A bill to be entitled

An act relating to workers' compensation; amending s. 440.02, F.S.; redefining the term "specificity"; amending s. 440.105, F.S.; removing a provision prohibiting certain individuals from receiving fees or other consideration for services related to Workers' Compensation Law; amending s. 440.13, F.S.; defining the term "respond"; requiring the Governor, or the Chief Financial Officer in certain circumstances, to appoint a member to fill a vacancy on a panel that establishes certain workers' compensation schedules within a specified timeframe; requiring such panel to annually adopt statewide schedules of maximum reimbursement allowances; authorizing such panel to adopt a reimbursement methodology under certain circumstances; revising and providing maximum reimbursement methodologies to be incorporated in such schedules; prohibiting dispensing practitioners from possessing prescription medications in certain circumstances; amending s. 440.15, F.S.; extending the timeframe in which certain employees may receive temporary total disability benefits; providing conditions under which employees may receive permanent impairment benefits; extending the timeframe in which carriers must notify treating doctors of certain

requirements; deleting a provision related to calculation of time; amending s. 440.192, F.S.; revising conditions under which the Office of the Judges of Compensation Claims must dismiss petitions for benefits; revising requirements for such petitions; revising construction relating to dismissals of petitions or portions thereof; requiring judges of compensation claims to enter orders on certain motions to dismiss within specified timeframes; revising a restriction on awarding attorney fees; amending s. 440.25, F.S.; extending the timeframe in which attorney fees attach; amending s. 440.34, F.S.; revising provisions relating to awarding attorney fees; providing that retainer agreements do not require approval by a judge of compensation claims but are required to be filed with the Office of the Judges of Compensation Claims; conforming a cross-reference; extending the timeframe in which attorney fees attach; authorizing a judge of compensation claims to depart from the attorney fees schedule under certain circumstances; requiring a judge to consider certain factors when awarding attorney fees that depart from such schedule; defining the term "departure fee"; limiting the amount of such fee; providing for the adjustment of such fee; amending s.

440.345, F.S.; providing requirements for a carrier's report; amending s. 440.491, F.S.; specifying that training and education benefits provided to a claimant are not in addition to the maximum number of weeks in which a claimant may receive temporary benefits; amending s. 627.211, F.S.; providing requirements for a member or subscriber of a rating organization to depart from the rates set by such organization; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (40) of section 440.02, Florida Statutes, is amended to read:

440.02 Definitions.—When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(40) "Specificity" means information on the petition for benefits sufficient to put the employer or carrier on notice of the exact statutory classification and outstanding time period for each requested benefit, the specific amount of each requested benefit, the calculation used for computing the requested benefit, ~~of benefits being requested~~ and ~~includes~~ a detailed explanation of any benefits received that should be increased, decreased, changed, or otherwise modified. If the

petition is for medical benefits, the information must ~~shall~~ include specific details as to why such benefits are being requested, why such benefits are medically necessary, and why current treatment, if any, is not sufficient. Any petition requesting alternate or other medical care, including, but not limited to, petitions requesting psychiatric or psychological treatment, must specifically identify the physician, as defined in s. 440.13(1), who is recommending such treatment. A copy of a report from such physician making the recommendation for alternate or other medical care must ~~shall~~ also be attached to the petition. A judge of compensation claims may ~~shall~~ not order such treatment if a physician is not recommending such treatment.

Section 2. Paragraph (c) of subsection (3) of section 440.105, Florida Statutes, is amended to read:

440.105 Prohibited activities; reports; penalties; limitations.—

(3) Whoever violates any provision of this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) Except for an attorney retained by or for an injured worker receiving a fee or other consideration from or on behalf of an injured worker, it is unlawful for any ~~attorney or other~~ person, in his or her individual capacity or in his or her capacity as a public or private employee, or for any firm,

corporation, partnership, or association to receive any fee or other consideration or any gratuity from a person on account of services rendered for a person in connection with any proceedings arising under this chapter, unless such fee, consideration, or gratuity is approved by a judge of compensation claims or by the Deputy Chief Judge of Compensation Claims.

Section 3. Paragraph (d) of subsection (3) and subsection (12) of section 440.13, Florida Statutes, are amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(d) By telephone or in writing, a carrier must authorize or deny ~~respond, by telephone or in writing, to~~ a request for authorization from an authorized health care provider, or inform the provider of material deficiencies that prevent authorization or denial, by the close of the third business day after receipt of the request. A carrier who fails to respond to a written request for authorization for referral for medical treatment by the close of the third business day after receipt of the request consents to the medical necessity for such treatment. All such requests must be made to the carrier. Notice to the employer ~~carrier~~ does not include notice to the carrier ~~employer~~.

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or

occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other specialty services that the department identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, unless the carrier has failed to authorize or deny, or inform the provider of material deficiencies that prevent authorization or denial, ~~respond~~ within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall authorize such consultation or procedure unless the health care provider or facility is not authorized, unless such treatment is not in accordance with practice parameters and protocols of treatment established in this chapter, or unless a judge of compensation claims has determined that the consultation or procedure is not medically necessary, not in accordance with the practice parameters and protocols of treatment established in this chapter, or otherwise not compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to identify and disallow overutilization or billing errors.

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(a)1. A three-member panel is created, consisting of the

Chief Financial Officer, or the Chief Financial Officer's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The Governor shall appoint a new member to the panel within 45 days after a vacancy occurs. If the Governor fails to fill such vacancy, the Chief Financial Officer shall appoint a new member to the panel within 45 days after the expiration of the Governor's opportunity to fill the vacancy, subject to confirmation by the Senate.

2. Annually, the panel shall adopt ~~determine~~ statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment, which incorporates the reimbursement methodologies provided in this subsection. ~~The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in~~

~~observation status, which shall not exceed 23 hours. All compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges, except as otherwise provided by this subsection. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.~~

(b) Except as provided in this subsection, the schedules of maximum reimbursement allowances adopted by the panel must be based upon the reimbursement methodologies provided in this subsection, except the panel may adopt a reimbursement methodology for compensable medical care for which a reimbursement methodology is not provided in this subsection. Reimbursements shall be made based upon adopted schedules of maximum reimbursement allowances. ~~It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions developed pursuant to this subsection are limited to the following:~~

1. Payments for outpatient physical, occupational, and speech therapy provided by hospitals shall be reimbursed at ~~reduced to~~ the schedule of maximum reimbursement allowances for these services which apply ~~applies~~ to nonhospital providers.

2. Payments for scheduled outpatient nonemergency radiological and clinical laboratory services that are not provided in conjunction with a surgical procedure shall be reimbursed at ~~reduced to~~ the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

3.a. Reimbursement for scheduled outpatient surgery in a hospital or ambulatory surgical center shall be 160 percent of the fee or rate established by the Medicare outpatient prospective payment system, except as otherwise provided by this subsection.

b. Reimbursement for scheduled outpatient surgery in a hospital or ambulatory surgical center that have no fee or rate under the Medicare outpatient prospective payment system shall be 60 percent of the statewide average charge for that service derived from the division's database of billed hospital or ambulatory surgical center charges, as applicable, over a consecutive 18-month period within the 36 months before the adoption of the schedule, as designated by the panel, if, for the period, at least 50 bills for the billed service are contained in the database. Scheduled hospital outpatient surgery

or ambulatory surgical center services that have no fee or rate under the Medicare outpatient prospective payment system and have no statewide average charge shall be reimbursed at 60 percent of the facility's actual billed charge ~~Outpatient reimbursement for scheduled surgeries shall be reduced from 75 percent of charges to 60 percent of charges~~.

4.a. Reimbursement for nonscheduled hospital outpatient care shall be 200 percent of the fee or rate established by the Medicare outpatient prospective payment system, except as otherwise provided by this subsection.

b. Reimbursement for nonscheduled hospital outpatient surgical services that have no fee or rate under the Medicare outpatient prospective payment system shall be 75 percent of the statewide average charge for that service derived from the division's database of billed hospital charges over a consecutive 18-month period within the 36 months before the adoption of the schedule, as designated by the panel, if, for the period, at least 50 bills for the billed service are contained in the database. Nonscheduled hospital outpatient surgical services that have no fee or rate under the Medicare outpatient prospective payment system and have no statewide average charge shall be reimbursed at 75 percent of the hospital's actual billed charge.

5. Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be at ~~increased to~~ 110 percent

of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the ~~three-member~~ panel as of January 1, 2003, whichever is greater.

6.~~5.~~ Maximum reimbursement for surgical procedures shall be at ~~increased to~~ 140 percent of the reimbursement allowed by Medicare or the medical reimbursement level adopted by the ~~three-member~~ panel as of January 1, 2003, whichever is greater.

7. Maximum reimbursement for inpatient hospital care shall be based on a schedule of per diem rates, subject to a stop-loss amount, approved by the panel to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in observation status, which reimbursement may not exceed 23 hours of observation, regardless of whether more than 23 hours of observation occurred.

8. Maximum reimbursement for a physician, hospital, ambulatory surgical center, work-hardening program, pain-management program, or durable medical equipment provider shall be the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule adopted under paragraph (a).

(c)1. ~~As to reimbursement for a prescription medication,~~ The reimbursement amount for a prescription medication shall be the average wholesale price plus $4.18 for the dispensing fee.

For repackaged or relabeled prescription medications dispensed by a dispensing practitioner as provided in s. 465.0276, the fee schedule for reimbursement shall be 112.5 percent of the average wholesale price, plus $8.00 for the dispensing fee. For purposes of this subsection, the average wholesale price shall be calculated by multiplying the number of units dispensed times the per-unit average wholesale price set by the original manufacturer of the underlying drug dispensed by the practitioner, based upon the published manufacturer's average wholesale price published in the Medi-Span Master Drug Database as of the date of dispensing. All pharmaceutical claims submitted for repackaged or relabeled prescription medications must include the National Drug Code of the original manufacturer. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount except where the employer or carrier, or a service company, third party administrator, or any entity acting on behalf of the employer or carrier directly contracts with the provider seeking reimbursement for a lower amount.

2. For prescription medication purchased under the requirements of this paragraph, a dispensing practitioner may not possess a prescription medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor,

or drug repackager within 60 days after such practitioner takes possession of such medication.

(d) Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, ambulatory surgical center, work-hardening program, or pain program, must not exceed the amounts provided by the ~~uniform~~ schedule of maximum reimbursement allowances as determined by the panel or as otherwise provided in this section. This subsection also applies to independent medical examinations performed by health care providers under this chapter. In determining the ~~uniform~~ schedule, the panel shall first approve the data which it finds representative of prevailing charges in the state for similar treatment, care, and attendance of injured persons. Each health care provider, health care facility, ambulatory surgical center, work-hardening program, or pain program receiving workers' compensation payments shall maintain records verifying their usual charges. In establishing the ~~uniform~~ schedule of maximum reimbursement allowances, the panel must consider:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers;

2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will

ensure the availability of treatment, care, and attendance required by injured workers;

3. 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 effect upon their ability to make available to injured workers such medically necessary remedial 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; and

4. The most recent average maximum allowable rate of increase for hospitals determined by the Health Care Board under chapter 408.

(e) In addition to establishing the ~~uniform~~ schedule of maximum reimbursement allowances, the panel shall:

1. Take testimony, receive records, and collect data to evaluate the adequacy of the workers' compensation fee schedule, nationally recognized fee schedules and alternative methods of reimbursement to health care providers and health care facilities for inpatient and outpatient treatment and care.

2. Survey health care providers and health care facilities to determine the availability and accessibility of workers'

compensation health care delivery systems for injured workers.

3. Survey carriers to determine the estimated impact on carrier costs and workers' compensation premium rates by implementing changes to the carrier reimbursement schedule or implementing alternative reimbursement methods.

4. Submit recommendations on or before January 15, 2017, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

(f) The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and ~~any~~ actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel. ~~For prescription medication purchased under the requirements of this subsection, a dispensing practitioner shall not possess such medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days of the dispensing practitioner taking possession of that medication.~~

Section 4. Paragraph (a) of subsection (2), paragraph (d)

of subsection (3), paragraph (e) of subsection (4), and subsection (6) of section 440.15, Florida Statutes, are amended to read:

440.15 Compensation for disability.—Compensation for disability shall be paid to the employee, subject to the limits provided in s. 440.12(2), as follows:

(2) TEMPORARY TOTAL DISABILITY.—

(a) Subject to subsection (7), in case of disability total in character but temporary in quality, 66 2/3 or 66.67 percent of the average weekly wages shall be paid to the employee during the continuance thereof, ~~not to exceed 104 weeks~~ except as provided in this subsection, subparagraph (3)(d)3., and s. 440.12(1), not to exceed 260 weeks ~~and s. 440.14(3)~~. Once the employee reaches the maximum number of weeks allowed, or the employee reaches overall ~~the date of~~ maximum medical improvement, whichever occurs earlier, temporary disability benefits shall cease and the injured worker's permanent impairment shall be determined. If the employee reaches the maximum number of weeks allowed, but has not reached overall maximum medical improvement, benefits shall be provided pursuant to subparagraph (3)(d)3.

(3) PERMANENT IMPAIRMENT BENEFITS.—

(d) After the employee has been certified by a doctor as having reached maximum medical improvement or 6 weeks before the expiration of temporary benefits, whichever occurs earlier, the

certifying doctor shall evaluate the condition of the employee and assign an impairment rating, using the impairment schedule referred to in paragraph (b). If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation must be submitted to the treating doctor, the employee, and the carrier within 10 days after the evaluation. The treating doctor must indicate to the carrier agreement or disagreement with the other doctor's certification and evaluation.

1. The certifying doctor shall issue a written report to the employee and the carrier certifying that maximum medical improvement has been reached, stating the impairment rating to the body as a whole, and providing any other information required by the department by rule. The carrier shall establish an overall maximum medical improvement date and permanent impairment rating, based upon all such reports.

2. Within 14 days after the carrier's knowledge of each maximum medical improvement date and impairment rating to the body as a whole upon which the carrier is paying benefits, the carrier shall report such maximum medical improvement date and, when determined, the overall maximum medical improvement date and associated impairment rating to the department in a format as set forth in department rule. If the employee has not been certified as having reached overall maximum medical improvement before the expiration of 254 ~~98~~ weeks after the date temporary

disability benefits begin to accrue, the carrier shall notify the treating doctor of the requirements of this section.

3. If an employee receiving benefits under subsection (2) has not reached overall maximum medical improvement before receiving the maximum number of weeks of temporary disability benefits, the maximum number of weeks are extended for up to an additional 26 weeks. If the employee has not reached overall maximum medical improvement after receiving the additional weeks allowed under this subparagraph, a judge of compensation claims, upon petition, must determine the employee's current eligibility for benefits under subsection (1).

4. If an employee receiving benefits under subsection (4) has not reached overall maximum medical improvement before receiving the maximum number of weeks of temporary disability benefits, the employee shall receive benefits under this subsection in accordance with the greatest single impairment rating assigned to the employee. Impairment benefits received under this subparagraph shall be credited against indemnity benefits subsequently due.

(4) TEMPORARY PARTIAL DISABILITY.—

(e) Such benefits shall be paid during the continuance of such disability, ~~not to exceed a period of 104 weeks,~~ as provided by this subsection and subsection (2), not to exceed 260 weeks, except as provided in subparagraph (3)(d)4. ~~Once the injured employee reaches the maximum number of weeks, temporary~~

~~disability benefits cease and the injured worker's permanent impairment must be determined.~~ If the employee is terminated from postinjury employment based on the employee's misconduct, temporary partial disability benefits are not payable as provided for in this section. The department shall by rule specify forms and procedures governing the method and time for payment of temporary disability benefits for dates of accidents before January 1, 1994, and for dates of accidents on or after January 1, 1994.

(6) EMPLOYEE REFUSES EMPLOYMENT.—If an injured employee refuses employment suitable to the capacity thereof, offered to or procured therefor, such employee shall not be entitled to any compensation at any time during the continuance of such refusal unless at any time in the opinion of the judge of compensation claims such refusal is justifiable. ~~Time periods for the payment of benefits in accordance with this section shall be counted in determining the limitation of benefits as provided for in paragraphs (2)(a), (3)(c), and (4)(b).~~

Section 5. Subsections (2), (5), and (7) of section 440.192, Florida Statutes, are amended to read:

440.192 Procedure for resolving benefit disputes.—

(2) Upon receipt, the Office of the Judges of Compensation Claims shall review each petition and shall dismiss each petition or any portion of such a petition that does not on its face meet the requirements of this section and the definition of

specificity under s. 440.02, and specifically identify or itemize the following:

(a) The name, address, and telephone number~~, and social security number~~ of the employee.

(b) The name, address, and telephone number of the employer.

(c) A detailed description of the injury and cause of the injury, including the Florida county or, if outside of Florida, the state ~~location~~ of the occurrence and the date or dates of the accident.

(d) A detailed description of the employee's job, work responsibilities, and work the employee was performing when the injury occurred.

(e) The specific time period for which compensation and the specific classification of compensation were not timely provided.

(f) The specific date of maximum medical improvement, character of disability, and specific statement of all benefits or compensation that the employee is seeking. A claim for permanent benefits must include the specific date of maximum medical improvement and the specific date that such permanent benefits are claimed to begin.

(g) All specific travel costs to which the employee believes she or he is entitled, including dates of travel and purpose of travel, means of transportation, and mileage and

including the date the request for mileage was filed with the carrier and a copy of the request filed with the carrier.

(h) A specific listing of all medical charges alleged unpaid, including the name and address of the medical provider, the amounts due, and the specific dates of treatment.

(i) The type or nature of treatment care or attendance sought and the justification for such treatment. If the employee is under the care of a physician for an injury identified under paragraph (c), a copy of the physician's request, authorization, or recommendation for treatment, care, or attendance must accompany the petition.

(j) The specific amount of compensation claimed to be accurate and the methodology claimed to accurately calculate the average weekly wage, if the average weekly wage calculated by the employer or carrier is disputed. If the petition does not include a claim under this paragraph, the average weekly wage and corresponding compensation calculated by the employer or carrier are presumed to be accurate.

(k) ~~(j)~~ A specific explanation of any other disputed issue that a judge of compensation claims will be called to rule upon.

The dismissal of any petition or portion of such a petition under this subsection ~~section~~ is without prejudice and does not require a hearing.

(5)(a) All motions to dismiss must state with

particularity the basis for the motion. The judge of compensation claims shall enter an order upon such motions without hearing, unless good cause for hearing is shown. Dismissal of any petition or portion of a petition under this subsection is without prejudice.

(b) Upon motion that a petition or portion of a petition be dismissed for lack of specificity, the judge of compensation claims shall enter an order on the motion, unless stipulated in writing by the parties, within 10 days after the motion is filed or, if good cause for hearing is shown, within 20 days after hearing on the motion. When any petition or portion of a petition is dismissed for lack of specificity under this subsection, the claimant must be allowed 20 days after the date of the order of dismissal in which to file an amended petition. Any grounds for dismissal for lack of specificity under this section which are not asserted within 30 days after receipt of the petition for benefits are thereby waived.

(7) Notwithstanding ~~the provisions of~~ s. 440.34, a judge of compensation claims may not award attorney ~~attorney's~~ fees payable by the employer or carrier for services expended or costs incurred before ~~prior to~~ the filing of a petition ~~that does not meet the requirements of this section~~.

Section 6. Paragraph (j) of subsection (4) of section 440.25, Florida Statutes, is amended to read:

440.25 Procedures for mediation and hearings.—

(4)

(j) A judge of compensation claims may not award interest on unpaid medical bills and the amount of such bills may not be used to calculate the amount of interest awarded. Regardless of the date benefits were initially requested, attorney ~~attorney's~~ fees do not attach under this subsection until 45 ~~30~~ days after the date the carrier ~~or self-insured employer~~ receives the petition.

Section 7. Section 440.34, Florida Statutes, is amended to read:

440.34 Attorney ~~Attorney's~~ fees; costs.—

(1) A judge of compensation claims may award attorney fees payable to the claimant pursuant to this section to be paid by the employer or carrier. An employer or carrier may not pay a fee, gratuity, or other consideration ~~may not be paid~~ for a claimant in connection with any proceedings arising under this chapter, unless approved by the judge of compensation claims or court having jurisdiction over such proceedings. Attorney fees awarded ~~Any attorney's fee approved~~ by a judge of compensation claims for benefits secured on behalf of a claimant must equal ~~to~~ 20 percent of the first $5,000 of the amount of the benefits secured, 15 percent of the next $5,000 of the amount of the benefits secured, 10 percent of the remaining amount of the benefits secured to be provided during the first 10 years after the date the claim is filed, and 5 percent of the benefits

secured after 10 years. A ~~The judge of compensation claims shall not approve a compensation order, a joint stipulation for lump-sum settlement, a stipulation or agreement between a claimant and his or her attorney, or any other agreement related to benefits under this chapter which provides for an attorney's fee in excess of the amount permitted by this section. The judge of compensation claims is not required to approve any~~ retainer agreement between the claimant and his or her attorney is not subject to approval by a judge of compensation claims but must be filed with the Office of the Judges of Compensation Claims. Attorney fees are a lien upon compensation payable to the claimant, notwithstanding s. 440.22. A retainer agreement may not place any portion of the employee's compensation into an escrow account until benefits are secured. ~~The retainer agreement as to fees and costs may not be for compensation in excess of the amount allowed under this subsection or subsection (7).~~

(2) In awarding a claimant's attorney fees ~~attorney's fee~~, a ~~the~~ judge of compensation claims must ~~shall~~ consider only those benefits secured by the attorney. ~~An~~ Attorney ~~is not entitled to attorney's~~ fees are not due for representation in any issue that was ripe, due, and owing and that reasonably could have been addressed, but was not addressed, during the pendency of other issues for the same injury. The amount, statutory basis, and type of benefits obtained through legal

representation shall be listed on all attorney ~~attorney's~~ fees awarded by a ~~the~~ judge of compensation claims. For purposes of this section, the term "benefits secured" does not include future medical benefits to be provided on any date more than 5 years after the date the petition ~~claim~~ is filed. In the event an offer to settle an issue pending before a judge of compensation claims, including attorney ~~attorney's~~ fees ~~as provided for in this section~~, is communicated in writing to the claimant or the claimant's attorney at least 30 days before ~~prior to~~ the trial date on such issue, for purposes of calculating the amount of attorney ~~attorney's~~ fees to be taxed against the employer or carrier, the term "benefits secured" includes ~~shall be deemed to include~~ only that amount awarded to the claimant above the amount specified in the offer to settle. If multiple issues are pending before a ~~the~~ judge of compensation claims, said offer of settlement must ~~shall~~ address each issue pending and ~~shall~~ state explicitly whether or not the offer on each issue is severable. The written offer must ~~shall~~ also unequivocally state whether or not it includes medical witness fees and expenses and all other costs associated with the claim.

(3) If a ~~any~~ party should prevail in ~~any~~ proceedings before a judge of compensation claims or court, there shall be taxed against the nonprevailing party the reasonable costs of such proceedings, not to include attorney ~~attorney's~~ fees. A

claimant is responsible for the payment of her or his own attorney ~~attorney's~~ fees, except that a claimant is entitled to recover attorney fees ~~an attorney's fee~~ in an amount equal to the amount provided for in subsection (1) or subsection (5), but not both, ~~(7)~~ from a carrier or employer:

(a) Against whom she or he successfully asserts a petition for medical benefits only, if the claimant has not filed or is not entitled to file at such time a claim for disability, permanent impairment, ~~wage-loss,~~ or death benefits, arising out of the same accident;

(b) In a ~~any~~ case in which the employer or carrier files a response to petition denying benefits with the Office of the Judges of Compensation Claims and the injured person has employed an attorney in the successful prosecution of the petition;

(c) In a proceeding in which a carrier or employer denies that an accident occurred for which compensation benefits are payable, and the claimant prevails on the issue of compensability; or

(d) In cases in which ~~where~~ the claimant successfully prevails in proceedings filed under s. 440.24 or s. 440.28.

Regardless of the date benefits were initially requested, attorney ~~attorney's~~ fees do ~~shall~~ not attach under this subsection until 45 ~~30~~ days after the date the carrier or

employer~~, if self-insured,~~ receives the petition.

~~(4) In such cases in which the claimant is responsible for the payment of her or his own attorney's fees, such fees are a lien upon compensation payable to the claimant, notwithstanding s. 440.22.~~

(4)~~(5)~~ If ~~any~~ proceedings are had for review of a ~~any~~ claim, award, or compensation order before any court, the court may, in its discretion, award the injured employee or dependent attorney fees ~~an attorney's fee~~ to be paid by the employer or carrier~~, in its discretion, which shall be paid~~ as the court may direct.

(5)(a) A judge of compensation claims may depart from the amount set forth in subsection (1) upon a finding that the attorney fees provided for in that subsection are less than 40 percent or greater than 125 percent of the average hourly rate that attorneys customarily charge in the same locality for similar legal services, which may include those related to civil tort claims, when the amount allowed under subsection (1) is converted to an hourly rate by dividing that amount by the attorney hours. "Attorney hours" are the number of hours necessary for the attorney to obtain the benefits secured as determined by a judge of compensation claims. A judge of compensation claims is not limited to an average hourly rate or number of attorney hours pled by a party, but may not exceed the amount or hours pled by the attorney for the claimant, and may

rely on proffered evidence or take notice of credible data, including claimant attorney fee data on file with the office of the judges of compensation claims or the Florida Bar. A judge of compensation claims must make specific findings regarding the number of attorney hours when resolving a motion for a departure fee under this subsection. A departure fee under this subsection is in place of, not in addition to, the amount allowed under subsection (1). As used in this subsection, "customarily charge" shall include the hourly rate customarily awarded by judges of compensation claims in the same locality and the locality is determined in the discretion of the judge of compensation claims.

(b) If a departure is permitted pursuant to paragraph (a), a judge of compensation claims shall consider the following factors when departing from the amount set forth in subsection (1):

1. The time and labor required, the novelty and difficulty of the questions involved, and the skill required to properly perform the legal services.

2. The fee customarily charged in the same locality for similar legal services.

3. The amount involved in the controversy and the benefits awarded to the claimant.

4. The time limits imposed by the circumstances.

5. The experience, reputation, and ability of the attorney

performing the legal services.

6. The contingency or certainty of a fee awarded under this section.

(c) Based on the considerations of the factors in paragraph (b), a judge of compensation claims shall determine the hourly rate used to compute the departure fee awarded under this subsection, in $10 increments, which may not exceed the hourly rate limit under paragraph (e). A judge of compensation claims is not limited to an hourly rate pled by a party. As used in this subsection, the term "departure fee" means the fee determined by a judge of compensation claims, if permitted under paragraph (a), in place of the fee allowed under subsection (1) when attorney fees are due under this section.

(d) Using the hourly rate determined under paragraph (c) and number of attorney hours determined under paragraph (a), a judge of compensation claims must determine the amount of the departure fee under this subsection by multiplying the hourly rate by the number of attorney hours. The claimant is responsible for attorney fees that exceed the departure fee pursuant to his or her retainer agreement.

(e) From July 1, 2017, through December 31, 2017, the hourly rate limit applicable to departure fees under this subsection is $250. On January 1, 2018, and annually each January 1 thereafter, this amount shall be adjusted in proportion to the percentage change between the statewide

average weekly wage in effect on the immediately previous January 1 and the statewide average weekly wage in effect for the applicable year rounded to the nearest dollar. For purposes of this paragraph, the term "statewide average weekly wage" has the same meaning as in s. 440.12(2).

(f) By January 1, 2018, and annually by each January 1 thereafter, the Deputy Chief Judge of Compensation Claims must determine and publish the hourly rate limit provided under paragraph (e).

~~(6) A judge of compensation claims may not enter an order approving the contents of a retainer agreement that permits placing any portion of the employee's compensation into an escrow account until benefits have been secured.~~

~~(7) If an attorney's fee is owed under paragraph (3)(a), the judge of compensation claims may approve an alternative attorney's fee not to exceed $1,500 only once per accident, based on a maximum hourly rate of $150 per hour, if the judge of compensation claims expressly finds that the attorney's fee amount provided for in subsection (1), based on benefits secured, fails to fairly compensate the attorney for disputed medical-only claims as provided in paragraph (3)(a) and the circumstances of the particular case warrant such action.~~

Section 8. Section 440.345, Florida Statutes, is amended to read:

440.345 Reporting of attorney ~~attorney's~~ fees.—All fees

paid to attorneys for services rendered under this chapter shall be reported to the Office of the Judges of Compensation Claims as the Division of Administrative Hearings requires by rule. A carrier must specify in its report the total amount of attorney fees paid for and the total number of attorney hours spent on services related to the defense of petitions, and the total amount of attorney fees paid for services unrelated to the defense of petitions.

Section 9. Paragraph (b) of subsection (6) of section 440.491, Florida Statutes, is amended to read:

440.491 Reemployment of injured workers; rehabilitation.—

(6) TRAINING AND EDUCATION.—

(b) When an employee who has attained maximum medical improvement is unable to earn at least 80 percent of the compensation rate and requires training and education to obtain suitable gainful employment, the employer or carrier shall pay the employee additional training and education temporary total compensation benefits while the employee receives such training and education for a period not to exceed 26 weeks, which period may be extended for an additional 26 weeks or less, if such extended period is determined to be necessary and proper by a judge of compensation claims. The benefits provided under this paragraph are ~~shall~~ not ~~be~~ in addition to the maximum number of ~~104~~ weeks as specified in s. 440.15(2). However, a carrier or employer is not precluded from voluntarily paying additional

temporary total disability compensation beyond that period. If an employee requires temporary residence at or near a facility or an institution providing training and education which is located more than 50 miles away from the employee's customary residence, the reasonable cost of board, lodging, or travel must be borne by the department from the Workers' Compensation Administration Trust Fund established by s. 440.50. An employee who refuses to accept training and education that is recommended by the vocational evaluator and considered necessary by the department will forfeit any additional training and education benefits and any additional compensation ~~payment for lost wages~~ under this chapter. The carrier shall notify the injured employee of the availability of training and education benefits as specified in this chapter. The Department of Financial Services shall include information regarding the eligibility for training and education benefits in informational materials specified in ss. 440.207 and 440.40.

Section 10. Subsection (1) of section 627.211, Florida Statutes, is amended, and subsection (7) is added to that section, to read:

627.211 Deviations and departures; workers' compensation and employer's liability insurances.—

(1) Except as provided in subsection (7), every member or subscriber to a rating organization shall, as to workers' compensation or employer's liability insurance, adhere to the

filings made on its behalf by such organization; except that any such insurer may make written application to the office for permission to file a uniform percentage decrease or increase to be applied to the premiums produced by the rating system so filed for a kind of insurance, for a class of insurance which is found by the office to be a proper rating unit for the application of such uniform percentage decrease or increase, or for a subdivision of workers' compensation or employer's liability insurance:

(a) Comprised of a group of manual classifications which is treated as a separate unit for ratemaking purposes; or

(b) For which separate expense provisions are included in the filings of the rating organization.

Such application shall specify the basis for the modification and shall be accompanied by the data upon which the applicant relies. A copy of the application and data shall be sent simultaneously to the rating organization.

(7) Without approval of the office, a member or subscriber to a rating organization may depart from the filings made on its behalf by a rating organization for a period of 12 months by a uniform decrease of up to 5 percent to be applied uniformly to the premiums resulting from the approved rates for the policy period. The member or subscriber must file an informational departure statement with the office within 30 days after initial

use of such departure specifying the percentage of the departure from the approved rates and an explanation of how the departure will be applied. If the departure is to be applied over a subsequent 12-month period, the member or subscriber must file a supplemental informational departure statement pursuant to this subsection at least 30 days before the end of the current period. If the office determines that a departure violates the applicable principles for ratemaking under ss. 627.062 and 627.072, would result in predatory pricing, or imperils the financial condition of the member or subscriber, the office must issue an order specifying its findings and stating the time period within which the departure expires, which must be within a reasonable time period after the order is issued. The order does not affect an insurance contract or policy made or issued before the departure expiration period set forth in the order.

Section 11. This act shall take effect July 1, 2017.