CHAPTER 2008-133

House Bill No. 5045

An act relating to workers' compensation medical services and supplies; providing for a type two transfer of responsibilities with respect to the provision of workers' compensation medical services and supplies from the Agency for Health Care Administration to the Department of Financial Services; amending s. 440.13, F.S.; revising terminology, to conform; providing an effective date.

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

Section 1. All powers, duties, functions, rules, records, personnel, property, and unexpended balances of appropriations, allocations, and other funds of the Agency for Health Care Administration with respect to the agency's responsibilities for the provision of workers' compensation medical services and supplies are transferred intact by a type two transfer, as defined in s. 20.06(2), Florida Statutes, from the Agency for Health Care Administration to the Department of Financial Services.

Section 2. Subsections (1), (3), (6) through (9), and (11) through (13) of section 440.13, Florida Statutes, are amended to read:

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

(e) "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.

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

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

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

(i) "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.

(j) "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 ~~agency~~ to assist in the resolution of a dispute arising under this chapter.

(k) "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.

(l) "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.

(m) "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.

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

(o) "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.

(p) "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.

(q) "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, each of whom must be certified by the department ~~agency~~ as a health care provider.

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

(s) "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.

(t) "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.

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(a) As a condition to eligibility for payment under this chapter, a health care provider who renders services must be a certified health care provider and must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care. The department ~~agency~~ shall adopt rules to implement the certification of health care providers.

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

(c) A health care provider may not refer the employee to another health care provider, diagnostic facility, therapy center, or other facility without

prior authorization from the carrier, except when emergency care is rendered. Any referral must be to a health care provider that has been certified by the department ~~agency~~, unless the referral is for emergency treatment, and the referral 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. Such procedures shall be for a health care provider certified under this section.

(f) By accepting payment under this chapter for treatment rendered to an injured employee, a health care provider consents to the jurisdiction of the department ~~agency~~ as set forth in subsection (11) and to the submission of all records and other information concerning such treatment to the department ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, or unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall authorize such consultation or procedure unless the health care provider or facility is not authorized or certified, 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 ~~agency~~, an employer, or a carrier, or any agent or representative of the department ~~agency~~, 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.

(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 ~~agency~~, if the carrier, in making its determination, has complied with this section and rules adopted by the department ~~agency~~.

(7) UTILIZATION AND REIMBURSEMENT DISPUTES.—

(a) Any health care provider, carrier, or employer who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 30 days after receipt of notice of disallowance or adjustment of payment, petition the department ~~agency~~ 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 ~~agency~~ results in dismissal of the petition.

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

(c) Within 60 days after receipt of all documentation, the department ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ 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 ~~agency~~:

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

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

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

(8) PATTERN OR PRACTICE OF OVERUTILIZATION.—

(a) Carriers must report to the department ~~agency~~ 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 ~~agency~~ shall determine whether a pattern or practice of overutilization exists.

(b) If the department ~~agency~~ 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 ~~agency~~, 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 of the department ~~agency~~ barring the provider from payment under this chapter;

2. Deauthorization of care under review;

3. Denial of payment for care rendered in the future;

4. Decertification of a health care provider certified as an expert medical advisor under subsection (9) or of a rehabilitation provider certified under s. 440.49;

5. An administrative fine assessed by the department ~~agency~~ in an amount not to exceed $5,000 per instance of overutilization or violation; and

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

(9) EXPERT MEDICAL ADVISORS.—

(a) The department ~~agency~~ shall certify expert medical advisors in each specialty to assist the department ~~agency~~ and the judges of compensation claims within the advisor's area of expertise as provided in this section. The department ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ 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 ~~agency~~, 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 ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ and to any officer, employee, or agent of any entity with which the department ~~agency~~ has contracted under this subsection.

(f) If the department ~~agency~~ 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 ~~agency~~. 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 ~~agency~~. The department ~~agency~~ may assess a penalty not to exceed $500 against any carrier that fails to timely compensate an advisor in accordance with this section.

(11) AUDITS.—

(a) The department ~~Agency for Health Care Administration~~ may investigate health care providers to determine whether providers are complying with this chapter and with rules adopted by the department ~~agency~~, 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 ~~agency~~ finds that a health care provider has improperly billed, overutilized, or failed to comply with department ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ or carrier.

(b) The department shall monitor carriers as provided in this chapter and the Office of Insurance Regulation shall audit insurers and group self-insurance funds as provided in s. 624.3161, to determine if medical bills are

paid in accordance with this section and rules of the department and Financial Services Commission, respectively. Any employer, if self-insured, or carrier found by the department or Office of Insurance Regulation not to be within 90 percent compliance as to the payment of medical bills after July 1, 1994, must be assessed a fine not to exceed 1 percent of the prior year's assessment levied against such entity under s. 440.51 for every quarter in which the entity fails to attain 90-percent compliance. The department shall fine or otherwise discipline an employer or carrier, pursuant to this chapter or rules adopted by the department, and the Office of Insurance Regulation shall fine or otherwise discipline an insurer or group self-insurance fund pursuant to the insurance code or rules adopted by the Financial Services Commission, for each late payment of compensation that is below the minimum 95-percent performance standard. Any carrier that is found to be not in compliance in subsequent consecutive quarters must implement a medical-bill review program approved by the department or office, and an insurer or group self-insurance fund is subject to disciplinary action by the Office of Insurance Regulation.

(c) The department ~~agency~~ 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 ~~agency~~ 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 ~~agency~~ 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, except where the carrier has contracted for a lower amount. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. No such contract shall rely on a provider that is not reasonably accessible to the employee.

(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 certified health care providers and health care facilities for inpatient and outpatient treatment and care.

2. Survey certified 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 ~~agency and 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 ~~agency~~ shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to s. 440.13(8). The department shall provide administrative support and service to the panel to the extent requested by the panel.

(13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE AUTHORIZED TO RENDER MEDICAL CARE.—The department ~~agency~~ shall remove from the list of physicians or facilities authorized to provide remedial treatment, care, and attendance under this chapter the name of any physician or facility found after reasonable investigation to have:

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

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

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

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

(e) Refused to appear before, or to answer upon request of, the department ~~agency~~ or any duly authorized officer of the state, any legal question, or to produce any relevant book or paper concerning his or her conduct under any authorization granted to him or her under this chapter;

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

(g) Engaged in a pattern of practice of overutilization or a violation of this chapter or rules adopted by the department ~~agency~~, including failure to adhere to practice parameters and protocols established in accordance with this chapter.

Section 3. This act shall take effect July 1, 2008.

Approved by the Governor June 10, 2008.

Filed in Office Secretary of State June 10, 2008.