Three-Member Panel

Biennial Report

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INTRODUCTION AND BACKGROUND DISCUSSION

The Florida Legislature enacted Senate Bill 108 in 2002, including a specific charge in s. 440.13(12)(e), Florida Statutes (F.S.), that the Three-Member Panel assess the adequacy of medical reimbursement, access to care, and other aspects of the health care delivery system in the Florida Workers' Compensation program. The Three-Member Panel was directed to issue an initial report in January 2003 with successive reports due biennially thereafter to the President of the Senate and the Speaker of the House of Representatives on methods for improving the workers' compensation health care delivery system. The initial 2003 report led to many of the medically related reforms enacted during 2003 in Senate Bill 50A (SB 50A). To further improve the health care delivery system, the Three-Member Panel made the following recommendation to the Legislature in January 2005:

- Support and Clarify the SB 50A reform.
- Transfer the Agency for Health Care Administration (Agency), Workers' Compensation Medical Services Unit to the Department of Financial Services, Division of Workers' Compensation.
- Grant the Division of Workers' Compensation (Division) statutory authority to enforce health care compliance, including the form DFS-F5-DWC-25 (DWC-25) requirement.
- Provide an alternate dispute resolution system to manage medical disputes.

The 2005 Three-Member Panel Biennial Report discussed the inefficiencies in the administration of the medical services program as discussed herein. The cause for the inefficiencies were stated to be "structural in nature, while others are a matter of divergent priorities and management issues" resulting from two different agencies sharing responsibility for one program. The effect of this arrangement was said to have dire "consequences on the standards by which all stakeholders would be held accountable for compliance with statute and rules".

It was further opined that the separation of the medical and other regulatory duties inherent to the workers' compensation system between two different agencies created an unnecessary financial burden on the workers compensation system because of the logistical issues resulting from the organizational location of the two entities. In concluding the argument for removing these structural and management barriers to the efficiency of the workers' compensation system, it was recommended that the medical services staff and the functions it performs be integrated into the Division's organizational structure and mission. This integration would enable the tasks for regulating health care services to be performed as an integral part of the overall workers' compensation regulatory framework, thereby promoting and encouraging a single consistent vision.

The most salient point made to support the recommendation for the integration of the medical services functions and task into the workers' compensation regulatory framework was that of access to medical claims data being collected by the Division. It

was noted that the majority of the tasks in s. 440.13, F.S., required access to medical claims data to carry out the regulatory or policy development responsibilities conferred on the Agency.

As a result of the Three-Member Panel recommendation, the Agency for Health Care Administration, Workers' Compensation Medical Services Unit was transferred via an interagency agreement to the Department of Financial Services, Division of Workers' Compensation in November 2005. Since then, the Division has worked closely with stakeholders to further refine the data required from health care providers concerning treatment which is necessary for the execution of most of the medical services responsibilities under s. 440.13, F.S. One significant example of positive results from this collaborative effort is the development and adoption of the DWC-25 as the vehicle for requesting authorization to provide treatment which a carrier must respond to by close of business on the third day after receipt for initial visits and by the next business day for all other visits. The DWC-25 is the exclusive form required from physicians to report the injured employee's medical treatment and status to the insurer. Another example of the partnering of resources of both agencies has been the refinement of the medical reimbursement dispute resolution process which expanded the medical reimbursement dispute processes in rule 59A-31, Florida Administrative Code (F.A.C.), Resolution of Workers' Compensation Reimbursement Disputes, which became effective on November 28, 2006. Collectively, these modifications have served to simplify the administrative burden to all concerned, facilitate understanding of the requirements of the Florida's Workers' Compensation Law, and promote timely reimbursement for health care providers. However, barriers currently still exist due to the Agency for Health Care Administration, Workers' Compensation Medical Services Unit not being formally transferred into the Department of Financial Services.

Additionally, SB 50A created new and revised statutory requirements for medical bill reimbursement including performance standards and penalties for untimely disposition and reporting. Specifically,

- Section 440.20(2)(b), F.S., requires insurers to pay, disallow, or deny all medical bills within forty-five calendar days of receipt.
- Section 440.20(6)(b), F.S., requires insurers to maintain a minimum ninety-five percent performance standard when processing medical bills for payment, disallowance, or denial in order to avoid penalties.
- Section 440.20(6)(b), F.S., requires the assessment of an administrative penalty of twenty-five dollars for each medical bill processed below the ninety-five percent performance standard but above a ninety percent performance standard.
- Section 440.20(6)(b), F.S., requires the assessment of an administrative penalty of fifty dollars for each medical bill processed below the ninety percent performance standard.

Therefore, the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, rule 69L-7.602, F.A.C., was revised. As a result of the new rule, a series

of statewide educational sessions were conducted. Rule 69L-7.602, F.A.C., provides health care providers with clear guidance and instruction for submitting a medical bill, sets out the insurer standards for both timely processing and timely reporting of medical payment data to the Division and specifies administrative penalties resulting from sub-standard performance.

In addition, the reimbursement manuals for hospitals, health care providers and ambulatory surgical centers were revised to reflect the new statutory requirements. Several updates have occurred over the past two years. Notably, the Florida Workers' Compensation Health Care Provider Reimbursement Manual has been revised four times: January 1, 2004, July 4, 2004, May 9, 2005, and September 4, 2005. The Florida Workers' Compensation Reimbursement Manual for Hospitals has been revised twice, January 1, 2004 and July 4, 2004. Finally, the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers was revised September 4, 2005. Each of the manual updates has facilitated increased understanding and fostered better communication between the health care provider and the insurer.

In summary, the 2003 statutory reforms and the ensuing rulemaking and other regulatory efforts over the last years have clearly had a beneficial effect on the overall system. The collective interplay of the various reform provisions work well together, resulting in a collaborative workers' compensation ***"system"*** rather than a patchwork quilt of rules and practices. However, the fundamental and almost organic nature of these reforms dictate changes in behavior of almost every stakeholder group and as a result, are still in the developmental process of being fully understood, effectively utilized and properly integrated into wide and consistent practice throughout the system.

Therefore, the overarching message of this report is that, other than the few specific recommendations that are technical (yet still significant and consequential), current efforts should be on continued implementation, execution and integration of the already defined reform provisions and issues. A number of these issues were raised in the 2005 report and will identify additional areas specific to administrative burden, reimbursement, and teaching and education to further improve the workers' compensation health care system.

This report is organized into four distinct sections.

The initial section discusses the issue of *administrative burden* as it relates to the communications between the health care provider and the insurer in the billing cycle, concerning patient status, the role of electronics and the Division's data systems that evaluate this process. The next section discusses *reimbursement* for medical services including general issues, dispute resolution and audits of insurer performance. The third section discusses *education and training* both in terms of Division outreach to stakeholders and the requirements for health care providers. The final section includes a series of *conclusions and recommendations* from the Three-Member Panel concerning the health care delivery system under the Florida Workers' Compensation Law.

PROGRAM ADMINISTRATION: EXPLANATION OF BILL REVIEW

Clear and understandable communication in the workers' compensation billing and reimbursement process is critical for the efficient delivery of quality health care.

Health care provider administrative burdens in the workers' compensation system include several arenas where they are obligated to interact with the insurer to complete the various administrative duties and responsibilities associated with the care and treatment of injured workers. The system must continuously explore ways to minimize this administrative burden while maintaining the provision of quality care in a transparent manner. Reporting of information by the health care provider is necessary to the administrative system which reviews and processes medical billings, yet the administrative system must constantly recognize that health care provider energies are best devoted to the complexities of medical care.

One administrative responsibility is communication, which relays information from the insurer concerning the disposition of medical bills at the line item level. This communication occurs through the Explanation of Bill Review, which is the uniform communications system that standardizes and abbreviates communication involving reimbursement decision making by the insurer to the health care provider. Well-designed Explanation of Bill Review coding systems establish the common lexicon through which the insurer effectively communicates their decisions involving a medical bill to the health care provider. Due to the statutory requirement found in s. 440.20(2)(b), F.S., specifying that each medical bill must receive proper disposition within a forty-five day timeframe from insurer receipt, implementation of such a standardized coding system reduces the administrative burden to the health care provider by providing the most efficient transmittal of specific information regarding the medical bill in a clear and understandable format.

In order to facilitate communication between the insurer and the health care provider, the Division is continuing in the developmental steps necessary for establishing an enhanced system of Explanation of Bill Review coding. To accomplish the stated goal of improved communication, the Explanation of Bill Review coding system will allow precise and simple explanations concerning decisions to pay medical bills, to adjust and pay medical bills, to disallow payment for individual components of a medical bill or to deny the compensability of the injury or illness for which service was rendered.

When the issues are mutually understood based on a common lexicon, health care providers and insurers are both able to move forward using a platform of shared knowledge about the process, which is applicable to future communications concerning the billing process. This standardized platform adds value to the health care provider concerning the outcome of the insurer bill review process, and will transfer from provider to provider and from insurer to insurer with each utilizing a mutually shared and understandable information base. By providing clarity about the billing and reimbursement process, more certainty is introduced into the process. Administrative overhead to all participants will be reduced by minimizing or eliminating corrective

administrative tasks as participants understand how the process works regarding payments, timing and resolution of problems.

Throughout this process, the Division has involved stakeholders in both the medical and insurer communities and has fostered cooperative discussions concerning the most comprehensive approach to the revision of the Explanation of Bill Review coding system. These discussions involved the general issue of how the system can best operate for the benefit of all stakeholders, and the Division received information in a cooperative forum about prospective improvements rather than in an environment which is directed to the specific elements, which are the subject of a specific case.

PROGRAM ADMINISTRATION: THE MEDICAL DATA SYSTEM

Make quality medical data available for workers' compensation program evaluation and decision making.

During 2004, in response to new requirements in SB 50A, the Division promulgated the Workers' Compensation Medical Services Billing, Filing, and Reporting Rule, 69L-7.602, F.A.C. This rule was developed in conjunction with industry stakeholders through the administratively required public workshop and hearing process and now requires insurers to report the disposition of every medical bill to the Division including those from physicians, pharmacies, hospitals, ambulatory surgical centers and dentists. In order to facilitate this reporting requirement, an electronic reporting format, known as Electronic Data Interchange, was established that provided the technical aspects for data collection and included a staggered phase-in conversion schedule over a nine-month period, which allowed for an orderly and manageable transition by insurers. In addition, this rule established the insurer performance standards for timely disposition and reporting of medical bills to the Division, as well as the administrative penalties for failing to achieve statutory performance standards.

By April 2005, all medical bills from health care providers were being reported by insurers either directly to the Division or through the use of one of several submitting organizations providing electronic reporting support services. This concluded the transitional phase-in and all insurers and self-insurers were reporting all medical data electronically to the Division in a "real time" business environment, which included stringent data quality requirements. The inception of electronic medical reporting is significant for several reasons:

- For the very first time in Florida, 100 percent (4.5 million annually) of all medical bills submitted are examined for timely disposition and compliance pursuant to s. 440.20(2)(b), F.S.
- Past practices of random sampling of medical bills for data collection purposes have been eliminated. Conversely, valuable medical system data are no longer lost.
- The Division has realized an increase of nearly one million medical bills per year since the introduction of electronic reporting when compared to the number reported on paper during previous years.
- A superior accounting system for each medical bill reported to the Division has been established with seamless integration to other internal program offices such as the Centralized Performance System in the Bureau of Monitoring and Audit.
- The Division has increased examination of medical bills for timely disposition from approximately two percent manual examination to 100 percent electronic examination through this administrative rule adoption and application of new Electronic Data Interchange technology.

- The Division was now in a position to develop and create a Medical Data System that would store an abundance of detailed data from all facets of Florida's health care providers participating in the system.

In 2006, the Division began development of the Medical Data System. The system will eventually possess the capability of reviewing medical data across many years on a variety of aggregate levels, as well as on an individual case level, and was designed to house the huge volume of medical data generated annually by the Florida workers' compensation system. Electronic receipt of all medical bill data and the subsequent deposit of these data into a data warehouse will provide a unique opportunity to analyze and assess trends and conditions of relevant medical data leading to a more meaningful oversight of the workers' compensation medical care delivery system.

The Medical Data System now includes over 35 million records (including migrated historic data). These data afford an unprecedented opportunity to analyze medical data trends and to accurately assess the current operation of the system based on more reliable and more current information than was ever available before.

Florida has now progressed to the next level in preparing to have the nation's most comprehensive and accessible medical database. Among the many foreseeable benefits resulting from medical data analysis, policy makers will have the opportunity to evaluate both treatment and payment data by physician specialties, conduct geographic studies of health care delivery costs for comparison purposes, perform detailed studies of drugs being prescribed by the health care provider, and the opportunity to potentially forecast severe and/or high cost cases in order to extend program assistance early in the life of a case. For the first time, this information will provide the opportunity to accurately account for dollars spent in the health care delivery system in Florida. Historically, medical data for workers' compensation has included estimations and opinions about medical only cases without access to verified data beyond the sampling data for lost time cases. Since preliminary analysis indicates medical only cases comprise about three of every four workers' compensation injuries, having new data on these medical only cases opens up a wealth of new medical information for policy makers. It will now be possible to analyze medical treatment for the universe of workers' compensation patients during the course of treatment regardless of disability or work status.

As the Medical Data System matures, programs to extract data can be developed and reports which evaluate results can be designed. This will develop into an information source for the Three-Member Panel and policymakers that can be used both to evaluate the effectiveness and operation of current programs and also to estimate the impact of proposed changes. In fact, at the Three-Member Panel meeting on December 14, 2006, the Division was able to support the panel when they considered three different reimbursement levels for Ambulatory Surgical Centers by applying these three different strategies against recently submitted bills and comparing the actual payments to what the payment would have been under each reimbursement strategy being considered. As a result, the Three-Member Panel was able to make their decision with a detailed annual projection concerning the additional cost to the system for each strategy. In turn, the

National Council on Compensation Insurance validated the Division's projections and provided their estimation concerning the effect on premiums.

With more accurate, extensive, and complete data, the Three-Member Panel will be able to make informed decisions concerning medical issues and will be able to implement improvements from a foundation of concrete data reported from insurers, rather than relying upon opinions and anecdotal predictions expressed by stakeholders. These data elements will permit the analysis of system-wide data concerning overall medical costs and trends such as total medical costs or the allocation of these costs among the different provider specialties and facilities, as well as tracking regional patterns and differences. These same data elements will also allow a detailed examination of very specific issues such as the frequency and costs associated with a particular medical condition/diagnosis, service or by an individual health care provider.

Overall, Florida's Three-Member Panel will have access to one of the most comprehensive medical databases in the nation and will be able to rely on this data in order to make the most informed decisions related to Florida's workers' compensation health care delivery system.

PROGRAM ADMINISTRATION: ELECTRONIC TRANSMISSION OF MEDICAL DATA FROM HEALTH CARE PROVIDER TO INSURER UTILIZING NATIONAL STANDARDS

To analyze the benefits of the electronic transmission of medical bills from health care providers to insurers, utilizing established national electronic standards and national code sets. The electronic transmissions include all communication between a health care provider and an insurer as required to adjudicate a medical bill.

In its continued goal of decreasing the collection of data via paper, the Division mandated that all medical data required to be filed with the Division must be submitted electronically as of March 16, 2005, as addressed under the *Medical Data System* section of this report. The next logical Division action is to promote the electronic transmission of medical bills from a health care provider to an insurer. Historically, the Division provides language within rule 69L-7.602, F.A.C., Florida Workers' Compensation Medical Services Billing, Filing and Report Rule, permitting health care providers to submit medical bills electronically, provided the insurer agrees. In addition, s. 440.13(4)(a), F. S., mandates that health care providers are to submit treatment reports to insurers in a format indicated by the Division. This statutory language is in keeping with Federal law and regulation. As of May 2003, HIPAA (Health Insurance Portability & Accountability Act) mandated that all health care providers billing for medical services rendered to patients covered by Medicare, Medicaid, health insurance, etc., must utilize national electronic standards to transmit medical data required for the adjudication of a medical bill. The HIPAA format utilizes the standards developed by the Accredited Standards Committee which was chartered in 1979 by the American National Standards Institute. This mandate applies to all health care providers with limited exceptions.

While jurisdictional workers' compensation programs are exempt from compliance with HIPAA requirements, it is important to understand that the same health care providers who are required to comply with HIPAA regulations, and are treating patients covered under Medicare, Medicaid, and private health insurance also treat injured employees who are covered under the Florida Workers' Compensation system. Therefore, it is reasonable to allow the health care provider to utilize the electronic standards' software existing in their offices, thereby, eliminating any additional administrative burden on the providers.

Currently, two large states, California and Texas, have passed legislation mandating that insurers must accept workers' compensation medical bills submitted by health care providers in an electronic format. Both states involved multiple organizations representing various industry stakeholders in the development of rules to implement the statutory language mandating that insurers must accept medical billing data electronically from health care providers. In these states, stakeholders in attendance included representatives of various health care provider organizations who in turn were not opposed to submitting workers' compensation medical bills electronically, but were adamant that the electronic billing format for the workers' compensation programs utilize the HIPAA compliant software programs already in use.

A number of other state workers' compensation programs, such as Ohio, Pennsylvania, North Carolina and Oregon, are contemplating the implementation of similar legislative mandates for workers' compensation insurers conducting business in these states. This certainly demonstrates a united movement across the country by health care providers who desire uniformity in the electronic billing format.

It should be noted that electronic billing is not limited to the submission of the medical bill. Rather, it involves all communication between a health care provider and an insurer necessary to adjudicate a medical bill. The electronic communication includes, but is not limited to, the electronic transmission of medical records, treatment plans, functional restrictions and limitations, dates of maximum medical improvement, and permanent impairment ratings.

An even more compelling example involves the International Association of Industrial Accident Boards and Commissions (IAIABC), a not-for-profit trade association representing government agencies charged with the administration of workers' compensation systems throughout the United States, Canada, and other nations and territories. Founded in 1914, the IAIABC is the world's oldest trade association dedicated to promoting the advancement of workers' compensation systems throughout the world through education, research, and resource management. To demonstrate their commitment on this issue, a standing committee within the organization, the Electronic Data Interchange Committee is currently developing generic companion guides that are HIPAA compliant which support multiple state jurisdictions considering regulation for electronic filing of medical data between a health care provider and an insurer. The committee's goal is to finalize the companion guides in 2007, thus providing the generic standards addressing workers' compensation business needs to state jurisdictional workers' compensation programs.

Many health care providers are currently utilizing national electronic billing standards to bill for services rendered to patients covered under Medicare, Medicaid, private health insurance, etc. As these health care providers also treat injured employees covered under the Florida workers' compensation system, it is logical that the health care provider is demanding the ability to electronically transmit workers' compensation medical bill data to the insurer utilizing national standards.

Many health care providers throughout Florida are converting office functions to an electronic system. Through the integration of standardized national electronic transmissions, health care providers are able to reduce operational effort and expense and promote the efficient timely filing of medical bills by: 1) electronically validating workers' compensation eligibility; 2) utilizing national standards to transmit medical data to a myriad of payors; 3) maintaining electronic medical records, thus eliminating paper files and the need to maintain excessive office space; 4) electronically transmitting required medical records to payors resulting in an elimination of paper files; 5) validating compliance with the submission of medical information pursuant to the payors' document submission policies; 6) giving the health care provider submission validation of a medical bill; and 7) reducing the likelihood for disputes and other issues that cause delays in

payment, thereby reducing operational expense and enhancing reimbursement and cash flow.

Currently, insurers conducting workers' compensation business in multiple states as well as providing health insurance coverage in these states maintain numerous proprietary electronic formats and legacy software systems. Converting to the use of national standards for all lines of business would generate a tremendous cost savings to the industry by reducing internal operating expenses.

As the electronic transmission of medical data is not limited to the medical billing form, but includes all information necessary to adjudicate a medical bill, i.e., medical records, treatment plans, etc., insurer requirement to provide multiple copies of the provider's medical records is eliminated as the electronic information would be available to multiple insurer staff. Additionally, electronic transmission of medical data reduces the amount of paper handling, facilitates timely utilization review of medical services rendered to the injured employee, improves treatment authorization timelines, and enhances timely determination of the injured employee's status and treatment plans as related to injured employee benefits.

Insurers receiving medical data electronically from a health care provider will experience a reduction in both data entry and data entry errors as the use of standardized electronic transmissions affords the insurer the ability to assimilate the provider data directly into the insurer's system. The insurer can then extract the required provider medical data when electronically filing state required medical data to workers' compensation jurisdictions.

The electronic standards elevate timely communication between an insurer and a health care provider. The insurer is able to electronically transfer remittance and utilize national code sets to explain the insurers' reimbursement decisions to the health care provider.

Utilization of national electronic transaction sets and code sets is a win-win situation for health care providers, insurers and the Florida workers' compensation system. Stakeholders experience a reduction of operational effort and expense by using standard transmissions to communicate between the health care provider and insurer, file medical bills and necessary medical information, and report medical data to the state workers' compensation program. The stakeholders should also experience a reduction in data entry and data entry errors. With the availability of valid data, the Florida workers' compensation program is better able to compare medical costs and medical treatment with other state workers' compensation programs, identify cost drivers, and implement programmatic changes to improve the system to ensure quality medical care to the injured employees in the state of Florida and promote early return to work, all at a more reasonable cost to employers. Specifically:

- Pursuant to Rule 69L-7.602(4)(f)2, F.A.C., the Division should continue to allow health care providers to electronically submit medical bills to insurers,

provided the insurer agrees to accept the submission of electronic medical bills.

- Texas and California have statutorily mandated that insurers accept medical bills that are electronically submitted to them from health care providers. The Division should evaluate and analyze the results from Texas and California regarding the outcomes of their respective mandates, and determine what, if any, benefits such a mandate would have on the Florida's workers' compensation system.

PROGRAM ADMINISTRATION: UNIFORM MEDICAL TREATMENT/STATUS REPORTING FORM, DFS-F5-DWC-25

Physicians must regularly provide information to the insurer concerning patient treatment and status. To minimize the administrative burden for these necessary communications, the *Uniform Medical Treatment/Status Reporting Form*, Form DFS-F5-DWC-25 (DWC-25) was created as the sole and exclusive Division-required form to be completed by the physician.

This standardized approach allows timely physician communication with any insurer and/or employer to report the medical status of the injured employee. The form includes identification of functional restrictions and limitations to facilitate earlier return to work, the establishment of maximum medical improvement and assignment of permanent impairment rating, documentation of the physician's determination if the accident/injury is the major contributing cause and provides the injured employee with timely information regarding his/her condition. Additionally, the DWC-25 form is a written request for authorization that facilitates timely approval of medically necessary treatment of the injured employee, thereby enhancing timely access to medical care. The intent of the DWC-25 form as a standardized communication tool is to reduce the flow of paperwork in the provider and insurer offices while enhancing communication between the insurer, provider, employer and patient regarding the injured employee's treatment and status to provide the best medical care, in real time, to the injured employee.

In 2002, the Division and the Agency conducted a survey of the statewide workers' compensation certified physician population, pursuant to s. 440.13(12)(e), F.S. The results of this survey revealed the physician's foremost complaints related to the Florida workers' compensation system: 1) low reimbursement; 2) excessive paperwork; 3) untimely carrier authorization of services; and 4) lack of communication. In addition, the Agency and Division received input from the insurer community regarding the inability to obtain timely reports of patient status, specifically the inability to gain functional restrictions and limitations related to work status, treatment plans and permanent impairment ratings from physicians.

The 2003 Workers' Compensation Statutory Reform addressed the physicians' primary complaint regarding the workers' compensation system by providing increased reimbursement to physicians and clinicians. This increased reimbursement served as an incentive for physicians to participate in the workers' compensation system as is evidenced by the increase in the total number of physicians providing services during 2003 (27473) compared to the total number of physicians providing services during 2004 (28507), according to the Division's Office of Data Quality and Collection. However, the complaints regarding excessive paperwork, untimely authorization of physician recommended treatment and lack of communication remained unanswered by the statutes. Although the 2003 Workers' Compensation Statutory Reform did not directly address these physician issues, the statutes did provide rule authority in s. 440.13(4), F.S., to develop the *Uniform Medical Treatment/Status Reporting Form* (DWC-25), which was

created to address the physician, insurer, employer and employee concerns identified above.

The creation of a singular, structured vehicle for: 1) enhancing communication between all parties involved in the medical care and treatment of the injured worker, 2) reducing the amount of paperwork involved in that communication, and 3) promoting the injured employee's access to care arose from collaboration between the Division, the Agency and industry experts, as well as feedback and input from representative industry stakeholders and all the major medical societies. After a brief implementation period, the Division obtained additional input through partnering with the Florida Medical Association in a focus group meeting that included Division associates, members of the Medical Services Unit and approximately 25 physicians of varied specialties from around the state, as well as representatives from the carrier community and medical networks. Practical feedback and input was gained from the end-users for incorporation into the reporting form, which resulted in a revised version of the DWC-25 that is now widely accepted by physicians and insurers alike, and provides the stability of a document that the industry can incorporate into their regular work flow, policies and procedures.

The use of a standardized form for communication, the DWC-25, affords the following additional benefits to the system:

- Reduction of paperwork in both the physician and insurer offices. The DWC-25 form eliminated the previously required DWC-8, *Preliminary Notice of Injury and Treatment* and DWC-9a, *Report of Permanent Impairment Rating*. Furthermore, the Division established that no other forms could be used in lieu of or in addition to the DWC-25. The DWC-25 form provides one uniform, standardized document for completion by the physician and eliminates the variety of forms and paperwork previously used by individual insurers and physicians. In turn, this answered the physician's complaint of excessive paperwork that was identified in the Division-conducted survey in 2002.
- Timely communication of the injured employee's status to the employee, employer and insurer. The DWC-25 form is required to be submitted to the insurer, and employer upon request, by close of business on the day following treatment. The exception to this submission timeframe occurs following initial treatment of the injured employee, which, pursuant to s. 440.13(4), F.S., allows the physician three days to notify the insurer of the injured employee's status. Physicians have reported that, while not required, they give a copy of the DWC-25 form to the injured employee to clearly communicate the functional limitations and restrictions related to the work injury/illness. This, in turn, identifies to the injured employee his/her functional abilities that will not impede or prolong recovery and the ongoing treatment plan.
- Physician declaration of causality of the medical condition. While compensability of an injury/illness remains the domain of the employer and/or insurer, the physician, when able to objectively relate the clinical dysfunction or condition to a specific accident, occurrence, exposure or other stimuli,

establishes causality. The DWC-25 form requires the physician to declare whether or not the accident or occurrence is more responsible for the resulting clinical disturbance and/or functional loss than all other factors combined (major contributing cause), as defined in s. 440.09, F.S.

- Timely provision of the date of maximum medical improvement or an estimate of when the injured employee may achieve maximum medical improvement. The DWC-25 requires the physician to evaluate the injured employee's progress toward maximum medical improvement at each and every visit. In turn, with timely notification of the injured employee's achievement of maximum medical improvement and establishment of any permanent impairment rating, the insurer may provide additional benefits due the injured employee and facilitate return to work without prolonged lost time.

- Timely insurer authorization of physician referrals, diagnostic testing and treatment plans. Since the DWC-25 form serves as a written request for authorization of treatment, the insurer has a maximum of three days to respond (ten days for select circumstances), pursuant to ss. 440.13(3)(d) and (i), F.S. In the event that the insurer fails to respond to a written request for authorization of treatment within the prescribed timeframe, the statutes provide that the insurer "consents to the medical necessity for such treatment", pursuant to s. 440.13(3)(d), F.S. This directly addresses the physician's complaint of untimely insurer authorization of treatment plans and enhances the employee's access to medically necessary care. In addition, the transmission of critical information in a standardized format addresses the employer and/or insurer's concerns about the lack of information from which to make authorization determinations. The net result is that the obstacles to authorizing and obtaining medical care have been significantly addressed from both the consumer and provider perspectives.

- Timely employer notification of the injured employee's functional limitations and restrictions**.** The physician is required to be specific about limitations and restrictions prescribed for the patient. Generic terms, such as light duty, are no longer permitted. The physician must specify the parameters of function such as frequency, activity, load and repetitions that may be performed by the injured employee without anticipated injury or delayed recovery. Provision of the completed DWC-25 form to the injured employee and employer eliminates confusion about the injured employee's functional limitations and restrictions related to suitable work. Additionally, it allows the employer to determine if work is available that will accommodate the prescribed limitations and restrictions although the work duties of that job may differ from the injured employee's normal work duties.

- Utilization and implementation of the Standards of Care through clearly defined plans of treatment. The form requires the physician to base the treatment plan on objective, relevant medical findings and: 1) specify frequency and duration for therapies; 2) recommend referral to a physician specialty, but allow the carrier to determine the specialist; 3) order medically

necessary supplies or equipment; and 4) order additional diagnostic testing. This increased clarity, specificity, and consistency of documentation results in more timely authorizations, faster access to needed care, and reduced disputes over medically related issues.

- Physician on-going re-evaluation of all care that is being provided, including functional limitations/restrictions and prescription medications. The DWC-25 form must be completed by the physician and submitted to the insurer, and employer upon request, after each and every encounter, between visits based on reports from specialists, physical therapists or other relevant sources, or at a minimum of once every thirty days. Completion of the form requires the physician to review the injured employee's status and current treatment plan, report any changes in clinical or functional status, review prescribed medication, evaluate the injured employee's progress and reassess the medical necessity of the ongoing treatment plan, which promotes physician compliance with s. 440.13(16), F.S. Prior to the change in statutory requirements and the implementation of the DWC-25 form, case durations were often extended unnecessarily resulting in poor clinical outcomes and prolonged disability. In fact, in many of the older claims, patients and treatment plans were only evaluated once per year to maintain the open status of their claim. This more responsive standard of reporting, including the thirty-day minimum submission requirement, promotes physician compliance with statutory requirements as well as facilitates appropriate treatment and optimal outcomes for the injured employee.
- Provision of Patient Classifications which:
  - Convey to the insurer the complexity of services that may be required for optimal clinical management.
  - Distinguish the overall critical differences among cases that influence the intensity, scope and cost of services provide.
  - Facilitate recognition of configurations that affect the medical treatment plan and treatment plan progress or other available benefits for an injured employee.
  - Facilitate decisions related to authorization of recommended treatment plans or treatment plan revisions.

The standardization of this information aids in addressing the most commonly disputed issue in workers' compensation, specifically the authorization of medical services. The patient classifications assist in defining the injured worker's specific clinical picture so both physician and consumer have an objective, practical basis from which to make decisions.

The Division, in concert with all disciplines involved in the provision of medical care to the Florida injured employee, developed the DWC-25. Direct input was received from all stakeholders. The Division participated in a series of statewide educational seminars to present information regarding the completion, submission, purpose and benefits of the DWC-25. Additionally, since the concept of one standardized form was a departure from

the historic forms used in the workers' compensation program, an internet-based tutorial was made available to the public, at no charge, to enhance understanding of the form.

Since the DWC-25 was first adopted for use on July 4, 2004, the Medical Services Unit, which is responsible for providing technical assistance to both health care providers and insurers, has noted an absence of complaints from the physician community regarding the ability to gain timely authorization for proposed treatment and from the insurers regarding the ability to gain meaningful functional restrictions and limitations, dates of maximum medical improvement, and assignment of permanent impairment ratings. Additionally, data analysis conducted by the Division's Office of Data Quality and Collection confirms an overall seven percent increase in the number of physicians providing medical services to workers' compensation patients from calendar year 2003 to 2005. Previously, the increase in the number of physician's participating in the workers' compensation system in 2003 versus those participating in the system in 2004 was attributed to the increased reimbursement that resulted from the 2003 Workers' Compensation Statutory Reform. However, the increase in the total number of physicians providing medical services in 2004 (28507) as compared to the total number of physicians providing services in 2005 (29115) must be considered the result of not only the increased reimbursement for physicians and clinicians which addressed the number one complaint in the 2002 Division-conducted survey of physicians, but also the implementation of the DWC-25, which positively impacted the physicians' complaints regarding excessive paperwork, untimely authorization of care and treatment plans, and lack of communication. Future plans include a resurvey of the physicians providing medical services in the workers' compensation system to obtain input as to whether there are currently any additional barriers to assuring an effective, accessible health care delivery system for Florida's injured employees.

PROGRAM ADMINISTRATION: PRACTICE GUIDELINES AND EVIDENCE BASED MEDICINE

Historically, the most challenging aspect of workers' compensation has been the lack of agreement on the core tenet of the entire system…"*medical*." In fact, a widely stated axiom among industry stakeholders is that "*medical* drives the claim" noting that, ultimately, all issues and decisions in workers' compensation are either directly or indirectly linked to a medically-related determination. Yet as fundamental to the system as is the diagnosis and treatment of the injured worker, it is routinely poorly understood, poorly communicated and widely disputed. It has been well documented in the literature that there are wide variations in medical care that can not be accounted for by the demographic or clinical factors of the individual case[1]. Consistent with that finding is a fact noted during the investigation mandated in 2002 by Senate Bill 108 that, other than attorneys' fees[2], medically-related disputes comprised the overwhelming majority of issues cited on petitions-for-benefits, appearing on well over 90 percent of the filings. Finally, the cost of medical care has continued to rise, both in real dollars and as a percentage of the overall workers' compensation cost. Given the fundamental basis that medically-related determinations serve in the system, the practice variations and associated confusion and conflict, escalating costs and excessive litigation, it is understandable that jurisdictions have looked for options to better define and regulate medical services.

To that end, one of the major areas of reform included in the 2003 workers' compensation legislation (SB 50A) was in the area of medical definitions and criteria for practice. Further clarification of the criteria for what does and does not substantiate an illness, serves as the basis for medical causality, and effective medical care and recovery now have a fundamental basis in statute (s. 440.09(1), F.S. and s. 440.13(16), F.S.). In addition, further clarification and application of these statutory principles are outlined in the associated regulations implementing the statute, specifically, rule 69L-7.020, F.A.C. (Florida Workers' Compensation Health Care Provider Reimbursement Manual) and rule 69L-7.602(4)(c), F.A.C. (Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule).

As noted elsewhere in this report, the statutory and regulatory provisions are still in the evolutionary process of being fully integrated into the workers' compensation medical delivery system in that there is still not universal and consistent use and application of these principles and criteria. However, it seems to be widely acknowledged that to the extent that there has been a reasonable level of integration and utilization, these medically-related system enhancements must, at least in part, be responsible for many of the system improvements that have been reported elsewhere in this report, including, but not limited to increased access to care, improved communication between providers and consumers, decreased disputes regarding authorization for services or medical necessity,

[1] E.P. Steinberg et al., "Evidence Based? Caveat Emptor!" Health Affairs Vol. 24 No. 1 (2005) 80-92.
[2] At the time, the procedure for filings required that attorneys' fees be included with the petitions, and therefore was not an accurate representation about when the fees were actually an issue of dispute.

decreased lost time and disability, and greater satisfaction of the various industry stakeholders. These results are especially evident in those market-driven situations where the employers, carriers and local clinicians have worked together to capitalize on the reforms by ensuring compliance and mutual understanding.

Senate Bill 50A included language regarding the adoption of practice parameters. Specifically, s. 440.13(15), F.S., states "The practice parameters and protocols mandated under this chapter shall be the practice parameters and protocols adopted by the United States Agency for Healthcare Research and Quality (AHRQ) in effect on January 1, 2003." AHRQ maintains a data base called the National Guideline Clearinghouse (NGC) where it provides a listing and access to the practice guidelines it adopts. The NGC can be accessed at http://www.guideline.gov/. Unfortunately, although the intention of the promulgation of this provision was well intended, s. 440.13(15), F.S., has both substantive and technical problems.

One of the most problematic aspects of s. 440.13(15), F.S., is the fact that there were *little or no* relevant practice guidelines adopted by AHRQ and listed on the NGC website as of January 1, 2003. For example, two of the more popular practice guidelines concerning occupational injuries, The Official Disability Guidelines (ODG) published by the Work Loss Data Institute (WLDI) *and* the Occupational Medicine Practice Guideline published by the American College of Occupational and Environmental Physicians would *not* be acceptable for use given the current statutory directive of being listed as of January 1, 2003. The one major guideline that had been adopted prior to January 1, 2003, Acute Low Back Problems in Adults (Clinical Practice Guideline No. 14 AHCPR Dec 1994), was withdrawn prior to the legislation and continues to be listed as a "withdrawn guideline". Therefore, from a technical standpoint, one *cannot* be in compliance with this statutory provision, as it mandates a requirement that is essentially impossible to fulfill.

More to the issue, *regardless* of the January 1, 2003 date limitation issue, the adoption of practice guidelines and protocols by AHRQ does not necessarily equate with the quality or validity of the guidelines. AHRQ states:

> Although AHRQ, AMA, and AAHP-HIAA set minimum inclusion criteria which are published in the *Federal Register* and on this site, NGC partners do not make judgments regarding the comparative quality of information on the site. AHRQ verifies that each guideline meets the established minimum criteria for inclusion, but does not verify or evaluate accuracy of the individual guideline content. Guideline summaries provide users of the site with categories for comparing the guidelines in the database.

Therefore, the mere inclusion of a given guideline does not insure the relative quality or validity of the resultant recommendations or the science behind them. In fairness, this last issue is a problem that transcends inclusion on the NGC website. Defining what is and is not acceptable science or a valid recommendation regarding clinical practice is an extremely challenging endeavor on a multitude of levels. Therefore, some historical perspective and background is required in order to fully understand the options and

limitations of moving towards a more scientific and accountable approach to providing and consuming medical care and service.

Florida's first attempt at implementing legislation to adopt the use of specific practice guidelines was in 1993. Workers' compensation legislation was passed during a special session and along with an industry changing move to mandated state certified managed care, the use of practice parameters were also mandated. Specifically, the 1993 version of s. 440.13(15), F.S., stated:

(15) PRACTICE PARAMETERS

(a) The Agency for Health Care Administration, in conjunction with the division and appropriate health professional associations and health-related organizations, shall develop and may adopt by rule scientifically sound practice parameters for medical procedures relevant to workers' compensation claimants. Practice parameters developed under this section must focus on identifying effective remedial treatments and promoting the appropriate utilization of health care resources. Priority must be given to those procedures that involve the greatest utilization of resources either because they are the most costly or because they are the most frequently performed. Practice parameters for treatment of the ten top procedures associated with workers' compensation injuries including the remedial treatment of lower-back injuries must be developed by December 31, 1994.

(b) The guidelines may be initially based on guidelines prepared by nationally recognized health care institutions and professional organizations but should be tailored to meet the workers' compensation goal of returning employees to full employment as quickly as medically possible, taking into consideration outcomes-data collected from managed care providers and any other inpatient and outpatient facilities serving workers' compensation claimants.

(c) Procedures must be instituted which provide for the periodic review and revision of practice parameters based on the latest outcomes-data, research findings, technological advancements, and clinical experiences, at least once every 3 years.

(d) Practice parameters developed under this section must be used by carriers and the division in evaluating the appropriateness and over-utilization of medical services provided to injured employees.

Subsequently, the Agency did address two guidelines:

1) Universe of Florida Patients with Low Back Pain or Injury was endorsed on October 6, 1995 and amended on February 2, 1996.
2) Universe of Florida Patients with Neck Pain or Injury endorsed on March 15, 1996 were published, but never adopted by rule.

Interestingly, the AHCPR Adult Low Back Guidelines No. 14 noted in the NGC discussion above were the original guidelines adopted, and then an additional Agency version was promulgated as well to coexist with the AHCRP version. The above statutory language above did not change until SB 50A in 2003, when s. 440.13(15), F.S., was changed (as discussed earlier in this section) to read:

> (15) PRACTICE PARAMETERS.—The practice parameters and protocols mandated under this chapter shall be the practice parameters and protocols adopted by the United States Agency for Healthcare Research and Quality in effect on January 1, 2003.

Over the last decade or more, a wide-scale movement towards integrating more science and accountability into both the provision and consumption of medical services has occurred. This has been especially challenging for occupational medicine and workers' compensation systems as the type of injuries and conditions typically associated with workplace accidents and exposures do not have as much research as other areas of medical practice (e.g. cardiology, oncology). In addition, the confirmation of those illnesses tend to be more tangible (e.g. lab tests, biopsy, ECG) where many of the injuries and illnesses seen in the workers" compensation arena are more difficult to isolate and quantify. Medical assessments of workers' compensation injuries and illnesses frequently focus on subjective complaints and reported functional difficulties and are often difficult to substantiate clinically, or are a result of the natural wear and tear on the body, which makes it difficult to separate and identify the medical conditions that are a result of a *work-related* injury or illness. Moreover, the system's *additional* responsibility for the *disability* aspect of an illness (i.e. functional limitations, work status) only further complicates the overall clinical picture and makes specificity of measures and formal investigation that much more convoluted.

Despite the inherent difficulties, most states and many governmental jurisdictions internationally are either involved in or are considering integrating some sort of system of practice guidelines into their workers' compensation systems. However, the issue is not guidelines per se, but the use of ***evidenced-based medical practice*** **(EBM)**. The factors driving this trend include[3]:

1. recognition that there is much geographic variation in the frequency with medical and surgical procedures are performed, the way in which patients with a given disease are managed, patient outcomes, and the costs of care, which cannot be explained by differences in the patients' demographic or clinical characteristics;
2. strong evidence that much of the care that is being provided is inappropriate (that is likely to provide no benefit or cause more harm than good);
3. indications that many patients are not receiving beneficial services;
4. continuously rising health care costs.

Therefore, it would seem good public policy to institute legislative or regulatory provisions that would mandate, or at the very least, facilitate the use of evidenced-based

[3] E.P. Steinberg et al., "Evidence Based? Caveat Emptor!" Health Affairs Vol. 24 No. 1 (2005) 80-92.

medical practice. Unfortunately, implementation of an EBM system is not as straightforward a task as it would seem.

Dr. D.L. Sackett, an early proponent and one of the most authoritative voices in the field, defined EBM as the "conscious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" the practice of which requires "integrating individual clinical expertise with the best available clinical evidence from systematic research."[4]

Logical and unarguable, it is not the definition but the application that becomes difficult to apply, as the question now becomes "what constitutes evidence?" Steinberg and Lee, in their critical analysis of EBM, provide the following insights.[5] They warn that although there has been much progress over the last two decades in evaluating the strength of evidence of an individual study, implicit in a body of evidence composed of the results of many studies, and underlying a clinical practice guideline or standard, there are still significant limitations in each activity. Furthermore, additional methodological issues and concerns arise as one moves from assessing an individual study, to a body of evidence, to a guideline or standard. In general, the ability to assess the strength of evidence becomes increasingly difficult as one moves through the continuum (*individual study*, a *body of evidence*, a *guideline or standard*).

The mere fact that a scientific study has been published in a peer-reviewed journal does not guarantee that the study was methodologically sound, was well conducted, that the analysis was performed correctly, or that results were interpreted properly. Therefore, before one decides how much credence to apply to a studies finding, it is necessary to evaluate the "quality" and relevance (applicability) of the study. Different types of studies have different degrees of susceptibility of bias; therefore study design is an important consideration. There is general agreement that susceptibility of bias is lowest in well-designed and executed randomized controlled trials (RCT), and increases in the following order of study designs: nonrandomized controlled trials, prospective studies or retrospective cohort studies, cross-sectional studies, case control studies, case series and registries, and case reports. However, a study design is but one criterion among many that can affect a studies quality.

Beyond a *single study*, it seems desirable to assess a *body of evidence* (multiple studies). Obvious benefits of reviewing more than one study are increased sample size and the ability to see if the results could be repeated or were a result of chance. However, it is more difficult to rate the quality of a *body of evidence* when reviewing multiple studies, as it is not only necessary to assess the quality of each study, but to also assess the consistency of the various study results and the heterogeneity of key elements of study design in order to determine comparability. Meta-analysis and other statistical approaches have become more sophisticated over the last decade, but still require a fair amount of subjectivity in judgments regarding admissibility, relevance, or importance of a particular piece of evidence.

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[4] Sackett DL, et al., "Evidenced based medicine: what it is and what it isn't." BMJ 1996, 312(7023):71-2
[5] Ibid.

In turn, evaluating the strength of evidence underlying a *practice guideline* is even more difficult than assessing the strength of a *body of evidence* (multiple studies) because guidelines often requires evaluation of several *bodies of evidence*, each which relates to a different link in the chain of reasoning. This only complicates matters further by requiring more judgments on more issues introducing even greater subjectivity and potential for bias.

Finally, the absence of evidence for a particular procedure or intervention does not necessarily mean it is not effective or safe. Currently, many medical practices have not yet been vigorously evaluated. Estimates in this area are staggering. One author noted that between 50-85 percent of all medical treatments have never been validated by clinical trials,[6] while the Institute of Medicine (IOM) note that only about four percent have strong strength of evidence, while more than 50 percent have weak or no evidence.[7]

Even the United States Agency for Healthcare Research and Quality (AHRQ)/National Guideline Clearinghouse (NGC) provides the following caveat in their discussion of the use of the practice guidelines they chose to include:

> These guidelines are not fixed protocols that must be followed, but are intended for health care professionals and providers to consider. While they identify and describe generally recommended courses of intervention, they are not presented as a substitute for the advice of a physician or other knowledgeable health care professional or provider. Individual patients may require different treatments from those specified in a given guideline. Guidelines are not entirely inclusive or exclusive of all methods of reasonable care that can obtain/produce the same results. While guidelines can be written that take into account variations in clinical settings, resources, or common patient characteristics, they cannot address the unique needs of each patient nor the combination of resources available to a particular community or health care professional or provider. Deviations from clinical practice guidelines may be justified by individual circumstances. Thus, guidelines must be applied based on individual patient needs using professional judgment.[8]

This raises the eternal argument by many whether medicine is an art or a science. One definition offered may provide a practical definition and resolve this debate; "medicine is a science – the science of which is the ability to consistently and predictably reproduce the art".

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[6] M.M. Millenson, Beyond the Managed Care Backlash: Medicine in the Information Age, PPI Policy Report no 1 (Washington: Progressive Policy Institute, 1997).
[7] M.J. Field and K.N. Lohr, eds,. Guidelines for Clinical Practice: From development to Use (Washington: National Academies press, 1992).
[8] http://www.guideline.gov/about/disclaimer.aspx.

The good news is that the medical community and the health care industry are increasingly becoming more committed to both performing well-constructed scientific studies and clinical investigations and integrating the results of validated clinical research into their practice patterns. Employers, insurers, the legal community, regulators and public policy makers are also likewise becoming more judicious consumers by increasingly integrating evidenced-based medicine as a cornerstone to their decisions. This is critical as only through accountability and scientific rigor can we hope to improve the care we provide and the results we achieve, in both human and financial terms.

In summary, both as consumers and providers, we are at a crossroads. Significant limitations in the availability, definitive nature and relative applicability of the available clinical research and scientific literature regarding work related illness and injury still exist. However, there is also little doubt that the judicious and responsible use of this same information is safer, provides greater accountability, and produces far better results both clinically and financially. Therefore, given the present stage of development and fluid nature of the body of knowledge, it is strongly recommended that workers' compensation statute ***avoid*** any endorsement or specific assignment of a given practice guideline or resource. It is, however, recommended that statute and regulation mandate the appropriate use of evidenced-based medical practice (EBM) and a framework for the responsible and practical integration of research and best practice strategies into all aspects of the workers' compensation system.

As always, a comprehensive and integrated approach must be taken in regards to EBM or it will create more problems that it resolves. For example, successful application of EBM requires that:

- The statute and regulations establish a policy of support for, and a deference to, determinations based on science and clinical research, as well as clear and practical definitions, criteria and rules of engagement for applying EBM.
- Physicians and other clinician providers are given incentives via referral, authorization and reimbursement enhancements, given proper and ongoing education and training, and are supported in the dispute and litigation process.
- Employers and carriers must utilize the same information and criteria in their decisions regarding referrals, authorizations, and reimbursement practices, administrative work flow, work/duty status and other related disability determinations.
- The legal system must adjudicate medically-related disputes using the same information, i.e. based *on* the relative merit (strength and applicability of the evidence) of the relevant clinical variables in question, and *not* on the credentials of the practitioners, the behavior of the participants, or as a compromise or based on other irrelevant criteria.

Therefore, a conceptual model that is both practical and academically honest is required. The following model accounts for all three aspects of responsible criteria-based clinical practice and provides a fundamental framework for utilization.

- There should be a ***deference*** to the treating practitioners, therefore, recommendations and requests for evaluation, diagnostic testing, and/or treatment should be routinely approved *unless* there are specific, relevant, merit-based reasons to question or deny authorization (i.e. requested service is clearly not necessary, appropriate, or additional information or clarification is required). This same *deference* shall be applied in dispute resolution in that, given essentially equal levels of documentation and support for either side of a dispute between the treating clinician and a consulting clinician, the treating clinician would be given deference.
- All parties, including, but not limited to, physicians and other relevant clinicians, employers, injured workers, carriers, medical case managers and advisors, medical networks, attorneys and Judges of Compensation Claims and even regulators and legislators shall make all attempts to make medical and related decisions and determinations based on the merits of the issue utilizing evidenced-based medicine. A criteria-based ***hierarchy*** is outlined, in descending order, below:

    - **Specific Research Support**
        - Specific, relevant, scientific studies published in widely-respected juried journals (i.e. random controlled trials (RCT), systematic reviews of controlled trials).
    - **Professional Consensus**
        - Integrating science and practice (i.e. evidenced-based practice guidelines or other relevant position papers from respected organizations such as ODG/WDLI, AAOS, AHRQ, etc).
    - **Principle-based** (*inherent logic*)
        - Established and well-defined clinical reasoning applied to relevant anatomical, physiological, pathological, and clinical principles. Case-specific data (objective, relevant exam findings), outcomes and measures should be utilized for accountability.

Therefore, the following is specifically recommended as an overall approach to further integrating EBM into the Florida workers' compensation system:

1. ***Eliminate*** the current language in s. 440.13(15), F.S.
2. ***Revise*** s. 440.13(15), F.S., to adopt the following statutory framework:

    In addition to and consistent with, clinical definitions, criteria and standards already outlined elsewhere in this chapter, all medical and related decisions shall be made utilizing evidenced-based medicine (EBM) as defined in the following ***hierarchy***:

    a. **Specific Research Support:** Highest level of deference - Specific, relevant, scientific studies published in widely-respected juried journals, i.e. random controlled trials (RCT), systematic reviews of controlled trials.

b. **Professional Consensus:** Second level of deference - Integrating science and practice, i.e. evidenced-based practice guidelines or other relevant position papers from widely recognized organizations.
c. **Principle-Based (*inherent logic*):** Third level of deference - established and well-defined clinical reasoning applied to relevant anatomical, physiological, pathological, and clinical principles. Case-specific data (objective, relevant exam findings), outcomes and measures should be utilized for accountability.
d. Deference by ***all*** parties should be made regarding medical and related decisions and determinations to those best supported by and consistent with the clinical definitions, criteria and standards outlined elsewhere in this chapter and via evidenced-based criteria as outlined above.
e. Regarding intention and competency, there should be a deference on behalf of the treating practitioners, and therefore recommendations and requests for evaluation, diagnostic testing, and/or treatment should be routinely approved unless there are specific, relevant, merit-based reasons to question or deny authorization (i.e. requested service is clearly not necessary, appropriate, or additional information or clarification is required). This same deference should be applied in dispute resolution in that, given essentially equal levels of documentation and support for either side of a dispute between the treating clinician and a consulting clinician, the treating clinician would be given deference.
    i. This does not eliminate the requirement and responsibility of the treating physician to utilize evidenced-medicine as defined above, nor does it eliminate the employer/carriers' responsibility or the obligation to question, or if appropriate, deny services that are not consistent with the evidenced-based provisions outlined above.

3. ***Insert*** language in the s. 440.02, F.S. (i.e. definition section):

    a. ***Evidenced-based medicine*** is defined as the conscious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients, the practice of which requires integrating individual clinical expertise with the best available clinical evidence from systematic research.
    b. ***Practice Guidelines*** are defined as systematically developed statements to assist practitioner and patient/consumer decisions about appropriate health care for specific clinical circumstances. They are a set of statements, directions, or principles presenting current or future clinical rules or policy concerning the proper indications for performing a procedure or treatment or the proper management for specific clinical problems.

REIMBURSEMENT: GENERAL ISSUES

It is axiomatic that medical costs drive all other costs in the workers' compensation system. Within the workers' compensation health care delivery system, historically, reimbursement to physicians and other clinicians has been one of the central and more contentious issues affecting the successes or difficulties in the overall system. Issues such as access to care, utilization of services and medical decision-making, related benefit determinations, dispute resolution and litigation, and even final case resolution in both clinical and financial terms, are all significantly affected by both the dollar amount allowed for reimbursement and the structure of the reimbursement methodology.

Therefore, besides the perceived adequacy of the medical reimbursement (most typically represented by the specific dollar amount paid for a service), a number of other variables specifically relating to the health care delivery system provide opportunities to minimize administrative and economic burdens while still ensuring prompt and efficient delivery of medical benefits to the injured employee. As such, the following variables, while not all inclusive, require further research and consideration of their inter-relationships in accomplishing the legislative intent of facilitating the injured employee's optimal medical recovery and return to gainful employment at an affordable cost to Florida's employers. At a minimum, when considering methods to improve the workers' compensation health care delivery system, these fundamental variables relating to medical reimbursement should be considered:

- Clarity of definitions, rules and parameters within which services are rendered and reimbursed.
- Consistency in the application of definitions, rules and processes among all providers and insurers.
- Relative parity of reimbursement for the same or similar services irrespective of venue.
- Relative reimbursement among procedures based on complexity and resources required.
- Ease of billing.
- Timeliness of payment.
- The impact of specific reimbursement policies as either incentive or disincentive to appropriate access or utilization of a given service or procedure.
- Availability of an effective and efficient reimbursement dispute process.

These items, both individually and collectively, have as much influence on the relative success of the workers' compensation health care delivery system as does the actual dollar amount allowed for services in the statewide schedules of maximum reimbursement allowances adopted by the Three-Member Panel. To that end, a discussion of the current issues regarding reimbursement is offered, including recommendations for further consideration.

Florida's reimbursement schedule for physicians and other clinicians was widely known to be one of the lowest in the country until the mandate in SB 50A to increase the maximum reimbursement allowances for osteopaths and medical doctors to 110 percent of the Medicare allowance for non-surgical services and 140 percent for surgery. In that the Medicare allowances are based on the Resource-Based Relative Value System (RBRVS), which considers clinician knowledge and skill as well as other resources required to deliver the service, two important things were accomplished. First, clinicians received a much needed upward adjustment in what they were paid for the care that they rendered. Second, many of the procedures which had been reimbursed disproportionately less or more for no logical reason (because maximum reimbursement allowances had at one time been based almost exclusively on a designated percentile of the charge data collected from providers) were now reimbursed at more appropriate levels compared to other procedures. The Three-Member Panel expanded the increase to all physicians and to other designated clinicians (effective May 2005), thereby successfully implementing a true resource-based reimbursement methodology in the Florida workers' compensation program. This single action achieved a long-standing mutual objective of employers, clinicians, insurers and several previously appointed Three-Member Panels.

Since then, observation reveals that while the volume of overall petitions filed with the Agency for reimbursement dispute resolution has not decreased, the proportion of petitions from physicians and other practitioners (by far the largest group of health care providers) has decreased dramatically. In contrast, petitions received from the far smaller group of facility providers (hospitals and ambulatory surgery centers) have increased dramatically. Furthermore, in many cases, the physician and other practitioner disputes are more often associated with a technicality, such as the validity of the Current Physician's Terminology ® (CPT®) procedure code billed by the provider, the applicable CPT® edition from which the code is taken, or the carrier's independent application of proprietary edits or publicly available Medicare reimbursement policy edits rather than the "reasonableness"[9] or level of reimbursement in relationship to resources required to deliver the services or the relative reimbursement for similar service.

Regarding insurers' use of the Medicare edits for cost containment in workers' compensation, since 1996, the Medicare program has developed extensive reimbursement policies that encompass more than the basic procedure reporting guidelines that are published by the American Medical Association in the CPT®. The Centers for Medicare and Medicaid Services, as the administrator of the Medicare program (which, as noted earlier, the Florida workers' compensation program now uses to benchmark its maximum reimbursement allowances for most clinicians), is responsible for ensuring that beneficiaries and recipients of medical care receive the necessary covered services within its established program budgets. As a significant consumer of health care services, the

[9] See s. 440.13(12)(d)3, F.S. The Three-Member Panel must consider: " The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.4001, and its affect upon their ability to make available to injured workers such medically necessary treatment, care and attendance. The uniform *schedule* of maximum reimbursement allowances *must be reasonable*, must promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care and attendance to injured workers." (Italics added.)

Centers for Medicare and Medicaid Services is in the position to work with stakeholders on the provider and insurer sides to promote more cost-effective rules, definitions, and parameters within which medical services must be reported as well as uniform cost-containment adjudication policies for the purchasers of medical care. The cost-containment initiative undertaken by the Centers for Medicare and Medicaid Services was explicitly to minimize payment that might result from potential "reporting abuses" of certain kinds of services. The undertaking involved establishing policies, definitions and edits against which health care provider bills would be evaluated by insurers to identify procedure codes (not otherwise addressed by CPT® guidelines) that should be disallowed or allowed only after special scrutiny. Conducted in the public arena, and subject to on-going updating and revision, the extensive work product is known as the National Correct Coding Initiative. Because it addresses many issues beyond the minimal regulation in the current Florida workers' compensation reimbursement schedule for the same provider group, the National Correct Coding Initiative may be a valuable tool in expanding reimbursement rules and guidelines for some services to help control utilization and further contain costs.

The American Medical Association specialty societies and other interested parties are actively involved in providing input as to the appropriateness of the edits which are distributed by Medicare to its carriers and fiscal intermediaries and are available for public access via the Centers for Medicare and Medicaid Services website. The on-going revisions and updates are released on a quarterly basis, allowing time for the Three-Member Panel to work with the Division to evaluate whether specific edits are necessary or appropriate for specific application in the workers' compensation program. Examples of the National Correct Coding Initiative edits include the identification of certain codes that are never appropriate to reimburse when reported as rendered to the same person on the same date (i.e., "mutually exclusive" or "medically unlikely" such as services that are limited by anatomical or gender considerations) or codes that are considered an integral part of a more comprehensive service and should not be itemized separately (i.e., "unbundled" or charged individually to garner a higher reimbursement).

Clearly, not all the National Correct Coding Initiative edits are transferable to the workers' compensation program because Medicare does not cover all medical services that may be needed by an injured employee. However, it is recommended that there be a detailed investigation of applicability and, where appropriate, consideration of whether adoption by the Three-Member Panel of specific edits is feasible, in conjunction with the statewide schedule. Operationally, adoption of uniform edits will promote consistent billing practices among health care providers who have a clear understanding of what will be paid. Health care providers will not be frustrated by the uncertainty of reimbursement policies among different carriers attempting to contain medical payout. Additionally, standardized reimbursement policies will minimize the inappropriate application of proprietary edits developed internally by insurers. Both results will reduce unnecessary reimbursement disputes between carriers and individual health care providers. Moreover, to the extent that reimbursement policy affects health care providers' behavior, edits such as those developed under the National Correct Coding Initiative not only help to control utilization – but may even prevent over-utilization.

Turning from the implementation and follow-up issues stemming from SB 50A as it relates to reimbursement schedules for physicians and other practitioners, an even more significant set of issues requiring attention are the challenges encountered in the promulgation of facility reimbursement schedules adopted by the Three-Member Panel. Several factors appear to be impediments to successful regulation of reimbursement for services provided at hospitals and ambulatory surgery centers. In theory, SB 50A reduced payments to hospitals for selected outpatient services as a means of paying for the increases to physicians (see s. 440.13(12)(b), F.S.). However, in addition to the specified reductions in reimbursement for outpatient hospital services, SB 50A also resulted in the removal of two important stipulations in s. 440.13(12)(a), F.S. First, the Three-Member Panel would no longer be confined to limit schedule increases in any individual allowance to no more than the Consumer Price Index for the previous year. Secondly, the language was removed that required the carrier to pay a health care provider the lesser of the "usual and customary charge", the agreed-upon contract price, or the allowance in the schedule. The remaining statutory language required that all health care providers would be paid either the agreed-upon contract price or the allowance in the appropriate schedule – apparently, irrespective of the "charge", unless otherwise specified in the law. Herein lies the problem in that the statute retained the term "usual and customary charges" as a reference point for outpatient hospital reimbursement.

Current statutory language binds the Three-Member Panel to the adoption of a schedule based on a per diem reimbursement methodology for inpatient hospital care and dictates that outpatient hospital care (other than scheduled clinical laboratory, radiology and certain therapies) shall be reimbursed based on a percentage of "usual and customary charges." Inadvertently or not, the term "usual and customary charge" is not defined by Florida statute. (Research reveals that the definition of the term "usual and customary charge" can vary from state to state and among insurers.)

According to data available from the Agency for Health Care Administration, State Center for Health Statistics (2005) and other anecdotal reports, workers' compensation cases comprise three to six percent of hospital revenue. However, data filed with the Division's, Office of Data Quality and Collection reflects that approximately forty-one percent of the workers' compensation medical dollar is paid to hospitals, while another six percent is paid to ambulatory surgery centers. In addition to this disproportional revenue to volume relationship (the three to six percent of hospital revenue accounting for over forty percent of the workers' compensation medical dollars paid to hospitals), it is noteworthy that, during calendar year 2006, among petitions for reimbursement dispute resolution closed by the Agency, slightly more than sixty-six percent were from hospitals[10] (again, as noted, a far smaller provider constituency than the physician/ practitioner group). Adding to the difficulties is the fact that administrative appeals to the Agency determinations are no longer uncommon and add litigation and other friction costs to the system as insurers aggressively reject the previous laissez-faire acceptance of a "usual and customary charge" as the particular charge of a facility for its services.

[10] Ten percent of the petitions closed during the calendar year 2006 were from ambulatory surgery centers.

The lack of definition of this key criteria (i.e., "usual and customary charge") upon which reimbursement is to be determined, and legitimate differences in interpretation among stakeholders, will only increase litigation between facilities (each with unique accounting systems) and insurers attempting to determine "reasonable"[11] reimbursement for bills that routinely involve tens of thousands of dollars per admission or episode of treatment. Compelling arguments are raised on both sides in the growing quagmire of litigation over reimbursement based on "usual and customary charges".

Evidence of the impasse to which facilities and insurers have come on the issue of "usual and customary charge" is revealed in the written comments to the Division subsequent to the May 2006 public workshop with hospitals and insurers concerning the proposed hospital reimbursement manual and the application of "usual and customary charges". On May 30, 2006, Stephen Emmanuel, on behalf of the Florida Hospital Association wrote:

> The term "Usual and Customary" is not used in determining the reimbursement for outpatient surgeries in s. 440.13(12)(b)3. "Usual and Customary" should be defined (as it has historically been interpreted) as an individual's <sic> hospital's "billed charges". Under federal rules, these charges must be uniformly applied for all patients and insurers. Charges for specific services will vary from hospital to hospital. If they were uniform, hospitals would be accused of "price fixing".

On May 26, 2006, Tom Koval, Chairman of the Florida Insurance Council, and Tamela Perdue, Vice Chairman, sent a letter stating:

> Developing a solution to these ever increasing charges with no justifiable basis or even an avenue to determine their basis, is not only in the best interest of our members, it is part of our statutory obligation as carriers and employers in this state.

Currently, the Florida workers' compensation system does not allow control over how hospitals charge, nor does it define how costs are allocated among revenue centers when hospital services are billed or reported to insurers. Therefore, as there is no regulatory input (by either definition or accounting standards) over how hospital costs are translated into charges, it should be clear how fundamental issues such as the lack of a clear definition and inconsistent processes need to be addressed to eliminate the current contentiousness, lack of uniformity, and potential abuse regarding reimbursement based on "usual and customary charges".

Moreover, given that workers' compensation is a guaranteed insurer source for hospitals with no "hassle factor" associated with deductibles, co-payments, exclusions or policy limits, there is the potential for the workers' compensation system to bear more than its fair share of "usual and customary charges" through cost-shifting. If the primary purpose of a reimbursement schedule is to ensure

[11] Supra, footnote 1.

that there is appropriate access to needed services at an affordable cost to the employer, then, clearly the Three-Member Panel requires the flexibility to consider reimbursement methods that account for resource consumption (such as Resource-Based Relative Value Scale) or a prospective payment system that is resource-based according to diagnosis and procedure (such as diagnosis related groups (DRGs), rather than one based on charges for the "volume of service" or one that is "commodity driven" (such as in a per diem methodology for each hospital day overlaid with the current fixed dollar amount as a stop loss point). If the Legislature were to consider removing the existing mandates for ***specific*** reimbursement methodologies from the statute, the Three-Member Panel could then more faithfully and effectively execute their primary and statutory responsibility to ensure access to quality care at an affordable cost to the employer. Specifically, s. 440.13(12)(d), F.S., requires that when the Three-Member Panel determines statewide schedules, it must consider:

- Levels of reimbursement for similar treatment,
- Financial impact on providers and facilities on their ability to make the services available[12], and
- Impact on cost to employers for providing a level of reimbursement which will ensure treatment availability.

Additionally, the Three-Member Panel must:

> Take testimony, receive records, and collect data to evaluate the adequacy of the . . . schedule, nationally recognized fee schedules and alternative methods of reimbursement to . . . providers . . . and facilities for inpatient and outpatient treatment and care. (see s. 440.13(12)(e), F.S.)

As long as there exits the specific statutory directives in Florida law for the Three-Member Panel to adopt a schedule based on a per diem reimbursement methodology for inpatient hospital services and a factor of "usual and customary charges" for outpatient hospital services, information about other "nationally recognized fee schedules and alternative methods of reimbursement" for inpatient and outpatient care are superfluous. Information from California and several other workers' compensation jurisdictions that have successfully implemented reimbursement based on diagnosis related groups for inpatient hospital services indicates that a reimbursement methodology that is resource-based:

- Increases predictability for medical costs.
- Does not impede access to services for injured employees.
- Is affordable for employers.
- Assures a more relevant and fair level of payment for services provided.

[12] Ibid.

Moreover, there is no indication that this alternate methodology adversely impacts the ability of a hospital to make inpatient services available.

Examples of how the Three-Member Panel is encumbered (by the very legislation under which it was created) in the adoption of uniform statewide schedules are not limited to reimbursement schedules for *inpatient* care. Consider the inertia created by statutory language that mandates, on one hand, that the Three-Member Panel consider nationally recognized and alternative methods of reimbursement **and** reimbursement for similar treatment, then on the other hand, requires that *outpatient* surgery in a hospital shall be reimbursed at sixty percent of "usual and customary charges". Florida could observe the experiences of Texas and California (two of the most comparable jurisdictions) in the implementation of an outpatient prospective payment system of reimbursement for outpatient surgery. California is using the outpatient prospective payment system methodology and level of reimbursement for outpatient surgery, irrespective of whether the surgery is performed in an outpatient hospital setting or an ambulatory surgery center. In contrast, Florida has *no* flexibility in how it approaches reimbursement for hospital outpatient surgery – much less the opportunity to achieve parity in reimbursement for the same procedures regardless of venue.

In consideration of the requirement for the Three-Member Panel to consider reimbursement levels for similar treatment, note that in the 2005 Ambulatory Surgery Center Reimbursement Manual, the pre-established maximum reimbursement allowances were limited to eleven procedure codes. Eight of the procedure codes were for the same maximum reimbursement allowances as published in the 1992 Ambulatory Surgery Center Reimbursement Manual – that were established from charge data collected in the early 1990s. The 2005 maximum reimbursement allowances covered a mere two point four percent of the procedure codes billed by ambulatory surgery centers.[13] For the remaining majority of procedure codes that had *no* maximum reimbursement allowances, the ambulatory surgery centers were paid at seventy percent of "usual and customary charges". (When the 2006 Ambulatory Surgery Center Reimbursement Manual goes into effect, there will be pre-established maximum reimbursement allowances, based on charge data filed with the Office of Data Quality and Collection, for approximately thirty percent of the procedure codes billed by ambulatory surgery centers, while the remaining procedures for which no maximum reimbursement allowance has been adopted by the Three-Member Panel will continue to be reimbursed at seventy percent of "usual and customary charges.")

[13] According to billing and reimbursement data filed with Office of Data Quality and Collection, **8.2%** of the total charges were for one of the 11 CPT® codes with an maximum reimbursement allowances in the 2005 Ambulatory Surgery Center Reimbursement Manual; however, when you remove those paid under a contract or managed care arrangement, only **2.4%** of total payments were paid according to the reimbursement manual maximum reimbursement allowances. Be aware that the Reimbursement Manual language provided for payment, ***not at the*** maximum reimbursement allowances, but at 65% of "usual and customary charge" when the ambulatory surgery center's charge exceeded the maximum reimbursement allowances and at 80% of "usual and customary charge" when the ambulatory surgery center's charge was below the maximum reimbursement allowances value.

To further illustrate, examine the potential inequity in reimbursement for "similar treatment" by contrasting the outpatient surgery reimbursement paid to a hospital or an ambulatory surgery center with that which would be paid if the same surgery were performed on a patient admitted overnight to the hospital. The inpatient surgical per diem for a single night at an acute care hospital would cost the insurer $3,213.73 compared to several thousand more dollars if the same surgery were performed at an ambulatory surgery center or as a hospital outpatient. Given the scope of this issue in terms of volume of procedures and resultant costs, this is an area in which a relatively minor but strategic change in statutory language can be expected to have a significant positive impact on savings without a loss in access or quality. In fact, there is anecdotal evidence to support that it might even improve proper utilization of services as the inappropriate incentives are removed, thereby refocusing on clinical necessity and case specifics, rather than on economic drivers.

The opportunity for the Three-Member Panel to consider alternative facility reimbursement methods may even reach beyond *inpatient* hospital reimbursement and *outpatient* surgery. The outpatient prospective payment system used by California and Texas is modeled after that used by the Medicare program, although the reimbursement amounts are adjusted as deemed appropriate by each jurisdiction. Medicare's outpatient prospective payment system extends beyond outpatient surgery and includes visits to the emergency room, certain diagnostic services and even partial hospitalizations. These outpatient services are grouped into clinically relevant "ambulatory patient classifications" (APCs) based – as in the other examples of reimbursement methods throughout this discussion - on similar resource consumption. However, just as in the case of the National Correct Coding Initiative edits for clinician services, not all of the provisions may be appropriate for the workers compensation program. Federal law requires Centers for Medicare and Medicaid Services to update on an annual basis to integrate changes in practice and new technology. While updates were stalled for a period of time, the Centers for Medicare and Medicaid Services has issued a comprehensive revision that expands and updates the CPT® procedure codes assigned to the ambulatory patient classifications and for which reimbursement is established under Medicare. When one compares the reimbursement allowed in Florida for facility services to other workers' compensation jurisdictions, it becomes apparent that the lack of accountability and control mechanisms inherent in a charge based reimbursement system can not be addressed unless alternative reimbursement methods are options. If legislative language truly enabled the Three-Member Panel to compare and contrast alternative reimbursement methods, adopted schedules could minimize inappropriate incentives that currently exist to use one type of facility over another for financial rather than clinical reasons. Furthermore, the opportunity for the Three-Member Panel to evaluate the usefulness of ambulatory patient classifications applicability beyond outpatient surgery may generate savings similar to that which accrued to the system when it "leveled the playing field" by providing for the same reimbursement allowances between outpatient hospitals and free-standing facilities for non-emergency clinical laboratory services, radiology and physical, occupational and speech therapy.

In summary, to the extent that the overall successes and difficulties in workers' compensation are influenced by the relative successes and difficulties in its health care delivery system, it is recommended that the Legislature review and revise statutory language concerning the specific reimbursement methodology for inpatient and outpatient hospital services in order that the Three-Member Panel meets its legislative obligations pursuant to s. 440.13(12)(d) and (e), F.S. To that end, the following specific recommendations are imperative:

- Remove the statutory mandate in s. 440.13(12)(a), F.S., that requires reimbursement for inpatient hospital services to be based on per diem.
- Remove the statutory mandate in s. 440.13(12)(a), F.S., that requires reimbursement for outpatient hospital services to be based on a percent of "usual and customary charges".
- Require the Three-Member Panel to consider reimbursement methodologies representative of resource consumption and provider costs associated with the provision of services when determining uniform schedules (e.g., diagnosis related groups, outpatient prospective payment system).
- Define the term "usual and customary charge" – ***if and when*** it is to be used at all in determining reimbursement for medically necessary treatment, care and attendance.
- Either define the word "reasonable" or delete it altogether as a standard against which the reimbursement schedules are measured. (s. 440.13(12)(d), F.S.)
- Require that reimbursement for the same or similar services provided at different locations or by different providers shall not exceed the lowest reimbursement established for any provider of the service unless a higher reimbursement is agreed to in writing pursuant to s. 440.13(14)(b), F.S.

While the above recommendations are specific to the challenges encountered by the Three-Member Panel and require action to enable the successful promulgation of facility schedules, it is equally important to understand that the current methodology for physician and other practitioner reimbursement should not be altered as it is clearly having a positive effect on the delivery of medical services to injured employees and the overall functioning of the of the workers' compensation system.

REIMBURSEMENT: DISPUTE RESOLUTION

In so far as reimbursement levels, reimbursement methodologies, and reimbursement parity among providers for the same services can all positively or negatively affect the workers' compensation health care delivery system, the availability of an effective and efficient reimbursement dispute process also impacts the participation of providers and potential litigation costs to the system. As mentioned, while the overall number of disputes received by the Agency for Health Care Administration, Medical Services Unit has increased from calendar year 2005, the current issues in dispute do *not* indicate the potential for any destabilization of the delivery of health care services which employers must provide for injured employees or that physicians and other practitioners are asked to render. Determinations issued by the Agency generally indicate that the insurer has reimbursed improperly according to the law or rules promulgated by the Division for worker's compensation. Furthermore, as of the writing of this report, there is no substantiation of a trend among insurers to reject determinations from the Agency on physician and practitioner disputes or that insurers fail to take corrective action according to the findings issued.

As mentioned earlier, the Agency is receiving an increasing proportion of petitions for the resolution of reimbursement disputes from hospitals. However, the common denominators between hospital and ambulatory surgery center disputes are the issues relating to "usual and customary charges" and "reasonableness". Interwoven with these two issues is their relationship to insurers' determinations of what represents "prevailing charges in the geographic locality". Needless to say, the dollar value involved in facility disputes, whatever the basis for the dispute, typically far exceeds that associated with disputes between non-facility providers and insurers. Therefore, with the increase in facility disputes, Agency and Division staff quickly became aware of the inadequacy of its existing reimbursement dispute rule and the informal procedures often employed in an attempt to resolve the growing number of disputes.[14]

On April 4, 2006, the Agency repealed the 1991 rules promulgated under the Department of Labor and Employment Security, entitled "Disputed Reimbursement Avoidance" and "Disputed Reimbursement". After several months of public input and revisions, the Agency promulgated a new rule, 59A-31.003, F.A.C., "Resolution of Workers' Compensation Reimbursement Disputes", effective November 28, 2006. This new rule provides more transparency in the dispute resolution process as all documentation submitted to the Agency by the parties to the dispute must now also be exchanged between the parties. Furthermore, carriers will, in the near future, be required, to use an expanded list of more explicit Explanation of Bill Review codes promulgated as revisions to rule 69L-7.602, F.A.C. As mentioned elsewhere in this report, several aspects of rule 69L-7.602, F.A.C., promote preemptive communication between providers and insurers,

[14] Section 440.13(12)(e)4, F.S., requires the Agency to provide the Three-Member Panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to s. 440.13(8). The report provides an in-depth history and trend analysis of reimbursement disputes received during the calendar year 2006 and the process revisions ensuing from the substantial rewriting of rule 59A-31.003, F.A.C., and the impact on all parties to medical reimbursement disputes.

including the revised Explanation of Bill Review codes to demystify the rationale for reimbursement determinations, ease in billing and a uniform tool to document requests for authorization[15] (i.e., the DWC-25).

In conclusion, without the recommended statutory changes to s. 440.13(12), F.S., as they pertain to the Three-Member Panel adoption of uniform statewide schedules, it is expected that certain types of reimbursement disputes will only increase. However, it behooves the Legislature to take note of both the positive and negative trends in reimbursement disputes as further validation for the success to date of, and need for further, statutory language that supports the adoption of schedules based on clear, concise, resource-based and uniform reimbursement for medically necessary services and is equitable for all providers and affordable for employers.

[15] Rarely has the Agency had to resolve a dispute based solely on whether "authorization" was requested or granted. Usually, issues of authorization have not been raised by either party to the dispute. However, effective November 28, 2006, pursuant to rule 59A-31.003, F.A.C., each petition submitted to the Medical Services Unit of the Agency must be accompanied by documentation that authorization was obtained from the insurer for non-emergency services.

REIMBURSEMENT: CENTRALIZED PERFORMANCE SYSTEM – MEDICAL MODULE

In an effort to improve upon Florida's self-executing workers' compensation system, the 2003 workers' compensation reform sought to heighten accountability standards for insurers. Effective January 1, 2004, legislators increased timely payment performance standards from ninety percent to ninety-five percent for all medical bills. Subsection 440.20(6)(b), F.S., was revised to include the new timely payment standards, specified statutory penalties for insurers that failed to meet the new standard, and required the Division to evaluate insurers' performance on all medical bills.

Within the first year of the reform, the Division promulgated rule 69L-7.602, F.A.C, which successfully mandated the electronic reporting of all medical bills through its Medical Data System and implemented statutory penalties for the timely filing and the timely payment of all medical bills. As the Division was developing the Medical Data System to address the electronic delivery of an estimated 4.5 million medical bills annually, it was simultaneously developing a web-based system that provides insurers with a real-time assessment of their timely payment and timely reporting performance for all medical bills. This system is called the Centralized Performance System.

The Division's development of the Medical Data System and the Centralized Performance System is providing insurers, self-insured employers, claims-handling entities and medical vendors with vital performance information in a real-time environment. Stakeholders are embracing real-time performance information and are finding innovative ways to utilize the information to improve their timely payment performance. Insurers, claims-handling entities and medical vendors are using the information to identify persons, offices, areas or entities that are performing well or poorly. In the past year, the Division's management has seen many examples where system stakeholders expend resources to address poor performance areas and reward others that have implemented processes that achieve statutory standards. Real-time performance information is being received and acted upon by insurers, claims-handling entities and medical vendors to improve performance within each organization.

Real-time performance information is fast becoming an essential competitive element in the workers' compensation system. Employers, insurers, insureds, and claims-handling entities are using the information as they compete for business in an open market. Public availability of each stakeholder's performance is becoming as important an issue as the statutory penalties imposed in the 2003 reform. The Centralized Performance System allows stakeholders to run reports that share precise performance information for specified periods of time. The Centralized Performance System also allows stakeholders to compare themselves to others or to industry averages.

Prior to the implementation of Medical Data System and Centralized Performance System, the Division conducted physical audits of insurers' to determine if they were meeting the timely payment performance standards established in s. 440.20, F.S. The physical audit process allowed the Division to manually assess approximately 70,000

medical bills annually. On average, insurers paid ninety-four percent of these medical bills timely. Subsequent to the implementation of Medical Data System and Centralized Performance System, the Division assesses performance on approximately 4.5 million medical bills while insurers have improved their timely payment performance to ninety-eight percent. The Centralized Performance System provides the insurers, self-insurers, servicing agents and the Division with the ability to efficiently and effectively manage their performance.

The Division continues to compliment its enforcement role with aggressive education and outreach. The Division plays a key role in educating insurers, employers, claims-handling entities, injured workers and other states on many workers' compensation issues. Florida continues to be a national leader in requiring and utilizing electronic workers' compensation data. Division staff and managers play key leadership roles in national associations such as the International Association of Industrial Accident Boards and Commissions and the Southern Association of Workers' Compensation Administrators. The Division routinely offers educational seminars throughout the state while also participating in educational conferences throughout the southeastern United States.

EDUCATION AND TRAINING: EDUCATION OF STAKEHOLDERS

Subsection 440.207(1), F.S., states: "The department shall educate all persons providing or receiving benefits pursuant to this chapter as to their rights and responsibilities under this chapter."

Historically, the Division has been an active proponent of education to employees, employers and stakeholders. Daily the division provides informal education to employees and employers and all stakeholders through telephone calls and correspondence. During 2005 and 2006, the Division provided approximately thirty-five formal education and training sessions through participation in seminars, conferences, etc., which targeted employers, the carrier community, self-insures, health care providers, attorneys, etc. A listing of these sessions is included in Appendix A.

A variety of stakeholders have offered education and training. However, this has resulted in conflicting interpretations, often at odds with the intended purpose of Division rules. Some of the confusion can be attributed to a genuine lack of understanding of the issues or the related content. On the other hand, some of it is also attributable to the particular perspective bias of the vendor. Unfortunately, there also may be cases of specific intent to abuse or manipulate the process for personal gain.

Therefore, it is imperative that the Division provide a comprehensive, definitive, authoritative, single-source, education program covering the medically-related statutory and regulatory provisions to health care providers and all other relevant parties, including carriers, Judge of Compensation Claims, nurse case managers, provider networks, and employers. The governmental entity and professional personnel that have developed rules and associated forms, and are responsible for its maintenance, and as necessary, updating rules and forms, should be the ones to provide education about what the various rule content mean, when and how it is used, what are the benefits and value, what are the consequences of a lack of compliance, etc.

The education effort should be an active as opposed to a passive process, aggressively and proactively working towards ensuring widespread understanding and behavior change among the system participants. Once education has been provided, then the same tracking and compliance measures that are being so effectively instituted regarding other provisions need to be brought to bear regarding the health care providers. Compliance regarding the use of the DWC-25 is the single best tool currently available to get the entire workers' compensation system working off the same information and holding all parties accountable regarding that information.

Besides providing education at seminars, conferences and submitting educational articles to be published in health care provider professional newsletters, the Division has reached out to technology to assist in training stakeholders and to decrease costs. Education has been provided through the Division's website that provides flexible opportunities for stakeholders to access the educational material.

Another methodology that is gaining popularity is training via WebEx. This permits the presenter to share educational material prior to the meeting time and affords interactive participation between the audience and the presenter during the training. Additionally, this eliminates participant expense related to travel.

As the Division, the regulatory body has a statutory obligation to provide education to all entities providing or receiving workers' compensation benefits, all education and training must be conducted by the regulatory body. As the regulatory body, the Division has the obligation to determine what to regulate based on statutory language and then educate the stakeholders as to what will be regulated. If the Division fails to meet its responsibility, outside vendors will fill the void which would result in inaccurate, conflicting interpretations of the statutory responsibility of the Division, employers and stakeholders.

EDUCATION AND TRAINING: HEALTH CARE PROVIDER CERTIFICATION VERSUS SPECIAL EDUCATION

Today, the Florida workers' compensation health care delivery system requires mandatory health care provider certification. Providers must be certified by the Agency, except when providing emergency care, as a condition to eligibility for payment of services provided to injured workers, pursuant to s. 440.13(3)(a), F.S. However, due to a series of changes in the system over time, certification has become administratively burdensome for both the health care provider and the Agency. Currently, health care provider certification provides no verifiable added benefit to the workers' compensation system.

Therefore, it is proposed that we consider eliminating the current health care provider certification process performed by the Agency, thereby reducing the administrative burden to the Agency and the clinical providers. To implement Division-sponsored special education directed at the health care provider who desires to become more informed about treating injured workers and the Florida workers' compensation system, and gain recognition as a workers' compensation specialist.

This requirement was created pursuant to s. 440.13(3)(a), F.S., the Agency created rule 59A-29, F.A.C., *Health Care Provider Certification*, which was adopted March 14, 1995. This was in response to the 1993 Statutory Reform, which as a condition to eligibility for reimbursement, required health care providers to complete a single Division-approved five-hour educational course related to workers' compensation. Specifically, s. 440.13(3)(a), F.S., stated the subject areas of the required education were to include cost containment, utilization control, ergonomics and practice parameters. The only alternative to completion of the five-hour course existed if the health care provider was a participating member of an authorized Workers' Compensation Managed Care Arrangement who would supply the required educational information to the health care provider. Outside vendors were allowed to provide the training. Upon retrospective review, the Division determined that often the quality and focus of the training was inconsistent with the stated goals of the statute, noting wide variations in content and interpretation from course to course.

Effective October 1, 2001, the statutory requirement for health care provider completion of the five-hour educational course was eliminated; however the Agency continued certification of health care providers. Course attendance had been one of the fundamental criteria met before a health care provider was granted certification from the Agency. When submitting an application for certification, providers had to attest to other criteria, such as:

- No prior revocation, suspension or voluntary relinquishment of licensure within the past twelve months.
- No incidence of being placed on probationary status by a professional credentialing body within the past twelve months.

- No personal or facility conviction of a felony, crime or ethical violation within the past twelve months.
- No current decertification pursuant to the *Health Care Provider Certification* rule, 59A-29, F.A.C.

Once the five-hour training requirement had been eliminated, the remaining (and still current) Agency process to certify physicians resulted in an essentially duplicative screening required by the Florida Department of Health. This created an unnecessary administrative burden on both the Agency and the health care provider without any added value to either party.

In addition, many providers who do not see a regular volume of injured workers may not have applied to the certification process at the time of a given referral; thereby, under statute, these providers are ineligible for reimbursement of services. In the interest of maximizing access to care and increasing the universe of clinicians that can see injured workers under workers' compensation, it would seem that the basic certification process, as it now stands, is obsolete.

A two-step recommendation is offered in order to decrease administrative burden, increase access to a larger universe of health care providers and create enhanced consumer options regarding quality care while still retaining Agency and Division oversight of provider behavior.

- First, eliminate the current health care provider certification process performed by the Agency. The minimum standard would then be replaced by the standards used by the Department of Health denoting all practitioners who are currently in good standing regarding licensure to practice in their respective discipline and specialty. As noted, this reduces the unnecessary administrative burden for the Agency and the providers, as well as increases the universe of potential health care providers available to see injured workers.
- Second, create a voluntary class of "workers' compensation dedicated" physicians/clinicians that attend specialty workers' compensation education courses provided exclusively under the direction, control and direct involvement of the Division. Courses would not be contracted out to vendors, but would be developed and provided by appropriate Division staff. This additional control feature would avoid the difficulties of past efforts at training and would serve to preserve the quality and insure the content was consistent in all educational sessions. Such educational courses would offer core critical material specifically targeted to the physician's and other related clinician's role in meeting the needs of the injured workers, their employers to promote optimal care, and facilitate the injured worker's return to gainful employment.

The new certification training would focus on the core content required for successful practice managing injured workers in the Florida system, including the statutory and

regulatory provisions that establish definitions and criteria for determining illness, medical causality, functional restrictions and limitations, treatment plans, communication and reporting responsibilities, roles and responsibilities of the various stakeholders, dispute resolution, and other relevant issues.

The primary benefit of this new certification process is the increased market opportunity for both provider and employer/carrier. From a consumer perspective, the employer/carrier may benefit from this specialized group of health care providers with increased ease in identifying providers dedicated to the workers' compensation system. This network of specially trained providers should result in earlier access to care, enhanced understanding of the needs of the employer, insurer and employee, enhanced levels and consistency of clinical services, more timely notification and improved documentation regarding the patient's status and treatment needs, and decreased friction regarding care over time.

The health care provider will benefit from the ability to be distinguished from peers as a specialty provider within the workers' compensation system. This new status will represent enhanced knowledge of and commitment to the principles of occupational medicine and providers desiring to participate in the Florida workers' compensation program. In turn, the provider could expect not only an increase in referrals, enhanced respect, trust, and cooperation of the system and it's stakeholders, but as noted in s. 440.13(14)(b), F.S., the potential for enhanced reimbursement. By voluntarily completing this specialized education, the health care provider will be demonstrating personal dedication to improvement of the workers' compensation system by the effort to gain a greater understanding of the components of the Florida workers' compensation system: statutes, rules, expectations, benefits, limitations, guidelines, strategies, etc.

In addition to the core fundamentals, the Division-provided education would be tailored to the legitimate needs of the stakeholders based on direct input, as well as relevant data analysis, thereby making the educational experience more meaningful to all concerned. A broadening of the universe of potential clinicians who are available to treat injured workers, combined with the creation of a specialty class of physicians/clinicians who have been specifically educated to more successfully meet the needs of the injured worker, employer, insurer or insurance administrator, and legal community within the Florida workers' compensation system will result in a win-win situation for all.

CONCLUSIONS AND RECOMMENDATIONS

In summary, this report detailed current regulatory activity and ongoing plans required for continued implementation, execution and integration of the already defined workers' compensation reform provisions and issues. To that end, the following recommendations are offered for study and consideration:

Electronic Submission of Medical Bill Data from Provider to Insurer

1. Pursuant to rule 69L-7.602(4)(e)2, F.A.C., the Division should continue to allow health care providers to electronically submit medical bills to insurers, provided the insurer agrees to accept the submission of electronic medical bills.

2. Texas and California have statutorily mandated that insurers accept medical bills that are electronically submitted to them from health care providers by 2008. The Division should evaluate and analyze the results from Texas and California regarding the outcomes of their respective mandates, and determine what, if any, benefits such a mandate would have on Florida's workers' compensation system.

Reimbursement

3. Review and revise statutory language concerning the specific reimbursement methodology for inpatient and outpatient hospital services in order that the Three-Member Panel meets its legislative obligations pursuant to s. 440.13(12)(d) and (e), F.S. To accomplish those obligations, all of the following are necessary:

    - Remove the statutory mandate in s. 440.13(12)(a), F.S. that requires reimbursement for inpatient hospital services to be based on per diem.
    - Remove the statutory mandate in s. 440.13(12)(a), F.S. that requires reimbursement for outpatient hospital services to be based on a percent of "usual and customary charges".
    - Require the Three-Member Panel to consider reimbursement methodologies representative of resource consumption and provider costs associated with the provision of services when determining uniform schedules (e.g., diagnosis related groups, outpatient prospective payment system).
    - Define the term "usual and customary charge" – if and when it is to be used at all in determining reimbursement for medically necessary treatment, care and attendance.
    - Either define the word "reasonable" or delete it altogether as a standard against which the reimbursement schedules are measured (s. 440.13(12)(d), F.S.).

- Require that reimbursement for the same or similar services provided at different locations or by different providers shall not exceed the lowest reimbursement established for any provider of the service unless a higher reimbursement is agreed to in writing pursuant to s. 440.13(14)(b), F.S.

4. The current methodology for physician and other practitioner reimbursement should ***not*** be altered as it is clearly having a positive effect on the delivery of medical services to injured employees.

Education & Training

5. Continue to support the Division's proactive and progressive outreach and training initiatives. These initiatives help insure that all system stakeholders are accurately and fully informed of relevant statutory and regulatory provisions.

Health Care Provider Certification

6. Eliminate the current workers' compensation health care provider certification process performed by the Agency and allow, as the minimum standard, those practitioners who are currently in good standing with the Department of Health regarding licensure to provide remedial treatment, care, and attendance to injured workers.

7. Create an education and training program that will allow physicians/clinicians to receive a special Division-assigned designation following attendance and completion of workers' compensation education courses. The program would be provided exclusively under the direction, control and direct involvement of the Division.

Division of Workers' Compensation

8. Codify, in statute, the transfer of the Agency for Health Care Administration, Workers' Compensation Medical Services Unit to the Department of Financial Services, Division of Workers' Compensation.

9. Building on the productive relationship that already exists between the Legislature and the Division, and the enhanced capabilities articulated in this report, it is hoped that the Legislature will continue to take full advantage of the wealth of data and expertise available at the Division when considering any legislative activity involving workers' compensation.

Practice Guidelines and Evidence Based Medicine

The following is specifically recommended as an overall approach to further integrating EBM into the Florida workers' compensation system:

10. ***Eliminate*** the current language in s. 440.13(15), F.S.

11. ***Revise*** s. 440.13(15), F.S., to adopt the following statutory framework:

    In addition to and consistent with, clinical definitions, criteria and standards already outlined elsewhere in this chapter, all medical and related decisions shall be made utilizing evidenced-based medicine (EBM) as defined in the following ***hierarchy***:

    a. **Specific Research Support:** Highest level of deference - Specific, relevant, scientific studies published in widely-respected juried journals, i.e. random controlled trials (RCT), systematic reviews of controlled trials.
    b. **Professional Consensus:** Second level of deference - Integrating science and practice, i.e. evidenced-based practice guidelines or other relevant position papers from widely recognized organizations.
    c. **Principle-Based (*inherent logic*):** Third level of deference - established and well-defined clinical reasoning applied to relevant anatomical, physiological, pathological, and clinical principles. Case-specific data (objective, relevant exam findings), outcomes and measures should be utilized for accountability.
    d. Deference by ***all*** parties should be made regarding medical and related decisions and determinations to those best supported by and consistent with the clinical definitions, criteria and standards outlined elsewhere in this chapter and via evidenced-based criteria as outlined above.
    e. Regarding intention and competency, there should be a deference on behalf of the treating practitioners, and therefore recommendations and requests for evaluation, diagnostic testing, and/or treatment should be routinely approved unless there are specific, relevant, merit-based reasons to question or deny authorization (i.e. requested service is clearly not necessary, appropriate, or additional information or clarification is required). This same deference should be applied in dispute resolution in that, given essentially equal levels of documentation and support for either side of a dispute between the treating clinician and a consulting clinician, the treating clinician would be given deference.
        i. This does not eliminate the requirement and responsibility of the treating physician to utilize evidenced-medicine as defined above, nor does it eliminate the employer/carriers' responsibility or the obligation to question, or if appropriate, deny services that are not consistent with the evidenced-based provisions outlined above.

12. ***Insert*** language in the s. 440.02, F.S. (i.e. definition section):

a. ***Evidenced-based medicine*** is defined as the conscious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients, the practice of which requires integrating individual clinical expertise with the best available clinical evidence from systematic research.
b. ***Practice Guidelines*** are defined as systematically developed statements to assist practitioner and patient/consumer decisions about appropriate health care for specific clinical circumstances. They are a set of statements, directions, or principles presenting current or future clinical rules or policy concerning the proper indications for performing a procedure or treatment or the proper management for specific clinical problems.

APPENDIX A

Date of Training	Training/Presentation	Location	Audience
3/1/05-3/2/05	Annual Out-of-State Conference	Atlanta, GA	Carriers, Employers, Medical Providers
4/15/05	Workers' Compensation Medical Update	Presentation prepared by a Medial Service staff, but presented by a member of APC	Association of Professional Coders (APC)
5/17/06-6/17/06	Florida Workers' Compensation Institute (FWCI) Annual Spring Forum	Orlando, FL	Carriers, Employers, Medical Providers, Attorneys
6/6/05-6/8/05	Association of WC Claim Professionals	Bonita Springs, FL	Claims Managers, Carriers
6/9/05	2005 WC Education Seminar	Jacksonville, FL	Medical Providers, Carriers, Employers, Attorneys, Self-Insurers
7/05	FL Assoc. of Self-Insurers (FASI) - "How to Survive a WC Audit	Naples, FL	Self-Insurers
6/25/05	WC Medical Services: Anesthesiology	Palm Beach, FL	FL Anesthesia Administrators, Anesthesiologists
7/4/05 through 10/20/05	DWC-25 (Division Medical Communication Form)	Division of Workers' Compensation website	Medical Providers, Insurers, Employers
7/14/05	2005 WC Education Seminar	Tampa, FL	Medical Providers, Carriers, Employers, Attorneys, Self-Insurers
7/24/05-7/27/05	Southern Assoc. of WC Administrators (SAWCA) Annual Meeting	St. Petersburg, FL	Carriers, Employers, Medical Providers, Attorneys
8/21/05-8/24/05	Florida Workers' Compensation Institute (FWCI) Comp Conference	Orlando, FL	Carriers, Employers, Medical Providers

8/24/05	Rule 69L-7.602, F.A.C., Florida Workers' Compensation Medical Services Billing, Filing and Reporting.	Orlando, FL	Carriers, Employers, Medical Providers, Attorneys
9/16/05	2005 WC Education Seminar	Tallahassee, FL	Medical Providers, Carriers, Employers, Attorneys, Self-Insurers
9/20/05	2005 WC Education Seminar	Ft. Lauderdale	Medical Providers, Carriers, Employers, Attorneys, Self-Insurers
10/24/05	Workers' Compensation Claims Professionals (WCCP) Conference – Adjustor Seminar	Tampa, FL	Adjustors
11/4/05	2005 WC Education Seminar	Orlando, FL	Medical Providers, Carriers, Employers, Attorneys, Self-Insurers
12/1/05	WC Medical Services/Monitoring & Auditing	Orlando, FL	Manufacturing Summit
12/10/05-12/13/05	All Committee Conference	Miami Beach, FL	Carriers, Employers, Medical Providers
2/8/06	Overview of Workers' Compensation: Billing, Forms, Certification	Tampa, FL	Occupational Medicine Residents
3/23/-06-3/22/06	2006 Seminar, "Florida WC & General Liability Issues: 2006 Claims Handling Update"	Atlanta, FL	Carriers, Employers, Medical Providers, Attorneys
3/22/06	FL Workers' Compensation Institute (FWCI)/Adjustor Training Medical Issues	Atlanta, GA	Adjustor Training
7/15/06-7/19/06	Southern Assoc. of WC Administrators (SAWCA)	Baltimore, MD	State WC Administrators, Carriers, Employers, Medical Providers
7/23/06-7/26/06	FL Assoc. of Self-Insurers (FASI) 2006 Annual Convention	Naples, FL	Self-Insurers

8/13/-06-8/16/06	2006 WC Education Conference	Orlando, FL	Carriers, Medical Providers, Employers, Self-Insurers, Attorneys
8/16/06	Rule 59A-31, Resolution of Workers' Compensation Reimbursement Dispute.	Orlando, FL	Carriers, Medical Providers, Employers
Posted 10/11/06	Expert Medical Advisors (EMA) Tutorial	Division of Workers' Compensation website	Expert Medical Advisors - (physicians)
10/25/06	Overview of Workers' Compensation: Billing, Forms, Certification	Tampa, FL	Occupational Medicine Residents
10/26/06-10/27/06	Occupational Health Conference	Orlando, FL	FL Occupational Nurses
10/27/06	FL Self-Insurers Guaranty (FSIGA) Board Meeting	Tallahassee, FL	Self-Insurers
11/7/06-11/8-06	WC Educational Seminar	Miami/Ft. Lauderdale, FL	Carriers, Medical Providers, Employers, Attorneys
11/13/06-11/14/06	Southern Assoc. of WC Administrators (SAWCA)	Charleston, SC	State WC Administrators Carriers, Employers, Medical Providers,
11/14/06-11/15/06	State of FL Human Resource (HR) 2006 Conference– "HR: Collaboration at Work"	Tallahassee, FL	State of FL Employee Human Resource Managers
12/5/06-12/6/06	EAO Statewide Meeting	Tallahassee, FL	EAO Division of Workers' Compensation Staff
11/8/06	Rule 59A-31, Resolution of Workers' Compensation Reimbursement Dispute and other medical services issues.	Ft. Lauderdale, FL	Carriers, Medial Providers, Employers