totally disabled in January 1991. The PT Section investigated this claim and determined that the insurer used an incorrect average weekly wage and compensation rate in calculating the amount of the benefits due, which had resulted in an underpayment of benefits. Through the PT Section's intervention, the insurer issued a $41,971 check to the injured worker.

Audit Section

The Audit Section examines claims-handling practices of insurers, self-insurers, self-insurance funds, and claims-handling entities pursuant to ss. 440.20, 440.185, 440.525, F.S. and administrative rules. Examinations and investigations conducted by the Audit Section address patterns and practices of unreasonable delay in claims-handling, timely and accurate payment of benefits to injured workers, timely and accurate filing of required reports, and the inspection and enforcement of compliance with compensation orders of Judges of Compensation Claims. Penalties are assessed for failure to meet the required statutory performance standards.

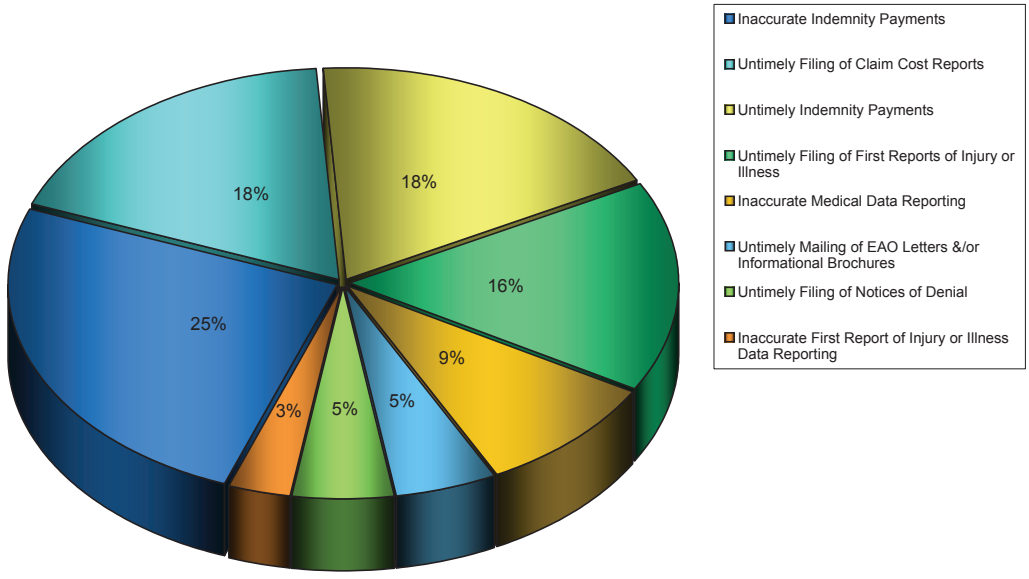
Information and data from all areas within the Division are utilized by the Audit Section to monitor and evaluate the performance of insurers, self-insurers, self-insurance funds, and claims-handling entities. Electronic data reported to the Division are analyzed to monitor claims-handling patterns and practices regarding the timely and accurate payment of indemnity and medical bills and timely filing of all required information. In addition, EAO provides the Bureau with input regarding requests for assistance and/or complaints from injured workers. All of the information and data received by the Division are utilized to determine which regulated entities will be audited.

In Fiscal Year 2009-2010, the Audit Section expanded the review of denied workers' compensation claims. Employees from the EAO Denial Team participated in audits and assisted in the review of denied claims. Denied claims are analyzed to ensure they are filed in accordance with Florida Statutes.

The Audit Section conducts audits to identify claims-handling violations of administrative rule and/or statute. **Graphic 3.3** illustrates the claims-handling violations identified during audits conducted in Fiscal Year 2009-2010. Claims-handling violations include, but are not limited to:

- Untimely and/or inaccurate payment of benefits to injured workers;
- Untimely mailing of EAO letters or informational brochures to injured workers;
- Untimely filing and/or payment of medical bills;
- Untimely and/or inaccurate filing of required reports;
- Non-compliance with Orders of Judges of Compensation Claims.

3.3 Claims-Handling Violations Identified During Audits FY 09-10

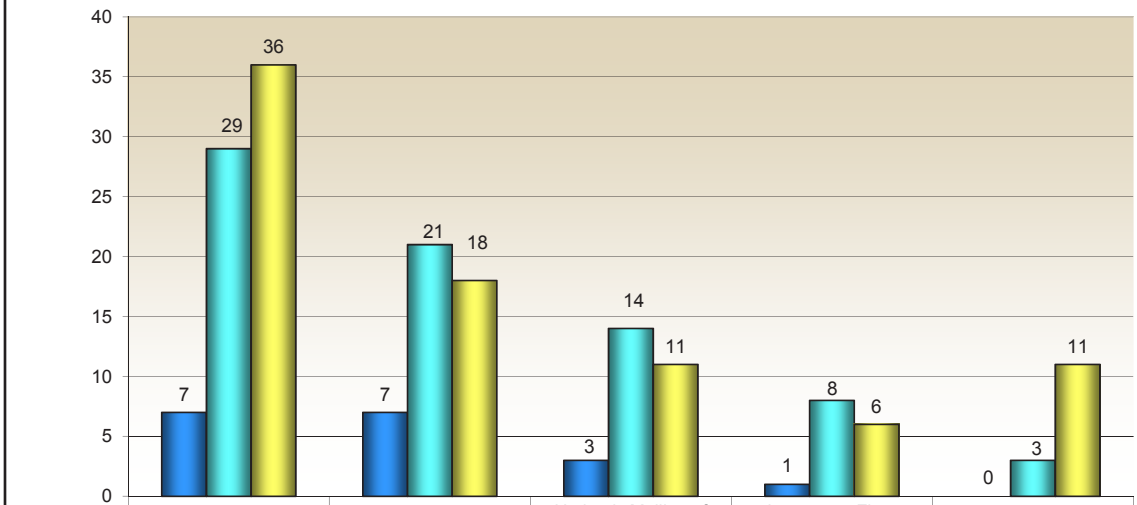


Source: DWC Bureau of Monitoring and Audit as of 6/30/10

The Audit Section identifies and addresses poor claims-handling patterns and practices, such as unreasonable delay in claims handling or timeliness and accuracy of payments and reports.

Graphic 3.4 illustrates the most frequent types of pattern and practice violations identified during audits.

3.4 Pattern and Practice Violations by Type Identified During Audits

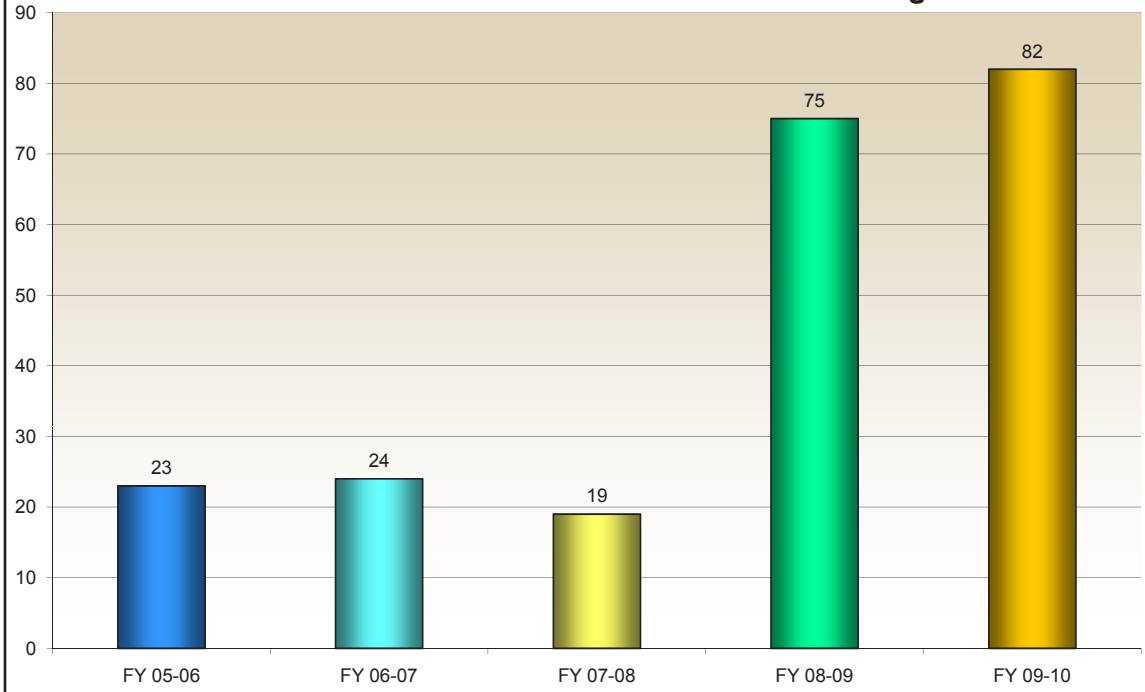


	Untimely Filing of Claim Cost Reports	Inaccurate Medical Data Reporting	Untimely Mailing of EAO Letters and/or Informational Brochures	Inaccurate First Report of Injury or Illness Data Reporting	Untimely Filing of Notices of Denial
FY 07-08	7	7	3	1	0
FY 08-09	29	21	14	8	3
FY 09-10	36	18	11	6	11

Source: DWC Bureau of Monitoring and Audit as of 6/30/10

Graphic 3.5 compares the number of pattern and practice violations identified during audits in the last five fiscal years. The increase over the past two fiscal years reflects the increase in the number of audits performed and the expanded comprehensiveness of all audits.

3.5 Pattern and Practice Violations Identified During Audits

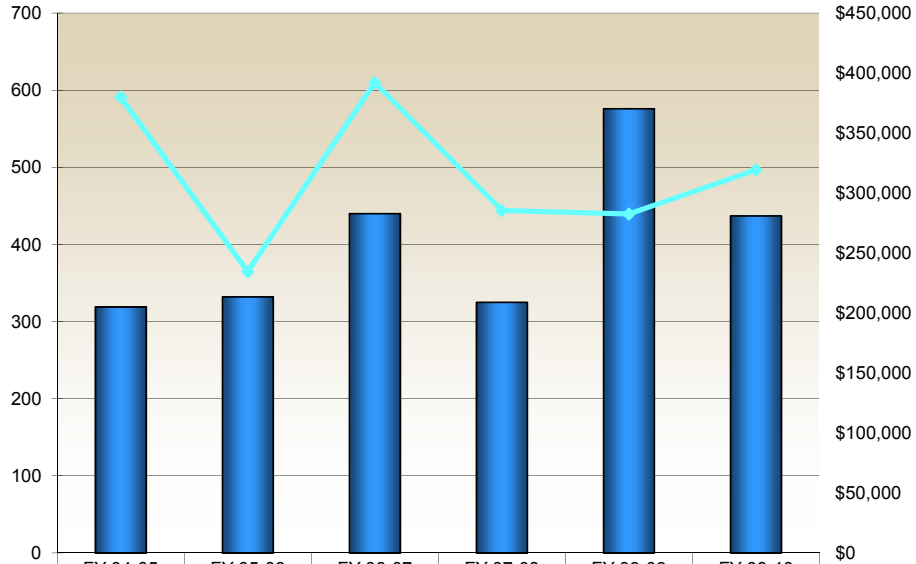


Source: DWC Bureau of Monitoring and Audit as of 6/30/10

During FY 2009-2010, the Audit Section:

- Completed 52 on-site insurer audits and audited 5,223 insurer claim files which contain all records, medical reports, and benefit information relative to a particular worker's injury or illness;
- Analyzed 2,804 claim files for accuracy and timeliness and identified 437 files with underpayments. These underpayments resulted in additional payments of $161,740 in indemnity benefits and $157,572 in penalties and interest, for a total of $319,312 paid to injured workers. **Graphic 3.6** illustrates the number of underpayments identified and total amount of indemnity benefits, penalties, and interest paid to injured workers as a result of audits conducted during the last six fiscal years;

3.6 Underpaid Indemnity Benefits Identified During Audits



	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10
# of Underpayments	319	332	440	325	576	437
Amount of Underpayments	$379,948	$234,421	$392,003	$285,402	$282,459	$319,312

Source: DWC Bureau of Monitoring and Audit as of 6/30/10

- Determined that 93% 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 10,539 claim forms required to be filed with the Division;
- Reviewed 12,190 medical bills and electronic First Reports of Injury or Illness at on-site audits to determine if the Division had received all filings required and whether accurate data had been submitted to the Division;
- Identified 82 pattern and practice violations during 52 audits for failure to meet statutory claims-handling requirements. Specific violations are as follows:
  - ♦ Thirty-six violations for failure to timely file electronic Claim Cost Reports with the Division;
  - ♦ Eighteen violations for failure to report accurate medical data to the Division;
  - ♦ Eleven violations for the untimely mailing of the Important Workers' Compensation Information for Florida's Workers and/or the Informacion Importante de Seguro de Indemnizacion Por Accidentes de Trabajadores de la Florida or the Employee Notification Letter to injured workers;
  - ♦ Eleven violations for failure to timely file Notices of Denial with the Division;
  - ♦ Six violations for failure to report accurate data on electronic First Reports of Injury or Illness filed with the Division;

- As a result of audits conducted during Fiscal Year 2009-2010, $318,700 in penalties were assessed as follows:
  - $78,600 for untimely indemnity payment performance that fell below the 95% required standard;
  - $35,100 for untimely filing of electronic First Reports of Injury or Illness;
  - $205,000 for 82 pattern and practice violations.

Penalty Section

The Penalty Section is responsible for monitoring and evaluating insurer performance regarding the timely payment and accuracy of initial indemnity benefit payments and timely payment of medical bills. The Section also ensures that electronic First Reports of Injury or Illness and all medical bill data are filed timely with the Division. The Penalty Section monitors insurer performance on these measures through the Centralized Performance System (CPS).

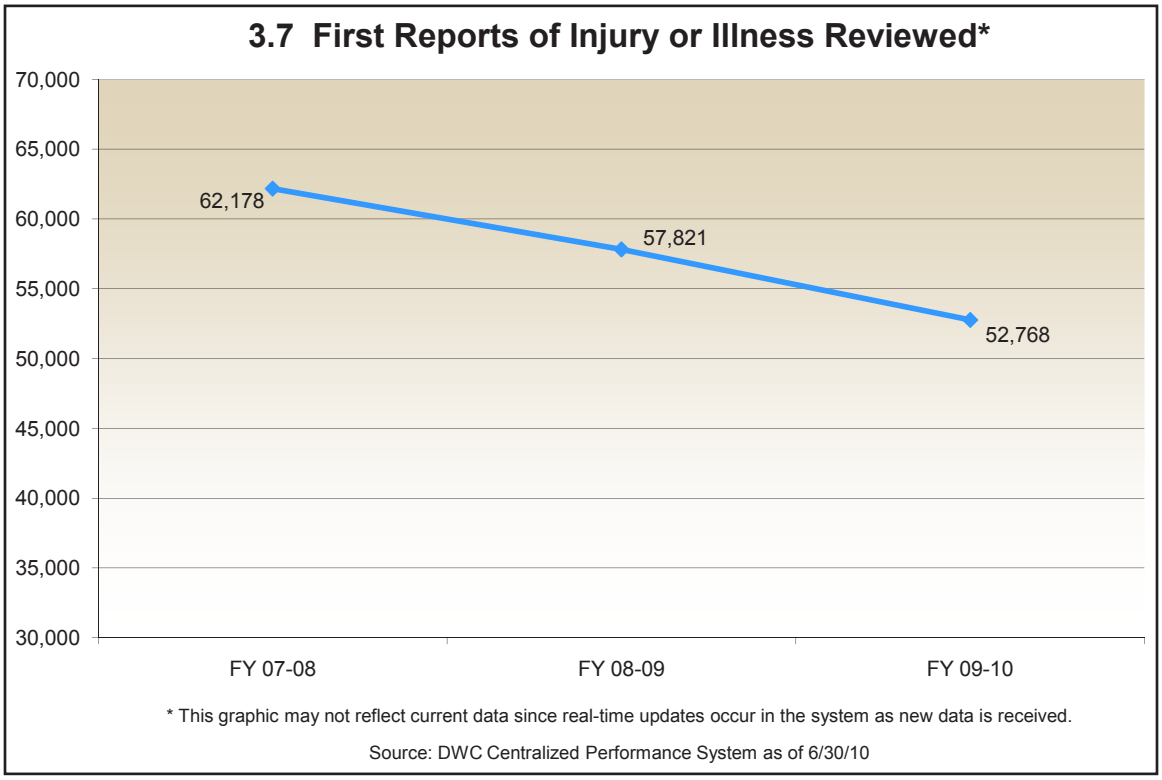
There are two components within the CPS system: a Medical Module and an Indemnity Module. Both modules provide claims-handling entities with the ability to monitor their own claims-handling performance and compare their company's performance to the industry. CPS plays a key role in identifying insurers and other claims-handling entities whose performance fall below industry standards, which may require additional monitoring or auditing. CPS provides insurers and claims-handling entities with the ability to review and respond to their performance information in real-time. The system electronically maintains penalty payments, documents communications with regulated entities, and records payment information provided by insurers and other claims-handling entities.

Rule 69L-24, F.A.C., was revised effective January 12, 2010, and changed the way CPS filing penalties are determined. The maximum penalty assessment for untimely filed medical bill data was reduced from $100 to $50 per bill. In addition, a monthly cap of $10,000 was established for the untimely filing of medical bill data and electronic First Reports of Injury or Illness. The cap was effective retroactively to January 1, 2008, and the Division was authorized to distribute refunds to those insurers that had paid a filing penalty over $10,000. The Division has refunded more than $1.8 million dollars to insurers and claims-handling entities since the implementation of this rule amendment.

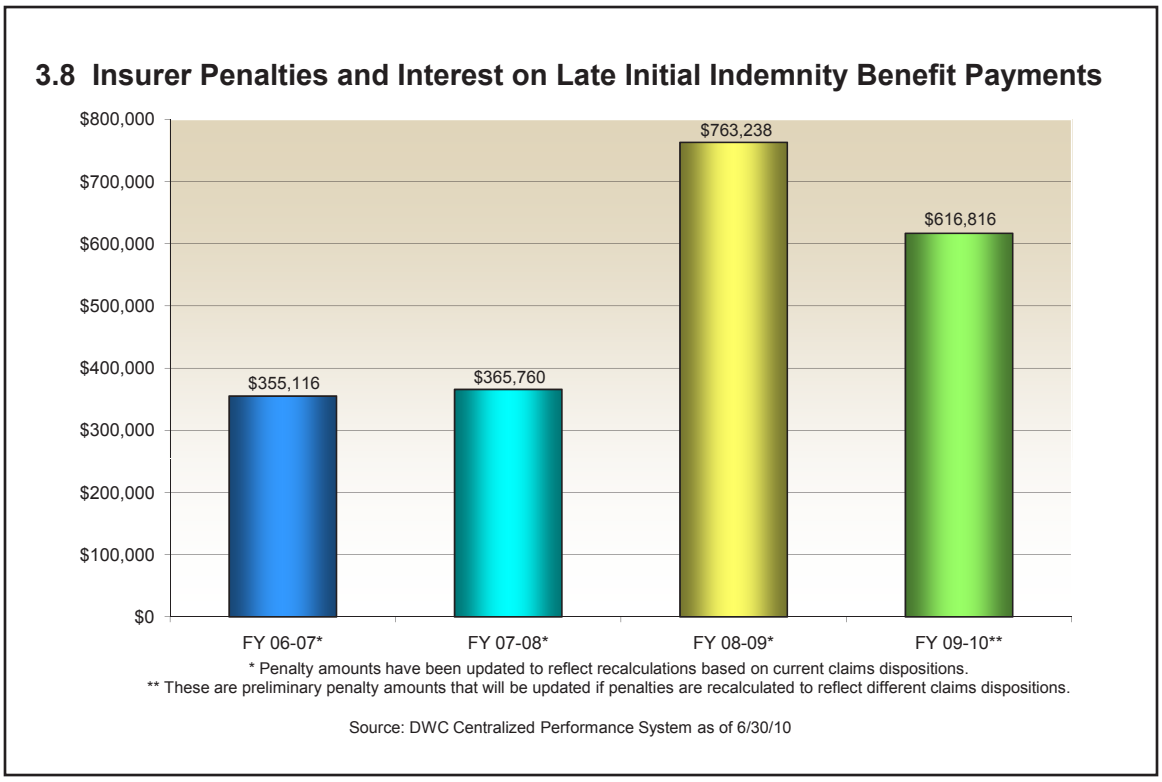
Indemnity Module

The CPS Indemnity Module was implemented in June 2005 to electronically evaluate insurer performance in two areas: the timely filing of First Reports of Injury or Illness and the timely payment of the initial installment of indemnity benefits to injured workers. Prior to that implementation, the Division was only able to manually review approximately 17% (13,000) of all filed First Reports of Injury or Illness per year. Since the implementation of this module, the Division has been able to electronically review all forms submitted by insurers.

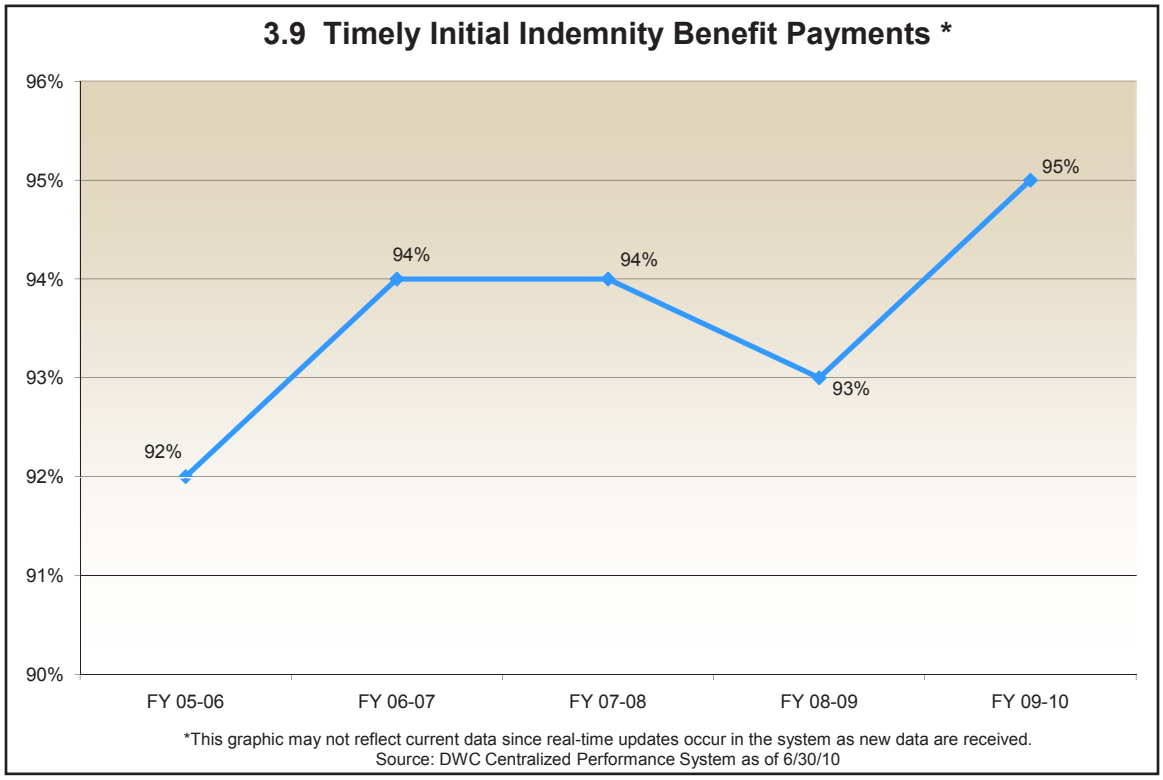
Graphic 3.7 illustrates the changes in the volume of First Reports of Injury or Illness reviewed over the last three fiscal years.



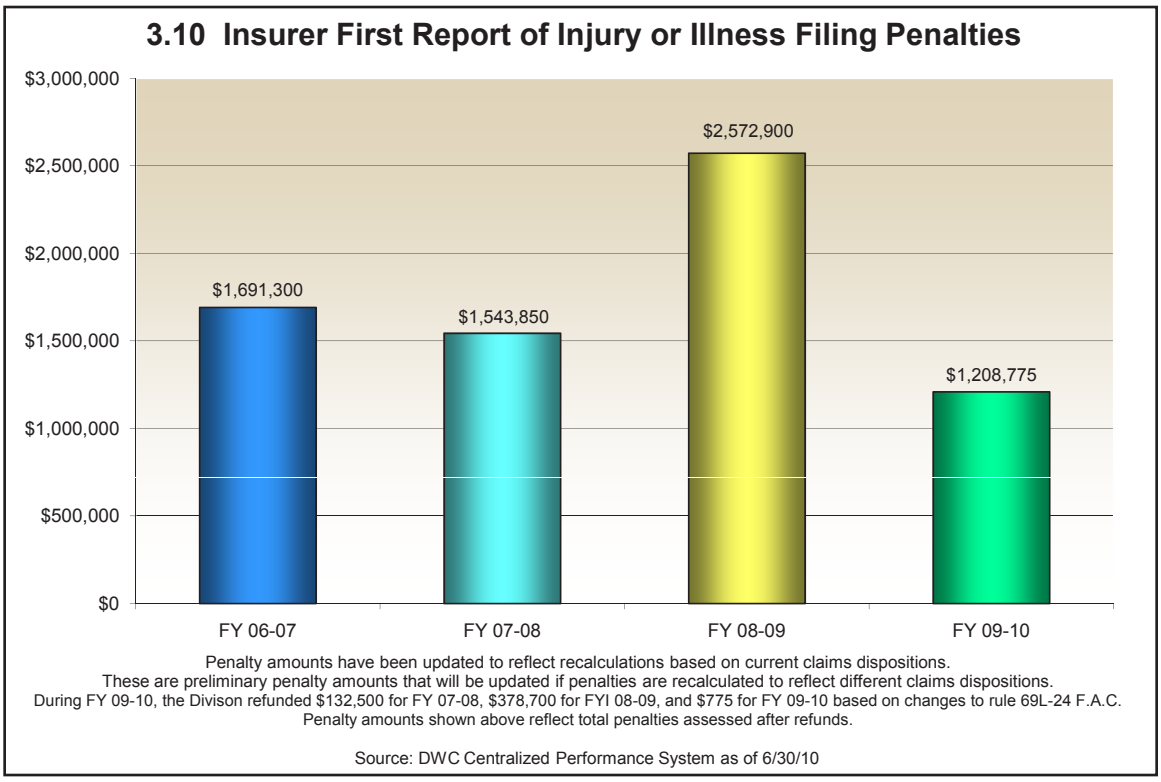
Graphic 3.8 illustrates the penalties and interest awarded to injured workers over the past four fiscal years as a result of CPS analyses of late payments of initial indemnity benefit payments.



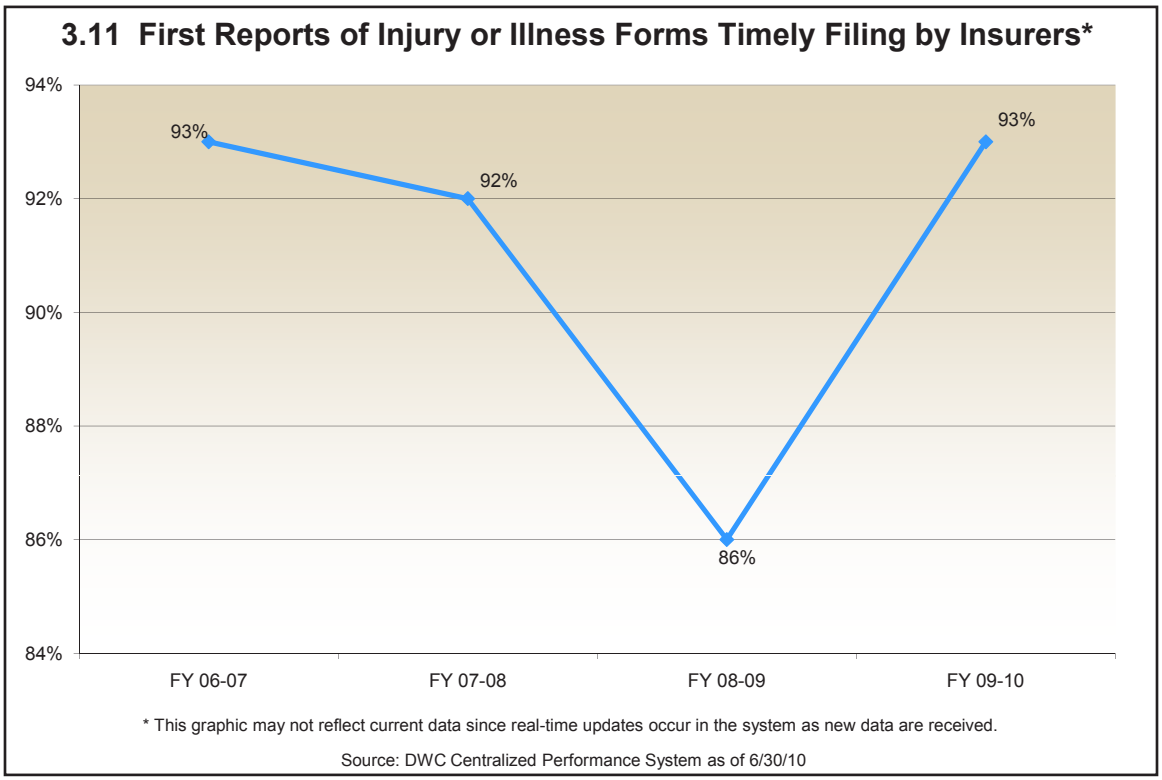
Graphic 3.9 illustrates insurer performance for timely payment of initial indemnity benefits from Fiscal Year 2005-2006 through Fiscal Year 2009-2010. Claims-handling entities have for the first time, met the statutory timely payment performance standard of 95%.



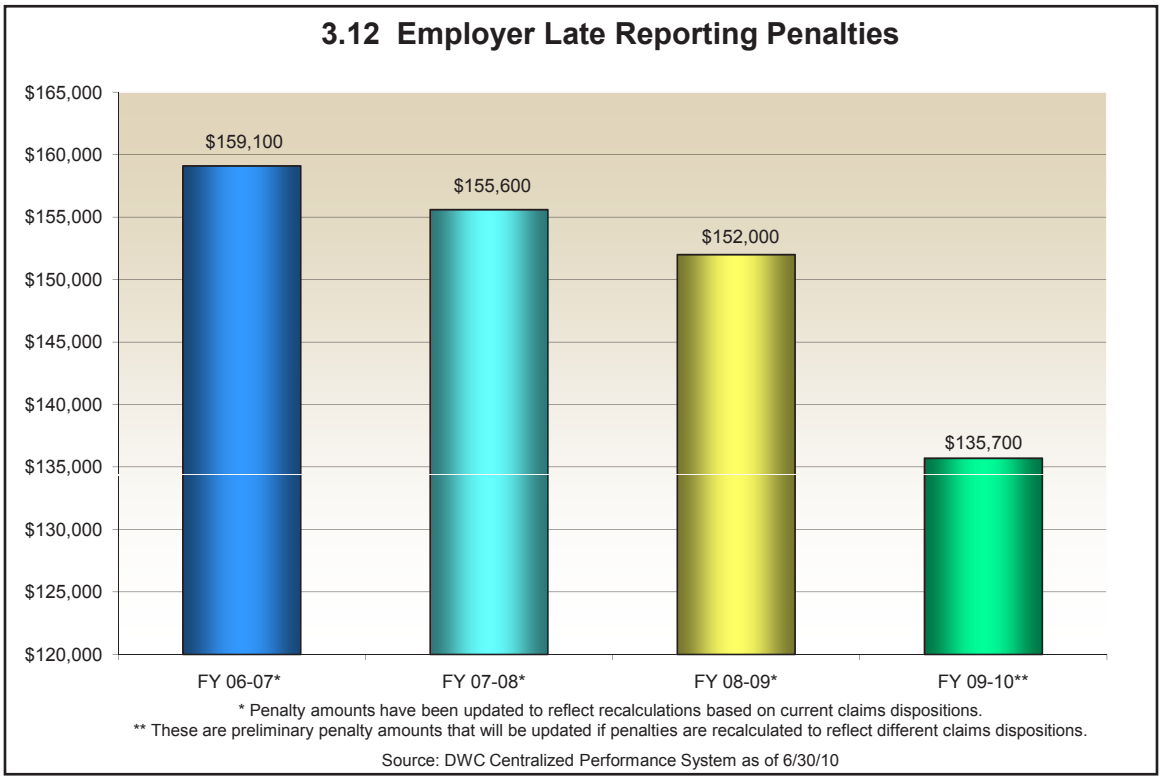
Graphic 3.10 illustrates insurer penalties assessed for late filing of First Reports of Injury or Illness in accordance with Rules 69L-24 or 69L-56.301, F.A.C.



Graphic 3.11 illustrates insurers' performance for timely filing of First Reports of Injury or Illness over time.

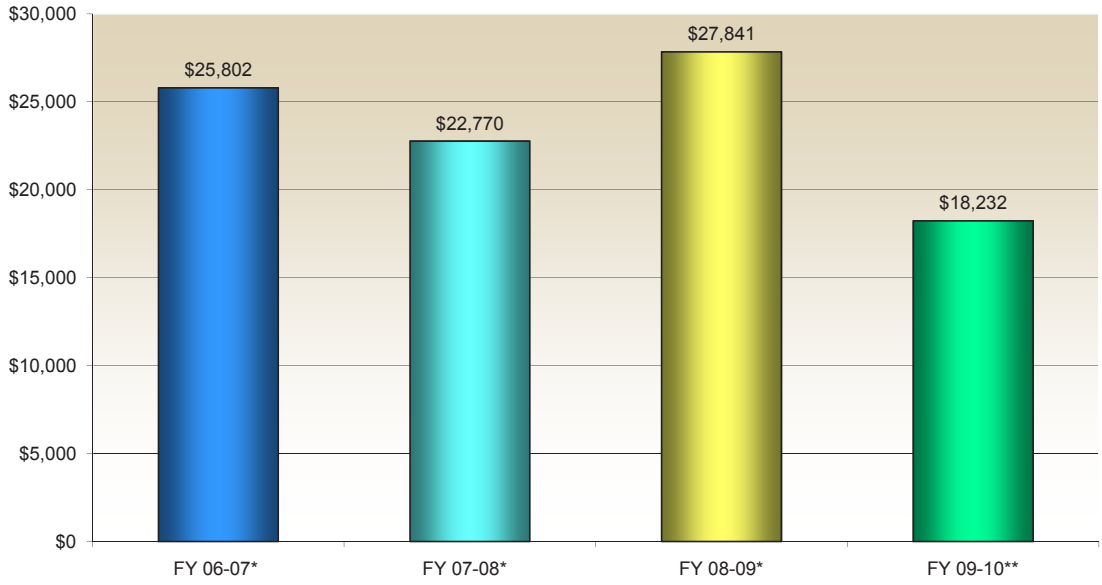


Graphic 3.12 reflects the total employer penalties assessed for the late reporting of injuries or illnesses over the last four fiscal years in accordance with Rule 69L-24, F.A.C.



Employers are required to pay penalties and interest to the injured worker if their late reporting results in a late payment of indemnity benefits, as shown in **Graphic 3.13**.

3.13 Employer Penalties & Interest Assessed on Late Initial Indemnity Benefit Payments



* Penalty amounts have been updated to reflect recalculations based on current claims dispositions.
** These are preliminary penalty amounts that will be updated if penalties are recalculated to reflect different claims dispositions.

Source: DWC Centralized Performance System as of 6/30/10

Medical Module

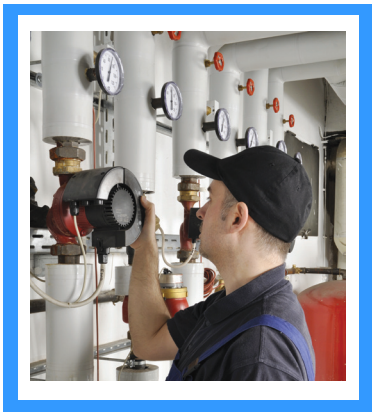
Since November 2004, the CPS Medical Module has allowed the Division to electronically evaluate insurer performance on a monthly basis for timely payment and filing of medical bill data. Medical bills must be paid, disallowed, or denied within 45 calendar days after the date the bill is received by the insurer and data must be filed with the Division within 45 calendar days of disposition.

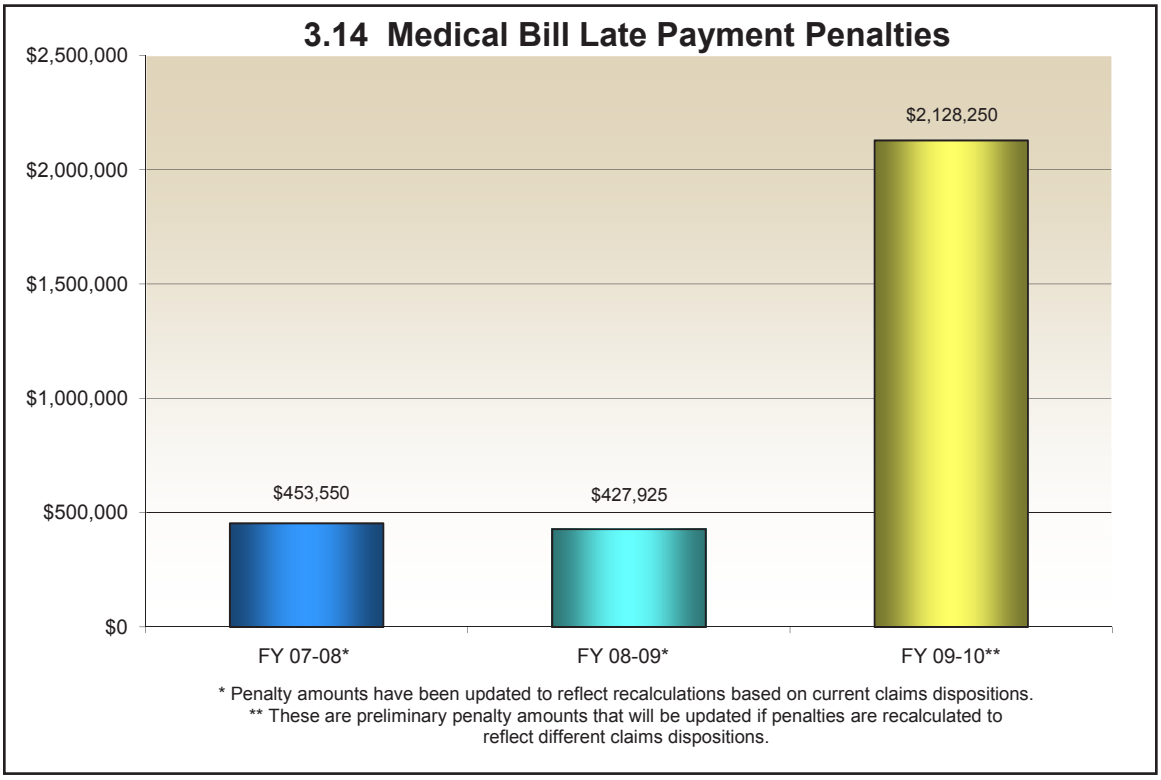
Monthly bill payment information is reviewed and penalties are assessed in accordance with Rule 69L-24, F.A.C. Insurers who fail to pay medical bills timely are subject to administrative fines according to the following schedule:

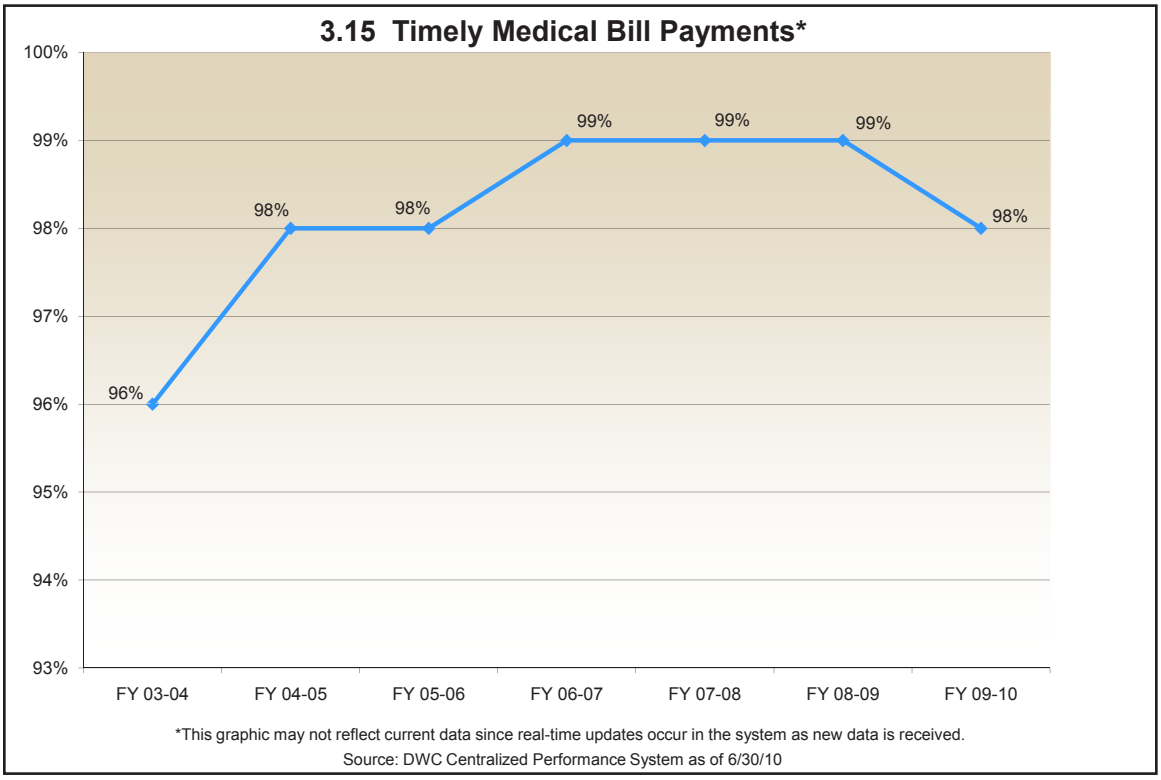
- $25.00 for each bill below the 95% timely performance standard, but meeting a 90% timely standard;
- $50.00 for each bill below a 90% timely performance standard.

Graphic 3.14 illustrates insurer penalties assessed for late payment of medical bills for the past three fiscal years.

Graphic 3.15 illustrates timely medical bill payment performance.

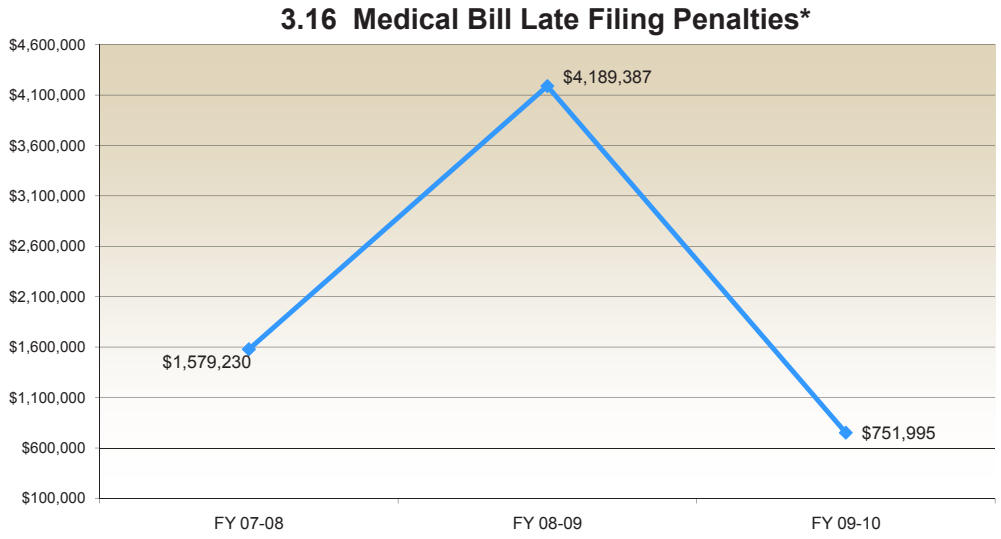






Monthly bill filing information is reviewed and penalties are assessed in accordance with Rule 69L-24, F.A.C. Insurers who fail to timely submit data on 95% of all medical bills are subject to an administrative fine.

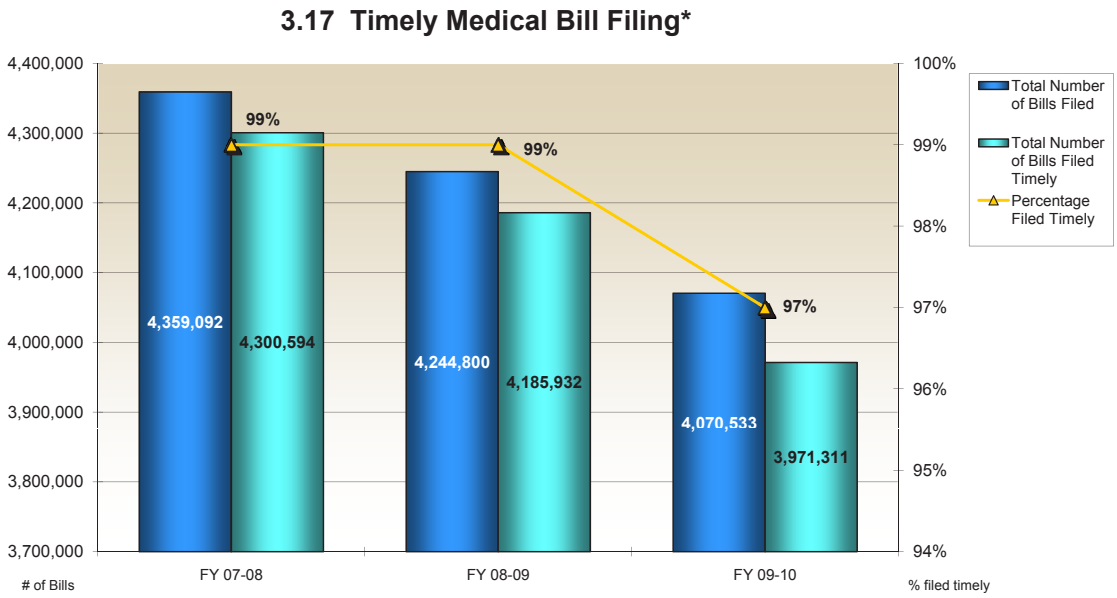
Graphic 3.16 illustrates the penalties assessed for late filing of medical bill data during the last three fiscal years.



*Penalty amounts have been updated to reflect recalculations based on current claims dispositions.
These are preliminary penalty amounts that will be updated if penalties are recalculated to reflect different claims dispositions.
During FY 09-10, the Division refunded $341,940 for FY 07-08, $877,783 for FY 08-09 and $70,960 for FY 09-10 based on changes to Rule 69L-24 F.A.C.
Penalty amounts shown above reflect total penalties assessed after refunds.

Source: DWC Centralized Performance System as of 6/30/10

Graphic 3.17 compares the total number of medical bills for which electronic data was submitted to the total number of medical bills for which data was electronically submitted timely.



* This graphic may not reflect current data since real-time updates occur in the system as new data as received.

Source: DWC Centralized Performance System as of 6/30/10

During FY 2009-2010, the Penalty Section:

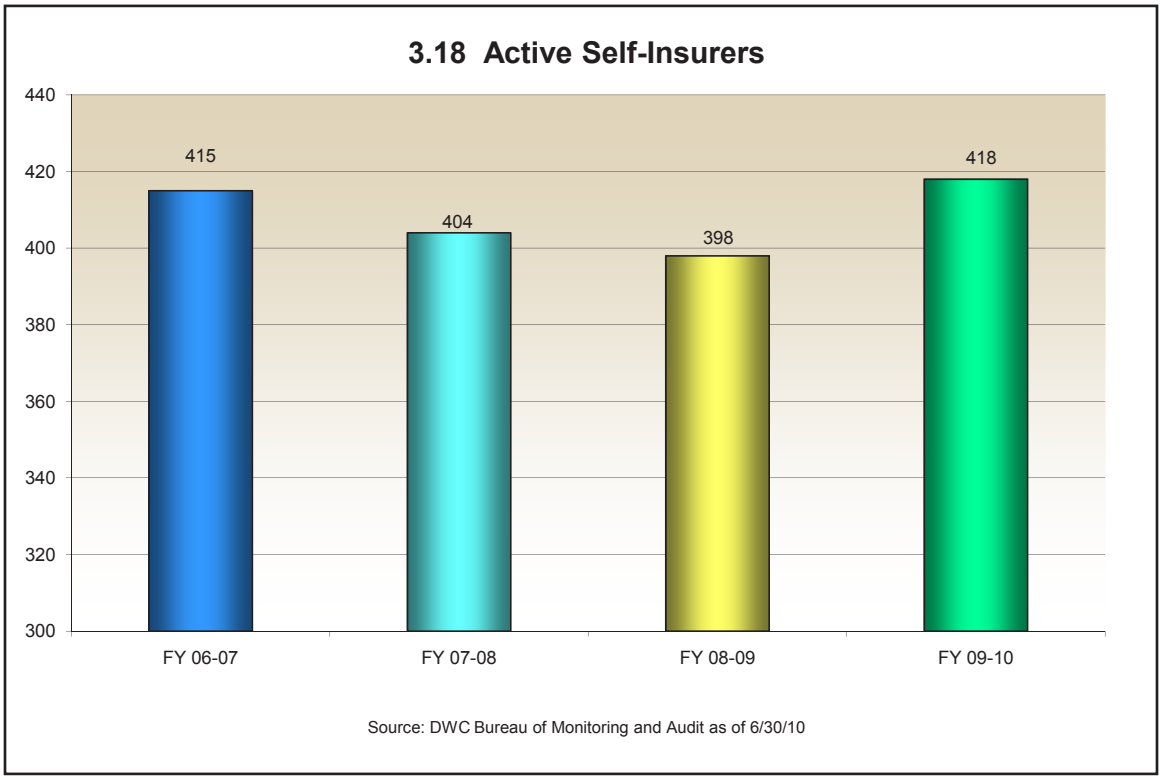
- Evaluated and monitored the accuracy and timeliness of 52,768 First Reports of Injury or Illness electronically filed by employers, insurers, and claims-handling entities. This evaluation resulted in $635,048 in penalties assessed against employers and insurers due to late payments and $1,344,475 in assessed penalties due to late filings.

- Evaluated and monitored data through CPS on 4,070,533 medical bills for timely disposition and timely filing, which resulted in $2,128,250 in late disposition assessed penalties and $751,995 in late filing assessed penalties.

Self-Insurance Section

The Self-Insurance Section is responsible for approving self-insurance programs for governmental and non-governmental entities that meet statutory requirements and demonstrate the required financial strength to fund their present and future workers' compensation liabilities.

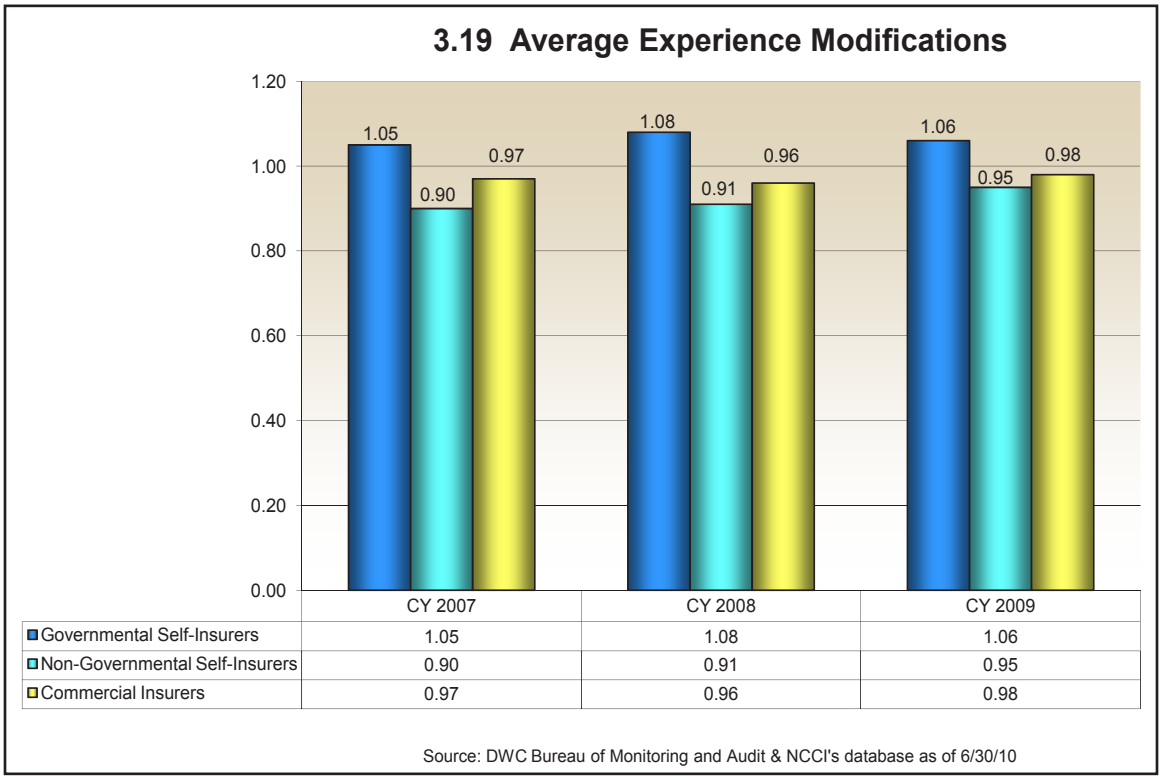
Graphic 3.18 shows the number of active self-insurers over the last four fiscal years. The first increase in the number of active insurers after three years of decreases was due to twenty-seven educational institution members of a consortium becoming individually self-insured.



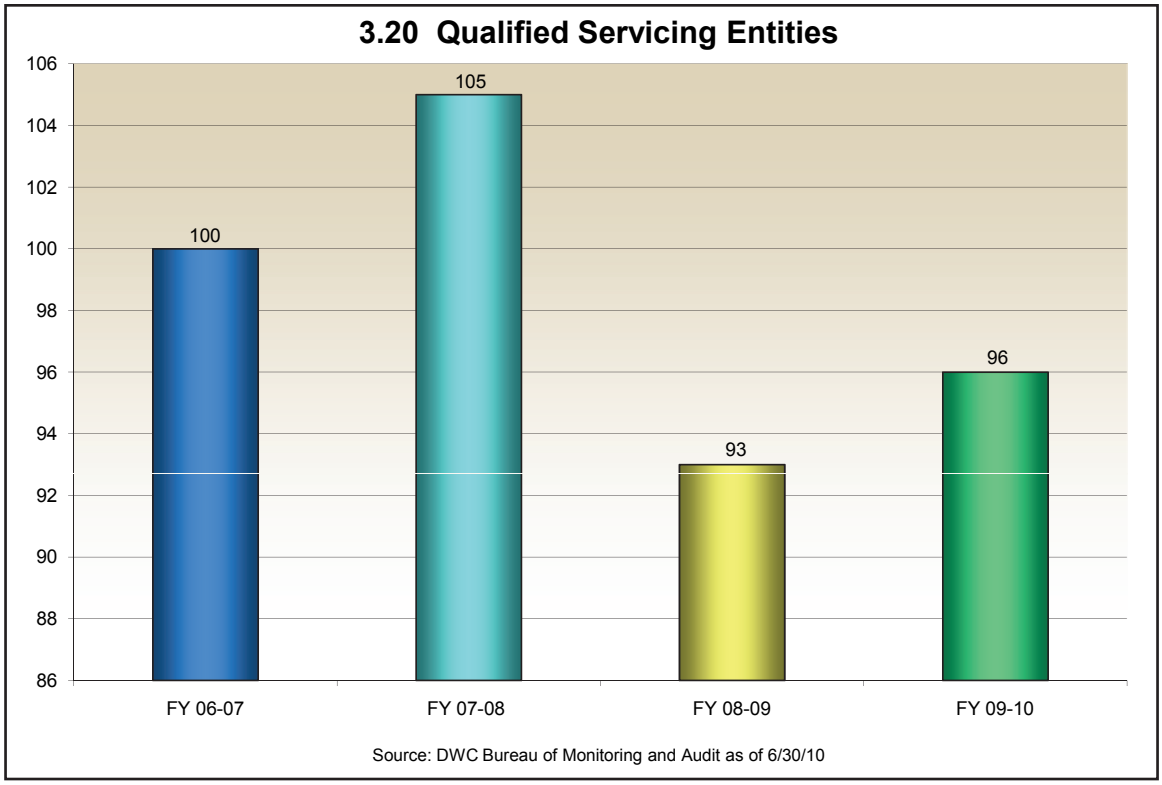
To ensure the financial stability of the companies approved to self-insure, the Division contracts with the Florida Self-Insurers Guaranty Association (FSIGA) to review financial statements and monitor self-insurers' ability to pay current and future workers' compensation liabilities. The Self-Insurance Section, in conjunction with FSIGA evaluates security deposits, grants the self-insurance privilege, and collects, examines, and processes self-insurance payroll, loss data, outstanding liabilities, and financial statements.

On-site audits are conducted by the Self-Insurance Section to ensure the accurate reporting of payroll and employee classification data by self-insurers. In addition, the Self-Insurance Section compiles payroll and loss data from all self-insurers in order to promulgate the experience modification factor for individual self-insurers. Both the payroll information and experience modification factor are used by the Division to determine the assessment amounts to be paid by each self-insurer to the STDF and WCATF. The experience modification factor also indicates the self-insurer's loss experience for the past three years and is a factor in calculating workers' compensation premiums.

Graphic 3.19 shows the average experience modifications of governmental self-insurers, non-governmental self-insurers, and commercial insurers for the last three years.



Qualified Servicing Entities that request certification to provide claims adjusting, loss control, and rehabilitation services to self-insurers must submit an application and be approved by the Self-Insurance Section. The performance of Qualified Servicing Entities is monitored by the Self-Insurance Section and each entity must apply annually, by March 1st, for recertification. **Graphic 3.20** shows the number of approved Qualified Servicing Entities for the past four fiscal years.



During FY 2009-2010, the Self-Insurance Section:

- Promulgated 418 experience modification factors for active self-insurers;
- Approved eight new Qualified Servicing Entities and recertified 96;
- Approved 33 new self-insurance entities;
- Audited the reporting and payroll classifications of 29 self-insurers and 72,659 payroll records. The audits resulted in the payroll reclassification of 6,850 employees and the reporting of an additional $44,093,000 in payroll and $237,715 in premium.

BUREAU OF DATA QUALITY AND COLLECTION

The Bureau of Data Quality and Collection (DQC) serves as the information repository for the Division by collecting and maintaining essential workers' compensation data required to be filed with the Division in accordance with Florida Statutes and various administrative rules. DQC facilitates the distribution of claims, medical, and proof of coverage data to other areas of the Division as well as external customers. Hundreds of electronic edits validate data and organize it into standardized acknowledgement formats which provide real-time feedback to submitters. These edits have resulted in greater integrity and accessibility of the data for all end users. Key to this process is ensuring the confidentiality of information protected by statute from public disclosure when processing requests for data, public records requests, and subpoena compliance. Other DQC responsibilities include research and analysis of data collected by the Division and provision of data to Florida's Three-Member Panel concerning medical reimbursement issues.

DQC accomplishes these objectives by:

- Implementing procedures for proper reporting of electronic First Reports of Injury or Illness and subsequent claims data including: electronic Notices of Action/Change, Claim Cost Reports, Notices of Denial, and Proof of Coverage (POC) filings, using national EDI standardized file formats;
- Implementing procedures for proper reporting of medical bill data from or on behalf of health care providers, ambulatory surgical centers, dentists, pharmacists, and hospitals. This information is used by the Division to monitor compliance with timeliness of medical reimbursement to medical providers and filing of medical reports with the Division and for research;
- Analyzing and modifying various system requirements and edits for increasing the reliability and integrity of information submitted to the Division regarding injured workers' claim filings, medical services billings, and the status of an employer's coverage;
- Training insurers on filing requirements and techniques to ensure successful electronic submissions, while completing the process of facilitating and supervising the transition process from paper to electronic submission of required reports for new insurers and claim administrators;
- Generating performance results and reports to claims and medical submitters regarding the status of their electronic submissions, which includes feedback to individual submitters about performance levels for accepted and rejected filings and percentage of accepted and rejected filings compared to all other submitters as a whole;
- Archiving workers' compensation paper records by use of electronic imaging technology;
- Collaborating with other governmental agencies and municipalities to maintain confidential profiles for certain occupational classes of employees to prevent disclosure of statutorily protected personal information, including employees' social security numbers, home telephone numbers, and addresses;
- Compiling statistics and analyzing data in response to legislative and other external data requests;
- Protecting medical and personal financial information with public records inspection;
- Managing information released to external customers via the Division's website, including data for the Construction Policy Tracking Database, Insurer/Claim Administrator Database, and the Claims EDI Data Warehouse.

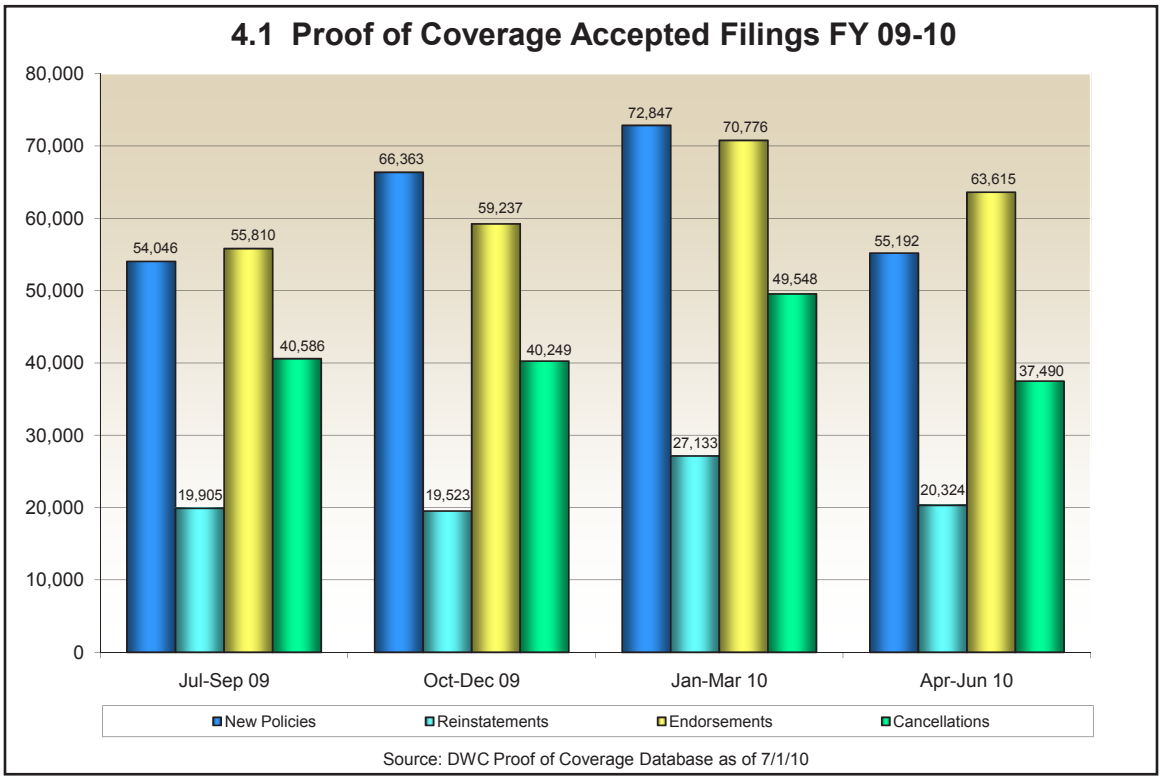
FY 2009-2010 Accomplishments

- Received and processed 4,080,348 electronic medical bills from health care providers including physicians, hospitals, ambulatory surgical centers, pharmacies, therapists and dentists. The total number of medical bill records stored in the Division's Medical Data Warehouse exceeded 48 million as of June 30, 2010;

- Received and processed 752,644 electronic POC filings;
- Received and processed 80,739 Electronic First Reports of Injury or Illness, 140,380 Notices of Action/Change, 34,430 Notices of Denial, and 229,943 Claim Cost Reports, which is a total of 485,492 electronic claims filings;
- Received and processed 645 paper First Reports of Injury or Illness (DWC-1), 5,585 paper Notices of Action/Change (DWC-4), 282 paper Notices of Denial (DWC-12), and 4,190 Claim Cost Reports (DWC-13), for a total of 10,702 paper filings;
- Received and processed 3,720 subpoenas for record production and 3,737 public records requests;
- Provided five training sessions on R3 Claims EDI reporting standards and requirements to 353 claims-handling entity representatives;
- Identified and flagged 23,724 workers' compensation accidents and/or profile records as exempt from public records inspection in accordance with s. 119.071(4)(d), F.S., to protect the release of personal information including social security numbers, home addresses and telephone numbers for certain occupational classes of employees.

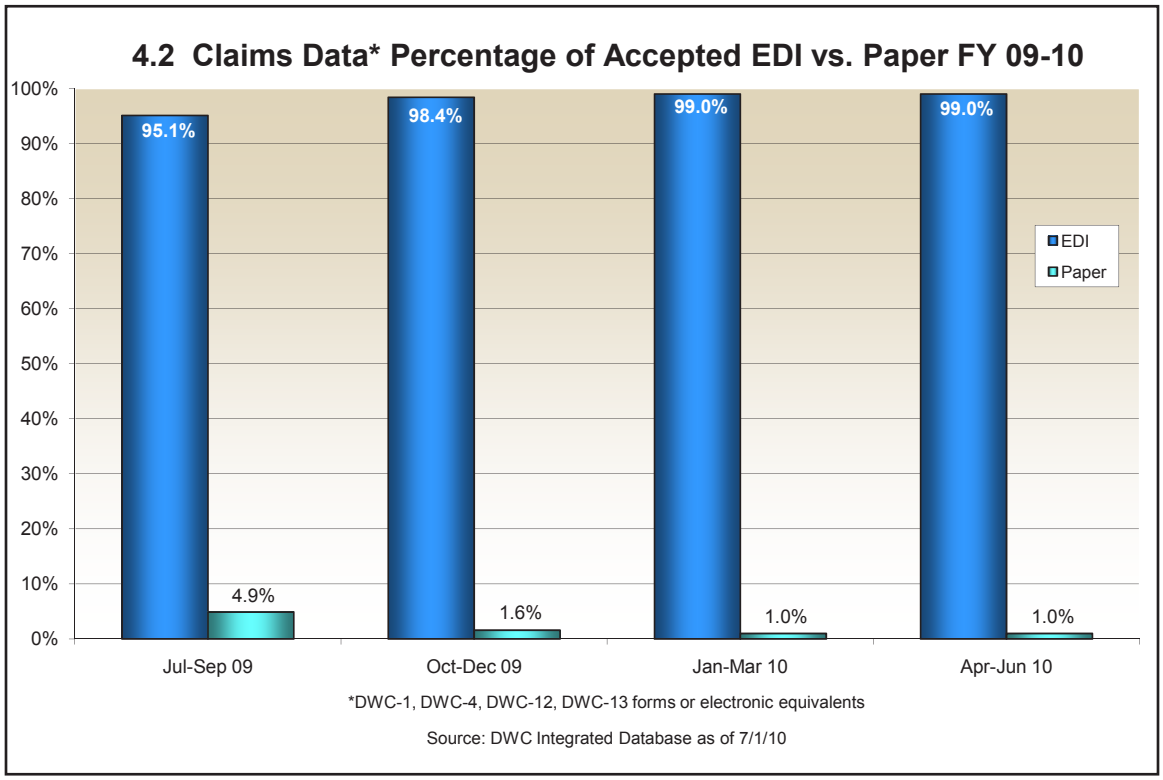
Proof of Coverage Update

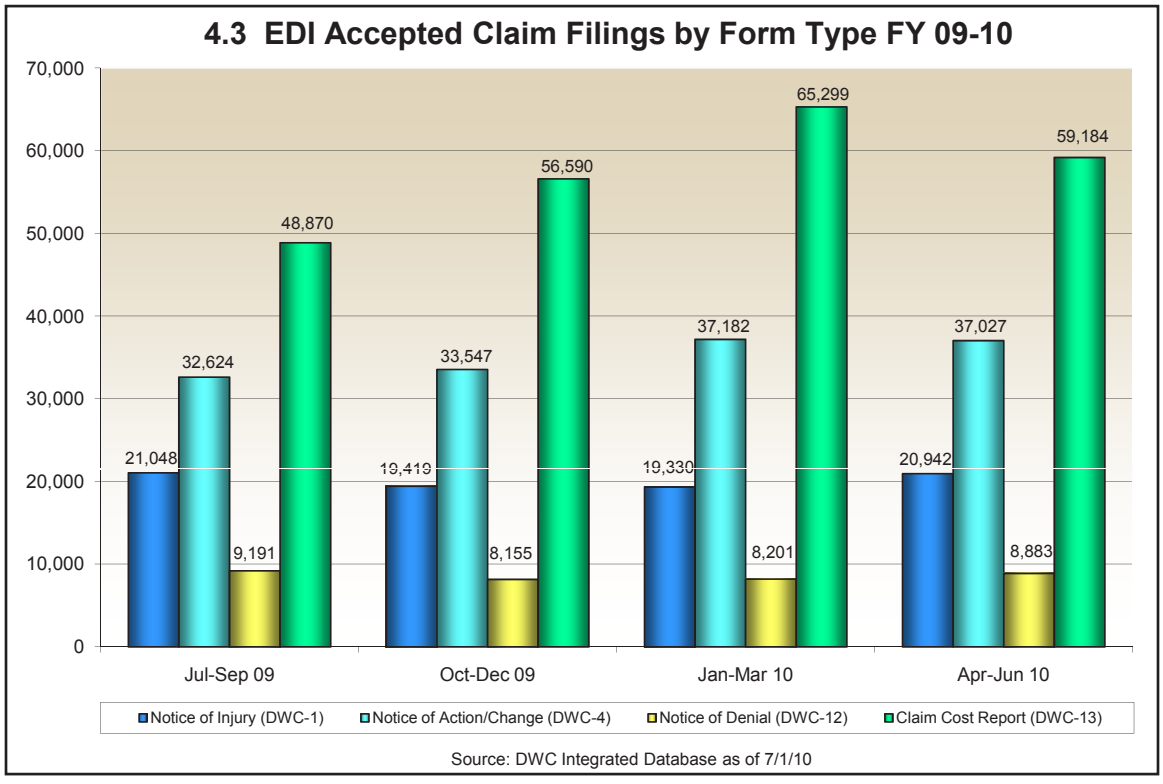
The Proof of Coverage Process was the Division's first business process to undergo the transition from paper to EDI. Every insurer, except for individual self-insurers, is required to file policy information with the Division in place of previously required paper Certificates of Insurance, Notices of Reinstatement, Endorsements, and Cancellations. Over the last three fiscal years, the collection of proof of coverage data for these electronic form equivalents has remained relatively constant. **Graphic 4.1** shows Fiscal Year 2009-2010 proof of coverage accepted filings by form type.



Claims EDI Data Collection

DQC experienced significant progress in its collection of electronically filed First Reports of Injury or Illness, Notices of Denials, Claim Cost Reports, and Notices of Action/Change reports this past fiscal year. Compared to the previous fiscal year during which 58% of these reports were filed electronically, there was a significant increase during Fiscal Year 2009-2010 which resulted in 97.8% of these reports being filed with the Division electronically using the Claims EDI R3 formats. **Graphic 4.2** illustrates the substantial increase in the amount of accepted electronic claim filings during Fiscal Year 2009-2010. **Graphic 4.3** depicts the acceptance of EDI claims information by form type for Fiscal Year 2009-2010.





During Fiscal Year 2009-2010, DQC increased compliance levels of insurers converting from paper to Claims EDI R3. By the end of June 2010, 100% of all 165 trading partners (insurers and third party administrators that have been approved to transmit electronic data) representing 1,118 insurers had been approved to file Claims EDI R3 transactions with the Division compared to 156 trading partners and 1,093 insurers at the end of last fiscal year. DQC provides ongoing education and technical assistance to its trading partners via training sessions, webinars, and numerous teleconferences. Additionally, DQC's Claims EDI Team responded to 28,430 emails to educate claims-handling entities on proper submission techniques.

The Division's Claims EDI Data Warehouse provides information to trading partners about their electronic filings. Through the Claims EDI Warehouse, a trading partner can electronically generate a Report Card that identifies the number and percentage of its accepted and rejected transactions. The top five reject errors are summarized in this report to assist the trading partner in resolving system-related issues and identify areas that might benefit from trading partner training. The most frequent reason for the rejection of electronic First Reports of Injury or Illness filings is because one of the two companion transactions required to be processed the same day did not pass edits, which results in both filings being rejected. Other common electronic claims submission errors involve data that are incongruent with other data contained in the same or previously reported transactions and missing or invalid data.

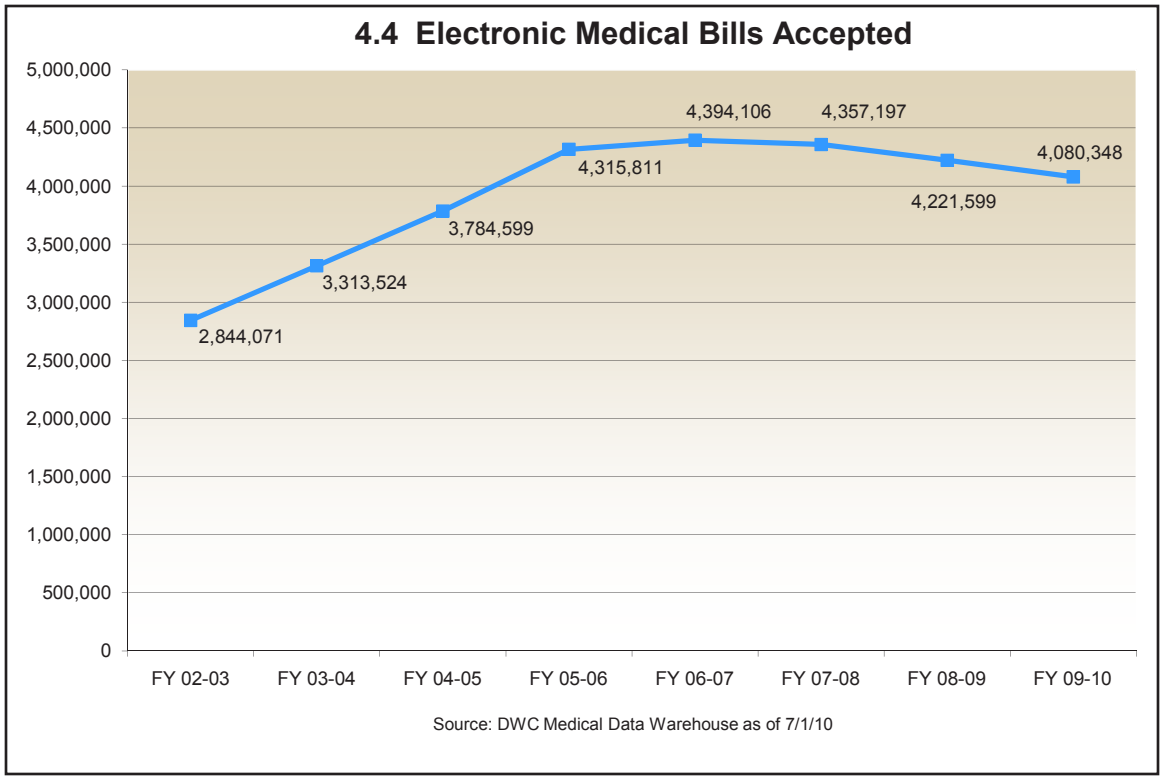
In addition to the identification of accepted and rejected transactions, information is posted in the Claims EDI Data Warehouse to inform the trading partner about potential workers' compensation benefit underpayments to injured workers. Suspected indemnity benefit overpayment information is also posted in the Warehouse to identify workers' compensation benefits that may need to be recouped or reclassified from cost to expense dollars. The Claims EDI Warehouse design allows the Division to provide claims-handling entities with real-time information that allows opportunities to make timely adjustments to benefits and provide more accurate compensation to injured workers.

During November 2009, the Division began a new initiative to notify trading partners monthly about a compliance report which lists overdue electronic equivalents of Claim Cost Reports. Upon receipt of the email notification, trading partners can access the report via the Claims EDI Warehouse. This new report is a proactive tool to alert claims-handling entities about potential violations of the filing requirements for claim cost transactions. This new initiative has resulted in the collection of additional claim cost data by the Division.

Medical EDI Data

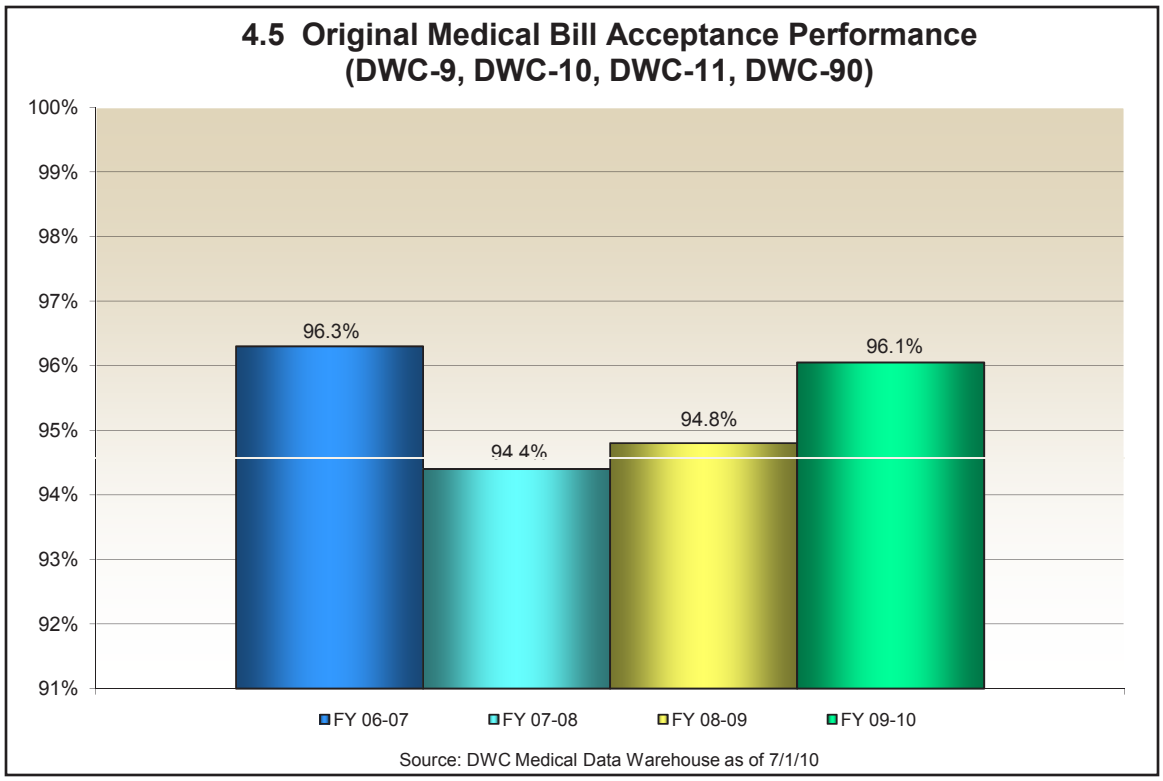
During Fiscal Year 2009-2010, DQC and the Office of Medical Services collaborated to develop new business rules, quality edits, and adjudication codes as part of a new initiative to collect data from nursing home facilities and home health agencies that treat workers' compensation patients. This required that the Medical Data System (MDS) electronic layout for submission of medical bill data be revised. As a result of the revisions, all medical EDI submitters were required to undergo extensive testing procedures to obtain approval to submit the newly required data elements and use updated electronic file formats by August 2010. As of June 30, 2010, 72% of medical EDI submitters had been approved to submit data under the new record layout reporting requirement.

Graphic 4.4 illustrates the volume of medical bills submitted in electronic form over time.



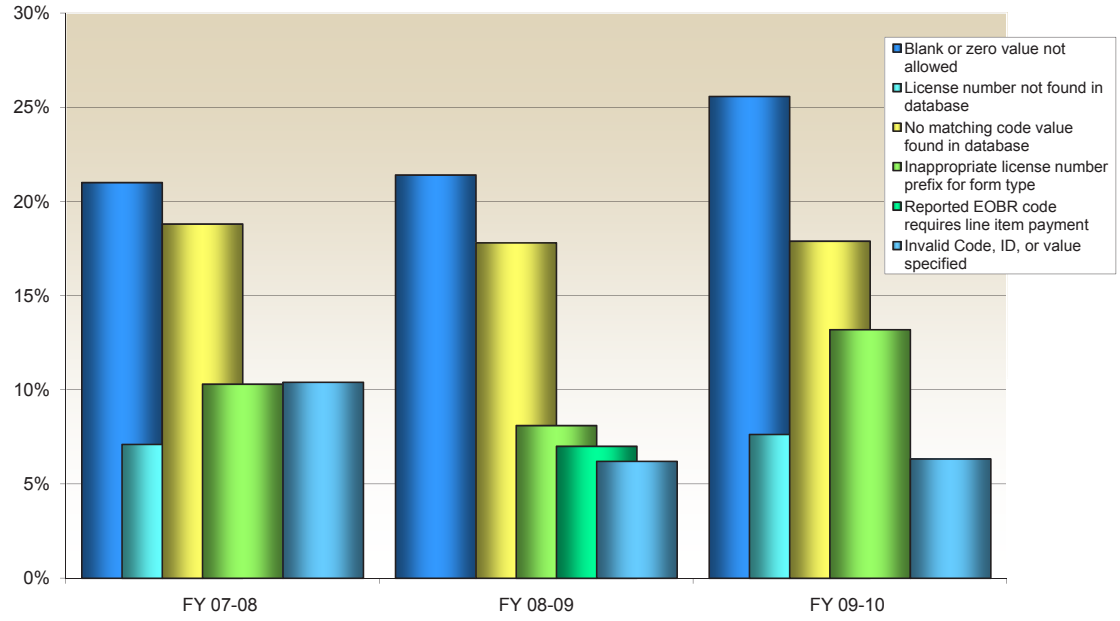
To ensure the validity of medical data, each medical record submitted to the Division undergoes extensive system edits to ensure it meets data quality requirements before it is accepted. Electronic medical filings are edited for the presence of required data fields, excessive charge and payment amounts, and the validity of specified data elements. As part of internal control standards, the records must be submitted to the Division via secure methods to ensure they comply with Health Insurance Portability Accountability Act (HIPAA) compliant data encryption standards.

When a record fails edits and is rejected, the submitter must re-submit corrected data within 45 days of the date the bill was adjudicated in order to meet administrative rule requirements for timely filing. **Graphic 4.5** illustrates submitters' performance for initial filing acceptance of electronic medical bills during Fiscal Year 2009-2010.



The Division generates monthly report cards for all submitters that detail the reasons for initial bill data rejection. The report card also compares the performance of each submitter to the performance of all submitters to allow improvement benchmarking. **Graphic 4.6** illustrates the top five reasons for medical bill rejection over the past three fiscal years.

4.6 Top Five Rejection Reasons for Medical Bills (DWC-9, DWC-10, DWC-11, DWC-90)



Source: DWC Medical Data Warehouse as of 7/1/10

Database Cross-Matching Initiative

DQC has begun using more advanced data analysis to improve its data validity and business processes. One new initiative involves cross-matching different data collection systems to determine the accuracy of data submitted and insurer compliance with filing requirements in statutes or administrative rules. While some Division databases can seamlessly interact with each other, the Division has several unique systems that stand alone and cannot interface with other systems. DQC created software programs that could reliably examine data in each stand-alone system and detect potential filing problems with a high degree of accuracy, so the Division could then contact insurers to reconcile suspect filing issues.

The initial strategy for this cross-matching effort was to compare the Division's Claims System with MDS to identify claim records where either First Reports of Injury or Illness for lost-time claims had not been filed with the Division or claim records where medical bills had not been filed for reported lost-time claims. This cross-matching effort identified discrepancies that were then reconciled with the submitters/claims-handling entities, which has resulted in greater accuracy of the information captured in both databases. Among the discrepancies found were medicals bills filed in error with the Division that related to the Federal Longshoreman's Act or another state's jurisdiction. These improperly reported medical dollars were removed from MDS. Other improvements to data validity resulted from identifying First Reports of Injury or Illness that had not been received by the Division, for which medical bills for lost-time injuries had been reported.

Confidentiality of Information

In an effort to educate employers and injured workers about s. 119.071(4)(d), F.S., of the Public Records Law, which allows the protection and non-disclosure of personal information for certain occupational classes of employees, DQC posted information on the Division's website instructing employers and employees how to request this protection.

BUREAU OF DATA QUALITY AND COLLECTION CROSS-MATCHING SUCCESS

One database cross-matching success was the result of collaboration between the Florida and Michigan state workers' compensation jurisdictions. A match query performed between the Claims and Medical Data systems identified two serious injuries with a large volume of medical bills for which no corresponding First Reports of Injury or Illness had been filed with the Division. DQC investigated and was advised that the accident employer was based in Michigan so the injury reports for the two employees had been filed in Michigan. DQC also learned that the injured employees were living and receiving medical treatment in Florida and that the medical bills had been filed with Florida authorities in error. DQC contacted the Michigan workers' compensation office and determined that the First Reports of Injury or Illness had not been filed in Michigan as claimed by the insurer. Therefore, DQC referred the matter to the Division's Bureau of Monitoring and Audit to determine which state had proper jurisdiction. Bureau of Monitoring and Audit staff learned that the two injured workers had been injured in a plane crash in Columbia, South America. Further, Division research found information about the plane crash and the names of eight members of the flight crew who had been injured in the accident. DQC provided the information to Michigan authorities who advised that only one of the claims had been reported. Michigan authorities ultimately obtained all eight injury reports and injury data from the insurer, contacted the injured workers, and began monitoring their claim activities.

In response to numerous requests from governmental agencies seeking public records protection for large numbers of employees, DQC implemented a new process to handle these requests promptly and efficiently. Section 119.071(4) (d), F.S., identifies specific information, including home addresses, telephone numbers, and social security numbers that may be excluded from public records inspection. Protection applies to specified occupations, such as active and former law enforcement personnel, correctional officers and personnel whose duties include the investigation and enforcement of abuse, neglect, exploitation, fraud, theft, or other criminal activities. Additionally, this protection is afforded to firefighters, state attorneys, other judicial personnel, and certain human resource staff. This statute requires the Division, as custodian of the information, to maintain the exempt status of the information only if the protected employee or his/her employing agency submits a written request for exemption to the Division. If that request is submitted to the Division, the relevant personal information in the employee's record(s) will not be released in response to public records requests. If a worker's compensation claim record does not exist at the time of a request for exemption, the Division creates a profile record marked confidential to associate with any future accident report(s) filed with the Division for that employee. Employers submitting requests for a large number of employees must use a specified file format DQC created for this purpose. As of June 30, 2010, 23,724 employees' personal information had been flagged for confidential status.

Administrative Rule Amendment

Florida Administrative Code Rule 69L-7.602, the Florida Workers' Compensation Medical Services Billing, Filing, and Reporting Rule, was amended and became effective on January 12, 2010. The rule introduced new reporting requirements and additional data elements as part of the 2010 Florida Medical EDI Implementation Guide, which is incorporated into this rule.

Among the changes, the revised rule:

- Required Ambulatory Surgical Centers to bill on Form DFS-F5-DWC-90, effective July 8, 2010, and report services to the Division via a revised electronic file format;
- Required Home Health Agencies to begin billing on Form DFS-F5-DWC-90, effective July 8, 2010, and report services to the Division via a revised electronic file format;
- Required Nursing Homes to begin billing on the DFS-F5-DWC-90, effective July 8, 2010, and report services to the Division via a revised electronic file format.

OFFICE OF MEDICAL SERVICES

The Office of Medical Services (OMS) is responsible for the regulation of medical services in the Workers' Compensation System. Its duties are almost exclusively contained in Section 440.13, Florida Statutes. These duties fall into the following four areas:

- Developing and adopting workers' compensation health care reimbursement manuals;
- Resolving medical service reimbursement disputes;
- Certifying Health Care Providers and Expert Medical Advisors;
- Investigating overutilization, improper billing practices, or other Health Care Provider violations of Chapter 440, F.S., and rules adopted by the Department.

OMS also provides administrative support to the Three-Member Panel. The Three-Member Panel is responsible for the adoption of schedules of maximum reimbursement allowances for physicians, hospitals, ambulatory surgical centers and other service providers. Upon approval by the Three-Member Panel, OMS incorporates the schedules into reimbursement manuals and implements related policies.

OMS, in collaboration with DQC, is responsible for developing subsequent revisions to the reimbursement manuals. The three reimbursement manuals are:

- Florida Workers' Compensation Health Care Provider Reimbursement Manual;
- Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers;
- Florida Workers' Compensation Reimbursement Manual for Hospitals.

OMS also works with DQC to develop and revise the Florida Workers' Compensation Medical Services, Billing, Filing and Reporting Rule (Billing Rule). This Rule specifies the forms and information that must be included on medical bills submitted to insurers, timeframes and requirements for insurer responses to medical bill submitters, and data reporting requirements for Division submissions. As a result, frequent revisions are necessary due to changes in national billing standards and formats to enable health care providers to use standardized forms and methodologies.

Rulemaking Activities

Rulemaking and its related activities are a significant part of OMS' business processes due to the almost constant revision of national billing and coding standards and annual Medicare rate revisions which impact Florida physician reimbursement. The primary rulemaking activity in the past fiscal year has been the Florida Workers' Compensation Hospital Reimbursement Manual, (2006 Edition) and the Billing Rule. The rule making activity for the revised hospital manual has been suspended due to ongoing litigation.

The current Billing Rule became effective January, 12, 2010. Provider billing instructions are incorporated into the Billing Rule. Likewise, the insurers' medical claims reporting requirements are contained in the Billing Rule and the Florida Medical EDI Implementation Guide (MEIG). This rule also provides specifics on proper electronic data submission and how to report and request payment for services addressed by the reimbursement manuals.

The revised Billing Rule applies to all dates of service on or after July 8, 2010, and also included a new requirement for home health agencies and nursing home facilities to bill their services on the DFS-F5-DWC-90 (UB-04). Prior to this change, both provider types billed claims-handling entities on an invoice or business letterhead. The lack of a standard billing form combined with the absence of uniform instructions, made it impractical for the Division to require insurers to report medical claims data received from these providers. The changes will allow the Division to collect data on these services and determine relevant trends.

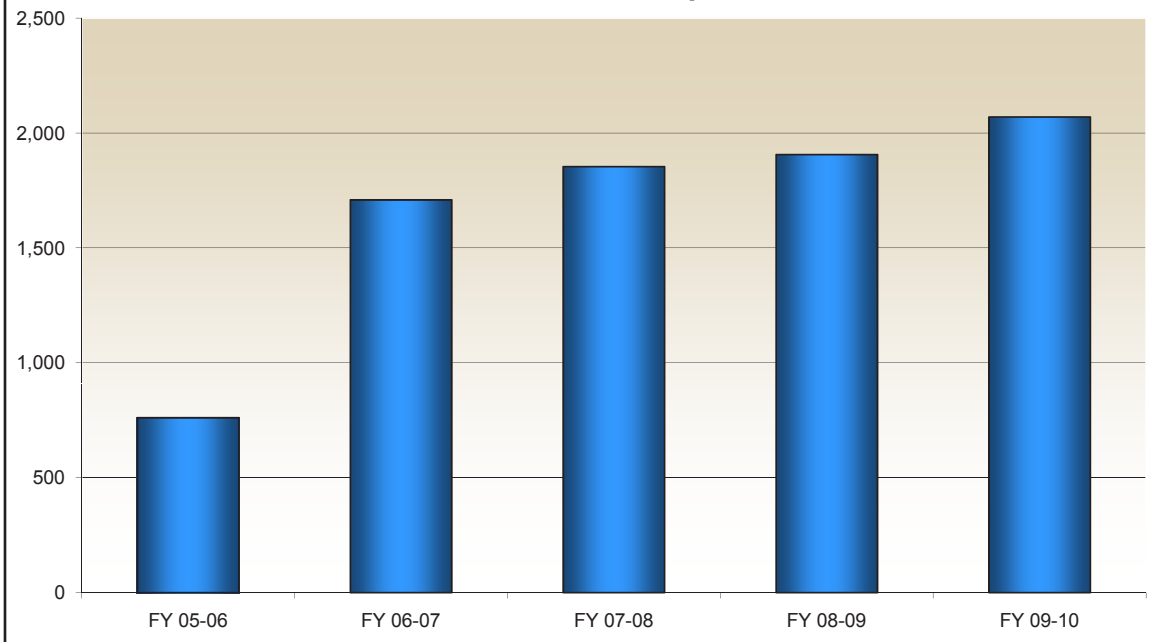
Resolution of Medical Reimbursement Disputes

OMS is responsible for resolving medical reimbursement disputes between health care providers and carriers. Disputes about

compensability and medical authorization are addressed by Judges of Compensation Claims. The following graphics provide an overview of the medical reimbursement dispute resolution process. References to the term “practitioner” in the graphics are to individual providers licensed by the Florida Department of Health to provide medical care who may bill for services provided either directly or through a supervising physician.

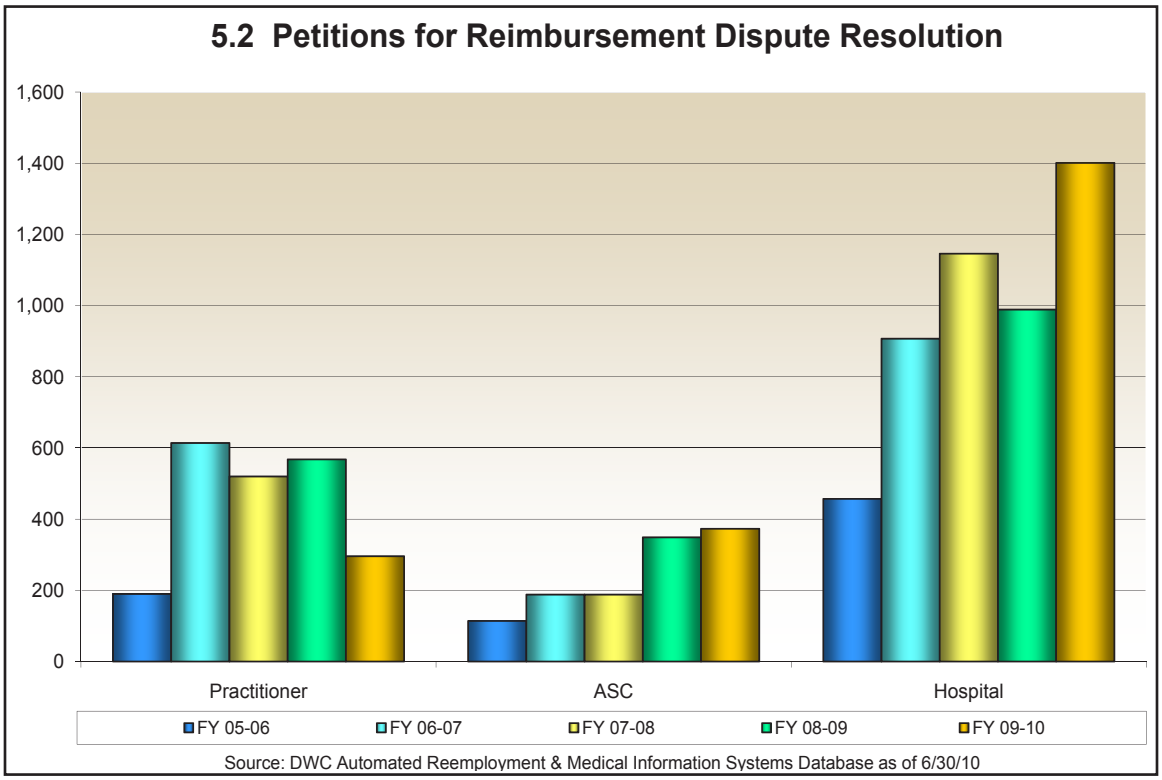
Graphic 5.1 illustrates the total number of Petitions for Resolution of Reimbursement Dispute submitted to OMS during the last five fiscal years. There was a significant increase in the number of petitions submitted in Fiscal Year 2006-2007 over the prior year and then a slight, but consistent increase in total petition submissions each year after that.

5.1 Petitions for Reimbursement Dispute Resolution Submitted

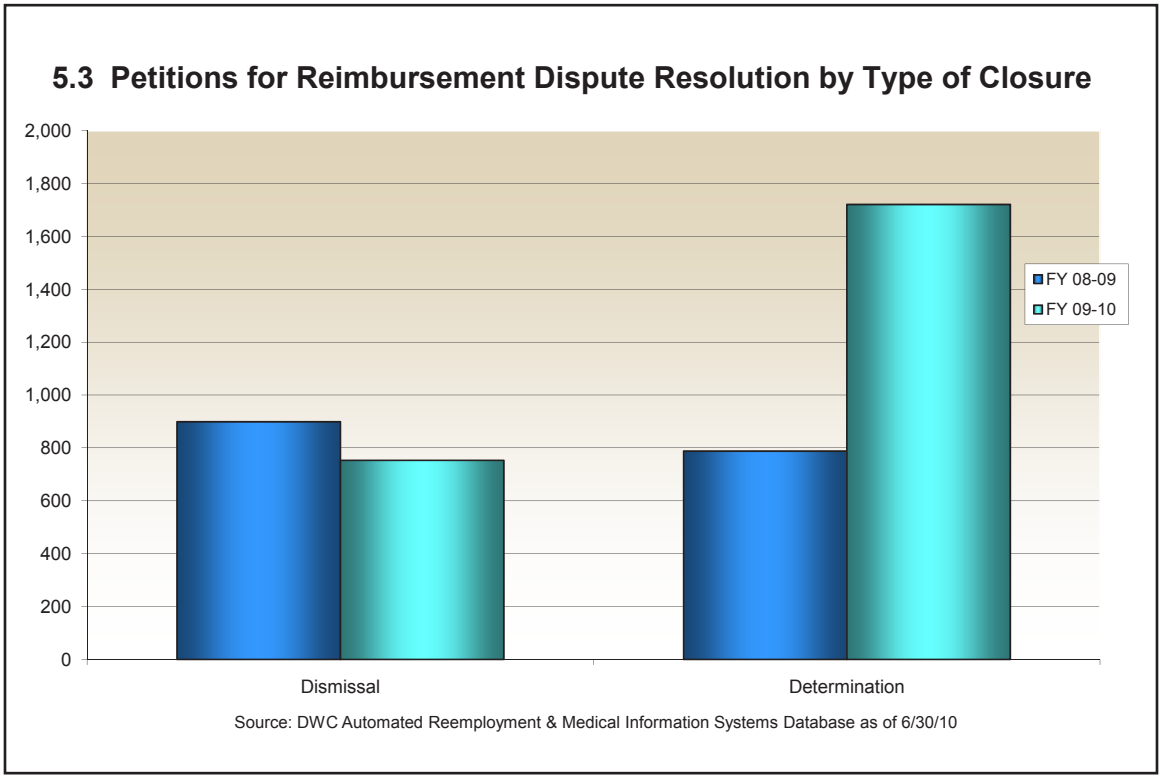


Source: DWC Automated Reemployment & Medical Information Systems Database as of 6/30/10

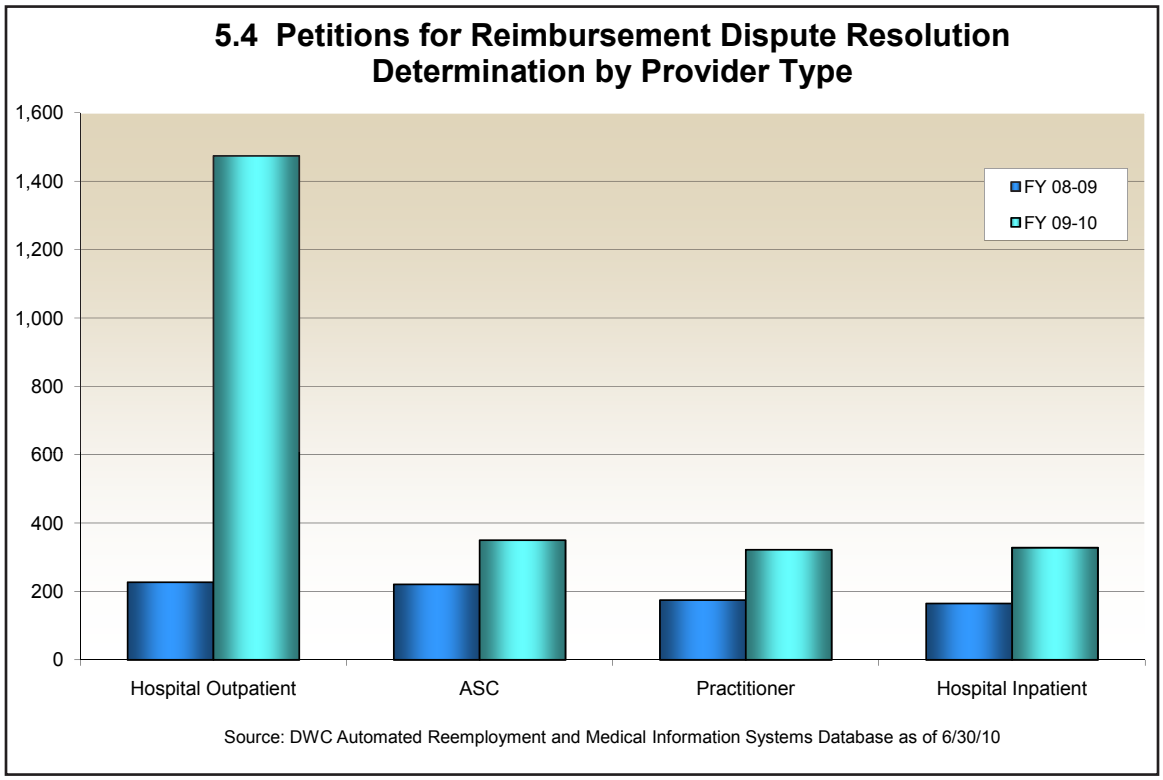
Graphic 5.2 illustrates, by provider type, the distribution of Petitions for Resolution of Reimbursement Dispute submitted during the last five fiscal years. This graphic shows that each year, the number of petitions submitted by hospitals exceeded the combined number of petitions submitted by the other two provider types. Of the 1,401 petitions submitted by hospitals during Fiscal Year 2009-2010, 1,071 were for outpatient services and 330 were for inpatient services.



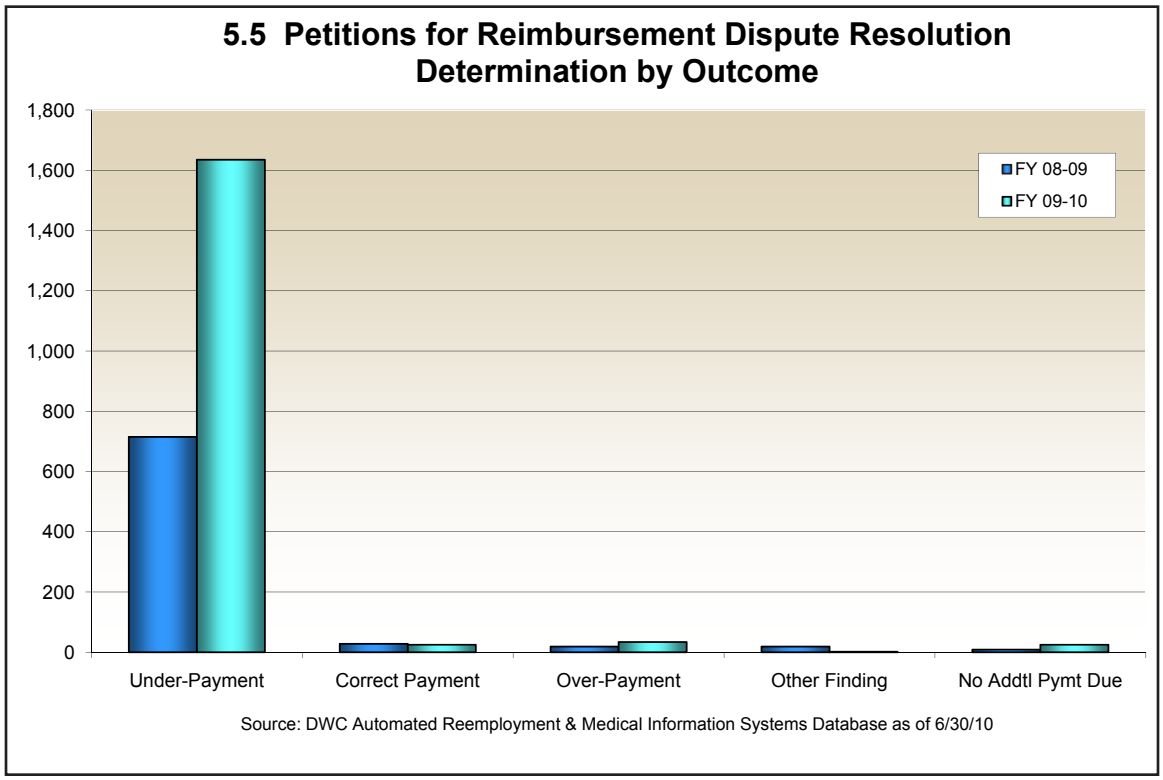
Graphic 5.3 presents the total number of Petitions for Resolution of Reimbursement Dispute closed during the last two fiscal years by type of agency action (dismissal or determination).



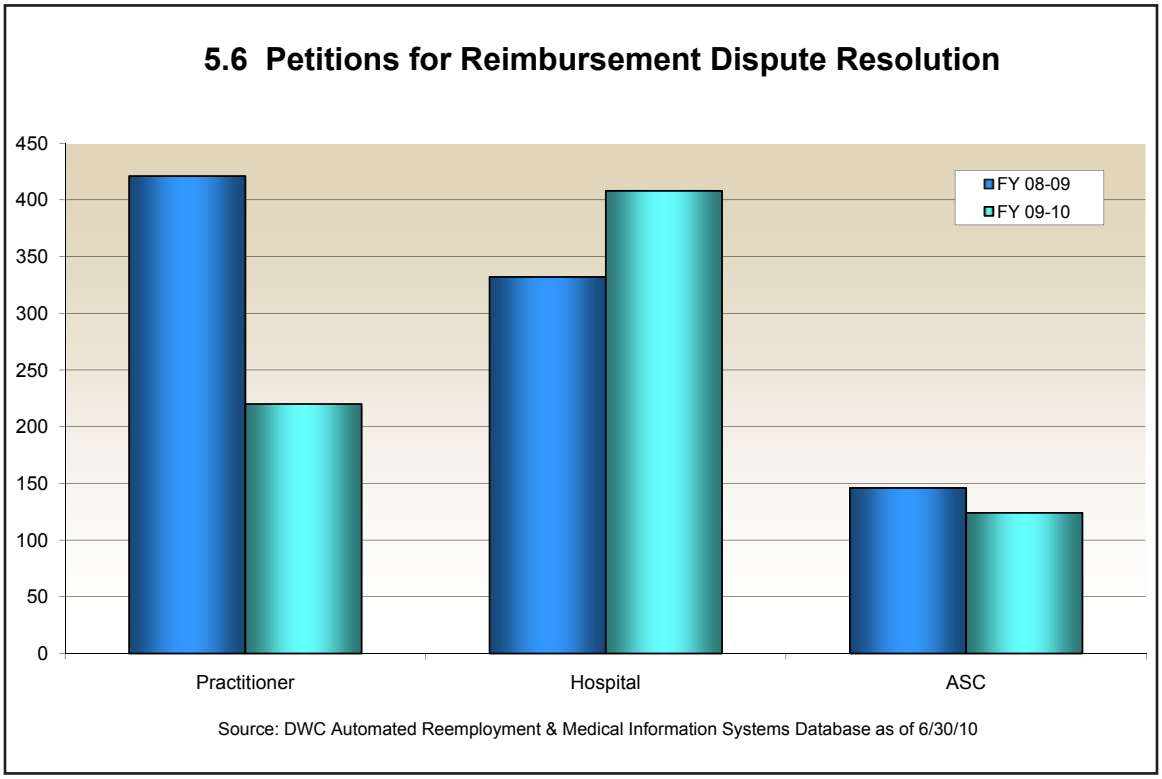
Graphic 5.4 illustrates the distribution of submitted Petitions for Resolution of Reimbursement Dispute, by provider type, for which a Determination was issued during Fiscal Year 2008-2009 and Fiscal Year 2009-2010.



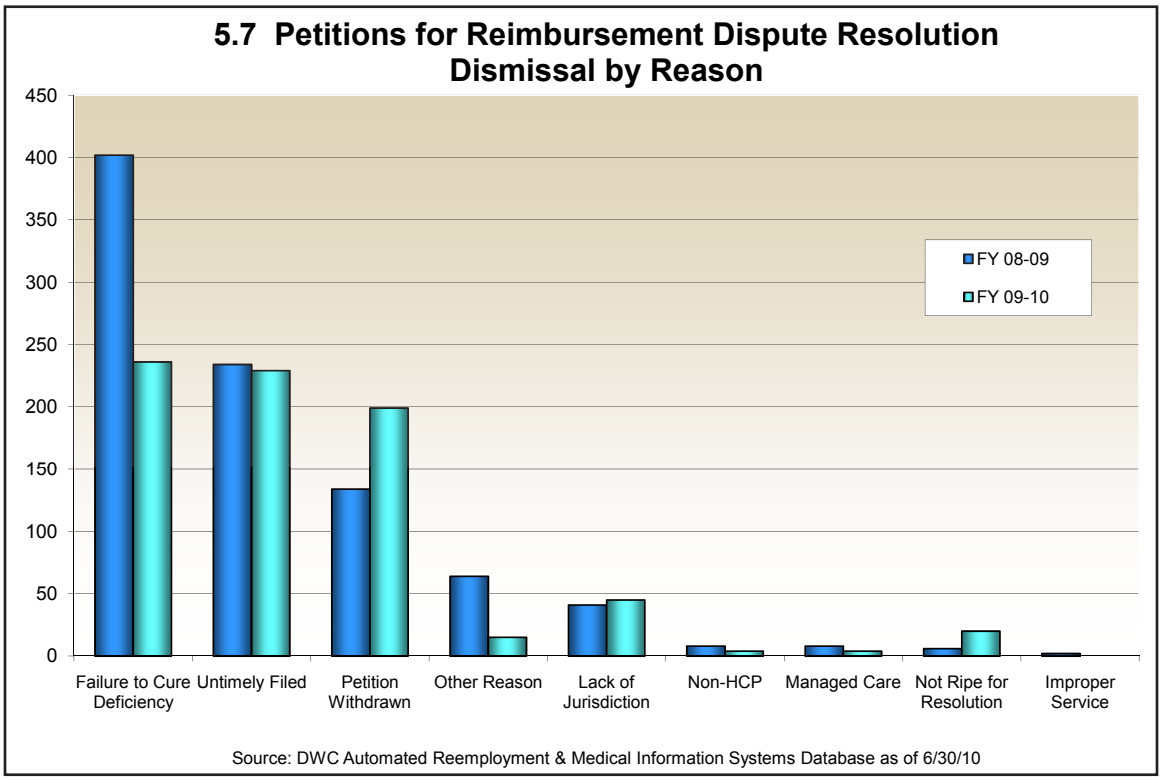
Graphic 5.5 illustrates the petitions for which a determination was issued during the last two fiscal years by determination outcome. OMS found that the petitioner had been underpaid in more than 95% of all determinations issued. However, the correct reimbursement amount is rarely the amount charged.



Graphic 5.6 illustrates, by provider type, the number of petitions that were dismissed during Fiscal Year 2008-2009 and Fiscal Year 2009-2010. There were 752 petitions dismissed during Fiscal Year 2009-2010. Of this total, 220 petitions were submitted by practitioners, 408 were submitted by hospitals, and 124 were submitted by ambulatory surgical centers (ASCs).



Graphic 5.7 illustrates, by reason, the number of petitions dismissed during the last two fiscal years. The graphic lists nine reasons that identify all dismissed petitions over the two most recent fiscal years. There were 147 fewer petitions dismissed during Fiscal Year 2009-2010 than during Fiscal Year 2008-2009.



Health Care Provider and Expert Medical Advisor Certification

OMS certifies health care providers so that they may provide workers' compensation medical services. This permits physicians and other recognized practitioners licensed by the Department of Health to participate in the Workers' Compensation System. As of June 30, 2010, there were 35,727 certified health care providers. OMS also certifies eligible health care providers as Expert Medical Advisors so that they may provide examinations and render expert testimony in OMS investigations and Office of the Judges of Compensation Claims proceedings. As of June 30, 2010, there were 127 certified Expert Medical Advisors.

Provider Investigations

Carriers are required to report overutilization to the Division which covers both recommended and provided services. Further, OMS is responsible for investigating alleged health care provider violations of Florida's Workers' Compensation Law or administrative rules. However, there is no administrative rule that governs the overutilization reporting or investigation. Therefore, OMS began rule development during Fiscal Year 2009-2010. This rulemaking has resulted in an increased number of carrier filed reports of overutilization and other provider violations. The review and investigation of these cases can be lengthy and complex as they involve the compilation and review of extensive medical records.

OFFICE OF MEDICAL SERVICES OVERUTILIZATION DETERMINATION

During a medical bill reimbursement dispute review, OMS staff determined there was a need to also review the case for overutilization of medical services by the certified medical provider who had prescribed the treatment at issue in the reimbursement dispute. The Provider Violations Section of OMS obtained an opinion by an Expert Medical Advisor and determined that the provider had prescribed treatment that was excessive or inconsistent with the standards of care and had engaged in overutilization of medical services. This Department action resulted in the prescribing provider being removed from the list of certified health care providers eligible to render workers' compensation care and barred the health care provider from any payment for future care rendered under the Workers' Compensation Law. This is the first overutilization determination and decertification action taken by the Department subsequent to the transfer of responsibility for workers' compensation medical services regulation to the Department in July 2008.

OFFICE OF SPECIAL DISABILITY TRUST FUND

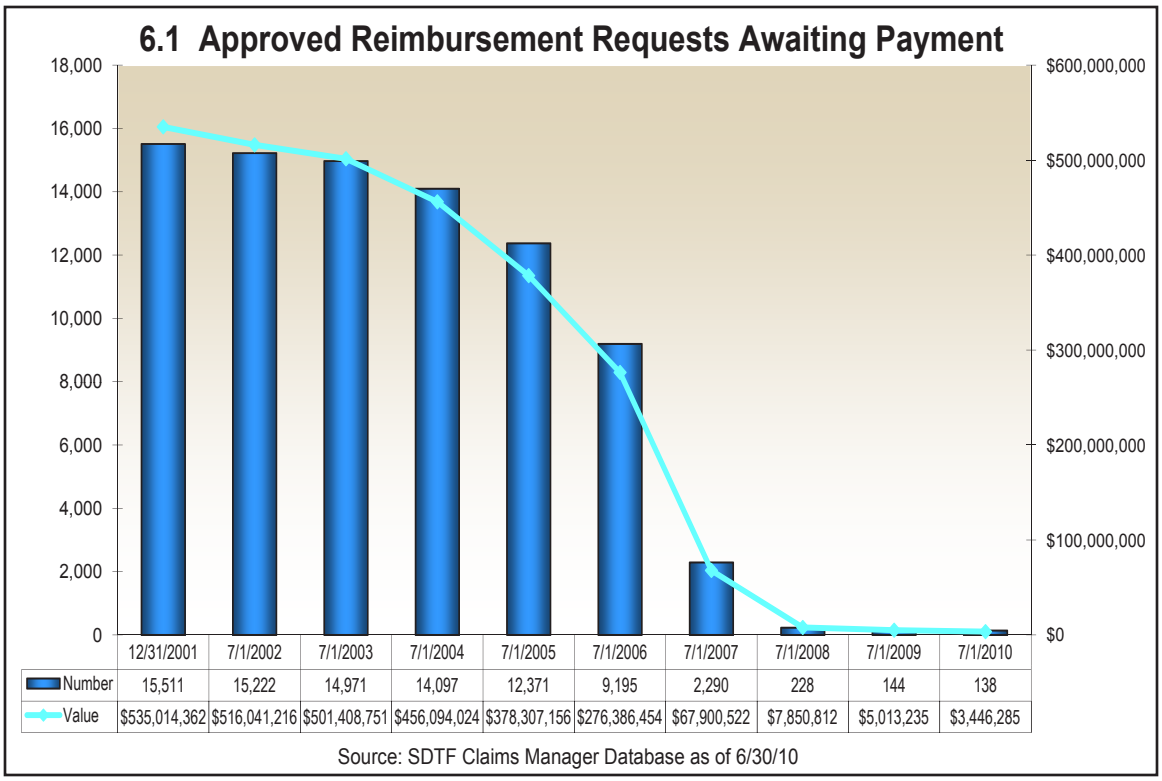
The Special Disability Trust Fund (SDTF) was created by the Florida Legislature in 1955 to encourage employers to hire and reemploy individuals with a pre-existing permanent physical disability by reimbursing the employer for excess costs if the employee experienced a new injury subsequent to being hired and the subsequent work-related injury resulted in a greater permanent impairment. Legislative changes in 1997 resulted in the SDTF being prospectively abolished and statutorily prohibited from accepting any new claims for dates of accident after December 31, 1997. However, in accordance with the statute, insurers continue to be assessed to fund the run-off claims.

The cost of operating the SDTF, including reimbursements to insurers, 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 formula for computing assessments is set by statute and from 1994 to 2010, insurers were assessed annually at 4.52%.

On May 7, 2010, the Department issued an SDTF Assessment Rate Order that reduced the assessment rate to 1.46% effective July 1, 2010, for all new and renewal premiums.

As a direct result of the prospective abolishment of the Fund, there has been a steady decline in the number of Proofs of Claims submitted. This changed the Fund's primary focus to claim reimbursement to employer/carriers. Presently, the SDTF has two main business processes: the determination of eligibility for reimbursement and the auditing and distribution of reimbursements. The SDTF reviews Proofs of Claim submitted by insurers to determine if they meet eligibility requirements for Fund recovery and then notifies the insurers whether the claims have been accepted or denied. The auditing and distribution of payments involves the review of Reimbursement Requests submitted by insurers on eligible claims. The payment of Reimbursement Requests is limited to those documented benefits related to the accepted claim and is the result of audits conducted and approved by the SDTF.

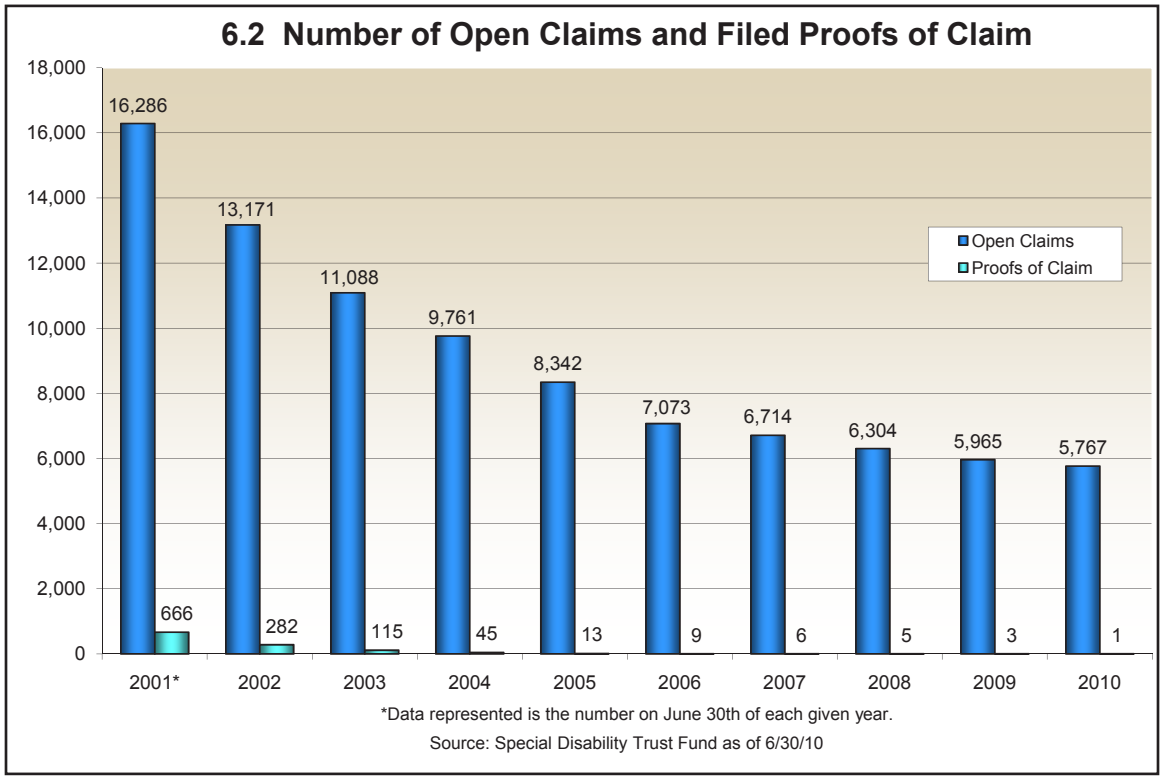
Graphic 6.1 Illustrates the number and amount of Reimbursement Requests approved and awaiting payment over time. Prior to 2002, there was not sufficient revenue from the statutorily capped assessment to fund all approved Reimbursement Requests, which resulted in a significant backlog until March 2008. Since March 2008, the SDTF has paid Reimbursement Requests as they have been approved.



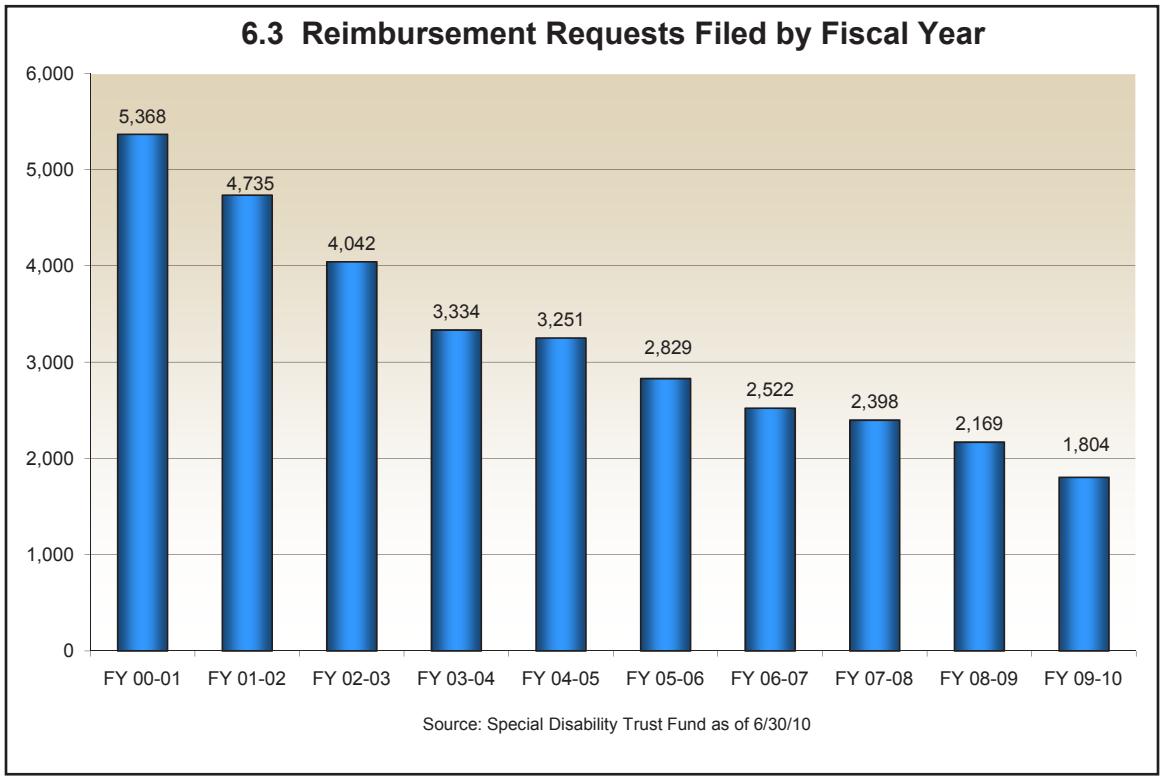
	12/31/2001	7/1/2002	7/1/2003	7/1/2004	7/1/2005	7/1/2006	7/1/2007	7/1/2008	7/1/2009	7/1/2010
Number	15,511	15,222	14,971	14,097	12,371	9,195	2,290	228	144	138
Value	$535,014,362	$516,041,216	$501,408,751	$456,094,024	$378,307,156	$276,386,454	$67,900,522	$7,850,812	$5,013,235	$3,446,285

Source: SDTF Claims Manager Database as of 6/30/10

There has also been a steady reduction in the number of open claims and filed Proofs of Claim. The number of open claims as of June 30, 2010, represents a decline of over 64.6% during the last ten years. **Graphic 6.2** shows the change in the number of Open Claims and the near cessation of Proof of Claim filings.



Graphic 6.3 shows the number of Reimbursement Requests filed per fiscal year which has also steadily declined. For Fiscal Year 2009-2010, the number of Reimbursement Requests filed was 1,804, down from 5,368 filed in Fiscal Year 2000-2001, which is a reduction of 66.4%.



The SDTF has always been very reliant on paper files and documentation. However, the SDTF began expanding the amount of documents converted to electronic images in order to conserve space, preserve records, and reduce the costs associated with the long-term storage of paper files. With the implementation of this successful imaging initiative in Fiscal Year 2009-2010, the Fund imaged 14,400 parcels of incoming and outgoing correspondence totaling 453,772 pages.

ASSESSMENTS AND FUNDING

The Division administers the Workers' Compensation Administration Trust Fund and the Special Disability Trust Fund, which includes the collection, validation, and audit of assessments from insurers and self-insurers.

The WCATF was formed for the purposes of administering the State's Workers' Compensation Law and is funded through a combination of assessments on workers' compensation insurance premiums, the collection of fines, penalties, fees, investment earnings, and other miscellaneous revenue. Among the expenses paid through this fund are administrative expenses of the Division of Workers' Compensation, permanent total disability supplemental benefit payments to eligible injured workers with dates of accident preceding July 1, 1984; the expenses of the Office of the Judges of Compensation Claims; and a portion of the expenses of the First District Court of Appeals, the Agency for Health Care Administration, the Department of Education, Division of Insurance Fraud, and the Department of Business and Professional Regulation.

The SDTF reimburses employers and their insurers for eligible second injury claims and is primarily funded through an annual assessment on premiums, which is supplemented by investment income and the collection of fees.

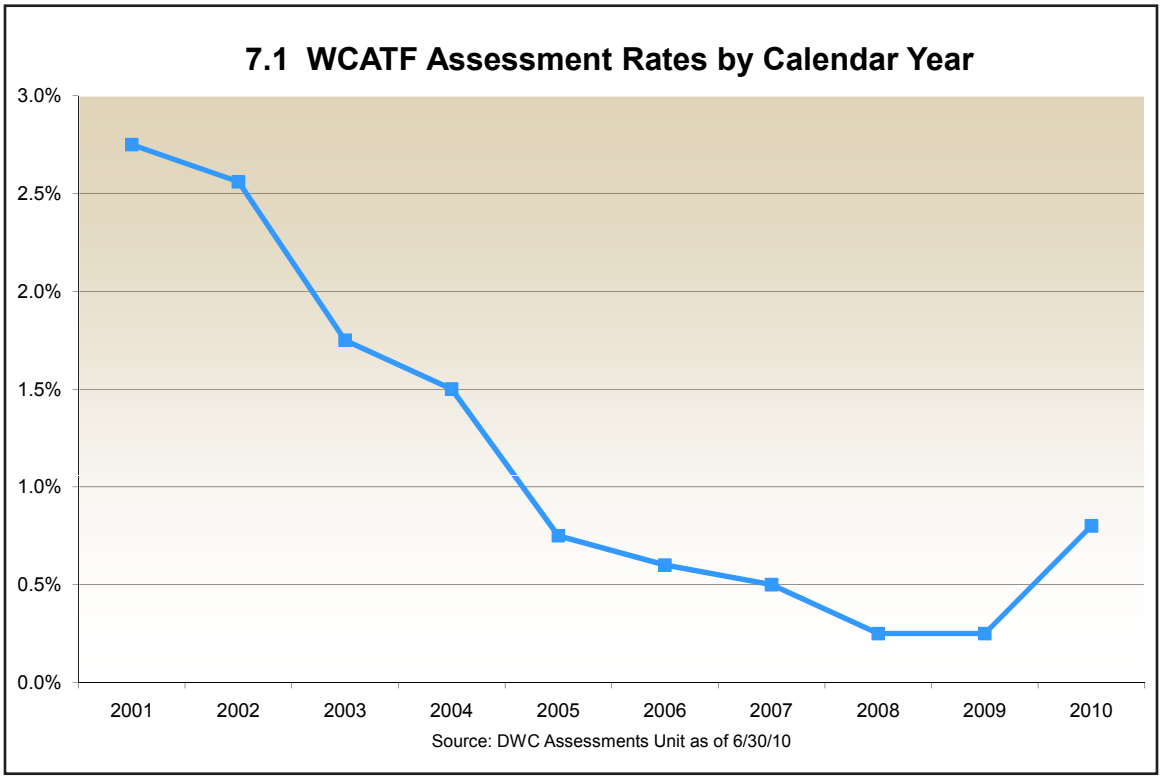
The Workers' Compensation Administration Trust Fund

Each year, the Division estimates the assessment rate necessary to fund the anticipated expenses for the upcoming calendar year. Any excess revenue or deficit from a given year is considered in the computation of the next calendar year's assessment rate analysis. After the Chief Financial Officer signs the assessment rate order, it is released to insurers and self-insurers. Florida Statutes require this notification be provided prior to July 1st.

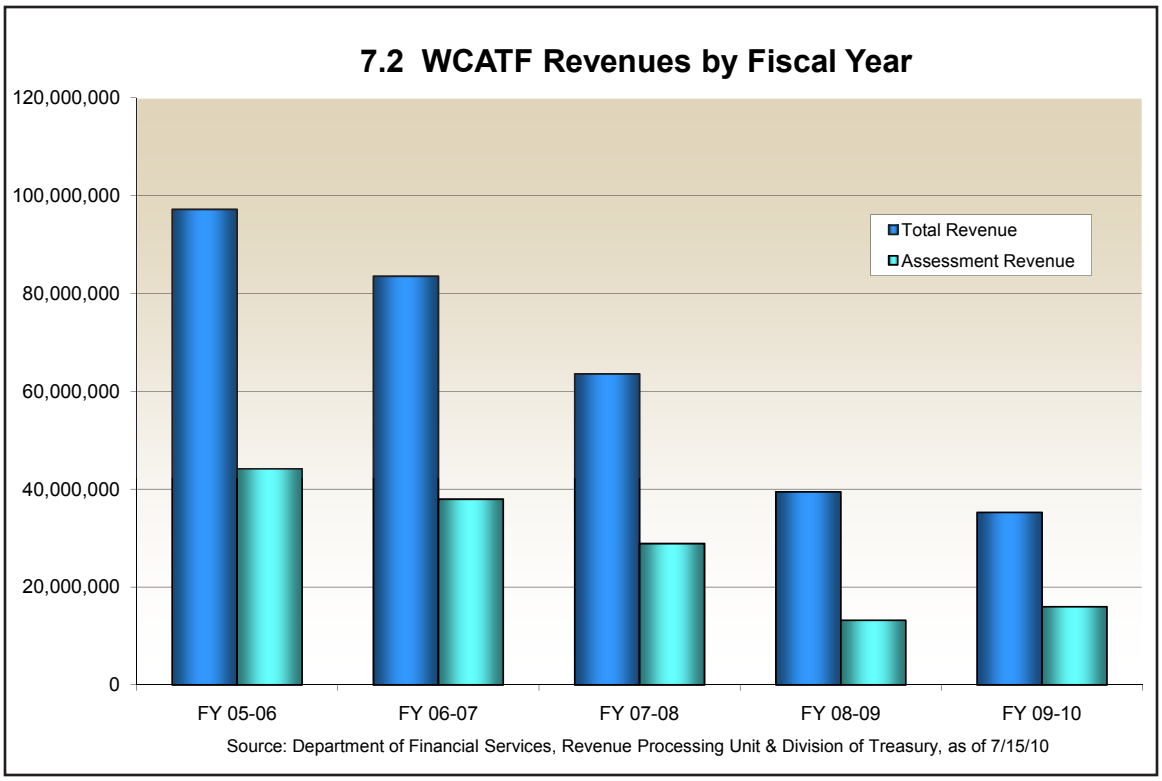
Beginning January 1, 2001, the WCATF assessment rate was capped at 2.75% of net premiums based on full policy premium values prior to the application of any deductible discounts. During the next nine calendar years (2001 – 2009), the WCATF assessment rate was decreased over time from 2.75% in 2001, to a low of 0.25% in 2008, where it remained for two years. The assessment decreases from 2001 to 2009 resulted in a 91% net cumulative decrease partially due to Fund surpluses and increased penalty revenue. Factors that contributed to the magnitude of the surplus included underestimation of the effect of inclusion of full policy premium values in the assessment base and monies set aside in consideration of pending refund lawsuits that were ultimately decided in the Division's favor in 2004. These surplus monies were used over time to maintain significantly lower assessment rates than would have otherwise been necessary to fund the expenses described above. Given the current level of workers' compensation premiums in Florida, a considerably larger assessment rate would have been required to fund the WCATF if surplus dollars had not been available to help fund the administration of the Workers' Compensation System. The current economic conditions impacting employment rates, payroll dollars, and ultimately reduced premiums, have accelerated the use of the surplus and necessitated an incremental increase to 0.8% for Calendar Year 2010.

The WCATF reserve, which was being used to subsidize the assessment rate, was subjected to an approximate $5 million legislative appropriation to general revenue, during Fiscal Year 2007-2008, and an additional $35 million appropriation to general revenue during Fiscal Year 2008-2009. (There was no similar appropriation during the 2010 legislative session.)

Graphic 7.1 illustrates the decline in the WCATF assessment rate since 2001.

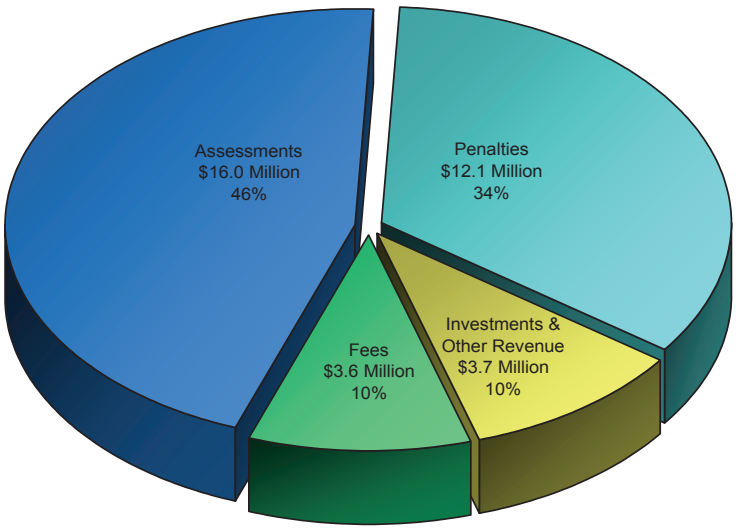


Graphic 7.2 summarizes the decline in WCATF total revenue and assessment revenue over the last five fiscal years.



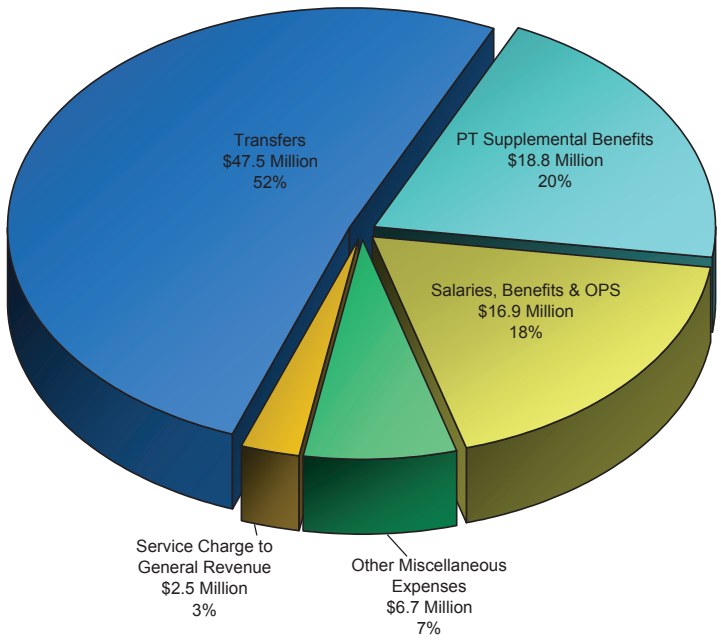
Graphic 7.3 and **Graphic 7.4** provide another view of the breakout of total revenues and disbursements for the WCATF during Fiscal Year 2009-2010.

7.3 WCATF Revenues FY 09-10



Source: Department of Financial Services, Revenue Processing Unit & Division of Treasury, as of 7/15/10

7.4 WCATF Disbursements FY 09-10



Source: Florida Accounting Information Resource (FLAIR) Database as of 7/15/10

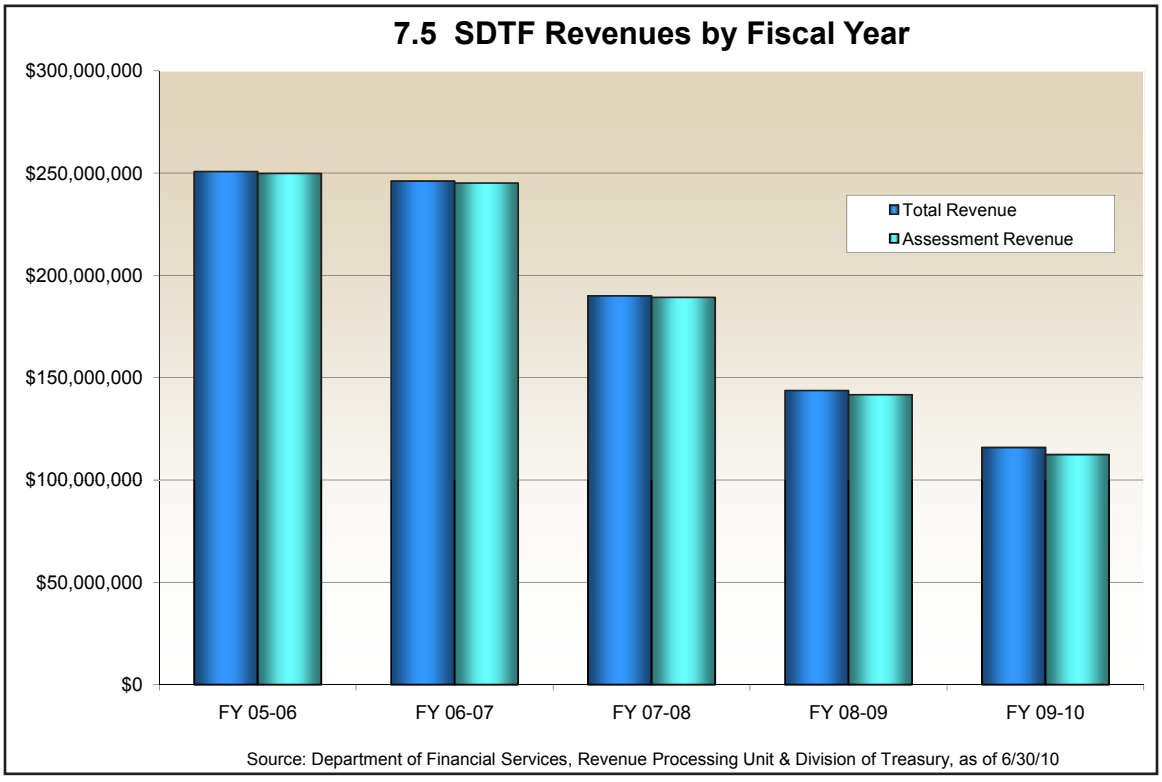
The Special Disability Trust Fund

The SDTF, Florida's Second-Injury Fund, was created in 1955 to encourage the hiring and reemployment of persons with disabilities. This purpose was accomplished by reimbursing employers and their carriers for the excess costs that resulted when workers with permanent disabilities were subsequently injured again at work. However, the SDTF was prospectively abolished in 1997 by the Legislature. While the SDTF continues to accept and reimburse eligible claims, the SDTF is prohibited from accepting or reimbursing any claim for dates of accident after December 31, 1997.

The SDTF is funded through assessments on workers' compensation premiums written by Florida carriers or calculated for authorized individual self-insured employers. The Department collects the SDTF assessment to fund the operations of the program.

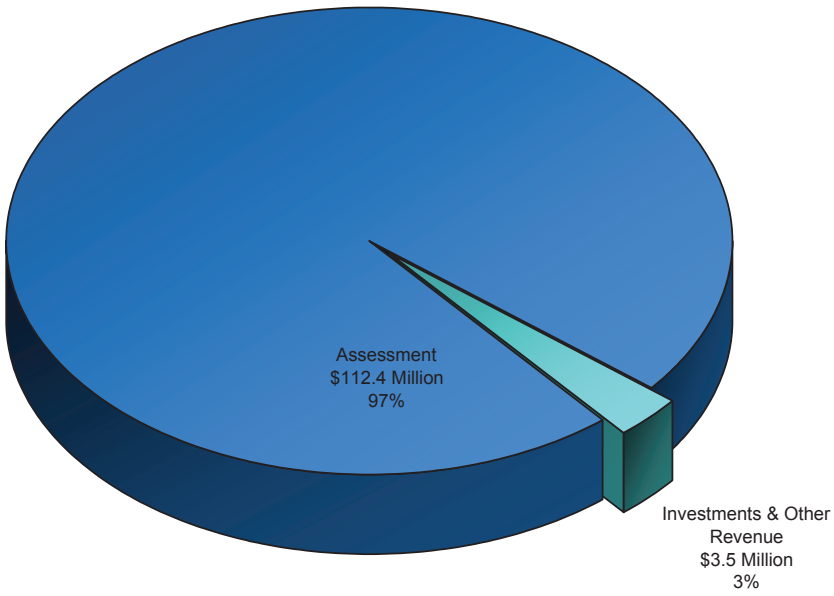
The SDTF assessment rate is set annually according to statutory formula and the assessment rate order had been issued annually at the same time as the annual WCATF assessment rate order. However, on May 7, 2010, the Department issued an SDTF Assessment Rate Order that reduced the assessment rate to 1.46% effective July 1, 2010 for all new and renewal premiums. The assessment rate is statutorily capped at 4.52% and has been levied at that rate since 1994. At a reduction of more than three percentage points, the 1.46% assessment rate for Fiscal Year 2010-2011 is the lowest assessment rate since Fiscal Year 1988-89. As a result of the reduced SDTF assessment rate, the Florida Office of Insurance Regulation approved a 4.2% reduction in approved manual workers' compensation rates effective July 1, 2010.

Graphic 7.5 illustrates SDTF total revenue and assessment revenue over the last five fiscal years.



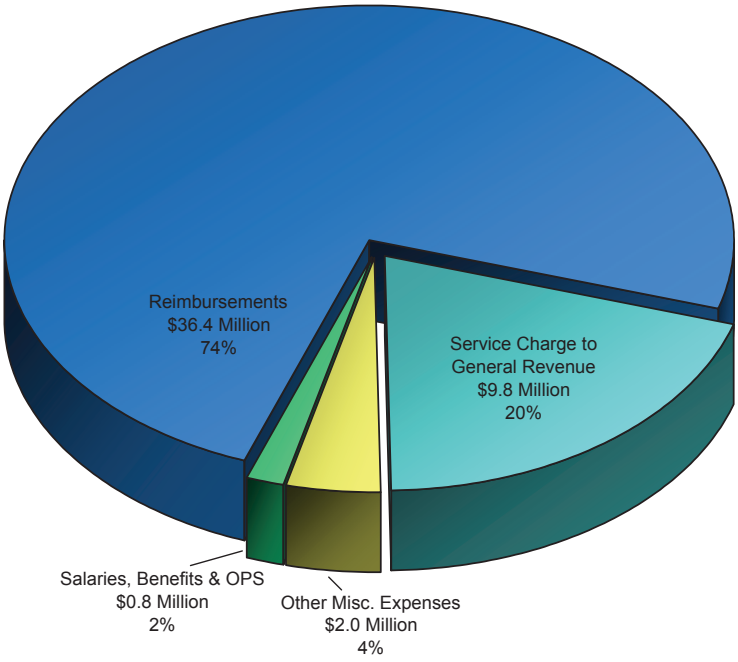
The SDTF assessment is collected to fund the reimbursements paid to employers and their carriers on eligible claims against the SDTF and the administrative expenses associated with the operation of the SDTF. **Graphic 7.6** and **Graphic 7.7** illustrate the breakout of total revenues and disbursements for the SDTF during Fiscal Year 2009-2010.

7.6 SDTF Revenues Fiscal Year 09-10



Source: Department of Financial Services, Revenue Processing Unit & Division of Treasury, as of 7/15/10

7.7 SDTF Disbursements Fiscal Year 09-10



Source: Florida Accounting Information Resource (FLAIR), as of 7/15/10

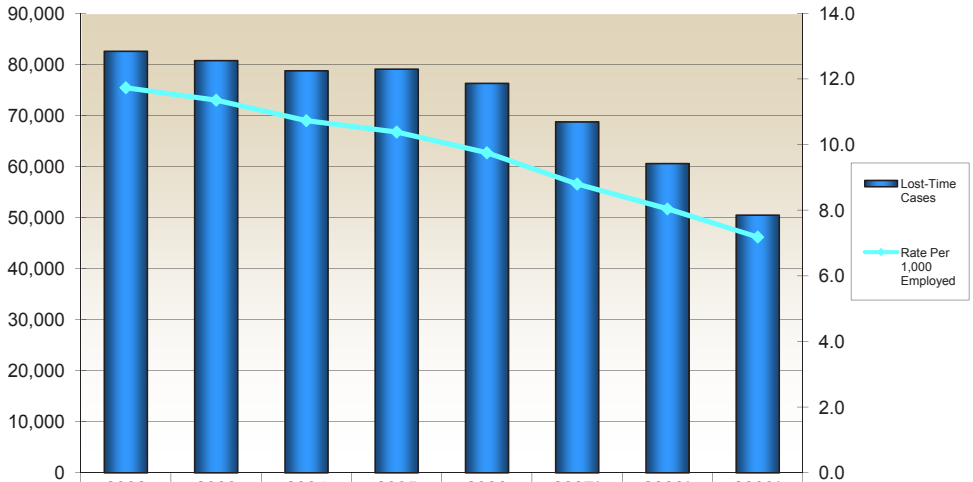
LOST-TIME CLAIMS DATA

Frequency and Rate of Lost-Time Claims

The frequency of lost-time claims continued to show a steady decline between Calendar Year 2002 and Calendar Year 2006 and the overall frequency decrease for that period of time was 7.6%. Frequencies for injury years after 2006 are preliminary in that the numbers will increase as additional accidents develop into lost-time cases. In addition to the number of lost-time cases currently reported for each accident year since Calendar Year 2002, **Graphic 8.1** provides the lost-time case rate per 1,000 employees.

During 2009, the rate of lost-time claims per 1,000 employees varied considerably throughout Florida, ranging from a low of 4.3 in Leon County to a high of 15.2 in Glades County. The number of statewide lost-time claims per 1,000 employees for 2009 was 7.2. Thirteen counties have lost-time case rates exceeding 10.0 cases per 1,000 employees. The statewide lost-time case rate per 1,000 employees shows a downward trend, dropping from 11.7 lost-time accidents per 1,000 employees in Calendar Year 2002 to 9.7 lost-time accidents per 1,000 employees in Calendar Year 2006, which is a 17.1% decrease in the lost-time case rate.

8.1 Lost-Time Cases and Lost-Time Case Rate**



	2002	2003	2004	2005	2006	2007*	2008*	2009*
Lost-Time Cases	82,568	80,732	78,740	79,064	76,279	68,740	60,569	50,475
Rate Per 1,000 Employed	11.7	11.4	10.7	10.4	9.7	8.8	8.0	7.2

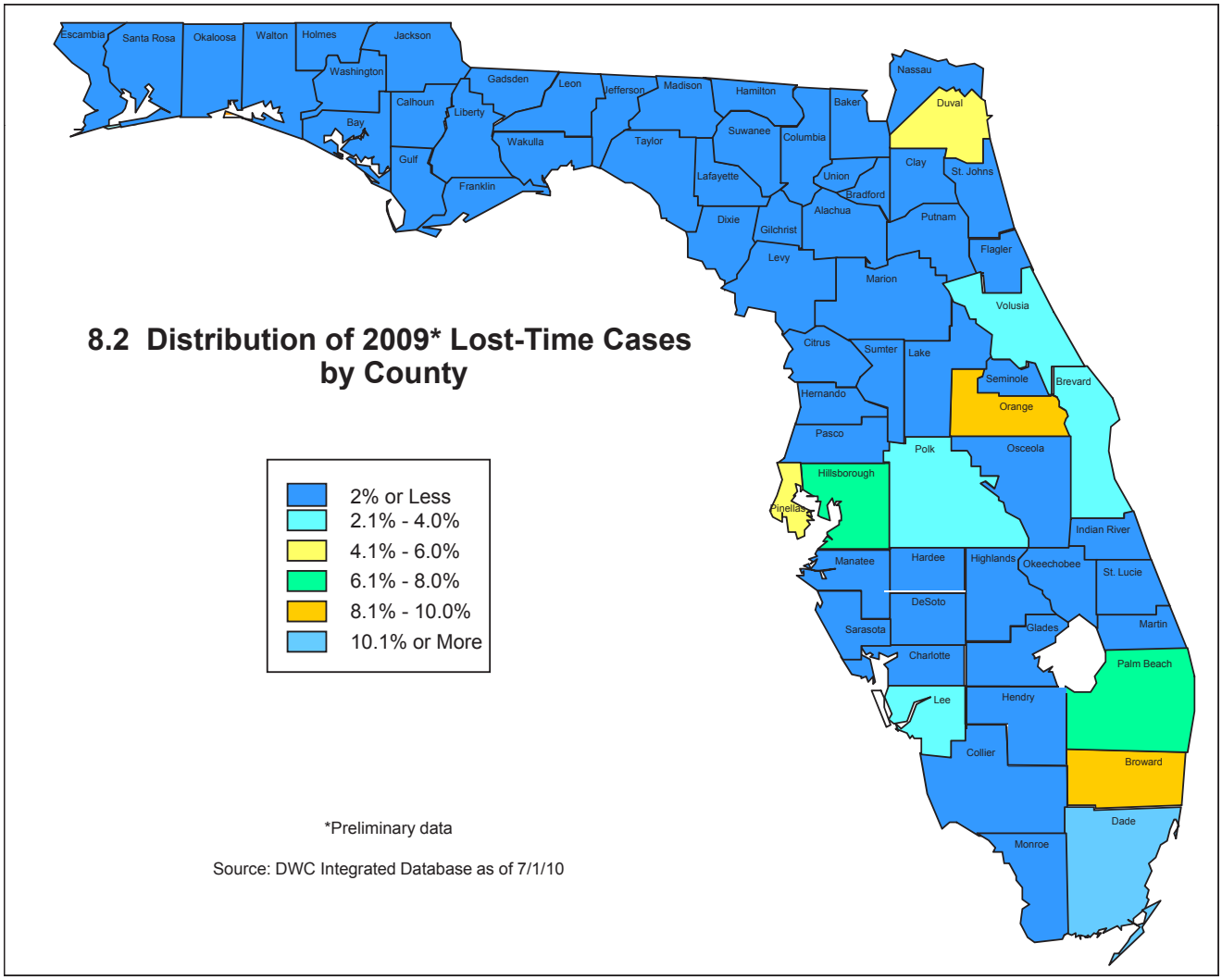
*Preliminary data

**Lost-time claim frequencies are as of 7/1/10, based on the most recent information from insurers about determinations & dispositions.

Source: DWC Integrated Database as of 7/1/10 & the Agency for Workforce Innovation, 2002-2010 Statewide Quarterly Census of Employment & Wages (QCEW) (excluding federal government employment) released July 2010

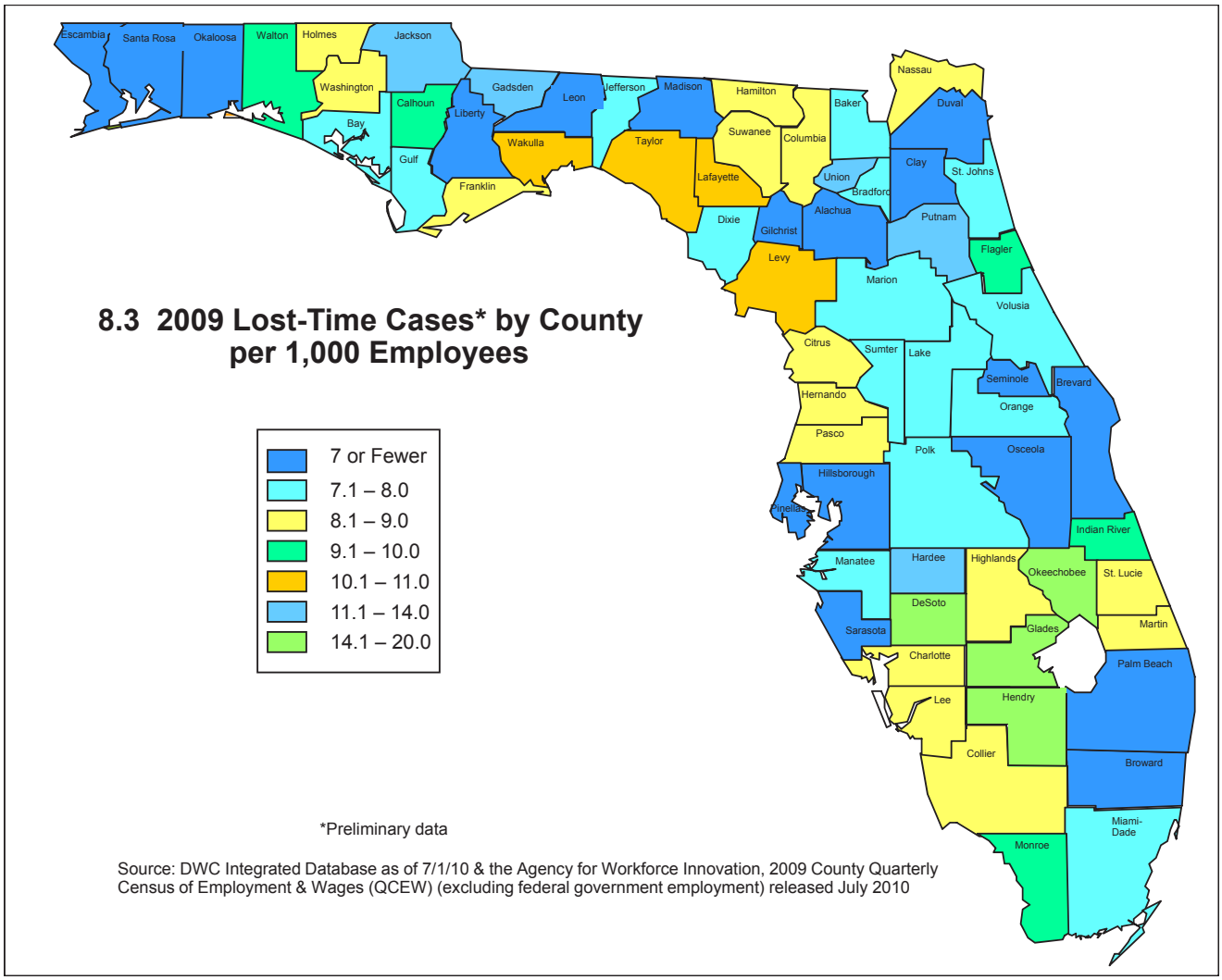
Geographic Distribution of Lost-Time Cases

The next two graphics illustrate the geographic distribution of lost-time cases as a percent of total cases reported and the rate of lost-time cases per 1,000 employees for each county. **Graphic 8.2** shows that lost-time accidents tend to occur most frequently in regions with a larger number of employed persons. For example, Miami-Dade County, with the largest workforce in the State, accounted for the largest number of lost-time cases reported for a single county in Calendar Year 2009.

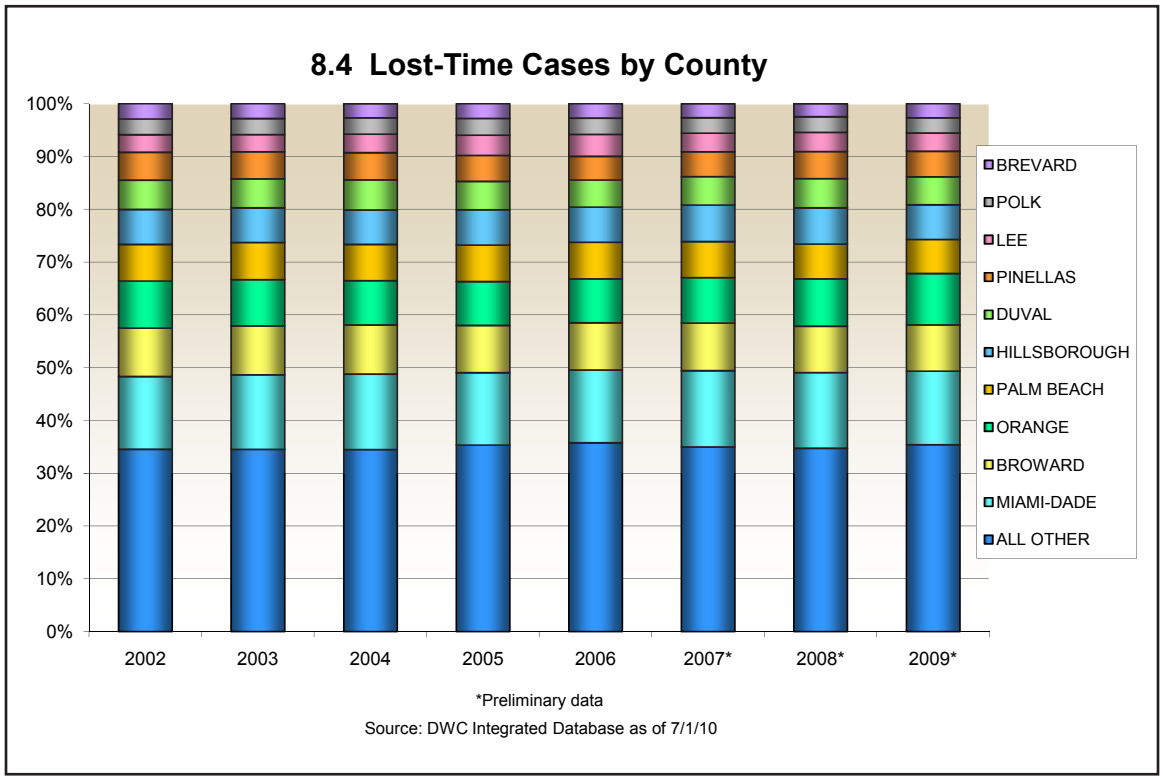


However, when compared to the size of its workforce, the lost-time case rate for Miami-Dade County in Calendar Year 2009 was a relatively modest 7.1 cases per 1,000 employees as illustrated in **Graphic 8.3**. Numerous counties in Florida with the largest concentrations of employment had lost-time rates below the statewide rate of 7.0 per 1,000 employed. Duval, Pinellas, Hillsborough, Palm Beach, and Broward Counties are all examples of this pattern.

Counties with smaller workforces may show a higher lost-time case rate even though the actual number of reported lost-time cases is relatively small. Glades, Desoto, Okeechobee and Hendry have a comparatively small workforce. Lost-time case rates in these four counties ranged between 14.1 and 15.2 per 1,000 employees. Counties with higher concentrations of public employees tend to have somewhat lower lost-time case rates, such as Leon County, which had a lost-time case rate of 4.3 per 1,000 employees.



Graphic 8.4 illustrates that the relative concentration of lost-time cases among Florida's counties has remained relatively consistent from year to year. The larger and more populous counties of the state contribute the most to lost-time case counts, accounting for 64.6% of the total cases in Calendar Year 2009.



Prior Claims

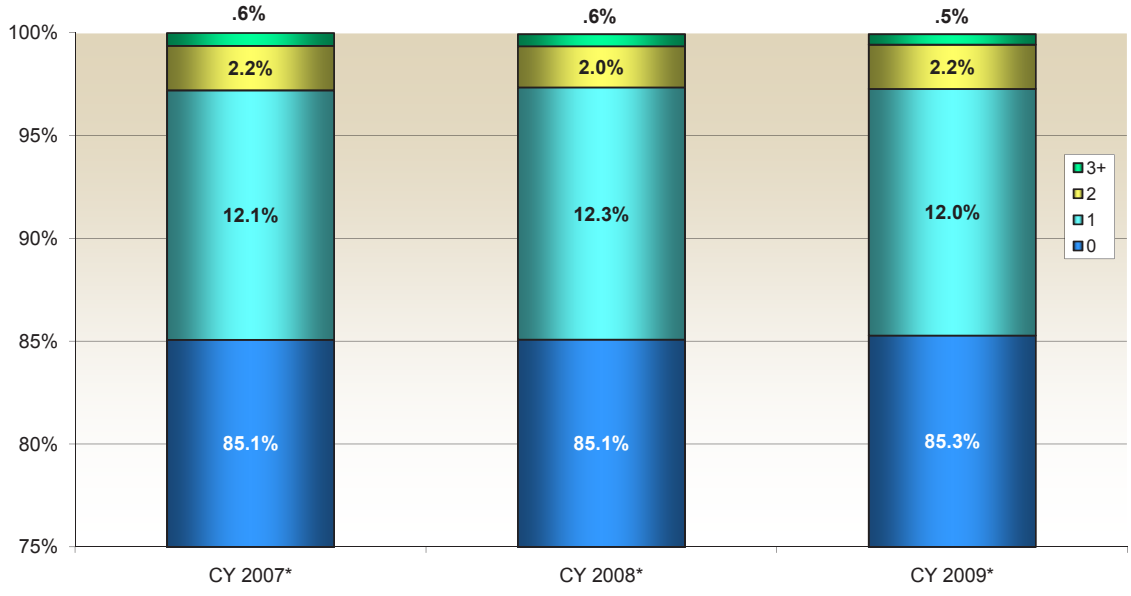
For the past three years, 85% of injured workers reported no additional lost-time claims within the preceding five calendar years. An additional 12% of injured workers reported one additional lost-time claim over the same period. The remaining 3% of lost-time claimants filed at least two additional claims in the preceding five calendar years. **Graphic 8.5** shows that this pattern has been consistent since Calendar Year 2007.

Insurer Type

Within the Workers' Compensation System, three types of insurers dominate the market: commercial insurers, self-insured employers, and self-insurance funds. Florida's self-insured employers include large employers such as municipalities, school districts, large hospitals, large retail operations, energy and waste management companies, and large transportation companies. The relative share of lost-time cases handled by each of these three types of insurers over the past eight years is depicted in **Graphic 8.6**.

As this graphic illustrates, commercial insurers continue to dominate the workers' compensation insurance market, and have been responsible for the bulk of lost-time claims over the past eight years. However, from Calendar Year 2002 to Calendar Year 2006, the claim share for commercial insurers declined from 79.7% to 75.2% of the claims. Self-insured employers and self-insurance funds have shared, almost equally in small, offsetting gains for the same period.

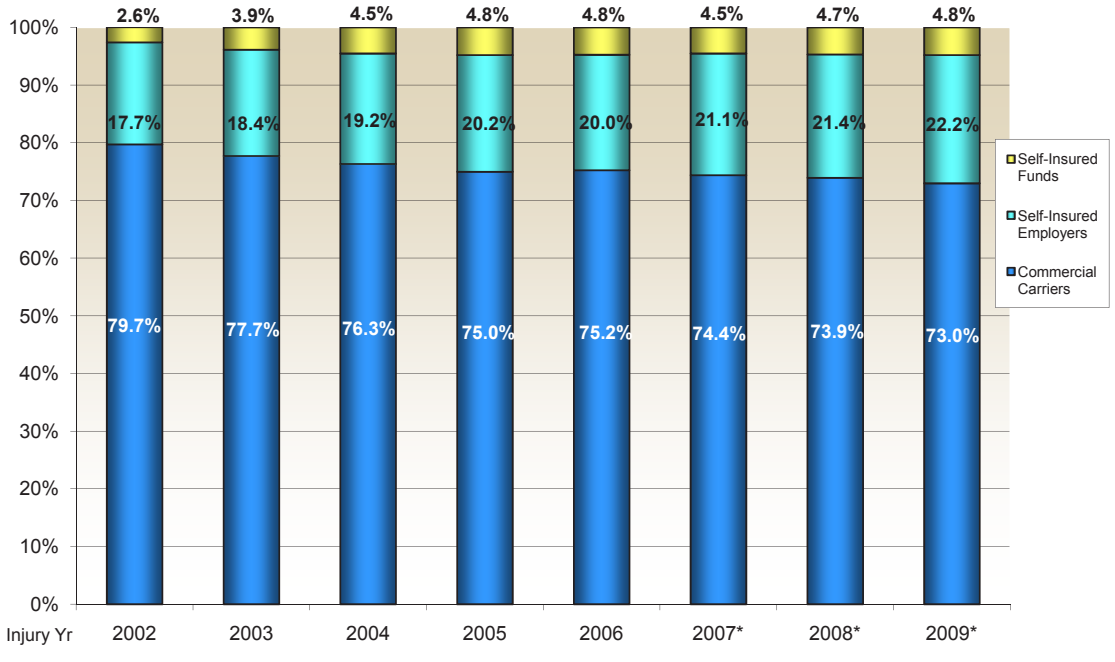
8.5 Prior Lost-Time Claims within Five Years Among Injured Workers with Lost-Time Claims



*Preliminary data

Source: DWC Integrated Database as of 7/1/10

8.6 Distribution of Lost-Time Cases by Insurer Type



*Preliminary data

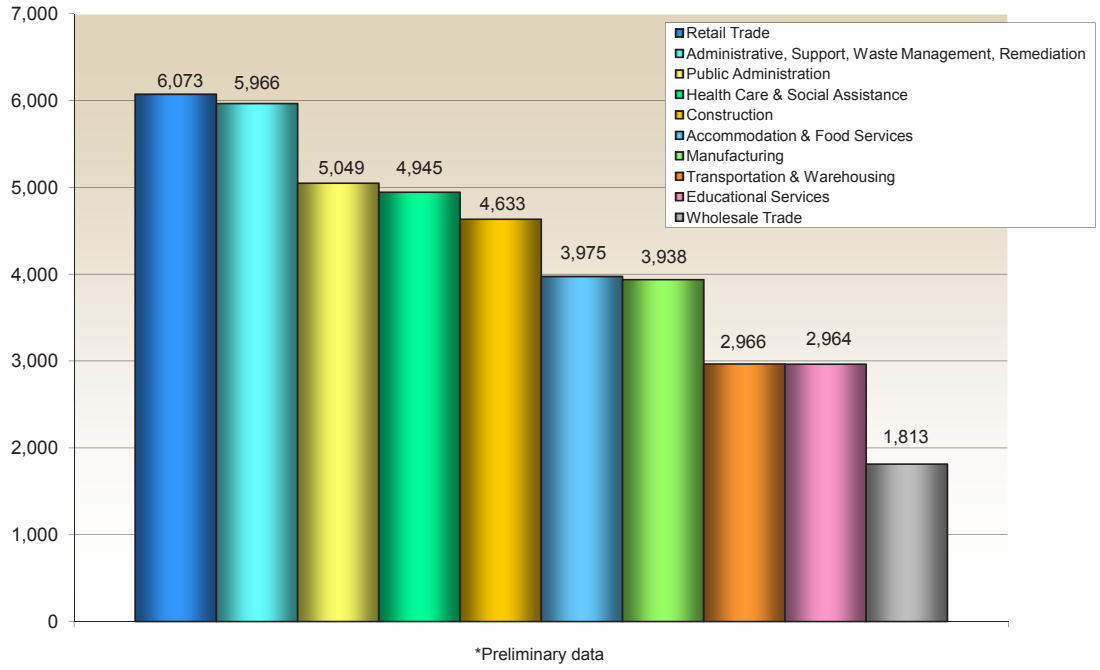
Source: DWC Integrated Database as of 7/1/10

Industry Type

Graphic 8.7 provides the frequency of 2009 lost-time cases for the top ten industry classifications, based on the North American Industry Classification System (NAICS). These classifications were reported on 99.5% of First Reports of Injury or Illness for Injury Year 2009. It is possible that the ordering may shift somewhat as new or updated Calendar Year 2009 accident information is reported to the Division.

In Calendar Year 2009, most lost-time injuries occurred in the Retail Trade sector which has been consistent since 2007. For the second year in a row, injuries for the Administrative, Support, Waste Management & Remediation sector ranked second, while Construction injuries, for the first time, declined to fifth place for frequency. The top ten industrial classifications represent 83.9% of all lost-time cases reported.

Graphic 8.7 Top Ten Industrial Classifications for 2009* Lost-Time Cases



*Preliminary data

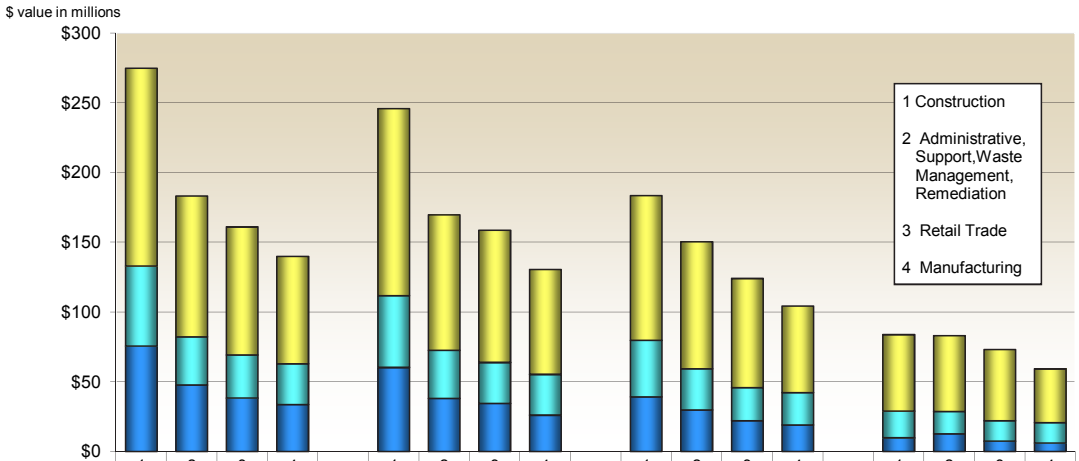
Source: DWC Integrated Database as of 7/1/10

Graphic 8.8 presents the benefit costs for each of the three major benefit types for the top four major industrial classifications by frequency. This graphic illustrates claim development and reflects benefits paid on each accident year's injuries, reported as of July 1, 2010. Despite the decline in the number of injuries, construction-related injures continue to rank among the most expensive, in terms of both medical, indemnity, and settlement benefits paid.

Benefits Paid

Florida's Workers' Compensation Law operates to ensure that any covered employee who is injured in the course of employment be provided with medical benefits for such period as the nature of injury or the process of recovery may require, and be compensated in accordance with statutory provisions for wages lost as a result of the injury. Compensation for lost wages depends on many factors including the injured employee's wage history, the nature and extent of injury, and return to work status. Medical benefits may include payments to physicians and other authorized health care providers; payments to facilities such as hospitals, ambulatory surgical centers, or skilled nursing facilities; and all medically necessary medicines, supplies, equipment, and apparatus including prosthetic devices, implants, and dental care. In addition, some or all of indemnity or medical benefits owed may be paid out in a lump sum settlement. The next three graphics all display data for lost-time cases for all injury years as of July 1, 2010, to illustrate the impact of claim development over time.

8.8 Benefit Payments for the Four Leading Industrial Classifications



	2006				2007*				2008*				2009*			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Medical	$141.	$101.	$91.8	$76.9	$134.	$97.1	$94.7	$75.2	$103.	$91.0	$78.2	$62.1	$54.7	$54.3	$51.1	$38.5
Indemnity	$57.4	$34.5	$30.9	$29.3	$51.5	$34.4	$29.4	$29.3	$40.3	$29.5	$23.6	$23.3	$19.2	$16.0	$14.6	$14.8
Settlement	$75.7	$47.7	$38.3	$33.7	$60.3	$38.2	$34.6	$26.1	$39.3	$29.9	$22.2	$19.0	$9.8	$12.8	$7.4	$6.0

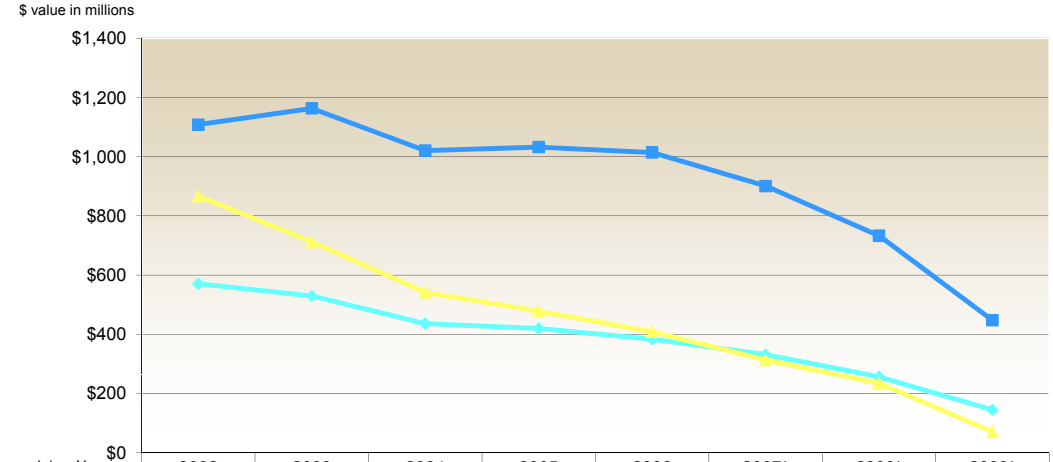
Injury Yr

*Preliminary data

Source: DWC Integrated Database and Medical Data Warehouse as of 7/1/10

Graphic 8.9 shows total payments for medical and indemnity benefits and settlements over time for all lost-time cases. While the graphic does show that the amount paid for medical benefits is three times as much as indemnity benefits for injuries that occurred in 2009 and more than two and a half times as much as 2007 and 2008, these are largely a factor of development since most medical benefits are paid earlier in the life of the claim. These proportions will likely decrease over time to a little more than twice the amount of indemnity benefits. The benefit amounts shown have not been adjusted for inflation.

8.9 Cumulative Medical, Indemnity, and Settlement Costs for Lost-Time Cases

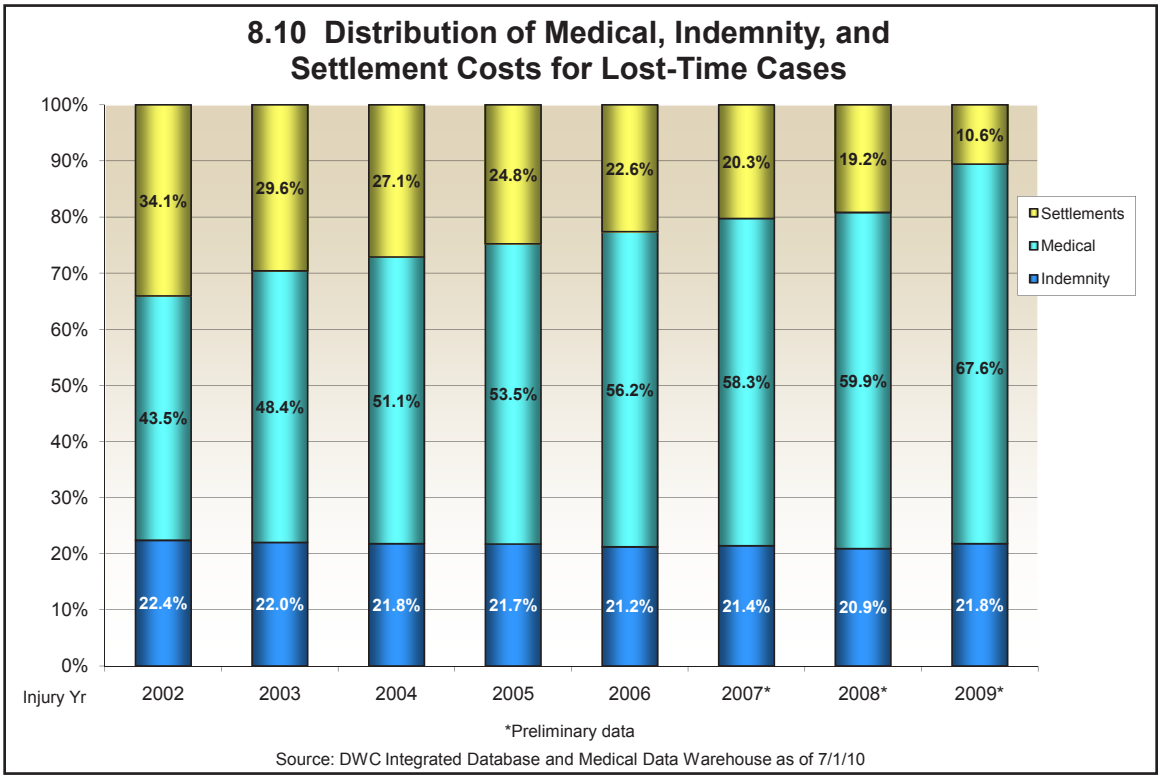


Injury Yr	2002	2003	2004	2005	2006	2007*	2008*	2009*
Medical	$1,108.2	$1,163.3	$1,020.5	$1,032.5	$1,014.1	$900.7	$732.8	$447.2
Indemnity	$570.3	$529.3	$435.6	$419.4	$383.6	$331.2	$256.0	$144.1
Settlements	$866.6	$711.4	$541.7	$478.0	$408.2	$312.8	$234.4	$69.9

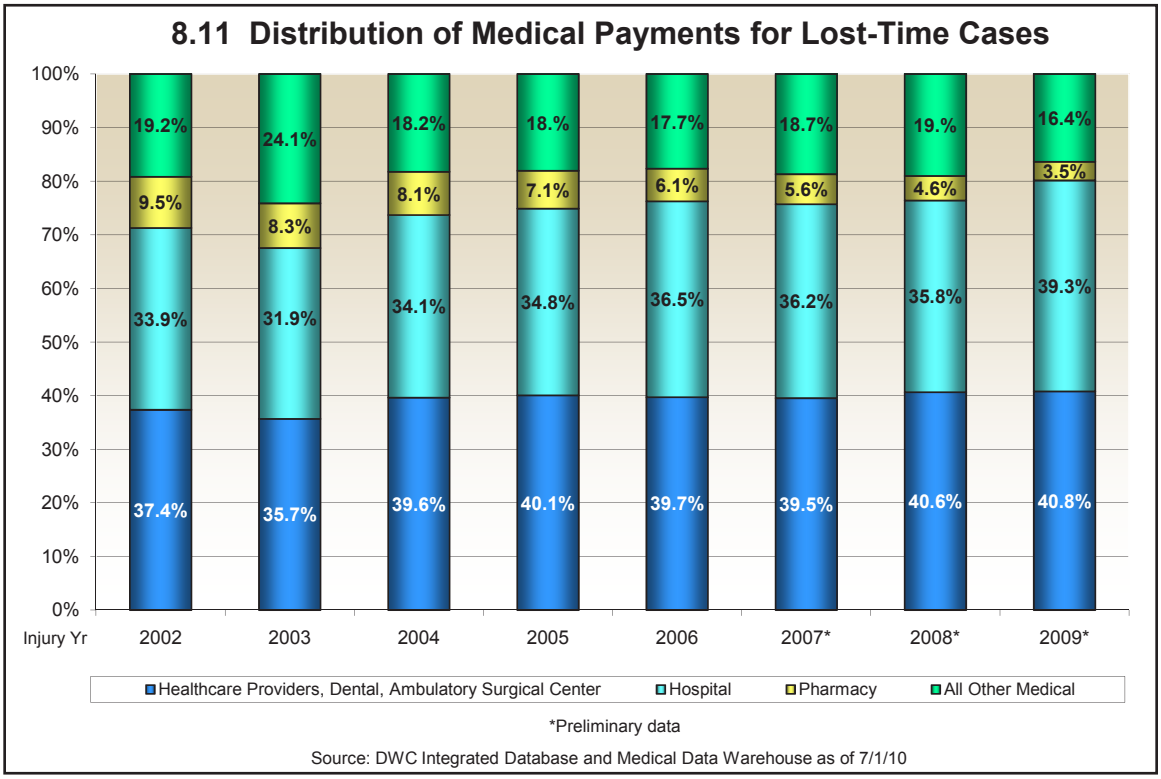
*Preliminary data

Source: DWC Integrated Database & Medical Data Warehouse as of 7/1/10

Expressed as a percent of total benefits paid, **Graphic 8.10** illustrates another perspective on claim development, showing a larger percentage of medical benefits for immature cases.



Graphic 8.11 illustrates in more detail the relative proportion of different medical cost components over time. As a percent of total medical benefits paid, amounts paid to the combination of health care providers, ambulatory surgical centers, and dentists comprised the largest share of total medical benefits paid during each injury year from Calendar Year 2002 through Calendar Year 2009. This is followed closely by amounts paid to hospitals. As a component of overall claim costs, the proportion of medical benefits decreases over time (as shown in **Graphic 8.10** above), while the individual components of medical benefits are relatively consistent over time as shown in **Graphic 8.11.**



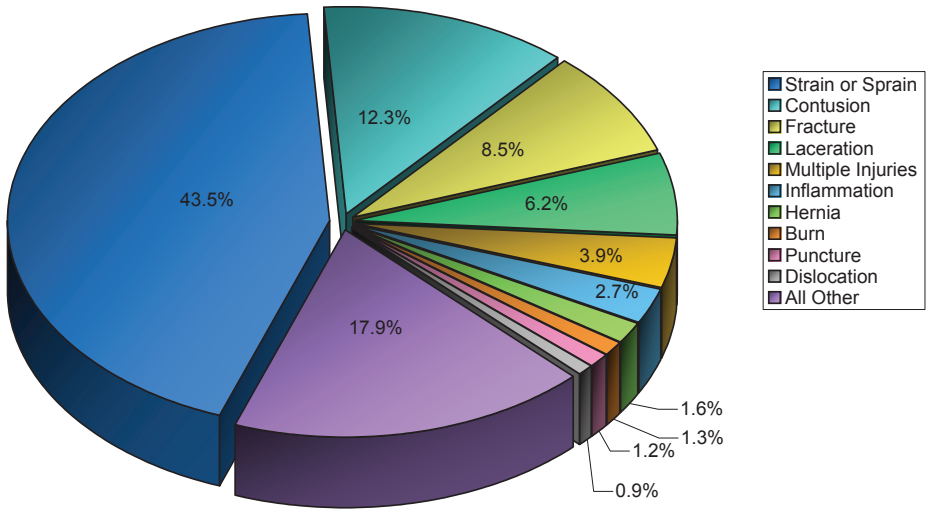
NATURE, CAUSE, AND BODY LOCATION OF WORKPLACE INJURIES

Nature of Injury

Among the many different types of injuries an employee can potentially suffer while on the job, there are several which consistently rank among the leading injury types that result in a lost-time claim. **Graphic 9.1** illustrates the leading injury types among the lost-time cases reported to employers in Calendar Year 2009.

Strain and Sprain injuries accounted for 43.5% of Calendar Year 2009's lost-time accidents. The Strain and Sprain category is followed by Contusion (12.3%), Fracture (8.5%), and Laceration (6.2%), in terms of relative prevalence. These four injury types alone account for more than 70% of all lost-time injuries. It is possible that these rankings may change slightly in the future as additional information for Calendar Year 2009 accidents is reported and the data mature.

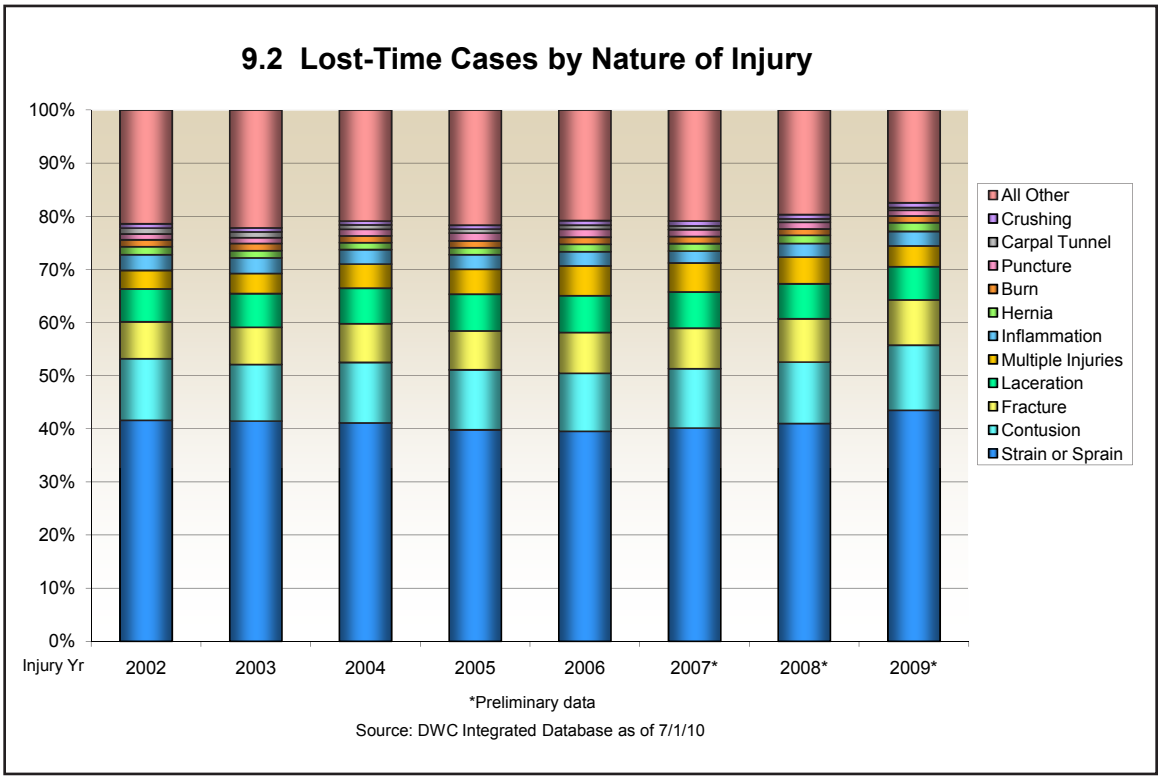
9.1 2009* Lost-Time Cases by Nature of Injury



*Preliminary data

Source: DWC Integrated Database as of 7/1/10

Graphic 9.2 provides a historical perspective of the relative prevalence of these various injury types among lost-time claims for each injury year between Calendar Year 2002 and Calendar Year 2009. The distribution of injuries by their specific natures did not change appreciably from one year to the next.

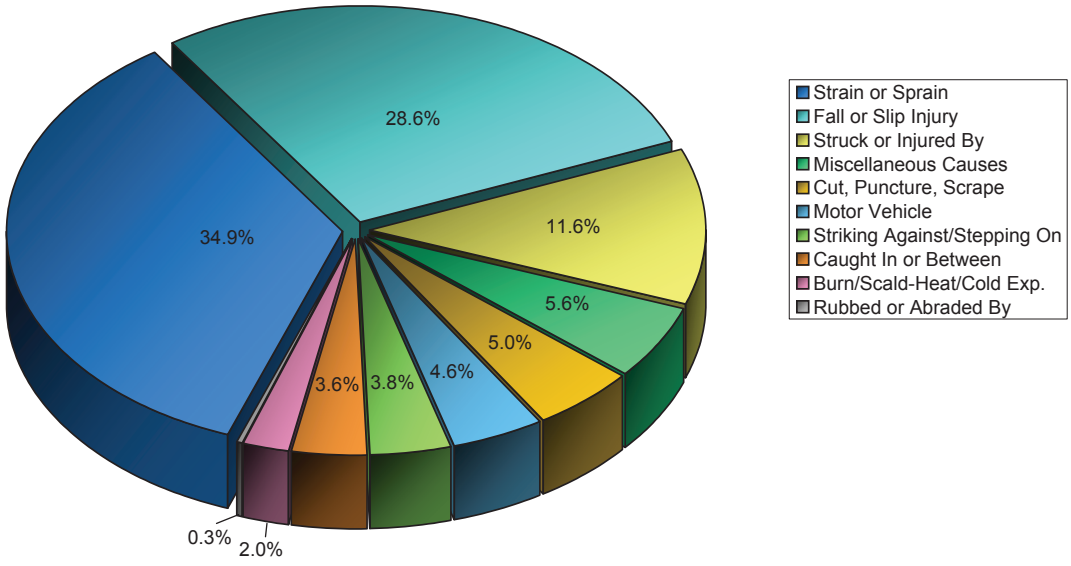


Cause of Injury

Three major causes accounted for three-quarters of all lost-time accidents in Calendar Year 2009: Strain or Sprain, Fall or Slip, and Struck or Injured By. The leading causes of workplace injuries in Calendar Year 2009 are presented in **Graphic 9.3**. Strain or Sprain led all other causes, resulting in 34.9% of reported lost-time accidents. The designation of Strain or Sprain as a cause of workplace injury includes such specific causes as twisting, lifting, pushing, pulling, reaching, throwing, carrying, or jumping which results in a strain or sprain injury. Fall or Slip, the second most frequently indicated cause of injury, accounted for an additional 28.6% of lost-time accidents in Calendar Year 2009. Struck or injured by was the third leading cause of injury at 11.6% of lost-time injuries for Calendar Year 2009 and includes injuries such as contact with electrical current, encounters with insects or animals, explosions, and flare backs. Miscellaneous Causes include injuries caused by events such as natural disasters, mold, absorption or ingestion of foreign substances, or foreign bodies resulting in specific eye injuries.

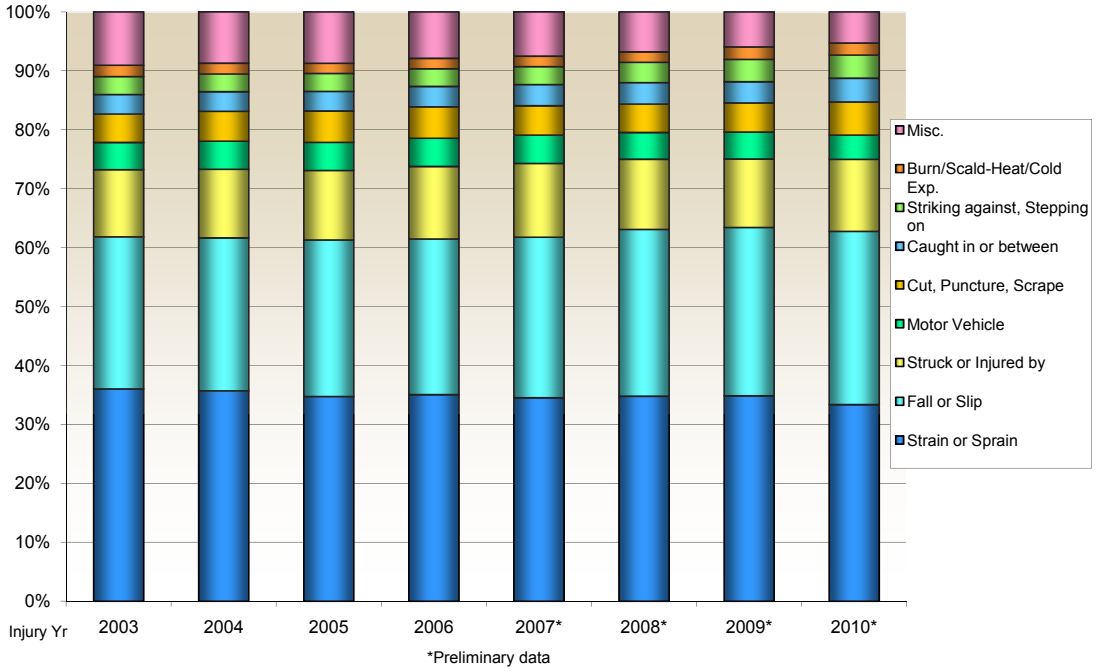
The relative contribution to lost-time accidents of the leading causes listed in **Graphic 9.3** have changed little from year to year, as shown in **Graphic 9.4**.

9.3 2009* Lost-Time Cases by Cause of Injury



*Preliminary reporting
Source: DWC Integrated Database as of 7/1/10

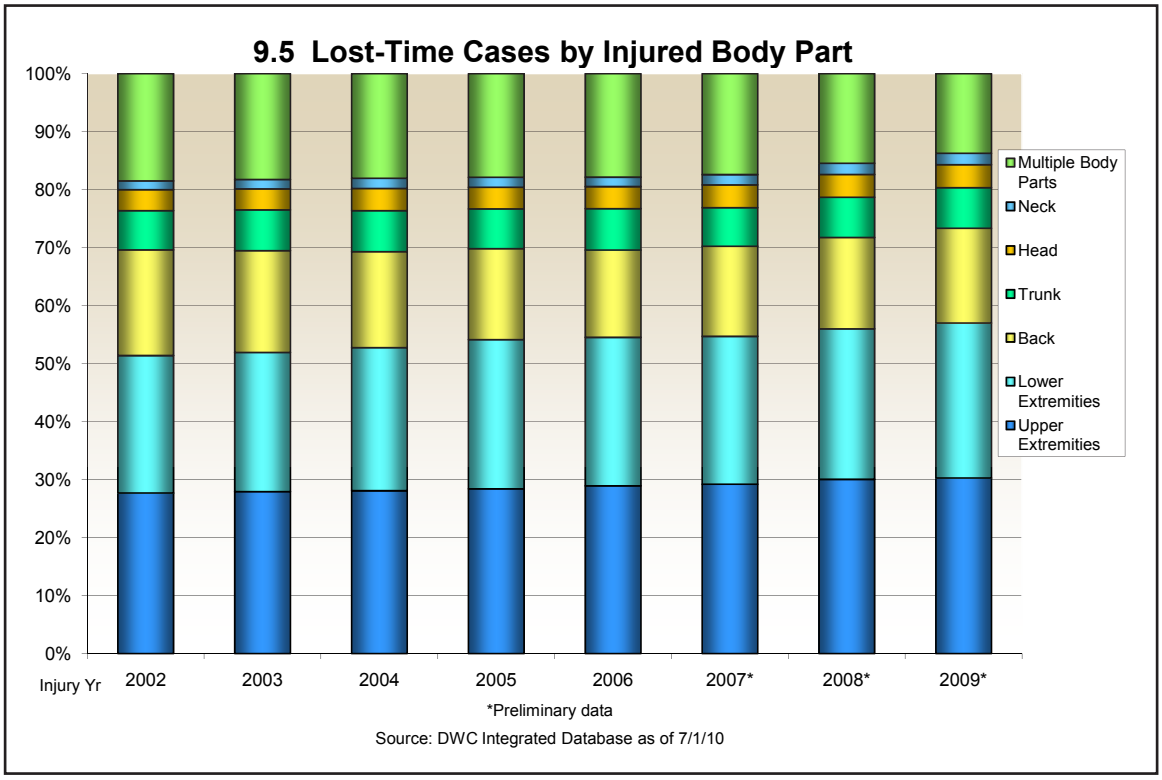
9.4 Lost-Time Cases by Cause of Injury



*Preliminary data
Source: DWC Integrated Database as of 7/1/10

Body Location of Injury

Graphic 9.5 depicts the relative distribution of lost-time cases by injured body part since Calendar Year 2002. The injured body part is reported by the employee to the employer and may not correspond to the health care provider's diagnosis. As a percent of total lost-time injuries, during the period with mature data (2002 – 2006), injuries to both the Upper and Lower Extremities appear to have increased slightly. Between Calendar Year 2002 and Calendar Year 2006, injuries to Upper Extremities increased 1.2% to 28.9%. Likewise, during the same five year interval, injuries to the Lower Extremities increased 1.9%, to 25.6% of all cases. Offsetting these gains somewhat are injuries to the Back, which declined 3.1% to 15.1% from Calendar Year 2002 to 2006. Preliminary data for the Calendar Year 2007 through Calendar Year 2009 show these trends continuing.

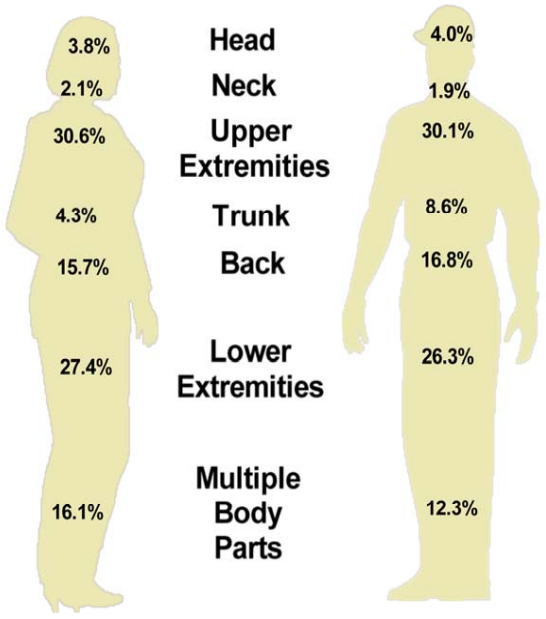


Gender and Age

Graphic 9.6 illustrates gender differences associated with body location of 2009 lost-time injuries. For Head, Upper Extremities, Neck and Back injuries, gender differences in relative frequency are minimal, within one percentage point. Only two body locations of injury exhibited more pronounced gender differences: Trunk and Multiple Body Parts. Nearly nine percent (8.6%) of lost-time injuries sustained by men involved the Trunk, compared to 4.3% of injuries to women. Conversely, women were more likely than men to sustain Multiple Body Part injuries, 16.1% versus 12.3%.

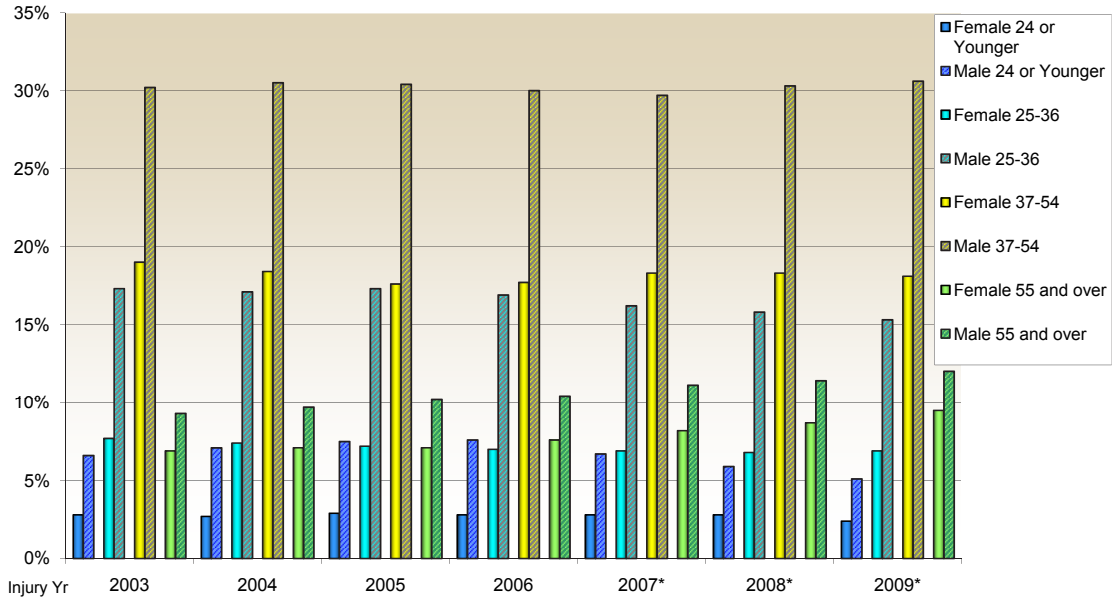
If you consider gender alone, lost-time cases reflect close to a two-to-one ratio of men to women. During 2009, men sustained 63.1% of the injuries and women sustained 36.9% of the injuries. As can be seen in **Graphic 9.7**, Males in the 37-54 age range have consistently constituted the largest segment of the lost-time population. Females, in that same age bracket (37-54) have likewise made up the second largest segment of the lost-time injury population. Combined, workers in this age range account for almost half of the lost-time claim injuries sustained in Calendar Year 2009. The next highest age/gender range by frequency is Males aged 25-36. Males 55 and older continue to experience lost-time injuries at a small, but steadily increasing pace, rising from 9.3% of all lost-time injured workers in Calendar Year 2003 to 12% by Calendar Year 2009. This gain is somewhat offset by a small, but consistent decline in annual accident rates among both men and women in the 25-36 age bracket.

9.6 Injury Body Location by Gender for 2009 Lost-Time Cases



Source: DWC Integrated Database as of 7/1/10

9.7 Lost-Time Claims by Age/Gender



*Preliminary data

Source: DWC Integrated Database as of 7/1/10

MEDICAL DATA

Medical bill data are submitted to the Division at the rate of more than four million medical bill records annually via electronic data interchange (EDI). Physicians, hospitals, ambulatory surgical centers (ASCs), dentists, pharmacies, and other health care providers submit their bills for services to insurers for reimbursement. Most insurers, but not all, employ vendors to adjudicate these bills from health care provider groups and then transmit the billing data and corresponding adjudication results to the Division via EDI. Many different parties may participate in an insurer's medical bill review and adjudication processes, which then must be translated into electronic data transmissions and submitted to the Division. This is especially true when health care providers submit their bills for services on paper billing forms. Paper forms require that information be manually entered into various software systems to determine proper payment, which increases the possibility of data entry errors in the adjudication process. To improve the quality of data collected, the Division's Medical Data System utilizes hundreds of quality control edits and rejects bill data that fail these edits.

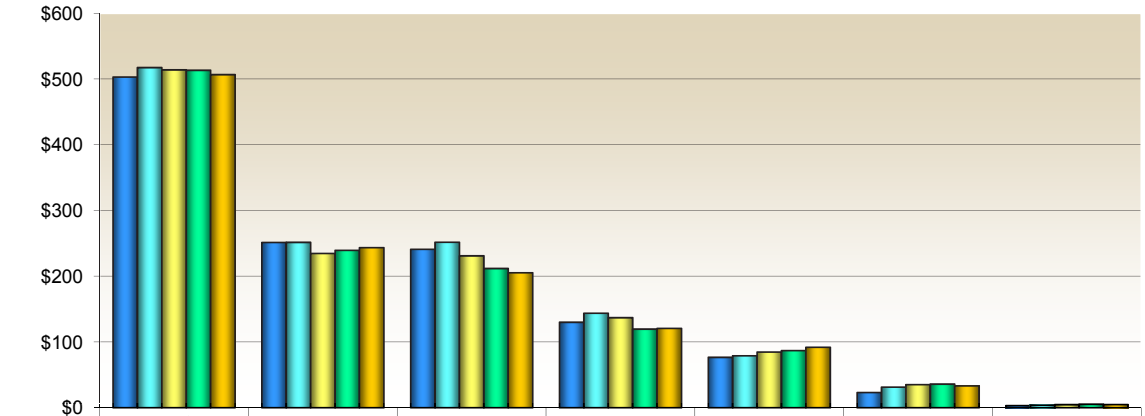
The graphics in this section focus on medical costs for both lost-time and medical only cases and the data come from medical billing data rather than Claim Cost Report data. Additionally, all of the graphics in this series contain medical data based on the calendar year during which the medical service was provided rather than the year the injury occurred. In order to view medical data by similar periods of time, the data in this section were restricted to service dates within a given calendar year that were received by the Division no more than six months into the following calendar year.

For example, to be included in the analysis for Calendar Year 2009, a bill containing services rendered in Calendar Year 2009 would have to have been submitted to the Division by June 30, 2010. When reviewing these graphics, note that declines in services or bill frequency over time may be more reflective of changes in claim frequency, rather than a decline in the frequency in services provided or severity of injuries.

Graphic 10.1 illustrates the payments for each of seven types of medical services over the past five years which were consistently above $1.2 billion each year. Total dollars paid to health care providers comprise the largest portion of medical benefits, exceeding the combined payment amounts for both inpatient and outpatient hospital services. Payments for pharmaceuticals are slightly less than half that of hospital inpatient or outpatient benefits and payments to ambulatory surgical centers are at levels a little more than half that paid for pharmaceuticals. Because of medical data reporting delays, disputes regarding some medical bill payments, and adjustments to previously reported data, payment totals may change somewhat over time. While year-to-year variations in benefits paid to health care providers, hospital outpatient, pharmacy, medical supplies, and dental appear to be relatively small, payments for ambulatory surgical centers have risen steadily since Calendar Year 2005, increasing 20% between 2005 and 2009. Payments for hospital inpatient services have decreased somewhat over the same time span.

Graphic 10.2 shows the proportion of medical costs for the top seven service types over time. Payments to health care providers consistently account for more than 40% of total benefits. Payments for hospital outpatient and inpatient services consistently account for more than 37% of the total. The remaining benefits paid for pharmacy, ambulatory surgical center, medical supplies and dental services account for another 20% of benefits.

10.1 Medical Payments* by Cost Type

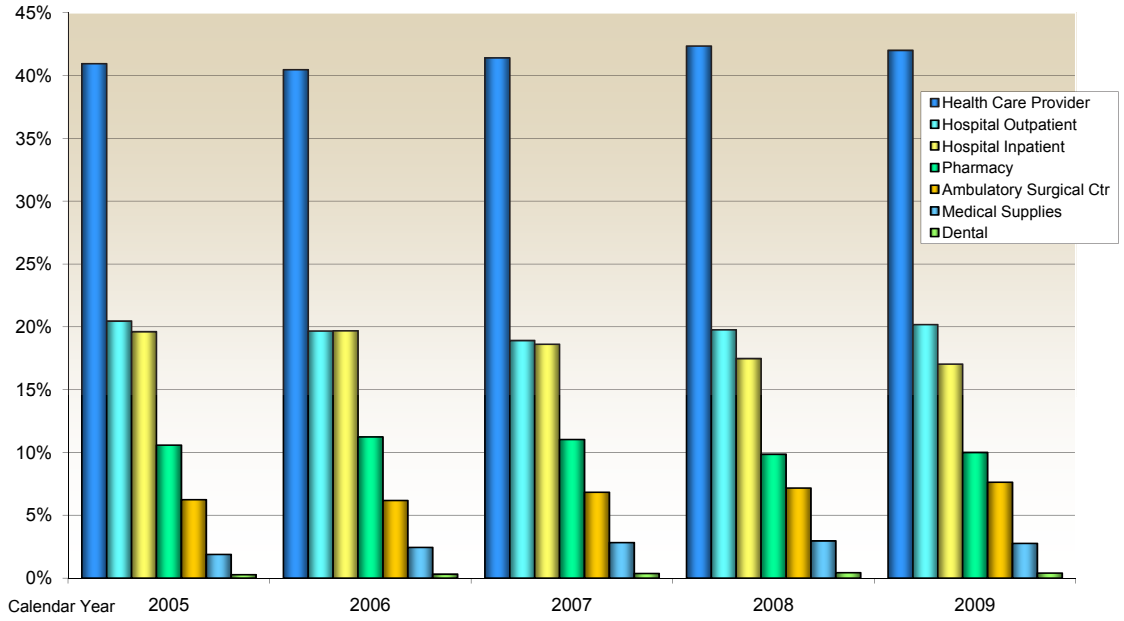


Calendar Year	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Pharmacy	Ambulatory Surgical Center	Medical Supplies	Dental
2005	$503.0	$251.4	$241.0	$130.0	$76.7	$23.1	$3.3
2006	$517.4	$251.6	$251.7	$143.8	$79.1	$31.2	$3.9
2007	$514.1	$234.8	$231.0	$137.0	$84.7	$35.1	$4.6
2008	$513.4	$239.5	$211.8	$119.6	$86.9	$35.9	$5.2
2009	$506.8	$243.4	$205.4	$120.7	$92.0	$33.3	$4.8

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

Source: DWC Medical Data Warehouse as of 7/1/10

10.2 Distribution of Medical Payments*

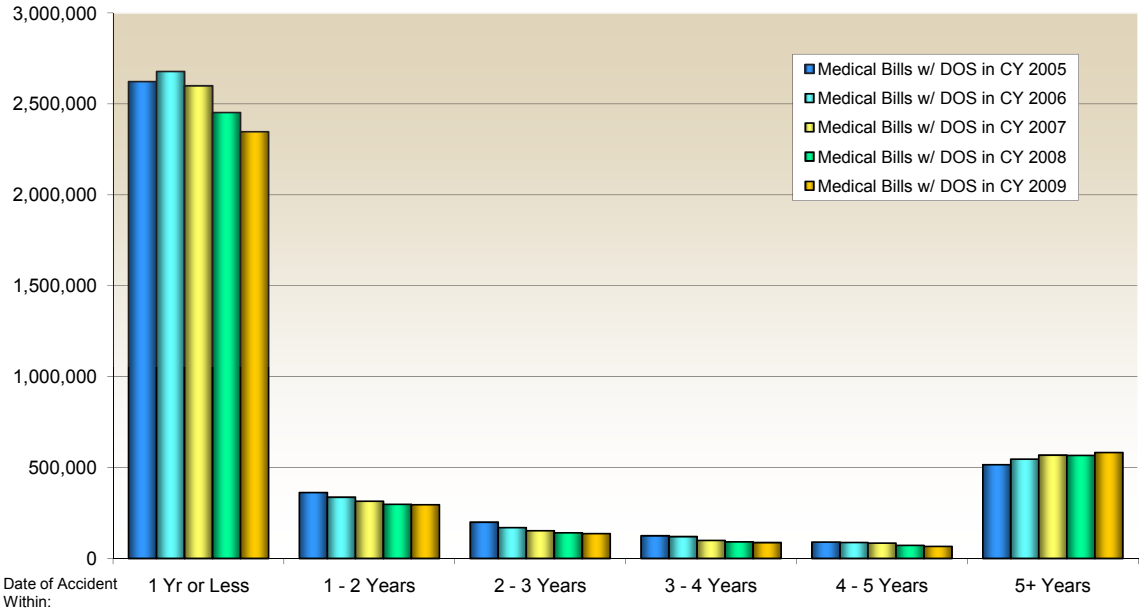


*Excludes bills received beyond six months of the end of the calendar year of service.

Source: DWC Medical Data Warehouse as of 7/1/10

The vast majority of medical services are provided to injured workers within one year of the date of accident, as illustrated in **Graphic 10.3.** Significantly fewer services are billed after the initial year following the accident. A detailed breakout of the types of services provided within the first year following an accident are shown in **Graphic 10.4**. More than 44% of the payments for medical services consistently go to health care providers. This is followed by payments for outpatient and inpatient hospital services. Combined payments for hospital outpatient and inpatient services are almost equal to the amounts paid to health care providers.

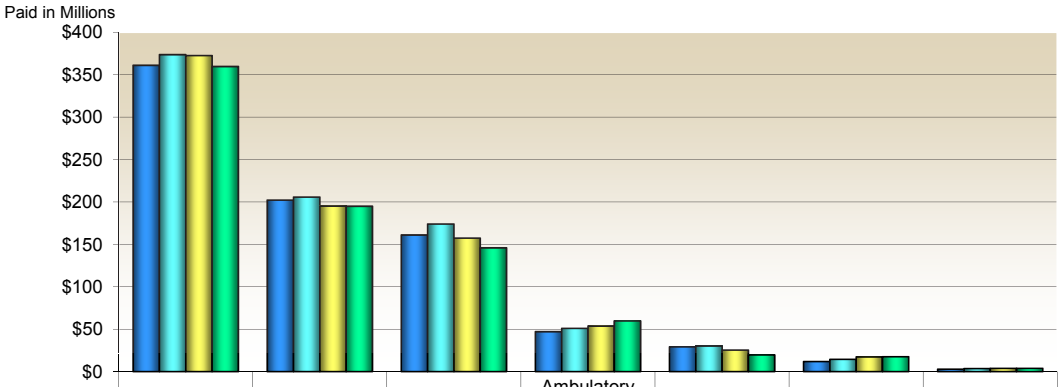
10.3 Correlation Between Medical Bill Date of Service* and Date of Accident



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

Source: DWC Medical Data Warehouse as of 7/1/10

10.4 Total Medical Paid* for Services Provided within 12 Months of Injury



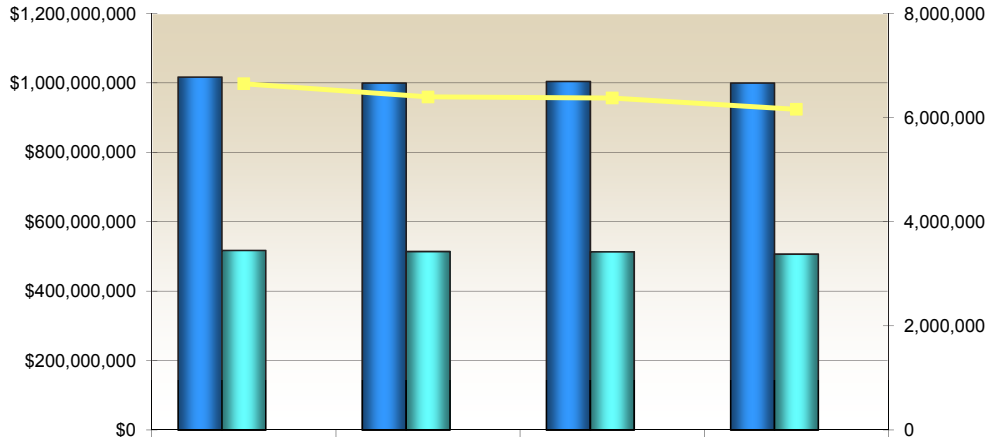
Injury Yr	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental
2005	$361.1	$202.2	$161.0	$47.1	$29.2	$11.8	$2.9
2006	$373.7	$205.8	$174.0	$51.0	$30.2	$14.4	$3.6
2007	$372.6	$195.2	$157.3	$53.7	$25.3	$17.3	$3.8
2008	$359.7	$194.9	$145.9	$59.7	$19.7	$17.5	$3.8

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

Source: DWC Medical Data Warehouse as of 7/1/10

Graphic 10.5 displays the total charges and payments and the average charges and payment amount per detail line item for health care provider services by calendar year of service. Both the average line item charges and payments have increased slightly each year over the four year period. The Division's health care provider reimbursement manual is updated annually and changes to reimbursement levels for each service are statutorily tied directly to annual modifications to the Medicare reimbursement system.

10.5 Total Charges and Total Paid for Health Care Provider Services by CY of Service



	CY 2006	CY 2007	CY 2008	CY 2009
Charges	$1,016,977,327	$999,790,163	$1,004,134,800	$999,798,626
Paid	$517,493,306	$514,204,280	$513,595,310	$506,882,981
Avg Charge/Per Line Item	$153	$156	$157	$162
Avg Paid/Per Line Item	$78	$80	$81	$82
Total Line Items	6,650,264	6,396,367	6,376,215	6,158,818

Note: Only bills with payment amount >$0 are included. Prescription drugs & supplies are included when dispensed by a health care provider.
Source: DWC Medical Data Warehouse as of 7/1/10

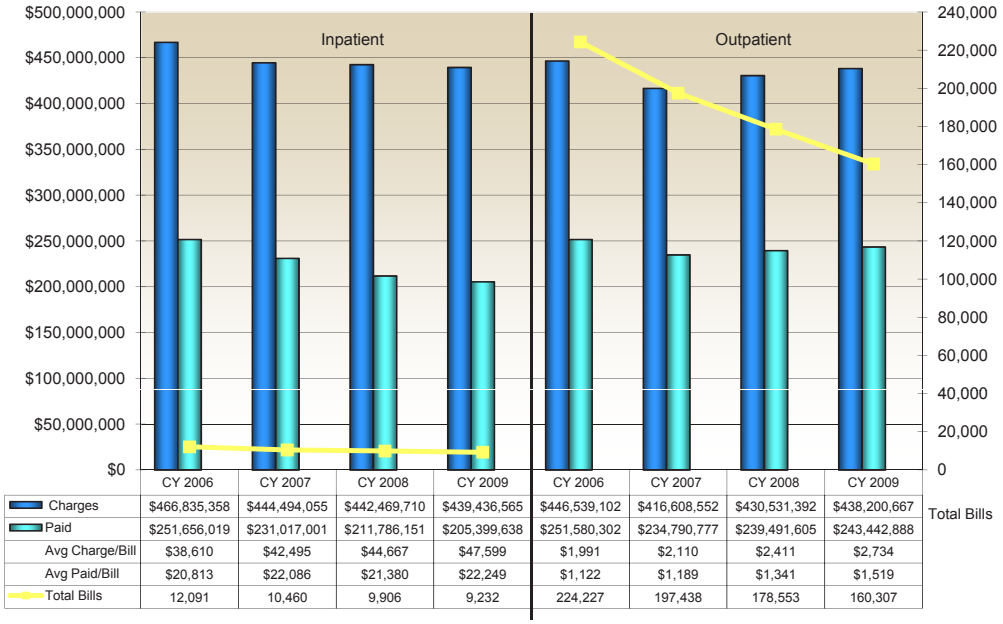
Graphic 10.6 depicts an upward trend for both average charges and average reimbursement for inpatient hospital bills, despite the decreasing number of inpatient bills submitted to the Division each year over the four-year period. From Calendar Year 2006 to Calendar Year 2009, there has been a 23.3% increase in the average charge per bill and a 6.9% increase in the average payment per bill.

Likewise, the average charges and average reimbursement for hospital outpatient bills also reflect increases over time. In comparing Calendar Year 2006 to 2009, there has been a 37.3% increase in hospital outpatient charges per bill and a 35.4% increase in hospital outpatient reimbursement per bill. The reimbursement methodology for hospital outpatient charges is statutorily specified as follows: physical therapy, occupational therapy, and speech therapy, as well as non-emergency radiology and laboratory services (not performed in conjunction with a surgical procedure) are all statutorily reimbursed under the health care provider reimbursement manual. Scheduled surgeries are reimbursed at 60% of charges. All other outpatient hospital services are reimbursed at 75% of usual and customary charges.

The Division's 2006 hospital reimbursement manual requires that hospital inpatient services be reimbursed according to a per diem schedule subject to a stop-loss of $51,400. After implant charges are removed from the computation, hospital bills that still exceed $51,400 are reimbursed at 75% of charges or the agreed-upon contract price. In addition, implants are reimbursed at 60% of charges. **Graphic 10.7** shows the total number of inpatient hospital bills that exceeded the stop-loss amount, compared to the number of bills that exceeded the stop-loss amount after removing the implant charges. Of all the hospital bills that exceeded the stop-loss amount, 41.9% of 2008 bills and 43.4% of 2009 bills exceeded the stop-loss after implant charges were removed. Had the implant charges not been removed, the number of bills exceeding the stop-loss would have been more than 31% higher in 2008 and 32% higher in 2009.

Although the number of bills that qualify for the stop-loss reimbursement methodology was 18% in 2008 and 20% in Calendar Year 2009, they represented 60% of all payments for inpatient services in Calendar Year 2008 and 64% of all payments in Calendar Year 2009.

10.6. Total Charges and Total Paid By Hospital Bill Type and CY of Service

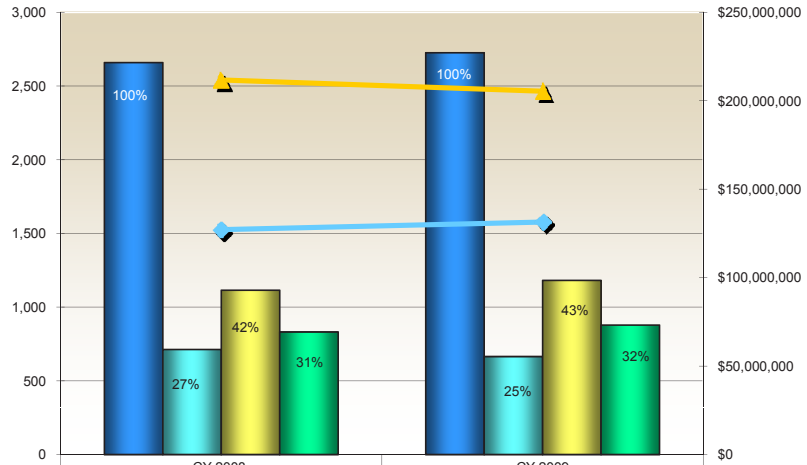


	Inpatient				Outpatient			
	CY 2006	CY 2007	CY 2008	CY 2009	CY 2006	CY 2007	CY 2008	CY 2009
Charges	$466,835,358	$444,494,055	$442,469,710	$439,436,565	$446,539,102	$416,608,552	$430,531,392	$438,200,667
Paid	$251,656,019	$231,017,001	$211,786,151	$205,399,638	$251,580,302	$234,790,777	$239,491,605	$243,442,888
Avg Charge/Bill	$38,610	$42,495	$44,667	$47,599	$1,991	$2,110	$2,411	$2,734
Avg Paid/Bill	$20,813	$22,086	$21,380	$22,249	$1,122	$1,189	$1,341	$1,519
Total Bills	12,091	10,460	9,906	9,232	224,227	197,438	178,553	160,307

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

Source: DWC Medical Data Warehouse as of 7/1/10

10.7 Inpatient Hospital Bills that Exceed $51,400 Stop-Loss



	CY 2008	CY 2009
Total # of Inpatient Hospital Bills Received > Stop-Loss	2,660	2,726
# of Bills Without Implants > Stop-Loss	713	665
# of Bills With Implants > Stop-Loss After Excluding Implant Charges	1,115	1,182
# of Bills < Stop-Loss After Excluding Implant Charges	832	879
Amount Paid for All Inpatient Hospital Bills	$211,786,151	$205,399,638
Amt Paid All Bills > Stop-Loss With & Without Implants	$127,098,663	$131,485,852

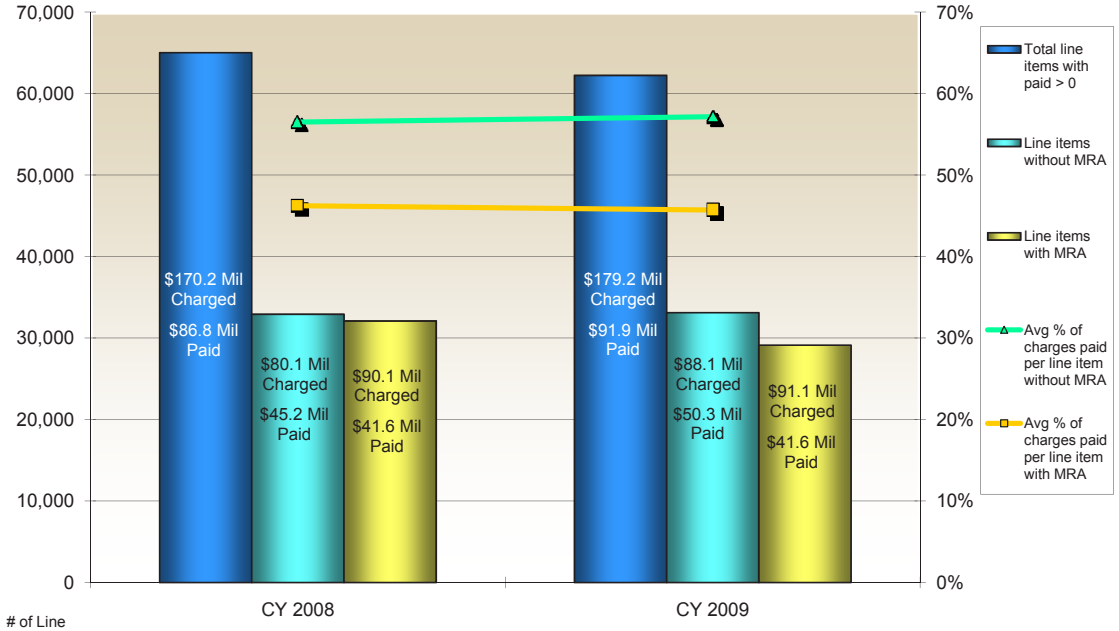
Note: Only bills with payment amount >$0 are included.

Source: DWC Medical Data Warehouse as of 7/1/10

Graphic 10.8 illustrates the impact of maximum reimbursement allowances (MRA) on ASC reimbursement levels. The Division's 2006 ambulatory surgical center reimbursement manual contains 27 MRA codes. When services are provided which are not covered by an MRA code, ASC facilities are reimbursed at 70% of the charges or the agreed-upon contract price. Ambulatory surgical center bills for Calendar Years 2008 and 2009 respectively, contained one or more MRA codes on 66.1% and 64.9% of the bills.

Another way to look at this data is to compare the total number of ASC bill line items to line items containing an MRA code. Of all the ASC line items paid, 49.4% of Calendar Year 2008 line items paid and 46.8% of Calendar Year 2009 line items paid were covered by an MRA. ASC bill line items covered by an MRA code were paid at an average of 46.2% of charges for Calendar Year 2008 and 45.7% of charges for Calendar Year 2009. ASC bill line items that did not contain an MRA code were paid at an average of 56.5% of charges in Calendar Year 2008 and 57.2% in Calendar Year 2009.

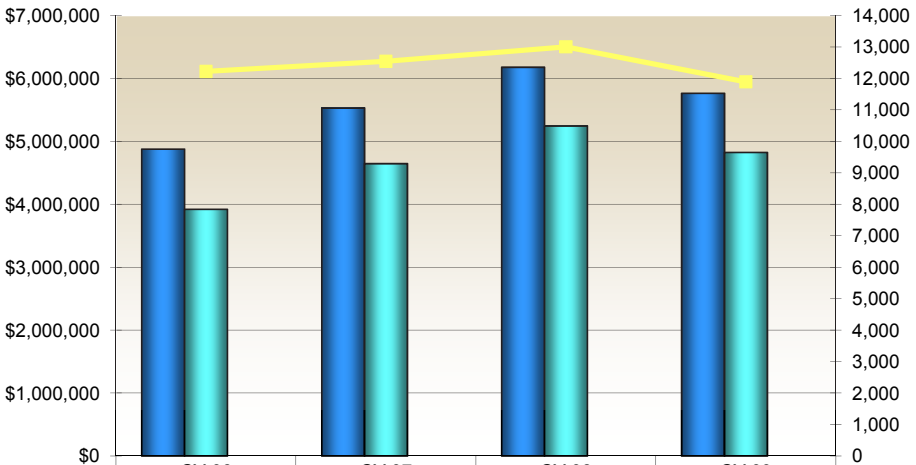
10.8 Impact of Maximum Reimbursement Allowances on Ambulatory Surgical Center Bills



Source: DWC Medical Data Warehouse as of 7/1/10

Graphic 10.9 illustrates dental services provided during the last four calendar years. The frequency of dental services paid increased slightly in Calendar Years 2007 and 2008 and then declined somewhat in 2009. When comparing Calendar Year 2006 to Calendar Year 2009, the average charges per line item increased 21.6% and the average paid per line item increased 26.5%.

10.9 Total Charges and Total Paid for Dental Services by CY of Service



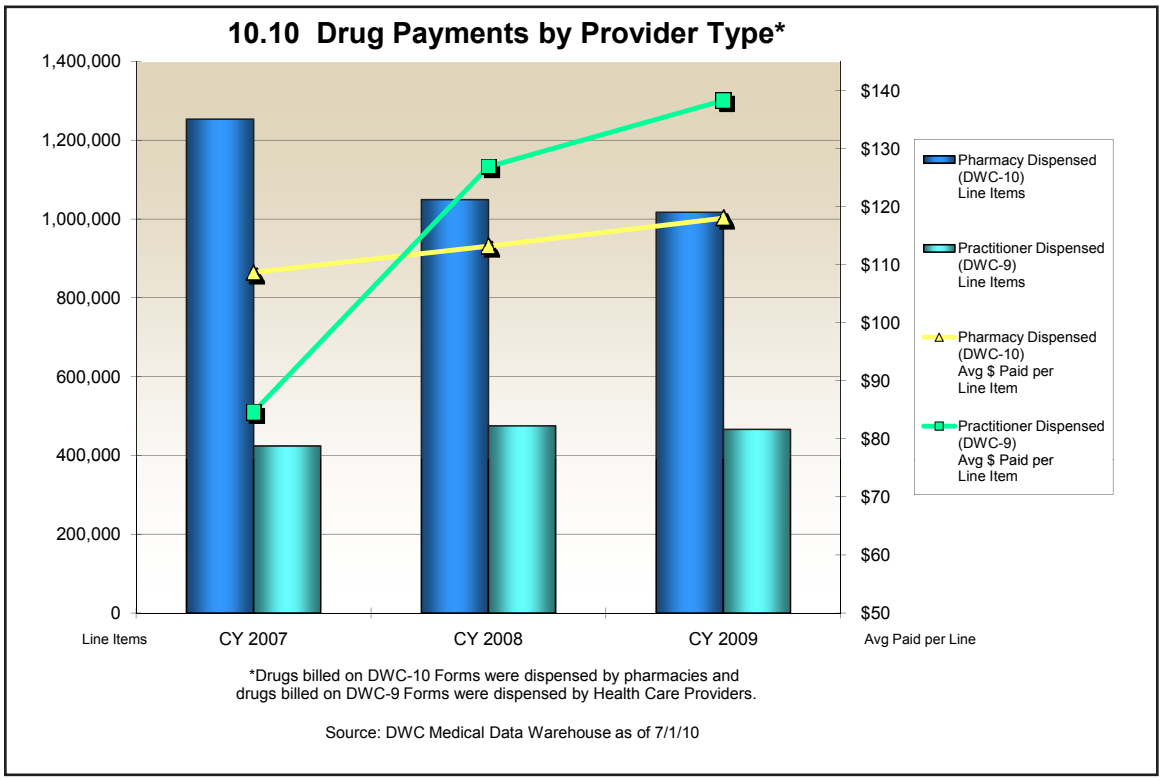
	CY 06	CY 07	CY 08	CY 09
Charges	$4,877,625	$5,530,809	$6,178,183	$5,764,352
Paid	$3,920,209	$4,646,437	$5,245,784	$4,824,306
Avg Chg Per Line Item	$399	$441	$475	$485
Avg Paid Per Line Item	$321	$370	$403	$406
Total Line Items	12,223	12,544	13,006	11,892

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

Source: DWC Medical Data Warehouse as of 7/1/10

Pharmaceuticals can be billed on behalf of both dispensing practitioners and pharmacies. Dispensing practitioners bill on the DWC-9 form (Health Provider Claim Form/CMS-1500) and pharmacies bill on the DWC-10 form (Statement of Charges for Drugs and Medical Supplies Form).

Graphic 10.10 compares pharmaceutical payments for these two provider types. The data for **Graphics 10.10** and **10.11** include only prescription and over-the-counter medications. Injections (J codes) and compound drugs were not included.



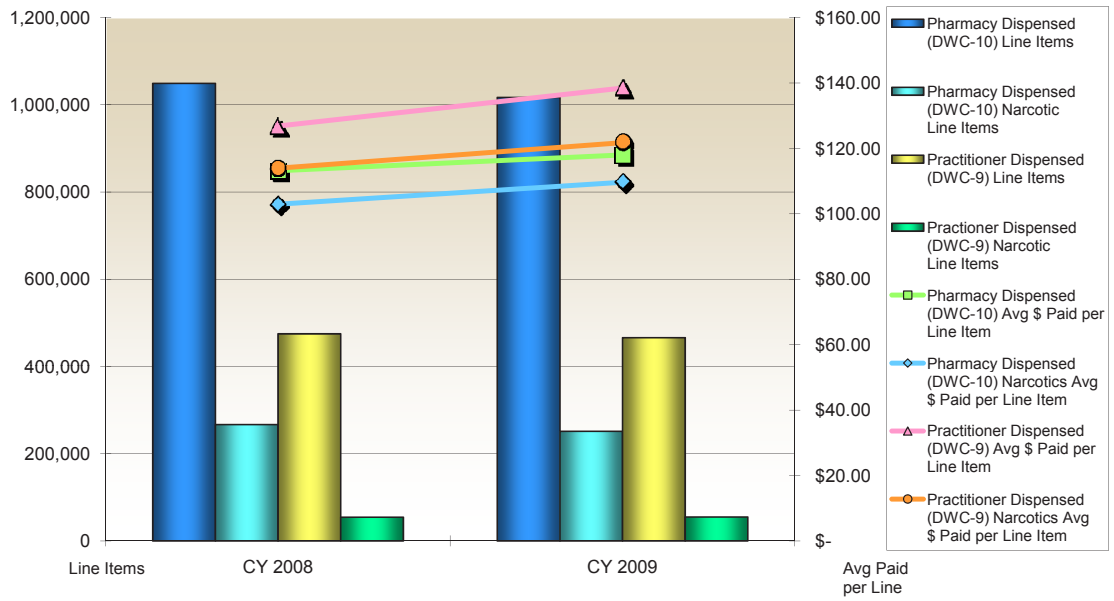
The total amount paid to all pharmacies decreased 11.9% over the last three calendar years, from $136.2 million in Calendar Year 2007 to $120 million in 2009. For the same timeframe, the total amount paid to dispensing practitioners increased 80.2% from $35.8 million in Calendar Year 2007 to $64.5 million in 2009. The average reimbursement per line item for dispensing practitioners increased 62.4%, from $85 per line item in Calendar Year 2007 to $138 per line item in Calendar Year 2009. During that same period, the average reimbursement per line item to pharmacies increased 8.3%, from $109 per line item to $118 per line item.

Graphic 10.11 illustrates the total number of paid prescription line items for Calendar Years 2008 and 2009 as well as the total number of line items that represent narcotics, as classified by the U.S. Food and Drug Administration (FDA). From Calendar Year 2008 to Calendar Year 2009, there was a negligible change in the number of prescription line items dispensed.

During Calendar Year 2008, pharmacies were reimbursed an average of $113.19 per bill line item compared to an average line item reimbursement of $126.82 for practitioners. During Calendar Year 2009, pharmacies were reimbursed an average of $118.00 per bill line item compared to an average line item reimbursement of $138.46 for practitioners.

During Calendar Year 2008, 21.1% of the prescription bill line items were for narcotics (with 83.1% dispensed by pharmacies and 16.9% dispensed by practitioners). During Calendar Year 2009, 20.7% of the prescription bill line items were for narcotics (with 82.1% dispensed by pharmacies and 17.9% dispensed by practitioners). When comparing the average amount reimbursed per bill line item for narcotics, pharmacies were paid an average of $102.92 in Calendar Year 2008 and $109.65 in Calendar Year 2009, compared to average practitioner bill line item reimbursement of $113.93 in 2008 and $121.79 in Calendar Year 2009.

10.11 Narcotics and Prescription Drug Payments by Provider Type*



Source: DWC Medical Data Warehouse as of 7/1/10

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Office of Assessments:
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Gene Smith, Assessments Coordinator

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(850) 413-1944
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(800) 219-8953

Compliance Fraud Referral Hotline:
(800) 742-2214

Employee Assistance Office Hotline:
(800) 342-1741

Customer Service Center:
(850) 413-1601

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

DIVISION OF WORKERS' COMPENSATION WEBSITE

The Division of Workers' Compensation website home page is located at:http://myfloridacfo.com/WC and provides direct information access for all stakeholders in the Workers' Compensation System. On average, the Division's home page was visited more than 55,793 times per month. The website organizes items of interest by stakeholder group with tabs for Employer, Insurer, Injured Employee, and Health Provider.