To the Members of the Board

Re:  New York Workers Compensation Statistical Plan Revisions
   a. Additional Data Elements
   b. Managed Care Pilot Program

The Rates Committee has authorized, and the New York State Insurance Department has approved, amendments to the New York Workers Compensation Statistical Plan which (a) establishes additional required data elements, and (b) removes reference to the Managed Care Pilot Program.

(a) When the rewritten Workers Compensation Statistical Plan was implemented in 1996 by the Rating Board and other data collection organizations, a decision was made to not require the submission of several new data elements in the reporting of New York losses on unit statistical reports. A primary reason for the exclusion of these elements was the limitation of the Rating Board’s computer systems to accommodate the new data fields in its database.

With the advent of a new internal processing system, the Board is now able to accept and process these data elements. Consequently, the following loss data elements are required on unit statistical reports for all New York claims reported on policies effective January 1, 2004 and thereafter:

- Lump-Sum Indicator
- Paid Indemnity Loss
- Paid Medical Loss
- Paid ALAE
- Incurred ALAE (optional)

These data elements will enable the Rating Board to analyze New York loss experience in more detail at the class, industry group and hazard group level.
(b) An editorial change has been made to Rule 10 f. in recognition that the New York Managed Care Pilot Program has expired. Verbiage has been revised to reference managed care and preferred provider organizations in general within the context of this rule.

The applicable pages from the statistical plan, reflecting the new required data fields and the editorial change for managed care are attached.

Revised manual pages will be distributed as soon as they are available.

Very truly yours,

Monte Almer

President

MH/ab
Encl
g. Lump-Sum Claims

When the claim involves a lump sum representing the discounted or commuted value of a specific award or benefit, report the actual loss payment, including the lump-sum amount subdivided according to indemnity and medical.

* Report the applicable Lump-Sum Indicator on each claim.

* Y-The claim has been settled by an agreement between the insurer and claimant for a specified amount representing a discounted or commuted value.

* N-The claim is not settled or the claim was settled by other than a lump-sum agreement.

h. Physical Rehabilitation

Physical rehabilitation costs incurred due to the purchase of physical rehabilitation services from outside vendors shall be reported as part of incurred medical loss. For the purposes of this rule, physical rehabilitation concerns all medical activities performed, and/or services rendered, in the treatment of an industrial injury or disease to achieve maximum recovery, relief and/or cure. The following physical rehabilitation activities by medically trained persons, including registered nurses, performed by outside vendors shall be reported as incurred medical losses:

(1) Various necessary evaluations and therapies including physical, occupational, speech and hearing.

(2) Coordination of services such as necessary medical equipment or special nursing care in a facility or the home.

(3) Necessary consultation(s) with physician(s).

(4) Monitoring the treatment and progress of a claimant's medical condition.

(5) Coordination of family, agency, and community services to provide optimal recovery.

Additionally, expenses associated with the above activities performed by carrier personnel (other than claims supervisors' or claims adjusters' efforts to return an injured worker to gainful employment) may also be reported as part of medical losses if the carrier personnel are medically trained as one of the following:

(1) physicians
(2) licensed registered nurses
(3) licensed speech therapists
(4) registered physical therapists
(5) dentists and dental technicians
(6) occupational therapists
(7) chiropractors
(8) podiatrists
(9) licensed physician assistants
(10) licensed cardio-pulmonary technicians

i. Fraudulent Claims

(1) In cases where a claim has officially been determined to be fully or partially fraudulent by the courts or ruling of the Workers' Compensation Board, the carrier must file a correction report to show the incurred amount of the claim that has not been declared fraudulent. If an entire claim is officially declared fraudulent, a $0 amount must be reported.
2) When a claim has officially been determined to be fraudulent subsequent to the first reporting of the claim, a correction report must be filed with the Rating Board revising the claim amount to the incurred loss as defined above. This should be done for reports which would impact the current and up to four prior modifications. Refer to Part Two, D.4. of the New York Experience Rating Plan Manual. If fourth and/or fifth unit reports have been previously filed, correction reports to the fourth and/or fifth reports must also be submitted. Refer to Part VI for further instructions regarding correction reports.

j. Other

Expenses and any general allowances for contingencies shall be excluded.

6. Paid Losses

a. Paid Indemnity Amount

Report the whole dollar amount of paid indemnity costs for the claim as of the loss valuation date. These losses consist of all paid benefits due to an employee’s lost wages or inability to work, including compensation paid to a deceased prior to death, burial expense, payments to the state, and employers liability losses and expenses. Allocated Loss Adjustment Expense (ALAE) for other than employers liability coverage must be excluded from indemnity losses. Subrogation or Special Funds recoveries must be subtracted from paid indemnity if the recovery applies to the indemnity loss.

Payments required by the compensation law in connection with certain types of injury shall be included in the paid indemnity loss amounts on the unit statistical report.

b. Paid Medical Amount

Report the whole dollar amount of medical losses paid for the claim as of the loss valuation date. Paid medical should not include any claim expense. Subrogation or Special Funds recoveries must be subtracted from paid medical if the recovery applies to the medical loss.

Paid medical amounts shall include surcharges on hospital and related services imposed pursuant to the New York Health Care Reform Act.

Paid medical amounts for claims that are not required to be reported to the Workers’ Compensation Board, as defined in Section 110 of the New York Workers’ Compensation Law, shall not be reported to the Rating Board.

7. Allocated Loss Adjustment Expense (ALAE) Paid Amount

Report the whole dollar amount of loss adjustment expense allocated and paid for each claim as of the loss valuation date. ALAE encompasses the following costs to a carrier, which can be directly allocated to a particular claim:

a. Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside vendors or staff representatives.

b. Court, Alternate Dispute Resolution and other specific items of expense such as:

Medical examinations of a claimant to determine the extent of the carrier’s liability, degree of permanency of length or disability.
Expert medical or other testimony.

Autopsy.

Witnesses and summonses.

Copies of documents such as birth and death certificates, and medical treatment records.

Arbitration fees.

Surveillance.

Appeal bond costs and appeal filing fees.

c. Medical cost containment expenses incurred with respect to a particular claim, whether by an outside vendor or done internally by a staff representative for the purpose of controlling losses, to ensure that only reasonable and necessary costs of services are paid. The expenses include:

- Bill auditing expenses for any medical or vocational services rendered, including hospital bills (inpatient or outpatient), nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills, and medical or vocational rehabilitation vendor bills.

- Hospital and other treatment utilization reviews, including precertification/preadmission, concurrent or retrospective reviews.

- Preferred provider network/organization expenses

- Medical fee review panel expenses

d. Expenses that are not defined as losses and are directly related to the handling of a particular claim for services that are required to be performed by statute or regulation.

8. Allocated Loss Adjustment Expense (ALAE) Incurred Amount (Optional)

Report the whole dollar amount of ALAE paid and reserved for this claim as of the loss valuation date.

9. Classification Code

Report the classification code under which the injured worker’s payroll or other exposure was reported even if, at the time of injury, the worker may have been involved in an activity that would be classified differently. **No claim shall be assigned to any classification unless payroll or other exposure has also been reported for that class.**

**Note:** With respect to aircraft losses, losses related to employees of an insured, other than members of the flying crew, arising out of the operation of an aircraft subject to a passenger seat surcharge, shall be reported under Statistical Code 9108.

In addition, losses related to strike duty in connection with Classification Code 7720—Detective or Patrol Agency shall be reported under Statistical Code 0111.
10. Injury Type

Report the two-digit numeric code that identifies under which provision of the Workers' Compensation Law benefits are paid or are expected to be paid. The injury type code must correspond to the carrier's estimate, as of the valuation date, of the ultimate injury type of the claim. It does not have to correspond to the type of benefit being paid on the valuation date.

a. Death—Code 01

Report each death claim unless it has been established that the carrier has incurred no liability.

The amount reported as incurred indemnity shall include all paid and outstanding benefits, including compensation paid to the deceased prior to death, burial expenses and payments to the state.

If there is compensation paid prior to the death of a claimant and there is later found to be no liability on the death claim, the loss is to be reported on the basis of the injury for which payments have previously been made.

See Section g. below for rules concerning the computation of death claims which are payable to the Aggregate Trust Fund.

b. Permanent Total—Code 02

Report as permanent total, each claim that has been adjudged to constitute permanent total disability or that is defined as such under the Workers' Compensation Law, or that, in the judgment of the carrier, will result in permanent total disability.
f. Contract Medical—Code 07

* In conjunction with managed care or preferred provider organization programs in New York, medical costs incurred under a contract for medical services that cannot be allocated to individual claims shall be reported in the aggregate as incurred medical and shall be assigned to the governing classification. Contract medical costs, or medical costs incurred outside of the contractual arrangement that are allocable to individual claims shall be reported in connection with these claims and shall not be included in the amount otherwise reported as contract medical.

g. Aggregate Trust Fund

All death cases and some permanent total and permanent partial disability cases are payable to the Aggregate Trust Fund. In determining the present value of the losses incurred on these claims, the tables published by the Workers’ Compensation Board (Bulletin 222B) must be used.

When an award directing such payment has been made, include in the indemnity losses the assessment charged by the Aggregate Trust Fund for the handling of such cases. This assessment should not, however, be included in the calculation of the present value of any case in which the award has not yet been made.

For all permanent total and permanent partial disability cases for which a life award is being made, but for which payments have not been designated for placement into the Aggregate Trust Fund, the table shown below shall be used in determining the present value for reporting under this Plan.

<table>
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<th>TABLE I</th>
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<tr>
<td>Life Awards—Permanent Total and Permanent Partial Disabilities</td>
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1989-1991 U.S. Decennial Life Tables for Total Population
3.5% Annual Rate of Interest

11. Claim Status

Report the one-digit numeric code that indicates the status of the claim. Report "0" if the claim is open, "1" if the claim is closed or "2" if the claim is reopened as of the valuation date.
Open means that the carrier still expects to make further indemnity or medical payments on that claim (the exact nature of these payments is not known), or may not have determined as of yet whether payments will be made in the future.

Reopened means that subsequent indemnity and/or medical payments have been made on a claim previously closed by the carrier or, due to a recent event, further indemnity and/or medical payments are expected and a reserve has been established for a claim previously closed by the carrier.

Closed means that the carrier does not expect to make any further indemnity or medical payment on that resolved claim.

Report claims covered entirely by contract medical with a closed claim status unless more payments are expected in addition to the contract amount.

12. **Loss Conditions**

Report the two-digit codes for each Loss Condition element described below. On hard copy, it is acceptable to suppress leading zeros of each element of the Loss Conditions.

a. **Act**

For coverage under the State Act, report "01 " . For coverage under the Federal (USL&H) Act for "F" classes or "Non-F" classes, report "02".

b. **Type of Loss**

Report the type of loss corresponding to the definitions below:

(1) **Trauma—Code 01**

Trauma is an injury resulting in disability or death that is traceable to a definite compensable accident occurring during the worker's present or past employment and cannot be classified as either a Cumulative Injury or an Occupational Disease.

(2) **Occupational Disease—Code 02**

Occupational Disease is any abnormal condition resulting in disability or death which is not traceable to a definite compensable accident occurring during the worker's present or past employment. The injury is understood to have been caused by exposure to a disease producing agent or agents present in the worker's occupational environment.

**Example:** A granite worker presents a claim for the occupational disease of silicosis due to exposure to the disease agent silica.

It is intended that, in order for a claim to be coded as an occupational disease case, it must have resulted from repetitive exposure extending over a period of time. It is not intended that claims which arise from single identifiable incidents be coded as occupational disease claims even though they may have been caused by inhalation, absorption, ingestion or other environmental factors.
NEW YORK WORKERS COMPENSATION STATISTICAL PLAN

PART IV

Effective January 1, 2004

5th Reprint

e. Type of Settlement

Report the applicable Type of Settlement associated with each claim.

Code 00 - Claim not Subject to Settlement
Code 05 - Non-Compensable
Code 09 - All Other Settlements

13. Jurisdiction State

Report the two-digit state code of the governing jurisdiction that will administer the claim and whose statutes will apply to the claim adjustment process when that state is not New York.

14. Catastrophe Number

Report the two-digit sequential number for 2 or more claims resulting from the same occurrence. For each policy, the claims from the first such occurrence shall be assigned a Catastrophe Number of 01, claims from the second occurrence shall be 02, etc. When an occurrence results in only one claim being reported, leave this field blank.

EXCEPTION: Report Catastrophe Number 48 for all claims directly arising from the commercial airline hijackings of September 11, 2001 and the resulting subsequent events with accident dates of September 11, 2001 through September 14, 2001.

Note: Catastrophe Number 48 will apply to both single and multiple claims.

15. Managed Care Organization Type

Report the two-digit code that corresponds to the type of organization which administers the applicable medical loss on the claim

Code 00 - Not Administered by an approved Managed Care Organization
Code 01 - Administered by an approved Managed Care Organization
Code 03 - Administered by an approved Preferred Provider Organization

16. Injury Description Code

Report the 3 two-digit codes that represent the Part of Body, Nature of Injury and Cause of Injury for each claim. Refer to Part VIII for the applicable codes.

17. Fraudulent Claim Code

Report the two-digit code that identifies the involvement of fraud in the claim. Specific fraudulent claim coding instructions are located in Part 5.i of this part of the Plan.

Code 00 - The claim does not involve fraud
Code 01 - Partially Fraudulent: a portion of the claim has been deemed fraudulent by the courts or ruling of the Workers’ Compensation Board
Code 02 - Fully Fraudulent: the entire claim has been found to be fraudulent by the courts or ruling of the Workers’ Compensation Board

18. Totals

Report the arithmetic totals of the amounts reported for Number of Claims, Incurred Indemnity, Incurred Medical, Paid Indemnity, Paid Medical, ALAE Paid and ALAE Incurred.

In the case of corrections and subsequent reports, the totals shown must be the revised totals.

For multi-page reports, report the totals on the last card only.

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