2014 Florida Workers' Compensation Law

2014 CHAPTER 440

WORKERS' COMPENSATION LAW

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440.01 Short title.—This chapter may be cited as the "**Workers' Compensation Law**".

440.015 Legislative intent.—It is the intent of the Legislature that the Workers' Compensation Law be interpreted so as to assure the quick and efficient delivery of disability and medical benefits to an injured worker and to facilitate the worker's return to gainful reemployment at a reasonable cost to the employer. It is the specific intent of the Legislature that workers' compensation cases shall be decided on their merits. The workers' compensation system in Florida is based on a mutual renunciation of common-law rights and defenses by employers and employees alike. In addition, it is the intent of the Legislature that the facts in a workers' compensation case are not to be interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Additionally, the Legislature hereby declares that disputes concerning the facts in workers' compensation cases are not to be given a broad liberal construction in favor of the employee on the one hand or of the employer on the other hand, and the laws pertaining to workers' compensation are to be construed in accordance with the basic principles of statutory construction and not liberally in favor of either employee or employer. It is the intent of the Legislature to ensure the prompt delivery of benefits to the injured worker. Therefore, an efficient and self-executing system must be created which is not an economic or administrative burden. The department, agency, the Office of Insurance Regulation, and the Division of Administrative Hearings shall administer the Workers' Compensation Law in a manner which facilitates the self-execution of the system and the process of ensuring a prompt and cost-effective delivery of payments.

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

(1) "Accident" means only an unexpected or unusual event or result that happens suddenly. Disability or death due to the accidental acceleration or aggravation of a venereal disease or of a disease due to the habitual use of alcohol or controlled substances or narcotic drugs, or a disease that manifests itself in the fear of or dislike for an individual because of the individual's race, color, religion, sex, national origin, age, or handicap is not an injury by accident arising out of the employment. Subject to s. 440.15(5), if a preexisting disease or anomaly is accelerated or aggravated by an accident arising out of and in the course of employment, only acceleration of death or acceleration or aggravation of the preexisting condition reasonably attributable to the accident is compensable, with respect to any compensation otherwise payable under this chapter. An injury or disease caused by exposure to a toxic substance, including, but not limited to, fungus or mold, is not an injury by accident arising out of the employment unless there is clear and convincing evidence establishing that exposure to the specific substance involved, at the levels to which the employee was exposed, can cause the injury or disease sustained by the employee.

(2) "Adoption" or "adopted" means legal adoption prior to the time of the injury.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Carrier" means any person or fund authorized under s. 440.38 to insure under this chapter and includes a self-insurer, and a commercial self-insurance fund authorized under s. 624.462.

(5) "Casual" as used in this section refers only to employments for work that is anticipated to be completed in 10 working days or less, without regard to the number of persons employed, and at a total labor cost of less than $500.

(6) "Child" includes a posthumous child, a child legally adopted prior to the injury of the employee, and a stepchild or acknowledged child born out of wedlock dependent upon the deceased, but does not include married children unless wholly dependent on the employee. "Grandchild" means a child as above defined of a child as above defined. "Brother" and "sister" include stepbrothers and stepsisters, half brothers and half sisters, and brothers and sisters by adoption, but does not include married brothers or married sisters unless wholly dependent on the employee. "Child," "grandchild," "brother,"

and “sister” include only persons who at the time of the death of the deceased employees are under 18 years of age, or under 22 years of age if a full-time student in an accredited educational institution.

(7) “Compensation” means the money allowance payable to an employee or to his or her dependents as provided for in this chapter.

(8) “Construction industry” means for-profit activities involving any building, clearing, filling, excavation, or substantial improvement in the size or use of any structure or the appearance of any land. However, “construction” does not mean a homeowner’s act of construction or the result of a construction upon his or her own premises, provided such premises are not intended to be sold, resold, or leased by the owner within 1 year after the commencement of construction. The division may, by rule, establish codes and definitions thereof that meet the criteria of the term “construction industry” as set forth in this section.

(9) “Corporate officer” or “officer of a corporation” means any person who fills an office provided for in the corporate charter or articles of incorporation filed with the Division of Corporations of the Department of State or as authorized or required under part I of chapter 607. The term “officer of a corporation” includes a member owning at least 10 percent of a limited liability company created and approved under chapter 608.

(10) “Date of maximum medical improvement” means the date after which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.

(11) “Death” as a basis for a right to compensation means only death resulting from an injury.

(12) “Department” means the Department of Financial Services; the term does not include the Financial Services Commission or any office of the commission.

(13) “Disability” means incapacity because of the injury to earn in the same or any other employment the wages which the employee was receiving at the time of the injury.

(14) “Division” means the Division of Workers’ Compensation of the Department of Financial Services.

(15) (a) “Employee” means any person who receives remuneration from an employer for the performance of any work or service while engaged in any employment under any appointment or

contract for hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes, but is not limited to, aliens and minors.

(b) "Employee" includes any person who is an officer of a corporation and who performs services for remuneration for such corporation within this state, whether or not such services are continuous.

1. Any officer of a corporation may elect to be exempt from this chapter by filing notice of the election with the department as provided in s. 440.05.

2. As to officers of a corporation who are engaged in the construction industry, no more than three officers of a corporation or of any group of affiliated corporations may elect to be exempt from this chapter by filing a notice of the election with the department as provided in s. 440.05. Officers must be shareholders, each owning at least 10 percent of the stock of such corporation and listed as an officer of such corporation with the Division of Corporations of the Department of State, in order to elect exemptions under this chapter. For purposes of this subparagraph, the term "affiliated" means and includes one or more corporations or entities, any one of which is a corporation engaged in the construction industry, under the same or substantially the same control of a group of business entities which are connected or associated so that one entity controls or has the power to control each of the other business entities. The term "affiliated" includes, but is not limited to, the officers, directors, executives, shareholders active in management, employees, and agents of the affiliated corporation. The ownership by one business entity of a controlling interest in another business entity or a pooling of equipment or income among business entities shall be prima facie evidence that one business is affiliated with the other.

3. An officer of a corporation who elects to be exempt from this chapter by filing a notice of the election with the department as provided in s. 440.05 is not an employee.

Services are presumed to have been rendered to the corporation if the officer is compensated by other than dividends upon shares of stock of the corporation which the officer owns.

(c) "Employee" includes:

1. A sole proprietor or a partner who is not engaged in the construction industry, devotes full time to the proprietorship or partnership, and elects to be included in the definition of employee by filing notice thereof as provided in s. 440.05.

2. All persons who are being paid by a construction contractor as a subcontractor, unless the subcontractor has validly elected an exemption as permitted by this chapter, or has otherwise secured the payment of compensation coverage as a subcontractor, consistent with s. 440.10, for work performed by or as a subcontractor.

3. An independent contractor working or performing services in the construction industry.

4. A sole proprietor who engages in the construction industry and a partner or partnership that is engaged in the construction industry.

(d) "Employee" does not include:

1. An independent contractor who is not engaged in the construction industry.

a. In order to meet the definition of independent contractor, at least four of the following criteria must be met:

(I) The independent contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations;

(II) The independent contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal regulations;

(III) The independent contractor receives compensation for services rendered or work performed and such compensation is paid to a business rather than to an individual;

(IV) The independent contractor holds one or more bank accounts in the name of the business entity for purposes of paying business expenses or other expenses related to services rendered or work performed for compensation;

(V) The independent contractor performs work or is able to perform work for any entity in addition to or besides the employer at his or her own election without the necessity of completing an employment application or process; or

(VI) The independent contractor receives compensation for work or services rendered on a competitive-bid basis or completion of a task or a set of tasks as defined by a contractual agreement, unless such contractual agreement expressly states that an employment relationship exists.

b. If four of the criteria listed in sub-subparagraph a. do not exist, an individual may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying any of the following conditions:

(I) The independent contractor performs or agrees to perform specific services or work for a specific amount of money and controls the means of performing the services or work.

(II) The independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform.

(III) The independent contractor is responsible for the satisfactory completion of the work or services that he or she performs or agrees to perform.

(IV) The independent contractor receives compensation for work or services performed for a commission or on a per-job basis and not on any other basis.

(V) The independent contractor may realize a profit or suffer a loss in connection with performing work or services.

(VI) The independent contractor has continuing or recurring business liabilities or obligations.

(VII) The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures.

c. Notwithstanding anything to the contrary in this subparagraph, an individual claiming to be an independent contractor has the burden of proving that he or she is an independent contractor for purposes of this chapter.

2. A real estate licensee, if that person agrees, in writing, to perform for remuneration solely by way of commission.

3. Bands, orchestras, and musical and theatrical performers, including disk jockeys, performing in licensed premises as defined in chapter 562, if a written contract evidencing an independent contractor relationship is entered into before the commencement of such entertainment.

4. An owner-operator of a motor vehicle who transports property under a written contract with a motor carrier which evidences a relationship by which the owner-operator assumes the responsibility of an employer for the performance of the contract, if the owner-operator is required to furnish motor vehicle equipment as identified in the written contract and the principal costs incidental to the

performance of the contract, including, but not limited to, fuel and repairs, provided a motor carrier's advance of costs to the owner-operator when a written contract evidences the owner-operator's obligation to reimburse such advance shall be treated as the owner-operator furnishing such cost and the owner-operator is not paid by the hour or on some other time-measured basis.

5. A person whose employment is both casual and not in the course of the trade, business, profession, or occupation of the employer.

6. A volunteer, except a volunteer worker for the state or a county, municipality, or other governmental entity. A person who does not receive monetary remuneration for services is presumed to be a volunteer unless there is substantial evidence that a valuable consideration was intended by both employer and employee. For purposes of this chapter, the term "volunteer" includes, but is not limited to:

a. Persons who serve in private nonprofit agencies and who receive no compensation other than expenses in an amount less than or equivalent to the standard mileage and per diem expenses provided to salaried employees in the same agency or, if such agency does not have salaried employees who receive mileage and per diem, then such volunteers who receive no compensation other than expenses in an amount less than or equivalent to the customary mileage and per diem paid to salaried workers in the community as determined by the department; and

b. Volunteers participating in federal programs established under Pub. L. No. 93-113.

7. Unless otherwise prohibited by this chapter, any officer of a corporation who elects to be exempt from this chapter. Such officer is not an employee for any reason under this chapter until the notice of revocation of election filed pursuant to s. 440.05 is effective.

8. An officer of a corporation that is engaged in the construction industry who elects to be exempt from the provisions of this chapter, as otherwise permitted by this chapter. Such officer is not an employee for any reason until the notice of revocation of election filed pursuant to s. 440.05 is effective.

9. An exercise rider who does not work for a single horse farm or breeder, and who is compensated for riding on a case-by-case basis, provided a written contract is entered into prior to the

commencement of such activity which evidences that an employee/employer relationship does not exist.

10. A taxicab, limousine, or other passenger vehicle-for-hire driver who operates said vehicles pursuant to a written agreement with a company which provides any dispatch, marketing, insurance, communications, or other services under which the driver and any fees or charges paid by the driver to the company for such services are not conditioned upon, or expressed as a proportion of, fare revenues.

11. A person who performs services as a sports official for an entity sponsoring an interscholastic sports event or for a public entity or private, nonprofit organization that sponsors an amateur sports event. For purposes of this subparagraph, such a person is an independent contractor. For purposes of this subparagraph, the term "sports official" means any person who is a neutral participant in a sports event, including, but not limited to, umpires, referees, judges, linespersons, scorekeepers, or timekeepers. This subparagraph does not apply to any person employed by a district school board who serves as a sports official as required by the employing school board or who serves as a sports official as part of his or her responsibilities during normal school hours.

12. Medicaid-enrolled clients under chapter 393 who are excluded from the definition of employment under s. 443.1216(4)(d) and served by Adult Day Training Services under the Home and Community-Based or the Family and Supported Living Medicaid Waiver program in a sheltered workshop setting licensed by the United States Department of Labor for the purpose of training and earning less than the federal hourly minimum wage.

13. Medicaid-enrolled clients under chapter 393 who are excluded from the definition of employment under s. 443.1216(4)(d) and served by Adult Day Training Services under the Family and Supported Living Medicaid Waiver program in a sheltered workshop setting licensed by the United States Department of Labor for the purpose of training and earning less than the federal hourly minimum wage.

(16) (a) "Employer" means the state and all political subdivisions thereof, all public and quasi-public corporations therein, every person carrying on any employment, and the legal representative of a deceased person or the receiver or trustees of any person. "Employer" also includes employment agencies, employee leasing companies, and similar agents who provide employees to other persons. If

the employer is a corporation, parties in actual control of the corporation, including, but not limited to, the president, officers who exercise broad corporate powers, directors, and all shareholders who directly or indirectly own a controlling interest in the corporation, are considered the employer for the purposes of ss. 440.105, 440.106, and 440.107.

(b) A homeowner shall not be considered the employer of persons hired by the homeowner to carry out construction on the homeowner's own premises if those premises are not intended for immediate lease, sale, or resale.

(c) Facilities serving individuals under subparagraph (15)(d)12. shall be considered agents of the Agency for Health Care Administration as it relates to providing Adult Day Training Services under the Home and Community-Based Medicaid Waiver program and not employers or third parties for the purpose of limiting or denying Medicaid benefits.

(17) (a) "Employment," subject to the other provisions of this chapter, means any service performed by an employee for the person employing him or her.

(b) "Employment" includes:

1. Employment by the state and all political subdivisions thereof and all public and quasi-public corporations therein, including officers elected at the polls.

2. All private employments in which four or more employees are employed by the same employer or, with respect to the construction industry, all private employment in which one or more employees are employed by the same employer.

3. Volunteer firefighters responding to or assisting with fire or medical emergencies whether or not the firefighters are on duty.

(c) "Employment" does not include service performed by or as:

1. Domestic servants in private homes.

2. Agricultural labor performed on a farm in the employ of a bona fide farmer, or association of farmers, that employs 5 or fewer regular employees and that employs fewer than 12 other employees at one time for seasonal agricultural labor that is completed in less than 30 days, provided such seasonal employment does not exceed 45 days in the same calendar year. The term "farm" includes stock, dairy, poultry, fruit, fur-bearing animals, fish, and truck farms, ranches, nurseries, and orchards. The term

“agricultural labor” includes field foremen, timekeepers, checkers, and other farm labor supervisory personnel.

3. Professional athletes, such as professional boxers, wrestlers, baseball, football, basketball, hockey, polo, tennis, jai alai, and similar players, and motorsports teams competing in a motor racing event as defined in s. 549.08.

4. Labor under a sentence of a court to perform community services as provided in s. 316.193.

5. State prisoners or county inmates, except those performing services for private employers or those enumerated in s. 948.036(1).

(18) “Misconduct” includes, but is not limited to, the following, which shall not be construed in pari materia with each other:

(a) Conduct evincing such willful or wanton disregard of an employer’s interests as is found in deliberate violation or disregard of standards of behavior which the employer has the right to expect of the employee; or

(b) Carelessness or negligence of such a degree or recurrence as to manifest culpability, wrongful intent, or evil design, or to show an intentional and substantial disregard of an employer’s interests or of the employee’s duties and obligations to the employer.

(19) “Injury” means personal injury or death by accident arising out of and in the course of employment, and such diseases or infection as naturally or unavoidably result from such injury. Damage to dentures, eyeglasses, prosthetic devices, and artificial limbs may be included in this definition only when the damage is shown to be part of, or in conjunction with, an accident. This damage must specifically occur as the result of an accident in the normal course of employment.

(20) “Parent” includes stepparents and parents by adoption, parents-in-law, and any persons who for more than 3 years prior to the death of the deceased employee stood in the place of a parent to him or her and were dependent on the injured employee.

(21) “Partner” means any person who is a member of a partnership that is formed by two or more persons to carry on as coowners of a business with the understanding that there will be a proportional sharing of the profits and losses between them. For the purposes of this chapter, a partner is a person who participates fully in the management of the partnership and who is personally liable for its debts.

(22) “Permanent impairment” means any anatomic or functional abnormality or loss determined as a percentage of the body as a whole, existing after the date of maximum medical improvement, which results from the injury.

(23) “Person” means individual, partnership, association, or corporation, including any public service corporation.

(24) “Self-insurer” means:

(a) Any employer who has secured payment of compensation pursuant to s. 440.38(1)(b) or (6) as an individual self-insurer;

(b) Any employer who has secured payment of compensation through a group self-insurance fund under s. 624.4621;

(c) Any group self-insurance fund established under s. 624.4621;

(d) A public utility as defined in s. 364.02 or s. 366.02 that has assumed by contract the liabilities of contractors or subcontractors pursuant to s. 624.46225; or

(e) Any local government self-insurance fund established under s. 624.4622.

(25) “Sole proprietor” means a natural person who owns a form of business in which that person owns all the assets of the business and is solely liable for all the debts of the business.

(26) “Spouse” includes only a spouse substantially dependent for financial support upon the decedent and living with the decedent at the time of the decedent’s injury and death, or substantially dependent upon the decedent for financial support and living apart at that time for justifiable cause.

(27) “Time of injury” means the time of the occurrence of the accident resulting in the injury.

(28) “Wages” means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the injury and includes only the wages earned and reported for federal income tax purposes on the job where the employee is injured and any other concurrent employment where he or she is also subject to workers’ compensation coverage and benefits, together with the reasonable value of housing furnished to the employee by the employer which is the permanent year-round residence of the employee, and gratuities to the extent reported to the employer in writing as taxable income received in the course of employment from others than the employer and employer contributions for health insurance for the employee or the employee’s dependents. However, housing

furnished to migrant workers shall be included in wages unless provided after the time of injury. In employment in which an employee receives consideration for housing, the reasonable value of such housing compensation shall be the actual cost to the employer or based upon the Fair Market Rent Survey promulgated pursuant to s. 8 of the Housing and Urban Development Act of 1974, whichever is less. However, if employer contributions for housing or health insurance are continued after the time of the injury, the contributions are not "wages" for the purpose of calculating an employee's average weekly wage.

(29) "Weekly compensation rate" means and refers to the amount of compensation payable for a period of 7 consecutive calendar days, including any Saturdays, Sundays, holidays, and other nonworking days which fall within such period of 7 consecutive calendar days. When Saturdays, Sundays, holidays, or other nonworking days immediately follow the first 7 calendar days of disability or occur at the end of a period of disability as the last day or days of such period, such nonworking days constitute a part of the period of disability with respect to which compensation is payable.

(30) "Construction design professional" means an architect, professional engineer, landscape architect, or surveyor and mapper, or any corporation, professional or general, that has a certificate to practice in the construction design field from the Department of Business and Professional Regulation.

(31) "Individual self-insurer" means any employer who has secured payment of compensation pursuant to s. 440.38(1)(b) as an individual self-insurer.

(32) "Domestic individual self-insurer" means an individual self-insurer:

(a) Which is a corporation formed under the laws of this state;

(b) Who is an individual who is a resident of this state or whose primary place of business is located in this state; or

(c) Which is a partnership whose principals are residents of this state or whose primary place of business is located in this state.

(33) "Foreign individual self-insurer" means an individual self-insurer:

(a) Which is a corporation formed under the laws of any state, district, territory, or commonwealth of the United States other than this state;

(b) Who is an individual who is not a resident of this state and whose primary place of business is not located in this state; or

(c) Which is a partnership whose principals are not residents of this state and whose primary place of business is not located in this state.

(34) "Insolvent member" means an individual self-insurer which is a member of the Florida Self-Insurers Guaranty Association, Incorporated, or which was a member and has withdrawn pursuant to s. 440.385(1)(b), and which has been found insolvent, as defined in subparagraph (35) (a)1., subparagraph (35)(a)2., or subparagraph (35)(a)3., by a court of competent jurisdiction in this or any other state, or meets the definition of subparagraph (35)(a)4.

(35) "Insolvency" or "insolvent" means:

(a) With respect to an individual self-insurer:

1. That all assets of the individual self-insurer, if made immediately available, would not be sufficient to meet all the individual self-insurer's liabilities;

2. That the individual self-insurer is unable to pay its debts as they become due in the usual course of business;

3. That the individual self-insurer has substantially ceased or suspended the payment of compensation to its employees as required in this chapter; or

4. That the individual self-insurer has sought protection under the United States Bankruptcy Code or has been brought under the jurisdiction of a court of bankruptcy as a debtor pursuant to the United States Bankruptcy Code.

(b) With respect to an employee claiming insolvency pursuant to s. 440.25(5), a person is insolvent who:

1. Has ceased to pay his or her debts in the ordinary course of business and cannot pay his or her debts as they become due; or

2. Has been adjudicated insolvent pursuant to the federal bankruptcy law.

(36) "Arising out of" pertains to occupational causation. An accidental injury or death arises out of employment if work performed in the course and scope of employment is the major contributing cause of the injury or death.

(37) “Soft-tissue injury” means an injury that produces damage to the soft tissues, rather than to the skeletal tissues or soft organs.

(38) “Insurer” means a group self-insurers’ fund authorized by s. 624.4621, an individual self-insurer authorized by s. 440.38, a commercial self-insurance fund authorized by s. 624.462, an assessable mutual insurer authorized by s. 628.6011, and an insurer licensed to write workers’ compensation and employer’s liability insurance in this state. The term “carrier,” as used in this chapter, means an insurer as defined in this subsection.

(39) “Statement,” for the purposes of ss. 440.105 and 440.106, shall include the exact fraud statement language in s. 440.105(7). This requirement includes, but is not limited to, any notice, representation, statement, proof of injury, bill for services, diagnosis, prescription, hospital or doctor record, X ray, test result, or other evidence of loss, injury, or expense.

(40) “Specificity” means information on the petition for benefits sufficient to put the employer or carrier on notice of the exact statutory classification and outstanding time period of benefits being requested and includes a detailed explanation of any benefits received that should be increased, decreased, changed, or otherwise modified. If the petition is for medical benefits, the information shall include specific details as to why such benefits are being requested, why such benefits are medically necessary, and why current treatment, if any, is not sufficient. Any petition requesting alternate or other medical care, including, but not limited to, petitions requesting psychiatric or psychological treatment, must specifically identify the physician, as defined in s. 440.13(1), who is recommending such treatment. A copy of a report from such physician making the recommendation for alternate or other medical care shall also be attached to the petition. A judge of compensation claims shall not order such treatment if a physician is not recommending such treatment.

(41) “Office of Insurance Regulation” means the Office of Insurance Regulation of the Financial Services Commission.

440.021 Exemption of workers' compensation from chapter 120.—Workers' compensation adjudications by judges of compensation claims are exempt from chapter 120, and no judge of compensation claims shall be considered an agency or a part thereof. Communications of the result of investigations by the department pursuant to s. 440.185(4) are exempt from chapter 120. In all instances in which the department institutes action to collect a penalty or interest which may be due pursuant to this chapter, the penalty or interest shall be assessed without hearing, and the party against which such penalty or interest is assessed shall be given written notice of such assessment and shall have the right to protest within 20 days of such notice. Upon receipt of a timely notice of protest and after such investigation as may be necessary, the department shall, if it agrees with such protest, notify the protesting party that the assessment has been revoked. If the department does not agree with the protest, it shall refer the matter to the judge of compensation claims for determination pursuant to s. 440.25(2)-(5). Such action of the department is exempt from the provisions of chapter 120.

440.03 Application.—Every employer and employee as defined in s. 440.02 shall be bound by the provisions of this chapter.

440.04 Waiver of exemption.—

(1) Every employer having in her or his employment any employee not included in the definition "employee" or excluded or exempted from the operation of this chapter may at any time waive such exclusion or exemption and accept the provisions of this chapter by giving notice thereof as provided in s. 440.05, and by so doing be as fully protected and covered by the provisions of this chapter as if such exclusion or exemption had not been contained herein.

(2) When any policy or contract of insurance specifically secures the benefits of this chapter to any person not included in the definition of "employee" or whose services are not included in the definition of "employment" or who is otherwise excluded or exempted from the operation of this chapter, the acceptance of such policy or contract of insurance by the insured and the writing of same by the carrier

shall constitute a waiver of such exclusion or exemption and an acceptance of the provisions of this chapter with respect to such person, notwithstanding the provision of s. 440.05 with respect to notice.

(3) A corporate officer who has exempted herself or himself by proper notice from the operation of this chapter may at any time revoke such exemption and thereby accept the provisions of this chapter by giving notice as provided in s. 440.05.

440.05 Election of exemption; revocation of election; notice; certification.—

(1) Each corporate officer who elects not to accept the provisions of this chapter or who, after electing such exemption, revokes that exemption shall mail to the department in Tallahassee notice to such effect in accordance with a form to be prescribed by the department.

(2) Each sole proprietor or partner who elects to be included in the definition of "employee" or who, after such election, revokes that election must mail to the department in Tallahassee notice to such effect, in accordance with a form to be prescribed by the department.

(3) Each officer of a corporation who is engaged in the construction industry and who elects an exemption from this chapter or who, after electing such exemption, revokes that exemption must submit a notice to such effect to the department on a form prescribed by the department. The notice of election to be exempt must be electronically submitted to the department by the officer of a corporation who is allowed to claim an exemption as provided by this chapter and must list the name, federal tax identification number, date of birth, driver license number or Florida identification card number, and all certified or registered licenses issued pursuant to chapter 489 held by the person seeking the exemption, the registration number of the corporation filed with the Division of Corporations of the Department of State, and the percentage of ownership evidencing the required ownership under this chapter. The notice of election to be exempt must identify each corporation that employs the person electing the exemption and must list the social security number or federal tax identification number of each such employer and the additional documentation required by this section. In addition, the notice of election to be exempt must provide that the officer electing an exemption is not entitled to benefits under this chapter, must provide that the election does not exceed exemption limits for officers provided in s.

440.02, and must certify that any employees of the corporation whose officer elects an exemption are covered by workers' compensation insurance. Upon receipt of the notice of the election to be exempt, receipt of all application fees, and a determination by the department that the notice meets the requirements of this subsection, the department shall issue a certification of the election to the officer, unless the department determines that the information contained in the notice is invalid. The department shall revoke a certificate of election to be exempt from coverage upon a determination by the department that the person does not meet the requirements for exemption or that the information contained in the notice of election to be exempt is invalid. The certificate of election must list the name of the corporation listed in the request for exemption. A new certificate of election must be obtained each time the person is employed by a new or different corporation that is not listed on the certificate of election. A copy of the certificate of election must be sent to each workers' compensation carrier identified in the request for exemption. Upon filing a notice of revocation of election, an officer who is a subcontractor or an officer of a corporate subcontractor must notify her or his contractor. Upon revocation of a certificate of election of exemption by the department, the department shall notify the workers' compensation carriers identified in the request for exemption.

(4) The notice of election to be exempt from the provisions of this chapter must contain a notice that clearly states in substance the following: "Any person who, knowingly and with intent to injure, defraud, or deceive the department or any employer or employee, insurance company, or any other person, files a notice of election to be exempt containing any false or misleading information is guilty of a felony of the third degree." Each person filing a notice of election to be exempt shall personally sign the notice and attest that he or she has reviewed, understands, and acknowledges the foregoing notice.

(5) A notice given under subsection (1), subsection (2), or subsection (3) shall become effective when issued by the department or 30 days after an application for an exemption is received by the department, whichever occurs first. However, if an accident or occupational disease occurs less than 30 days after the effective date of the insurance policy under which the payment of compensation is secured or the date the employer qualified as a self-insurer, such notice is effective as of 12:01 a.m. of the day following the date it is mailed to the department in Tallahassee.

(6) A certificate of election to be exempt which is issued on or after January 1, 2013, in accordance with this section is valid for 2 years after the effective date stated thereon. Both the effective date and the expiration date must be listed on the face of the certificate by the department. The certificate must expire at midnight, 2 years from its issue date, as noted on the face of the exemption certificate. A certificate of election to be exempt may be revoked before its expiration by the officer for whom it was issued or by the department for the reasons stated in this section. At least 60 days before the expiration date of a certificate of exemption, the department shall send notice of the expiration date to the certificateholder at the address on the certificate or to the e-mail address on file with the department.

(7) Any contractor responsible for compensation under s. 440.10 may register in writing with the workers' compensation carrier for any subcontractor and shall thereafter be entitled to receive written notice from the carrier of any cancellation or nonrenewal of the policy.

(8) (a) The department must assess a fee of $50 with each request for a construction industry certificate of election to be exempt or renewal of election to be exempt under this section.

(b) The funds collected by the department shall be used to administer this section, to audit the businesses that pay the fee for compliance with any requirements of this chapter, and to enforce compliance with the provisions of this chapter.

(9) The department may by rule prescribe forms and procedures for filing an election of exemption, revocation of election to be exempt, and notice of election of coverage for all employers and require specified forms to be submitted by all employers in filing for the election of exemption. The department may by rule prescribe forms and procedures for issuing a certificate of the election of exemption.

(10) Each officer of a corporation who is actively engaged in the construction industry and who elects an exemption from this chapter shall maintain business records as specified by the department by rule, which rules must include the provision that any corporation with exempt officers engaged in the construction industry must maintain written statements of those exempted persons affirmatively acknowledging each such individual's exempt status.

(11) Any corporate officer permitted by this chapter to claim an exemption must be listed on the records of this state's Secretary of State, Division of Corporations, as a corporate officer. The

department shall issue a stop-work order under s. 440.107(7) to any corporation who employs a person who claims to be exempt as a corporate officer but who fails or refuses to produce the documents required under this subsection to the department within 3 business days after the request is made.

(12) Certificates of election to be exempt issued under subsection (3) shall apply only to the corporate officer named on the notice of election to be exempt and apply only within the scope of the business or trade listed on the notice of election to be exempt.

(13) Notices of election to be exempt and certificates of election to be exempt shall be subject to revocation if, at any time after the filing of the notice or the issuance of the certificate, the person named on the notice or certificate no longer meets the requirements of this section for issuance of a certificate. The department shall revoke a certificate at any time for failure of the person named on the certificate to meet the requirements of this section.

(14) An officer of a corporation who elects exemption from this chapter by filing a certificate of election under this section may not recover benefits or compensation under this chapter. For purposes of determining the appropriate premium for workers' compensation coverage, carriers may not consider any officer of a corporation who validly meets the requirements of this section to be an employee.

(15) Any corporate officer who is an affiliated person of a person who is delinquent in paying a stop-work order and penalty assessment order issued pursuant to s. 440.107, or owed pursuant to a court order, is ineligible for an election of exemption. The stop-work order and penalty assessment shall be in effect against any such affiliated person. As used in this subsection, the term "affiliated person" means:

(a) The spouse of such other person;

(b) Any person who directly or indirectly owns or controls, or holds with the power to vote, 10 percent or more of the outstanding voting securities of such other person;

(c) Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities that are directly or indirectly owned, controlled, or held with the power to vote by such other person;

(d) Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;

(e) Any person who directly or indirectly acquires all or substantially all of the other assets of such other person;

(f) Any officer, director, trustee, partner, owner, manager, joint venturer, or employee of such other person or a person performing duties similar to persons in such positions; or

(g) Any person who has an officer, director, trustee, partner, or joint venturer in common with such person.

440.055 Notice requirements.—An employer who employs fewer than four employees, who is permitted by law to elect not to secure payment of compensation under this chapter, and who elects not to do so shall post clear written notice in a conspicuous location at each worksite directed to all employees and other persons performing services at the worksite of their lack of entitlement to benefits under this chapter.

440.06 Failure to secure compensation; effect.—Every employer who fails to secure the payment of compensation, as provided in s. 440.10, by failing to meet the requirements of s. 440.38 may not, in any suit brought against him or her by an employee subject to this chapter to recover damages for injury or death, defend such a suit on the grounds that the injury was caused by the negligence of a fellow servant, that the employee assumed the risk of his or her employment, or that the injury was due to the comparative negligence of the employee.

440.075 When corporate officer rejects chapter; effect.—Every corporate officer who elects to reject this chapter shall, in any action to recover damages for injury or death brought against the corporate employer, proceed as at common law, and the employer in such suit may avail itself of all defenses that exist at common law.

440.077 When a corporate officer rejects chapter, effect.—An officer of a corporation who is permitted to elect an exemption under this chapter and who elects to be exempt from the provisions of this chapter may not recover benefits under this chapter.

440.09 Coverage.—

(1) The employer must pay compensation or furnish benefits required by this chapter if the employee suffers an accidental compensable injury or death arising out of work performed in the course and the scope of employment. The injury, its occupational cause, and any resulting manifestations or disability must be established to a reasonable degree of medical certainty, based on objective relevant medical findings, and the accidental compensable injury must be the major contributing cause of any resulting injuries. For purposes of this section, "major contributing cause" means the cause which is more than 50 percent responsible for the injury as compared to all other causes combined for which treatment or benefits are sought. In cases involving occupational disease or repetitive exposure, both causation and sufficient exposure to support causation must be proven by clear and convincing evidence. Pain or other subjective complaints alone, in the absence of objective relevant medical findings, are not compensable. For purposes of this section, "objective relevant medical findings" are those objective findings that correlate to the subjective complaints of the injured employee and are confirmed by physical examination findings or diagnostic testing. Establishment of the causal relationship between a compensable accident and injuries for conditions that are not readily observable must be by medical evidence only, as demonstrated by physical examination findings or diagnostic testing. Major contributing cause must be demonstrated by medical evidence only.

(a) This chapter does not require any compensation or benefits for any subsequent injury the employee suffers as a result of an original injury arising out of and in the course of employment unless the original injury is the major contributing cause of the subsequent injury. Major contributing cause must be demonstrated by medical evidence only.

(b) If an injury arising out of and in the course of employment combines with a preexisting disease or condition to cause or prolong disability or need for treatment, the employer must pay compensation or

benefits required by this chapter only to the extent that the injury arising out of and in the course of employment is and remains more than 50 percent responsible for the injury as compared to all other causes combined and thereafter remains the major contributing cause of the disability or need for treatment. Major contributing cause must be demonstrated by medical evidence only.

(c) Death resulting from an operation by a surgeon furnished by the employer for the cure of hernia as required in s. 440.15(6) [F.S. 1981] shall for the purpose of this chapter be considered to be a death resulting from the accident causing the hernia.

(d) If an accident happens while the employee is employed elsewhere than in this state, which would entitle the employee or his or her dependents to compensation if it had happened in this state, the employee or his or her dependents are entitled to compensation if the contract of employment was made in this state, or the employment was principally localized in this state. However, if an employee receives compensation or damages under the laws of any other state, the total compensation for the injury may not be greater than is provided in this chapter.

(2) Benefits are not payable in respect of the disability or death of any employee covered by the Federal Employer's Liability Act, the Longshoremen's and Harbor Worker's Compensation Act, the Defense Base Act, or the Jones Act.

(3) Compensation is not payable if the injury was occasioned primarily by the intoxication of the employee; by the influence of any drugs, barbiturates, or other stimulants not prescribed by a physician; or by the willful intention of the employee to injure or kill himself, herself, or another.

(4) (a) An employee shall not be entitled to compensation or benefits under this chapter if any judge of compensation claims, administrative law judge, court, or jury convened in this state determines that the employee has knowingly or intentionally engaged in any of the acts described in s. 440.105 or any criminal act for the purpose of securing workers' compensation benefits. For purposes of this section, the term "intentional" shall include, but is not limited to, pleas of guilty or nolo contendere in criminal matters. This section shall apply to accidents, regardless of the date of the accident. For injuries occurring prior to January 1, 1994, this section shall pertain to the acts of the employee described in s. 440.105 or criminal activities occurring subsequent to January 1, 1994.

(b) A judge of compensation claims, administrative law judge, or court of this state shall take judicial notice of a finding of insurance fraud by a court of competent jurisdiction and terminate or otherwise disallow benefits.

(c) Upon the denial of benefits in accordance with this section, a judge of compensation claims shall have the jurisdiction to order any benefits payable to the employee to be paid into the court registry or an escrow account during the pendency of an appeal or until such time as the time in which to file an appeal has expired.

(5) If injury is caused by the knowing refusal of the employee to use a safety appliance or observe a safety rule required by statute or lawfully adopted by the department, and brought prior to the accident to the employee's knowledge, or if injury is caused by the knowing refusal of the employee to use a safety appliance provided by the employer, the compensation as provided in this chapter shall be reduced 25 percent.

(6) Except as provided in this chapter, a construction design professional who is retained to perform professional services on a construction project, or an employee of a construction design professional in the performance of professional services on the site of the construction project, is not liable for any injuries resulting from the employer's failure to comply with safety standards on the construction project for which compensation is recoverable under this chapter, unless responsibility for safety practices is specifically assumed by contracts. The immunity provided by this subsection to a construction design professional does not apply to the negligent preparation of design plans or specifications.

(7) (a) To ensure that the workplace is a drug-free environment and to deter the use of drugs and alcohol at the workplace, if the employer has reason to suspect that the injury was occasioned primarily by the intoxication of the employee or by the use of any drug, as defined in this chapter, which affected the employee to the extent that the employee's normal faculties were impaired, and the employer has not implemented a drug-free workplace pursuant to ss. 440.101 and 440.102, the employer may require the employee to submit to a test for the presence of any or all drugs or alcohol in his or her system.

(b) If the employee has, at the time of the injury, a blood alcohol level equal to or greater than the level specified in s. 316.193, or if the employee has a positive confirmation of a drug as defined in this

act, it is presumed that the injury was occasioned primarily by the intoxication of, or by the influence of the drug upon, the employee. If the employer has implemented a drug-free workplace, this presumption may be rebutted only by evidence that there is no reasonable hypothesis that the intoxication or drug influence contributed to the injury. In the absence of a drug-free workplace program, this presumption may be rebutted by clear and convincing evidence that the intoxication or influence of the drug did not contribute to the injury. Percent by weight of alcohol in the blood must be based upon grams of alcohol per 100 milliliters of blood. If the results are positive, the testing facility must maintain the specimen for a minimum of 90 days. Blood serum may be used for testing purposes under this chapter; however, if this test is used, the presumptions under this section do not arise unless the blood alcohol level is proved to be medically and scientifically equivalent to or greater than the comparable blood alcohol level that would have been obtained if the test were based on percent by weight of alcohol in the blood. However, if, before the accident, the employer had actual knowledge of and expressly acquiesced in the employee's presence at the workplace while under the influence of such alcohol or drug, the presumptions specified in this subsection do not apply.

(c) If the injured worker refuses to submit to a drug test, it shall be presumed in the absence of clear and convincing evidence to the contrary that the injury was occasioned primarily by the influence of drugs.

(d) The agency shall provide by rule for the authorization and regulation of drug-testing policies, procedures, and methods. Testing of injured employees shall not commence until such rules are adopted.

(e) As a part of rebutting any presumptions under paragraph (b), the injured worker must prove the actual quantitative amounts of the drug or its metabolites as measured on the initial and confirmation post-accident drug tests of the injured worker's urine sample and provide additional evidence regarding the absence of drug influence other than the worker's denial of being under the influence of a drug. No drug test conducted on a urine sample shall be rejected as to its results or the presumption imposed under paragraph (b) on the basis of the urine being bodily fluid tested.

(8) If, by operation of s. 440.04, benefits become payable to a professional athlete under this chapter, such benefits shall be reduced or setoff in the total amount of injury benefits or wages payable during the period of disability by the employer under a collective bargaining agreement or contract for hire.

440.091 Law enforcement officer, firefighter, emergency medical technician, or paramedic; when acting within the course of employment.—

(1) If an employee:

(a) Is elected, appointed, or employed full time by a municipality, the state, or any political subdivision and is vested with authority to bear arms and make arrests and the employee's primary responsibility is the prevention or detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state;

(b) Was discharging that primary responsibility within the state in a place and under circumstances reasonably consistent with that primary responsibility; and

(c) Was not engaged in services for which he or she was paid by a private employer, and the employee and his or her public employer had no agreement providing for workers' compensation coverage for that private employment;

the employee is considered to have been acting within the course of employment. The term "employee" as used in this subsection includes all certified supervisory and command personnel whose duties include, in whole or in part, responsibilities for the supervision, training, guidance, and management of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency.

(2) If a firefighter as defined by s. 112.191(1)(b) is engaged in extinguishing a fire, or protecting and saving life or property due to a fire in this state in an emergency, and such activities would be considered to be within the course of his or her employment as a firefighter and covered by the employer's workers' compensation coverage except for the fact that the firefighter was off duty or that the location of the fire was outside the employer's jurisdiction or area of responsibility, such activities

are considered to be within the course of employment. This subsection does not apply if the firefighter is performing activities for which he or she is paid by another employer or contractor.

(3) If an emergency medical technician or paramedic is appointed or employed full time by a municipality, the state, or any political subdivision, is certified under chapter 401, is providing basic life support or advanced life support services, as defined in s. 401.23, in an emergency situation in this state, and such activities would be considered to be within the course of his or her employment as an emergency medical technician or paramedic and covered by the employer's workers' compensation coverage except for the fact that the location of the emergency was outside of the employer's jurisdiction or area of responsibility, such activities are considered to be within the course of employment. The provisions of this subsection do not apply if the emergency medical technician or paramedic is performing activities for which he or she is paid by another employer or contractor.

440.092 Special requirements for compensability; deviation from employment; subsequent intervening accidents.—

(1) RECREATIONAL AND SOCIAL ACTIVITIES.—Recreational or social activities are not compensable unless such recreational or social activities are an expressly required incident of employment and produce a substantial direct benefit to the employer beyond improvement in employee health and morale that is common to all kinds of recreation and social life.

(2) GOING OR COMING.—An injury suffered while going to or coming from work is not an injury arising out of and in the course of employment whether or not the employer provided transportation if such means of transportation was available for the exclusive personal use by the employee, unless the employee was engaged in a special errand or mission for the employer. For the purposes of this subsection and not withstanding any other provisions of law to the contrary, an injury to a law enforcement officer as defined in s. 943.10(1), during the officer's work period or while going to or coming from work in an official law enforcement vehicle, shall be presumed to be an injury arising out of and in the course of employment unless the injury occurred during a distinct deviation for a nonessential personal errand. If, however, the employer's policy or the collective bargaining agreement

that applies to the officer permits such deviations for nonessential errands, the injury shall be presumed to arise out of and in the course of employment.

(3) DEVIATION FROM EMPLOYMENT.—An employee who is injured while deviating from the course of employment, including leaving the employer's premises, is not eligible for benefits unless such deviation is expressly approved by the employer, or unless such deviation or act is in response to an emergency and designed to save life or property.

(4) TRAVELING EMPLOYEES.—An employee who is required to travel in connection with his or her employment who suffers an injury while in travel status shall be eligible for benefits under this chapter only if the injury arises out of and in the course of employment while he or she is actively engaged in the duties of employment. This subsection applies to travel necessarily incident to performance of the employee's job responsibility but does not include travel to and from work as provided in subsection (2).

(5) SUBSEQUENT INTERVENING ACCIDENTS.—Injuries caused by a subsequent intervening accident arising from an outside agency which are the direct and natural consequence of the original injury are not compensable unless suffered while traveling to or from a health care provider for the purpose of receiving remedial treatment for the compensable injury.

440.093 Mental and nervous injuries.—

(1) A mental or nervous injury due to stress, fright, or excitement only is not an injury by accident arising out of the employment. Nothing in this section shall be construed to allow for the payment of benefits under this chapter for mental or nervous injuries without an accompanying physical injury requiring medical treatment. A physical injury resulting from mental or nervous injuries unaccompanied by physical trauma requiring medical treatment shall not be compensable under this chapter.

(2) Mental or nervous injuries occurring as a manifestation of an injury compensable under this chapter shall be demonstrated by clear and convincing medical evidence by a licensed psychiatrist meeting criteria established in the most recent edition of the diagnostic and statistical manual of mental

disorders published by the American Psychiatric Association. The compensable physical injury must be and remain the major contributing cause of the mental or nervous condition and the compensable physical injury as determined by reasonable medical certainty must be at least 50 percent responsible for the mental or nervous condition as compared to all other contributing causes combined. Compensation is not payable for the mental, psychological, or emotional injury arising out of depression from being out of work or losing employment opportunities, resulting from a preexisting mental, psychological, or emotional condition or due to pain or other subjective complaints that cannot be substantiated by objective, relevant medical findings.

(3) Subject to the payment of permanent benefits under s. 440.15, in no event shall temporary benefits for a compensable mental or nervous injury be paid for more than 6 months after the date of maximum medical improvement for the injured employee's physical injury or injuries, which shall be included in the period of 104 weeks as provided in s. 440.15(2) and (4). Mental or nervous injuries are compensable only in accordance with the terms of this section.

440.094 Extraterritorial reciprocity.—

(1) If an employee in this state subject to this chapter temporarily leaves the state incidental to his or her employment and receives an accidental injury arising out of and in the course of employment, the employee is, or the beneficiaries of the employee if the injury results in death are, entitled to the benefits of this chapter as if the employee were injured within this state.

(2) An employee from another state and the employer of the employee in the other state are exempt from this chapter while the employee is temporarily in this state doing work for the employer if:

(a) The employer has furnished workers' compensation insurance coverage under the workers' compensation insurance or similar laws of the other state to cover the employee's employment while in this state;

(b) The extraterritorial provisions of this chapter are recognized in the other state; and

(c) Employees and employers who are covered in this state are likewise exempted from the application of the workers' compensation insurance or similar laws of the other state.

(3) The benefits under the workers' compensation insurance or similar laws of the other state, or other remedies under similar law, are the exclusive remedy against the employer for any injury, whether resulting in death or not, received by the employee while temporarily working for that employer in this state.

(4) A certificate from the duly authorized officer of the appropriate department of another state certifying that the employer of the other state is insured in that state and has provided extraterritorial coverage insuring employees while working in this state is prima facie evidence that the employer carries that workers' compensation insurance.

(5) Whenever in any appeal or other litigation the construction of the laws of another jurisdiction is required, the courts shall take judicial notice of such construction of the laws of the other jurisdiction.

(6) When an employee has a claim under the workers' compensation law of another state, territory, province, or foreign nation for the same injury or occupational disease as the claim filed in this state, the total amount of compensation paid or awarded under such other workers' compensation law shall be credited against the compensation due under the Florida Workers' Compensation Law.

(7) For purposes of this section, an employee is considered to be temporarily in a state doing work for an employer if the employee is working for his employer in a state other than the state where he or she is primarily employed, for no more than 10 consecutive days, or no more than 25 total days, during a calendar year.

(8) This section applies to any claim made on or after July 1, 2011, regardless of the date of the accident.

440.10 Liability for compensation.—

(1) (a) Every employer coming within the provisions of this chapter shall be liable for, and shall secure, the payment to his or her employees, or any physician, surgeon, or pharmacist providing services under the provisions of s. 440.13, of the compensation payable under ss. 440.13, 440.15, and 440.16. Any contractor or subcontractor who engages in any public or private construction in the state shall secure and maintain compensation for his or her employees under this chapter as provided in s. 440.38.

(b) In case a contractor sublets any part or parts of his or her contract work to a subcontractor or subcontractors, all of the employees of such contractor and subcontractor or subcontractors engaged on such contract work shall be deemed to be employed in one and the same business or establishment, and the contractor shall be liable for, and shall secure, the payment of compensation to all such employees, except to employees of a subcontractor who has secured such payment.

(c) A contractor shall require a subcontractor to provide evidence of workers' compensation insurance. A subcontractor who is a corporation and has an officer who elects to be exempt as permitted under this chapter shall provide a copy of his or her certificate of exemption to the contractor.

(d) 1. If a contractor becomes liable for the payment of compensation to the employees of a subcontractor who has failed to secure such payment in violation of s. 440.38, the contractor or other third-party payor shall be entitled to recover from the subcontractor all benefits paid or payable plus interest unless the contractor and subcontractor have agreed in writing that the contractor will provide coverage.

2. If a contractor or third-party payor becomes liable for the payment of compensation to the corporate officer of a subcontractor who is engaged in the construction industry and has elected to be exempt from the provisions of this chapter, but whose election is invalid, the contractor or third-party payor may recover from the claimant or corporation all benefits paid or payable plus interest, unless the contractor and the subcontractor have agreed in writing that the contractor will provide coverage.

(e) A subcontractor providing services in conjunction with a contractor on the same project or contract work is not liable for the payment of compensation to the employees of another subcontractor or the contractor on such contract work and is protected by the exclusiveness-of-liability provisions of

s. 440.11 from any action at law or in admiralty on account of injury to an employee of another subcontractor, or of the contractor, provided that:

1. The subcontractor has secured workers' compensation insurance for its employees or the contractor has secured such insurance on behalf of the subcontractor and its employees in accordance with paragraph (b); and

2. The subcontractor's own gross negligence was not the major contributing cause of the injury.

(f) If an employer fails to secure compensation as required by this chapter, the department shall assess against the employer a penalty not to exceed $5,000 for each employee of that employer who is classified by the employer as an independent contractor but who is found by the department to not meet the criteria for an independent contractor that are set forth in s. 440.02. The department shall adopt rules to administer the provisions of this paragraph.

(g) Subject to s. 440.38, any employer who has employees engaged in work in this state shall obtain a Florida policy or endorsement for such employees which utilizes Florida class codes, rates, rules, and manuals that are in compliance with and approved under the provisions of this chapter and the Florida Insurance Code. Failure to comply with this paragraph is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The department shall adopt rules for construction industry and nonconstruction-industry employers with regard to the activities that define what constitutes being "engaged in work" in this state, using the following standards:

1. For employees of nonconstruction-industry employers who have their headquarters outside of Florida and also operate in Florida and who are routinely crossing state lines, but usually return to their homes each night, the employee shall be assigned to the headquarters' state. However, the construction industry employees performing new construction or alterations in Florida shall be assigned to Florida even if the employees return to their home state each night.

2. The payroll of executive supervisors who may visit a Florida location but who are not in direct charge of a Florida location shall be assigned to the state in which the headquarters is located.

3. For construction contractors who maintain a permanent staff of employees and superintendents, if any of these employees or superintendents are assigned to a job that is located in Florida, either for the

duration of the job or any portion thereof, their payroll shall be assigned to Florida rather than the headquarters' state.

4. Employees who are hired for a specific project in Florida shall be assigned to Florida.

(2) Compensation shall be payable irrespective of fault as a cause for the injury, except as provided in s. 440.09(3).

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 or her 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; phencyclidine (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 s. 397.311(33), 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 s. 397.311(33).

(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 mandatory-testing 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 or her 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) "Mandatory-testing position" means, with respect to a public employer, a job assignment that requires the employee to carry a firearm, work closely with an employee who carries a firearm, perform life-threatening procedures, work with heavy or dangerous machinery, work as a safety inspector, work with children, work with detainees in the correctional system, work with confidential information or documents pertaining to criminal investigations, work with controlled substances, or a job assignment that requires an employee security background check, pursuant to s. 110.1127, or a job assignment 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 under this

section and to qualify for the discounts provided under s. 627.0915 and deny medical and indemnity benefits under this chapter, an employer must, at a minimum, implement drug testing that conforms to the standards and procedures established in this section and all applicable rules adopted pursuant to this section as required in subsection (4). 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 is ineligible for discounts under s. 627.0915. However, an employer qualifies for discounts under s. 627.0915 if the employer maintains a drug-free workplace program that is broader in scope than that provided for by the standards and procedures established in this section. An employer who qualifies for and receives discounts provided under s. 627.0915 must be reported annually by the insurer to the department.

(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 department.

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 or her 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 or she 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 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 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)(g), 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) If 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

mandatory-testing 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.

(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) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this section and part II of chapter 408 and to entities licensed by or applying for such licensure from the agency pursuant to this section. A license issued by the agency is required in order to operate a drug-free workplace laboratory.

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

1. The laboratory obtains a license under part II of chapter 408 and s. 112.0455(17). Each applicant for licensure and each licensee must comply with all requirements of this section, part II of chapter 408, and applicable rules.

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.

(c) 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.

(d) 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, part II of chapter 408, and criteria established by the United States Department of Health and Human Services as general guidelines for modeling drug-free workplace laboratories, 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 MANDATORY-TESTING OR SPECIAL-RISK POSITIONS.—

(a) If an employee who is employed by a public employer in a mandatory-testing position enters an employee assistance program or drug rehabilitation program, the employer must assign the employee to a position other than a mandatory-testing 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 mandatory-testing position of the public employer, but may be assigned to a position other than a mandatory-testing 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.

(15) STATE CONSTRUCTION CONTRACTS.—Each construction contractor regulated under part I of chapter 489, and each electrical contractor and alarm system contractor regulated under part II of chapter 489, who contracts to perform construction work under a state contract for educational facilities governed by chapter 1013, for public property or publicly owned buildings governed by chapter 255, or

for state correctional facilities governed by chapter 944 shall implement a drug-free workplace program under this section.

440.1025 Employer workplace safety program in ratesetting; program requirements; rulemaking.—

(1) For a public or private employer to be eligible for receipt of specific identifiable consideration under s. 627.0915 for a workplace safety program in the setting of rates, the employer must have a workplace safety program. At a minimum, the program must include a written safety policy and safety rules, and make provision for safety inspections, preventative maintenance, safety training, first-aid, accident investigation, and necessary recordkeeping. The department may adopt rules for insurers to utilize in determining employer compliance with the requirements of this section.

(2) The division shall publicize on the Internet, and shall encourage insurers to publicize, the availability of free safety consultation services and safety program resources.

440.103 Building permits; identification of minimum premium policy.—Every employer shall, as a condition to applying for and receiving a building permit, show proof and certify to the permit issuer that it has secured compensation for its employees under this chapter as provided in ss. 440.10 and 440.38. Such proof of compensation must be evidenced by a certificate of coverage issued by the carrier, a valid exemption certificate approved by the department, or a copy of the employer's authority to self-insure and shall be presented, electronically or physically, each time the employer applies for a building permit. As provided in s. 553.79(19), for the purpose of inspection and record retention, site plans or building permits may be maintained at the worksite in the original form or in the form of an electronic copy. These plans and permits must be open to inspection by the building official or a duly authorized representative, as required by the Florida Building Code. As provided in s. 627.413(5), each certificate of coverage must show, on its face, whether or not coverage is secured under the minimum premium provisions of rules adopted by rating organizations licensed pursuant to s. 627.221. The words "minimum premium policy" or equivalent language shall be typed, printed, stamped, or legibly handwritten.

440.104 Competitive bidder; civil actions.—

(1) Any person engaged in the construction industry, as provided in s. 440.02, who loses a competitive bid for a contract shall have a cause of action for damages against the person awarded the contract for which the bid was made, if the person making the losing bid establishes that the winning bidder knew or should have known that he or she was in violation of s. 440.10, s. 440.105, or s. 440.38 while performing the work under the contract.

(2) To recover in an action brought under this section, a party must establish a violation of s. 440.10, s. 440.105, or s. 440.38 by a preponderance of the evidence.

(3) Upon establishing that the winning bidder knew or should have known of the violation, the person shall recover as liquidated damages 30 percent of the total amount bid on the contract by the person bringing the action, or $15,000, whichever is greater.

(4) In any action under this section, the prevailing party is entitled to an award of reasonable attorney's fees.

(5) An action under this section must be commenced within 2 years after the performance of activities involving any building, clearing, filling, or execution contract, or the substantial improvement in the size or use of any structure, or the appearance of any land.

(6) A person may not recover any amounts under this section if the defendant in the action establishes by a preponderance of the evidence that the plaintiff:

(a) Was in violation of s. 440.10, s. 440.105, or s. 440.38 at the time of making the bid on the contract; or

(b) Was in violation of s. 440.10, s. 440.105, or s. 440.38 with respect to any contract performed by the plaintiff within 1 year before making the bid on the contract.

(7) (a) Any person who loses a competitive bid may petition the court to join in a suit brought under this section by another person against the winning bidder on the same contract and shall be joined in such suit. If more than one person is joined against the winning bidder and such persons prevail in the suit, the court must enter judgment dividing damages recoverable under this section between the parties equally.

(b) Any person who receives notice of a suit filed under this section and fails, within 20 days after receipt of such notice, to petition the court to join as a party to the suit is barred from bringing a cause of action under this section against the winning bidder on the contract at issue. For purposes of this subsection, publication in accordance with s. 49.10 constitutes sufficient notice.

440.105 Prohibited activities; reports; penalties; limitations.—

(1) (a) Any insurance carrier, any individual self-insured, any commercial or group self-insurance fund, any professional practitioner licensed or regulated by the Department of Health, except as otherwise provided by law, any medical review committee as defined in s. 766.101, any private medical review committee, and any insurer, agent, or other person licensed under the insurance code, or any employee thereof, having knowledge or who believes that a fraudulent act or any other act or practice which, upon conviction, constitutes a felony or misdemeanor under this chapter is being or has been committed shall send to the Division of Insurance Fraud, Bureau of Workers' Compensation Fraud, a report or information pertinent to such knowledge or belief and such additional information relative thereto as the bureau may require. The bureau shall review such information or reports and select such information or reports as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such information or report to be made to determine the extent, if any, to which a fraudulent act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under this chapter is being committed. The bureau shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency and state attorney or other prosecuting agency having jurisdiction with respect to any such violations of this chapter. If prosecution by the state attorney or other prosecuting agency having jurisdiction with respect to such violation is not begun within 60 days of the bureau's report, the state attorney or other prosecuting agency having jurisdiction with respect to such violation shall inform the bureau of the reasons for the lack of prosecution.

(b) In the absence of fraud or bad faith, a person is not subject to civil liability for libel, slander, or any other relevant tort by virtue of filing reports, without malice, or furnishing other information,

without malice, required by this section or required by the bureau, and no civil cause of action of any nature shall arise against such person:

1. For any information relating to suspected fraudulent acts furnished to or received from law enforcement officials, their agents, or employees;

2. For any information relating to suspected fraudulent acts furnished to or received from other persons subject to the provisions of this chapter; or

3. For any such information relating to suspected fraudulent acts furnished in reports to the bureau, or the National Association of Insurance Commissioners.

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

(a) It shall be unlawful for any employer to knowingly:

1. Coerce or attempt to coerce, as a precondition to employment or otherwise, an employee to obtain a certificate of election of exemption pursuant to s. 440.05.

2. Discharge or refuse to hire an employee or job applicant because the employee or applicant has filed a claim for benefits under this chapter.

3. Discharge, discipline, or take any other adverse personnel action against any employee for disclosing information to the department or any law enforcement agency relating to any violation or suspected violation of any of the provisions of this chapter or rules promulgated hereunder.

(b) It shall be unlawful for any insurance entity to revoke or cancel a workers' compensation insurance policy or membership because an employer has returned an employee to work or hired an employee who has filed a workers' compensation claim.

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

(a) It shall be unlawful for any employer to knowingly fail to update applications for coverage as required by s. 440.381(1) and 1department rules within 7 days after the reporting date for any change in the required information, or to post notice of coverage pursuant to s. 440.40.

(b) It shall be unlawful for any employer to knowingly participate in the creation of the employment relationship in which the employee has used any false, fraudulent, or misleading oral or written statement as evidence of identity.

(c) It is unlawful for any attorney or other person, in his or her individual capacity or in his or her capacity as a public or private employee, or for any firm, corporation, partnership, or association to receive any fee or other consideration or any gratuity from a person on account of services rendered for a person in connection with any proceedings arising under this chapter, unless such fee, consideration, or gratuity is approved by a judge of compensation claims or by the Deputy Chief Judge of Compensation Claims.

(4) Whoever violates any provision of this subsection commits insurance fraud, punishable as provided in paragraph (f).

(a) It shall be unlawful for any employer to knowingly:

1. Present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of compliance with s. 440.38.

2. Make a deduction from the pay of any employee entitled to the benefits of this chapter for the purpose of requiring the employee to pay any portion of premium paid by the employer to a carrier or to contribute to a benefit fund or department maintained by such employer for the purpose of providing compensation or medical services and supplies as required by this chapter.

3. Fail to secure workers' compensation insurance coverage if required to do so by this chapter.

(b) It shall be unlawful for any person:

1. To knowingly make, or cause to be made, any false, fraudulent, or misleading oral or written statement for the purpose of obtaining or denying any benefit or payment under this chapter.

2. To present or cause to be presented any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to any provision of this chapter, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim.

3. To prepare or cause to be prepared any written or oral statement that is intended to be presented to any employer, insurance company, or self-insured program in connection with, or in support of, any

claim for payment or other benefit pursuant to any provision of this chapter, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim.

4. To knowingly assist, conspire with, or urge any person to engage in activity prohibited by this section.

5. To knowingly make any false, fraudulent, or misleading oral or written statement, or to knowingly omit or conceal material information, required by s. 440.185 or s. 440.381, for the purpose of obtaining workers' compensation coverage or for the purpose of avoiding, delaying, or diminishing the amount of payment of any workers' compensation premiums.

6. To knowingly misrepresent or conceal payroll, classification of workers, or information regarding an employer's loss history which would be material to the computation and application of an experience rating modification factor for the purpose of avoiding or diminishing the amount of payment of any workers' compensation premiums.

7. To knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of compliance with s. 440.38, as evidence of eligibility for a certificate of exemption under s. 440.05.

8. To knowingly violate a stop-work order issued by the department pursuant to s. 440.107.

9. To knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of identity for the purpose of obtaining employment or filing or supporting a claim for workers' compensation benefits.

(c) It shall be unlawful for any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, optometric physician licensed under chapter 463, or any other practitioner licensed under the laws of this state to knowingly and willfully assist, conspire with, or urge any person to fraudulently violate any of the provisions of this chapter.

(d) It shall be unlawful for any person or governmental entity licensed under chapter 395 to maintain or operate a hospital in such a manner so that such person or governmental entity knowingly and

willfully allows the use of the facilities of such hospital by any person, in a scheme or conspiracy to fraudulently violate any of the provisions of this chapter.

(e) It shall be unlawful for any attorney or other person, in his or her individual capacity or in his or her capacity as a public or private employee, or any firm, corporation, partnership, or association, to knowingly assist, conspire with, or urge any person to fraudulently violate any of the provisions of this chapter.

(f) If the monetary value of any violation of this subsection:

1. Is less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Is $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(5) It shall be unlawful for any attorney or other person, in his or her individual capacity or in his or her capacity as a public or private employee or for any firm, corporation, partnership, or association, to unlawfully solicit any business in and about city or county hospitals, courts, or any public institution or public place; in and about private hospitals or sanitariums; in and about any private institution; or upon private property of any character whatsoever for the purpose of making workers' compensation claims. Whoever violates any provision of this subsection commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(6) This section shall not be construed to preclude the applicability of any other provision of criminal law that applies or may apply to any transaction.

(7) An injured employee or any other party making a claim under this chapter shall provide his or her personal signature attesting that he or she has reviewed, understands, and acknowledges the following statement: "Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234." If the injured employee or other party refuses to sign the document attesting that he or she has reviewed,

understands, and acknowledges the statement, benefits, or payments under this chapter shall be suspended until such signature is obtained.

440.1051 Fraud reports; civil immunity; criminal penalties.—

(1) The Bureau of Workers' Compensation Insurance Fraud of the Division of Insurance Fraud of the department shall establish a toll-free telephone number to receive reports of workers' compensation fraud committed by an employee, employer, insurance provider, physician, attorney, or other person.

(2) Any person who reports workers' compensation fraud to the Division of Insurance Fraud under subsection (1) is immune from civil liability for doing so, and the person or entity alleged to have committed the fraud may not retaliate against him or her for providing such report, unless the person making the report knows it to be false.

(3) A person who calls and, knowingly and falsely, reports workers' compensation fraud or who, in violation of subsection (2) retaliates against a person for making such report, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

440.106 Civil remedies; administrative penalties.—

(1) Whenever any circuit or special grievance committee acting under the jurisdiction of the Supreme Court finds probable cause to believe that an attorney has violated s. 440.105, such committee may forward to the appropriate state attorney a copy of the findings of probable cause and a copy of the report being filed in the matter.

(2) Whenever a physician, osteopathic physician, chiropractic physician, podiatric physician, or other practitioner is determined to have violated s. 440.105, the Board of Medicine as set forth in chapter 458, the Board of Osteopathic Medicine as set forth in chapter 459, the Board of Chiropractic Medicine as set forth in chapter 460, the Board of Podiatric Medicine as set forth in chapter 461, or other appropriate licensing authority, shall hold an administrative hearing to consider the imposition of

administrative sanctions as provided by law against said physician, osteopathic physician, chiropractic physician, or other practitioner.

(3) Whenever any group or individual self-insurer, carrier, rating bureau, or agent or other representative of any carrier or rating bureau is determined to have violated s. 440.105, the agency responsible for licensure or certification may revoke or suspend the authority or certification of the group or individual self-insurer, carrier, agent, or broker.

(4) The department or the Office of Insurance Regulation shall report any contractor determined in violation of requirements of this chapter to the appropriate state licensing board for disciplinary action.

(5) The terms "violation" or "violated" shall include having been found guilty of or having pleaded guilty or nolo contendere to a felony or misdemeanor under the law of the United States of America or any state thereof or under the law of any other country without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.

440.107 Department powers to enforce employer compliance with coverage requirements.—

(1) The Legislature finds that the failure of an employer to comply with the workers' compensation coverage requirements under this chapter poses an immediate danger to public health, safety, and welfare.

(2) For the purposes of this section, "securing the payment of workers' compensation" means obtaining coverage that meets the requirements of this chapter and the Florida Insurance Code. However, if at any time an employer materially understates or conceals payroll, materially misrepresents or conceals employee duties so as to avoid proper classification for premium calculations, or materially misrepresents or conceals information pertinent to the computation and application of an experience rating modification factor, such employer shall be deemed to have failed to secure payment of workers' compensation and shall be subject to the sanctions set forth in this section. A stop-work order issued because an employer is deemed to have failed to secure the payment of workers' compensation required under this chapter because the employer has materially understated or concealed payroll, materially misrepresented or concealed employee duties so as to avoid proper classification for premium calculations, or materially misrepresented or concealed information pertinent to the computation and application of an experience rating modification factor shall have no

effect upon an employer's or carrier's duty to provide benefits under this chapter or upon any of the employer's or carrier's rights and defenses under this chapter, including exclusive remedy.

(3) The department shall enforce workers' compensation coverage requirements, including the requirement that the employer secure the payment of workers' compensation, and the requirement that the employer provide the carrier with information to accurately determine payroll and correctly assign classification codes. In addition to any other powers under this chapter, the department shall have the power to:

(a) Conduct investigations for the purpose of ensuring employer compliance.

(b) Enter and inspect any place of business at any reasonable time for the purpose of investigating employer compliance.

(c) Examine and copy business records.

(d) Administer oaths and affirmations.

(e) Certify to official acts.

(f) Issue and serve subpoenas for attendance of witnesses or production of business records, books, papers, correspondence, memoranda, and other records.

(g) Issue stop-work orders, penalty assessment orders, and any other orders necessary for the administration of this section.

(h) Enforce the terms of a stop-work order.

(i) Levy and pursue actions to recover penalties.

(j) Seek injunctions and other appropriate relief.

(4) The department shall designate representatives who may serve subpoenas and other process of the department issued under this section.

(5) The department shall specify by rule the business records that employers must maintain and produce to comply with this section.

(6) If a person has refused to obey a subpoena to appear before the department or its authorized representative or produce evidence requested by the department or to give testimony about the matter that is under investigation, a court has jurisdiction to issue an order requiring compliance with the subpoena if the court has jurisdiction in the geographical area where the inquiry is being carried on or

in the area where the person who has refused the subpoena is found, resides, or transacts business. Failure to obey such a court order may be punished by the court as contempt, either civilly or criminally. Costs, including reasonable attorney's fees, incurred by the department to obtain an order granting, in whole or in part, a petition to enforce a subpoena or a subpoena duces tecum shall be taxed against the subpoenaed party.

(7) (a) Whenever the department determines that an employer who is required to secure the payment to his or her employees of the compensation provided for by this chapter has failed to secure the payment of workers' compensation required by this chapter or to produce the required business records under subsection (5) within 10 business days after receipt of the written request of the department, such failure shall be deemed an immediate serious danger to public health, safety, or welfare sufficient to justify service by the department of a stop-work order on the employer, requiring the cessation of all business operations. If the department makes such a determination, the department shall issue a stop-work order within 72 hours. The order shall take effect when served upon the employer or, for a particular employer worksite, when served at that worksite. In addition to serving a stop-work order at a particular worksite which shall be effective immediately, the department shall immediately proceed with service upon the employer which shall be effective upon all employer worksites in the state for which the employer is not in compliance. A stop-work order may be served with regard to an employer's worksite by posting a copy of the stop-work order in a conspicuous location at the worksite. Information related to an employer's stop-work order shall be made available on the division's website, be updated daily, and remain on the website for at least 5 years. The order shall remain in effect until the department issues an order releasing the stop-work order upon a finding that the employer has come into compliance with the coverage requirements of this chapter and has paid any penalty assessed under this section. The department may issue an order of conditional release from a stop-work order to an employer upon a finding that the employer has complied with the coverage requirements of this chapter, paid a penalty of $1,000 as a down payment, and agreed to remit periodic payments of the remaining penalty amount pursuant to a payment agreement schedule with the department or pay the remaining penalty amount in full. If an order of conditional release is issued, failure by the employer to pay the penalty in full or enter into a payment agreement with the

department within 28 days after service of the stop-work order upon the employer, or to meet any term or condition of such penalty payment agreement, shall result in the immediate reinstatement of the stop-work order and the entire unpaid balance of the penalty shall become immediately due.

(b) Stop-work orders and penalty assessment orders issued under this section against a corporation, limited liability company, partnership, or sole proprietorship shall be in effect against any successor corporation or business entity that has one or more of the same principals or officers as the corporation, limited liability company, or partnership against which the stop-work order was issued and are engaged in the same or equivalent trade or activity.

(c) The department shall assess a penalty of $1,000 per day against an employer for each day that the employer conducts business operations that are in violation of a stop-work order.

(d) 1. In addition to any penalty, stop-work order, or injunction, the department shall assess against any employer who has failed to secure the payment of compensation as required by this chapter a penalty equal to 2 times the amount the employer would have paid in premium when applying approved manual rates to the employer's payroll during periods for which it failed to secure the payment of workers' compensation required by this chapter within the preceding 2-year period or $1,000, whichever is greater. For employers who have not been previously issued a stop-work order, the department must allow the employer to receive a credit for the initial payment of the estimated annual workers' compensation policy premium, as determined by the carrier, to be applied to the penalty. Before applying the credit to the penalty, the employer must provide the department with documentation reflecting that the employer has secured the payment of compensation pursuant to s. 440.38 and proof of payment to the carrier. In order for the department to apply a credit for an employer that has secured workers' compensation for leased employees by entering into an employee leasing contract with a licensed employee leasing company, the employer must provide the department with a written confirmation, by a representative from the employee leasing company, of the dollar or percentage amount attributable to the initial estimated workers' compensation expense for leased employees, and proof of payment to the employee leasing company. The $1,000 penalty shall be assessed against the employer even if the calculated penalty after the credit has been applied is less than $1,000.

2. Any subsequent violation within 5 years after the most recent violation shall, in addition to the penalties set forth in this subsection, be deemed a knowing act within the meaning of s. 440.105.

(e) When an employer fails to provide business records sufficient to enable the department to determine the employer's payroll for the period requested for the calculation of the penalty provided in paragraph (d), for penalty calculation purposes, the imputed weekly payroll for each employee, corporate officer, sole proprietor, or partner shall be the statewide average weekly wage as defined in s. 440.12(2) multiplied by 2.

(f) In addition to any other penalties provided for in this chapter, the department may assess against the employer a penalty of $5,000 for each employee of that employer who the employer represents to the department or carrier as an independent contractor but who is determined by the department not to be an independent contractor as defined in s. 440.02.

(8) In addition to the issuance of a stop-work order under subsection (7), the department may file a complaint in the circuit court in and for Leon County to enjoin any employer who has failed to secure the payment of workers' compensation required by this chapter from employing individuals and from conducting business until the employer presents evidence satisfactory to the department of having secured the payment of workers' compensation required by this chapter and pays a civil penalty assessed by the department under this section.

(9) The department shall adopt rules to administer this section.

(10) The department may bring an action in circuit court to recover penalties assessed under this section, including any interest owed to the department pursuant to this section. In any action brought by the department pursuant to this section in which it prevails, the circuit court shall award costs, including the reasonable costs of investigation and a reasonable attorney's fee.

(11) Any judgment obtained by the department and any penalty due pursuant to the service of a stop-work order or otherwise due under this section shall, until collected, constitute a lien upon the entire interest of the employer, legal or equitable, in any property, real or personal, tangible or intangible; however, such lien is subordinate to claims for unpaid wages and any prior recorded liens, and a lien created by this section is not valid against any person who, subsequent to such lien and in good faith and for value, purchases real or personal property from such employer or becomes the mortgagee on

real or personal property of such employer, or against a subsequent attaching creditor, unless, with respect to real estate of the employer, a notice of the lien is recorded in the public records of the county where the real estate is located, and with respect to personal property of the employer, the notice is recorded with the Secretary of State.

(12) Any law enforcement agency in the state may, at the request of the department, render any assistance necessary to carry out the provisions of this section, including, but not limited to, preventing any employee or other person from remaining at a place of employment or job site after a stop-work order or injunction has taken effect.

(13) Agency action by the department under this section, if contested, must be contested as provided in chapter 120. All penalties assessed by the department must be paid into the Workers' Compensation Administration Trust Fund.

(14) If the department finds that an employer who is certified or registered under part I or part II of chapter 489 and who is required to secure the payment of workers' compensation under this chapter to his or her employees has failed to do so, the department shall immediately notify the Department of Business and Professional Regulation.

(15) A limited liability company that is not engaged in the construction industry and that meets the definition of "employment" at any time between July 1, 2013, and December 31, 2013, may not be issued a penalty pursuant to this section for failing to secure the payment of workers' compensation.

440.108 Investigatory records relating to workers' compensation employer compliance; confidentiality.—

(1) All investigatory records made or received pursuant to s. 440.107 and any records necessary to complete an investigation held by the department 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. For purposes of this section, an investigation is considered "active" while such investigation is being conducted by the department 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 a good faith belief that action may be initiated by the agency or other administrative or law enforcement agency.

(2) After an investigation is completed or ceases to be active, information in records relating to the investigation remains confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution if disclosure of that information would:

(a) Jeopardize the integrity of another active investigation;

(b) Reveal a trade secret, as defined in s. 688.002;

(c) Reveal business or personal financial information;

(d) Reveal personal identifying information regarding the identity of a confidential source;

(e) Defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual; or

(f) Reveal investigative techniques or procedures.

(3) The department may provide information made confidential and exempt by this section to any law enforcement agency or administrative agency for use in the performance of its official duties and responsibilities. The receiving agency must maintain the confidential and exempt status of such information.

440.11 Exclusiveness of liability.—

(1) The liability of an employer prescribed in s. 440.10 shall be exclusive and in place of all other liability, including vicarious liability, of such employer to any third-party tortfeasor and to the employee, the legal representative thereof, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to recover damages from such employer at law or in admiralty on account of such injury or death, except as follows:

(a) If an employer fails to secure payment of compensation as required by this chapter, an injured employee, or the legal representative thereof in case death results from the injury, may elect to claim compensation under this chapter or to maintain an action at law or in admiralty for damages on account of such injury or death. In such action the defendant may not plead as a defense that the injury was

caused by negligence of a fellow employee, that the employee assumed the risk of the employment, or that the injury was due to the comparative negligence of the employee.

(b) When an employer commits an intentional tort that causes the injury or death of the employee. For purposes of this paragraph, an employer's actions shall be deemed to constitute an intentional tort and not an accident only when the employee proves, by clear and convincing evidence, that:

1. The employer deliberately intended to injure the employee; or

2. The employer engaged in conduct that the employer knew, based on prior similar accidents or on explicit warnings specifically identifying a known danger, was virtually certain to result in injury or death to the employee, and the employee was not aware of the risk because the danger was not apparent and the employer deliberately concealed or misrepresented the danger so as to prevent the employee from exercising informed judgment about whether to perform the work.

The same immunities from liability enjoyed by an employer shall extend as well to each employee of the employer when such employee is acting in furtherance of the employer's business and the injured employee is entitled to receive benefits under this chapter. Such fellow-employee immunities shall not be applicable to an employee who acts, with respect to a fellow employee, with willful and wanton disregard or unprovoked physical aggression or with gross negligence when such acts result in injury or death or such acts proximately cause such injury or death, nor shall such immunities be applicable to employees of the same employer when each is operating in the furtherance of the employer's business but they are assigned primarily to unrelated works within private or public employment. The same immunity provisions enjoyed by an employer shall also apply to any sole proprietor, partner, corporate officer or director, supervisor, or other person who in the course and scope of his or her duties acts in a managerial or policymaking capacity and the conduct which caused the alleged injury arose within the course and scope of said managerial or policymaking duties and was not a violation of a law, whether or not a violation was charged, for which the maximum penalty which may be imposed does not exceed 60 days' imprisonment as set forth in s. 775.082. The immunity from liability provided in this subsection extends to county governments with respect to employees of county constitutional officers whose offices are funded by the board of county commissioners.

(2) The immunity from liability described in subsection (1) shall extend to an employer and to each employee of the employer which uses the services of the employees of a help supply services company, as set forth in North American Industrial Classification System Codes 561320 and 561330, when such employees, whether management or staff, are acting in furtherance of the employer's business. An employee so engaged by the employer shall be considered a borrowed employee of the employer and, for the purposes of this section, shall be treated as any other employee of the employer. The employer shall be liable for and shall secure the payment of compensation to all such borrowed employees as required in s. 440.10, except when such payment has been secured by the help supply services company.

(3) An employer's workers' compensation carrier, service agent, or safety consultant shall not be liable as a third-party tortfeasor to employees of the employer or employees of its subcontractors for assisting the employer and its subcontractors, if any, in carrying out the employer's rights and responsibilities under this chapter by furnishing any safety inspection, safety consultative service, or other safety service incidental to the workers' compensation or employers' liability coverage or to the workers' compensation or employer's liability servicing contract. Without limitation, a safety consultant may include an owner, as defined in chapter 713, or an owner's related, affiliated, or subsidiary companies and the employees of each. The exclusion from liability under this subsection shall not apply in any case in which injury or death is proximately caused by the willful and unprovoked physical aggression, or by the negligent operation of a motor vehicle, by employees, officers, or directors of the employer's workers' compensation carrier, service agent, or safety consultant.

(4) Notwithstanding the provisions of s. 624.155, the liability of a carrier to an employee or to anyone entitled to bring suit in the name of the employee shall be as provided in this chapter, which shall be exclusive and in place of all other liability.

440.12 Time for commencement and limits on weekly rate of compensation.—

(1) Compensation is not allowed for the first 7 days of the disability, except for benefits provided under s. 440.13. However, if the injury results in more than 21 days of disability, compensation is allowed from the commencement of the disability.

(a) All weekly compensation payments, except for the first payment, must be paid by check or, if authorized by the employee, on a prepaid card pursuant to paragraph (b) or deposited directly into the employee's account at a financial institution as defined in s. 655.005.

(b) Upon receipt of authorization by the employee as provided in paragraph (a), a carrier may use a prepaid card to deliver the payment of compensation to an employee if the employee is:

1. Provided with at least one means of accessing his or her entire compensation payment once per week without incurring fees;

2. Provided with the ability to make point-of-sale purchases without incurring fees from the financial institution issuing the prepaid card; and

3. Provided with the terms and conditions of the prepaid card program, including a description of any fees that may be assessed.

(c) Each carrier shall keep a record of all payments made under this subsection, including the time and manner of such payments, and shall furnish these records or a report based on these records to the Division of Insurance Fraud and the Division of Workers' Compensation, upon request.

(d) The department may adopt rules to administer this section.

(2) Compensation for disability resulting from injuries which occur after December 31, 1974, shall not be less than $20 per week. However, if the employee's wages at the time of injury are less than $20 per week, he or she shall receive his or her full weekly wages. If the employee's wages at the time of the injury exceed $20 per week, compensation shall not exceed an amount per week which is:

(a) Equal to 100 percent of the statewide average weekly wage, determined as hereinafter provided for the year in which the injury occurred; however, the increase to 100 percent from 662/3 percent of the statewide average weekly wage shall apply only to injuries occurring on or after August 1, 1979; and

(b) Adjusted to the nearest dollar.

For the purpose of this subsection, the "statewide average weekly wage" means the average weekly wage paid by employers subject to the Florida Reemployment Assistance Program Law as reported to the Department of Economic Opportunity for the four calendar quarters ending each June 30, which average weekly wage shall be determined by the Department of Economic Opportunity on or before November 30 of each year and shall be used in determining the maximum weekly compensation rate with respect to injuries occurring in the calendar year immediately following. The statewide average weekly wage determined by the Department of Economic Opportunity shall be reported annually to the Legislature.

(3) The provisions of this section as amended effective July 1, 1951, shall govern with respect to disability due to injuries suffered prior to July 1, 1959. The provisions of this section as amended effective July 1, 1959, shall govern with respect to disability due to injuries suffered after June 30, 1959, and prior to January 1, 1968. The provisions of this section as amended effective January 1, 1968, shall govern with respect to disability due to injuries suffered after December 31, 1967, and prior to July 1, 1970. The provisions of this section as amended effective July 1, 1970, shall govern with respect to disability due to injuries suffered after June 30, 1970, and prior to July 1, 1972. The provisions of this section as amended effective July 1, 1972, shall govern with respect to disability due to injuries suffered after June 30, 1972, and prior to July 1, 1973. The provisions of this section, as amended effective July 1, 1973, shall govern with respect to disability due to injuries suffered after June 30, 1973, and prior to January 1, 1975.

440.125 Medical records and reports; identifying information in employee medical bills; confidentiality.—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 department, 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. The department may share any such confidential and exempt records, reports, or information received pursuant to s. 440.13 with the Agency for Health Care Administration in furtherance of their official duties under ss. 440.13 and

440.134. The agency and the department shall maintain the confidential and exempt status of such records, reports, and information received.

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) "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.

(e) "Emergency services and care" means emergency services and care as defined in s. 395.002.

(f) "Health care facility" means any hospital licensed under chapter 395 and any health care institution licensed under chapter 400 or chapter 429.

(g) "Health care provider" means a physician or any recognized practitioner licensed to provide skilled services pursuant to a prescription or under the supervision or direction of a physician. The term "health care provider" includes a health care facility.

(h) "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.

(i) "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 department to assist in the resolution of a dispute arising under this chapter.

(j) "Instance of overutilization" means a specific inappropriate service or level of service provided to an injured employee that includes the provision of treatment in excess of established practice parameters and protocols of treatment established in accordance with this chapter.

(k) "Medically necessary" or "medical necessity" 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.

(l) "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.

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

(n) "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.

(o) "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.

(p) "Physician" or "doctor" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466.

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

(r) “Utilization control” means a systematic process of implementing measures that assure overall management and cost containment of services delivered, including compliance with practice parameters and protocols of treatment as provided for in this chapter.

(s) “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 practice parameters and protocols of treatment as provided for in this chapter.

(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, which is in accordance with established practice parameters and protocols of treatment as provided for in this chapter, 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 an accrediting organization whose standards incorporate comparable regulations required by this state or pain-management programs affiliated with medical schools, shall be considered covered treatment only when such care is given based on a referral by a physician as defined in this chapter. Medically necessary treatment, care, and attendance does not include chiropractic services in excess of 24 treatments or rendered 12 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 physician shall prescribe such care in writing. The employer or carrier shall not be responsible for such care until the prescription for attendant care is received by the employer and carrier, which shall specify the time

periods for such care, the level of care required, and the type of assistance required. A prescription for attendant care shall not prescribe such care retroactively. The value of nonprofessional attendant care provided by a family member must be determined as follows:

1. If the family member is not employed or if the family member is employed and is providing attendant care services during hours that he or she is not engaged in employment, 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.

3. If the family member remains employed while providing attendant or custodial care, the per-hour value of that care equals the per-hour value of the family member's employment, not to exceed the per-hour value of such care available in the community at large.

(c) If the employer fails to provide initial treatment or care required by this section after request by the injured employee, the employee may obtain such initial treatment at the expense of the employer, if the initial treatment or care is compensable and medically necessary and is in accordance with established practice parameters and protocols of treatment as provided for in this chapter. There must be a specific request for the initial treatment or care, and the employer or carrier must be given a reasonable time period within which to provide the initial treatment or care. However, the employee is not entitled to recover any amount personally expended for the initial treatment or care unless he or she has requested the employer to furnish that initial 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 initial treatment, nursing, and services and the employer or his or her superintendent or foreman, having knowledge of the injury, has neglected to provide the initial treatment or care.

(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 and protocols of treatment established in accordance with this chapter. 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.

(f) Upon the written request of the employee, the carrier shall give the employee the opportunity for one change of physician during the course of treatment for any one accident. Upon the granting of a change of physician, the originally authorized physician in the same specialty as the changed physician shall become deauthorized upon written notification by the employer or carrier. The carrier shall authorize an alternative physician who shall not be professionally affiliated with the previous physician within 5 days after receipt of the request. If the carrier fails to provide a change of physician as requested by the employee, the employee may select the physician and such physician shall be considered authorized if the treatment being provided is compensable and medically necessary.

Failure of the carrier to timely comply with this subsection shall be a violation of this chapter and the carrier shall be subject to penalties as provided for in s. 440.525.

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(a) As a condition to eligibility for payment under this chapter, a health care provider who renders services must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care.

(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, unless the referral is for emergency treatment, and must be made in accordance with practice parameters and protocols of treatment as provided for in this chapter.

(d) A carrier must respond, by telephone or in writing, to a request for authorization from an authorized health care provider 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.

(f) By accepting payment under this chapter for treatment rendered to an injured employee, a health care provider consents to the jurisdiction of the department as set forth in subsection (11) and to the submission of all records and other information concerning such treatment to the department 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 department 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. 456.053 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 department identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall authorize such consultation or procedure unless the health care provider or facility is not authorized, unless such treatment is not in accordance with practice parameters and protocols of treatment established in this chapter, or unless a judge of compensation claims has determined that the consultation or procedure is not medically necessary, not in accordance with the practice parameters and protocols of treatment established in this chapter, or otherwise not compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to identify and disallow overutilization or billing errors.

(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 department, an employer, or a carrier, or any agent or representative of the department, 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.

(k) Reimbursement shall not be made for oral vitamins, nutrient preparations, or dietary supplements. Reimbursement shall not be made for medical food, as defined in 21 U.S.C. s. 360ee(b)(3), unless the self-insured employer or the carrier in its sole discretion authorizes the provision of such food. Such authorization may be limited by frequency, type, dosage, and reimbursement amount of such food as part of a proposed written course of medical treatment.

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

(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 department. 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 in a format prescribed by the department 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 in a format prescribed by the department.

(b) Upon the request of the department, 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, care, and attendance of the injured employee, including any report of an examination, diagnosis, or disability evaluation, must be produced by the health care provider to the department pursuant to rules adopted by the department. The health care provider shall also furnish to the injured employee or his or her attorney and the employer or carrier or its attorney, on demand, a copy of his or her office chart, records, and reports, and may charge the injured employee no more than 50 cents per page for copying the records and the actual direct cost to the health care provider or health care facility for X rays, microfilm, or other nonpaper records. Each such health care provider shall provide to the department information about the remedial treatment, care, and attendance which the department reasonably requests.

(c) It is the policy for the administration of the workers' compensation system that there shall be reasonable access to medical information by all parties to facilitate the self-executing features of the law. An employee who reports an injury or illness alleged to be work-related waives any physician-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding the limitations in s. 456.057 and subject to the limitations in s. 381.004, upon the request of the employer, the carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or carrier, the medical records, reports, and information of an injured employee relevant to the particular injury or illness for which compensation is sought 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. Release of medical information by the health care provider or other physician

does not require the authorization of the injured employee. If medical records, reports, and information of an injured employee are sought from health care providers who are not subject to the jurisdiction of the state, the injured employee shall sign an authorization allowing for the employer or carrier to obtain the medical records, reports, or information. Any such discussions or release of information may be held before or after the filing of a claim or petition for benefits without the knowledge, consent, or presence of any other party or his or her 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 department to one or more of the penalties set forth in paragraph (8)(b). The department may adopt rules to carry out this subsection.

(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. If the parties agree, 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 or her area of expertise, as demonstrated by licensure and applicable practice parameters. The employer and employee shall be entitled to only one independent medical examination per accident and not one independent medical examination per medical specialty. The party requesting and selecting the independent medical examination shall be responsible for all expenses associated with said examination, including, but not limited to, medically necessary diagnostic testing performed and physician or medical care provider fees for the evaluation. The party selecting the independent medical examination shall identify the choice of the independent medical examiner to all other parties within 15 days after the date the independent medical examination is to take place. Failure to timely provide such notification shall preclude the requesting party from submitting the findings of such independent medical examiner in a proceeding before a judge of compensation claims. The independent medical examiner may not provide followup care if such recommendation for care is found to be medically necessary. If the employee prevails in a medical dispute as determined in an order by a judge of compensation claims or if benefits are paid or treatment provided after the employee has obtained an independent medical examination

based upon the examiner's findings, the costs of such examination shall be paid by the employer or carrier.

(b) Each party is bound by his or her selection of an independent medical examiner, including the selection of the independent medical examiner in accordance with s. 440.134 and the opinions of such independent medical examiner. Each party 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.

(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 with the claimant and the 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 the self-insured employer's or carrier's independent medical evaluations under this subsection. Neither the self-insured employer nor the carrier shall be responsible for scheduling any independent medical examination other than an employer or carrier independent medical examination.

(d) If the employee fails to appear for the independent medical examination scheduled by the employer or carrier without good cause and fails to advise the physician at least 24 hours before the scheduled date for the examination that he or she cannot appear, the employee is barred from recovering compensation for any period during which he or she has refused to submit to such examination. Further, the employee shall reimburse the employer or carrier 50 percent of the physician's cancellation or no-show fee unless the employer or 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 or she failed to appear. The employee may

appeal to a judge of compensation claims for reimbursement when the employer or 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 the department, 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.

(g) When a medical dispute arises, the parties may mutually agree to refer the employee to a licensed physician specializing in the diagnosis and treatment of the medical condition at issue for an independent medical examination and report. Such medical examination shall be referred to as a "consensus independent medical examination." The findings and conclusions of such mutually agreed upon consensus independent medical examination shall be binding on the parties and shall constitute resolution of the medical dispute addressed in the independent consensus medical examination and in any proceeding. Agreement by the parties to a consensus independent medical examination shall not affect the employer's, carrier's, or employee's entitlement to one independent medical examination per accident as provided for in this subsection.

(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, including compliance with practice parameters and protocols of treatment established in accordance with this chapter, 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, or there is a violation of the practice parameters and protocols of treatment established in accordance with this chapter, it must disallow or adjust payment for such services or error without order of a judge of compensation claims or the department, if the carrier, in making its determination, has complied with this section and rules adopted by the department.

(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 45 days after receipt of notice of disallowance or adjustment of payment, petition the department 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 department results in dismissal of the petition.

(b) The carrier must submit to the department within 30 days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to timely submit such documentation to the department within 30 days constitutes a waiver of all objections to the petition.

(c) Within 120 days after receipt of all documentation, the department must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The department must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, practice parameters, and protocols of treatment, in rendering its determination.

(d) If the department 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 department 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 department:

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

2. An administrative fine assessed by the department 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 fee, for prosecuting the petition.

(8) PATTERN OR PRACTICE OF OVERUTILIZATION.—

(a) Carriers must report to the department all instances of overutilization including, but not limited to, all instances in which the carrier disallows or adjusts payment or a determination has been made that the provided or recommended treatment is in excess of the practice parameters and protocols of treatment established in this chapter. The department shall determine whether a pattern or practice of overutilization exists.

(b) If the department 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 department, including a pattern or practice of providing treatment in excess of the practice parameters or protocols of treatment, it may impose one or more of the following penalties:

1. An order 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. An administrative fine of $5,000; and

5. Notification of and review by the appropriate licensing authority pursuant to s. 440.106(3).

(9) EXPERT MEDICAL ADVISORS.—

(a) The department shall certify expert medical advisors in each specialty to assist the department and the judges of compensation claims within the advisor's area of expertise as provided in this section. The department 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 department 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 department shall contract with one or more entities that employ, contract with, or otherwise secure expert medical advisors to provide peer review or expert medical consultation, opinions, and testimony to the department 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, including utilization issues. The department shall by rule establish the qualifications of expert medical advisors, including training and experience in the workers' compensation system in the state and the expert medical advisor's knowledge of and commitment to the standards of care, practice parameters, and protocols established pursuant to this chapter. Expert medical advisors contracting with the department 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 department, including, but not limited to, rules pertaining to procedures for review of the services rendered by health care providers and preparation of reports and testimony or recommendations for submission to the department or the judge of compensation claims.

(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 department 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 or her evaluation and issue his or her report to the department or to the judge of compensation claims within 15 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 department and to any officer, employee, or agent of any entity with which the department has contracted under this subsection.

(f) If the department or a judge of compensation claims orders the services of a certified expert medical advisor to resolve a dispute under this section, the party requesting such examination must compensate the advisor for his or her time in accordance with a schedule adopted by the department. If the employee prevails in a dispute as determined in an order by a judge of compensation claims based upon the expert medical advisor's findings, the employer or carrier shall pay for the costs of such expert medical advisor. If a judge of compensation claims, upon his or her motion, finds that an expert medical advisor is needed to resolve the dispute, the carrier must compensate the advisor for his or her time in accordance with a schedule adopted by the department. The department 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) INVESTIGATION; MONITORING; JURISDICTION.—

(a) The department may investigate health care providers to determine whether providers are complying with this chapter and with rules adopted by the department, whether the providers are engaging in overutilization, whether providers are engaging in improper billing practices, and whether providers are adhering to practice parameters and protocols established in accordance with this chapter. If the department finds that a health care provider has improperly billed, overutilized, or failed to comply with department rules or the requirements of this chapter, including, but not limited to, practice parameters and protocols established in accordance with 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, that constitute overutilization, or that were outside practice parameters or protocols established in accordance with this chapter, it must return those payments to the carrier. The department may assess a penalty not to exceed $500 for each overpayment that is not refunded within 30 days after notification of overpayment by the department or carrier.

(b) The department shall monitor carriers as provided in this chapter.

(c) The department 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 January 1, 1994.

(d) The following department 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 department 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 services; and the review proceedings, report, and recommendation of the peer review committee.

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

(a) A three-member panel is created, consisting of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification

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

(b) It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions developed pursuant to this subsection are limited to the following:

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

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

3. Outpatient reimbursement for scheduled surgeries shall be reduced from 75 percent of charges to 60 percent of charges.

4. Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be increased to 110 percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

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

(c) As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price plus $4.18 for the dispensing fee. For repackaged or relabeled

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

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

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

2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will ensure the availability of treatment, care, and attendance required by injured workers;

3. The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.4001, and its effect upon their ability to make available to injured workers such medically necessary remedial treatment, care, and attendance. The uniform schedule of maximum reimbursement allowances must be reasonable, must promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers; and

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

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

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

2. Survey health care providers and health care facilities to determine the availability and accessibility of workers' compensation health care delivery systems for injured workers.

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

4. Submit recommendations on or before January 1, 2003, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel. For prescription medication purchased under the requirements of

this subsection, a dispensing practitioner shall not possess such medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days of the dispensing practitioner taking possession of that medication.

(13) PAYMENT OF MEDICAL FEES.—

(a) Except for emergency care treatment, fees for medical services are payable only to a health care provider authorized to render remedial treatment, care, or attendance under this chapter. Carriers shall pay, disallow, or deny payment to health care providers in the manner and at times set forth in 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. Payment to health care providers or physicians shall be subject to the medical fee schedule and applicable practice parameters and protocols, regardless of whether the health care provider or claimant is asserting that the payment should be made.

(b) Fees charged for remedial treatment, care, and attendance, except for independent medical examinations and consensus independent medical examinations, may not exceed the applicable fee schedules adopted under this chapter and department rule. Notwithstanding any other provision in this chapter, if a physician or health care provider specifically agrees in writing to follow identified procedures aimed at providing quality medical care to injured workers at reasonable costs, deviations from established fee schedules shall be permitted. Written agreements warranting deviations may include, but are not limited to, the timely scheduling of appointments for injured workers, participating in return-to-work programs with injured workers' employers, expediting the reporting of treatments provided to injured workers, and agreeing to continuing education, utilization review, quality assurance, precertification, and case management systems that are designed to provide needed treatment for injured workers.

(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.

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

(15) STANDARDS OF CARE.—The following standards of care shall be followed in providing medical care under this chapter:

(a) Abnormal anatomical findings alone, in the absence of objective relevant medical findings, shall not be an indicator of injury or illness, a justification for the provision of remedial medical care or the assignment of restrictions, or a foundation for limitations.

(b) At all times during evaluation and treatment, the provider shall act on the premise that returning to work is an integral part of the treatment plan. The goal of removing all restrictions and limitations as early as appropriate shall be part of the treatment plan on a continuous basis. The assignment of restrictions and limitations shall be reviewed with each patient exam and upon receipt of new information, such as progress reports from physical therapists and other providers. Consideration shall be given to upgrading or removing the restrictions and limitations with each patient exam, based upon the presence or absence of objective relevant medical findings.

(c) Reasonable necessary medical care of injured employees shall in all situations:

1. Utilize a high intensity, short duration treatment approach that focuses on early activation and restoration of function whenever possible.

2. Include reassessment of the treatment plans, regimes, therapies, prescriptions, and functional limitations or restrictions prescribed by the provider every 30 days.

3. Be focused on treatment of the individual employee’s specific clinical dysfunction or status and shall not be based upon nondescript diagnostic labels.

All treatment shall be inherently scientifically logical, and the evaluation or treatment procedure must match the documented physiologic and clinical problem. Treatment shall match the type, intensity, and duration of service required by the problem identified.

(16) Failure to comply with this section shall be considered a violation of this chapter and is subject to penalties as provided for in s. 440.525.

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

440.134 Workers' compensation managed care arrangement.—

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

(a) "Agency" means the Agency for Health Care Administration.

(b) "Complaint" means any dissatisfaction expressed by an injured worker concerning an insurer's workers' compensation managed care arrangement.

(c) "Emergency care" means medical services as defined in chapter 395.

(d) "Grievance" means a written complaint, other than a petition for benefits, filed by the injured worker pursuant to the requirements of the managed care arrangement, expressing dissatisfaction with the insurer's workers' compensation managed care arrangement's refusal to provide medical care or the medical care provided.

(e) "Insurer" means an insurance carrier, self-insurance fund, assessable mutual insurer, or individually self-insured employer.

(f) "Service area" means the agency-approved geographic area within which an insurer is authorized to offer a workers' compensation managed care arrangement.

(g) "Workers' compensation managed care arrangement" means an arrangement under which a provider of health care, a health care facility, a group of providers of health care, a group of providers of health care and health care facilities, an insurer that has an exclusive provider organization approved under s. 627.6472 or a health maintenance organization licensed under part I of chapter 641 has entered into a written agreement directly or indirectly with an insurer to provide and to manage appropriate remedial treatment, care, and attendance to injured workers in accordance with this chapter.

(h) "Capitated contract" means a contract in which an insurer pays directly or indirectly a fixed amount to a health care provider in exchange for the future rendering of medical services for covered expenses.

(i) "Medical care coordinator" means a primary care provider within a provider network who is responsible for managing the medical care of an injured worker including determining other health care providers and health care facilities to which the injured employee will be referred for evaluation or treatment. A medical care coordinator shall be a physician licensed under chapter 458, an osteopathic

physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, or a podiatric physician licensed under chapter 461.

(j) "Provider network" means a comprehensive panel of health care providers and health care facilities who have contracted directly or indirectly with an insurer to provide appropriate remedial treatment, care, and attendance to injured workers in accordance with this chapter.

(k) "Primary care provider" means, except in the case of emergency treatment, the initial treating physician and, when appropriate, continuing treating physician, who may be a family practitioner, general practitioner, or internist physician licensed under chapter 458; a family practitioner, general practitioner, or internist osteopathic physician licensed under chapter 459; a chiropractic physician licensed under chapter 460; a podiatric physician licensed under chapter 461; an optometrist licensed under chapter 463; or a dentist licensed under chapter 466.

(2) (a) The self-insured employer or carrier may, subject to the terms and limitations specified elsewhere in this section and chapter, furnish to the employee solely through managed care arrangements such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery requires and which shall be in accordance with practice parameters and protocols established pursuant to this chapter. For any self-insured employer or carrier who elects to deliver the medical benefits required by this chapter through a method other than a workers' compensation managed care arrangement, the discontinuance of the use of the workers' compensation managed care arrangement shall be without regard to the date of the accident, notwithstanding any other provision of law or rule.

(b) The agency shall authorize an insurer to offer or utilize a workers' compensation managed care arrangement after the insurer files a completed application along with the payment of a $1,000 application fee, and upon the agency's being satisfied that the applicant has the ability to provide quality of care consistent with the prevailing professional standards of care and the insurer and its workers' compensation managed care arrangement otherwise meets the requirements of this section. No insurer may offer or utilize a managed care arrangement without such authorization. The authorization, unless sooner suspended or revoked, shall automatically expire 2 years after the date of issuance unless renewed by the insurer. The authorization shall be renewed upon application for renewal and payment

of a renewal fee of $1,000, provided that the insurer is in compliance with the requirements of this section and any rules adopted hereunder. An application for renewal of the authorization shall be made 90 days prior to expiration of the authorization, on forms provided by the agency. The renewal application shall not require the resubmission of any documents previously filed with the agency if such documents have remained valid and unchanged since their original filing.

(3) An insurer may not directly or indirectly enter into a capitated contract with any person who is not a health care provider, a health care facility, a health maintenance organization licensed under part I of chapter 641, or a health insurer that has an exclusive provider organization approved under s. 627.6472. A capitated contract must provide that the capitated amount for rendering of covered medical services be paid directly to the person who has contracted with the insurer. Such contracts excluding the capitated amount must be filed with the agency for approval prior to use.

(4) An insurer may not offer or utilize a workers' compensation managed care arrangement in this state until its managed care plan of operation has been approved by the agency and the insurer is authorized by the agency to offer or utilize a workers' compensation managed care arrangement.

(5) An insurer must file a proposed managed care plan of operation with the agency in a format prescribed by the agency. The plan of operation must contain evidence that all covered services are available and accessible, including a demonstration that:

(a) Such services can be provided with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care must reflect usual practice in the local area. Geographic availability must reflect the usual travel times within the community.

(b) Unless the agency determines that insufficient numbers of providers are available, the number of providers in the workers' compensation managed care arrangement service area are sufficient, with respect to current and expected workers to be served by the arrangement, either:

1. By delivery of all required medical services; or

2. Through the ability to make appropriate referrals within the provider network.

(c) There are written agreements with providers describing specific responsibilities.

(d) Emergency care is available 24 hours a day and 7 days a week.

(e) In the case of covered services, there are written agreements with providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any injured worker.

(6) The proposed managed care plan of operation must include:

(a) A statement or map providing a clear description of the service area.

(b) A description of the grievance procedure to be used.

(c) A description of the quality assurance program which assures that the health care services provided to workers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the medical community. The program shall include, but not be limited to:

1. A written statement of goals and objectives that stresses health and return-to-work outcomes as the principal criteria for the evaluation of the quality of care rendered to injured workers.

2. A written statement describing how methodology has been incorporated into an ongoing system for monitoring of care that is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers.

3. Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

4. A written plan, which includes ongoing review, for providing review of physicians and other licensed medical providers.

5. Appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service.

6. Adequate methods of peer review and utilization review. The utilization review process shall include a health care facility’s precertification mechanism, including, but not limited to, all elective admissions and nonemergency surgeries and adherence to practice parameters and protocols established in accordance with this chapter.

7. Provisions for resolution of disputes arising between a health care provider and an insurer regarding reimbursements and utilization review.

8. Availability of a process for aggressive medical care coordination, as well as a program involving cooperative efforts by the workers, the employer, and the workers' compensation managed care arrangement to promote early return to work for injured workers.

9. A written plan allowing for the independent medical examination provided for in s. 440.13(5). Notwithstanding any provision to the contrary, the costs for the independent medical examination shall be paid by the carrier if such examination is performed by a physician in the provider network. Otherwise, such costs shall be paid in accordance with s. 440.13(5). An independent medical examination requested by a claimant and paid for by the carrier shall constitute the claimant's one independent medical examination per accident under s. 440.13(5).

10. A provision for the selection of a primary care provider by the employee from among primary providers in the provider network.

11. The written information proposed to be used by the insurer to comply with subparagraph 8.

(7) Written procedures to provide the insurer with timely medical records and information including, but not limited to, work status, work restrictions, date of maximum medical improvement, permanent impairment ratings, and other information as required, including information demonstrating compliance with the practice parameters and protocols of treatment established pursuant to this chapter.

(8) Evidence that appropriate health care providers and administrative staff of the insurer's workers' compensation managed care arrangement have received training and education on the provisions of this chapter; the administrative rules that govern the provision of remedial treatment, care, and attendance of injured workers; and the practice parameters and protocols of treatment established pursuant to this chapter.

(9) Written procedures and methods to prevent inappropriate or excessive treatment that are in accordance with the practice parameters and protocols of treatment established pursuant to this chapter.

(10) Written procedures and methods for the management of an injured worker's medical care by a medical care coordinator including:

(a) The mechanism for assuring that covered employees receive all initial covered services from a primary care provider participating in the provider network, except for emergency care.

(b) The mechanism for assuring that all continuing covered services be received from the same primary care provider participating in the provider network that provided the initial covered services, except when services from another provider are authorized by the medical care coordinator pursuant to paragraph (d).

(c) The policies and procedures for allowing an employee one change to another provider within the provider network as the authorized treating physician during the course of treatment for a work-related injury, in accordance with the procedures provided in s. 440.13(2)(f).

(d) The process for assuring that all referrals authorized by a medical care coordinator, in accordance with the practice parameters and protocols of treatment established pursuant to this chapter, are made to the participating network providers, unless medically necessary treatment, care, and attendance are not available and accessible to the injured worker in the provider network.

(e) Assignment of a medical care coordinator licensed under chapter 458 or chapter 459 to manage care by physicians licensed under chapter 458 or chapter 459, a medical care coordinator licensed under chapter 460 to manage care by physicians licensed under chapter 460, and a medical care coordinator licensed under chapter 461 to manage care by physicians licensed under chapter 461 upon request by an injured employee for care by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461.

(11) A description of the use of workers' compensation practice parameters and protocols of treatment for health care services.

(12) An insurer must file any proposed changes to the plan of operation, except for changes to the list of providers, with the agency prior to implementing the changes. The changes are considered approved by the agency after 45 days unless specifically disapproved.

(13) An updated list of providers must be filed with the agency at least semiannually.

(14) An insurer must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the workers' compensation managed care arrangement to affected workers, including at least:

(a) A description, including address and phone number, of the providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(b) A description of coverage for emergency and urgently needed care provided within and outside the service area.

(c) A description of limitations on referrals.

(d) A description of the grievance procedure.

(15) (a) A workers' compensation managed care arrangement must have and use procedures for hearing complaints and resolving written grievances from injured workers and health care providers. The procedures must be aimed at mutual agreement for settlement and may include arbitration procedures. Procedures provided herein are in addition to other procedures contained in this chapter.

(b) The grievance procedure must be described in writing and provided to the affected workers and health care providers.

(c) At the time the workers' compensation managed care arrangement is implemented, the insurer must provide detailed information to workers and health care providers describing how a grievance may be registered with the insurer.

(d) Grievances must be considered in a timely manner and must be transmitted to appropriate decisionmakers who have the authority to fully investigate the issue and take corrective action.

(e) If a grievance is found to be valid, corrective action must be taken promptly.

(f) All concerned parties must be notified of the results of a grievance.

(g) The insurer must report annually, no later than March 31, to the agency regarding its grievance procedure activities for the prior calendar year. The report must be in a format prescribed by the agency and must contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

(16) When a carrier enters into a managed care arrangement pursuant to this section the employees who are covered by the provisions of such arrangement shall be deemed to have received all the benefits to which they are entitled pursuant to s. 440.13(2)(a) and (b). In addition, the employer shall be deemed to have complied completely with the requirements of such provisions. The provisions governing managed care arrangements shall govern exclusively unless specifically stated otherwise in this section.

(17) Notwithstanding any other provisions of this chapter, when a carrier provides medical care through a workers' compensation managed care arrangement, pursuant to this section, those workers who are subject to the arrangement must receive medical services for work-related injuries and diseases as prescribed in the contract, provided the employer and carrier have provided notice to the employees of the arrangement in a manner approved by the agency and the medical services are in accordance with the practice parameters and protocols established pursuant to this chapter. Treatment received outside the workers' compensation managed care arrangement is not compensable, regardless of the purpose of the treatment, including, but not limited to, evaluations, examinations, or diagnostic studies to determine causation between medical findings and a compensable accident, the existence or extent of impairments or disabilities, and whether the injured employee has reached maximum medical improvement, unless authorized by the carrier prior to the treatment date.

(18) The agency may suspend the authority of an insurer to offer a workers' compensation managed care arrangement or order compliance within 60 days, if it finds that:

(a) The insurer is in substantial violation of its contracts;

(b) The insurer is unable to fulfill its obligations under outstanding contracts entered into with its employers;

(c) The insurer knowingly utilizes a provider who is furnishing or has furnished health care services and who does not have an existing license or other authority to practice or furnish health care services in this state;

(d) The insurer no longer meets the requirements for the authorization as originally issued; or

(e) The insurer has violated any lawful rule or order of the agency or any provision of this section.

(19) Revocation of an insurer's authorization shall be for a period of 2 years. After 2 years, the insurer may apply for a new authorization by compliance with all application requirements applicable to first-time applicants.

(20) Suspension of an insurer's authority to offer a workers' compensation managed care arrangement shall be for such period, not to exceed 1 year, as is fixed by the agency. The agency shall, in its order suspending the authority of an insurer to offer workers' compensation managed care, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the insurer

prior to reinstatement of its authority. The order of suspension is subject to rescission or modification by further order of the agency prior to the expiration of the suspension period. Reinstatement shall not be made unless requested by the insurer; however, the agency shall not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(21) Upon expiration of the suspension period, the insurer's authorization shall automatically be reinstated unless the agency finds that the causes of the suspension have not been rectified or that the insurer is otherwise not in compliance with the requirements of this chapter. If not so automatically reinstated, the authorization shall be deemed to have expired as of the end of the suspension period.

(22) If the agency finds that one or more grounds exist for the revocation or suspension of an authorization issued under this section, the agency may, in lieu of such revocation or suspension, impose a fine upon the insurer. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of a lawful order or rule of the agency or a provision of this section, the agency may impose a fine upon the insurer in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.

(23) The agency shall immediately notify the office whenever it issues an administrative complaint or an order or otherwise initiates legal proceedings resulting in, or which may result in, suspension or revocation of an insurer's authorization.

(24) Nothing in this chapter shall be deemed to authorize any entity to transact any insurance business, assume risk, or otherwise engage in any other type of insurance unless it is authorized as an insurer or a health maintenance organization under a certificate of authority issued under the provisions of the Florida Insurance Code.

(25) The agency shall adopt rules that specify:

(a) Procedures for authorization and examination of workers' compensation managed care arrangements by the agency.

(b) Requirements and procedures for authorization of workers' compensation arrangement provider networks and procedures for the agency to grant exceptions from accessibility of services.

(c) Requirements and procedures for case management, utilization management, and peer review.

(d) Requirements and procedures for quality assurance and medical records.

(e) Requirements and procedures for dispute resolution in conformance with this chapter.

(f) Requirements and procedures for employee and provider education.

(g) Requirements and procedures for reporting data regarding grievances, return-to-work outcomes, and provider networks.

440.14 Determination of pay.—

(1) Except as otherwise provided in this chapter, the average weekly wages of the injured employee on the date of the accident shall be taken as the basis upon which to compute compensation and shall be determined, subject to the limitations of s. 440.12(2), as follows:

(a) If the injured employee has worked in the employment in which she or he was working on the date of the accident, whether for the same or another employer, during substantially the whole of 13 weeks immediately preceding the accident, her or his average weekly wage shall be one-thirteenth of the total amount of wages earned in such employment during the 13 weeks. As used in this paragraph, the term "substantially the whole of 13 weeks" means the calendar period of 13 weeks as a whole, which shall be defined as the 13 calendar weeks before the date of the accident, excluding the week during which the accident occurred. The term "during substantially the whole of 13 weeks" shall be deemed to mean during not less than 75 percent of the total customary hours of employment within such period considered as a whole.

(b) If the injured employee has not worked in such employment during substantially the whole of 13 weeks immediately preceding the accident, the wages of a similar employee in the same employment who has worked substantially the whole of such 13 weeks shall be used in making the determination under the preceding paragraph.

(c) If an employee is a seasonal worker and the foregoing method cannot be fairly applied in determining the average weekly wage, then the employee may use, instead of the 13 weeks immediately preceding the accident, the calendar year or the 52 weeks immediately preceding the accident. The employee will have the burden of proving that this method will be more reasonable and fairer than the method set forth in paragraphs (a) and (b) and, further, must document prior earnings with W-2 forms, written wage statements, or income tax returns. The employer shall have 30 days following the receipt of this written proof to adjust the compensation rate, including the making of any additional payment due for prior weekly payments, based on the lower rate compensation.

(d) If any of the foregoing methods cannot reasonably and fairly be applied, the full-time weekly wages of the injured employee shall be used, except as otherwise provided in paragraph (e) or paragraph (f).

(e) If it is established that the injured employee was under 22 years of age when the accident occurred and that under normal conditions her or his wages should be expected to increase during the period of disability, the fact may be considered in arriving at her or his average weekly wages.

(f) If it is established that the injured employee was a part-time worker on the date of the accident, that she or he had adopted part-time employment as a customary practice, and that under normal working conditions she or he probably would have remained a part-time worker during the period of disability, these factors shall be considered in arriving at her or his average weekly wages. For the purpose of this paragraph, the term "part-time worker" means an individual who customarily works less than the full-time hours or full-time workweek of a similar employee in the same employment.

(g) If compensation is due for a fractional part of the week, the compensation for such fractional part shall be determined by dividing the weekly compensation rate by the number of days employed per week to compute the amount due for each day.

(2) If, during the period of disability, the employer continues to provide consideration, including board, rent, housing, or lodging, the value of such consideration shall be deducted when calculating the average weekly wage of the employee so long as these benefits continue to be provided.

(3) The department shall establish by rule a form which shall contain a simplified checklist of those items which may be included as "wage" for determining the average weekly wage.

(4) Upon termination of the employee or upon termination of the payment of fringe benefits of any employee who is collecting indemnity benefits pursuant to s. 440.15(2) or (3), the employer shall within 7 days of such termination file a corrected 13-week wage statement reflecting the wages paid and the fringe benefits that had been paid to the injured employee, as provided in s. 440.02(28).

(5) (a) If the lost wages from concurrent employment are used in calculating the average weekly wage, the employee is responsible for providing information concerning the loss of earnings from the concurrent employment.

(b) The employee waives any entitlement to interest, penalties, and attorney's fees during the period in which the employee has not provided information concerning the loss of earnings from concurrent employment. Carriers are not subject to penalties under s. 440.20(8)(b) for unpaid compensation related

to concurrent employment during the period in which the employee has not provided information concerning the loss of earnings from concurrent employment.

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, 662/3 or 66.67 percent of the average weekly wages shall be paid to the employee during the continuance of such total disability. No compensation shall be payable under this section if the employee is engaged in, or is physically capable of engaging in, at least sedentary employment.

(b) In the following cases, an injured employee is presumed to be permanently and totally disabled unless the employer or carrier establishes that the employee is physically capable of engaging in at least sedentary employment within a 50-mile radius of the employee's residence:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;

2. Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;

3. Severe brain or closed-head injury as evidenced by:

a. Severe sensory or motor disturbances;

b. Severe communication disturbances;

c. Severe complex integrated disturbances of cerebral function;

d. Severe episodic neurological disorders; or

e. Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in sub-subparagraphs a.-d.;

4. Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands; or

5. Total or industrial blindness.

In all other cases, in order to obtain permanent total disability benefits, the employee must establish that he or she is not able to engage in at least sedentary employment, within a 50-mile radius of the

employee's residence, due to his or her physical limitation. Entitlement to such benefits shall cease when the employee reaches age 75, unless the employee is not eligible for social security benefits under 42 U.S.C. s. 402 or s. 423 because the employee's compensable injury has prevented the employee from working sufficient quarters to be eligible for such benefits, notwithstanding any age limits. If the accident occurred on or after the employee reaches age 70, benefits shall be payable during the continuance of permanent total disability, not to exceed 5 years following the determination of permanent total disability. Only claimants with catastrophic injuries or claimants who are incapable of engaging in employment, as described in this paragraph, 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 she or he establishes an earning capacity, the employee shall be paid, instead of the compensation provided in paragraph (a), benefits pursuant to subsection (3). The department 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 her or his return to permanent total status in the case that such employee is unable to sustain an earning capacity.

(e) 1. The employer's or carrier's right to conduct vocational evaluations or testing by the employer's or carrier's chosen rehabilitation advisor or provider continues even after the employee has been accepted or adjudicated as entitled to compensation under this chapter and costs for such evaluations and testing shall be borne by the employer or carrier, respectively. 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 the employee and the employee's counsel, if any, at least 7 days before the date on which vocational evaluation or testing is scheduled to occur.

3. The employer or carrier may withhold payment of benefits for permanent total disability or supplements for any period during which the employee willfully fails or refuses to appear without good cause for the scheduled vocational evaluation or testing.

(f) 1. 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(11), the injured employee shall receive additional weekly compensation benefits equal to 3 percent of her or his weekly compensation rate, as established pursuant to the law in effect on the date of her or 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). These supplemental payments shall not be paid or payable after the employee attains age 62, regardless of whether the employee has applied for or is eligible to apply for social security benefits under 42 U.S.C. s. 402 or s. 423, unless the employee is not eligible for social security benefits under 42 U.S.C. s. 402 or s. 423 because the employee's compensable injury has prevented the employee from working sufficient quarters to be eligible for such benefits. These supplemental benefits shall be paid by the department 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.

2.a. The department shall provide by rule for the periodic reporting to the department 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 department 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 department in the manner prescribed by such rules.

b. The department 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) Subject to subsection (7), in case of disability total in character but temporary in quality, 662/3 or 66.67 percent of the average weekly wages shall be paid to the employee during the continuance thereof, not to exceed 104 weeks except as provided in this subsection, 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 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 her or 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; however, such benefits shall not be due or payable if the employee is eligible for, entitled to, or collecting permanent total disability benefits. The compensation provided by this paragraph is not subject to the limits provided in s. 440.12(2). 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 s. 440.491.

(d) The department shall, by rule, provide for the periodic reporting to the department, 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 she or he has reviewed, understands, and acknowledges the foregoing.

(3) PERMANENT IMPAIRMENT BENEFITS.—

(a) Once the employee has reached the date of maximum medical improvement, impairment benefits are due and payable within 14 days after the carrier has knowledge of the impairment.

(b) The three-member panel, in cooperation with the department, 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 the American Medical Association Committee for Eye Injuries; and the Minnesota Department of Labor and Industry Disability Schedules. The schedule must 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 rule of a uniform disability rating agency 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 osteopathic medicine licensed under chapters 458 and 459, a chiropractic physician licensed under chapter 460, a podiatric physician 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.

(c) All impairment income benefits shall be based on an impairment rating using the impairment schedule referred to in paragraph (b). Impairment income benefits are paid biweekly at the rate of 75 percent of the employee's average weekly temporary total disability benefit not to exceed the maximum weekly benefit under s. 440.12; provided, however, that such benefits shall be reduced by 50 percent for each week in which the employee has earned income equal to or in excess of the employee's average weekly wage. 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:

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

2. The death of the employee.

Impairment income benefits as defined by this subsection are payable only for impairment ratings for physical impairments. If objective medical findings can substantiate a permanent psychiatric impairment resulting from the accident, permanent impairment benefits are limited for the permanent psychiatric impairment to 1-percent permanent impairment.

(d) After the employee has been certified by a doctor as having reached maximum medical improvement or 6 weeks before the expiration of temporary benefits, whichever occurs earlier, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating, using the impairment schedule referred to in paragraph (b). If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation must be

submitted to the treating doctor, the employee, and the carrier within 10 days after the evaluation. The treating doctor must indicate to the carrier agreement or disagreement with the other doctor's certification and evaluation.

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

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

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

(f) The department may by rule specify forms and procedures governing the method of payment of benefits under this section.

(g) Notwithstanding paragraph (c), for accidents occurring on or after October 1, 2003, 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 for the following periods:

1. Two weeks of benefits are to be paid to the employee for each percentage point of impairment from 1 percent up to and including 10 percent.

2. For each percentage point of impairment from 11 percent up to and including 15 percent, 3 weeks of benefits are to be paid.

3. For each percentage point of impairment from 16 percent up to and including 20 percent, 4 weeks of benefits are to be paid.

4. For each percentage point of impairment from 21 percent and higher, 6 weeks of benefits are to be paid.

(4) TEMPORARY PARTIAL DISABILITY.—

(a) Subject to subsection (7), 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 postinjury, as compared weekly; however, weekly temporary partial disability benefits may not exceed an amount equal to 662/3 or 66.67 percent of the employee's average weekly wage at the time of accident. 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 postinjury, the department may by rule provide for payment of the initial installment of temporary partial disability benefits to be paid as a partial week so that payment for remaining weeks of temporary partial disability can coincide as closely as possible with the postinjury employer's work week. 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. Benefits shall be payable under this subsection only if overall maximum medical improvement has not been reached and the medical conditions resulting from the accident create restrictions on the injured employee's ability to return to work.

(b) Within 5 business days after the carrier's knowledge of the employee's release to restricted work, the carrier shall mail to the employee and employer an informational letter, adopted by department rule, explaining the employee's possible eligibility and responsibilities for temporary partial disability benefits.

(c) When an employee returns to work with the restrictions resulting from the accident and is earning wages less than 80 percent of the preinjury average weekly wage, the first installment of temporary partial disability benefits is due 7 days after the last date of the postinjury employer's first biweekly work week. Thereafter, payment for temporary partial benefits shall be paid biweekly no later than the 7th day following the last day of each biweekly work week.

(d) If the employee is unable to return to work with the restrictions resulting from the accident and is not earning wages, salary, or other remuneration, temporary partial disability benefits shall be paid no later than the last day of each biweekly period. The employee shall notify the carrier within 5 business days after returning to work. Failure to notify the carrier of the establishment of an earning capacity in the required time shall result in a suspension or nonpayment of temporary partial disability benefits until the proper notification is provided.

(e) Such benefits shall be paid during the continuance of such disability, not to exceed a period of 104 weeks, as provided by this subsection and subsection (2). Once the injured employee reaches the maximum number of weeks, temporary disability benefits cease and the injured worker's permanent impairment must be determined. If the employee is terminated from postinjury employment based on the employee's misconduct, temporary partial disability benefits are not payable as provided for in this section. The department shall by rule specify forms and procedures governing the method and time for payment of temporary disability benefits for dates of accidents before January 1, 1994, and for dates of accidents on or after January 1, 1994.

(5) SUBSEQUENT INJURY.—

(a) The fact that an employee has suffered previous disability, impairment, anomaly, or disease, or received compensation therefor, shall not preclude her or him from benefits, as specified in paragraph (b), for a subsequent aggravation or acceleration of the preexisting condition or 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 herself or 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.

(b) If a compensable injury, disability, or need for medical care, or any portion thereof, is a result of aggravation or acceleration of a preexisting condition, or is the result of merger with a preexisting condition, only the disabilities and medical treatment associated with such compensable injury shall be payable under this chapter, excluding the degree of disability or medical conditions existing at the time of the impairment rating or at the time of the accident, regardless of whether the preexisting condition

was disabling at the time of the accident or at the time of the impairment rating and without considering whether the preexisting condition would be disabling without the compensable accident. The degree of permanent impairment or disability attributable to the accident or injury shall be compensated in accordance with this section, apportioning out the preexisting condition based on the anatomical impairment rating attributable to the preexisting condition. Medical benefits shall be paid apportioning out the percentage of the need for such care attributable to the preexisting condition. As used in this paragraph, "merger" means the combining of a preexisting permanent impairment or disability with a subsequent compensable permanent impairment or disability which, when the effects of both are considered together, result in a permanent impairment or disability rating which is greater than the sum of the two permanent impairment or disability ratings when each impairment or disability is considered individually.

(6) EMPLOYEE REFUSES EMPLOYMENT.—If an injured employee refuses employment suitable to the capacity thereof, offered to or procured therefor, such employee shall not be entitled to any compensation at any time during the continuance of such refusal unless at any time in the opinion of the judge of compensation claims such refusal is justifiable. Time periods for the payment of benefits in accordance with this section shall be counted in determining the limitation of benefits as provided for in paragraphs (2)(a), (3)(c), and 1(4)(b).

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

temporary partial disability shall cease until such affidavit is made and furnished. If the employee leaves her or his employment while receiving temporary partial benefits without just cause as determined by the judge of compensation claims, temporary partial benefits shall be payable based on the deemed earnings of the employee as if she or he had remained employed.

(8) EMPLOYEE BECOMES INMATE OF INSTITUTION.—In case an employee becomes an inmate of a public institution, then no compensation shall be payable unless she or he has dependent upon her or 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 she or he remains such inmate.

(9) 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 her or 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. The department may by rule specify forms and procedures governing the method for calculating and administering the offset of benefits payable under this chapter and benefits payable under 42 U.S.C. ss.

402 and 423. The department shall have first priority in taking any available social security offsets on dates of accidents occurring before July 1, 1984.

(c) Disability compensation benefits payable for any week, including those benefits provided by paragraph (1)(f), may not 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 department, the employer, or the carrier, authorize the Social Security Administration to release disability information relating to her or him and authorize the Department of Economic Opportunity to release reemployment assistance information relating to her or him, in accordance with rules to be adopted by the department prescribing the procedure and manner for requesting the authorization and for compliance by the employee. The department or the employer or carrier may not make any payment of benefits for total disability or those additional benefits provided by paragraph (1)(f) 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 is effective for a period not to exceed 12 months and such authority may be renewed, as the department prescribes by rule.

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

(10) EMPLOYEE ELIGIBLE FOR BENEFITS UNDER THIS CHAPTER WHO HAS RECEIVED OR IS ENTITLED TO RECEIVE REEMPLOYMENT ASSISTANCE.—

(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, reemployment assistance or unemployment compensation benefits.

(b) If an employee is entitled to temporary partial benefits pursuant to subsection (4) and reemployment assistance or unemployment compensation benefits, such reemployment assistance or 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.

(11) 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.

(12) REPAYMENT.—If an employee has received a sum as an indemnity benefit under any classification or category of benefit under this chapter to which she or 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 biweekly payment.

440.151 Occupational diseases.—

(1) (a) Where the employer and employee are subject to the provisions of the Workers' Compensation Law, the disablement or death of an employee resulting from an occupational disease as hereinafter defined shall be treated as the happening of an injury by accident, notwithstanding any other provisions of this chapter, and the employee or, in case of death, the employee's dependents shall be entitled to compensation as provided by this chapter, except as hereinafter otherwise provided; and the practice and procedure prescribed by this chapter shall apply to all proceedings under this section, except as hereinafter otherwise provided. Provided, however, that in no case shall an employer be liable for compensation under the provisions of this section unless such disease has resulted from the nature of the employment in which the employee was engaged under such employer, was actually contracted while so engaged, and the nature of the employment was the major contributing cause of the disease. Major contributing cause must be shown by medical evidence only, as demonstrated by physical

examination findings and diagnostic testing. “Nature of the employment” means that in the occupation in which the employee was so engaged there is attached a particular hazard of such disease that distinguishes it from the usual run of occupations, or the incidence of such disease is substantially higher in the occupation in which the employee was so engaged than in the usual run of occupations. In claims for death under s. 440.16, death must occur within 350 weeks after last exposure. Both causation and sufficient exposure to a specific harmful substance shown to be present in the workplace to support causation shall be proven by clear and convincing evidence.

(b) No compensation shall be payable for an occupational disease if the employee, at the time of entering into the employment of the employer by whom the compensation would otherwise be payable, falsely represents herself or himself in writing as not having previously been disabled, laid off or compensated in damages or otherwise, because of such disease.

(c) Where an occupational disease is aggravated by any other disease or infirmity, not itself compensable, or where disability or death from any other cause, not itself compensable, is aggravated, prolonged, accelerated or in anywise contributed to by an occupational disease, the compensation shall be payable only if the occupational disease is the major contributing cause of the injury. Any compensation shall be reduced and limited to such proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death as such occupational disease, as a causative factor, bears to all the causes of such disability or death, such reduction in compensation to be effected by reducing the number of weekly or monthly payments or the amounts of such payments, as under the circumstances of the particular case may be for the best interest of the claimant or claimants. Major contributing cause must be demonstrated by medical evidence based on physical examination findings and diagnostic testing.

(d) No compensation for death from an occupational disease shall be payable to any person whose relationship to the deceased, which under the provisions of this Workers’ Compensation Law would give right to compensation, arose subsequent to the beginning of the first compensable disability, save only to afterborn children of a marriage existing at the beginning of such disability.

(e) No compensation shall be payable for disability or death resulting from tuberculosis arising out of and in the course of employment by the Department of Health at a state tuberculosis hospital, or

aggravated by such employment, when the employee had suffered from said disease at any time prior to the commencement of such employment.

(2) Whenever used in this section the term "occupational disease" shall be construed to mean only a disease which is due to causes and conditions which are characteristic of and peculiar to a particular trade, occupation, process, or employment, and to exclude all ordinary diseases of life to which the general public is exposed, unless the incidence of the disease is substantially higher in the particular trade, occupation, process, or employment than for the general public. "Occupational disease" means only a disease for which there are epidemiological studies showing that exposure to the specific substance involved, at the levels to which the employee was exposed, may cause the precise disease sustained by the employee.

(3) Except as otherwise provided in this section, "disablement" means disability as described in s. 440.02(13).

(4) This section shall not apply to cases of occupational disease in which the last injurious exposure to the hazards of such disease occurred before this section shall have taken effect.

(5) Where compensation is payable for an occupational disease, the employer in whose employment the employee was last injuriously exposed to the hazards of such disease, and the insurance carrier, if any, on the risk when such employee was last so exposed under such employer, shall alone be liable therefor, without right to contribution from any prior employer or insurance carrier; and the notice of injury and claim for compensation, as hereinafter required, shall be given and made to such employer; provided, however, that in case of disability from any dust disease the only employer and insurance carrier liable shall be the last employer in whose employment the employee was last injuriously exposed to the hazards of the disease for a period of at least 60 days.

(6) The time for notice of injury or death provided in s. 440.185(1) shall be extended in cases of occupational diseases to a period of 90 days.

440.16 Compensation for death.—

(1) If death results from the accident within 1 year thereafter or follows continuous disability and results from the accident within 5 years thereafter, the employer shall pay:

(a) Within 14 days after receiving the bill, actual funeral expenses not to exceed $7,500.

(b) Compensation, in addition to the above, in the following percentages of the average weekly wages to the following persons entitled thereto on account of dependency upon the deceased, and in the following order of preference, subject to the limitation provided in subparagraph 2., but such compensation shall be subject to the limits provided in s. 440.12(2), shall not exceed $150,000, and may be less than, but shall not exceed, for all dependents or persons entitled to compensation, 662/3 or 66.67 percent of the average wage:

1. To the spouse, if there is no child, 50 percent of the average weekly wage, such compensation to cease upon the spouse's death.

2. To the spouse, if there is a child or children, the compensation payable under subparagraph 1. and, in addition, 162/3 percent on account of the child or children. However, when the deceased is survived by a spouse and also a child or children, whether such child or children are the product of the union existing at the time of death or of a former marriage or marriages, the judge of compensation claims may provide for the payment of compensation in such manner as may appear to the judge of compensation claims just and proper and for the best interests of the respective parties and, in so doing, may provide for the entire compensation to be paid exclusively to the child or children; and, in the case of death of such spouse, 331/3 percent for each child. However, upon the surviving spouse's remarriage, the spouse shall be entitled to a lump-sum payment equal to 26 weeks of compensation at the rate of 50 percent of the average weekly wage as provided in s. 440.12(2), unless the $150,000 limit provided in this paragraph is exceeded, in which case the surviving spouse shall receive a lump-sum payment equal to the remaining available benefits in lieu of any further indemnity benefits. In no case shall a surviving spouse's acceptance of a lump-sum payment affect payment of death benefits to other dependents.

3. To the child or children, if there is no spouse, 331/3 percent for each child.

4. To the parents, 25 percent to each, such compensation to be paid during the continuance of dependency.

5. To the brothers, sisters, and grandchildren, 15 percent for each brother, sister, or grandchild.

(c) To the surviving spouse, payment of postsecondary student fees for instruction at any career center established under s. 1001.44 for up to 1,800 classroom hours or payment of student fees at any community college established under part III of chapter 1004 for up to 80 semester hours. The spouse of a deceased state employee shall be entitled to a full waiver of such fees as provided in ss. 1009.22 and 1009.23 in lieu of the payment of such fees. The benefits provided for in this paragraph shall be in addition to other benefits provided for in this section and shall terminate 7 years after the death of the deceased employee, or when the total payment in eligible compensation under paragraph (b) has been received. To qualify for the educational benefit under this paragraph, the spouse shall be required to meet and maintain the regular admission requirements of, and be registered at, such career center or community college, and make satisfactory academic progress as defined by the educational institution in which the student is enrolled.

(2) The dependence of a child, except a child physically or mentally incapacitated from earning a livelihood, shall terminate with the attainment of 18 years of age, with the attainment of 22 years of age if a full-time student in an accredited educational institution, or upon marriage.

(3) Where, because of the limitation in paragraph (1)(b), a person or class of persons cannot receive the percentage of compensation specified as payable to or on account of such person or class, there shall be available to such person or class that proportion of such percentage as, when added to the total percentage payable to all persons having priority of preference, will not exceed a total of said 662/3 or 66.67 percent, which proportion shall be paid:

(a) To such person; or

(b) To such class, share and share alike, unless the judge of compensation claims determines otherwise in accordance with the provisions of subsection (4).

(4) If the judge of compensation claims determines that payments in accordance with paragraph (3)(b) would provide no substantial benefit to any person of such class, the judge of compensation claims

may provide for the payment of such compensation to the person or persons within such class who the judge of compensation claims considers will be most benefited by such payment.

(5) Upon the cessation of compensation under this section to any person, the compensation of the remaining persons entitled to compensation, for the unexpired part of the period during which their compensation is payable, shall be that which such persons would have received if they had been the only persons entitled to compensation at the time of the decedent's death.

(6) Relationship to the deceased giving right to compensation under the provisions of this section must have existed at the time of the accident, save only in the case of afterborn children of the deceased.

440.17 Guardian for minor or incompetent.—Prior to the filing of a claim, the department, and after the filing of a claim, a judge of compensation claims, may require the appointment by a court of competent jurisdiction, for any person who is mentally incompetent or a minor, of a guardian or other representative to receive compensation payable to such person under this chapter and to exercise the powers granted to or to perform the duties required of such person under this chapter; however, the judge of compensation claims, in the judge of compensation claims' discretion, may designate in the compensation award a person to whom payment of compensation may be paid for a minor or incompetent, in which event payment to such designated person shall discharge all liability for such compensation.

440.185 Notice of injury or death; reports; penalties for violations.—

(1) An employee who suffers an injury arising out of and in the course of employment shall advise his or her employer of the injury within 30 days after the date of or initial manifestation of the injury. Failure to so advise the employer shall bar a petition under this chapter unless:

(a) The employer or the employer's agent had actual knowledge of the injury;

(b) The cause of the injury could not be identified without a medical opinion and the employee advised the employer within 30 days after obtaining a medical opinion indicating that the injury arose out of and in the course of employment;

(c) The employer did not put its employees on notice of the requirements of this section by posting notice pursuant to s. 440.055; or

(d) Exceptional circumstances, outside the scope of paragraph (a) or paragraph (b) justify such failure.

In the event of death arising out of and in the course of employment, the requirements of this subsection shall be satisfied by the employee's agent or estate. Documents prepared by counsel in connection with litigation, including but not limited to notices of appearance, petitions, motions, or complaints, shall not constitute notice for purposes of this section.

(2) Within 7 days after actual knowledge of injury or death, the employer shall report such injury or death to its carrier, in a format prescribed by the department, and shall provide a copy of such report to the employee or the employee's estate. The report of injury shall contain the following information:

(a) The name, address, and business of the employer;

(b) The name, social security number, street, mailing address, telephone number, and occupation of the employee;

(c) The cause and nature of the injury or death;

(d) The year, month, day, and hour when, and the particular locality where, the injury or death occurred; and

(e) Such other information as the department may require.

The carrier shall, within 14 days after the employer's receipt of the form reporting the injury, file the information required by this subsection with the department. However, the department may by rule

provide for a different reporting system for those types of injuries which it determines should be reported in a different manner and for those cases which involve minor injuries requiring professional medical attention in which the employee does not lose more than 7 days of work as a result of the injury and is able to return to the job immediately after treatment and resume regular work.

(3) In addition to the requirements of subsection (2), the employer shall notify the department within 24 hours by telephone or telegraph of any injury resulting in death. However, this special notice shall not be required when death results subsequent to the submission to the department of a previous report of the injury pursuant to subsection (2).

(4) Within 3 days after the employer or the employee informs the carrier of an injury the carrier shall mail to the injured worker an informational brochure approved by the department which sets forth in clear and understandable language an explanation of the rights, benefits, procedures for obtaining benefits and assistance, criminal penalties, and obligations of injured workers and their employers under the Florida Workers' Compensation Law. Annually, the carrier or its third-party administrator shall mail to the employer an informational brochure approved by the department which sets forth in clear and understandable language an explanation of the rights, benefits, procedures for obtaining benefits and assistance, criminal penalties, and obligations of injured workers and their employers under the Florida Workers' Compensation Law. All such informational brochures shall contain a notice that clearly states in substance the following: "Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits a felony of the third degree."

(5) Additional reports with respect to such injury and of the condition of such employee, including copies of medical reports, funeral expenses, and wage statements, shall be filed by the employer or carrier to the department at such times and in such manner as the department may prescribe by rule. In carrying out its responsibilities under this chapter, the department or agency may by rule provide for the obtaining of any medical records relating to medical treatment provided pursuant to this chapter, notwithstanding the provisions of ss. 90.503 and 395.3025(4).

(6) In the absence of a stipulation by the parties, reports provided for in subsection (2), subsection (4), or subsection (5) shall not be evidence of any fact stated in such report in any proceeding relating thereto, except for medical reports which, if otherwise qualified, may be admitted at the discretion of the judge of compensation claims.

(7) Every carrier shall file with the department within 21 days after the issuance of a policy or contract of insurance such policy information as the department requires, including notice of whether the policy is a minimum premium policy. Notice of cancellation or expiration of a policy as set out in s. 440.42(3) shall be mailed to the department in accordance with rules adopted by the department under chapter 120. The department may contract with a private entity for the collection of policy information required to be filed by carriers under this subsection and the receipt of notices of cancellation or expiration of a policy required to be filed by carriers under s. 440.42(3). The submission of policy information or notices of cancellation or expiration to the contracted private entity satisfies the filing requirements of this subsection and s. 440.42(3).

(8) When a claimant, employer, or carrier has the right, or is required, to mail a report or notice with required copies within the times prescribed in subsection (2), subsection (4), or subsection (5), such mailing will be completed and in compliance with this section if it is postmarked and mailed prepaid to the appropriate recipient prior to the expiration of the time periods prescribed in this section.

(9) Any employer or carrier who fails or refuses to timely send any form, report, or notice required by this section shall be subject to an administrative fine by the department not to exceed $500 for each such failure or refusal. However, any employer who fails to notify the carrier of an injury on the prescribed form or by letter within the 7 days required in subsection (2) shall be liable for the administrative fine, which shall be paid by the employer and not the carrier. Failure by the employer to meet its obligations under subsection (2) shall not relieve the carrier from liability for the administrative fine if it fails to comply with subsections (4) and (5).

(10) The department may by rule prescribe forms and procedures governing the submission of the change in claims administration report and the risk class code and standard industry code report for all lost time and denied lost-time cases. The department may by rule define terms that are necessary for the effective administration of this section.

(11) Upon receiving notice of an injury from an employee under subsection (1), the employer or carrier shall provide the employee with a written notice, in the form and manner determined by the department by rule, of the availability of services from the Employee Assistance and Ombudsman Office. The substance of the notice to the employee shall include:

(a) A description of the scope of services provided by the office.

(b) A listing of the toll-free telephone number of, the e-mail address, and the postal address of the office.

(c) A statement that the informational brochure referred to in subsection (4) will be mailed to the employee within 3 days after the carrier receives notice of the injury.

(d) Any other information regarding access to assistance that the department finds is immediately necessary for an injured employee.

440.19 Time bars to filing petitions for benefits.—

(1) Except to the extent provided elsewhere in this section, all employee petitions for benefits under this chapter shall be barred unless the employee, or the employee's estate if the employee is deceased, has advised the employer of the injury or death pursuant to s. 440.185(1) and the petition is filed within 2 years after the date on which the employee knew or should have known that the injury or death arose out of work performed in the course and scope of employment.

(2) Payment of any indemnity benefit or the furnishing of remedial treatment, care, or attendance pursuant to either a notice of injury or a petition for benefits shall toll the limitations period set forth above for 1 year from the date of such payment. This tolling period does not apply to the issues of compensability, date of maximum medical improvement, or permanent impairment.

(3) The filing of a petition for benefits does not toll the limitations period set forth in this section unless the petition meets the specificity requirements set forth in s. 440.192.

(4) Notwithstanding the provisions of this section, the failure to file a petition for benefits within the periods prescribed is not a bar to the employee's claim unless the carrier advances the defense of a statute of limitations in its initial response to the petition for benefits. If a claimant contends that an

employer or its carrier is estopped from raising a statute of limitations defense and the carrier demonstrates that it has provided notice to the employee in accordance with s. 440.185 and that the employer has posted notice in accordance with s. 440.055, the employee must demonstrate estoppel by clear and convincing evidence.

(5) If a person who is entitled to compensation under this chapter is mentally incompetent or a minor, the limitations period is tolled while that person has no guardian or other authorized representative, but the period shall begin to run from the date of appointment of such guardian or other representative, or in the case of a minor, if no guardian is appointed before the minor becomes of age, from the date the minor becomes of age.

(6) When recovery is denied to any person in a suit brought at law or in admiralty to recover damages for injury or death on the ground that such person was an employee, that the defendant was an employer within the meaning of this chapter, and that such employer had secured compensation of such employee under this chapter, the limitations period set forth in this section shall begin to run from the date of termination of such suit; however, in such an event, the employer is allowed a credit of his or her actual cost of defending such suit in an amount not to exceed $250, which amount must be deducted from any compensation allowed or awarded to the employee under this chapter.

440.191 Employee Assistance and Ombudsman Office.—

(1) (a) In order to effect the self-executing features of the Workers' Compensation Law, this chapter shall be construed to permit injured employees and employers or the employer's carrier to resolve disagreements without undue expense, costly litigation, or delay in the provisions of benefits. It is the duty of all who participate in the workers' compensation system, including, but not limited to, carriers, service providers, health care providers, attorneys, employers, managed care arrangements, and employees, to attempt to resolve disagreements in good faith and to cooperate with the department's efforts to resolve disagreements between the parties. The department may by rule prescribe definitions that are necessary for the effective administration of this section.

(b) An Employee Assistance and Ombudsman Office is created within the department to inform and assist injured workers, employers, carriers, health care providers, and managed care arrangements in fulfilling their responsibilities under this chapter. The department may by rule specify forms and procedures for administering this section.

(c) The Employee Assistance and Ombudsman Office shall be a resource available to all employees who participate in the workers' compensation system and shall take all steps necessary to educate and disseminate information to employees and employers. Upon receiving a notice of injury or death, the Employee Assistance and Ombudsman Office may initiate contact with the injured employee or employee's representative to discuss rights and responsibilities of the employee under this chapter and the services available through the Employee Assistance and Ombudsman Office.

(2) (a) If at any time the employer or its carrier fails to provide benefits to which the employee believes she or he is entitled, the employee shall contact the office to request assistance in resolving the dispute. The office may review a petition for benefits filed under s. 440.192 and may attempt to facilitate an agreement between the employee and the employer or carrier. The employee, the employer, and the carrier shall cooperate with the office and shall timely provide the office with any documents or other information that it may require in connection with its efforts under this section.

(b) The office may compel parties to attend conferences in person or by telephone in an attempt to resolve disputes quickly and in the most efficient manner possible. Settlement agreements resulting from such conferences must be submitted to the Office of the Judges of Compensation Claims for approval.

(c) The Employee Assistance and Ombudsman Office may assign an ombudsman to assist the employee in resolving the dispute. The ombudsman may, at the employee's request, assist the employee in drafting a petition for benefits and explain the procedures for filing petitions. The Employee Assistance and Ombudsman Office may not represent employees before the judges of compensation claims. An employer or carrier may not pay any attorneys' fees on behalf of the employee for services rendered or costs incurred in connection with this section, unless expressly authorized elsewhere in this chapter.

440.192 Procedure for resolving benefit disputes.—

(1) Any employee may, for any benefit that is ripe, due, and owing, file with the Office of the Judges of Compensation Claims a petition for benefits which meets the requirements of this section and the definition of specificity in s. 440.02. An employee represented by an attorney shall file by electronic means approved by the Deputy Chief Judge. An employee not represented by an attorney may file by certified mail or by electronic means approved by the Deputy Chief Judge. The department shall inform employees of the location of the Office of the Judges of Compensation Claims and the office's website address for purposes of filing a petition for benefits. The employee shall also serve copies of the petition for benefits by certified mail, or by electronic means approved by the Deputy Chief Judge, upon the employer and the employer's carrier. The Deputy Chief Judge shall refer the petitions to the judges of compensation claims.

(2) Upon receipt, the Office of the Judges of Compensation Claims shall review each petition and shall dismiss each petition or any portion of such a petition that does not on its face specifically identify or itemize the following:

(a) Name, address, telephone number, and social security number of the employee.

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

(c) A detailed description of the injury and cause of the injury, including the location of the occurrence and the date or dates of the accident.

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

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

(f) Date of maximum medical improvement, character of disability, and specific statement of all benefits or compensation that the employee is seeking.

(g) All specific travel costs to which the employee believes she or he is entitled, including dates of travel and purpose of travel, means of transportation, and mileage and including the date the request for mileage was filed with the carrier and a copy of the request filed with the carrier.

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

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

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

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

(3) A petition for benefits may contain a claim for past benefits and continuing benefits in any benefit category, but is limited to those in default and ripe, due, and owing on the date the petition is filed. If the employer has elected to satisfy its obligation to provide medical treatment, care, and attendance through a managed care arrangement designated under this chapter, the employee must exhaust all managed care grievance procedures before filing a petition for benefits under this section.

(4) The petition must include a certification by the claimant or, if the claimant is represented by counsel, the claimant's attorney, stating that the claimant, or attorney if the claimant is represented by counsel, has made a good faith effort to resolve the dispute and that the claimant or attorney was unable to resolve the dispute with the carrier.

(5) All motions to dismiss must state with particularity the basis for the motion. The judge of compensation claims shall enter an order upon such motions without hearing, unless good cause for hearing is shown. When any petition or portion of a petition is dismissed for lack of specificity under this subsection, the claimant must be allowed 20 days after the date of the order of dismissal in which to file an amended petition. Any grounds for dismissal for lack of specificity under this section which are not asserted within 30 days after receipt of the petition for benefits are thereby waived.

(6) If the claimant is not represented by counsel, the Office of the Judges of Compensation Claims may request the Employee Assistance and Ombudsman Office to assist the claimant in filing a petition that meets the requirements of this section.

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

(8) Within 14 days after receipt of a petition for benefits by certified mail or by approved electronic means, the carrier must either pay the requested benefits without prejudice to its right to deny within 120 days from receipt of the petition or file a response to petition with the Office of the Judges of Compensation Claims. The response shall be filed by electronic means approved by the Deputy Chief Judge. The carrier must list all benefits requested but not paid and explain its justification for nonpayment in the response to petition. A carrier that does not deny compensability in accordance with s. 440.20(4) is deemed to have accepted the employee's injuries as compensable, unless it can establish material facts relevant to the issue of compensability that could not have been discovered through reasonable investigation within the 120-day period. The carrier shall provide copies of the response to the filing party, employer, and claimant by certified mail or by electronic means approved by the Deputy Chief Judge.

(9) A petition for benefits must contain claims for all benefits that are ripe, due, and owing on the date the petition is filed. Unless stipulated in writing by the parties, only claims which have been properly raised in a petition for benefits and have undergone mediation may be considered for adjudication by a judge of compensation claims.

440.1926 Alternate dispute resolution; claim arbitration.—Notwithstanding any other provision of this chapter, the employer, carrier, and employee may mutually agree to seek consent from a judge of compensation claims to enter into binding claim arbitration in lieu of any other remedy provided for in this chapter to resolve all issues in dispute regarding an injury. Arbitrations agreed to pursuant to this section shall be governed by chapter 682, the Revised Florida Arbitration Code, except that, notwithstanding any provision in chapter 682, the term "court" shall mean a judge of compensation claims. An arbitration award in accordance with this section is enforceable in the same manner and with the same powers as any final compensation order.

440.20 Time for payment of compensation and medical bills; penalties for late payment.—

(1) (a) Unless the carrier denies compensability or entitlement to benefits, the carrier shall pay compensation directly to the employee as required by ss. 440.14, 440.15, and 440.16, in accordance with those sections. Upon receipt of the employee's authorization as provided for in s. 440.12(1)(a), the carrier's obligation to pay compensation directly to the employee is satisfied when the carrier directly deposits, by electronic transfer or other means, compensation into the employee's account at a financial institution as defined in s. 655.005 or onto a prepaid card in accordance with s. 440.12(1). Compensation by direct deposit or through the use of a prepaid card is considered paid on the date the funds become available for withdrawal by the employee.

(b) Notwithstanding any other provision of this chapter, all insurance carriers, group self-insurance funds, assessable mutual insurers, and the Joint Underwriting Association authorized to write workers' compensation insurance in this state shall make available a notice in writing to the employer the fact that a state-authorized deductible plan is available. Under this plan, an employer may pay, for each injury for which an employee files a claim under this chapter as a deductible, up to the first $2,500 of the total amount payable under compensable claims related to such injury. An employer shall not be reimbursed for any amount paid under this paragraph; however, the reporting requirements of the employer, relating to injuries required under any provision under this chapter, are not altered or alleviated. The rate base of any workers' compensation insurance offered pursuant to this chapter shall include the deductible provision authorized by this paragraph. Any amounts paid by an employer pursuant to this paragraph shall not apply in any way to such employer's experience rating for injury.

(2) (a) The carrier must pay the first installment of compensation for total disability or death benefits or deny compensability no later than the 14th calendar day after the employer receives notification of the injury or death, when disability is immediate and continuous for 8 calendar days or more after the injury. If the first 7 days after disability are nonconsecutive or delayed, the first installment of compensation is due on the 6th day after the first 8 calendar days of disability. The carrier shall thereafter pay compensation in biweekly installments or as otherwise provided in s. 440.15, unless the judge of compensation claims determines or the parties agree that an alternate installment schedule is in the best interests of the employee.

(b) The carrier must pay, disallow, or deny all medical, dental, pharmacy, and hospital bills submitted to the carrier in accordance with department rule no later than 45 calendar days after the carrier's receipt of the bill.

(3) Upon making initial payment of indemnity benefits, or upon suspension or cessation of payment for any reason, the carrier shall immediately notify the injured employee, the employer, and the department that it has commenced, suspended, or ceased payment of compensation. The department may require such notification to the injured employee, employer, and the department in a format and manner it deems necessary to obtain accurate and timely notification.

(4) If the carrier is uncertain of its obligation to provide all benefits or compensation, the carrier shall immediately and in good faith commence investigation of the employee's entitlement to benefits under this chapter and shall admit or deny compensability within 120 days after the initial provision of compensation or benefits as required under subsection (2) or s. 440.192(8). Additionally, the carrier shall initiate payment and continue the provision of all benefits and compensation as if the claim had been accepted as compensable, without prejudice and without admitting liability. Upon commencement of payment as required under subsection (2) or s. 440.192(8), the carrier shall provide written notice to the employee that it has elected to pay the claim pending further investigation, and that it will advise the employee of claim acceptance or denial within 120 days. A carrier that fails to deny compensability within 120 days after the initial provision of benefits or payment of compensation as required under subsection (2) or s. 440.192(8) waives the right to deny compensability, unless the carrier can establish material facts relevant to the issue of compensability that it could not have discovered through reasonable investigation within the 120-day period. The initial provision of compensation or benefits, for purposes of this subsection, means the first installment of compensation or benefits to be paid by the carrier under subsection (2) or pursuant to a petition for benefits under s. 440.192(8).

(5) If the employer has advanced compensation payments or benefits to the employee, the carrier shall reimburse the employer for the advanced payments if the employee is entitled to compensation and benefits pursuant to this chapter. The carrier may deduct such reimbursements from the employee's compensation installments or, if applicable, from payments to the employee ordered by a judge of compensation claims.

(6) (a) If any installment of compensation for death or dependency benefits, or compensation for disability benefits payable without an award is not paid within 7 days after it becomes due, as provided in subsection (2), subsection (3), or subsection (4), there shall be added to such unpaid installment a penalty of an amount equal to 20 percent of the unpaid installment, which shall be paid at the same time as, but in addition to, such installment of compensation. This penalty shall not apply for late payments resulting from conditions over which the employer or carrier had no control. When any installment of compensation payable without an award has not been paid within 7 days after it became due and the claimant concludes the prosecution of the claim before a judge of compensation claims without having specifically claimed additional compensation in the nature of a penalty under this section, the claimant will be deemed to have acknowledged that, owing to conditions over which the employer or carrier had no control, such installment could not be paid within the period prescribed for payment and to have waived the right to claim such penalty. However, during the course of a hearing, the judge of compensation claims shall on her or his own motion raise the question of whether such penalty should be awarded or excused. The department may assess without a hearing the penalty against either the employer or the carrier, depending upon who was at fault in causing the delay. The insurance policy cannot provide that this sum will be paid by the carrier if the department or the judge of compensation claims determines that the penalty should be paid by the employer rather than the carrier. Any additional installment of compensation paid by the carrier pursuant to this section shall be paid directly to the employee by check or, if authorized by the employee, by direct deposit into the employee's account at a financial institution.

(b) For medical services provided on or after January 1, 2004, the department shall require that all medical, hospital, pharmacy, or dental bills properly submitted by the provider, except for bills that are disallowed or denied by the carrier or its authorized vendor in accordance with department rule, are timely paid within 45 calendar days after the carrier's receipt of the bill. The department shall impose penalties for late payments or disallowances or denials of medical, hospital, pharmacy, or dental bills that are below a minimum 95 percent timely performance standard. The carrier shall pay to the Workers' Compensation Administration Trust Fund a penalty of:

1. Twenty-five dollars for each bill below the 95 percent timely performance standard, but meeting a 90 percent timely standard.

2. Fifty dollars for each bill below a 90 percent timely performance standard.

(7) If any compensation, payable under the terms of an award, is not paid within 7 days after it becomes due, there shall be added to such unpaid compensation an amount equal to 20 percent thereof, which shall be paid at the same time as, but in addition to, such compensation, unless review of the compensation order making such award is had as provided in s. 440.25.

(8) (a) In addition to any other penalties provided by this chapter for late payment, if any installment of compensation is not paid when it becomes due, the employer, carrier, or servicing agent shall pay interest thereon at the rate of 12 percent per year from the date the installment becomes due until it is paid, whether such installment is payable without an order or under the terms of an order. The interest payment shall be the greater of the amount of interest due or $5.

(b) In order to ensure carrier compliance under this chapter, the department shall monitor, audit, and investigate the performance of carriers. The department shall require that all compensation benefits be timely paid in accordance with this section. The department shall impose penalties for late payments of compensation that are below a minimum 95-percent timely payment performance standard. The carrier shall pay to the Workers' Compensation Administration Trust Fund a penalty of:

1. Fifty dollars per number of installments of compensation below the 95-percent timely payment performance standard and equal to or greater than a 90-percent timely payment performance standard.

2. One hundred dollars per number of installments of compensation below a 90-percent timely payment performance standard.

This section does not affect the imposition of any penalties or interest due to the claimant. If a carrier contracts with a servicing agent to fulfill its administrative responsibilities under this chapter, the payment practices of the servicing agent are deemed the payment practices of the carrier for the purpose of assessing penalties against the carrier.

(9) The department may upon its own initiative at any time in a case in which payments are being made without an award investigate same and shall, in any case in which the right to compensation is controverted, or in which payments of compensation have been stopped or suspended, upon receipt of

notice from any person entitled to compensation or from the employer that the right to compensation is controverted or that payments of compensation have been stopped or suspended, make such investigations, cause such medical examination to be made, or hold such hearings, and take such further action as it considers will properly protect the rights of all parties.

(10) Whenever the department deems it advisable, it may require any employer to make a deposit with the Chief Financial Officer to secure the prompt and convenient payments of such compensation; and payments therefrom upon any awards shall be made upon order of the department or judge of compensation claims.

(11) (a) When a claimant is not represented by counsel, upon joint petition of all interested parties, a lump-sum payment in exchange for the employer's or carrier's release from liability for future medical expenses, as well as future payments of compensation expenses and any other benefits provided under this chapter, shall be allowed at any time in any case in which the employer or carrier has filed a written notice of denial within 120 days after the employer receives notice of the injury, and the judge of compensation claims at a hearing to consider the settlement proposal finds a justiciable controversy as to legal or medical compensability of the claimed injury or the alleged accident. The employer or carrier may not pay any attorney's fees on behalf of the claimant for any settlement under this section unless expressly authorized elsewhere in this chapter. Upon the joint petition of all interested parties and after giving due consideration to the interests of all interested parties, the judge of compensation claims may enter a compensation order approving and authorizing the discharge of the liability of the employer for compensation and remedial treatment, care, and attendance, as well as rehabilitation expenses, by the payment of a lump sum. Such a compensation order so entered upon joint petition of all interested parties is not subject to modification or review under s. 440.28. If the settlement proposal together with supporting evidence is not approved by the judge of compensation claims, it shall be considered void. Upon approval of a lump-sum settlement under this subsection, the judge of compensation claims shall send a report to the Chief Judge of the amount of the settlement and a statement of the nature of the controversy. The Chief Judge shall keep a record of all such reports filed by each judge of compensation claims and shall submit to the Legislature a summary of all such reports filed under this subsection annually by September 15.

(b) When a claimant is not represented by counsel, upon joint petition of all interested parties, a lump-sum payment in exchange for the employer's or carrier's release from liability for future medical expenses, as well as future payments of compensation and rehabilitation expenses, and any other benefits provided under this chapter, may be allowed at any time in any case after the injured employee has attained maximum medical improvement. An employer or carrier may not pay any attorney's fees on behalf of the claimant for any settlement, unless expressly authorized elsewhere in this chapter. A compensation order so entered upon joint petition of all interested parties shall not be subject to modification or review under s. 440.28. However, a judge of compensation claims is not required to approve any award for lump-sum payment when it is determined by the judge of compensation claims that the payment being made is in excess of the value of benefits the claimant would be entitled to under this chapter. The judge of compensation claims shall make or cause to be made such investigations as she or he considers necessary, in each case in which the parties have stipulated that a proposed final settlement of liability of the employer for compensation shall not be subject to modification or review under s. 440.28, to determine whether such final disposition will definitely aid the rehabilitation of the injured worker or otherwise is clearly for the best interests of the person entitled to compensation and, in her or his discretion, may have an investigation made. The joint petition and the report of any investigation so made will be deemed a part of the proceeding. An employer shall have the right to appear at any hearing pursuant to this subsection which relates to the discharge of such employer's liability and to present testimony at such hearing. The carrier shall provide reasonable notice to the employer of the time and date of any such hearing and inform the employer of her or his rights to appear and testify. The probability of the death of the injured employee or other person entitled to compensation before the expiration of the period during which such person is entitled to compensation shall, in the absence of special circumstances making such course improper, be determined in accordance with the most recent United States Life Tables published by the National Office of Vital Statistics of the United States Department of Health and Human Services. The probability of the happening of any other contingency affecting the amount or duration of the compensation, except the possibility of the remarriage of a surviving spouse, shall be disregarded. As a condition of approving a lump-sum payment to a surviving spouse, the judge of compensation claims,

in the judge of compensation claims' discretion, may require security which will ensure that, in the event of the remarriage of such surviving spouse, any unaccrued future payments so paid may be recovered or recouped by the employer or carrier. Such applications shall be considered and determined in accordance with s. 440.25.

(c) Notwithstanding s. 440.21(2), when a claimant is represented by counsel, the claimant may waive all rights to any and all benefits under this chapter by entering into a settlement agreement releasing the employer and the carrier from liability for workers' compensation benefits in exchange for a lump-sum payment to the claimant. The settlement agreement requires approval by the judge of compensation claims only as to the attorney's fees paid to the claimant's attorney by the claimant. The parties need not submit any information or documentation in support of the settlement, except as needed to justify the amount of the attorney's fees. Neither the employer nor the carrier is responsible for any attorney's fees relating to the settlement and release of claims under this section. Payment of the lump-sum settlement amount must be made within 14 days after the date the judge of compensation claims mails the order approving the attorney's fees. Any order entered by a judge of compensation claims approving the attorney's fees as set out in the settlement under this subsection is not considered to be an award and is not subject to modification or review. The judge of compensation claims shall report these settlements to the Deputy Chief Judge in accordance with the requirements set forth in paragraphs (a) and (b). Settlements entered into under this subsection are valid and apply to all dates of accident.

(d) 1. With respect to any lump-sum settlement under this subsection, a judge of compensation claims must consider at the time of the settlement, whether the settlement allocation provides for the appropriate recovery of child support arrearages. An employer or carrier does not have a duty to investigate or collect information regarding child support arrearages.

2. When reviewing any settlement of lump-sum payment pursuant to this subsection, judges of compensation claims shall consider the interests of the worker and the worker's family when approving the settlement, which must consider and provide for appropriate recovery of past due support.

3. With respect to any lump-sum settlement under this subsection, any correspondence to a clerk of the circuit court of this state regarding child support documentation shall be exempt from any fees or costs ordinarily assessed by the clerk's office.

(e) This section applies to all claims that the parties have not previously settled, regardless of the date of accident.

(12) (a) Liability of an employer for future payments of compensation may not be discharged by advance payment unless prior approval of a judge of compensation claims has been obtained as hereinafter provided. The approval shall not constitute an adjudication of the claimant's percentage of disability.

(b) When the claimant has reached maximum recovery and returned to her or his former or equivalent employment with no substantial reduction in wages, such approval of a reasonable advance payment of a part of the compensation payable to the claimant may be given informally by letter by a judge of compensation claims.

(c) In the event the claimant has not returned to the same or equivalent employment with no substantial reduction in wages or has suffered a substantial loss of earning capacity or a physical impairment, actual or apparent:

1. An advance payment of compensation not in excess of $2,000 may be approved informally by letter, without hearing, by any judge of compensation claims or the Chief Judge.

2. An advance payment of compensation not in excess of $2,000 may be ordered by any judge of compensation claims after giving the interested parties an opportunity for a hearing thereon pursuant to not less than 10 days' notice by mail, unless such notice is waived, and after giving due consideration to the interests of the person entitled thereto. When the parties have stipulated to an advance payment of compensation not in excess of $2,000, such advance may be approved by an order of a judge of compensation claims, with or without hearing, or informally by letter by any such judge of compensation claims, if such advance is found to be for the best interests of the person entitled thereto.

3. When the parties have stipulated to an advance payment in excess of $2,000, such payment may be approved by a judge of compensation claims by order if the judge finds that such advance payment is for the best interests of the person entitled thereto and is reasonable under the circumstances of the particular case. The judge of compensation claims shall make or cause to be made such investigations as she or he considers necessary concerning the stipulation and, in her or his discretion, may have an

investigation of the matter made. The stipulation and the report of any investigation shall be deemed a part of the record of the proceedings.

(d) When an application for an advance payment in excess of $2,000 is opposed by the employer or carrier, it shall be heard by a judge of compensation claims after giving the interested parties not less than 10 days' notice of such hearing by mail, unless such notice is waived. In her or his discretion, the judge of compensation claims may have an investigation of the matter made, in which event the report and recommendation will be deemed a part of the record of the proceedings. If the judge of compensation claims finds that such advance payment is for the best interests of the person entitled to compensation, will not materially prejudice the rights of the employer and carrier, and is reasonable under the circumstances of the case, she or he may order the same paid. However, in no event may any such advance payment under this paragraph be granted in excess of $7,500 or 26 weeks of benefits in any 48-month period, whichever is greater, from the date of the last advance payment.

(13) If the employer has made advance payments of compensation, she or he shall be entitled to be reimbursed out of any unpaid installment or installments of compensation due.

(14) When an employee is injured and the employer pays the employee's full wages or any part thereof during the period of disability, or pays medical expenses for such employee, and the case is contested by the carrier or the carrier and employer and thereafter the carrier, either voluntarily or pursuant to an award, makes a payment of compensation or medical benefits, the employer shall be entitled to reimbursement to the extent of the compensation paid or awarded, plus medical benefits, if any, out of the first proceeds paid by the carrier in compliance with such voluntary payment or award, provided the employer furnishes satisfactory proof to the judge of compensation claims of such payment of compensation and medical benefits. Any payment by the employer over and above compensation paid or awarded and medical benefits, pursuant to subsection (13), shall be considered a gratuity.

(15) (a) The office shall examine on an ongoing basis claims files in accordance with s. 624.3161 and may impose fines pursuant to s. 624.310(5) and this chapter in order to identify questionable claims-handling techniques, questionable patterns or practices of claims, or a pattern of repeated unreasonably controverted claims by carriers, as defined in s. 440.02, providing services to employees

pursuant to this chapter. If the office finds such questionable techniques, patterns, or repeated unreasonably controverted claims as constitute a general business practice of a carrier, as defined in s. 440.02, the office shall take appropriate action so as to bring such general business practices to a halt pursuant to s. 440.38(3) or may impose penalties pursuant to s. 624.4211. The department and office may initiate investigations of questionable techniques, patterns, practices, or repeated unreasonably controverted claims. The Financial Services Commission may by rule establish forms and procedures for corrective action plans and for auditing carriers.

(b) As to any examination, investigation, or hearing being conducted under this chapter, the department and office:

1. May administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence; and

2. Shall have the power to subpoena witnesses, compel their attendance and testimony, and require by subpoena the production of books, papers, records, files, correspondence, documents, or other evidence which is relevant to the inquiry.

(c) If any person refuses to comply with any such subpoena or to testify as to any matter concerning which she or he may be lawfully interrogated, the Circuit Court of Leon County or of the county wherein such examination, investigation, or hearing is being conducted, or of the county wherein such person resides, may, on the application of the department or the office, issue an order requiring such person to comply with the subpoena and to testify.

(d) Subpoenas shall be served, and proof of such service made, in the same manner as if issued by a circuit court. Witness fees, costs, and reasonable travel expenses, if claimed, shall be allowed the same as for testimony in a circuit court.

(e) The department shall publish annually a report which indicates the promptness of first payment of compensation records of each carrier or self-insurer so as to focus attention on those carriers or self-insurers with poor payment records for the preceding year. The department and the office shall take appropriate steps so as to cause such poor carrier payment practices to halt pursuant to s. 440.38(3). In addition, the department shall take appropriate action so as to halt such poor payment practices of self-

insurers. “Poor payment practice” means a practice of late payment sufficient to constitute a general business practice.

(f) The Financial Services Commission, in consultation with the department, shall adopt rules providing guidelines to carriers, as defined in s. 440.02, self-insurers, and employers to indicate behavior that may be construed as questionable claims-handling techniques, questionable patterns of claims, repeated unreasonably controverted claims, or poor payment practices.

(16) No penalty assessed under this section may be recouped by any carrier or self-insurer in the rate base, the premium, or any rate filing. The office shall enforce this subsection.

(17) The Financial Services Commission may by rule establish audit procedures and set standards for the Automated Carrier Performance System.

440.205 Coercion of employees.—No employer shall discharge, threaten to discharge, intimidate, or coerce any employee by reason of such employee’s valid claim for compensation or attempt to claim compensation under the Workers’ Compensation Law.

440.207 Workers’ compensation system guide.—

(1) The department shall educate all persons providing or receiving benefits pursuant to this chapter as to their rights and responsibilities under this chapter.

(2) The department shall publish an understandable guide to the workers’ compensation system which shall contain an explanation of benefits provided; services provided by the Employee Assistance and Ombudsman Office; procedures regarding mediation, the hearing process, and civil and criminal penalties; relevant rules of the department; and such other information as the department believes will inform employees, employers, carriers, and those providing services pursuant to this chapter of their rights and responsibilities under this chapter and the rules of the department. For the purposes of this subsection, a guide is understandable if the text of the guide is written at a level of readability not exceeding the eighth grade level, as determined by a recognized readability test.

(3) The guide must be updated as necessary and must be available at cost.

(4) The guide does not constitute either rules or agency action for purposes of chapter 120.

440.21 Invalid agreements.—

(1) Any agreement by an employee to pay any portion of premium paid by her or his employer to a carrier or to contribute to a benefit fund or department maintained by the employer for the purpose of providing compensation or medical services and supplies as required by this chapter is invalid.

(2) An agreement by an employee to waive her or his right to compensation under this chapter is invalid.

440.211 Authorization of collective bargaining agreement.—

(1) Subject to the limitation stated in subsection (2), a provision that is mutually agreed upon in any collective bargaining agreement between an individually self-insured employer or other employer upon consent of the employer's carrier and a recognized or certified exclusive bargaining representative establishing any of the following shall be valid and binding:

(a) An alternative dispute resolution system to supplement, modify, or replace the provisions of this chapter which may include, but is not limited to, conciliation, mediation, and arbitration. Arbitration held pursuant to this section shall be binding on the parties.

(b) The use of an agreed-upon list of health care providers of medical treatment which may be the exclusive source of all medical treatment under this chapter.

(c) The use of a limited list of physicians to conduct independent medical examinations which the parties may agree shall be the exclusive source of independent medical examiners pursuant to this chapter.

(d) A light-duty, modified-job, or return-to-work program.

(e) A vocational rehabilitation or retraining program.

(2) Nothing in this section shall allow any agreement that diminishes an employee's entitlement to benefits as otherwise set forth in this chapter. Any such agreement in violation of this provision shall be null and void.

440.22 Assignment and exemption from claims of creditors.—No assignment, release, or commutation of compensation or benefits due or payable under this chapter except as provided by this chapter shall be valid, and such compensation and benefits shall be exempt from all claims of creditors, and from levy, execution and attachments or other remedy for recovery or collection of a debt, which exemption may not be waived. However, the exemption of workers' compensation claims from creditors does not extend to claims based on an award of child support or alimony.

440.23 Compensation a lien against assets.—Compensation shall have the same preference of lien against the assets of the carrier or employer without limit of an amount as is now or may hereafter be allowed by law to the claimant for unpaid wages or otherwise.

440.24 Enforcement of compensation orders; penalties.—

(1) In case of default by the employer or carrier in the payment of compensation due under any compensation order of a judge of compensation claims or other failure by the employer or carrier to comply with such order within 10 days after the order becomes final, any circuit court of this state within the jurisdiction of which the employer or carrier resides or transacts business shall, upon application by the department or any beneficiary under such order, have jurisdiction to issue a rule nisi directing such employer or carrier to show cause why a writ of execution, or such other process as may be necessary to enforce the terms of such order, shall not be issued, and, unless such cause is shown, the court shall have jurisdiction to issue a writ of execution or such other process or final order as may be necessary to enforce the terms of such order of the judge of compensation claims.

(2) In any case where the employer is insured and the carrier fails to comply with any compensation order of a judge of compensation claims or court within 10 days after such order becomes final, the department shall notify the office of such failure and the office shall suspend the license of such carrier to do an insurance business in this state, until such carrier has complied with such order.

(3) In any case where the employer is a self-insurer and fails to comply with any compensation order of a judge of compensation claims or court within 10 days after such order becomes final, the department may suspend or revoke any authorization previously given to the employer to be a self-insurer, and the Florida Self-Insurers Guaranty Association, Incorporated, may call or sue upon the surety bond or exercise its rights under the letter of credit deposited by the self-insurer with the association as a qualifying security deposit as may be necessary to satisfy the order.

(4) In any case wherein the employee fails to comply with any order of a judge of compensation claims within 10 days after such order becomes final, the judge of compensation claims may dismiss the claim or suspend payments due under said claim until the employee complies with such order. The judge of compensation claims may strike the defenses of the employer, if said employer is self-insured, or of the insurance carrier, if said employer is not self-insured, if said employer or carrier fails to comply with any order of a judge of compensation claims within 10 days after such order becomes final.

440.25 Procedures for mediation and hearings.—

(1) Forty days after a petition for benefits is filed under s. 440.192, the judge of compensation claims shall notify the interested parties by order that a mediation conference concerning such petition has been scheduled unless the parties have notified the judge of compensation claims that a private mediation has been held or is scheduled to be held. A mediation, whether private or public, shall be held within 130 days after the filing of the petition. Such order must give the date the mediation conference is to be held. Such order may be served personally upon the interested parties or may be sent to the interested parties by mail or by electronic means approved by the Deputy Chief Judge. If multiple petitions are pending, or if additional petitions are filed after the scheduling of a mediation, the judge of compensation claims shall consolidate all petitions into one mediation. The claimant or the adjuster of the employer or carrier may, at the mediator's discretion, attend the mediation conference by telephone or, if agreed to by the parties, other electronic means. A continuance may be granted upon the agreement of the parties or if the requesting party demonstrates to the judge of compensation claims

that the reason for requesting the continuance arises from circumstances beyond the party's control. Any order granting a continuance must set forth the date of the rescheduled mediation conference. A mediation conference may not be used solely for the purpose of mediating attorney's fees.

(2) Any party who participates in a mediation conference shall not be precluded from requesting a hearing following the mediation conference should both parties not agree to be bound by the results of the mediation conference. A mediation conference is required to be held unless this requirement is waived by the Deputy Chief Judge.

(3) Such mediation conference shall be conducted informally and does not require the use of formal rules of evidence or procedure. Any information from the files, reports, case summaries, mediator's notes, or other communications or materials, oral or written, relating to a mediation conference under this section obtained by any person performing mediation duties is privileged and confidential and may not be disclosed without the written consent of all parties to the conference. Any research or evaluation effort directed at assessing the mediation program activities or performance must protect the confidentiality of such information. Each party to a mediation conference has a privilege during and after the conference to refuse to disclose and to prevent another from disclosing communications made during the conference whether or not the contested issues are successfully resolved. This subsection and paragraphs (4)(a) and (b) shall not be construed to prevent or inhibit the discovery or admissibility of any information that is otherwise subject to discovery or that is admissible under applicable law or rule of procedure, except that any conduct or statements made during a mediation conference or in negotiations concerning the conference are inadmissible in any proceeding under this chapter.

(a) Unless the parties conduct a private mediation under paragraph (b), mediation shall be conducted by a mediator selected by the Director of the Division of Administrative Hearings from among mediators employed on a full-time basis by the Office of the Judges of Compensation Claims. A mediator must be a member of The Florida Bar for at least 5 years and must complete a mediation training program approved by the Deputy Chief Judge. Adjunct mediators may be employed by the Office of the Judges of Compensation Claims on an as-needed basis and shall be selected from a list prepared by the Director of the Division of Administrative Hearings. An adjunct mediator must be independent of all parties participating in the mediation conference. An adjunct mediator must be a

member of The Florida Bar for at least 5 years and must complete a mediation training program approved by the Office of the Judges of Compensation Claims. An adjunct mediator shall have access to the office, equipment, and supplies of the judge of compensation claims in each district.

(b) With respect to any private mediation, if the parties agree or if mediators are not available under paragraph (a), pursuant to notice from the judge of compensation claims, to conduct the required mediation within the period specified in this section, the parties shall hold a mediation conference at the carrier's expense within the 130-day period set for mediation. The mediation conference shall be conducted by a mediator certified under s. 44.106. If the parties do not agree upon a mediator within 10 days after the date of the order, the claimant shall notify the judge in writing and the judge shall appoint a mediator under this paragraph within 7 days. In the event both parties agree, the results of the mediation conference shall be binding and neither party shall have a right to appeal the results. In the event either party refuses to agree to the results of the mediation conference, the results of the mediation conference as well as the testimony, witnesses, and evidence presented at the conference shall not be admissible at any subsequent proceeding on the claim. The mediator shall not be called in to testify or give deposition to resolve any claim for any hearing before the judge of compensation claims. The employer may be represented by an attorney at the mediation conference if the employee is also represented by an attorney at the mediation conference.

(4) (a) If the parties fail to agree to written submission of pretrial stipulations, the judge of compensation claims shall conduct a live pretrial hearing. The judge of compensation claims shall give the interested parties at least 14 days' advance notice of the pretrial hearing by mail or by electronic means approved by the Deputy Chief Judge.

(b) The final hearing must be held and concluded within 90 days after the mediation conference is held, allowing the parties sufficient time to complete discovery. Except as set forth in this section, continuances may be granted only if the requesting party demonstrates to the judge of compensation claims that the reason for requesting the continuance arises from circumstances beyond the party's control. The written consent of the claimant must be obtained before any request from a claimant's attorney is granted for an additional continuance after the initial continuance has been granted. Any order granting a continuance must set forth the date and time of the rescheduled hearing. A continuance

may be granted only if the requesting party demonstrates to the judge of compensation claims that the reason for requesting the continuance arises from circumstances beyond the control of the parties. The judge of compensation claims shall report any grant of two or more continuances to the Deputy Chief Judge.

(c) The judge of compensation claims shall give the interested parties at least 14 days' advance notice of the final hearing, served upon the interested parties by mail or by electronic means approved by the Deputy Chief Judge.

(d) The final hearing shall be held within 210 days after receipt of the petition for benefits in the county where the injury occurred, if the injury occurred in this state, unless otherwise agreed to between the parties and authorized by the judge of compensation claims in the county where the injury occurred. However, the claimant may waive the timeframes within this section for good cause shown. If the injury occurred outside the state and is one for which compensation is payable under this chapter, then the final hearing may be held in the county of the employer's residence or place of business, or in any other county of the state that will, in the discretion of the Deputy Chief Judge, be the most convenient for a hearing. The final hearing shall be conducted by a judge of compensation claims, who shall, within 30 days after final hearing or closure of the hearing record, unless otherwise agreed by the parties, enter a final order on the merits of the disputed issues. The judge of compensation claims may enter an abbreviated final order in cases in which compensability is not disputed. Either party may request separate findings of fact and conclusions of law. At the final hearing, the claimant and employer may each present evidence with respect to the claims presented by the petition for benefits and may be represented by any attorney authorized in writing for such purpose. When there is a conflict in the medical evidence submitted at the hearing, the provisions of s. 440.13 shall apply. The report or testimony of the expert medical advisor shall be admitted into evidence in a proceeding and all costs incurred in connection with such examination and testimony may be assessed as costs in the proceeding, subject to the provisions of s. 440.13. No judge of compensation claims may make a finding of a degree of permanent impairment that is greater than the greatest permanent impairment rating given the claimant by any examining or treating physician, except upon stipulation of the parties.

Any benefit due but not raised at the final hearing which was ripe, due, or owing at the time of the final hearing is waived.

(e) The order making an award or rejecting the claim, referred to in this chapter as a "compensation order," shall set forth the findings of ultimate facts and the mandate; and the order need not include any other reason or justification for such mandate. The compensation order shall be filed in the Office of the Judges of Compensation Claims at Tallahassee. A copy of such compensation order shall be sent by mail or by electronic means approved by the Deputy Chief Judge to the attorneys of record and any parties not represented by an attorney at the last known address of each, with the date of mailing noted thereon.

(f) Notwithstanding any other provision of this section, the judge of compensation claims may require the appearance of the parties and counsel before her or him without written notice for an emergency conference where there is a bona fide emergency involving the health, safety, or welfare of an employee. An emergency conference under this section may result in the entry of an order or the rendering of an adjudication by the judge of compensation claims.

(g) To expedite dispute resolution and to enhance the self-executing features of the Workers' Compensation Law, the Deputy Chief Judge shall make provision by rule or order for the resolution of appropriate motions by judges of compensation claims without oral hearing upon submission of brief written statements in support and opposition, and for expedited discovery and docketing. Unless the judge of compensation claims, for good cause, orders a hearing under paragraph (h), each claim in a petition relating to the determination of the average weekly wage under s. 440.14 shall be resolved under this paragraph without oral hearing.

(h) To further expedite dispute resolution and to enhance the self-executing features of the system, those petitions filed in accordance with s. 440.192 that involve a claim for benefits of $5,000 or less shall, in the absence of compelling evidence to the contrary, be presumed to be appropriate for expedited resolution under this paragraph; and any other claim filed in accordance with s. 440.192, upon the written agreement of both parties and application by either party, may similarly be resolved under this paragraph. A claim in a petition of $5,000 or less for medical benefits only or a petition for reimbursement for mileage for medical purposes shall, in the absence of compelling evidence to the

contrary, be resolved through the expedited dispute resolution process provided in this paragraph. For purposes of expedited resolution pursuant to this paragraph, the Deputy Chief Judge shall make provision by rule or order for expedited and limited discovery and expedited docketing in such cases. At least 15 days prior to hearing, the parties shall exchange and file with the judge of compensation claims a pretrial outline of all issues, defenses, and witnesses on a form adopted by the Deputy Chief Judge; provided, in no event shall such hearing be held without 15 days' written notice to all parties. No pretrial hearing shall be held and no mediation scheduled unless requested by a party. The judge of compensation claims shall limit all argument and presentation of evidence at the hearing to a maximum of 30 minutes, and such hearings shall not exceed 30 minutes in length. Neither party shall be required to be represented by counsel. The employer or carrier may be represented by an adjuster or other qualified representative. The employer or carrier and any witness may appear at such hearing by telephone. The rules of evidence shall be liberally construed in favor of allowing introduction of evidence.

(i) A judge of compensation claims may, upon the motion of a party or the judge's own motion, dismiss a petition for lack of prosecution if a petition, response, motion, order, request for hearing, or notice of deposition has not been filed during the previous 12 months unless good cause is shown. A dismissal for lack of prosecution is without prejudice and does not require a hearing.

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

(5) (a) Procedures with respect to appeals from orders of judges of compensation claims shall be governed by rules adopted by the Supreme Court. Such an order shall become final 30 days after mailing of copies of such order to the parties, unless appealed pursuant to such rules.

(b) An appellant may be relieved of any necessary filing fee by filing a verified petition of indigency for approval as provided in s. 57.081(1) and may be relieved in whole or in part from the costs for preparation of the record on appeal if, within 15 days after the date notice of the estimated costs for the preparation is served, the appellant files with the judge of compensation claims a copy of the

designation of the record on appeal, and a verified petition to be relieved of costs. A verified petition filed prior to the date of service of the notice of the estimated costs shall be deemed not timely filed. The verified petition relating to record costs shall contain a sworn statement that the appellant is insolvent and a complete, detailed, and sworn financial affidavit showing all the appellant's assets, liabilities, and income. Failure to state in the affidavit all assets and income, including marital assets and income, shall be grounds for denying the petition with prejudice. The Office of the Judges of Compensation Claims shall adopt rules as may be required pursuant to this subsection, including forms for use in all petitions brought under this subsection. The appellant's attorney, or the appellant if she or he is not represented by an attorney, shall include as a part of the verified petition relating to record costs an affidavit or affirmation that, in her or his opinion, the notice of appeal was filed in good faith and that there is a probable basis for the District Court of Appeal, First District, to find reversible error, and shall state with particularity the specific legal and factual grounds for the opinion. Failure to so affirm shall be grounds for denying the petition. A copy of the verified petition relating to record costs shall be served upon all interested parties. The judge of compensation claims shall promptly conduct a hearing on the verified petition relating to record costs, giving at least 15 days' notice to the appellant, the department, and all other interested parties, all of whom shall be parties to the proceedings. The judge of compensation claims may enter an order without such hearing if no objection is filed by an interested party within 20 days from the service date of the verified petition relating to record costs. Such proceedings shall be conducted in accordance with the provisions of this section and with the workers' compensation rules of procedure, to the extent applicable. In the event an insolvency petition is granted, the judge of compensation claims shall direct the department to pay record costs and filing fees from the Workers' Compensation Administration Trust Fund pending final disposition of the costs of appeal. The department may transcribe or arrange for the transcription of the record in any proceeding for which it is ordered to pay the cost of the record.

(c) As a condition of filing a notice of appeal to the District Court of Appeal, First District, an employer who has not secured the payment of compensation under this chapter in compliance with s. 440.38 shall file with the notice of appeal a good and sufficient bond, as provided in s. 59.13, conditioned to pay the amount of the demand and any interest and costs payable under the terms of the

order if the appeal is dismissed, or if the District Court of Appeal, First District, affirms the award in any amount. Upon the failure of such employer to file such bond with the District Court of Appeal, First District, along with the notice of appeal, the District Court of Appeal, First District, shall dismiss the notice of appeal.

(6) An award of compensation for disability may be made after the death of an injured employee.

(7) Any interested party shall have the right in any case of death to require an autopsy, the cost thereof to be borne by the party requesting it; and the judge of compensation claims shall have authority to order and require an autopsy and may, in her or his discretion, withhold her or his findings and award until an autopsy is held.

440.271 Appeal of order of judge of compensation claims.—Review of any order of a judge of compensation claims entered pursuant to this chapter shall be by appeal to the District Court of Appeal, First District. Appeals shall be filed in accordance with rules of procedure prescribed by the Supreme Court for review of such orders. The department shall be given notice of any proceedings pertaining to s. 440.25, regarding indigency, or s. 440.49, regarding the Special Disability Trust Fund, and shall have the right to intervene in any proceedings.

440.2715 Access to courts through state video teleconferencing network.—The First District Court of Appeal shall use the state video teleconferencing network established by the Department of Management Services to facilitate access to courts for purposes of workers' compensation actions.

440.28 Modification of orders.—Upon a judge of compensation claims' own initiative, or upon the application of any party in interest, on the ground of a change in condition or because of a mistake in a determination of fact, the judge of compensation claims may, at any time prior to 2 years after the date of the last payment of compensation pursuant to the compensation order the party seeks to modify, or at any time prior to 2 years after the date copies of an order rejecting a claim are mailed to the parties at the last known address of each, review a compensation case in accordance with the procedure prescribed in respect of claims in s. 440.25 and, in accordance with such section, issue a new compensation order which may terminate, continue, reinstate, increase, or decrease such compensation or award compensation. Such new order shall not affect any compensation previously paid, except that an award increasing the compensation rate may be made effective from the date of the injury, and, if any part of the compensation due or to become due is unpaid, an award decreasing the compensation rate may be made effective from the date of the injury, and any payment made prior thereto in excess of such decreased rate shall be deducted from any unpaid compensation, in such manner and by such method as may be determined by the judge of compensation claims.

440.29 Procedure before the judge of compensation claims.—

(1) In making an investigation or inquiry or conducting a hearing, the judge of compensation claims shall not be bound by technical or formal rules of procedure, except as provided by this chapter, but may make such investigation or inquiry, or conduct such hearing, in such manner as to best ascertain the rights of the parties. A declaration of a deceased employee concerning the injury in respect of which the investigation or inquiry is being made or the hearing conducted shall be received in evidence and shall, if corroborated by other evidence, be sufficient to establish the injury.

(2) Hearings before the judge of compensation claims shall be open to the public, and the Deputy Chief Judge is authorized to designate the manner in which particular types of hearings are recorded and reported and, when necessary, to contract for the reporting of such hearings. The Deputy Chief Judge shall arrange for the preparation of a record of the hearings and other proceedings before judges of compensation claims, as necessary, and is authorized to allow for the attendance of court reporters at

hearings, for preparation of transcripts of testimony, for copies of any instrument, and for other reporting or recording services. The Deputy Chief Judge may charge the same fees allowed by law or court rule to reporters, persons preparing transcripts, or clerks of courts of this state for like services.

(3) The practice and procedure before the judges of compensation claims shall be governed by rules adopted by the Office of the Judges of Compensation Claims, except to the extent that such rules conflict with the provisions of this chapter.

(4) All medical reports of authorized treating health care providers relating to the claimant and subject accident shall be received into evidence by the judge of compensation claims upon proper motion. However, such records must be served on the opposing party at least 30 days before the final hearing. This section does not limit any right of further discovery, including, but not limited to, depositions.

440.30 Depositions.—Depositions of witnesses or parties, residing within or without the state, may be taken and may be used in connection with proceedings under the Workers' Compensation Law, either upon order of the judge of compensation claims or at the instance of any party or prospective party to such proceedings, and either prior to the institution of a claim, if the claimant is represented by an attorney, or after the filing of the claim in the same manner, for the same purposes, including the purposes of discovery, and subject to the same rules; all as now or hereafter prescribed by law or by rules of court governing the taking and use of such depositions in civil actions at law in the circuit courts of this state. Such depositions may be taken before any notary public, court reporter, or deputy, and the fees of the officer taking the same and the fees of the witnesses attending the same, including expert witness fees as provided by law or court rule, shall be the same as in depositions taken for such circuit courts. Such fees may be taxed as costs and recovered by the claimant, if successful in such workers' compensation proceedings. If no claim has been filed, then the carrier or employer taking the deposition shall pay the claimant's attorney a reasonable attorney's fee for attending said deposition.

440.31 Witness fees.—Each witness who appears in obedience to a subpoena shall be entitled to the same fees as witnesses in a civil action in the circuit court; however, any expert witness, as defined in Rule 1.390(a) of the Florida Rules of Civil Procedure, who shall have testified in any proceeding under this chapter shall be allowed a witness fee, including the cost of any exhibits used by such witness, in such reasonable amount as the judge of compensation claims may determine, not in excess of the rate prevailing in the locality for witness fees for such expert witnesses in workers' compensation proceedings, notwithstanding the limitation provided in s. 92.231.

440.32 Cost in proceedings brought without reasonable ground.—

(1) If the judge of compensation claims or any court having jurisdiction of proceedings in respect of any claim or compensation order determines that the proceedings in respect of such claim or order have been instituted or continued without reasonable ground, the cost of such proceedings shall be assessed against the party who has so instituted or continued the proceedings.

(2) If the judge of compensation claims or any court having jurisdiction of proceedings in respect to any claims or defense under this section determines that the proceedings were maintained or continued frivolously, the cost of the proceedings, including reasonable attorney's fees, shall be assessed against the offending attorney. If a penalty is assessed under this subsection, a copy of the order assessing the penalty must be forwarded to the appropriate grievance committee acting under the jurisdiction of the Supreme Court. Penalties, fees, and costs awarded under this provision may not be recouped from the party.

(3) Every pleading, motion, and other paper of a party represented by an attorney shall be signed by at least one attorney of record in the attorney's individual name, whose address shall be stated. The signature of an attorney constitutes a certificate by the signer that the signer has read the pleading, motion, or other paper; that to the best of the signer's knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of

litigation. If a pleading, motion, or other paper is not signed, it shall be stricken unless it is signed promptly after the omission is called to the attention of the pleader or movant. If a pleading, motion, or other paper is signed in violation of this section, the judge of compensation claims or any court having jurisdiction of proceedings, upon motion or upon its own initiative, shall impose upon the person who signed it an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee.

440.33 Powers of judges of compensation claims.—

(1) The judge of compensation claims may preserve and enforce order during any such proceeding; issue subpoenas for, administer oaths or affirmations to, and compel the attendance and testimony of witnesses, or the production of books, papers, documents, and other evidence, or the taking of depositions before any designated individual competent to administer oaths; examine witnesses; and do all things conformable to law which may be necessary to enable the judge effectively to discharge the duties of her or his office. Whenever a law requires an order of a court of competent jurisdiction for the obtention of medical or hospital records, an order of a judge of compensation claims entered for such purposes shall be deemed to be an order of a court of competent jurisdiction.

(2) If any person in proceedings before the judge of compensation claims disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the hearing, or neglects to produce, after having been ordered to do so, any pertinent book, paper, or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take oath or affirmation as a witness, or after having taken the oath refuses to be examined according to law, the judge of compensation claims shall certify the facts to the court having jurisdiction in the place in which it is sitting, which shall thereupon in a summary manner hear the evidence as to the acts complained of and, if the evidence so warrants, punish such person in the same manner and to the same extent as for a contempt committed before the court, or commit such person upon the same conditions

as if the doing of the forbidden act had occurred with reference to the process of or in the presence of the court.

(3) Before adjudicating a claim for permanent total disability benefits, the judge of compensation claims may request an evaluation pursuant to s. 440.491(6) for the purpose of assisting the judge of compensation claims in the determination of whether there is a reasonable probability that, with appropriate training or education, the employee may be rehabilitated to the extent that such employee can achieve suitable gainful employment and whether it is in the best interest of the employee to undertake such training or education.

440.34 Attorney's fees; costs.—

(1) A fee, gratuity, or other consideration may not be paid for a claimant in connection with any proceedings arising under this chapter, unless approved by the judge of compensation claims or court having jurisdiction over such proceedings. Any attorney's fee approved by a judge of compensation claims for benefits secured on behalf of a claimant must equal to 20 percent of the first $5,000 of the amount of the benefits secured, 15 percent of the next $5,000 of the amount of the benefits secured, 10 percent of the remaining amount of the benefits secured to be provided during the first 10 years after the date the claim is filed, and 5 percent of the benefits secured after 10 years. The judge of compensation claims shall not approve a compensation order, a joint stipulation for lump-sum settlement, a stipulation or agreement between a claimant and his or her attorney, or any other agreement related to benefits under this chapter which provides for an attorney's fee in excess of the amount permitted by this section. The judge of compensation claims is not required to approve any retainer agreement between the claimant and his or her attorney. The retainer agreement as to fees and costs may not be for compensation in excess of the amount allowed under this subsection or subsection (7).

(2) In awarding a claimant's attorney's fee, the judge of compensation claims shall consider only those benefits secured by the attorney. An attorney is not entitled to attorney's fees for representation in any issue that was ripe, due, and owing and that reasonably could have been addressed, but was not

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

(3) If any party should prevail in any proceedings before a judge of compensation claims or court, there shall be taxed against the nonprevailing party the reasonable costs of such proceedings, not to include attorney's fees. A claimant is responsible for the payment of her or his own attorney's fees, except that a claimant is entitled to recover an attorney's fee in an amount equal to the amount provided for in subsection (1) or subsection (7) from a carrier or employer:

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

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

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

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

Regardless of the date benefits were initially requested, attorney's fees shall not attach under this subsection until 30 days after the date the carrier or employer, if self-insured, receives the petition.

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

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

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

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

440.345 Reporting of attorney's fees.—All fees paid to attorneys for services rendered under this chapter shall be reported to the Office of the Judges of Compensation Claims as the Division of Administrative Hearings requires by rule.

440.35 Record of injury or death.—Every employer shall keep a record in respect of any injury to an employee. Such record shall contain such information of disability or death in respect of such injury as the department may by regulation require, and shall be available to inspection by the department or by any state authority at such time and under such conditions as the department may by regulation prescribe.

440.38 Security for compensation; insurance carriers and self-insurers.—

(1) Every employer shall secure the payment of compensation under this chapter:

(a) By insuring and keeping insured the payment of such compensation with any stock company or mutual company or association or exchange, authorized to do business in the state;

(b) By furnishing satisfactory proof to the Florida Self-Insurers Guaranty Association, Incorporated, created in s. 440.385, that it has the financial strength necessary to ensure timely payment of all current and future claims individually and on behalf of its subsidiary and affiliated companies with employees in this state and receiving an authorization from the department to pay such compensation directly. The association shall review the financial strength of applicants for membership, current members, and former members and make recommendations to the department regarding their qualifications to self-insure in accordance with this section and ss. 440.385 and 440.386. The department shall act in accordance with the recommendations unless it finds by clear and convincing evidence that the recommendations are erroneous.

1. As a condition of authorization under paragraph (a), the association may recommend that the department require an employer to deposit with the association a qualifying security deposit. The association shall recommend the type and amount of the qualifying security deposit and shall prescribe conditions for the qualifying security deposit, which shall include authorization for the association to call the qualifying security deposit in the case of default to pay compensation awards and related expenses of the association. As a condition to authorization to self-insure, the employer shall provide proof that the employer has provided for competent personnel with whom to deliver benefits and to provide a safe working environment. The employer shall also provide evidence that it carries reinsurance at levels that will ensure the financial strength and actuarial soundness of such employer in accordance with rules adopted by the department. The department may by rule require that, in the event of an individual self-insurer's insolvency, such qualifying security deposits and reinsurance policies are payable to the association. Any employer securing compensation in accordance with the provisions of this paragraph shall be known as a self-insurer and shall be classed as a carrier of her or his own insurance. The employer shall, if requested, provide the association an actuarial report signed by a member of the American Academy of Actuaries providing an opinion of the appropriate present value

of the reserves, using a 4-percent discount rate, for current and future compensation claims. If any member or former member of the association refuses to timely provide such a report, the association may obtain an order from a circuit court requiring the member to produce such a report and ordering any other relief that the court determines is appropriate. The association may recover all reasonable costs and attorney's fees in such proceedings.

2. If the employer fails to maintain the foregoing requirements, the association shall recommend to the department that the department revoke the employer's authority to self-insure, unless the employer provides to the association the certified opinion of an independent actuary who is a member of the American Academy of Actuaries as to the actuarial present value of the employer's determined and estimated future compensation payments based on cash reserves, using a 4-percent discount rate, and a qualifying security deposit equal to 1.5 times the value so certified. The employer shall thereafter annually provide such a certified opinion until such time as the employer meets the requirements of subparagraph 1. The qualifying security deposit shall be adjusted at the time of each such annual report. Upon the failure of the employer to timely provide such opinion or to timely provide a security deposit in an amount equal to 1.5 times the value certified in the latest opinion, the association shall provide that information to the department along with a recommendation, and the department shall then revoke such employer's authorization to self-insure. Failure to comply with this subparagraph constitutes an immediate serious danger to the public health, safety, or welfare sufficient to justify the summary suspension of the employer's authorization to self-insure pursuant to s. 120.68.

3. Upon the suspension or revocation of the employer's authorization to self-insure, the employer shall provide to the association the certified opinion of an independent actuary who is a member of the American Academy of Actuaries of the actuarial present value of the determined and estimated future compensation payments of the employer for claims incurred while the member exercised the privilege of self-insurance, using a discount rate of 4 percent. The employer shall provide such an opinion at 6-month intervals thereafter until such time as the latest opinion shows no remaining value of claims. With each such opinion, the employer shall deposit with the association a qualifying security deposit in an amount equal to the value certified by the actuary. The association has a cause of action against an employer, and against any successor of the employer, who fails to timely provide such opinion or who

fails to timely maintain the required security deposit with the association. The association shall recover a judgment in the amount of the actuarial present value of the determined and estimated future compensation payments of the employer for claims incurred while the employer exercised the privilege of self-insurance, together with attorney's fees. For purposes of this section, the successor of an employer means any person, business entity, or group of persons or business entities, which holds or acquires legal or beneficial title to the majority of the assets or the majority of the shares of the employer.

4. A qualifying security deposit shall consist, at the option of the employer, of:

a. Surety bonds, in a form and containing such terms as prescribed by the association, issued by a corporation surety authorized to transact surety business by the office, and whose policyholders' and financial ratings, as reported in A.M. Best's Insurance Reports, Property-Liability, are not less than "A" and "V", respectively.

b. Irrevocable letters of credit in favor of the association issued by financial institutions located within this state, the deposits of which are insured through the Federal Deposit Insurance Corporation.

5. The qualifying security deposit shall be held by the association exclusively for the benefit of workers' compensation claimants. The security shall not be subject to assignment, execution, attachment, or any legal process whatsoever, except as necessary to guarantee the payment of compensation under this chapter. No surety bond may be terminated, and no letter of credit may be allowed to expire, without 90 days' prior written notice to the association and deposit by the self-insuring employer of some other qualifying security deposit of equal value within 10 business days after such notice. Failure to provide such written notice or failure to timely provide qualifying replacement security after such notice shall constitute grounds for the association to call or sue upon the surety bond or to exercise its rights under a letter of credit. Current self-insured employers must comply with this section on or before December 31, 2001, or upon the maturity of existing security deposits, whichever occurs later. The department may specify by rule the amount of the qualifying security deposit required prior to authorizing an employer to self-insure and the amount of net worth required for an employer to qualify for authorization to self-insure;

(c) By entering into a contract with a public utility under an approved utility-provided self-insurance program as set forth in s. 624.46225 in effect as of July 1, 1983. The department shall adopt rules to implement this paragraph;

(d) By entering into an interlocal agreement with other local governmental entities to create a local government pool pursuant to s. 624.4622; or

(e) By entering into a contract with an individual self-insurer under an approved individual self-insurer-provided self-insurance program as set forth in s. 624.46225. The department may adopt rules to administer this subsection.

(2) (a) The department shall adopt rules by which businesses may become qualified to provide underwriting claims-adjusting, loss control, and safety engineering services to self-insurers.

(b) The department shall adopt rules requiring self-insurers to file any reports necessary to fulfill the requirements of this chapter. Any self-insurer who fails to file any report as prescribed by the rules adopted by the department shall be subject to a civil penalty.

(3) (a) The license of any stock company or mutual company or association or exchange authorized to do insurance business in the state shall for good cause, upon recommendation of the department, be suspended or revoked by the office. No suspension or revocation shall affect the liability of any carrier already incurred.

(b) The department shall suspend or revoke any authorization to a self-insurer for failure to comply with this section or for good cause, as defined by rule of the department. No suspension or revocation shall affect the liability of any self-insurer already incurred.

(c) Violation of s. 440.381 by a self-insurance fund shall result in the imposition of a fine not to exceed $1,000 per audit if the self-insurance fund fails to act on said audits by correcting errors in employee classification or accepted applications for coverage where it knew employee classifications were incorrect. Such fines shall be levied by the department and deposited into the Workers' Compensation Administration Trust Fund.

(4) (a) A carrier of insurance, including the parties to any mutual, reciprocal, or other association, may not write any compensation insurance under this chapter without a certificate of authority from the office. Such certificate of authority shall be given, upon application therefor, to any insurance or mutual

or reciprocal insurance association upon the office's being satisfied of the solvency of such corporation or association and its ability to perform all its undertakings. The office may revoke any certificate of authority so issued for violation of any provision of this chapter.

(b) A carrier of insurance, including the parties to any mutual, reciprocal, or other association, may not write any compensation insurance under this chapter unless such carrier has a claims adjuster, either in-house or under contract, situated within this state. Self-insurers whose compensation payments are administered through a third party and carriers of insurance shall maintain a claims adjuster within this state during any period for which there are any open claims against such self-insurer or carrier arising under the compensation insurance written by the self-insurer or carrier. Individual self-insurers whose compensation payments are administered by employees of the self-insurer shall not be required to have their claims adjuster situated within this state. Individual self-insurers shall not be required to have their claims adjusters situated within this state.

(5) All insurance carriers authorized to write workers' compensation insurance in this state shall make available, at the written request of the employer, an insurance policy containing deductibles in the amount of $500, $1,000, $1,500, $2,000, and $2,500 per claim and a coinsurance provision per claim. Any amount of coinsurance shall bind the carrier to pay 80 percent, and the employer to pay 20 percent, of the benefits due to an employee for an injury compensable under this chapter of the amount of benefits above the deductible, up to the limit of $21,000. One hundred percent of the benefits above the amount of any deductible and coinsurance, as the case may be, due to an employee for one injury shall be paid solely by the carrier. Regardless of any coinsurance or deductible amount, the claim shall be paid by the applicable carrier, which shall then be reimbursed by the employer for any coinsurance or deductible amounts paid by the carrier. No insurance carrier shall be required to offer a deductible or coinsurance to any employer if, as a result of a credit investigation, the carrier determines that the employer is not sufficiently financially stable to be responsible for payment of such deductible or coinsurance amounts.

(6) The state and its boards, bureaus, departments, and agencies and all of its political subdivisions which employ labor, and the state universities, shall be deemed self-insurers under the terms of this

chapter, unless they elect to procure and maintain insurance to secure the benefits of this chapter to their employees; and they are hereby authorized to pay the premiums for such insurance.

(7) Any employer who meets the requirements of subsection (1) through a policy of insurance issued outside of this state must at all times, with respect to all employees working in this state, maintain the required coverage under a Florida endorsement using Florida rates and rules pursuant to payroll reporting that accurately reflects the work performed in this state by such employees.

440.381 Application for coverage; reporting payroll; payroll audit procedures; penalties.—

(1) Applications by an employer to a carrier for coverage required by s. 440.38 must be made on a form prescribed by the Financial Services Commission. The Financial Services Commission shall adopt rules for applications for coverage required by s. 440.38. The rules must provide that an application include information on the employer, the type of business, past and prospective payroll, estimated revenue, previous workers' compensation experience, employee classification, employee names, and any other information necessary to enable a carrier to accurately underwrite the applicant. The rules must include a provision that a carrier or self-insurance fund may require that an employer update an application monthly to reflect any change in the required application information.

(2) Submission of an application that contains false, misleading, or incomplete information provided with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The application must contain a statement that the filing of an application containing false, misleading, or incomplete information provided with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The application must contain a sworn statement by the employer attesting to the accuracy of the information submitted and acknowledging the provisions of former s. 440.37(4). The application must contain a sworn statement by the agent attesting that the agent explained to the employer or officer the classification codes that are used for premium calculations.

(3) The Financial Services Commission, in consultation with the department, shall establish by rule minimum requirements for audits of payroll and classifications in order to ensure that the appropriate premium is charged for workers' compensation coverage. The rules shall ensure that audits performed by both carriers and employers are adequate to provide that all sources of payments to employees, subcontractors, and independent contractors have been reviewed and that the accuracy of classification of employees has been verified. The rules shall provide that employers in all classes other than the construction class be audited not less frequently than biennially and may provide for more frequent audits of employers in specified classifications based on factors such as amount of premium, type of business, loss ratios, or other relevant factors. In no event shall employers in the construction class, generating more than the amount of premium required to be experience rated, be audited less than annually. The annual audits required for construction classes shall consist of physical onsite audits. Payroll verification audit rules must include, but need not be limited to, the use of state and federal reports of employee income, payroll and other accounting records, certificates of insurance maintained by subcontractors, and duties of employees. At the completion of an audit, the employer or officer of the corporation and the auditor must print and sign their names on the audit document and attach proof of identification to the audit document.

(4) Each employer must submit a copy of the quarterly earnings report required by chapter 443 at the end of each quarter to the carrier and submit self-audits supported by the quarterly earnings reports required by chapter 443 and the rules adopted by the Department of Economic Opportunity or by the state agency providing reemployment assistance tax collection services under contract with the Department of Economic Opportunity through an interagency agreement pursuant to s. 443.1316. The reports must include a sworn statement by an officer or principal of the employer attesting to the accuracy of the information contained in the report.

(5) Employers shall make available all records necessary for the payroll verification audit and permit the auditor to make a physical inspection of the employer's operation. If the employer fails upon request of the auditor to provide access to the documents specified in this section and the carrier cannot complete the audit as a result, the employer shall pay $500 to the carrier to defray the costs of the audits.

(6) (a) If an employer understates or conceals payroll, or misrepresents or conceals employee duties so as to avoid proper classification for premium calculations, or misrepresents or conceals information pertinent to the computation and application of an experience rating modification factor, the employer, or the employer's agent or attorney, shall pay to the insurance carrier a penalty of 10 times the amount of the difference in premium paid and the amount the employer should have paid and reasonable attorney's fees. The penalty may be enforced in the circuit courts of this state.

(b) If the department determines that an employer has materially understated or concealed payroll, has materially misrepresented or concealed employee duties so as to avoid proper classification for premium calculations, or has materially misrepresented or concealed information pertinent to the computation and application of an experience rating modification factor, the department shall immediately notify the employer's carrier of such determination. The carrier shall commence a physical onsite audit of the employer within 30 days after receiving notification from the department. If the carrier fails to commence the audit as required by this section, the department shall contract with auditing professionals to conduct the audit at the carrier's expense. A copy of the carrier's audit of the employer shall be provided to the department upon completion. The carrier is not required to conduct the physical onsite audit of the employer as set forth in this paragraph if the carrier gives written notice of cancellation to the employer within 30 days after receiving notification from the department of the material misrepresentation, understatement, or concealment and an audit is conducted in conjunction with the cancellation.

(7) If an employee suffering a compensable injury was not reported as earning wages on the last quarterly earnings report filed with the Department of Economic Opportunity or the state agency providing reemployment assistance tax collection services under contract with the Department of Economic Opportunity through an interagency agreement pursuant to s. 443.1316 before the accident, the employer shall indemnify the carrier for all workers' compensation benefits paid to or on behalf of the employee unless the employer establishes that the employee was hired after the filing of the quarterly report, in which case the employer and employee shall attest to the fact that the employee was employed by the employer at the time of the injury. Failure of the employer to indemnify the insurer within 21 days after demand by the insurer is grounds for the insurer to immediately cancel coverage.

Any action for indemnification brought by the carrier is cognizable in the circuit court having jurisdiction where the employer or carrier resides or transacts business. The insurer is entitled to a reasonable attorney's fee if it recovers any portion of the benefits paid in the action.

(8) If an employer fails to provide reasonable access to payroll records for a payroll verification audit, the employer shall pay a premium to the carrier or self-insurer not to exceed three times the most recent estimated annual premium.

440.385 Florida Self-Insurers Guaranty Association, Incorporated.—

(1) CREATION OF ASSOCIATION.—

(a) There is created a nonprofit corporation to be known as the "Florida Self-Insurers Guaranty Association, Incorporated," hereinafter referred to as "the association." Upon incorporation of the association, all individual self-insurers as defined in ss. 440.02(24)(a) and 440.38(1)(b), other than individual self-insurers which are public utilities or governmental entities, shall be members of the association as a condition of their authority to individually self-insure in this state. The association shall perform its functions under a plan of operation as established and approved under subsection (5) and shall exercise its powers and duties through a board of directors as established under subsection (2). The association shall have those powers granted or permitted corporations not for profit, as provided in chapter 617. The activities of the association shall be subject to review by the department. The department shall have oversight responsibility as set forth in this section. The association is specifically authorized to enter into agreements with this state to perform specified services.

(b) A member may voluntarily withdraw from the association when the member voluntarily terminates the self-insurance privilege and pays all assessments due to the date of such termination. However, the withdrawing member shall continue to be bound by the provisions of this section relating to the period of his or her membership and any claims charged pursuant thereto. The withdrawing member who is a member on or after January 1, 1991, shall also be required to provide to the association upon withdrawal, and at 12-month intervals thereafter, satisfactory proof, including, if requested by the association, a report of known and potential claims certified by a member of the

American Academy of Actuaries, that it continues to meet the standards of s. 440.38(1)(b) in relation to claims incurred while the withdrawing member exercised the privilege of self-insurance. Such reporting shall continue until the withdrawing member demonstrates to the association that there is no remaining value to claims incurred while the withdrawing member was self-insured. If a withdrawing member fails or refuses to timely provide an actuarial report to the association, the association may obtain an order from a circuit court requiring the member to produce such a report and ordering any other relief that the court determines appropriate. The association is entitled to recover all reasonable costs and attorney fees expended in such proceedings. If during this reporting period the withdrawing member fails to meet the standards of s. 440.38(1)(b), the withdrawing member who is a member on or after January 1, 1991, shall thereupon, and at 6-month intervals thereafter, provide to the association the certified opinion of an independent actuary who is a member of the American Academy of Actuaries of the actuarial present value of the determined and estimated future compensation payments of the member for claims incurred while the member was a self-insurer, using a discount rate of 4 percent. With each such opinion, the withdrawing member shall deposit with the association security in an amount equal to the value certified by the actuary and of a type that is acceptable for qualifying security deposits under s. 440.38(1)(b). The withdrawing member shall continue to provide such opinions and to provide such security until such time as the latest opinion shows no remaining value of claims. The association has a cause of action against a withdrawing member, and against any successor of a withdrawing member, who fails to timely provide the required opinion or who fails to maintain the required deposit with the association. The association shall be entitled to recover a judgment in the amount of the actuarial present value of the determined and estimated future compensation payments of the withdrawing member for claims incurred during the time that the withdrawing member exercised the privilege of self-insurance, together with reasonable attorney fees. The association is also entitled to recover reasonable attorney fees in any action to compel production of any actuarial report required by this section. For purposes of this section, the successor of a withdrawing member means any person, business entity, or group of persons or business entities, which holds or acquires legal or beneficial title to the majority of the assets or the majority of the shares of the withdrawing member.

(2) BOARD OF DIRECTORS.—The board of directors of the association shall consist of nine persons and shall be organized as established in the plan of operation. All board members shall be experienced in self-insurance in this state. Each director shall serve for a 4-year term and may be reappointed. Appointments after January 1, 2002, shall be made by the department upon recommendation of members of the association. Any vacancy on the board shall be filled for the remaining period of the term in the same manner as appointments other than initial appointments are made. Each director shall be reimbursed for expenses incurred in carrying out the duties of the board on behalf of the association.

(3) POWERS AND DUTIES.—

(a) Upon creation of the Insolvency Fund pursuant to the provisions of subsection (4), the association is obligated for payment of compensation under this chapter to insolvent members' employees resulting from incidents and injuries existing prior to the member becoming an insolvent member and from incidents and injuries occurring within 30 days after the member has become an insolvent member, provided the incidents giving rise to claims for compensation under this chapter occur during the year in which such insolvent member is a member of the guaranty fund and was assessable pursuant to the plan of operation, and provided the employee makes timely claim for such payments according to procedures set forth by a court of competent jurisdiction over the delinquency or bankruptcy proceedings of the insolvent member. Such obligation includes only that amount due the injured worker or workers of the insolvent member under this chapter. In no event is the association obligated to a claimant in an amount in excess of the obligation of the insolvent member. The association shall be deemed the insolvent employer for purposes of this chapter to the extent of its obligation on the covered claims and, to such extent, shall have all rights, duties, and obligations of the insolvent employer as if the employer had not become insolvent. However, in no event shall the association be liable for any penalties or interest.

(b) The association may:

1. Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

2. Borrow funds necessary to effect the purposes of this section in accord with the plan of operation.

3. Sue or be sued.

4. Negotiate and become a party to such contracts as are necessary to carry out the purposes of this section.

5. Purchase such reinsurance as is determined necessary pursuant to the plan of operation.

6. Review all applicants for membership in the association to determine whether the applicant is qualified for membership under the law. The association shall recommend to the department that the application be accepted or rejected based on the criteria set forth in s. 440.38(1)(b). The department shall approve or disapprove the application as provided in paragraph (6)(a).

7. Collect and review financial information from employers and make recommendations to the department regarding the appropriate security deposit and reinsurance amounts necessary for an employer to demonstrate that it has the financial strength necessary to ensure the timely payment of all current and future claims. The association may audit and examine an employer to verify the financial strength of its current and former members. If the association determines that a current or former self-insured employer does not have the financial strength necessary to ensure the timely payment of all current and estimated future claims, the association may recommend to the department that the department:

a. Revoke the employer's self-insurance privilege.

b. Require the employer to provide a certified opinion of an independent actuary who is a member of the American Academy of Actuaries as to the actuarial present value of the employer's estimated current and future compensation payments, using a 4-percent discount rate.

c. Require an increase in the employer's security deposit in an amount determined by the association to be necessary to ensure payment of compensation claims. The department shall act on such recommendations as provided in paragraph (6)(a). The association has a cause of action against an employer, and against any successor of an employer, who fails to provide an additional security deposit required by the department. The association shall file an action in circuit court to recover a judgment in the amount of the requested additional security deposit together with reasonable attorney's fees. For the purposes of this section, the successor of an employer is any person, business entity, or group of

persons or business entities which holds or acquires legal or beneficial title to the majority of the assets or the majority of the shares of the employer.

8. Charge fees to any member of the association to cover the actual costs of examining the financial and safety conditions of that member.

9. Charge an applicant for membership in the association a fee sufficient to cover the actual costs of examining the financial condition of the applicant.

10. Implement any procedures necessary to ensure compliance with regulatory actions taken by the department.

(c) 1. To the extent necessary to secure funds for the payment of covered claims and also to pay the reasonable costs to administer them, the association, subject to approval by the department, shall levy assessments based on the annual written premium each employer would have paid had the employer not been self-insured. Every assessment shall be made as a uniform percentage of the figure applicable to all individual self-insurers, provided that the assessment levied against any self-insurer in any one year shall not exceed 1 percent of the annual written premium during the calendar year preceding the date of the assessment. Assessments shall be remitted to and administered by the board of directors in the manner specified by the approved plan. Each employer so assessed shall have at least 30 days' written notice as to the date the assessment is due and payable. The association shall levy assessments against any newly admitted member of the association so that the basis of contribution of any newly admitted member is the same as previously admitted members, provision for which shall be contained in the plan of operation.

2. If, in any one year, funds available from such assessments, together with funds previously raised, are not sufficient to make all the payments or reimbursements then owing, the funds available shall be prorated, and the unpaid portion shall be paid as soon thereafter as sufficient additional funds become available.

3. Funds may be allocated or paid from the Workers' Compensation Administration Trust Fund to contract with the association to perform services required by law. However, no state funds of any kind shall be allocated or paid to the association or any of its accounts for payment of covered claims or

related expenses except those state funds accruing to the association by and through the assignment of rights of an insolvent employer. The department may not levy any assessment on the association.

(4) INSOLVENCY FUND.—Upon the adoption of a plan of operation, there shall be created an Insolvency Fund to be managed by the association.

(a) The Insolvency Fund is created for purposes of meeting the obligations of insolvent members incurred while members of the association and after the exhaustion of any security deposit, as required under this chapter. However, if such security deposit or reinsurance policy is payable to the association, the association shall commence to provide benefits out of the Insolvency Fund and be reimbursed from the security deposit or reinsurance policy. The method of operation of the Insolvency Fund shall be defined in the plan of operation as provided in subsection (5).

(b) The department shall have the authority to audit the financial soundness of the Insolvency Fund annually.

(c) The department may offer certain amendments to the plan of operation to the board of directors of the association for purposes of assuring the ongoing financial soundness of the Insolvency Fund and its ability to meet the obligations of this section.

(5) PLAN OF OPERATION.—The association shall operate pursuant to a plan of operation approved by the board of directors. The plan of operation must be approved by the Department of Financial Services, and any amendments to the plan shall not become effective until approved by the department.

(a) The purpose of the plan of operation shall be to provide the association and the board of directors with the authority and responsibility to establish the necessary programs and to take the necessary actions to protect against the insolvency of a member of the association. In addition, the plan shall provide that the members of the association shall be responsible for maintaining an adequate Insolvency Fund to meet the obligations of insolvent members provided for under this act and shall authorize the board of directors to contract and employ those persons with the necessary expertise to carry out this stated purpose. The board of directors shall submit to the department a proposed plan of operation for the administration of the association. The department shall approve the plan by order, consistent with this section. The department shall approve any amendments to the plan, consistent with

this section, which are determined appropriate to carry out the duties and responsibilities of the association.

(b) All member employers shall comply with the plan of operation.

(c) The plan of operation shall:

1. Establish the procedures whereby all the powers and duties of the association under subsection (3) will be performed.

2. Establish procedures for handling assets of the association.

3. Establish the amount and method of reimbursing members of the board of directors under subsection (2).

4. Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent employer shall be deemed notice to the association or its agent, and a list of such claims shall be submitted periodically to the association or similar organization in another state by the receiver or liquidator.

5. Establish regular places and times for meetings of the board of directors.

6. Establish procedures for records to be kept of all financial transactions of the association and its agents and the board of directors.

7. Provide that any member employer aggrieved by any final action or decision of the association may appeal to the department within 30 days after the action or decision.

8. Establish the procedures whereby recommendations of candidates for the board of directors shall be submitted to the department.

9. Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(d) The plan of operation may provide that any or all of the powers and duties of the association, except those specified under subparagraphs (c)1. and 2., be delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association or its equivalent in two or more states. Such a corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of

the association. A delegation of powers or duties under this subsection shall take effect only with the approval of both the board of directors and the department and may be made only to a corporation, association, or organization which extends protection which is not substantially less favorable and effective than the protection provided by this section.

(6) POWERS AND DUTIES OF DEPARTMENT.—The department shall:

(a) Review recommendations of the association concerning whether current or former self-insured employers or members of the association have the financial strength necessary to ensure the timely payment of all current and estimated future claims. If the association determines an employer does not have the financial strength necessary to ensure the timely payment of all current and future claims and recommends action pursuant to paragraph (3)(b), the department shall take such action as necessary to order the employer to comply with the recommendation, unless the department finds by clear and convincing evidence that the recommendation is erroneous.

(b) Contract with the association for services, which may include, but are not limited to:

1. Processing applications for self-insurance.

2. Collecting and reviewing financial statements and loss reserve information from individual self-insurers.

3. Collecting and maintaining files for original security deposit documents and reinsurance policies from individual self-insurers and, if necessary, perfecting security interests in security deposits.

4. Processing compliance documentation for individual self-insurers and providing copies of such documentation to the department.

5. Collecting all data necessary to calculate annual premium for all individual self-insurers, including individual self-insurers that are public utilities or governmental entities, and providing such calculated annual premium to the department for assessment purposes.

6. Inspecting and auditing annually, if necessary, the payroll and other records of each individual self-insurer, including individual self-insurers that are public utilities or governmental entities, in order to determine the wages paid by each individual self-insurer, the premium such individual self-insurer would have to pay if insured, and all payments of compensation made by such individual self-insurer during each prior period with the results of such audit provided to the department. For purposes of this

section, the payroll records of each individual self-insurer shall be open to inspection and audit by the association and the department, or their authorized representatives, during regular business hours.

7. Processing applications and making recommendations with respect to the qualification of a business to be approved to provide or continue to provide services to individual self-insurers in the areas of underwriting, claims adjusting, loss control, and safety engineering.

8. Providing legal representation to implement the administration and audit of individual self-insurers and making recommendations regarding prosecution of any administrative or legal proceedings necessitated by the regulation of the individual self-insurers by the department.

(c) Contract with an attorney or attorneys recommended by the association for representation of the department in any administrative or legal proceedings necessitated by the recommended regulation of the individual self-insurers.

(d) Direct the association to require from each individual self-insurer, at such time and in accordance with such regulations as the department prescribes, reports relating to wages paid, the amount of premiums such individual self-insurer would have to pay if insured, and all payments of compensation made by such individual self-insurer during each prior period and to determine the amounts paid by each individual self-insurer and the amounts paid by all individual self-insurers during such period. For purposes of this section, the payroll records of each individual self-insurer shall be open to annual inspection and audit by the association and the department, or their authorized representative, during regular business hours, and if any audit of such records of an individual self-insurer discloses a deficiency in the amount reported to the association or in the amounts paid to the department by an individual self-insurer for its assessment for the Workers' Compensation Administration Trust Fund, the department or the association may assess the cost of such audit against the individual self-insurer.

(e) Require that the association notify the member employers and any other interested parties of the determination of insolvency and of their rights under this section. Such notification shall be by mail at the last known address thereof when available; but, if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(f) Suspend or revoke the authority of any member employer failing to pay an assessment when due or failing to comply with the plan of operation to self-insure in this state. As an alternative, the

department may levy a fine on any member employer failing to pay an assessment when due. Such fine shall not exceed 5 percent of the unpaid assessment per month, except that no fine shall be less than $100 per month.

(g) Revoke the designation of any servicing facility if the department finds that claims are being handled unsatisfactorily.

(7) EFFECT OF PAID CLAIMS.—

(a) Any person who recovers from the association under this section shall be deemed to have assigned his or her rights to the association to the extent of such recovery. Every claimant seeking the protection of this section shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent member. The association shall have no cause of action against the employee of the insolvent member for any sums the association has paid out, except such causes of action as the insolvent member would have had if such sums had been paid by the insolvent member. In the case of an insolvent member operating on a plan with assessment liability, payments of claims by the association shall not operate to reduce the liability of the insolvent member to the receiver, liquidator, or statutory successor for unpaid assessments.

(b) The receiver, liquidator, or statutory successor of an insolvent member shall be bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority against the assets of the insolvent member equal to that to which the claimant would have been entitled in the absence of this section. The expense of the association or similar organization in handling claims shall be accorded the same priority as the expenses of the liquidator.

(c) The association shall file periodically with the receiver or liquidator of the insolvent member statements of the covered claims paid by the association and estimates of anticipated claims on the association, which shall preserve the rights of the association against the assets of the insolvent member.

(8) NOTIFICATION OF INSOLVENCIES.—To aid in the detection and prevention of employer insolvencies: Upon determination by majority vote that any member employer may be insolvent or in a

financial condition hazardous to the employees thereof or to the public, it shall be the duty of the board of directors to notify the department of any information indicating such condition.

(9) EXAMINATION OF THE ASSOCIATION.—The association shall be subject to examination and regulation by the department. No later than March 30 of each year, the board of directors shall submit an audited financial statement for the preceding calendar year in a form approved by the department.

(10) IMMUNITY.—There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member employer, the association or its agents or employees, the board of directors, or the department or its representatives for any action taken by them in the performance of their powers and duties under this section.

(11) STAY OF PROCEEDINGS; REOPENING OF DEFAULT JUDGMENTS.—All proceedings in which an insolvent employer is a party, or is obligated to defend a party, in any court or before any quasi-judicial body or administrative board in this state shall be stayed for up to 6 months, or for such additional period from the date the employer becomes an insolvent member, as is deemed necessary by a court of competent jurisdiction to permit proper defense by the association of all pending causes of action as to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent member. The association, either on its own behalf or on behalf of the insolvent member, may apply to have such judgment, order, decision, verdict, or finding set aside by the same court or administrator that made such judgment, order, decision, verdict, or finding and shall be permitted to defend against such claim on the merits. If requested by the association, the stay of proceedings may be shortened or waived.

(12) LIMITATION ON CERTAIN ACTIONS.—Notwithstanding any other provision of this chapter, a covered claim, as defined herein, with respect to which settlement is not effected and pursuant to which suit is not instituted against the insured of an insolvent member or the association within 1 year after the deadline for filing claims with the receiver of the insolvent member, or any extension of the deadline, shall thenceforth be barred as a claim against the association.

(13) CORPORATE INCOME TAX CREDIT.—Any sums acquired by a member by refund, dividend, or otherwise from the association shall be payable within 30 days of receipt to the Department of Revenue for deposit with the Chief Financial Officer to the credit of the General Revenue Fund. All

provisions of chapter 220 relating to penalties and interest on delinquent corporate income tax payments apply to payments due under this subsection.

440.3851 Public records and public meetings exemptions.—

(1) The following records of the Florida Self-Insurers Guaranty Association, Incorporated, are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Claims files, until termination of all litigation and settlement of all claims arising out of the same accident.

(b) Medical records that are part of a claims file and other information relating to the medical condition or medical status of a claimant.

(c) Minutes of exempt portions of meetings, as provided in subsection (3), until termination of all litigation and settlement of all claims with regard to that claim.

(2) Records or portions of records made confidential and exempt by this section may be released, upon written request, to another agency in the performance of that agency's official duties and responsibilities. The receiving agency shall maintain the confidential and exempt status of such record or portion of a record.

(3) (a) That portion of a meeting of the association's board of directors or any subcommittee of the association's board at which records made confidential and exempt by this section are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) All exempt portions of meetings shall be recorded and transcribed. The board shall record the times of commencement and termination of the meeting, all discussion and proceedings, the names of all persons present at any time, and the names of all persons speaking. An exempt portion of any meeting may not be off the record.

(c) Subject to this section and s. 119.021(2), the court reporter's notes of any exempt portion of a meeting shall be retained by the association for a minimum of 5 years.

(d) A copy of the transcript of any exempt portion of a meeting in which claims files are discussed shall become public as to individual claims after settlement of the claim with any confidential and exempt information redacted.

440.386 Individual self-insurers' insolvency; conservation; liquidation.—

(1) JURISDICTION OF DELINQUENCY PROCEEDING VENUE; CHANGE OF APPEAL.—

(a) The circuit court shall have original jurisdiction in any delinquency proceeding under this section, and any court with jurisdiction is authorized to make all necessary or proper orders to carry out the purposes of this section.

(b) The venue of a delinquency proceeding or summary proceeding against a domestic or foreign individual self-insurer shall be in the Circuit Court of Leon County.

(c) An appeal shall be to the District Court of Appeal, First District, from an order granting or refusing liquidation or conservation and from every order in a delinquency proceeding having the character of a final order as to the particular portion of the proceeding embraced therein.

(2) COMMENCEMENT OF DELINQUENCY PROCEEDING.—The department or the Florida Self-Insurers Guaranty Association, Incorporated, may commence a delinquency proceeding by application to the court for an order directing the individual self-insurer to show cause why the department or association should not have the relief sought. On the return of such order to show cause, and after a full hearing, the court shall either deny the application or grant the application, together with such other relief as the nature of the case and the interests of the claimants, creditors, stockholders, members, subscribers, or public may require. The department and the association shall give reasonable written notice to each other of all hearings which pertain to an adjudication of insolvency of a member individual self-insurer.

(3) GROUNDS FOR LIQUIDATION.—The department or the association may apply to the court for an order appointing a receiver and directing the receiver to liquidate the business of a domestic individual self-insurer if such individual self-insurer is insolvent.

(4) GROUNDS FOR CONSERVATION; FOREIGN INDIVIDUAL SELF-INSURERS.—

(a) The department or the association may apply to the court for an order appointing a receiver or ancillary receiver, and directing the receiver to conserve the assets within this state, of a foreign individual self-insurer if such individual self-insurer is insolvent.

(b) An order to conserve the assets of an individual self-insurer shall require the receiver forthwith to take possession of the property of the receiver within the state and to conserve it, subject to the further direction of the court.

(5) PROCEDURE IN LIQUIDATIONS OF INDIVIDUAL SELF-INSURER BY COURT.—

(a) In proceedings to liquidate the assets and business of an individual self-insurer, the court shall have power:

1. To issue injunctions.

2. To appoint a receiver or receivers pendente lite with such powers and duties as the court, from time to time, may direct.

3. To take such other proceedings as may be requisite to preserve the individual self-insurer assets, wherever situated, and carry on the business of the individual self-insurer until a full hearing can be held.

(b) After a hearing had upon such notice as the court may direct to be given to all parties to the proceedings and to any other parties in interest designated by the court, the court may appoint a liquidating receiver or receivers with authority to collect the assets of the individual self-insurer. Such liquidating receiver or receivers shall have authority, subject to the order of the court, to sell, convey, and dispose of all or any part of the assets of the individual self-insurer, wherever situated, either at public or private sale. The assets of the individual self-insurer or the proceeds resulting from a sale, conveyance, or other disposition thereof shall be applied to the expenses of such liquidation and to the payment of the liabilities and obligations of the individual self-insurer, and any remaining assets or proceeds shall be distributed among its owners or shareholders according to their respective rights and interests. The order appointing such liquidating receiver or receivers shall state their powers and duties. Such powers and duties may be increased or diminished at any time during the proceedings.

(c) The court shall have power to allow, from time to time, as expenses of the liquidation, compensation to the receiver or receivers and to the receiver’s attorneys in the proceeding and to direct

the payment thereof out of the assets of the individual self-insurer or the proceeds of any sale or disposition of such assets.

(d) A receiver of an individual self-insurer appointed under the provisions of this section shall have authority to sue and defend in all courts in her or his own name as receiver of such individual self-insurer. The court appointing such receiver shall have exclusive jurisdiction of the individual self-insurer and its property, wherever situated.

(e) The circuit court shall have jurisdiction to appoint an ancillary receiver for the assets and business of such individual self-insurer, to serve ancillary to the receiver for the assets and business of the individual self-insurer acting under orders of a court having jurisdiction to appoint such a receiver for the individual self-insurer, located in any other state, whenever circumstances exist deemed by the court to require the appointment of such ancillary receiver. Such court, whenever circumstances exist deemed by it to require the appointment of a receiver for all the assets in and out of this state, and the business, of a foreign individual self-insurer doing business in this state, in accordance with the ordinary usages of equity, may appoint such a receiver for all its assets in and out of this state, and its business, even though no receiver has been appointed elsewhere. Such receivership shall be converted into an ancillary receivership when deemed appropriate by such circuit court in the light of orders entered by a court of competent jurisdiction in some other state, providing for a receivership of all assets and business of such individual self-insurer.

(6) QUALIFICATIONS OF RECEIVERS.—A receiver shall in all cases be a natural person or a corporation authorized to act as receiver, which corporation may be a domestic corporation or a foreign corporation authorized to transact business in this state, and shall in all cases give such bond as the court may direct, with such sureties as the court may require.

(7) FILING OF CLAIMS IN LIQUIDATION PROCEEDINGS.—In proceedings to liquidate the assets and business of an individual self-insurer, the court may require all creditors of the individual self-insurer to file with the clerk of the court or with the receiver, in such form as the court may prescribe, proofs under oath of their respective claims. If the court requires the filing of claims, it shall fix a date, which shall be not less than 4 months from the date of the offer, as the last day for filing of claims, and shall prescribe the notice of the date so fixed that shall be given to creditors and claimants.

Prior to the date so fixed, the court may extend the time for the filing of claims. Creditors and claimants failing to file proofs of claim on or before the date so fixed may be barred, by order of court, from participating in the distribution of the assets of the individual self-insurer. Nothing in this section affects the enforceability of any recorded mortgage or lien or the perfected security interest or rights of a person in possession of real or personal property.

(8) DISCONTINUANCE OF DELINQUENCY PROCEEDINGS.—The liquidation of the assets and business or other delinquency proceedings of an individual self-insurer may be discontinued at any time during the proceedings when it is established that cause for the delinquency proceeding no longer exists. In such event, the court shall dismiss the proceedings and direct the receiver to redeliver to the individual self-insurer all its remaining property and assets.

(9) VOIDABLE TRANSFERS.—

(a) Any transfer of, or lien upon, the property of an individual self-insurer which is made or created within 4 months prior to the granting of an order to show cause under this section with the intent of giving to any creditor a preference or of enabling the creditor to obtain a greater percentage of her or his debt than any other creditor of the same class, and which is accepted by such creditor having reasonable cause to believe that such preference will occur, shall be voidable.

(b) Every director, officer, employee, stockholder, member, subscriber, and any other person acting on behalf of such individual self-insurer who shall be concerned in any such act or deed and every person receiving thereby any property of such individual self-insurer or the benefit thereof shall be personally liable therefor and shall be bound to account to the court.

(c) The receiver in any proceeding under this section may avoid any transfer of or lien upon the property of an individual self-insurer which any creditor, stockholder, or subscriber of such individual self-insurer might have avoided and may recover the property so transferred unless such person was a bona fide holder for value prior to the date of the entering of an order to show cause under this chapter. Such property or its value may be recovered from anyone who has received it except a bona fide holder for value as herein specified.

(10) TRANSFERS PRIOR TO PETITION.—

(a) Every transfer made or suffered and every obligation incurred by an individual self-insurer within 1 year prior to the filing of a successful petition in any delinquency proceeding under this section, upon a showing by the receiver that the same was incurred without fair consideration, or with actual intent to hinder, delay, or defraud either then-existing or future creditors, shall be fraudulent and voidable. However, every such transfer or obligation incurred or suffered within 6 months prior to the filing of the above petition shall be presumed void and fraudulent, with the burden of proof upon the obligee or transferee to show otherwise. This paragraph shall not apply to a person who in good faith is a purchaser, lienor, or obligee, for a present fair equivalent value, but any purchaser, lienor, or obligee who in good faith has given a valuable consideration less than fair for such transfer, lien, or obligation may retain the property, lien, or obligation as a security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

(b) Transfers shall be deemed to have been made or suffered, or obligations incurred, when perfected according to the following criteria:

1. A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

2. A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the individual self-insurer could obtain rights superior to the rights of the transferee.

3. A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

4. Any transfer not perfected prior to the filing of a petition in a delinquency proceeding shall be deemed to be made immediately before the filing of a successful petition.

Subparagraphs 1.-4. apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(c) The transferor or obligor individual self-insurer shall record and preserve adequate official memoranda by corporate minutes which shall fully reflect all transactions involving transfers as contemplated by this section of real property or securities of any type and, in the case of all other property or assets, any transfer out of the individual self-insurer's ordinary course of business. Any person, firm, or corporation, or any officer, director, or employee thereof, who violates this paragraph commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or by a fine of not more than $5,000. Each instance of such violation shall be considered a separate offense.

(d) The personal liability of the officers or directors of an insolvent individual self-insurer is subject to part I of chapter 607 and the penalties provided therein.

(e) Every transaction of the individual self-insurer with a reinsurer or an excess insurer within 1 year prior to the filing of the petition shall be voidable upon a showing that such transaction was made without fair consideration or with intent to hinder, delay, or defraud either then-existing or future creditors notwithstanding the provisions of subsection (1).

(11) TRANSFERS AFTER PETITION.—

(a) After the original petition is filed in any delinquency proceeding, a transfer of any of the real property of the individual self-insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The recording of a copy of the petition for, or order in, any delinquency proceeding with the clerk of the circuit court in the county where any real property in question is located is constructive notice of the commencement of a delinquency proceeding. The exercise by a court of the United States or any state with jurisdiction to authorize or effect a judicial sale of real property of the individual self-insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(b) After the original petition for a delinquency proceeding has been filed and before an order of conservation or liquidation is granted:

1. A transfer of any of the property of the individual self-insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred.

2. A person indebted to the individual self-insurer or holding property of the individual self-insurer may, if acting in good faith, pay the indebtedness or deliver the property or any part thereof to the individual self-insurer or upon her or his order, with the same effect as if the petition were not pending.

(c) A person having actual knowledge of the pending delinquency proceeding shall be deemed not to act in good faith.

(d) A person asserting the validity of a transfer under this subsection has the burden of proof. Except as elsewhere provided in this subsection, any transfer by or in behalf of the individual self-insurer after the date of filing of the original petition in any delinquency proceeding requesting the appointment of a receiver by any person other than the receiver is not valid against the receiver.

(e) Nothing in this section shall impair the negotiability of currency or negotiable instruments.

(12) JUDGMENT OF INVOLUNTARY DISSOLUTION; ENTRY; FILING.—

(a) In proceedings to liquidate the assets and business of an individual self-insurer which is a corporation, when the costs and expenses of such proceedings and all debts, obligations, and liabilities of the corporation shall have been paid and discharged and all of its remaining property and assets distributed to its shareholders or, in case its property and assets are not sufficient to satisfy and discharge such costs, expenses, debts, and obligations, all the property and assets have been applied so far as they will go to their payment, the court shall enter a judgment dissolving the corporation, whereupon the existence of the corporation shall cease.

(b) In case the court shall enter a judgment dissolving a corporation, it shall be the duty of the clerk of such court to cause a certified copy of the judgment to be filed with the Department of State. No fee shall be charged by the Department of State for the filing thereof.

(13) GUARANTY FUND; ORDERS OF COURT.—Any delinquency order issued pursuant to this section shall authorize and direct the receiver to coordinate the operation of the receivership with the

operation of the Florida Self-Insurers Guaranty Association, Incorporated. Such authorization shall include, but not be limited to, release of copies of any of the following:

(a) Workers' compensation claims files, records, or documents pertaining to workers' compensation claims on file with the insolvent individual self-insurer.

(b) Workers' compensation claims filed with the receiver.

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 or her employment by the negligence or wrongful act of a third-party tortfeasor, such injured employee or, in the case of his or her death, the employee's dependents may accept compensation benefits under the provisions of this law, and at the same time such injured employee or his or her dependents or personal representatives may pursue his or her remedy by action at law or otherwise against such third-party tortfeasor.

(2) If the employee or his or her 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 or her 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 or her 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 or her dependents or those entitled by law to sue in the event he or she 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 or her dependents or those entitled by law to sue in the event he or she 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 or her 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 or she 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 shall be served upon the employer and compensation carrier and upon all parties to the suit or their attorneys of record by the employee. Notice of payment of compensation benefits shall be served upon the employee and upon all parties to the suit or their attorneys of record by the employer and compensation carrier. However, if a migrant worker prevails under a private cause of action under the Migrant and Seasonal Agricultural Worker Protection Act (AWPA) 96 Stat. 2583, as amended, 29 U.S.C. ss. 1801 et seq. (1962 ed. and Supp. V), any recovery by the migrant worker under this act shall be offset 100 percent against any recovery under AWPA.

(b) If the employer or insurance carrier has given written notice of his or her rights of subrogation to the third-party tortfeasor, and, thereafter, 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 or her 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 or her dependents and the injured employee's attorney, if represented by counsel, institute suit against such third-party tortfeasor, either in his or her 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 or her 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 the employee's 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 or her dependents and the employer or his or her insurance carrier, as the case may be.

(6) Any amounts recovered under this section by the employer or his or her 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.

440.40 Compensation notice.—Every employer who has secured compensation under the provisions of this chapter shall keep posted in a conspicuous place or places in and about her or his place or places of business typewritten or printed notices, in accordance with a form prescribed by the department, the following:

(1) A notice stating that such employer has secured the payment of compensation in accordance with the provisions of this chapter. Such notices shall contain the name and address of the carrier, if any, with whom the employer has secured payment of compensation and the date of the expiration of the policy. The department may by rule prescribe the form of the notices and require carriers to provide the notices to policyholders.

(2) A notice stating: "Anti-Fraud Reward Program.—Rewards of up to $25,000 may be paid to persons providing information to the Department of Financial Services leading to the arrest and

conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the department at (Phone No.). A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud, or bad faith."

440.41 Substitution of carrier for employer.—In any case where the employer is not a self-insurer, in order that the liability for compensation imposed by this chapter may be most effectively discharged by the employer, and in order that the administration of this chapter in respect of such liability may be facilitated, the department shall by regulation provide for the discharge, by the carrier for such employer, of such obligations and duties of the employer in respect of such liability, imposed by this chapter upon the employer, as it considers proper in order to effectuate the provisions of this chapter. For such purposes:

(1) Notice to or knowledge of an employer of the occurrence of the injury shall be notice to or knowledge of the carrier.

(2) Jurisdiction of the employer by the judges of compensation claims, the department, or any court under this chapter shall be jurisdiction of the carrier.

(3) Any requirement by the judges of compensation claims, the department, or any court under any compensation order, finding, or decision shall be binding upon the carrier in the same manner and to the same extent as upon the employer.

440.42 Insurance policies; liability.—

(1) Every policy or contract of insurance issued under authority of this chapter shall contain:

(a) A provision to carry out the provisions of s. 440.41; and

(b) A provision that insolvency or bankruptcy of the employer and discharge therein shall not relieve the carrier from payment of compensation for disability or death sustained by an employee during the life of such policy or contract.

(2) A workers' compensation insurance policy may require the employer to release certain employment and wage information maintained by the state pursuant to federal and state reemployment assistance laws except to the extent prohibited or limited under federal law. By entering into a workers' compensation insurance policy with such a provision, the employer consents to the release of the information. The insurance carrier requiring such consent shall safeguard the information and maintain its confidentiality. The carrier shall limit use of the information to verifying compliance with the terms of the workers' compensation insurance policy. The department may charge a fee to cover the cost of disclosing the information.

(3) No contract or policy of insurance issued by a carrier under this chapter shall expire or be canceled until at least 30 days have elapsed after a notice of cancellation has been sent to the department and to the employer in accordance with the provisions of s. 440.185(7). For cancellation due to nonpayment of premium, the insurer shall mail notification to the employer at least 10 days prior to the effective date of the cancellation. However, when duplicate or dual coverage exists by reason of two different carriers having issued policies of insurance to the same employer securing the same liability, it shall be presumed that only that policy with the later effective date shall be in force and that the earlier policy terminated upon the effective date of the latter. In the event that both policies carry the same effective date, one of the policies may be canceled instanter upon filing a notice of cancellation with the department and serving a copy thereof upon the employer in such manner as the department prescribes by rule. The department may by rule prescribe the content of the notice of retroactive cancellation and specify the time, place, and manner in which the notice of cancellation is to be served.

(4) When there is any controversy as to which of two or more carriers is liable for the discharge of the obligations and duties of one or more employers with respect to a claim for compensation, remedial treatment, or other benefits under this chapter, the judge of compensation claims shall have jurisdiction to adjudicate such controversy; and if one of the carriers voluntarily or in compliance with a compensation order makes payments in discharge of such liability and it is finally determined that another carrier is liable for all or any part of such obligations and duties with respect to such claim, the carrier which has made payments either voluntarily or in compliance with a compensation order shall be entitled to reimbursement from the carrier finally determined liable, and the judge of compensation claims shall have jurisdiction to order such reimbursement; however, if the carrier finally determined liable can demonstrate that it has been prejudiced by lack of knowledge or notice of its potential liability, such reimbursement shall be only with respect to payments made after it had knowledge or notice of its potential liability.

440.44 Workers' compensation; staff organization.—

(1) INTERPRETATION OF LAW.—As a guide to the interpretation of this chapter, the Legislature takes due notice of federal social and labor acts and hereby creates an agency to administer such acts passed for the benefit of employees and employers in Florida industry, and desires to meet the requirements of such federal acts wherever not inconsistent with the Constitution and laws of Florida.

(2) INTENT.—It is the intent of the Legislature that the department, the agency, and the Division of Administrative Hearings assume an active and forceful role in its administration of this act, so as to ensure that the system operates efficiently and with maximum benefit to both employers and employees.

(3) EXPENDITURES.—The department, the agency, the office, and the director of the Division of Administrative Hearings shall make such expenditures, including expenditures for personal services and rent at the seat of government and elsewhere, for law books; for telephone services and WATS lines; for books of reference, periodicals, equipment, and supplies; and for printing and binding as may be necessary in the administration of this chapter. All expenditures in the administration of this chapter

shall be allowed and paid as provided in s. 440.50 upon the presentation of itemized vouchers therefor approved by the department, the agency, the office, or the director of the Division of Administrative Hearings.

(4) PERSONNEL ADMINISTRATION.—Subject to the other provisions of this chapter, the department, the agency, the office, and the Division of Administrative Hearings may appoint, and prescribe the duties and powers of, bureau chiefs, attorneys, accountants, medical advisers, technical assistants, inspectors, claims examiners, and such other employees as may be necessary in the performance of their duties under this chapter.

(5) OFFICE.—The department, the agency, and the Deputy Chief Judge shall maintain and keep open during reasonable business hours an office, which shall be provided in the Capitol or some other suitable building in the City of Tallahassee, for the transaction of business under this chapter, at which office the official records and papers shall be kept. The office shall be furnished and equipped. The department, the agency, any judge of compensation claims, or the Deputy Chief Judge may hold sessions and conduct hearings at any place within the state. The Office of the Judges of Compensation Claims shall maintain the 17 district offices, 31 judges of compensation claims, and 31 mediators as they exist on June 30, 2001.

(6) SEAL.—The department and the judges of compensation claims shall have a seal upon which shall be inscribed the words “State of Florida Department of Financial Services—Seal” and “Division of Administrative Hearings—Seal,” respectively.

(7) DESTRUCTION OF OBSOLETE RECORDS.—The department is expressly authorized to provide by regulation for and to destroy obsolete records of the department. The Division of Administrative Hearings is expressly authorized to provide by regulation for and to destroy obsolete records of the Office of the Judges of Compensation Claims.

(8) PROCEDURE.—In the exercise of their duties and functions requiring administrative hearings, the department and the agency shall proceed in accordance with the Administrative Procedure Act. The authority of the department and the agency to issue orders resulting from administrative hearings as provided for in this chapter shall not infringe upon the jurisdiction of the judges of compensation claims.

440.442 Code of Judicial Conduct.—The Deputy Chief Judge and judges of compensation claims shall observe and abide by the Code of Judicial Conduct as adopted by the Florida Supreme Court. Any material violation of a provision of the Code of Judicial Conduct shall constitute either malfeasance or misfeasance in office and shall be grounds for suspension and removal of the Deputy Chief Judge or judge of compensation claims by the Governor.

440.45 Office of the Judges of Compensation Claims.—

(1) (a) There is created the Office of the Judges of Compensation Claims within the Department of Management Services. The Office of the Judges of Compensation Claims shall be headed by the Deputy Chief Judge of Compensation Claims. The Deputy Chief Judge shall report to the director of the Division of Administrative Hearings. The Deputy Chief Judge shall be appointed by the Governor for a term of 4 years from a list of three names submitted by the statewide nominating commission created under subsection (2). The Deputy Chief Judge must demonstrate prior administrative experience and possess the same qualifications for appointment as a judge of compensation claims, and the procedure for reappointment of the Deputy Chief Judge will be the same as for reappointment of a judge of compensation claims. The office shall be a separate budget entity and the director of the Division of Administrative Hearings shall be its agency head for all purposes, including, but not limited to, rulemaking pursuant to subsection (4) and establishing agency policies and procedures. The Department of Management Services shall provide administrative support and service to the office to the extent requested by the director of the Division of Administrative Hearings 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.

(b) Effective October 1, 2001, the position of Deputy Chief Judge of Compensation Claims is created.

(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 nominated to serve as a judge of compensation claims unless he or she has been a member of The Florida Bar in good standing for the previous 5 years and is experienced in the practice of law of workers' compensation. No judge of compensation claims shall engage in the private practice of law during a term of office.

(b) Except as provided in paragraph (c), the Governor shall 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:

1. Five members, at least one of whom must be a member of a minority group as defined in s. 288.703, 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. The Board of Governors shall appoint members who reside in the odd-numbered district court of appeal jurisdictions to 4-year terms each, beginning July 1, 1999, and members who reside in the even-numbered district court of appeal jurisdictions to 2-year terms each, beginning July 1, 1999. Thereafter, each member shall be appointed for a 4-year term;

2. Five electors, at least one of whom must be a member of a minority group as defined in s. 288.703, one of each who resides in each of the territorial jurisdictions of the district courts of appeal, appointed by the Governor. The Governor shall appoint members who reside in the odd-numbered district court of appeal jurisdictions to 2-year terms each, beginning July 1, 1999, and members who reside in the even-numbered district court of appeal jurisdictions to 4-year terms each, beginning July 1, 1999. Thereafter, each member shall be appointed for a 4-year term; and

3. Five electors, at least one of whom must be a member of a minority group as defined in s. 288.703, 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. A majority of the other members of the commission shall appoint members who reside in the odd-numbered district court of appeal jurisdictions to 2-year terms each, beginning October 1, 1999, and members who reside in the even-numbered district court of appeal jurisdictions to 4-year terms each, beginning October 1, 1999. Thereafter, each member shall be appointed for a 4-year term.

A vacancy occurring on the commission shall be filled by the original appointing authority for the unexpired balance of the term. 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 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 and determine whether the judge's performance is satisfactory. Effective July 1, 2002, in determining whether a judge's performance is satisfactory, the commission shall consider the extent to which the judge has met the requirements of this chapter, including, but not limited to, the requirements of ss. 440.25(1) and (4)(a)-(e), 440.34(2), and 440.442. If the judge's performance is deemed satisfactory, 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 Governor shall review the commission's report and may reappoint the judge for an additional 4-year term. If the Governor does not reappoint the judge, the Governor shall inform the commission. The judge shall remain in office until the Governor has appointed a successor judge in accordance with paragraphs (a) and (b). If a vacancy occurs during a judge's unexpired term, the statewide nominating commission does not find the judge's performance is satisfactory, or the Governor does not reappoint the judge, the Governor shall appoint a successor judge for a term of 4 years in accordance with paragraph (b).

(d) The Governor may appoint any attorney who has at least 5 years of experience in the practice of law in this state to serve as a judge of compensation claims pro hac vice in the absence or disqualification of any full-time judge of compensation claims or to serve temporarily as an additional judge of compensation claims in any area of the state in which the Governor determines that a need exists for such an additional judge. However, an attorney who is so appointed by the Governor may not serve for a period of more than 120 successive days.

(e) The director of the Division of Administrative Hearings may receive or initiate complaints, conduct investigations, and dismiss complaints against the Deputy Chief Judge and the judges of

compensation claims on the basis of the Code of Judicial Conduct. The director may recommend to the Governor the removal of the Deputy Chief Judge or a judge of compensation claims or recommend the discipline of a judge whose conduct during his or her term of office warrants such discipline. For purposes of this section, the term "discipline" includes reprimand, fine, and suspension with or without pay. At the conclusion of each investigation, the director shall submit preliminary findings of fact and recommendations to the judge of compensation claims who is the subject of the complaint. The judge of compensation claims has 20 days within which to respond to the preliminary findings. The response and the director's rebuttal to the response must be included in the final report submitted to the Governor.

(3) The Deputy Chief Judge shall establish training and continuing education for new and sitting judges.

(4) The Office of the Judges of Compensation Claims shall adopt rules to carry out the purposes of this section. Such rules must include procedural rules applicable to workers' compensation claim resolution, including rules requiring electronic filing and service where deemed appropriate by the Deputy Chief Judge, and uniform criteria for measuring the performance of the office, including, but not limited to, the number of cases assigned and resolved, the age of pending and resolved cases, timeliness of decisions, extraordinary fee awards, and other data necessary for the judicial nominating commission to review the performance of judges as required in paragraph (2)(c).

(5) Not later than December 1 of each year, the Office of the Judges of Compensation Claims shall issue a written report to the Governor, the House of Representatives, the Senate, The Florida Bar, and the statewide nominating commission summarizing the amount, cost, and outcome of all litigation resolved in the previous fiscal year; summarizing the disposition of mediation conferences, the number of mediation conferences held, the number of continuances granted for mediations and final hearings, the number and outcome of litigated cases, the amount of attorney's fees paid in each case according to order year and accident year, and the number of final orders not issued within 30 days after the final hearing or closure of the hearing record; and recommending changes or improvements to the dispute resolution elements of the Workers' Compensation Law and regulations. If the Deputy Chief Judge finds that judges generally are unable to meet a particular statutory requirement for reasons beyond

their control, the Deputy Chief Judge shall submit such findings and any recommendations to the Legislature.

440.47 Travel expenses.—The Deputy Chief Judge, judges of compensation claims, and employees of the department shall be reimbursed for travel expenses as provided in s. 112.061. Such expenses shall be sworn to by the person who incurred the same and shall be allowed and paid as provided in s. 440.50 upon the presentation of vouchers therefor approved by the director of the Division of Administrative Hearings or the department, whichever is applicable.

440.49 Limitation of liability for subsequent injury through Special Disability Trust Fund.—

(1) LEGISLATIVE INTENT.—Whereas it is often difficult for workers with disabilities to achieve employment or to become reemployed following an injury, and it is 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 her or 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 department or the administrator 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 her 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.

(e) "Administrator" means the entity selected by the department to review, allow, deny, compromise, controvert, and litigate claims of the Special Disability Trust Fund.

In addition to the definitions contained in this subsection, the department may by rule prescribe definitions that are necessary for the effective administration of this section.

(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 under1subparagraph (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, her or 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 (9) for 50 percent of all impairment benefits which the employer has been required to provide pursuant to s. 440.15(3) 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, her or 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 (9) 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 her or his employment, or suffers an injury as a result of a merger as defined in paragraph (2)(c), the employer shall provide all benefits provided by this chapter, but, subject to the limitations specified in subsection

(7), the employer shall be reimbursed by the Special Disability Trust Fund created by subsection (9) for 50 percent of its payments for temporary, medical, and attendant care benefits.

(5) WHEN DEATH RESULTS.—If death results from the subsequent permanent impairment contemplated in subsection (4) 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), she or he shall be reimbursed from the Special Disability Trust Fund created by subsection (9) 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.—

(a) Reimbursement is not allowed under this section unless it is established that the employer knew of the preexisting permanent physical impairment prior to the occurrence of the subsequent injury or occupational disease, and the permanent physical impairment is one of the following:

1. Epilepsy.
2. Diabetes.
3. Cardiac disease.
4. Amputation of foot, leg, arm, or hand.
5. Total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75 percent bilaterally.
6. Residual disability from poliomyelitis.
7. Cerebral palsy.
8. Multiple sclerosis.
9. Parkinson’s disease.
10. Meniscectomy.
11. Patellectomy.
12. Ruptured cruciate ligament.
13. Hemophilia.

14. Chronic osteomyelitis.

15. Surgical or spontaneous fusion of a major weight-bearing joint.

16. Hyperinsulinism.

17. Muscular dystrophy.

18. Thrombophlebitis.

19. Herniated intervertebral disk.

20. Surgical removal of an intervertebral disk or spinal fusion.

21. One or more back injuries or a disease process of the back resulting in disability over a total of 120 or more days, if substantiated by a doctor's opinion that there was a preexisting impairment to the claimant's back.

22. Total deafness.

23. Intellectual disability if the employee's intelligence quotient is such that she or he falls within the lowest 2 percentile of the general population. However, the employer does not need to know the employee's actual intelligence quotient or actual relative ranking in relation to the intelligence quotient of the general population.

24. Any permanent physical condition that, prior to the industrial accident or occupational disease, constitutes a 20 percent impairment of a member or of the body as a whole.

25. Obesity if the employee is 30 percent or more over the average weight designated for her or his height and age in the Table of Average Weight of Americans by Height and Age prepared by the Society of Actuaries using data from the 1979 Build and Blood Pressure Study.

26. Any permanent physical impairment as provided in s. 440.15(3) which is a result of a prior industrial accident with the same employer or the employer's parent company, subsidiary, sister company, or affiliate located within the geographical boundaries of this state.

(b) The Special Disability Trust Fund is not liable for any costs, interest, penalties, or attorneys' fees.

(c) An employer's or carrier's right to apportionment or deduction pursuant to ss. 440.02(1), 440.15(5)(b), and 440.151(1)(c) does not preclude reimbursement from such fund, except when the merger comes within the definition of paragraph (2)(c) and such apportionment or deduction relieves

the employer or carrier from providing the materially and substantially greater permanent disability benefits otherwise contemplated in those paragraphs.

(7) REIMBURSEMENT OF EMPLOYER.—

(a) The right to reimbursement as provided in this section is barred unless written notice of claim of the right to such reimbursement is filed by the employer or carrier entitled to such reimbursement with the department or administrator at Tallahassee within 2 years after the date the employee last reached maximum medical improvement, or within 2 years after the date of the first payment of compensation for permanent total disability, wage loss, or death, whichever is later. The notice of claim must contain such information as the department by rule requires or as established by the administrator; and the employer or carrier claiming reimbursement shall furnish such evidence in support of the claim as the department or administrator reasonably may require.

(b) For notice of claims on the Special Disability Trust Fund filed on or after July 1, 1978, the Special Disability Trust Fund shall, within 120 days after receipt of notice that a carrier has paid, been required to pay, or accepted liability for excess compensation, serve notice of the acceptance of the claim for reimbursement.

(c) A proof of claim must be filed on each notice of claim on file as of June 30, 1997, within 1 year after July 1, 1997, or the right to reimbursement of the claim shall be barred. A notice of claim on file on or before June 30, 1997, may be withdrawn and refiled if, at the time refiled, the notice of claim remains within the limitation period specified in paragraph (a). Such refiling shall not toll, extend, or otherwise alter in any way the limitation period applicable to the withdrawn and subsequently refiled notice of claim. Each proof of claim filed shall be accompanied by a proof-of-claim fee as provided in paragraph (9)(d). The Special Disability Trust Fund shall, within 120 days after receipt of the proof of claim, serve notice of the acceptance of the claim for reimbursement. This paragraph shall apply to all claims notwithstanding the provisions of subsection (12).

(d) Each notice of claim filed or refiled on or after July 1, 1997, must be accompanied by a notification fee as provided in paragraph (9)(d). A proof of claim must be filed within 1 year after the date the notice of claim is filed or refiled, accompanied by a proof-of-claim fee as provided in paragraph (9)(d), or the claim shall be barred. The notification fee shall be waived if both the notice of

claim and proof of claim are submitted together as a single filing. The Special Disability Trust Fund shall, within 180 days after receipt of the proof of claim, serve notice of the acceptance of the claim for reimbursement. This paragraph shall apply to all claims notwithstanding the provisions of subsection (12).

(e) For dates of accident on or after January 1, 1994, the Special Disability Trust Fund shall, within 120 days of receipt of notice that a carrier has been required to pay, and has paid over $10,000 in benefits, serve notice of the acceptance 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 department or administrator at Tallahassee within 60 days after notice to the employer or carrier of such denial or controversion. 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 reimbursement, 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, including any finding made or order entered pursuant to s. 440.20(11), shall be res judicata. The Special Disability Trust Fund may not be joined or made a party to any controversy or dispute between an employee and the dependents and the employer or between two or more employers or carriers without the written consent of the fund.

(f) 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 payment in accordance with rules prescribed by the department, which rules may include parameters for annual audits. The Special Disability Trust Fund shall pay the approved reimbursement requests on a first-in, first-out basis reflecting the order in which the reimbursement requests were received.

(g) The department may by rule require specific forms and procedures for the administration and processing of claims made through the Special Disability Trust Fund.

(8) PREFERRED WORKER PROGRAM.—The Department of Education or administrator shall issue identity cards to preferred workers upon request by qualified employees and the Department of Financial Services shall reimburse an employer, from the Special Disability Trust Fund, for the cost of 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. The Department of Financial Services and the Department of Education may by rule prescribe definitions, forms, and procedures for the administration of the preferred worker program. The Department of Education may by rule prescribe the schedule for submission of forms for participation in the program.

(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 Chief Financial Officer shall be the custodian of such fund, and all moneys and securities in such fund shall be held in trust by such Chief Financial Officer and shall not be the money or property of the state. The Chief Financial Officer is authorized to disburse moneys from such fund only when approved by the department or corporation. The Chief Financial Officer shall deposit any moneys paid into such fund into such depository banks as the department may designate and is authorized to invest any portion of the fund which, in the opinion of the department, 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 Chief Financial Officer. All interest earned by such portion of the fund as may be invested by the Chief Financial Officer shall be collected by her or him and placed to the credit of such fund.

(b) 1. 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 as defined in s. 628.6011, 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. Payments of assessments shall be made by each carrier, self-insurer, and self-insured employer to the department for the Special Disability Trust Fund pursuant to department rule establishing such method of payment.

2. The department shall estimate annually in advance the amount necessary for the administration of this subsection and the maintenance of this fund pursuant to this paragraph. By July 1 of each year, the department shall calculate the assessment rate, which shall be based upon the net premiums written by carriers and self-insurers, the amount of premiums calculated by the department for self-insured employers, the sum of the anticipated disbursements and expenses of the Special Disability Trust Fund for the next calendar year, and the expected fund balance for the next calendar year. Such assessment rate shall take effect January 1 of the next calendar year. Such amount shall be prorated among the insurance companies writing workers' compensation insurance in the state, the self-insurers, and the self-insured employers.

3. All reimbursement requests that are approved, but remain unpaid as of June 30, 2014, shall be paid by October 31, 2014.

4. The Chief Financial Officer 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 Special Disability Trust Fund assessment rate calculated pursuant to this section, the rate assessed may not exceed 2.50 percent.

(d) The Special Disability Trust Fund shall be supplemented by a $250 notification fee on each notice of claim filed or refiled after July 1, 1997, and a $500 fee on each proof of claim filed in accordance with subsection (7). Revenues from the fee shall be deposited into the Special Disability Trust Fund and are exempt from the deduction required by s. 215.20. The fees provided in this paragraph shall not be imposed upon any insurer which is in receivership with the department.

(e) The department or administrator shall report annually on the status of the Special Disability Trust Fund. The report shall update the estimated undiscounted and discounted fund liability, as determined by an independent actuary, change in the total number of notices of claim on file with the fund in

addition to the number of newly filed notices of claim, change in the number of proofs of claim processed by the fund, the fee revenues refunded and revenues applied to pay down the liability of the fund, the average time required to reimburse accepted claims, and the average administrative costs per claim. The department or administrator shall submit its report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1 of each year.

(10) DEPARTMENT ADMINISTRATION OF FUND; CLAIMS; EXPENSES.—The department or administrator 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 department or administrator 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. 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 department.

(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, or on or after January 1, 1998. In no event shall the Special Disability Trust Fund be liable for, or reimburse employers or carriers for, any case in which the accident causing the subsequent injury or death or the disablement or death from a subsequent occupational disease occurred on or after January 1, 1998. The Special Disability Trust Fund shall continue to reimburse employers or carriers for subsequent injuries occurring prior to January 1, 1998, and the department shall continue to assess for and the department or administrator shall fund reimbursements as provided in subsection (9) for this purpose.

(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.

440.491 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) "Rehabilitation provider" means a rehabilitation nurse, rehabilitation counselor, or vocational evaluator providing reemployment assessments, medical care coordination, reemployment services, or vocational evaluations under this section, possessing one or more of the following nationally recognized rehabilitation provider credentials:

1. Certified Rehabilitation Registered Nurse, C.R.R.N., certified by the Association of Rehab Professionals.

2. Certified Rehabilitation Counselor, C.R.C., certified by the Commission of Rehabilitation Counselor Certifications.

3. Certified Case Manager, C.C.M., certified by the Commission for Case Management Certification.

4. Certified Disability Management Specialist, C.D.M.S., certified by the Certified Disability Management Specialist Commission.

5. Certified Vocational Evaluator, C.V.E., certified by the Commission of Rehabilitation Counselor Certification.

6. Certified Occupational Health Nurse, C.O.H.N., certified by the American Board of Occupational Health Nurses.

(d) "Reemployment assessment" means a written assessment performed by a 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 or her average weekly earnings at the time of injury.

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

(2) INTENT.—It is the intent of this section 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 employee. The report shall include the identification of both the carrier and the employee, the carrier claim number, and any case number assigned by the Office of the Judges of Compensation Claims. 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 a rehabilitation provider to provide the reemployment assessment. The rehabilitation provider shall conduct its assessment and issue a report to the carrier and the employee 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 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 department for a vocational evaluation. Notwithstanding any provision of 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. 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 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 department shall conduct a training and education screening to determine whether it should refer the employee for a vocational evaluation, approve training and education, or approve other vocational services for the employee. At the time of such referral, the carrier shall provide the department a copy of any reemployment assessment or reemployment plan provided to the carrier by a rehabilitation provider. The department may not approve formal training and education programs unless it determines, after consideration of the reemployment assessment, that the reemployment plan is likely

to result in return to suitable gainful employment. The department may expend moneys from the Workers' Compensation Administration Trust Fund, established by s. 440.50, to secure appropriate training and education at a Florida public college or at a career center established under s. 1001.44, or to secure other vocational services when necessary to satisfy the recommendation of a vocational evaluator. As used in this paragraph, "appropriate training and education" includes securing a high school equivalency diploma, if necessary. The department shall by rule establish training and education standards pertaining to employee eligibility, course curricula and duration, and associated costs. For purposes of this subsection, training and education services may be secured from additional providers if:

1. The injured employee currently holds an associate degree and requests to earn a bachelor's degree not offered by a Florida public college located within 50 miles from his or her customary residence;

2. The injured employee's enrollment in an education or training program in a Florida public college or career center would be significantly delayed; or

3. The most appropriate training and education program is available only through a provider other than a Florida public college or career center or at a Florida public college or career center located more than 50 miles from the injured employee's customary residence.

(b) When an employee who has attained maximum medical improvement is unable to earn at least 80 percent of the compensation rate and requires training and education to obtain suitable gainful employment, the employer or carrier shall pay the employee additional training and education temporary total compensation benefits while the employee receives such training and education for a period not to exceed 26 weeks, which period may be extended for an additional 26 weeks or less, if such extended period is determined to be necessary and proper by a judge of compensation claims. The benefits provided under this paragraph shall not be in addition to the 104 weeks as specified in s. 440.15(2). However, a carrier or employer is not precluded from voluntarily paying additional temporary total disability compensation beyond that period. If an employee requires temporary residence at or near a facility or an institution providing training and education which is located more than 50 miles away from the employee's customary residence, the reasonable cost of board, lodging, or travel must be borne by the department from the Workers' Compensation Administration Trust Fund

established by s. 440.50. An employee who refuses to accept training and education that is recommended by the vocational evaluator and considered necessary by the department will forfeit any additional training and education benefits and any additional payment for lost wages under this chapter. The carrier shall notify the injured employee of the availability of training and education benefits as specified in this chapter. The Department of Financial Services shall include information regarding the eligibility for training and education benefits in informational materials specified in ss. 440.207 and 440.40.

(7) 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.

(8) DEPARTMENT CONTRACTS.—The department may contract with one or more third parties including, but not limited to, rehabilitation providers, to administer training and education screenings, reemployment assessments, vocational evaluations, and reemployment services authorized under this section. Any person or firm selected by the department may not have a conflict of interest that might affect its ability to independently perform its responsibilities with respect to administering the provisions of this subsection. A rehabilitation provider who contracts with the department to provide screenings or evaluations may not provide training or education to the injured employee.

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), the funding of the fixed administrative expenses of the plan, and the funding of the Bureau of Workers' Compensation Fraud within the Department of Financial Services. Such fund shall be administered by the department.

(b) The department 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 Chief Financial Officer is authorized to disburse moneys from such fund only when approved by the department.

(3) The Chief Financial Officer shall deposit any moneys paid into such fund into such depository banks as the department may designate and is authorized to invest any portion of the fund which, in the opinion of the department, is not needed for current requirements, in the same manner and subject to all the provisions of the law with respect to the deposit of state funds by such Chief Financial Officer. All interest earned by such portion of the fund as may be invested by the Chief Financial Officer shall be collected by him or her and placed to the credit of such fund.

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

(5) Funds appropriated by an operating appropriation or a nonoperating transfer from the Workers' Compensation Administration Trust Fund to the Agency for Health Care Administration, the Department of Business and Professional Regulation, the Department of Management Services, the First District Court of Appeal, and the Justice Administrative Commission remaining unencumbered as of June 30 or undisbursed as of September 30 each year shall revert to the Workers' Compensation Administration Trust Fund.

440.51 Expenses of administration.—

(1) The department shall estimate annually in advance the amounts necessary for the administration of this chapter, in the following manner.

(a) The department shall, by July 1 of each year, notify carriers and self-insurers of the assessment rate, which shall be based on the anticipated expenses of the administration of this chapter for the next calendar year. Such assessment rate shall take effect January 1 of the next calendar year and shall be included in workers' compensation rate filings approved by the office which become effective on or after January 1 of the next calendar year. Assessments shall become due and be paid quarterly.

(b) The total expenses of administration shall be prorated among the carriers writing compensation insurance in the state and self-insurers. The net premiums collected by carriers and the amount of premiums calculated by the department for self-insured employers are the basis for computing the amount to be assessed. When reporting deductible policy premium for purposes of computing assessments levied after July 1, 2001, full policy premium value must be reported prior to application of deductible discounts or credits. This amount may be assessed as a specific amount or as a percentage of net premiums payable as the department may direct, provided such amount so assessed shall not exceed 2.75 percent, beginning January 1, 2001, except during the interim period from July 1, 2000, through December 31, 2000, such assessments shall not exceed 4 percent of such net premiums. The carriers may elect to make the payments required under s. 440.15(1)(f) rather than having these payments made by the department. In that event, such payments will be credited to the carriers, and the amount due by the carrier under this section will be reduced accordingly.

(2) The department shall provide by regulation for the collection of the amounts assessed against each carrier. Such amounts shall be paid within 30 days from the date that notice is served upon such carrier. If such amounts are not paid within such period, there may be assessed for each 30 days the amount so assessed remains unpaid, a civil penalty equal to 10 percent of the amount so unpaid, which shall be collected at the same time and a part of the amount assessed. For those carriers who excluded ceded reinsurance premiums from their assessments prior to January 1, 2000, the department shall not recover any past underpayments of assessments related to ceded reinsurance premiums prior to January 1, 2001, against such carriers.

(3) If any carrier fails to pay the amounts assessed against him or her under the provisions of this section within 60 days from the time such notice is served upon him or her, the office, upon being notified by the department, may suspend or revoke the authorization to insure compensation in accordance with the procedure in s. 440.38(3)(a). The department may permit a carrier to remit any underpayment of assessments for assessments levied after January 1, 2001.

(4) All amounts collected under the provisions of this section shall be paid into the fund established in s. 440.50.

(5) Any amount so assessed against and paid by an insurance carrier, self-insurer authorized pursuant to s. 624.4621, or commercial self-insurance fund authorized under ss. 624.460-624.488 shall be allowed as a deduction against the amount of any other tax levied by the state upon the premiums, assessments, or deposits for workers' compensation insurance on contracts or policies of said insurance carrier, self-insurer, or commercial self-insurance fund. Any insurance carrier claiming such a deduction against the amount of any such tax shall not be required to pay any additional retaliatory tax levied pursuant to s. 624.5091 as a result of claiming such deduction. Because deductions under this subsection are available to insurance carriers, s. 624.5091 does not limit such deductions in any manner.

(6) The department may require from each carrier, at such time and in accordance with such regulations as the department may prescribe, reports in respect to all gross earned premiums and of all payments of compensation made by such carrier during each prior period, and may determine the amounts paid by each carrier and the amounts paid by all carriers during such period.

(7) The department shall keep accumulated cost records of all injuries occurring within the state coming within the purview of this chapter on a policy and calendar-year basis. For the purpose of this chapter, a "calendar year" is defined as the year in which the injury is reported to the department; "policy year" is defined as that calendar year in which the policy becomes effective, and the losses under such policy shall be chargeable against the policy year so defined.

(8) The department shall assign an account number to each employer under this chapter and an account number to each insurance carrier authorized to write workers' compensation insurance in the state; and it shall be the duty of the department under the account number so assigned to keep the cost

experience of each carrier and the cost experience of each employer under the account number so assigned by calendar and policy year, as above defined.

(9) In addition to the above, it shall be the duty of the department to keep the accident experience, as classified by the department, by industry as follows:

(a) Cause of the injury;

(b) Nature of the injury; and

(c) Type of disability.

(10) In every case where the duration of disability exceeds 30 days, the carrier shall establish a sufficient reserve to pay all benefits to which the injured employee, or in case of death, his or her dependents, may be entitled to under the law. In establishing the reserve, consideration shall be given to the nature of the injury, the probable period of disability, and the estimated cost of medical benefits.

(11) The department shall furnish to any employer or carrier, upon request, its individual experience.

(12) In addition to any other penalties provided by this law, the failure to submit any report or other information required by this law shall be just cause to suspend the right of a self-insurer to operate as such or shall be just cause for the department to suspend or revoke the license of such carrier.

(13) As used in s. 440.50 and this section, the term:

(a) "Plan" means the workers' compensation joint underwriting plan provided for in s. 627.311(5).

(b) "Fixed administrative expenses" means the expenses of the plan, not to exceed $750,000, which are directly related to the plan's administration but which do not vary in direct relationship to the amount of premium written by the plan and which do not include loss adjustment premiums.

(14) Before July 1 in each year, the plan shall notify the department of the amount of the plan's gross written premiums for the preceding calendar year. Whenever the plan's gross written premiums reported to the department are less than $30 million, the department shall transfer to the plan, subject to appropriation by the Legislature, an amount not to exceed the plan's fixed administrative expenses for the preceding calendar year.

440.515 Reports from self-insurers; confidentiality.—The department shall maintain the reports filed in accordance with former 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.

440.52 Registration of insurance carriers; notice of cancellation or expiration of policy; suspension or revocation of authority.—

(1) Each insurance carrier who desires to write such compensation insurance in compliance with this chapter shall be required, before writing such insurance, to register with the department and pay a registration fee of $100. This shall be deposited by the department in the fund created by s. 440.50.

(2) A carrier or self-insurance fund that receives notice pursuant to s. 440.05 shall notify the contractor of the cancellation or expiration of the insurance.

(3) If the department finds, after due notice and a hearing at which the insurance carrier is entitled to be heard in person or by counsel and present evidence, that the insurance carrier has repeatedly failed to comply with its obligations under this chapter, the department may request the office to suspend or revoke the authorization of such insurance carrier to write workers' compensation insurance under this chapter. Such suspension or revocation shall not affect the liability of any such insurance carrier under policies in force prior to the suspension or revocation.

(4) In addition to the penalties prescribed in subsection (3), violation of s. 440.381 by an insurance carrier shall result in the imposition of a fine not to exceed $1,000 per audit, if the insurance carrier fails to act on said audits by correcting errors in employee classification or accepted applications for coverage where it knew employee classifications were incorrect. Such fines shall be levied by the office and deposited into the Insurance Regulatory Trust Fund.

440.525 Examination and investigation of carriers and claims-handling entities.—

(1) The department and office may examine, or investigate any carrier, third-party administrator, servicing agent, or other claims-handling entity as often as is warranted to ensure that it is fulfilling its obligations under this chapter.

(2) An examination may cover any period of the carrier's, third-party administrator's, servicing agent's, or other claims-handling entity's operations since the last previous examination. An investigation based upon a reasonable belief by the department that a material violation of this chapter has occurred may cover any time period, but may not predate the last examination by more than 5 years. The department may by rule establish procedures, standards, and protocols for examinations and investigations. If the department finds any violation of this chapter, it may impose administrative penalties pursuant to this chapter. If the department finds any self-insurer in violation of this chapter, it may take action pursuant s. 440.38(3). Examinations or investigations by the department may address, but are not limited to addressing, patterns or practices of unreasonable delay in claims handling; timeliness and accuracy of payments and reports under ss. 440.13, 440.16, and 440.185; or patterns or practices of harassment, coercion, or intimidation of claimants. The department may also specify by rule the documentation to be maintained for each claim file.

(3) As to any examination or investigation conducted under this chapter, the department shall have the power to conduct onsite inspections of claims records and documentation of a carrier, third-party administrator, servicing agent, or other claims-handling entity, and conduct interviews, both sworn and unsworn, of claims-handling personnel. Carriers, third-party administrators, servicing agents, and other claims-handling entities shall make all claims records, documentation, communication, and correspondence available to department personnel during regular business hours. If any person fails to comply with a request for production of records or documents or fails to produce an employee for interview, the department may compel production or attendance by subpoena. The results of an examination or investigation shall be provided to the carrier, third-party administrator, servicing agent, or other claims-handling entity in a written report setting forth the basis for any violations that are asserted. Such report is agency action for purposes of chapter 120, and the aggrieved party may request a proceeding under s. 120.57 with regard to the findings and conclusion of the report.

(4) If the department finds that violations of this chapter have occurred, the department may impose an administrative penalty upon the offending entity or entities. For each offending entity, such penalties shall not exceed $2,500 for each pattern or practice constituting nonwillful violation and shall not exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. If the department finds a pattern of practice that constitutes a willful violation, the department may impose an administrative penalty upon each offending entity not to exceed $20,000 for each willful pattern or practice. Such fines shall not exceed $100,000 for all willful violations arising out of the same action. No penalty assessed under this section may be recouped by any carrier in the rate base, the premium, or any rate filing. Any administrative penalty imposed under this section for a nonwillful violation shall not duplicate an administrative penalty imposed under another provision of this chapter or the insurance code. The department may adopt rules to implement this section. The department shall adopt penalty guidelines by rule to set penalties under this chapter.

440.53 Effect of unconstitutionality.—If any part of this chapter is adjudged unconstitutional by the courts, and such adjudication has the effect of invalidating any payment of compensation under this chapter, the period intervening between the time the injury was sustained and the time of such adjudication shall not be computed as a part of the time prescribed by law for the commencement of any action against the employer in respect of such injury; but the amount of any compensation paid under this chapter on account of such injury shall be deducted from the amount of damages awarded in such action in respect of such injury.

440.54 Violation of child labor law.—If the judge of compensation claims determines that an injured employee at the time of an accident is a minor employed, permitted, or suffered to work in violation of any of the provisions of the child labor laws of Florida, the employer shall, in addition to the normal compensation and death benefits provided by this chapter, pay such additional compensation as the judge of compensation claims may determine according to the circumstances of the case or the seriousness of the violation; however, the total compensation so payable shall not exceed double the amount otherwise payable under this chapter. The employer alone, and not the insurance carrier, shall be liable for the increased compensation or increased death benefits provided for by this section. Any provision in an insurance policy undertaking to protect an employer from such increased liability shall be void.

440.55 Proceedings against state.—Any person entitled to compensation benefits by reason of the injury or death of an employee of the state, its boards, bureaus, departments, agencies, or subdivisions employing labor, may maintain proceedings and actions at law against the state, its boards, bureaus, departments, agencies, and subdivisions, for such benefit, said proceedings and action at law to be in the same manner as provided herein with respect to other employers.

440.572 Authorization for individual self-insurer to provide coverage.—An individual self-insurer having a net worth of not less than $250 million as authorized by s. 440.38(1)(f) may assume by contract the liabilities under this chapter of contractors and subcontractors, or each of them, employed by or on behalf of such individual self-insurer when performing work on or adjacent to property owned or used by the individual self-insurer by the department. The net worth of the individual self-insurer shall include the assets of the self-insurer’s parent company and its subsidiaries, sister companies, affiliated companies, and other related entities, located within the geographic boundaries of the state.

440.585 Workers' compensation group self-insurance fund application disclosure.—Each application for workers' compensation coverage under a group self-insurance fund authorized under this chapter must contain in contrasting color and in not less than 10-point type, the following statement: "This is a fully assessable policy. If the fund is unable to pay its obligations, policyholders must contribute on a pro rata earned premium basis the money necessary to meet any unfilled obligations." If the application is signed by the applicant, it must be conclusively presumed that there was an informed, knowing acceptance of the assessment liability that exists as a result of participation in the fund.

440.591 Administrative procedure; rulemaking authority.—The department, the Financial Services Commission, and the agency may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon them.

440.593 Electronic reporting.—

(1) The department may establish an electronic reporting system requiring or authorizing an employer or carrier to submit required forms, reports, or other information electronically rather than by other means. The department may establish different deadlines for submitting forms, reports, or information to the department, or to its authorized agent, via the electronic reporting system than are otherwise required when reporting information by other means.

(2) The department may require any carrier to submit data electronically, either directly or through a third-party vendor, and may require any carrier or vendor submitting data to the department electronically to be certified by the department. The department may specify performance requirements for any carrier or vendor submitting data electronically.

(3) The department may revoke the certification of any carrier or vendor determined by the department to be in noncompliance with performance standards prescribed by rule for electronic submissions.

(4) The department may assess a civil penalty, not to exceed $500 for each violation, as prescribed by rule.

(5) The department may adopt rules to administer this section.

440.60 Application of laws.—

(1) Chapter 79-40, Laws of Florida, shall apply to all claims for injury arising out of accidents occurring on or after August 1, 1979.

(2) Sections 6-20, chapter 79-312, Laws of Florida, shall apply to all claims for injury arising out of accidents occurring on or after August 1, 1979.

(3) All acts or proceedings performed by or on behalf of the former Division of Workers' Compensation of the 1Department of Labor and Employment Security or the employer, or in which the division or the employer was a party under s. 440.15(1) and (3) between October 1, 1974, and July 10, 1987, are ratified and validated in all respects if such acts or proceedings would have been valid if chapter 87-330, Laws of Florida, had been in effect at the time such acts or proceedings were performed.