regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

(a) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
(b) Section 782.04, relating to murder.
(c) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.
(d) Section 782.071, relating to vehicular homicide.
(e) Section 782.09, relating to killing of an unborn child by injury to the mother.
(f) Section 784.011, relating to assault, if the victim of the offense was a minor.
(g) Section 784.021, relating to aggravated assault.
(h) Section 784.03, relating to battery, if the victim of the offense was a minor.
(i) Section 784.045, relating to aggravated battery.
(j) Section 787.01, relating to kidnapping.
(k) Section 787.02, relating to false imprisonment.
(l) Section 794.011, relating to sexual battery.
(m) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
(n) Chapter 796, relating to prostitution.
(o) Section 798.02, relating to lewd and lascivious behavior.
(p) Chapter 800, relating to lewdness and indecent exposure.
(q) Section 806.01, relating to arson.
(r) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
(s) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
(t) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
(u) Section 825.1025, relating to covered service provider.
(v) Section 825.103, relating to exploitation of an elderly person or disabled adult.

(3) Standards must also ensure that the person:

(a) For employees or employers licensed or registered pursuant to chapter 400, does not have a confirmed report of abuse, neglect, or exploitation as defined in s. 415.102(5), which has been uncontested or upheld under s. 415.103.
(b) Has not committed an act that constitutes domestic violence as defined in s. 741.30.

(4) Under penalty of perjury, all employees in such positions of trust or responsibility shall attest to meeting the requirements for qualifying for employment and agreeing to inform the employer immediately if convicted of any of the disqualifying offenses while employed by the employer. Each employer of employees in such positions of trust or responsibilities which is licensed or registered by a state agency shall submit to the licensing agency annually, under penalty of perjury, an affidavit of compliance with the provisions of this section.

**1435.09 Confidentiality of personnel background check information.**—No criminal, juvenile, or abuse hotline information obtained under this section may be used for any purpose other than determining whether persons meet the minimum standards for employment or for an owner or director of a covered service provider. The criminal records and juvenile records obtained by the department or by an employer are exempt from s. 119.07(1).

**1435.11 Penalties.**—

(1) It is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:

(a) Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for voluntary or paid employment a material fact used in making a determination as to such person’s qualifications for a position of special trust.

(b) Use records information for purposes other than screening for employment or release records information to other persons for purposes other than screening for employment.

(2) It is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, for any person willfully, knowingly, or intentionally to use juvenile records information for any purposes other than specified in this section or to release such information to other persons for purposes other than specified in this section.

**CHAPTER 440**

**WORKERS’ COMPENSATION**

- 440.101 Legislative intent; drug-free workplaces.
- 440.102 Drug-free workplace program requirements.
440.101 Legislative intent; drug-free workplaces.

(1) It is the intent of the Legislature to promote drug-free workplaces in order that employers in the state be afforded the opportunity to maximize their levels of productivity, enhance their competitive positions in the marketplace, and reach their desired levels of success without experiencing the costs, delays, and tragedies associated with work-related accidents resulting from drug abuse by employees. It is further the intent of the Legislature that drug abuse be discouraged and that employees who choose to engage in drug abuse face the risk of unemployment and the forfeiture of workers’ compensation benefits.

(2) If an employer implements a drug-free workplace program in accordance with s. 440.102 which includes notice, education, and procedural requirements for testing for drugs and alcohol pursuant to law or to rules developed by the Agency for Health Care Administration, the employer may require the employee to submit to a test for the presence of drugs or alcohol and, if a drug or alcohol is found to be present in the employee’s system at a level prescribed by rule adopted pursuant to this act, the employee may be terminated and forfeits his eligibility for medical and indemnity benefits. However, a drug-free workplace program must require the employer to notify all employees that it is a condition of employment for an employee to refrain from reporting to work or working with the presence of drugs or alcohol in his or her body and, if an injured employee refuses to submit to a test for drugs or alcohol, the employee forfeits eligibility for medical and indemnity benefits.

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(1) DEFINITIONS.—Except where the context otherwise requires, as used in this act:

(a) “Chain of custody” refers to the methodology of tracking specified materials or substances for the purpose of maintaining control and accountability from initial collection to final disposition for all such materials or substances and providing for accountability at each stage in handling, testing, and storing specimens and reporting test results.

(b) “Confirmation test,” “confirmed test,” or “confirmed drug test” means a second analytical procedure used to identify the presence of a specific drug or metabolite in a specimen, which test must be different in scientific principle from that of the initial test procedure and must be capable of providing requisite specificity, sensitivity, and quantitative accuracy.

(c) “Drug” means alcohol, including a distilled spirit, wine, a malt beverage, or an intoxicating liquor; an amphetamine; a cannabinoid; cocaine; phenycyclidine (PCP); a hallucinogen; methaqualone; an opiate; a barbiturate; a benzodiazepine; a synthetic narcotic; a designer drug; or a metabolite of any of the substances listed in this paragraph. An employer may test an individual for any or all of such drugs.

(d) “Drug rehabilitation program” means a service provider, established pursuant to ch. 397.30, that provides confidential, timely, and expert identification, assessment, and resolution of employee drug abuse.

(e) “Drug test” or “test” means any chemical, biological, or physical instrumental analysis administered by a laboratory certified by the United States Department of Health and Human Services or licensed by the Agency for Health Care Administration, for the purpose of determining the presence or absence of a drug or its metabolites.

(f) “Employee” means any person who works for salary, wages, or other remuneration for an employer.

(g) “Employee assistance program” means an established program capable of providing expert assessment of employee personal concerns; confidential and timely identification services with regard to employee drug abuse; referrals of employees for appropriate diagnosis, treatment, and assistance; and followup services for employees who participate in the program or require monitoring after returning to work. If, in addition to the above activities, an employee assistance program provides diagnostic and treatment services, these services shall in all cases be provided by service providers pursuant to ch. 397.30.

(h) “Employer” means a person or entity that employs a person and that is covered by the Workers’ Compensation Law.

(i) “Initial drug test” means a sensitive, rapid, and reliable procedure to identify negative and presumptive positive specimens, using an immunoassay procedure or an equivalent, or a more accurate scientifically accepted method approved by the United States Food and Drug Administration or the Agency for Health Care Administration as such more accurate technology becomes available in a cost-effective form.

(j) “Job applicant” means a person who has applied for a position with an employer and has been offered employment conditioned upon successfully passing a drug test, and may have begun work pending the results of the drug test. For a public employer, “job applicant” means only a person who has applied for a special-risk or safety-sensitive position.
(k) "Medical review officer" or "MRO" means a licensed physician, employed with or contracted with an employer, who has knowledge of substance abuse disorders, laboratory testing procedures, and chain of custody collection procedures; who verifies positive, confirmed test results; and who has the necessary medical training to interpret and evaluate an employee's positive test result in relation to the employee's medical history or any other relevant biomedical information.

(l) "Prescription or nonprescription medication" means a drug or medication obtained pursuant to a prescription as defined by s. 893.02 or a medication that is authorized pursuant to federal or state law for general distribution and use without a prescription in the treatment of human diseases, ailments, or injuries.

(m) "Public employer" means any agency within state, county, or municipal government that employs individuals for a salary, wages, or other remuneration.

(n) "Reasonable-suspicion drug testing" means drug testing based on a belief that an employee is using or has used drugs in violation of the employer's policy drawn from specific objective and articulable facts and reasonable inferences drawn from those facts in light of experience. Among other things, such facts and inferences may be based upon:
1. Observable phenomena while at work, such as direct observation of drug use or of the physical symptoms or manifestations of being under the influence of a drug.
2. Abnormal conduct or erratic behavior while at work or a significant deterioration in work performance.
3. A report of drug use, provided by a reliable and credible source.
4. Evidence that an individual has tampered with a drug test during his employment with the current employer.
5. Information that an employee has caused, contributed to, or been involved in an accident while at work.
6. Evidence that an employee has used, possessed, sold, solicited, or transferred drugs while working or while on the employer's premises or while operating the employer's vehicle, machinery, or equipment.

(o) "Safety-sensitive position" means, with respect to a public employer, a position in which a drug impairment constitutes an immediate and direct threat to public health or safety, such as a position that requires the employee to carry a firearm, perform life-threatening procedures, work with confidential information or documents pertaining to criminal investigations, or work with controlled substances; a position subject to s. 110.1127; or a position in which a momentary lapse in attention could result in injury or death to another person.

(p) "Special-risk position" means, with respect to a public employer, a position that is required to be filled by a person who is certified under chapter 633 or chapter 943.

(q) "Specimen" means tissue, hair, or a product of the human body capable of revealing the presence of drugs or their metabolites, as approved by the United States Food and Drug Administration or the Agency for Health Care Administration.

(2) DRUG TESTING.—An employer may test an employee or job applicant for any drug described in paragraph (1)(c). In order to qualify as having established a drug-free workplace program which affords an employer the ability to qualify for the discounts provided under s. 627.0915 and deny medical and indemnity benefits, under this chapter all drug testing conducted by employers shall be in conformity with the standards and procedures established in this section and all applicable rules adopted pursuant to this section. However, an employer does not have a legal duty under this section to request an employee or job applicant to undergo drug testing. If an employer fails to maintain a drug-free workplace program in accordance with the standards and procedures established in this section and in applicable rules, the employer shall not be eligible for discounts under s. 627.0915. All employers qualifying for and receiving discounts provided under s. 627.0915 must be reported annually by the insurer to the division.

(3) NOTICE TO EMPLOYEES AND JOB APPLICANTS.—

(a) One time only, prior to testing, an employer shall give all employees and job applicants for employment a written policy statement which contains:
1. A general statement of the employer's policy on employee drug use, which must identify:
   a. The types of drug testing an employee or job applicant may be required to submit to, including reasonable-suspicion drug testing or drug testing conducted on any other basis.
   b. The actions the employer may take against an employee or job applicant on the basis of a positive confirmed drug test result.
2. A statement advising the employee or job applicant of the existence of this section.
3. A general statement concerning confidentiality.
4. Procedures for employees and job applicants to confidentially report to a medical review officer the use of prescription or nonprescription medications to a medical review officer both before and after being tested.
5. A list of the most common medications, by brand name or common name, as applicable, as well as by chemical name, which may alter or affect a drug test. A list of such medications as developed by the Agency for Health Care Administration shall be available to employers through the Division of Workers' Compensation of the Department of Labor and Employment Security.
6. The consequences of refusing to submit to a drug test.
7. A representative sampling of names, addresses, and telephone numbers of employee assistance programs and local drug rehabilitation programs.
8. A statement that an employee or job applicant who receives a positive confirmed test result may contest or explain the result to the medical review officer within 5 working days after receiving written notification of the test result; that if an employee's or job applicant's explanation or challenge is unsatisfactory to the medical review officer, the medical review officer shall report a positive test result back to the employer; and that a person may contest the drug test result pursuant to law or to rules adopted by the Agency for Health Care Administration.
9. A statement informing the employee or job applicant of his responsibility to notify the laboratory of any administrative or civil action brought pursuant to this section.

10. A list of all drugs for which the employer will test, described by brand name or common name, as applicable, as well as by chemical name.

11. A statement regarding any applicable collective bargaining agreement or contract and the right to appeal to the Public Employees Relations Commission or applicable court.

12. A statement notifying employees and job applicants of their right to consult with a medical review officer for technical information regarding prescription or nonprescription medication.

(b) An employer not having a drug-testing program shall ensure that at least 60 days elapse between a general one-time notice to all employees that a drug-testing program is being implemented and the beginning of actual drug testing. An employer having a drug-testing program in place prior to July 1, 1990, is not required to provide a 60-day notice period.

(c) An employer shall include notice of drug testing on vacancy announcements for positions for which drug testing is required. A notice of the employer's drug-testing policy must also be posted in an appropriate and conspicuous location on the employer's premises, and copies of the policy must be made available for inspection by the employees or job applicants of the employer during regular business hours in the employer's personnel office or other suitable locations.

4. TYPES OF TESTING—

(a) An employer is required to conduct the following types of drug tests:

1. Job applicant drug testing.—An employer must require job applicants to submit to a drug test and may use a refusal to submit to a drug test or a positive confirmed drug test as a basis for refusing to hire a job applicant.

2. Reasonable-suspicion drug testing.—An employer must require an employee to submit to reasonable-suspicion drug testing.

3. Routine fitness-for-duty drug testing.—An employer must require an employee to submit to a drug test if the test is conducted as part of a routinely scheduled employee fitness-for-duty medical examination that is part of the employer's established policy or that is scheduled routinely for all members of an employment classification or group.

4. Followup drug testing.—If the employee in the course of employment enters an employee assistance program for drug-related problems, or a drug rehabilitation program, the employer must require the employee to submit to a drug test as a followup to such program, unless the employee voluntarily entered the program. In those cases, the employer has the option to not require followup testing. If followup testing is required, it must be conducted at least once a year for a 2-year period after completion of the program. Advance notice of a followup testing date must not be given to the employee to be tested.

(b) This subsection does not preclude a private employer from conducting random testing, or any other lawful testing, of employees for drugs.

(c) Limited testing of applicants, only if it is based on a reasonable classification basis, is permissible in accordance with law or with rules adopted by the Agency for Health Care Administration.

5. PROCEDURES AND EMPLOYEE PROTECTION.

All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(a) A sample shall be collected with due regard to the privacy of the individual providing the sample, and in a manner reasonably calculated to prevent substitution or contamination of the sample.

(b) Specimen collection must be documented, and the documentation procedures shall include:

1. Labeling of specimen containers so as to reasonably preclude the likelihood of erroneous identification of test results.

2. A form for the employee or job applicant to provide any information he considers relevant to the test, including identification of currently or recently used prescription or nonprescription medication or other relevant medical information. The form must provide notice of the most common medications by brand name or common name, as applicable, as well as by chemical name, which may alter or affect a drug test. The providing of information shall not preclude the administration of the drug test, but shall be taken into account in interpreting any positive confirmed test result.

(c) Specimen collection, storage, and transportation to the testing site shall be performed in a manner that reasonably precludes contamination or adulteration of specimens.

(d) Each initial drug test and confirmation test conducted under this section, not including the taking or collecting of a specimen to be tested, shall be conducted by a licensed or certified laboratory as described in subsection (9).

(e) A specimen for a drug test may be taken or collected by any of the following persons:

1. A physician, a physician assistant, a registered professional nurse, a licensed practical nurse, or a nurse practitioner or a certified paramedic who is present at the scene of an accident for the purpose of rendering emergency medical service or treatment.

2. A qualified person employed by a licensed or certified laboratory as described in subsection (9).

(f) A person who collects or takes a specimen for a drug test shall collect an amount sufficient for two drug tests as determined by the Agency for Health Care Administration.

(g) Every specimen that produces a positive, confirmed test result shall be preserved by the licensed or certified laboratory that conducted the confirmation test for a period of at least 210 days after the result of the test was mailed or otherwise delivered to the medical review officer. However, if an employee or job applicant undertakes an administrative or legal challenge to the test result, the employee or job applicant shall notify the laboratory and the sample shall be retained by the laboratory until the case or administrative appeal is settled. During the 180-day period after written notification of a positive test result, the employee or job applicant who has provided the specimen shall be permitted by the

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employer to have a portion of the specimen retested, at the employee’s or job applicant’s expense, at another laboratory, licensed and approved by the Agency for Health Care Administration, chosen by the employee or job applicant. The second laboratory must test at equal or greater sensitivity for the drug in question as the first laboratory. The first laboratory that performed the test for the employer is responsible for the transfer of the portion of the specimen to be retested, and for the integrity of the chain of custody during such transfer.

(h) Within 5 working days after receipt of a positive confirmed test result from the medical review officer, an employer shall inform an employee or job applicant in writing of such positive test result, the consequences of such results, and the options available to the employee or job applicant. The employer shall provide to the employee or job applicant, upon request, a copy of the test results.

(i) Within 5 working days after receiving notice of a positive confirmed test result, an employee or job applicant may submit information to the employer explaining or contesting the test result, and explaining why the result does not constitute a violation of the employer’s policy.

(j) The employee’s or job applicant’s explanation or challenge of the positive test result is unsatisfactory to the employer, a written explanation as to why the employee’s or job applicant’s explanation is unsatisfactory, along with the report of positive result, shall be provided by the employer to the employee or job applicant; and all such documentation shall be kept confidential by the employer pursuant to subsection (8) and shall be retained by the employer for at least 1 year.

(k) An employer may not discharge, discipline, refuse to hire, discriminate against, or request or require rehabilitation of an employee or job applicant on the sole basis of a positive test result that has not been verified by a confirmation test and by a medical review officer.

(l) An employer that performs drug testing or specimen collection shall use chain-of-custody procedures established by the Agency for Health Care Administration to ensure proper recordkeeping, handling, labeling, and identification of all specimens tested.

(m) An employer shall pay the cost of all drug tests, initial and confirmation, which the employer requires of employees. An employee or job applicant shall pay the costs of any additional drug tests not required by the employer.

(n) An employer shall not discharge, discipline, or discriminate against an employee solely upon the employee’s voluntarily seeking treatment, while under the employ of the employer, for a drug–related problem if the employee has not previously tested positive for drug use, entered an employee assistance program for drug–related problems, or entered a drug rehabilitation program. Unless otherwise provided by a collective bargaining agreement, an employer may select the employee assistance program or drug rehabilitation program if the employer pays the cost of the employee’s participation in the program.

(o) If drug testing is conducted based on reasonable suspicion, the employer shall promptly detail in writing the circumstances which formed the basis of the determination that reasonable suspicion existed to warrant the testing. A copy of this documentation shall be given to the employee upon request and the original documentation shall be kept confidential by the employer pursuant to subsection (8) and shall be retained by the employer for at least 1 year.

(p) All authorized remedial treatment, care, and attendance provided by a health care provider to an injured employee before medical and indemnity benefits are denied under this section must be paid for by the carrier or self–insurer. However, the carrier or self–insurer must have given reasonable notice to all affected health care providers that payment for treatment, care, and attendance provided to the employee after a future date certain will be denied. A health care provider, as defined in s. 440.13(1)(i), that refuses, without good cause, to continue treatment, care, and attendance before the provider receives notice of benefit denial commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(6) CONFIRMATION TESTING.—

(a) If an initial drug test is negative, the employer may in its sole discretion seek a confirmation test.

(b) Only licensed or certified laboratories as described in subsection (9) may conduct confirmation drug tests.

(c) All positive initial tests shall be confirmed using gas chromatography/mass spectrometry (GC/MS) or an equivalent or more accurate scientifically accepted method approved by the Agency for Health Care Administration or the United States Food and Drug Administration as such technology becomes available in a cost-effective form.

(d) An initial drug test of an employee or job applicant is confirmed as positive, the employer’s medical review officer shall provide technical assistance to the employer and to the employee or job applicant for the purpose of interpreting the test result to determine whether the result could have been caused by prescription or nonprescription medication taken by the employee or job applicant.

(7) EMPLOYER PROTECTION.—

(a) An employee or job applicant whose drug test result is confirmed as positive in accordance with this section shall not, by virtue of the result alone, be deemed to have a "handicap" or "disability" as defined under federal, state, or local handicap and disability discrimination laws.

(b) An employer who discharges or disciplines an employee or refuses to hire a job applicant in compliance with this section is considered to have discharged, disciplined, or refused to hire for cause.

(c) No physician–patient relationship is created between an employee or job applicant and an employer or any person performing or evaluating a drug test, solely by the establishment, implementation, or administration of a drug–testing program.

(d) Nothing in this section shall be construed to prevent an employer from establishing reasonable work rules related to employee possession, use, sale, or solicitation of drugs, including convictions for drug–related offenses, and taking action based upon a violation of any of those rules.
(e) This section does not operate retroactively, and does not abrogate the right of an employer under state law to conduct drug tests, or implement employee drug-testing programs; however, only those programs that meet the criteria outlined in this section qualify for reduced rates under s. 627.0915.

(f) If an employee or job applicant refuses to submit to a drug test, the employer is not barred from discharging or disciplining the employee or from refusing to hire the job applicant. However, this paragraph does not abrogate the rights and remedies of the employee or job applicant as otherwise provided in this section.

(g) This section does not prohibit an employer from conducting medical screening or other tests required, permitted, or not disallowed by any statute, rule, or regulation for the purpose of monitoring exposure of employees to toxic or other unhealthy substances in the workplace or in the performance of job responsibilities. Such screening or testing is limited to the specific substances expressly identified in the applicable statute, rule, or regulation, unless prior written consent of the employee is obtained for other tests. Such screening or testing need not be in compliance with the rules adopted by the Agency for Health Care Administration under this chapter or under s. 112.0455. A public employer may, through the use of an unbiased selection procedure, conduct random drug tests of employees occupying safety-sensitive or special-risk positions if the testing is performed in accordance with drug-testing rules adopted by the Agency for Health Care Administration and the Department of Labor and Employment Security. If applicable, random drug testing must be specified in a collective bargaining agreement as negotiated by the appropriate certified bargaining agent before such testing is implemented.

(h) No cause of action shall arise in favor of any person based upon the failure of an employer to establish a program or policy for drug testing.

(8) CONFIDENTIALITY.—

(a) Except as otherwise provided in this subsection, all information, interviews, reports, statements, memoranda, and drug test results, written or otherwise, received or produced as a result of a drug-testing program are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution, and may not be used or received in evidence, obtained in discovery, or disclosed in any public or private proceedings, except in accordance with this section or in determining compensability under this chapter.

(b) Employers, laboratories, medical review officers, employee assistance programs, drug rehabilitation programs, and their agents may not release any information concerning drug test results obtained pursuant to this section without a written consent form signed voluntarily by the person tested, unless such release is compelled by an administrative law judge, a hearing officer, or a court of competent jurisdiction pursuant to an appeal taken under this section or is deemed appropriate by a professional or occupational licensing board in a related disciplinary proceeding. The consent form must contain, at a minimum:

1. The name of the person who is authorized to obtain the information.
2. The purpose of the disclosure.
3. The precise information to be disclosed.
4. The duration of the consent.
5. The signature of the person authorizing release of the information.

(c) Information on drug test results shall not be used in any criminal proceeding against the employee or job applicant. Information released contrary to this section is inadmissible as evidence in any such criminal proceeding.

(d) This subsection does not prohibit an employer, agent of an employer, or laboratory conducting a drug test from having access to employee drug test information or using such information when consulting with legal counsel in connection with actions brought under or related to this section or when the information is relevant to its defense in a civil or administrative matter.

(9) DRUG-TESTING STANDARDS FOR LABORATORIES.—

(a) A laboratory may analyze initial or confirmation test specimens only if:

1. The laboratory is licensed and approved by the Agency for Health Care Administration using criteria established by the United States Department of Health and Human Services as general guidelines for modeling the state drug-testing program pursuant to this section or the laboratory is certified by the United States Department of Health and Human Services.

2. The laboratory has written procedures to ensure the chain of custody.

3. The laboratory follows proper quality control procedures, including, but not limited to:

   a. The use of internal quality controls, including the use of samples of known concentrations which are used to check the performance and calibration of testing equipment, and periodic use of blind samples for overall accuracy.

   b. An internal review and certification process for drug test results, conducted by a person qualified to perform that function in the testing laboratory.

   c. Security measures implemented by the testing laboratory to preclude adulteration of specimens and drug test results.

   d. Other necessary and proper actions taken to ensure reliable and accurate drug test results.

(b) A laboratory shall disclose to the medical review officer a written positive confirmed test result report within 7 working days after receipt of the sample. All laboratory reports of a drug test result must, at a minimum, state:

1. The name and address of the laboratory that performed the test and the positive identification of the person tested.

2. Positive results on confirmation tests only, or negative results, as applicable.

3. A list of the drugs for which the drug analyses were conducted.

4. The type of tests conducted for both initial tests and confirmation tests and the minimum cutoff levels of the tests.

5. Any correlation between medication reported by the employee or job applicant pursuant to subparagraph (5)(b)2. and a positive confirmed drug test result.
A report must not disclose the presence or absence of any drug other than a specific drug and its metabolites listed pursuant to this section.

(c) The laboratory shall submit to the Agency for Health Care Administration a monthly report with statistical information regarding the testing of employees and job applicants. The report must include information on the methods of analysis conducted, the drugs tested for, the number of positive and negative results for both initial tests and confirmation tests, and any other information deemed appropriate by the Agency for Health Care Administration. A monthly report must not identify specific employees or job applicants.

(10) RULES.—The Agency for Health Care Administration shall adopt rules pursuant to s. 112.0455 and criteria established by the United States Department of Health and Human Services as general guidelines for modeling the state drug-testing program, concerning, but not limited to:

(a) Standards for licensing drug-testing laboratories and suspension and revocation of such licenses.
(b) Urine, hair, blood, and other body specimens and minimum specimen amounts that are appropriate for drug testing.
(c) Methods of analysis and procedures to ensure reliable drug-testing results, including standards for initial tests and confirmation tests.
(d) Minimum cutoff detection levels for each drug or metabolites of such drug for the purposes of determining a positive test result.
(e) Chain-of-custody procedures to ensure proper identification, labeling, and handling of specimens tested.
(f) Retention, storage, and transportation procedures to ensure reliable results on confirmation tests and retests.

(11) PUBLIC EMPLOYEES IN SAFETY-SENSITIVE OR SPECIAL-RISK POSITIONS.—

(a) If an employee who is employed by a public employer in a safety-sensitive position enters an employee assistance program or drug rehabilitation program, the employer must assign the employee to a position other than a safety-sensitive position or, if such position is not available, place the employee on leave while the employee is participating in the program. However, the employee shall be permitted to use any accumulated annual leave credits before leave may be ordered without pay.

(b) An employee who is employed by a public employer in a special-risk position may be discharged or disciplined by a public employer for the first positive confirmed test result if the drug confirmed is an illicit drug under s. 893.03. A special-risk employee who is participating in an employee assistance program or drug rehabilitation program may not be allowed to continue to work in any special-risk or safety-sensitive position of the public employer, but may be assigned to a position other than a safety-sensitive position or placed on leave while the employee is participating in the program. However, the employee shall be permitted to use any accumulated annual leave credits before leave may be ordered without pay.

(12) DENIAL OF BENEFITS.—An employer shall deny an employee medical or indemnity benefits under this chapter, pursuant to this section.

(13) COLLECTIVE BARGAINING RIGHTS.—

(a) This section does not eliminate the bargainable rights as provided in the collective bargaining process if applicable.
(b) Drug-free workplace program requirements pursuant to this section shall be a mandatory topic of negotiations with any certified collective bargaining agent for nonfederal public sector employers that operate under a collective bargaining agreement.

(14) APPLICABILITY.—A drug testing policy or procedure adopted by an employer pursuant to this chapter shall be applied equally to all employee classifications where the employee is subject to workers’ compensation coverage.

440.125 Medical records and reports; identifying information in employee medical bills; confidentiality.

(1) Any medical records and medical reports of an injured employee and any information identifying an injured employee in medical bills which are provided to the Division of Workers’ Compensation of the Department of Labor and Employment Security pursuant to s. 440.13 are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution, except as otherwise provided by this chapter.

(2) The Legislature finds that it is a public necessity that an injured employee’s medical records and medical reports and information identifying the employee in medical bills held by the Division of Workers’ Compensation pursuant to s. 440.13 be confidential and exempt from the public records law. Public access to such information is an invasion of the injured employee’s right to privacy in that personal, sensitive information would be revealed, and public knowledge of such information could lead to discrimination against the employee by coworkers and others. Additionally, there is little utility in providing public access to such information in that the effectiveness and efficiency of the workers’ compensation program can be otherwise adequately monitored and evaluated.

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

(1) DEFINITIONS.—As used in this section, the term:

(a) “Alternate medical care” means a change in treatment or health care provider.
(b) “Attendant care” means care rendered by trained professional attendants which is beyond the scope of household duties. Family members may provide nonprofessional attendant care, but may not be compensated under this chapter for care that falls within the scope of household duties and other services normally and gratuitously provided by family members. “Family member” means a spouse, father, mother, brother, sister, child, grandchild, father-in-law, mother-in-law, aunt, or uncle.
(c) "Carrier" means, for purposes of this section, insurance carrier, self-insurance fund or individually self-insured employer, or assessable mutual insurer.

(d) "Catastrophic injury" means an injury as defined in s. 440.02.

(e) "Certified health care provider" means a health care provider who has been certified by the division or who has entered an agreement with a licensed managed care organization to provide treatment to injured workers under this section. Certification of such health care provider must include documentation that the health care provider has read and is familiar with the portions of the statute, impairment guides, and rules which govern the provision of remedial treatment, care, and attendance.

(f) "Compensable" means a determination by a carrier or judge of compensation claims that a condition suffered by an employee results from an injury arising out of and in the course of employment.

(g) "Emergency services and care" means services and care as defined in s. 395.002(9).

(h) "Health care facility" means any hospital licensed under chapter 395 and any health care institution licensed under chapter 400.

(i) "Health care provider" means a physician or any recognized practitioner who provides skilled services pursuant to a prescription or under the supervision or direction of a physician and who has been certified by the division as a health care provider. The term "health care provider" includes a health care facility.

(j) "Independent medical examiner" means a physician selected by either an employee or a carrier to render one or more independent medical examinations in connection with a dispute arising under this chapter.

(k) "Independent medical examination" means an objective evaluation of the injured employee's medical condition, including, but not limited to, impairment or work status, performed by a physician or an expert medical advisor at the request of a party, a judge of compensation claims, or the division to assist in the resolution of a dispute arising under this chapter.

(l) "Instance of overutilization" means a specific inappropriate service or level of service provided to an injured employee.

(m) "Medically necessary" means any medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature, except in those instances in which prior approval of the Agency for Health Care Administration has been obtained. The Agency for Health Care Administration shall adopt rules providing for such approval on a case-by-case basis when the service or supply is shown to have significant benefits to the recovery and well-being of the patient.

(n) "Medicine" means a drug prescribed by an authorized health care provider and includes only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes or states that the brand-name drug as defined in s. 465.025 is medically necessary, or is a drug appearing on the schedule of drugs created pursuant to s. 465.025(6), or is available at a cost lower than its generic equivalent.

(o) "Palliative care" means noncurative medical services that mitigate the conditions, effects, or pain of an injury.

(p) "Pattern or practice of overutilization" means repetition of instances of overutilization within a specific medical case or multiple cases by a single health care provider.

(q) "Peer review" means an evaluation by two or more physicians licensed under the same authority and with the same or similar specialty as the physician under review, of the appropriateness, quality, and cost of health care and health services provided to a patient, based on medically accepted standards.

(r) "Physician" or "doctor" means a medical doctor or doctor of osteopathy licensed under chapter 458, a physician licensed under chapter 459, an osteopath licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, each of whom must be certified by the division as a health care provider.

(s) "Reimbursement dispute" means any disagreement between a health care provider or health care facility and carrier concerning payment for medical treatment.

(t) "Utilization control" means a systematic process of implementing measures that assure overall management and cost containment of services delivered.

(u) "Utilization review" means the evaluation of the appropriateness of both the level and the quality of health care and health services provided to a patient, including, but not limited to, evaluation of the appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. Such evaluation must be accomplished by means of a system that identifies the utilization of medical services based on medically accepted standards as established by medical consultants with qualifications similar to those providing the care under review, and that refers patterns and practices of overutilization to the division.

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—

(a) Subject to the limitations specified elsewhere in this chapter, the employer shall furnish to the employee such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, including medicines, medical supplies, durable medical equipment, orthoses, prostheses, and other medically necessary apparatus. Remedial treatment, care, and attendance, including work-hardening programs or pain-management programs accredited by the Commission on Accreditation of Rehabilitation Facilities or Joint Commission on the Accreditation of Health Organizations or pain-management programs affiliated with medical schools, shall be considered as covered treatment only when such care is given based on a referral by a physi-
section as defined in this chapter. Each facility shall maintain outcome data, including work status at discharges, total program charges, total number of visits, and length of stay. The department shall utilize such data and report to the President of the Senate and the Speaker of the House of Representatives regarding the efficacy and cost-effectiveness of such program, no later than October 1, 1994. Medically necessary treatment, care, and attendance does not include chiropractic services in excess of 18 treatments or rendered 8 weeks beyond the date of the initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employee is catastrophically injured.

(b) The employer shall provide appropriate professional or nonprofessional attendant care performed only at the direction and control of a physician when such care is medically necessary. The value of nonprofessional attendant care provided by a family member must be determined as follows:

1. If the family member is not employed, the per-hour value equals the federal minimum hourly wage.

2. If the family member is employed and elects to leave that employment to provide attendant or custodial care, the per-hour value of that care equals the per-hour value of the family member’s former employment, not to exceed the per-hour value of such care available in the community at large. A family member or a combination of family members providing nonprofessional attendant care under this paragraph may not be compensated for more than a total of 12 hours per day.

(c) If the employer fails to provide treatment or care required by this section after request by the injured employee, the employee may obtain such treatment at the expense of the employer, if the treatment is compensable and medically necessary. There must be a specific request for the treatment, and the employer or carrier must be given a reasonable time period within which to provide the treatment or care. However, the employee is not entitled to recover any amount personally expended for the treatment or service unless he has requested the employer to furnish that treatment or service and the employer has failed, refused, or neglected to do so within a reasonable time or unless the nature of the injury requires such treatment, nursing, and services and the employer or his superintendent or foreman, having knowledge of the injury, has neglected to provide the treatment or service.

(d) The carrier has the right to transfer the care of an injured employee from the attending health care provider if an independent medical examination determines that the employee is not making appropriate progress in recuperation.

(e) Except in emergency situations and for treatment rendered by a managed care arrangement, after any initial examination and diagnosis by a physician providing remedial treatment, care, and attendance, and before a proposed course of medical treatment begins, each insurer shall review, in accordance with the requirements of this chapter, the proposed course of treatment, to determine whether such treatment would be recognized as reasonably prudent. The review must be in accordance with all applicable workers’ compensation practice parameters. The insurer must accept any such proposed course of treatment unless the insurer notifies the physician of its specific objections to the proposed course of treatment by the close of the tenth business day after notification by the physician, or a supervised designee of the physician, of the proposed course of treatment.

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(a) As a condition to eligibility for payment under this chapter, a health care provider who renders services must be a certified health care provider and must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care. The division shall adopt rules to implement the certification of health care providers. As a one-time prerequisite to obtaining certification, the division shall require each physician to demonstrate proof of completion of a minimum 5-hour course that covers the subject areas of cost containment, utilization control, ergonomics, and the practice parameters adopted by the division governing the physician’s field of practice. The division shall coordinate with the Agency for Health Care Administration, the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Chiropractic Association, the Florida Podiatric Medical Association, the Florida Optometric Association, the Florida Dental Association, and other health professional organizations and their respective boards as deemed necessary by the Agency for Health Care Administration in complying with this subsection. No later than October 1, 1994, the division shall adopt rules regarding the criteria and procedures for approval of courses and the filing of proof of completion by the physicians.

(b) A health care provider who renders emergency care must notify the carrier by the close of the third business day after it has rendered such care. If the emergency care results in admission of the employee to a health care facility, the health care provider must notify the carrier by telephone within 24 hours after initial treatment. Emergency care is not compensable under this chapter unless the injury requiring emergency care arose as a result of a work-related accident. Pursuant to chapter 395, all licensed physicians and health care providers in this state shall be required to make their services available for emergency treatment of any employee eligible for workers’ compensation benefits. To refuse to make such treatment available is cause for revocation of a license.

(c) A health care provider may not refer the employee to another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the carrier, except when emergency care is rendered. Any referral must be to a health care provider that has been certified by the division, unless the referral is for emergency treatment.

(d) A carrier must respond, by telephone or in writing, to a request for authorization 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 carrier does not include notice to the employer.
(e) Carriers shall adopt procedures for receiving, reviewing, documenting, and responding to requests for authorization. Such procedures shall be for a health care provider certified under this section.

(f) By accepting payment under this chapter for treatment rendered to an injured employee, a health care provider consents to the jurisdiction of the division as set forth in subsection (11) and to the submission of all records and other information concerning such treatment to the division in connection with a reimbursement dispute, audit, or review as provided by this section. The health care provider must further agree to comply with any decision of the division rendered under this section.

(g) The employee is not liable for payment for medical treatment or services provided pursuant to this section except as otherwise provided in this section.

(h) The provisions of s. 455.236 are applicable to referrals among health care providers, as defined in subsection (1), treating injured workers.

(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 division identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, or unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall not refuse to authorize such consultation or procedure unless the health care provider or facility is not authorized or certified or unless an expert medical advisor has determined that the consultation or procedure is not medically necessary or otherwise 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.

(j) Notwithstanding anything in this chapter to the contrary, a sick or injured employee shall be entitled, at all times, to free, full, and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines required under this chapter. It is expressly forbidden for the division, an employer, or a carrier, or any agent or representative of the division, an employer, or a carrier to select the pharmacy or pharmacist which the sick or injured employee must use; condition coverage or payment on the basis of the pharmacy or pharmacist utilized; or to otherwise interfere in the selection by the sick or injured employee of a pharmacy or pharmacist.

(4) NOTICE OF TREATMENT TO CARRIER; FILING WITH DIVISION.—

(a) Any health care provider providing necessary remedial treatment, care, or attendance to any injured worker shall submit treatment reports to the carrier in a format prescribed by the division. A claim for medical or surgical treatment is not valid or enforceable against such employer or employee, unless, by the close of the third business day following the first treatment, the physician providing the treatment furnishes to the employer or carrier a preliminary notice of the injury and treatment on forms prescribed by the division and, within 15 days thereafter, furnishes to the employer or carrier a complete report, and subsequent thereto furnishes progress reports, if requested by the employer or insurance carrier, at intervals of not less than 3 weeks apart or at less frequent intervals if requested on forms prescribed by the division.

(b) Each medical report or bill obtained or received by the employer, the carrier, or the injured employee, or the attorney for the employer, carrier, or injured employee, with respect to the remedial treatment or care of the injured employee, including any report of an examination, diagnosis, or disability evaluation, must be filed with the Division of Workers’ Compensation pursuant to rules adopted by the division. The health care provider shall also furnish to the injured employee or to his attorney, on demand, a copy of his office chart, records, and reports, and may charge the injured employee an amount authorized by the division for the copies. Each such health care provider shall provide to the division any additional information about the remedial treatment, care, and attendance that the division reasonably requests.

(c) It is the policy for the administration of the workers’ compensation system that there be reasonable access to medical information by all parties to facilitate the self-executing features of the law. Notwithstanding the limitations in s. 455.241 and subject to the limitations in s. 391.004, upon the request of the employer, the carrier, or the attorney for either of them, the medical records of an injured employee must be furnished to those persons and the medical condition of the injured employee must be discussed with those persons, if the records and the discussions are restricted to conditions relating to the workplace injury. Any such discussions may be held before or after the filing of a claim without the knowledge, consent, or presence of any other party or his agent or representative. A health care provider who willfully refuses to provide medical records or to discuss the medical condition of the injured employee, after a reasonable request is made for such information pursuant to this subsection, shall be subject by the division to one or more of the penalties set forth in paragraph (b).

(5) INDEPENDENT MEDICAL EXAMINATIONS.—

(a) In any dispute concerning overutilization, medical benefits, compensability, or disability under this chapter, the carrier or the employee may select an independent medical examiner. The examiner may be a health care provider treating or providing other care to the employee. An independent medical examiner may not render an opinion outside his area of expertise, as demonstrated by licensure and applicable practice parameters.

(b) Each party is bound by his selection of an independent medical examiner and is entitled to an alternate examiner only if:

1. The examiner is not qualified to render an opinion upon an aspect of the employee’s illness or injury which is material to the claim or petition for benefits;

2. The examiner ceases to practice in the specialty relevant to the employee’s condition;
3. The examiner is unavailable due to injury, death, or relocation outside a reasonably accessible geographic area; or

4. The parties agree to an alternate examiner.

Any party may request, or a judge of compensation claims may require, designation of a division medical advisor as an independent medical examiner. The opinion of the advisors acting as examiners shall not be afforded the presumption set forth in paragraph (9)(c).

(c) The carrier may, at its election, contact the claimant directly to schedule a reasonable time for an independent medical examination. The carrier must confirm the scheduling agreement in writing within 5 days and notify claimant's counsel, if any, at least 7 days before the date upon which the independent medical examination is scheduled to occur. An attorney representing a claimant is not authorized to schedule independent medical evaluations under this subsection.

(d) If the employee fails to appear for the independent medical examination without good cause and fails to advise the physician at least 24 hours before the scheduled date for the examination that he cannot appear, the employee is barred from recovering compensation for any period during which he has refused to submit to such examination. Further, the employee shall reimburse the carrier 50 percent of the physician's cancellation or no-show fee unless the carrier that schedules the examination fails to timely provide to the employee a written confirmation of the date of the examination pursuant to paragraph (c) which includes an explanation of why he failed to appear. The employee may appeal to a judge of compensation claims for reimbursement when the carrier withholds payment in excess of the authority granted by this section.

(e) No medical opinion other than the opinion of a medical advisor appointed by the judge of compensation claims or division, an independent medical examiner, or an authorized treating provider is admissible in proceedings before the judges of compensation claims.

(f) Attorney's fees incurred by an injured employee in connection with delay of or opposition to an independent medical examination, including, but not limited to, motions for protective orders, are not recoverable under this chapter.

(6) UTILIZATION REVIEW.—Carriers shall review all bills, invoices, and other claims for payment submitted by health care providers in order to identify overutilization and billing errors, and may hire peer review consultants or conduct independent medical evaluations. Such consultants, including peer review organizations, are immune from liability in the execution of their functions under this subsection to the extent provided in s. 766.101. If a carrier finds that overutilization of medical services or a billing error has occurred, it must disallow or adjust payment for such services or error without order of a judge of compensation claims or the division, if the carrier, in making its determination, has complied with this section and rules adopted by the division.

(7) UTILIZATION AND REIMBURSEMENT DISPUTES.—

(a) Any health care provider, carrier, or employer who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 30 days after receipt of notice of disallowance or adjustment of payment, petition the division to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a petitioner to submit such documentation to the division results in dismissal of the petition.

(b) The carrier must submit to the division within 10 days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to submit the requested documentation to the division within 10 days constitutes a waiver of all objections to the petition.

(c) Within 60 days after receipt of all documentation, the division must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The division must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, in rendering its determination.

(d) If the division finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider, facility, insurer, or employer within 30 days, subject to the penalties provided in this subsection.

(e) The division shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a petitioner and expanding the timetable for rendering a determination upon a consolidated petition.

(f) Any carrier that engages in a pattern or practice of arbitrarily or unreasonably disallowing or reducing payments to health care providers may be subject to one or more of the following penalties imposed by the division:

1. Repayment of the appropriate amount to the health care provider.

2. An administrative fine assessed by the division in an amount not to exceed $5,000 per instance of improperly disallowing or reducing payments.

3. Award of the health care provider's costs, including a reasonable attorney's fee, for prosecuting the petition.

(B) PATTERN OR PRACTICE OF OVERUTILIZATION.—

(a) Carriers must report to the division all instances of overutilization including, but not limited to, all instances in which the carrier disallows or adjusts payment. The division shall determine whether a pattern or practice of overutilization exists.

(b) If the division determines that a health care provider has engaged in a pattern or practice of overutilization or a violation of this chapter or rules adopted by the division, it may impose one or more of the following penalties:

1. An order of the division barring the provider from payment under this chapter;
2. Deauthorization of care under review;
3. Denial of payment for care rendered in the future;
4. Decertification of a health care provider certified as an expert medical advisor under subsection (9) or of a rehabilitation provider certified under s. 440.49;
5. An administrative fine assessed by the division in an amount not to exceed $5,000 per instance of overutilization or violation; and
6. Notification of and review by the appropriate licensing authority pursuant to s. 440.106(3);

(9) EXPERT MEDICAL ADVISORS.—
(a) The division shall certify expert medical advisors in each specialty to assist the division and the judges of compensation claims with respect to medical advice as provided in this section. The division shall, in a manner prescribed by rule, in certifying, recertifying, or decertifying an expert medical advisor, consider the qualifications, training, impartiality, and commitment of the health care provider to the provision of quality medical care at a reasonable cost. As a prerequisite for certification or recertification, the division shall require, at a minimum, that an expert medical advisor have specialized workers’ compensation training or experience under the workers’ compensation system of this state and board certification or board eligibility.

(b) The division shall contract with or employ expert medical advisors to provide peer review or medical consultation to the division or to a judge of compensation claims in connection with resolving disputes relating to reimbursement, differing opinions of health care providers, and health care and physician services rendered under this chapter. Expert medical advisors contracting with the division shall, as a term of such contract, agree to provide consultation or services in accordance with the timetables set forth in this chapter and to abide by rules adopted by the division, including, but not limited to, rules pertaining to procedures for review of the services rendered by health care providers and preparation of reports and recommendations for submission to the division.

(c) If there is disagreement in the opinions of the health care providers, if two health care providers disagree on medical evidence supporting the employee’s complaints or the need for additional medical treatment, or if two health care providers disagree that the employee is able to return to work, the division may, and the judge of compensation claims shall, upon his or her own motion or within 15 days after receipt of a written request by either the injured employee, the employer, or the carrier, order the injured employee to be evaluated by an expert medical advisor. The opinion of the expert medical advisor is presumed to be correct unless there is clear and convincing evidence to the contrary as determined by the judge of compensation claims. The expert medical advisor appointed to conduct the evaluation shall have free and complete access to the medical records of the employee. An employee who fails to report to and cooperate with such evaluation forfeits entitlement to compensation during the period of failure to report or cooperate.

(d) The expert medical advisor must complete his evaluation and issue his report to the division or to the judge of compensation claims within 45 days after receipt of all medical records. The expert medical advisor must furnish a copy of the report to the carrier and to the employee.

(e) An expert medical advisor is not liable under any theory of recovery for evaluations performed under this section without a showing of fraud or malice. The protections of s. 766.101 apply to any officer, employee, or agent of the division and to any officer, employee, or agent of any entity with which the division has contracted under this subsection.

(f) If the division or a judge of compensation claims determines that the services of a certified expert medical advisor are required to resolve a dispute under this section, the carrier must compensate the advisor for his time in accordance with a schedule adopted by the division. The division may assess a penalty not to exceed $500 against any carrier that fails to timely compensate an advisor in accordance with this section.

(10) WITNESS FEES.—Any health care provider who gives a deposition shall be allowed a witness fee. The amount charged by the witness may not exceed $200 per hour. An expert witness who has never provided direct professional services to a party but has merely reviewed medical records and provided an expert opinion or has provided only direct professional services that were unrelated to the workers’ compensation case may not be allowed a witness fee in excess of $200 per day.

(11) AUDITS BY DIVISION; JURISDICTION.—
(a) The Division of Workers’ Compensation of the Department of Labor and Employment Security may investigate health care providers to determine whether providers are complying with this chapter and with rules adopted by the division, whether the providers are engaging in overutilization, and whether providers are engaging in improper billing practices. If the division finds that a health care provider has improperly billed, overutilized, or failed to comply with division rules or the requirements of this chapter it must notify the provider of its findings and may determine that the health care provider may not receive payment from the carrier or may impose penalties as set forth in subsection (8) or other sections of this chapter. If the health care provider has received payment from a carrier for services that were improperly billed or for overutilization, it must return those payments to the carrier. The division may assess a penalty not to exceed $500 for each overpayment that is not refunded within 30 days after notification of overpayment by the division or carrier.

(b) The division shall monitor and audit carriers to determine if medical bills are paid in accordance with this section and division rules. Any employer, if self-insured, or carrier found by the division not to be within 90 percent compliance as to the payment of medical bills after July 1, 1994, must be assessed a fine not to exceed 1 percent of the prior year’s assessment levied against such entity under s. 440.51 for each quarter in which the entity fails to attain 90-percent compliance.

The division shall fine an employer or carrier, pursuant to rules adopted by the division, for each late payment of compensation that is below the minimum 90-percent performance standard. Any carrier that is found to be not in compliance in subsequent consecutive quarters must implement a medical-bill review program.
approved by the division, and the carrier is subject to
disciplinary action by the Department of Insurance.

(c) The division has exclusive jurisdiction to decide
any matters concerning reimbursement, to resolve any
overutilization dispute under subsection (7), and to
decide any question concerning overutilization under
subsection (8), which question or dispute arises after

(d) The following division actions do not constitute
agency action subject to review under ss. 120.569 and
120.57 and do not constitute actions subject to s.
120.56: referral by the entity responsible for utilization
review; a decision by the division to refer a matter to a
peer review committee; establishment by a health care
provider or entity of procedures by which a peer review
committee reviews the rendering of health care ser-
vice; and the review proceedings, report, and recom-
mandation of the peer review committee.

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

(a) A three-member panel is created, consisting of
the Insurance Commissioner, or his 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 previ-
ous vocation, employment, or affiliation, shall be classi-
fixed as a representative of employees. The panel shall
determine statewide schedules of maximum reimburse-
ment allowances for medically necessary treatment,
care, and attendance provided by physicians, hospitals,
ambulatory surgical centers, work-hardening programs,
pain programs, and durable medical equipment. The
maximum reimbursement allowances for inpatient hos-
pital 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 division.
All compensable charges for hospital outpatient care
shall be reimbursed at 75 percent of usual and custom-
ary charges. Until the three-member panel approves a
schedule of per diem rates for inpatient hospital care
and it becomes effective, all compensable charges for
hospital inpatient care must be reimbursed at 75 per-
cent of their usual and customary charges. Annually, the
three-member panel shall adopt schedules of maximum
reimbursement allowances for physicians, hospital inpa-
tient care, hospital outpatient care, ambulatory surgical
centers, work-hardening programs, and pain programs.
However, the maximum percentage of increase in the
individual reimbursement allowance may not exceed the
percentage of increase in the Consumer Price Index for
the previous year. An individual physician, hospital,
ambulatory surgical center, pain program, or work-
hardening program shall be reimbursed either the usual
and customary charge for treatment, care, and attend-
ance, the agreed-upon contract price, or the maximum
reimbursement allowance in the appropriate schedule,
whichever is less.

(b) As to reimbursement for a prescription medica-
tion, the reimbursement amount for a prescription shall
be the average wholesale price times 1.2 plus $4.18 for
the dispensing fee, except where the carrier has con-
tracted for a lower amount. Fees for pharmaceuticals
and pharmaceutical services shall be reimbursable at
the applicable fee schedule amount. Where the
employer or carrier has contracted for such services and
the employee elects to obtain them through a provider
not a party to the contract, the carrier shall reimburse
at the schedule, negotiated, or contract price, whichever
is lower.

(c) Reimbursement for all fees and other charges for
such treatment, care, and attendance, including treat-
ment, 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. Until the three-member panel approves a
uniform schedule of maximum reimbursement allow-
ances and it becomes effective, all compensable
charges for treatment, care, and attendance provided
by physicians, ambulatory surgical centers, work-
hardening programs, or pain programs shall be reim-
bursed at the lowest maximum reimbursement allow-
ance across all 1992 schedules of maximum reimburse-
ment allowances for the services provided regardless of
the place of service. In determining the uniform sched-
ule, the panel shall first approve the data which it finds
representative of prevailing charges in the state for simi-
lar treatment, care, and attendance of injured persons.
Each health care provider, health care facility, ambula-
tory 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 reim-
bursement allowances, the panel must consider:

1. The levels of reimbursement for similar treat-
ment, 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 attend-
anance which will ensure the availability of treatment, care,
and attendance required by injured workers;

3. The financial impact of the reimbursement allow-
ances upon health care providers and health care facili-
ties, including trauma centers as defined in s. 395.401,
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 rea-
sonable, must promote health care cost containment
and efficiency with respect to the workers' compensa-
tion health care delivery system, and must be sufficient
to ensure availability of such medically necessary reme-
dial treatment, care, and attendance to injured workers;

4. The most recent average maximum allowable
rate of increase for hospitals determined by the Health
Care Board under chapter 408.
(13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE AUTHORIZED TO RENDER MEDICAL CARE.—
The division shall remove from the list of physicians or facilities authorized to provide remedial treatment, care, and attendance under this chapter the name of any physician or facility found after reasonable investigation to have:

(a) Engaged in professional or other misconduct or incompetency in connection with medical services rendered under this chapter;

(b) Exceeded the limits of his or its professional competence in rendering medical care under this chapter, or to have made materially false statements regarding his or its qualifications in his application;

(c) Failed to transmit copies of medical reports to the employer or carrier, or failed to submit full and truthful medical reports of all his or its findings to the employer or carrier as required under this chapter;

(d) Solicited, or employed another to solicit for himself or itself or for another, professional treatment, examination, or care of an injured employee in connection with any claim under this chapter;

(e) Refused to appear before, or to answer upon request of, the division or any duly authorized officer of the state, any legal question, or to produce any relevant book or paper concerning his conduct under any claim under this chapter;

(f) Self-referred in violation of this chapter or other laws of this state; or

(g) Engaged in a pattern of practice of overutilization or a violation of this chapter or rules adopted by the division.

(14) PAYMENT OF MEDICAL FEES.—

(a) Except for emergency care treatment, fees for medical services are payable only to a health care provider certified and authorized to render remedial treatment, care, or attendance under this chapter. A health care provider may not collect or receive a fee from an injured employee within this state, except as otherwise provided by this chapter. Such providers have recourse against the employer or carrier for payment for services rendered in accordance with this chapter.

(b) Fees charged for remedial treatment, care, and attendance may not exceed the applicable fee schedules adopted under this chapter.

(c) Notwithstanding any other provision of this chapter, following overall maximum medical improvement from an injury compensable under this chapter, the employee is obligated to pay a copayment of $10 per visit for medical services. The copayment shall not apply to emergency care provided to the employee.

(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 10 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 overutilization of medical services provided to injured employees.

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s. 440.132 Investigatory records relating to workers' compensation managed care arrangements; confidentiality.—

(1) All investigatory records of the Agency for Health Care Administration made or received pursuant to s. 440.134 and any examination records necessary to complete an investigation are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution until the investigation is completed or ceases to be active, except that portions of medical records which specifically identify patients must remain confidential and exempt. An investigation is considered "active" while such investigation is being conducted by the agency with a reasonable, good faith belief that it may lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the agency is proceeding with reasonable dispatch and there is good faith belief that action may be initiated by the agency or other administrative or law enforcement agency.

(2) The Legislature finds that it is a public necessity that these investigatory and examination records be held confidential and exempt during an investigation in order not to compromise the investigation and disseminate potentially inaccurate information. To the extent this information is made available to the public, those persons being investigated will have access to such information which would potentially defeat the purpose of the investigation. This would impede the effective and efficient operation of investigatory governmental functions.
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:

1. PERMANENT TOTAL DISABILITY.—
   a. In case of total disability adjudged to be permanent, 66⅔ percent of the average weekly wages shall be paid to the employee during the continuance of such total disability.
   b. Only a catastrophic injury as defined in s. 440.02 shall, in the absence of conclusive proof of a substantial earning capacity, constitute permanent total disability. Only claimants with catastrophic injuries are eligible for permanent total benefits. In no other case may permanent total disability be awarded.
   c. In cases of permanent total disability resulting from injuries that occurred prior to July 1, 1955, such payments shall not be made in excess of 700 weeks.
   d. If an employee who is being paid compensation for permanent total disability becomes rehabilitated to the extent that he establishes an earning capacity, he shall be paid, instead of the compensation provided in paragraph (a), benefits pursuant to subsection (3). The division shall adopt rules to enable a permanently and totally disabled employee who may have reestablished an earning capacity to undertake a trial period of reemployment without prejudicing his return to permanent total status in the case that such employee is unable to sustain an earning capacity.
   e. The employee’s or carrier’s right to conduct vocational evaluations or testing pursuant to s. 440.491 continues even after the employee has been accepted or adjudicated as entitled to compensation under this chapter. This right includes, but is not limited to, instances in which such evaluations or tests are recommended by a treating physician or independent medical—examination physician, instances warranted by a change in the employee’s medical condition, or instances in which the employee appears to be making appropriate progress in recuperation. This right may not be exercised more than once every calendar year.

2. The carrier must confirm the scheduling of the vocational evaluation or testing in writing, and must notify employee’s counsel, if any, at least 7 days before the date on which vocational evaluation or testing is scheduled to occur.

3. Pursuant to an order of the judge of compensation claims, the employer or carrier may withhold payment of benefits for permanent total disability or supplemental benefits for any period during which the employee willfully fails or refuses to appear without good cause for the scheduled vocational evaluation or testing.

f. If permanent total disability results from injuries that occurred subsequent to June 30, 1955, and for which the liability of the employer for compensation has not been discharged under s. 440.20(12), the injured employee shall receive additional weekly compensation benefits equal to 5 percent of his weekly compensation rate, as established pursuant to the law in effect on the date of his injury, multiplied by the number of calendar years since the date of injury. The weekly compensation payable and the additional benefits payable under this paragraph, when combined, may not exceed the maximum weekly compensation rate in effect at the time of payment as determined pursuant to s. 440.12(2). Entitlement to these supplemental payments shall cease at age 62 if the employee is eligible for social security benefits under 42 U.S.C. ss. 402 and 423, whether or not the employee has applied for such benefits. These supplemental benefits shall be paid by the division out of the Workers’ Compensation Administration Trust Fund when the injury occurred subsequent to June 30, 1955, and before July 1, 1984. These supplemental benefits shall be paid by the employer when the injury occurred on or after July 1, 1984. Supplemental benefits are not payable for any period prior to October 1, 1974.

2a. The division shall provide by rule for the periodic reporting to the division of all earnings of any nature and social security income by the injured employee entitled to or claiming additional compensation under subparagraph 1. Neither the division nor the employer or carrier shall make any payment of those additional benefits provided by subparagraph 1. for any period during which the employee willfully fails or refuses to report upon request by the division in the manner prescribed by such rules.

b. The division shall provide by rule for the periodic reporting to the employer or carrier of all earnings of any nature and social security income by the injured employee entitled to or claiming benefits for permanent total disability. The employer or carrier is not required to make any payment of benefits for permanent total disability for any period during which the employee willfully fails or refuses to report upon request by the employer or carrier in the manner prescribed by such rules or if any employee who is receiving permanent total disability benefits refuses to apply for or cooperate with the employer or carrier in applying for social security benefits.

3. When an injured employee receives a full or partial lump-sum advance of the employee’s permanent total disability compensation benefits, the employee’s benefits under this paragraph shall be computed on the employee’s weekly compensation rate as reduced by the lump-sum advance.

2 TEMPORARY TOTAL DISABILITY.—

a. In case of disability in character but temporary in quality, 66⅔ 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, s. 440.12(1), and s. 440.14(3). Once the employee reaches the maximum number of weeks allowed, or the employee reaches the date of maximum medical improvement, whichever occurs earlier, temporary disability benefits shall cease and the injured worker’s permanent impairment shall be determined.

b. Notwithstanding the provisions of paragraph (a), an employee who has sustained the loss of an arm, leg, hand, or foot, has been rendered a paraplegic, paraparetic, quadriplegic, or quadriparetic, or has lost the sight of both eyes shall be paid temporary total disability of 80 percent of his average weekly wage. The increased temporary total disability compensation provided for in this paragraph must not extend beyond 6 months from the date of the accident. The compensation provided by this paragraph is not subject to the limit.
its provided in s. 440.12(2), but instead is subject to a maximum weekly compensation rate of $700. If, at the conclusion of this period of increased temporary total disability compensation, the employee is still temporarily totally disabled, the employee shall continue to receive temporary total disability compensation as set forth in paragraphs (a) and (c). The period of time the employee has received this increased compensation will be counted as part of, and not in addition to, the maximum periods of time for which the employee is entitled to compensation under paragraph (a) but not paragraph (c).

(c) Temporary total disability benefits paid pursuant to this subsection shall include such period as may be reasonably necessary for training in the use of artificial members and appliances, and shall include such period as the employee may be receiving training and education under a program pursuant to 2s. 440.49(1). Notwithstanding s. 440.02(8), the date of maximum medical improvement for purposes of 3paragraph (3)(b) shall be no earlier than the last day for which such temporary disability benefits are paid.

(d) The division shall, by rule, provide for the periodic reporting to the division, employer, or carrier of all earned income, including income from social security, by the injured employee who is entitled to or claiming benefits for temporary total disability. The employer or carrier is not required to make any payment of benefits for temporary total disability for any period during which the employee willfully fails or refuses to report upon request by the employer or carrier in the manner prescribed by the rules. The rule must require the claimant to personally sign the claim form and attest that he has reviewed, understands, and acknowledges the foregoing.

(3) PERMANENT IMPAIRMENT AND WAGE-LOSS BENEFITS.—

(a) Impairment benefits.—

1. Once the employee has reached the date of maximum medical improvement, impairment benefits are due and payable within 20 days after the carrier has knowledge of the impairment.

2. The three-member panel, in cooperation with the division, shall establish and use a uniform permanent impairment rating schedule. This schedule must be based on medically or scientifically demonstrable findings as well as the systems and criteria set forth in the American Medical Association's Guides to the Evaluation of Permanent Impairment; the Snellen Charts, published by American Medical Association Committee for Eye Injuries; and the Minnesota Department of Labor and Industry Disability Schedules. The schedule should be based upon objective findings. The schedule shall be more comprehensive than the AMA Guides to the Evaluation of Permanent Impairment and shall expand the areas already addressed and address additional areas not currently contained in the guides. On August 1, 1979, and pending the adoption, by rule, of a permanent schedule, Guides to the Evaluation of Permanent Impairment, copyright 1977, 1971, 1988, by the American Medical Association, shall be the temporary schedule and shall be used for the purposes hereof. For injuries after July 1, 1990, pending the adoption by division rule of a uniform disability rating schedule, the Minnesota Department of Labor and Industry Disability Schedule shall be used unless that schedule does not address an injury. In such case, the Guides to the Evaluation of Permanent Impairment by the American Medical Association shall be used. Determination of permanent impairment under this schedule must be made by a physician licensed under chapter 458, a doctor of osteopathy licensed under chapters 458 and 459, a chiropractor licensed under chapter 460, a podiatrist licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, as appropriate considering the nature of the injury. No other persons are authorized to render opinions regarding the existence of or the extent of permanent impairment.

3. All impairment income benefits shall be based on an impairment rating using the impairment schedule referred to in subparagraph 2. Impairment income benefits are paid weekly at the rate of 50 percent of the employee's average weekly temporary total disability benefit not to exceed the maximum weekly benefit under s. 440.12. An employee's entitlement to impairment income benefits begins the day after the employee reaches maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier, and continues until the earlier of:

   a. The expiration of a period computed at the rate of 3 weeks for each percentage point of impairment; or
   b. The death of the employee.

4. 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 subparagraph 2. Compensation is not payable for the mental, psychological, or emotional injury arising out of depression from being out of work. 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, and the treating doctor must indicate agreement or disagreement with the certification and evaluation. The certifying doctor shall issue a written report to the division, the employee, and the carrier certifying that maximum medical improvement has been reached, stating the impairment rating, and providing any other information required by the division. If the employee has not been certified as having reached maximum medical improvement before the expiration of 102 weeks after the date temporary total disability benefits begin to accrue, the carrier shall notify the treating doctor of the requirements of this section.

5. The carrier shall pay the employee impairment income benefits for a period based on the impairment rating.

(b) Supplemental benefits.—

1. All supplemental benefits must be paid in accordance with this subsection. An employee is entitled to supplemental benefits as provided in this paragraph as of the expiration of the impairment period, if:

   a. The employee has an impairment rating from the compensable injury of 20 percent or more as determined pursuant to this chapter;
b. The employee has not returned to work or has returned to work earning less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment; and

c. The employee has in good faith attempted to obtain employment commensurate with the employee's ability to work.

2. If an employee is not entitled to supplemental benefits at the time of payment of the final weekly impairment income benefit because the employee is earning at least 80 percent of the employee's average weekly wage, the employee may become entitled to supplemental benefits at any time within 1 year after the impairment income benefit period ends if:
   a. The employee earns wages that are less than 80 percent of the employee's average weekly wage for a period of at least 90 days;
   b. The employee meets the other requirements of subparagraph 1.; and
   c. The employee's decrease in earnings is a direct result of the employee's impairment from the compensable injury.

3. If an employee earns wages that are at least 80 percent of the employee's average weekly wage for a period of at least 90 days during which the employee is receiving supplemental benefits, the employee ceases to be entitled to supplemental benefits for the filing period. Supplemental benefits that have been terminated shall be reinstated when the employee satisfies the conditions enumerated in subparagraph 2. and files the statement required under subparagraph 5. Notwithstanding any other provision, if an employee is not entitled to supplemental benefits for 12 consecutive months, the employee ceases to be entitled to any additional income benefits for the compensable injury. If the employee is discharged within 12 months after losing entitlement under this subsection, benefits may be reinstated if the employee was discharged at that time with the intent to deprive the employee of supplemental benefits.

4. During the period that impairment income benefits or supplemental income benefits are being paid, the carrier has the affirmative duty to determine at least annually whether any extended unemployment or underemployment is a direct result of the employee's impairment. To accomplish this purpose, the division may require periodic reports from the employee and the carrier, and it may, at the carrier's expense, require any physical or other examinations, vocational assessments, or other tests or diagnoses necessary to verify that the carrier is performing its duty. Not more than once in each 12 calendar months, the employee and the carrier may each request that the division review the status of the employee and determine whether the carrier has performed its duty with respect to whether the employee's unemployment or underemployment is a direct result of impairment from the compensable injury.

5. After the initial determination of supplemental benefits, the employee must file a statement with the carrier stating that the employee has earned less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment, stating the amount of wages the employee earned in the filing period, and stating that the employee has in good faith sought employment commensurate with the employee's ability to work. The statement must be filed quarterly on a form and in the manner prescribed by the division. The division may modify the filing period as appropriate to an individual case. Failure to file a statement relieves the carrier of liability for supplemental benefits for the period during which a statement is not filed.

6. The carrier shall begin payment of supplemental benefits not later than the seventh day after the expiration date of the impairment income benefit period and shall continue to timely pay those benefits. The carrier may request a mediation conference for the purpose of contesting the employee's entitlement to or the amount of supplemental income benefits.

7. Supplemental benefits are calculated quarterly and paid monthly. For purposes of calculating supplemental benefits, 80 percent of the employee's average weekly wage and the average wages the employee has earned per week are compared quarterly. For purposes of this paragraph, if the employee is offered a bona fide position of employment that the employee is capable of performing, given the physical condition of the employee and the geographic accessibility of the position, the employee's weekly wages are considered equivalent to the weekly wages for the position offered to the employee.

8. Supplemental benefits are payable at the rate of 80 percent of the difference between 80 percent of the employee's average weekly wage determined pursuant to s. 440.14 and the weekly wages the employee has earned during the reporting period, not to exceed the maximum weekly income benefit under s. 440.12.

(c) Duration of temporary impairment and supplemental income benefits.—The employee's eligibility for temporary benefits, impairment income benefits, and supplemental benefits terminates on the expiration of 401 weeks after the date of injury.

(4) TEMPORARY PARTIAL DISABILITY.—

(a) In case of temporary partial disability, compensation shall be equal to 80 percent of the difference between 80 percent of the employee's average weekly wage and the salary, wages, and other remuneration the employee is able to earn, as compared weekly; however, the weekly benefits may not exceed an amount equal to 66 2/3 percent of the employee's average weekly wage at the time of injury. In order to simplify the comparison of the preinjury average weekly wage with the salary, wages, and other remuneration the employee is able to earn, the division may by rule provide for the modification of the weekly comparison so as to coincide as closely as possible with the injured worker's pay periods. The amount determined to be the salary, wages, and other remuneration the employee is able to earn shall in no case be less than the sum actually being earned by the employee, including earnings from sheltered employment.

(b) 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). Once the injured employee reaches the maximum number of weeks, temporary disability benefits cease and the injured worker's permanent impairment must be determined.
(5) **SUBSEQUENT INJURY.**—

(a) The fact that an employee has suffered previous disability, impairment, anomaly, or disease, or received compensation therefor, shall not preclude him from benefits for a subsequent aggravation or acceleration of the preexisting condition nor preclude benefits for death resulting therefrom, except that no benefits shall be payable if the employee, at the time of entering into the employment of the employer by whom the benefits would otherwise be payable, falsely represents himself in writing as not having previously been disabled or compensated because of such previous disability, impairment, anomaly, or disease and the employer detrimentally relies on the misrepresentation. Compensation for temporary disability, medical benefits, and wage-loss benefits shall not be subject to apportionment.

(b) If a compensable permanent impairment, or any portion thereof, is a result of aggravation or acceleration of a preexisting condition, or is the result of merger with a preexisting impairment, an employee eligible to receive impairment benefits under paragraph (3)(a) shall receive such benefits for the total impairment found to result, excluding the degree of impairment existing at the time of the subject accident or injury or which would have existed by the time of the impairment rating without the intervention of the compensable accident or injury. The degree of permanent impairment attributable to the accident or injury shall be compensated in accordance with paragraph (3)(a). As used in this paragraph, "merger" means the combining of a preexisting permanent impairment with a subsequent compensable permanent impairment which, when the effects of both are considered together, result in a permanent impairment rating which is greater than the sum of the two permanent impairment ratings when each impairment is considered individually.

(6) **OBLIGATION TO REHIRE.**—If the employer has not in good faith made available to the employee, within a 100-mile radius of the employee's residence, work appropriate to the employee's physical limitations within 30 days after the carrier notifies the employer of maximum medical improvement and the employee's physical limitations, the employer shall pay to the division for deposit into the Workers' Compensation Administration Trust Fund a fine of $250 for every $5,000 of the employer's workers' compensation premium or payroll, not to exceed $2,000 per violation, as the division requires by rule. The employer is not subject to this subsection if the employee is receiving permanent total disability benefits or if the employer has 50 or fewer employees.

(7) **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.

(8) **EMPLOYEE LEAVES EMPLOYMENT.**—If an injured employee, when receiving compensation for temporary partial disability, leaves the employment of the employer by whom he was employed at the time of the accident for which such compensation is being paid, he shall, upon securing employment elsewhere, give to such former employer an affidavit in writing containing the name of his new employer, the place of employment, and the amount of wages being received at such new employment; and, until he gives such affidavit, the compensation for temporary partial disability will cease. The employer by whom such employee was employed at the time of the accident for which such compensation is being paid may also at any time demand of such employee an additional affidavit in writing containing the name of his employer, the place of his employment, and the amount of wages he is receiving; and if the employee, upon such demand, fails or refuses to make and furnish such affidavit, his right to compensation for temporary partial disability shall cease until such affidavit is made and furnished.

(9) **EMPLOYEE BECOMES INMATE OF INSTITUTION.**—In case an employee becomes an inmate of a public institution, then no compensation shall be payable unless he has dependent upon him for support a person or persons defined as dependents elsewhere in this chapter, whose dependency shall be determined as if the employee were deceased and to whom compensation would be paid in case of death; and such compensation as is due such employee shall be paid such dependents during the time he remains such inmate.

(10) **EMPLOYEE ELIGIBLE FOR BENEFITS UNDER THIS CHAPTER AND FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE ACT.**—

(a) Weekly compensation benefits payable under this chapter for disability resulting from injuries to an employee who becomes eligible for benefits under 42 U.S.C. s. 423 shall be reduced to an amount whereby the sum of such compensation benefits payable under this chapter and such total benefits otherwise payable for such period to the employee and his dependents, had such employee not been entitled to benefits under this chapter, under 42 U.S.C. ss. 402 and 423, does not exceed 80 percent of the employee's average weekly wage. However, this provision shall not operate to reduce an injured worker's benefits under this chapter to a greater extent than such benefits would have otherwise been reduced under 42 U.S.C. s. 424(a). This reduction of compensation benefits is not applicable to any compensation benefits payable for any week subsequent to the week in which the injured worker reaches the age of 62 years.

(b) If the provisions of 42 U.S.C. s. 424(a) are amended to provide for a reduction or increase of the percentage of average current earnings that the sum of compensation benefits payable under this chapter and the benefits payable under 42 U.S.C. ss. 402 and 423 can equal, the amount of the reduction of benefits provided in this subsection shall be reduced or increased accordingly.

(c) No disability compensation benefits payable for any week, including those benefits provided by paragraph (1)(e), shall be reduced pursuant to this subsection until the Social Security Administration determines the amount otherwise payable to the employee under 42 U.S.C. ss. 402 and 423 and the employee has begun receiving such social security benefit payments. The employee shall, upon demand by the division, the employer, or the carrier, authorize the Social Security Administration to determine the amount otherwise payable to the employee under 42 U.S.C. ss. 402 and 423. If the division finds that the employee has been receiving social security benefits for at least 12 months, the division may reduce benefits under this chapter accordingly.
Administration to release disability information relating to him and authorize the Division of Unemployment Compensation to release unemployment compensation information relating to him, in accordance with rules to be promulgated by the division prescribing the procedure and manner for requesting the authorization and for compliance by the employee. Neither the division nor the employer or carrier shall make any payment of benefits for total disability or those additional benefits provided by paragraph (1)(e) for any period during which the employee willfully fails or refuses to authorize the release of information in the manner and within the time prescribed by such rules. The authority for release of disability information granted by an employee under this paragraph shall be effective for a period not to exceed 12 months, such authority to be renewable as the division may prescribe by rule.

(d) If compensation benefits are reduced pursuant to this subsection, the minimum compensation provisions of s. 440.12(2) do not apply.

(11) EMPLOYEE ELIGIBLE FOR BENEFITS UNDER THIS CHAPTER WHO HAS RECEIVED OR IS ENTITLED TO RECEIVE UNEMPLOYMENT COMPENSATION.—

(a) No compensation benefits shall be payable for temporary total disability or permanent total disability under this chapter for any week in which the injured employee has received, or is receiving, unemployment compensation benefits.

(b) If an employee is entitled to temporary partial benefits pursuant to subsection (4) and unemployment compensation benefits, such unemployment compensation benefits shall be primary and the temporary partial benefits shall be supplemental only, the sum of the two benefits not to exceed the amount of temporary partial benefits which would otherwise be payable.

(12) FULL-PAY STATUS FOR CERTAIN LAW ENFORCEMENT OFFICERS.—Any law enforcement officer as defined in s. 943.10(1), (2), or (3) who, while acting within the course of employment as provided by s. 440.091, is maliciously or intentionally injured and who thereby sustains a job-connected disability compensable under this chapter shall be carried in full-pay status rather than being required to use sick, annual, or other leave. Full-pay status shall be granted only after submission to the employing agency’s head of a medical report which gives a current diagnosis of the employee’s recovery and ability to return to work. In no case shall the employee’s salary and workers’ compensation benefits exceed the amount of the employee’s regular salary requirements.

(13) REPAYMENT.—If an employee has received a sum as an indemnity benefit under any classification or category of benefit under this chapter to which he is not entitled, the employee is liable to repay that sum to the employer or the carrier or to have that sum deducted from future benefits, regardless of the classification of benefits, payable to the employee under this chapter; however, a partial payment of the total repayment may not exceed 20 percent of the amount of the bimonthly payment.

LEGISLATURE.—s. 15, ch. 17461, 1935; CG 1506 Suggs 5965(15); s. 4, ch. 20671, 1941; s. 2, ch. 22614, 1945; s. 1, ch. 23921, 1947; s. 11, ch. 25035, 1949; s. 1, ch. 29677, 1951; s. 19, ch. 26984, 1951; s. 1, ch. 29393, 1955; s. 3, ch. 29776, 1959; s. 1, ch. 50-103, s. 1, ch. 50-102, s. 2, ch. 61-119, s. 1, ch. 61-188, s. 1, ch. 63-235, s. 1, ch. 65-169, s. 17, ch. 68-106, s. 1, ch. 70-71, s. 1, ch. 70-312, s. 5, ch. 73-127, s. 5, ch. 74-197, s. 6, ch. 75-305, s. 1, ch. 77-174, s. 4, ch. 77-250, s. 5, ch. 78-300, s. 10, ch. 79-40, s. 8, ch. 81-24, ch. 81-119, s. 275, ch. 81-250, s. 1, ch. 83-223, s. 8, ch. 83-174, s. 5, ch. 83-305, s. 2, ch. 96-207, s. 3, ch. 96-171, s. 3, ch. 97-230, s. 4, ch. 98-202, s. 1, ch. 99-289, s. 20, ch. 99-261, s. 18, ch. 99-1, s. 20, ch. 92-15, s. 73, ch. 96-418

Note.—Redesignated as s. 440.20(1)(b) by s. 26, ch. 53-415.

Note.—Amended by s. 440.39, ch. 93-415.

Note.—Amended by s. 20, ch. 53-415.

Note.—Redesignated as paragraph (1)(b) by s. 20, ch. 53-415.

s. 440.39 Compensation for injuries when third persons are liable.—

(1) If an employee, subject to the provisions of the Workers’ Compensation Law, is injured or killed in the course of his employment by the negligence or wrongful act of a third-party tortfeasor, such injured employee or, in the case of his death, his dependents may accept compensation benefits under the provisions of this law, and at the same time such injured employee or his dependents or personal representatives may pursue his remedy by action at law or otherwise against such third-party tortfeasor.

(2) If the employee or his dependents accept compensation or other benefits under this law or begin proceedings therefor, the employer or, in the event the employer is insured against liability hereunder, the insurer shall be subrogated to the rights of the employee or his dependents against such third-party tortfeasor, to the extent of the amount of compensation benefits paid or to be paid as provided by subsection (3). If the injured employee or his dependents recovers from a third-party tortfeasor by judgment or settlement, either before or after the filing of suit, before the employee has accepted compensation or other benefits under this chapter or before the employee has filed a written claim for compensation benefits, the amount recovered from the tortfeasor shall be set off against any compensation benefits other than for remedial care, treatment and attendance as well as rehabilitative services payable under this chapter. The amount of such offset shall be reduced by the amount of all court costs expended in the prosecution of the third-party suit or claim, including reasonable attorney fees for the plaintiff’s attorney. In no event shall the setoff provided in this section in lieu of payment of compensation benefits diminish the period for filing a claim for benefits as provided in s. 440.19.

(3)(a) In all claims or actions at law against a third-party tortfeasor, the employee, or his dependents or those entitled by law to sue in the event he is deceased, shall sue for the employee individually and for the use and benefit of the employer, if a self-insurer, or employer’s insurance carrier, in the event compensation benefits are claimed or paid; and such suit may be brought in the name of the employee, or his dependents or those entitled by law to sue in the event he is deceased, as plaintiff or, at the option of such plaintiff, may be brought in the name of such plaintiff and for the use and benefit of the employer or insurance carrier, as the case may be. Upon suit being filed, the employer or the insurance carrier, as the case may be, may file in the suit a notice of payment of compensation and medical benefits to the employee or his dependents, which notice shall constitute a lien upon any judgment or settlement recovered to the extent that the court may determine to be their pro rata share for compensation and medical benefits paid
or to be paid under the provisions of this law, less their pro rata share of all court costs expended by the plaintiff in the prosecution of the suit including reasonable attorney's fees for the plaintiff's attorney. In determining the employer's or carrier's pro rata share of those costs and attorney's fees, the employer or carrier shall have deducted from its recovery a percentage amount equal to the percentage of the judgment or settlement which is for costs and attorney's fees. Subject to this deduction, the employer or carrier shall recover from the judgment or settlement, after costs and attorney's fees incurred by the employee or dependent in that suit have been deducted, 100 percent of what it has paid and future benefits to be paid, except, if the employee or dependent can demonstrate to the court that he did not recover the full value of damages sustained, the employer or carrier shall recover from the judgment or settlement, after costs and attorney's fees incurred by the employee or dependent in that suit have been deducted, a percentage of what it has paid and future benefits to be paid equal to the percentage that the employee's net recovery is of the full value of the employee's damages, provided, the failure by the employer or carrier to comply with the duty to cooperate imposed by subsection (7) may be taken into account by the trial court in determining the amount of the employer's or carrier's recovery, and such recovery may be reduced, as the court deems equitable and appropriate under the circumstances, including as a mitigating factor whether a claim or potential claim against a third party is likely to impose liability upon the party whose cooperation is sought, if it finds such a failure has occurred. The burden of proof will be upon the employee. The determination of the amount of the employer's or carrier's recovery shall be made by the judge of the trial court upon application therefor and notice to the adverse party. Notice of suit being filed, cutting from the provisions of s. 124.091(7), the employee, employer, and carrier have a duty to cooperate with each other in investigating and settlement of any such claim or action at law is made, either before or after suit is filed, and the parties fail to agree on the proportion to be paid to each, the circuit court of the county in which the cause of action arose shall determine the amount to be paid to each by such third-party tortfeasor in accordance with the provisions of paragraph (a).

(4)(a) If the injured employee or his dependents, as the case may be, fail to bring suit against such third-party tortfeasor within 1 year after the cause of action thereof has accrued, the employer, if a self-insurer, and if not, the insurance carrier, may, after giving 30 days' notice to the injured employee or his dependents and the injured employee's attorney, if represented by counsel, institute suit against such third-party tortfeasor, either in his own name or as provided by subsection (3), and, in the event suit is so instituted, shall be subrogated to and entitled to retain from any judgment recovered against, or settlement made with, such third party, the following: All amounts paid as compensation and medical benefits under the provisions of this law and the present value of all future compensation benefits payable, to be reduced to its present value, and to be retained as a trust fund from which future payments of compensation are to be made, together with all court costs, including attorney's fees expended in the prosecution of such suit, to be prorated as provided by subsection (3). The remainder of the moneys derived from such judgment or settlement shall be paid to the employee or his dependents, as the case may be.

(b) If the carrier or employer does not bring suit within 2 years following the accrual of the cause of action against a third-party tortfeasor, the right of action shall revert to the employee or, in the case of his death, those entitled by law to sue, and in such event the provisions of subsection (3) shall apply.

(5) In all cases under subsection (4) involving third-party tortfeasors in which compensation benefits under this law are paid or are to be paid, settlement may not be made either before or after suit is instituted except upon agreement of the injured employee or his dependents and the employer or his insurance carrier, as the case may be.

(6) Any amounts recovered under this section by the employer or his insurance carrier shall be credited against the loss experience of such employer.

(7) The employee, employer, and carrier have a duty to cooperate with each other in investigating and prosecuting claims and potential claims against third-party tortfeasors by producing nonprivileged documents and allowing inspection of premises, but only to the extent necessary for such purpose. Such documents and the results of such inspections are confidential and exempt from the provisions of s. 119.07(1), and shall not be used or disclosed for any other purpose.
and Employment Security shall provide administrative support and service to the office to the extent requested by the Chief Judge but shall not direct, supervise, or control the Office of the Judges of Compensation Claims in any manner, including but not limited to personnel, purchasing, budgetary matters, or property transactions. The operating budget of the Office of the Judges of Compensation Claims shall be paid out of the Workers' Compensation Administration Trust Fund established in s. 440.50.

(2)(a) The Governor shall appoint full-time judges of compensation claims to conduct proceedings as required by this chapter or other law. No person may be appointed as a judge of compensation claims unless he or she has been a member of The Florida Bar in good standing for the preceding 5 years and is knowledgeable in the law of workers' compensation. No judge of compensation claims shall engage in the private practice of law during a term of office.

(b) The Governor shall initially appoint a judge of compensation claims from a list of three persons nominated by a statewide nominating commission. The statewide nominating commission shall be composed of the following: 5 members, at least one of whom must be a member of a minority group as defined in s. 288.703(3), one of each who resides in each of the territorial jurisdictions of the district courts of appeal, appointed by the Board of Governors of The Florida Bar from among The Florida Bar members who are engaged in the practice of law; 5 electors, at least one of whom must be a member of a minority group as defined in s. 288.703(3), one of each who resides in each of the territorial jurisdictions of the district courts of appeal, appointed by the Governor; and 5 electors, at least one of whom must be a member of a minority group as defined in s. 288.703(3), one of each who resides in the territorial jurisdictions of the district courts of appeal, selected and appointed by a majority vote of the other 10 members of the commission. No attorney who appears before any judge of compensation claims more than four times a year is eligible to serve on the statewide nominating commission. The meetings and determinations of the nominating commission as to the judges of compensation claims shall be open to the general public.

(c) Each judge of compensation claims shall be appointed for a term of 4 years, but during the term of office may be removed by the Governor for cause. Prior to the expiration of a judge's term of office, the statewide nominating commission shall review the judge's conduct. The commission shall report its finding to the Governor no later than 6 months prior to the expiration of the judge's term of office. The report of the commission shall include a list of three candidates for appointment. The candidates shall include the judge whose term is expiring, if that judge desires reappointment and the judge's performance is satisfactory upon review by the commission. If a vacancy occurs during a judge's unexpired term, the commission shall issue a report to the Governor which includes a list of three different candidates for appointment.

(3) The Chief Judge shall select from among the full time judges of the office two or more judges to rotate as docketing judges. Docketing judges shall review all claims for benefits for consistency with the requirements of this chapter and the rules of procedure, including but not limited to specificity requirements, and shall dismiss any claim that fails to comport with such rules and requirements. The docketing judge shall not dismiss any claim with prejudice without offering the parties an opportunity to appear and present argument. The Chief Judge may as he or she deems appropriate expand the duties of the docketing judges to include resolution without hearing of other types of procedural and substantive matters, including resolution of fee disputes.

(4) The Chief Judge shall have the discretion to require mediation and to designate qualified persons to act as mediators in any dispute pending before the judges of compensation claims and the division. The Chief Judge shall coordinate with the Director of the Division of Workers' Compensation to establish a mandatory mediation program to facilitate early and efficient resolution of disputes arising under this chapter and to establish training and continuing education for new and sitting judges.

(5) The Office of the Judges of Compensation Claims shall promulgate rules to effect the purposes of this section. Such rules shall include procedural rules applicable to workers' compensation claim resolution and uniform criteria for measuring the performance of the office, including but not limited to the number of cases assigned and disposed, the age of pending and disposed cases, timeliness of decisionmaking, extraordinary fee awards and other performance indicators. The workers' compensation rules of procedure approved by the Supreme Court shall apply until the rules promulgated by the Office of the Judges of Compensation Claims pursuant to this section become effective.

(6) Not later than December 1 of each year, the Office of the Judges of Compensation Claims and the Division of Workers' Compensation shall jointly issue a written report to the Governor, the House of Representatives, and the Senate summarizing the amount, cost, and outcome of all litigation resolved in the prior year, summarizing the disposition of applications and motions for mediation conferences and recommending changes or improvements to the dispute resolution elements of the Workers' Compensation Law and regulations.

History.--s. 45, ch. 17481, 1936; CGL 1936 Supp. 5966(43); s. 2, ch. 57-245; s. 1, ch. 61-133; s. 1, ch. 63-179; s. 1, ch. 63-275; s. 1, ch. 65-541; s. 1, ch. 67-315; s. 2, ch. 67-534; s. 1, ch. 69-201; s. 17, ch. 69-106; s. 1, ch. 71-313; s. 1, ch. 71-290; s. 20, ch. 74-197; s. 3, ch. 74-363; s. 22, ch. 75-209; s. 14, ch. 75-300; s. 35, ch. 77-49; s. 19, ch. 79-312; s. 17, ch. 80-236; s. 16, ch. 83-305; s. 8, ch. 84-267; s. 10, ch. 86-171; s. 29, ch. 89-209; s. 30, ch. 90-201; s. 37, ch. 91-1; s. 34, ch. 91-46; s. 40, ch. 93-415; s. 74, ch. 96-418.

Note.--Section 2, Art. V of the State Constitution does not provide for Judicial Nominating Commissions.
the desire of the Legislature to facilitate the return of these workers to the workplace, it is the purpose of this section to encourage the employment, reemployment, and accommodation of the physically disabled by reducing an employer’s insurance premium for reemploying an injured worker, to decrease litigation between carriers on apportionment issues, and to protect employers from excess liability for compensation and medical expense when an injury to a physically disabled worker merges with, aggravates, or accelerates his preexisting permanent physical impairment to cause either a greater disability or permanent impairment, or an increase in expenditures for temporary compensation or medical benefits than would have resulted from the injury alone. The division shall inform all employers of the existence and function of the fund and shall interpret eligibility requirements liberally. However, this subsection shall not be construed to create or provide any benefits for injured employees or their dependents not otherwise provided by this chapter. The entitlement of an injured employee or his dependents to compensation under this chapter shall be determined without regard to this subsection, the provisions of which shall be considered only in determining whether an employer or carrier who has paid compensation under this chapter is entitled to reimbursement from the Special Disability Trust Fund.

(2) DEFINITIONS.—As used in this section, the term:

(a) “Permanent physical impairment” means and is limited to the conditions listed in paragraph (6)(a).

(b) “Preferred worker” means a worker who, because of a permanent impairment resulting from a compensable injury or occupational disease, is unable to return to the worker’s regular employment.

(c) “Merger” describes or means that:

1. If the permanent physical impairment had not existed, the subsequent accident or occupational disease would not have occurred;

2. The permanent disability or permanent impairment resulting from the subsequent accident or occupational disease is materially and substantially greater than that which would have resulted had the permanent physical impairment not existed, and the employer has been required to pay, and has paid, permanent total disability or permanent impairment benefits for that materially and substantially greater disability;

3. The preexisting permanent physical impairment is aggravated or accelerated as a result of the subsequent injury or occupational disease, or the preexisting impairment has contributed, medically and circumstantially, to the need for temporary compensation, medical, or attendant care and the employer has been required to pay, and has paid, temporary compensation, medical, or attendant care benefits for the aggravated preexisting permanent impairment; or

4. Death would not have been accelerated if the permanent physical impairment had not existed.

(d) “Excess permanent compensation” means that compensation for permanent impairment, or permanent total disability or death benefits, for which the employer or carrier is otherwise entitled to reimbursement from the Special Disability Trust Fund.

(3) DEDUCTIBLE.—Reimbursement may not be obtained for the first $10,000 of benefits paid which otherwise qualify for reimbursement under this section. This deductible does not apply to claims by employers for reimbursement under subparagraph (b)3.

(4) PERMANENT IMPAIRMENT OR PERMANENT TOTAL DISABILITY, TEMPORARY BENEFITS, MEDICAL BENEFITS, OR ATTENDANT CARE AFTER OTHER PHYSICAL IMPAIRMENT.—

(a) Permanent impairment.—If an employee who has a preexisting permanent physical impairment incurs a subsequent permanent impairment from injury or occupational disease arising out of, and in the course of, his employment which merges with the preexisting permanent physical impairment to cause a permanent impairment, the employer shall, in the first instance, pay all benefits provided by this chapter; but, subject to the limitations specified in subsection (6), such employer shall be reimbursed from the Special Disability Trust Fund created by subsection (8) for 50 percent of all impairment benefits which the employer has been required to provide pursuant to s. 440.15(3)(a) as a result of the subsequent accident or occupational disease.

(b) Permanent total disability.—If an employee who has a preexisting permanent physical impairment incurs a subsequent permanent impairment from injury or occupational disease arising out of, and in the course of, his employment which merges with the preexisting permanent physical impairment to cause permanent total disability, the employer shall, in the first instance, pay all benefits provided by this chapter; but, subject to the limitations specified in subsection (6), such employer shall be reimbursed from the Special Disability Trust Fund created by subsection (8) for 50 percent of all compensation for permanent total disability.

(c) Temporary compensation and medical benefits; aggravation or acceleration of preexisting condition or circumstantial causation.—If an employee who has a preexisting permanent physical impairment experiences an aggravation or acceleration of the preexisting permanent physical impairment as a result of an injury or occupational disease arising out of and in the course of his employment, or suffers an injury as a result of a merger as defined in subparagraph (1)(b)2., the employer shall provide all benefits provided by this chapter; but, subject to the limitations specified in subsection (7), the employer shall be reimbursed from the Special Disability Trust Fund created by subsection (8) for 50 percent of all payments for temporary, medical, and attendant care benefits.

(5) WHEN DEATH RESULTS.—If death results from the subsequent permanent impairment contemplated in paragraph (c) within 1 year after the subsequent injury, or within 5 years after the subsequent injury when disability has been continuous since the subsequent injury, and it is determined that the death resulted from a merger, the employer shall, in the first instance, pay the funeral expenses and the death benefits prescribed by this chapter; but, subject to the limitations specified in subsection (6), he shall be reimbursed from the Special Disability Trust Fund created by subsection (8) for the last 50 percent of all compensation allowable and paid for such death and for 50 percent of the amount paid as funeral expenses.

(6) EMPLOYER KNOWLEDGE, EFFECT ON REIMBURSEMENT.—
controversion. When such application for a hearing is
made, the employers or carriers shall be served with
written notice of the accept-
dance of the claim for reim-
bursement. For notice of claims on the Special Disabil-
ity Trust Fund filed on or after July 1, 1978, the Spe-
cial Disability Trust Fund shall, within 120 days after re-
cipe notice that a carrier has been required to pay, and has
paid over $10,000 in benefits, serve notice of the ac-
ceptance of the claim for reimbursement. Failure of the
Special Disability Trust Fund to serve notice of acceptance
shall give rise to the right to request a hearing on the
claim for reimbursement. If the Special Disability Trust
Fund through its representative denies or controverts
the claim, the right to such reimbursement shall be
barred unless an application for a hearing thereon is filed
with the division at Tallahassee within 60 days after
notice to the employer or carrier of such denial or
controversy. When such application for a hearing is
timely filed, the claim shall be heard and determined in
accordance with the procedure prescribed in s. 440.25,
to the extent that such procedure is applicable, and in
accordance with the workers’ compensation rules of
procedure. In such proceeding on a claim for reimburse-
ment, the Special Disability Trust Fund shall be made
the party respondent, and no findings of fact made with
respect to the claim of the injured employee or the
dependents for compensation, excluding any finding
made or order entered pursuant to s. 440.20(12), shall
be res judicata. The Special Disability Trust Fund may
not be joined or made a party to any controversy or dis-
pute between an employee and the dependents and the
employer or between two or more employers or carriers
without the written consent of the fund. When it has
been determined that an employer or carrier is entitled
to reimbursement in any amount, the employer or carrier
shall be reimbursed annually from the Special Disability
Trust Fund for the compensation and medical benefits
paid by the employer or carrier for which the employer
or carrier is entitled to reimbursement, upon filing
request therefor and submitting evidence of such pay-
ment in accordance with rules prescribed by the divi-
sion, which rules may include parameters for annual
audits.
(8) PREFERRED WORKER PROGRAM.—The division shall issue identity cards to preferred workers upon request by qualified employees and shall reimburse an employer, from the Special Disability Trust Fund, for the cost of preferred workers' compensation premium related to the preferred workers' payroll for up to 3 years of continuous employment upon satisfactory evidence of placement and issuance of payroll and classification records and upon the employee's certification of employment.

(9) SPECIAL DISABILITY TRUST FUND.—

(a) There is established in the State Treasury a special fund to be known as the "Special Disability Trust Fund," which shall be available only for the purposes stated in this section; and the assets thereof may not at any time be appropriated or diverted to any other use or purpose. The Treasurer shall be the custodian of such fund, and all moneys and securities in such fund shall be held in trust by such Treasurer and shall not be the money or property of the state. The Treasurer is authorized to disburse moneys from such fund only when approved by the division and upon the order of the Comptroller. The Treasurer shall deposit any moneys paid into such fund into such depository banks as the division may designate and is authorized to invest any portion of the fund which, in the opinion of the division, is not needed for current requirements, in the same manner and subject to all the provisions of the law with respect to the deposits of state funds by such Treasurer. All interest earned by such portion of the fund as may be invested by the Treasurer shall be collected by him and placed to the credit of such fund.

(b1) The Special Disability Trust Fund shall be maintained by annual assessments upon the insurance companies writing compensation insurance in the state, the commercial self-insurers under ss. 624.462 and 624.4621, the assessable mutuals under ss. 628.601, and the self-insurers under this chapter, which assessments shall become due and be paid quarterly at the same time and in addition to the assessments provided in s. 440.51. The division shall estimate annually in advance the amount necessary for the administration of this subsection and the maintenance of this fund and shall make such assessment in the manner hereinafter provided.

2. The annual assessment shall be calculated to produce during the ensuing fiscal year an amount which, when combined with that part of the balance in the fund on June 30 of the current fiscal year which is in excess of $100,000, is equal to the average of:
   a. The sum of disbursements from the fund during the immediate past 3 calendar years, and
   b. Two times the disbursements of the most recent calendar year.

Such amount shall be prorated among the insurance companies writing compensation insurance in the state and the self-insurers.

3. The net premiums written by the companies for workers' compensation in this state and the net premium written applicable to the self-insurers in this state are the basis for computing the amount to be assessed as a percentage of net premiums. Such payments shall be made by each insurance company and self-insurer to the division for the Special Disability Trust Fund in accordance with such regulations as the division prescribes.

4. The Treasurer is authorized to receive and credit to such Special Disability Trust Fund any sum or sums that may at any time be contributed to the state by the United States under any Act of Congress, or otherwise, to which the state may be or become entitled by reason of any payments made out of such fund.

(c) Notwithstanding the provisions of this subsection, in order to implement specific appropriations 1475 and 1748 of the 1996-1997 General Appropriations Act, for fiscal year 1996-1997 only, the workers' compensation Special Disability Trust Fund assessment rate in effect in 1995 shall remain in effect until June 30, 1997. This paragraph is repealed on July 1, 1997.

(10) DIVISION ADMINISTRATION OF FUND; CLAIMS; ADVISORY COMMITTEE; EXPENSES.—The division shall administer the Special Disability Trust Fund with authority to allow, deny, compromise, controvert, and litigate claims made against it and to designate an attorney to represent it in proceedings involving claims against the fund, including negotiation and consummation of settlements, hearings before judges of compensation claims, and judicial review. The division or the attorney designated by it shall be given notice of all hearings and proceedings involving the rights or obligations of such fund and shall have authority to make expenditures for such medical examinations, expert witness fees, depositions, transcripts of testimony, and the like as may be necessary to the proper defense of any claim. The division shall appoint an advisory committee composed of representatives of management, compensation insurance carriers, and self-insurers to aid it in formulating policies with respect to conservation of the fund, who shall serve without compensation for such terms as specified by it, but be reimbursed for travel expenses as provided in s. 112.061. All expenditures made in connection with conservation of the fund, including the salary of the attorney designated to represent it and necessary travel expenses, shall be allowed and paid from the Special Disability Trust Fund as provided in this section upon the presentation of itemized vouchers therefor approved by the division.

(11) EFFECTIVE DATES.—This section does not apply to any case in which the accident causing the subsequent injury or death or the disablement or death from a subsequent occupational disease occurred prior to July 1, 1955.

(12) REIMBURSEMENT FROM THE SPECIAL DISABILITY TRUST FUND.—The applicable law for the purposes of determining entitlement to reimbursement from the Special Disability Trust Fund is the law in effect on the date the accident occurred.

History.—s. 49, ch. 17461, 1935; CGL 1936 Supp. 5666(47); s. 13, ch. 28741, 1953; s. 12, ch. 29779, 1955; s. 1, ch. 59-101; s. 2, ch. 63-335; s. 19, ch. 63-400; s. 2, ch. 57-394; s. 17, ch. 63-108; s. 21, ch. 74-107; s. 24, ch. 73-292; s. 101, ch. 77-104; ss. 15, 23, ch. 78-300; ss. 37, 124, ch. 79-40; s. 21, ch. 79-312; s. 11, ch. 81-119; s. 17, ch. 83-306; s. 10, ch. 85-61; s. 8, ch. 87-330; ss. 24, 43, ch. 89-289; ss. 40, 55, ch. 90-201; ss. 36, 57, ch. 91-1; s. 43, ch. 93-415; s. 4, ch. 95-285, s. 21, ch. 95-287, s. 12, ch. 96-423.

Note.—Section 6, ch. 95-285, provides that "[t]he purpose of this act shall take effect [June 15, 1995] and shall apply to those conditions diagnosed on or before January 1, 1996.," s. 49, ch. 95-285.

Note.—Subsection (3) is not divided into subunits.

Note.—The Special Disability Trust Fund is created in subsection (9).
Reemployment of injured workers; rehabilitation.—

1. DEFINITIONS.—As used in this section, the term:

(a) "Carrier" means group self-insurance funds or individual self-Insureds authorized under this chapter and commercial funds or insurance entities authorized to write workers' compensation insurance under Chapter 624.

(b) "Medical care coordination" includes, but is not limited to, coordinating physical rehabilitation services such as medical, psychiatric, or therapeutic treatment for the injured employee, providing health training to the employee and family, and monitoring the employee’s recovery. The purposes of medical care coordination are to minimize the disability and recovery period without jeopardizing medical stability, to assure that proper medical treatment and other restorative services are timely provided in a logical sequence, and to contain medical costs.

(c) "Qualified rehabilitation provider" means a rehabilitation nurse, rehabilitation counselor, vocational evaluator, rehabilitation facility, or agency approved by the division as qualified to provide reemployment assessments, medical care coordination, reemployment services, or vocational evaluations under this chapter.

(d) "Reemployment assessment" means a written assessment performed by a qualified rehabilitation provider which provides a comprehensive review of the medical diagnosis, treatment, and prognosis; includes conferences with the employer, physician, and claimant; and recommends a cost-effective physical and vocational rehabilitation plan to assist the employee in returning to suitable gainful employment.

(e) "Reemployment services" means services that include, but are not limited to, vocational counseling, job-seeking skills training, ergonomic job analysis, transferable skills analysis, selective job placement, labor market surveys, and arranging other services such as education or training, vocational and on-the-job, which may be needed by the employee to secure suitable gainful employment.

(f) "Reemployment status review" means a review to determine whether an injured employee is at risk of not returning to work.

(g) "Suitable gainful employment" means employment or self-employment that is reasonably attainable in light of the employee's age, education, work history, transferable skills, previous occupation, and injury, and which offers an opportunity to restore the individual as soon as practicable and as nearly as possible to his average weekly earnings at the time of injury.

(h) "Vocational evaluation" means a review of the employee's physical and intellectual capabilities, his aptitudes and achievements, and his work-related behaviors to identify the most cost-effective means toward his return to suitable gainful employment.

2. INTENT.—It is the intent of this section to implement a systematic review by carriers of the factors that are predictive of longer-term disability and to encourage the provision of medical care coordination and reemployment services that are necessary to assist the employee in returning to work as soon as is medically feasible.

3. REEMPLOYMENT STATUS REVIEWS AND REPORTS.—

(a) When an employee who has suffered an injury compensable under this chapter is unemployed 60 days after the date of injury and is receiving benefits for temporary total disability, temporary partial disability, or wage loss, and has not yet been provided medical care coordination and reemployment services voluntarily by the carrier, the carrier must determine whether the employee is likely to return to work and must report its determination to the division. The carrier must thereafter determine the reemployment status of the employee at 90-day intervals as long as the employee remains unemployed, is not receiving medical care coordination or reemployment services, and is receiving the benefits specified in this subsection.

(b) If medical care coordination or reemployment services are voluntarily undertaken within 60 days of the date of injury, such services may continue to be provided as agreed by the employee and the carrier.

4. REEMPLOYMENT ASSESSMENTS.—

(a) The carrier may require the employee to receive a reemployment assessment as it considers appropriate. However, the carrier is encouraged to obtain a reemployment assessment if:

1. The carrier determines that the employee is at risk of remaining unemployed.

2. The case involves catastrophic or serious injury.

(b) The carrier shall authorize only a qualified rehabilitation provider to provide the reemployment assessment. The rehabilitation provider shall conduct its assessment and issue a report to the carrier, the employee, and the division within 30 days after the time such assessment is complete.

(c) If the rehabilitation provider recommends that the employee receive medical care coordination or reemployment services, the carrier shall advise the employee of the recommendation and determine whether the employee wishes to receive such services. The employee shall have 15 days after the date of receipt of the recommendation in which to agree to accept such services. If the employee elects to receive services, the carrier may refer the employee to a rehabilitation provider for such coordination or services within 15 days of receipt of the assessment report or notice of the employee’s election, whichever is later.

5. MEDICAL CARE COORDINATION AND REEMPLOYMENT SERVICES.—

(a) Once the carrier has assigned a case to a qualified rehabilitation provider for medical care coordination or reemployment services, the provider shall develop a reemployment plan and submit the plan to the carrier and the employee for approval.

(b) If the rehabilitation provider concludes that training and education are necessary to return the employee to suitable gainful employment, or if the employee has
not returned to suitable gainful employment within 180 days after referral for reemployment services or receives $2,500 in reemployment services, whichever comes first, the carrier must discontinue reemployment services and refer the employee to the division for a vocational evaluation. Notwithstanding any provision of chapter 269 or chapter 627, the cost of a reemployment assessment and the first $2,500 in reemployment services to an injured employee must not be treated as loss adjustment expense for workers' compensation ratemaking purposes.

(c) A carrier may voluntarily provide medical care coordination or reemployment services to the employee at intervals more frequent than those required in this section. For the purpose of monitoring reemployment, the carrier or the rehabilitation provider shall report to the division, in the manner prescribed by the division, the date of reemployment and wages of the employee. The carrier shall report its voluntary service activity to the division as required by rule. Voluntary services offered by the carrier for any of the following injuries must be considered benefits for purposes of ratemaking: traumatic brain injury; spinal cord injury; amputation, including loss of an eye or eyes; burns of 5 percent or greater of the total body surface.

(d) If medical care coordination or reemployment services have not been undertaken as prescribed in paragraph (3)(b), a qualified rehabilitation service provider, facility, or agency that performs a reemployment assessment shall not provide medical care coordination or reemployment services for the employees it assesses.

(6) TRAINING AND EDUCATION.—

(a) Upon referral of an injured employee by the carrier, or upon the request of an injured employee, the division shall conduct a training and education screening to determine whether it should refer the employee for a vocational evaluation and, if appropriate, approve training and education or other vocational services for the employee. The division may not approve formal training and education programs unless it determines, after consideration of the reemployment assessment, pertinent reemployment status reviews or reports, and such other relevant factors as it prescribes by rule, that the reemployment plan is likely to result in return to suitable gainful employment. The division is authorized to expend moneys from the Workers' Compensation Administration Trust Fund, established by s. 440.50, to secure appropriate training and education or other vocational services when necessary to satisfy the recommendation of a vocational evaluator. The division shall establish training and education standards pertaining to employee eligibility, course curricula and duration, and associated costs.

(b) When it appears that an employee who has attained maximum medical improvement requires training and education to obtain suitable gainful employment, the employer shall pay the employee additional temporary total compensation 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. 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 division 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 division is subject to a 50-percent reduction in weekly compensation benefits, including wage-loss benefits, as determined under s. 440.15(3)(b).

(7) PROVIDER QUALIFICATIONS.—

(a) The division shall investigate and maintain a directory of each qualified public and private rehabilitation provider, facility, and agency, and shall establish by rule the minimum qualifications, credentials, and requirements that each rehabilitation service provider, facility, and agency must satisfy to be eligible for listing in the directory. These minimum qualifications and credentials must be based on those generally accepted within the service specialty for which the provider, facility, or agency is approved.

(b) The division shall impose a biennial application fee of $25 for each listing in the directory, and all such fees must be deposited in the Workers' Compensation Administration Trust Fund.

(c) The division shall monitor and evaluate each rehabilitation service provider, facility, and agency qualified under this subsection to ensure its compliance with the minimum qualifications and credentials established by the division. The failure of a qualified rehabilitation service provider, facility, or agency to provide the division with information requested or access necessary for the division to satisfy its responsibilities under this subsection is grounds for disqualifying the provider, facility, or agency from further referrals.

(d) A qualified rehabilitation service provider, facility, or agency may not be authorized by an employer, a carrier, or the division to provide any services, including expert testimony, under this section unless the provider, facility, or agency is approved for listing in the directory. This restriction does not apply to services provided outside this state under this section.

(e) The division, after consultation with representatives of employees, employers, carriers, rehabilitation providers, and qualified training and education providers, shall adopt rules governing professional practices and standards.

(8) CARRIER PRACTICES.—The division shall monitor the selection of providers and the provision of services by carriers under this section for consistency with legislative intent set forth in subsection (2).

(9) PERMANENT DISABILITY.—The judge of compensation claims may not adjudicate an injured employee as permanently and totally disabled until or unless the carrier is given the opportunity to provide a reemployment assessment.
440.50 Workers' Compensation Administration Trust Fund.—
(1)(a) There is established in the State Treasury a special fund to be known as the "Workers' Compensation Administration Trust Fund" for the purpose of providing for the payment of all expenses in respect to the administration of this chapter, including the vocational rehabilitation of injured employees as provided in s. 440.49 and the payments due under s. 440.15(1)(f) and the funding of the Bureau of Workers' Compensation Fraud within the Department of Insurance. Such fund shall be administered by the division.

(b) The division is authorized to transfer as a loan an amount not in excess of $250,000 from such special fund to the Special Disability Trust Fund established by s. 440.49(9), which amount shall be repaid to said special fund in annual payments equal to not less than 10 percent of moneys received for such Special Disability Trust Fund.

(2) The Treasurer is authorized to disburse moneys from such fund only when approved by the division and upon the order of the Comptroller. He shall be required to give bond in an amount to be approved by the division conditioned upon the faithful performance of his duty as custodian of such fund.

(3) The Treasurer shall deposit any moneys paid into such fund into such depository banks as the division may designate and is authorized to invest any portion of the fund earned by such portion of the fund as may be needed for current requirements, in the same manner as provided in s. 440.49(9), which amount may be utilized only with respect to the deposit of state funds by such Treasurer. Any moneys deposited into such fund shall be paid into the State Treasury a percent of moneys received for such Special Disability Trust Fund.

(4) All civil penalties provided in this chapter, if not voluntarily paid, may be collected by civil suit brought by the division and shall be paid into such fund.

440.515 Reports from self-insurers; confidentiality.—The Department of Insurance shall maintain the reports filed in accordance with s. 440.51(6)(b) as confidential and exempt from the provisions of s. 119.07(1), and such reports shall be released only for bona fide research or educational purposes or after receipt of consent from the employer.

442.012 Workplace safety committees and safety coordinators.—

442.014 Division cooperation with Federal Government; exemption from Division of Safety requirements.

442.109 Material safety data sheet required to be available for employee examination; employer and employee rights when unavailable.

442.111 Trade secrets; claim conditions; disclosure in medical emergency and nonemergency situations.

442.112 Referral to and action by secretary when request for information denied; orders by secretary; review.

442.118 Presence of toxic substances; notice to fire departments, emergency medical service providers, law enforcement agencies, and local emergency management agencies; penalty.

442.21 Information identifying employees exercising rights; confidentiality.

442.012 Workplace safety committees and safety coordinators.—

(1) In order to promote health and safety in places of employment in this state:

(a) Each public or private employer of 20 or more employees shall establish and administer a workplace safety committee in accordance with rules adopted under this section.

(b) Each public or private employer of fewer than 20 employees which is identified by the division as having high frequency or severity of work-related injuries shall establish and administer a workplace safety committee or designate a workplace safety coordinator who shall establish and administer workplace safety activities in accordance with rules adopted under this section.

(2) The division shall adopt rules:

(a) Prescribing the membership of the workplace safety committees so as to ensure an equal number of employee representatives, who are volunteers or are elected by their peers, and of employer representatives, and specifying the frequency of meetings.

(b) Requiring employers to make adequate records of each meeting and to file and to maintain the records subject to inspection by the division.

(c) Prescribing the duties and functions of the workplace safety committee and workplace safety coordinator, which include, but are not limited to:

1. Establishing procedures for workplace safety inspections by the committee.

2. Establishing procedures investigating all workplace accidents, safety-related incidents, illnesses, and deaths.


4. Prescribing guidelines for the training of safety committee members.

(3) The composition, selection, and function of safety committees shall be a mandatory topic of negotiations with any certified collective bargaining agent for nonfederal public sector employers that operate under a collective bargaining agreement. Employers that operate under a collective bargaining agreement that contains provisions regulating the formation and operation of workplace safety committees that meet or exceed the minimum requirements contained in this section, or employers who otherwise have existing workplace safety committees that meet or exceed the minimum requirements established by this section are in compliance with this section.

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