NYCIRB
New York Compensation
Insurance Rating Board
733 Third Avenue
New York, NY 10017
Tel: (212) 697-3535

February 22, 2023

R.C. 2576

Re: COVID-19 Catastrophe Number 12 /
Non-Compensable Claims and Jurisdiction State Reporting

Members of the Rating Board:

I write to provide information related to (i) reporting COVID-19 Nature of Injury, Cause of Injury and Catastrophe Codes; and (ii) amendments to the New York Workers' Compensation Statistical Plan ("Stat Plan") and the New York Workers' Compensation Experience Rating Plan ("Experience Rating Plan"), which are detailed below.

## I. COVID-19 Catastrophe Number 12

On March 26, 2020, the Rating Board issued R.C. Bulletin 2508 announcing the establishment of Catastrophe Number 12, among other codes, for reporting COVID-19 claims. Catastrophe Number 12 enables the Rating Board to identify, track, and understand the impact of the COVID-19 pandemic on the workers' compensation system in New York State. While Catastrophe Number 12 has been slated for expiration in other jurisdictions, it will remain in effect in New York until further notice.

## II. Non-Compensable Claims and Jurisdiction State Reporting

The New York State Department of Financial Services has approved rule revisions to Part IV of the Stat Plan. Specifically, the recently approved amendments add new Rule 9. Non-Compensable Reporting and revise Rule 16(e) Type of Settlement, to clarify the proper reporting of non-compensable and partially compensable claims. In addition, the amendments refine the language of Rule 17. Jurisdiction State to clarify the proper reporting of jurisdiction state code. The effective date of these amendments is January 1, 2024.

The amendments to the Stat Plan described above along with conforming amendments to the Experience Rating Plan are enclosed.

The following modified and final pages from the Stat Plan and Experience Rating Plan, reflecting the approved amendments, are attached for your convenience: (a) Stat Plan: Table of Contents pages iv & v, and pages R-29, R-31, R-32, R-34, R-37a, R-37b, R-37c, R-38, R-43, R-44, R-

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45, R-52, R-54, R-55, R-55a, R-56, R-56a, R-57 and R-59; and (b) Experience Rating Plan: Pages R-37 and R-38.

If you have any questions or concerns, please do not hesitate to contact Mr. David Knight, Vice President of the Operations Department, at (212) 697-3535, ext. 122 or at operations@nycirb.org.

Very truly yours,

Jeremy Attie
President and CEO

Enclosures

## PART IV – LOSS INFORMATION

| | 1. REPORTING OF LOSSES |
|---|---|
| | **(a)** Losses must be reported with the classification code corresponding to the classification to which the employee's payroll was assigned for premium determination purposes. |
| | **(b)** All claims must be reported to the Rating Board when, as of the valuation date, there are loss values in paid losses, incurred losses and/or ALAE, including those with only paid allocated loss adjustment expense amounts. Refer to Item (5)(b) of this Part for specific medical loss exception. The medical portion of losses on policies providing Excluding Medical coverage in accordance with Rule VIII (E) of the New York Workers' Compensation and Employers' Liability Manual should not be reported. |
| | **(c)** A claim, initially reported, but subsequently closed without payment at a later valuation must be reported as a closed claim with $0 indemnity and $0 medical loss amounts at that later valuation. |
| ★ | **(d)** An accident resulting in an injury to one worker, but on which losses are incurred under different coverages of the policy (e.g., workers' compensation; employers' liability) must be reported as one claim and be identified with the appropriate Type of Claim Code. Refer to Item (~~16~~17)(d) of this Part for Type of Claim codes. |
| ★ | **(e)** When an accident results in two or more reported claims, each claim must be reported separately, and an appropriate Catastrophe Number must be assigned. Refer to Item (~~18~~19) of this Part for instructions on the use of Catastrophe Number. |
| ★ | **(f)** Recoveries from subrogation and fraud determination, but not from reinsurance or deductible reimbursement, must net down the claim amounts. Refer to Item (8) of this Part for instructions regarding Fraudulent Claims, and to Item (~~9~~10) of this Part for instructions regarding Recoveries. |
| | **(g)** Claim Grouping Option: The grouping of claims for statistical reporting purposes is not permitted in New York for losses that occur on policies effective January 1, 2011 and subsequent. |

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| | **(a) Incurred Indemnity Amount**<br><br>Report the total amount of incurred indemnity costs for each claim as of the valuation date. Incurred indemnity loss amounts consist of all paid and outstanding benefits, including compensation paid to the deceased prior to death, burial expenses, payments to the state and employers' liability losses, including related expenses as described in Item (7) of this Part. Allocated loss adjustment expenses for other than employers' liability coverage must be **excluded** from reported incurred indemnity amounts and must be reported separately as allocated loss adjustment expense. |
| | **(i) Outstanding Benefits**<br><br>The outstanding indemnity costs are the carrier's individual case estimates of future indemnity payments, except in the case of pension claims where any outstanding loss valuation, as set forth in Article 3, Section 27 of the New York State Workers' Compensation Law, must be determined by use of the appropriate tables published by the New York State Workers' Compensation Board. |
| | **(ii) Reporting Special Payments:**<br><br>Where the New York State Workers' Compensation Law specifies that, in conjunction with certain types of injury, a specified amount shall be paid into a special fund, and that such amounts are in addition to the compensation payable to the injured worker or the dependents, then the combined total amount must be reported as the incurred indemnity amount on the unit statistical report.<br><br>**Examples of Special Payments:**<br><br>• Payments in no-dependent death cases<br>• Specified percentage of permanent partial awards designated for assignment for the Aggregate Trust Fund<br><br>**Note:** Assessments on the basis of total premium or total incurred or paid losses, instead of on a per claim basis, must **not** be included on unit statistical reports. |
| ★ | **(iii) Reporting Recoveries**<br><br>Incurred indemnity amounts must be reported net of recoveries from subrogation, special funds, fraudulent activities and findings of non-compensability. Refer to Item (8) of this Part for instructions regarding Fraudulent Claims, and to Item (~~9~~10) in this Part for instructions regarding Recoveries. |

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| | **(iv) Final Awards**<br><br>Where a final award has been made by the New York State Workers' Compensation Board, the total incurred compensation must be in agreement with such award, except under the following circumstances: |
| | **A.** Where a claimant has appealed for a higher award for a compensable claim, the carrier must report at least the amount of the award, but may report a higher amount if, in its judgment, the facts in the case indicate an additional reserve is advisable. |
| | **B.** In cases where a claim has been officially declared non-compensable, but an appeal has been filed and is pending as of the valuation date, the carrier must report the incurred cost that would have been reported had there been no declaration of non-compensability. |
| ★ | **C.** In cases where a claim has been ~~officially declared~~ deemed non-compensable as defined in Item (17)(e) of this Part, but the period during which an appeal may be filed has not expired by the valuation date, the carrier may report the incurred cost that would have been reported had there been no declaration of non-compensability. In any case where the period for filing an appeal has expired subsequent to the valuation date, but prior to the submission date of the next statistical report, without an appeal having been filed, ~~the carrier may eliminate from the report the reserve for the non-compensable claim~~ refer to Item (9) of this Part for the reporting requirements.<br><br>~~**Note**: The term "declared non-compensable", as used in this Rule, means either:~~<br><br>~~**(1)** An official ruling by the New York State Workers' Compensation Board, specifically holding that a claimant is not entitled to benefits under the provisions of the New York State Workers' Compensation Law;~~<br><br>~~**(2)** A claim was not filed during the two-year period provided by Law for the filing of a claim, and the carrier closes the case without medical or indemnity loss; or~~<br><br>~~**(3)** The carrier has raised the issues of accident, notice or causal relation prior to the valuation date and continues to contest the claim, and the claim is officially closed because of the claimant's non-appearance or failure to prosecute his/her claim without an official ruling on the questions raised, such closing is regarded for the purpose of this Rule as the equivalent of a specific official declaration of non-compensability.~~<br><br>**Note:** Where the carrier has appealed an award, it must report the full amount of such award until the appeal is decided. |

## 6. EXPENSES EXCLUDED FROM LOSSES

Expenses must be excluded from reported losses except as noted in Item (7) of this Part. Medical or legal expenses incurred for the benefit of the carrier are treated as loss adjustment expense. Refer to Item (7) of this Part for expenses developed for the benefit of the claimant.

Unallocated Loss Adjustment Expense (ULAE) is also excluded from losses. ULAE includes, but is not limited to:

- Carrier employee salaries and traveling expenses that are considered loss adjustment expenses and are not incurred while doing activities listed as allocated expenses.
- Fees paid to independent claims professionals or attorneys hired to perform the function of claim investigation normally performed by claim adjusters. Fees are paid for developing and investigating a claim so that a determination can be made of the cause or extent of responsibility for the injury or disease, including evaluation and settlement of covered claims.

## 7. EXPENSES INCLUDED IN LOSSES

**(a) Medical or Legal Expenses Incurred for the Benefit of the Claimant**

Medical or legal court expenses incurred for the benefit of the claimant, or that the carrier is required to produce for the benefit of the claimant, must be reported as either an indemnity or medical loss depending upon the nature of the expense.

★ **(b) Employers' Liability Loss Adjustment Expense (LAE)**

Employers' liability losses must include allocated loss adjustment expenses, as defined in Item ~~12~~ 13 of this Part. The entire amount of losses and allocated loss adjustment expenses for an employers' liability claim **must be reported as incurred indemnity losses** on the unit statistical report. If a deductible program applies, both losses and loss adjustment expense must be reported on a **gross** basis.

**(c) Impartial Examinations Ordered by the New York State Workers' Compensation Board**

Expenses for impartial examinations ordered by the New York State Workers' Compensation Board are to be reported as incurred losses.

## 9. NON-COMPENSABLE REPORTING

### A. Entire Claim Non-Compensable

When the entire claim has been determined to be non-compensable, in accordance with Part IV – Section (17)(e) of this Plan:

- As of the 1st report valuation, and the claim does not include any paid losses, incurred losses, and/or ALAE, the claim must not be reported.
- As of the 1st report valuation, and the claims includes paid losses, incurred losses, and/or ALAE, the claim must be reported with these loss values. Report this claim with the Type of Settlement (Loss Condition) Code 05.
- After the 1st report valuation and prior to the 10th report valuation, correction report(s) are required for all previously submitted unit reports to report the Type of Settlement (Loss Condition) Code 05. The paid losses, incurred losses, and/or ALAE must continue to reflect the loss values as of each specific report level(s).

**Example #1**

At the 1st unit report level, the following claim was reported:

- Policy Number: W123456 (Exposure State New York)
- Claim Number: 12345 (Jurisdiction State New Jersey)
- Incurred Indemnity: $20,000; Incurred Medical: $20,000
- Paid Indemnity: $1,000; Paid Medical: $1,000
- Paid ALAE: $2,000
- Claim Status: 0 (Open)

Between the 1st and 2nd unit reports, there was an official ruling that determined the claim was non-compensable.

This claim requires a correction to be reported on a 1st unit report to update the Type of Settlement Code to 05 Dismissal or Take Nothing (Non-Compensable). The Claim Status remains 0 (Open) and the loss amounts remain unchanged as originally reported.

Since this claim was open as of the 1st report, it will continue to be reported with Type of Settlement Code 05 until the claim is closed.

**Example #2**

At the 1st unit report level, the following claim was reported:

- Policy Number: W123456 (Exposure State New York)
- Claim Number: 23456 (Jurisdiction State New York)
- Incurred Indemnity: $20,000; Incurred Medical: $20,000
- Paid Indemnity: $1,000; Paid Medical: $1,000
- Paid ALAE: $2,000
- Claim Status: 0 (Open)

At the 2nd unit report level, the following claim was reported:

- Policy Number: W123456 (Exposure State New York)
- Claim Number: 23456 (Jurisdiction State – New York)
- Incurred Indemnity: $45,000; Incurred Medial $55,000
- Paid Indemnity: $45,000; Paid Medical: $55,000
- Paid ALAE: $10,000
- Claim Status: 1 (Closed)

Between the 2nd and 3rd unit reports, there was an official ruling that determined the claim was non-compensable.

In response to this ruling, the carrier submitted a correction to the 1st and 2nd unit reports to code the claim as non-compensable with Loss Condition Code – Type of Settlement 05 Dismissal or Take Nothing (Non-compensable). All loss amounts and Claim Status remain unchanged on both the 1st and 2nd reports.

This claim requires a correction to be reported to the 1st unit report, to include the Type of Settlement Code 05. The Claim Status remains 0 (Open) and the loss amounts remain unchanged as originally reported.

This claim requires a correction to be reported to the 2nd unit report to include the Type of Settlement Code 05. The Claim Status remains 1 (Closed) and the loss amounts remain unchanged as originally reported.

**B. Portion of a Claim Non-Compensable**

When a portion of a claim has been determined to be non-compensable, the claim is not reported as a non-compensable claim. Only the compensable portion of the claim is reported as follows:

- As of the 1st report valuation, and the claim does not include any paid losses, incurred losses, and/or ALAE, the claim must not be reported.
- As of the 1st report valuation, claims that include paid losses, incurred losses, and/or ALAE, must be reported with these loss values. Report this claim with the Type of Settlement (Loss Condition) Code other than 05.
- After the 1st report valuation, correction report(s) are required for all previously submitted unit reports to report the Type of Settlement (Loss Condition) Code other than 05. The paid losses, incurred losses, and/or ALAE must be corrected to reflect only the compensable portion of the loss values as of each specific report level(s).

## ~~9.~~ 10. RECOVERIES – SUBROGATION, THIRD-PARTY CASES

**(a) Net Loss Reporting**

Except as noted below, when there has been recovery of loss due to subrogation, the amount of incurred loss reported must be the net incurred loss, and the amount of paid loss reported should be the net paid loss.

The net incurred loss is the gross incurred loss (i.e., the gross evaluation of the claim prior to any actual or expected recovery on which the award was based, whether the claim is still open or not) minus the amount recovered less recovery expenses. The net paid loss is the gross paid loss minus the amount recovered less recovery expenses. When the allocation of recovery to indemnity and medical is unknown, the net incurred loss must be proportionally split between indemnity and medical losses in the same proportion as the original gross incurred indemnity and medical amounts, and the net paid loss must be proportionally split between indemnity and medical losses in the same proportion as the original gross paid indemnity and medical amounts.

**Exception:** When the recovery expenses exceed the amount recovered, report the gross incurred loss instead of the net incurred loss and the gross paid loss instead of the net paid loss.

A claim involving subrogation must be reported with Loss Condition Code — Type of Recovery Code 03 (Subrogation-Only).

**(b) Correction Reporting**

When a subrogation recovery is received by the carrier at any point subsequent to the 1st unit report, but prior to the 10th report valuation date, correction report(s) must be filed for prior reports that reflected a total incurred amount higher than the net incurred loss.

If a correction is required:

Report the net incurred indemnity loss amount if it is lower than the originally reported amount.
Report the net incurred medical loss amount if it is lower than the originally reported amount.
Report the net paid indemnity loss amount if it is lower than the originally reported amount.
Report the net paid medical loss amount if it is lower than the originally reported amount.

It was determined above that a second report correction is required. The net incurred loss for the 2nd unit report is determined by comparing the originally reported loss amount at 2nd report to the net losses as of the 3rd report:

- Net Incurred Indemnity: Report $32,400 because it is less than the $35,000 reported on the 2nd report originally.
- Net Paid Indemnity: Report $22,000 (unchanged because it is less than the $32,400 net paid amount at 3rd report)
- Net Incurred Medical: Report $25,600 because it is less than the $40,000 reported on the 2nd report originally.
- Net Paid Medical: Report $25,600 because it is less than the $28,000 reported on the 2nd report originally.

Because the Paid Indemnity was less than the calculated Net Paid Indemnity, the Paid Indemnity on the 2nd report level remains at $22,000.

The above example shows this claim reported on a correction to a 2nd unit report to include the revised loss amounts and Type of Recovery Code 03. Because the claim was still open, the Claim Status remains 0 (Open).

## ~~10.~~11. 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 proportionally between indemnity and medical.

Report the applicable Lump-Sum Indicator on each claim as follows:

| Code | Description |
|---|---|
| Y | The claim has been settled by an agreement between the carrier and claimant for a specified amount representing a discounted or commuted value. |
| N | The claim has not been settled with a lump-sum agreement. |

| | ~~11.~~12. PAID LOSSES |
|---|---|
| ★ | **(a) Paid Indemnity Amount**<br><br>Report the dollar amount of paid indemnity costs for the claim as of the 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 recoveries must be subtracted from paid indemnity if the recovery applies to the indemnity loss. Refer to Item (~~9~~10) of this Part for instructions regarding recoveries.<br><br>Payments required by the New York State Workers' 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**<br><br>Report the dollar amount of medical losses paid for the claim as of the valuation date. Paid medical must not include any claim expense. Subrogation recoveries must be subtracted from paid medical if the recovery applies to the medical loss. Refer to Item (~~9~~10) of this Part for instructions regarding recoveries.<br><br>Paid medical amounts must include surcharges on hospital and related services imposed pursuant to the New York State Health Care Reform Act ("HCRA").<br><br>Paid medical amounts for claims that are not required to be reported to the New York State Workers' Compensation Board, as defined in Section 110 of the New York State Workers' Compensation Law, should not be reported to the Rating Board. |

| | ~~12.~~13. ALLOCATED LOSS ADJUSTMENT EXPENSE ("ALAE") PAID AMOUNT |
|---|---|
| | Report the dollar amount of loss adjustment expense allocated and paid for each claim as of the valuation date. ALAE encompass the following costs to a carrier, which can be directly allocated to a particular claim:<br><br>**(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:

- **(i)** Medical examinations of a claimant to determine the extent of the carrier's liability, degree of permanency or disability
- **(ii)** Expert medical or other testimony
- **(iii)** Autopsy
- **(iv)** Witness and summonses
- **(v)** Copies of documents such as birth and death certificates, and medical treatment records
- **(vi)** Arbitration fees
- **(vii)** Surveillance
- **(viii)** 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:

- **(i)** 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
- **(ii)** Hospital and other treatment utilization reviews, including precertification/preadmission, concurrent or respective reviews
- **(iii)** Preferred provider network/organization expenses
- **(iv)** Medical fee review panel expenses
- **(v)** 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

## ~~13.~~14. CLASSIFICATION CODE

Report the classification code under which the injured worker's payroll or other exposure was assigned 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 classification.**

## ~~14.~~15. INJURY TYPE

Report the type of injury code as defined under provisions of the New York State Workers' Compensation Law corresponding to the carrier's estimate, as of the valuation date, of the ultimate injury type of the claim. The injury type does not have to correspond to the type of benefit being paid as of the valuation date; e.g., if temporary total payments are being made on a claim that is reserved as a permanent partial case, report the claim as a permanent partial injury type.

## ~~15.~~16. CLAIM STATUS

Report the code that indicates the status of the claim as of the valuation date.

| Code | Description |
|---|---|
| 0 | Claim is open |
| 1 | Claim is closed |
| 2 | Claim is reopened |

Open means that the carrier still expects to make further indemnity or medical payments on the claim (the exact nature of these payments is not known) or may not have determined as of the valuation date 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 the 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.

## ~~16.~~17. LOSS CONDITION CODE

Report the applicable code corresponding to the Act, Type of Loss, Type of Recovery, Type of Claim, and Type of Settlement for each individual claim.

An accident resulting in an injury to one worker with payments made under different coverages of the policy must be reported as **one** claim with all of the incurred amounts combined.

**Example:** If the entire loss is incurred under the provisions of both Part One and Part Two of the Workers' Compensation and Employers' Liability Insurance policy, the claim would be coded to Type of Claim (03) Workers' Compensation, including Employers' Liability. Refer to section (d) of this Part, Type of Claim, within this section.

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|---|---|
| ★ | **(c) Type of Recovery**<br><br>• **No Recovery – Code 01**<br>• **Subrogation Only (Third Party) Code – 03**<br>A recovery that occurs when the carrier has received reimbursements from an entity, other than the employer, with legal liability due to circumstances for the injury.<br><br>Refer to Item (~~9~~10) of this Part regarding recoveries from subrogation and other third parties. |
| | **(d) Type of Claim**<br><br>• **Workers' Compensation Only – Code 01**<br>The entire loss is incurred under the provisions of Part One of the Workers' Compensation and Employers' Liability Insurance Policy<br>• **Employers' Liability Only – Code 02**<br>The entire loss is incurred under the provisions of Part Two of the Workers' Compensation and Employers' Liability Insurance Policy.<br>• **Workers' Compensation Including Employers' Liability or Liability-Over – Code 03**<br>The loss is incurred under the provisions of Parts One and Two of the Workers' Compensation and Employers' Liability Insurance Policy.<br>• **Liability Over – Code 04**<br>A particular Employers' Liability coverage situation where a third party, who is being sued by an employee, in turn sues the employer on the grounds of negligence, or like theory.<br><br>**Example:** A person operating a drill press is injured, and, although the injury is compensable, the worker brings suit against the manufacturer of the drill press on the grounds of faulty design or manufacture. The manufacturer then succeeds in suing the employer for damages on the grounds of faulty installation or maintenance of the drill press. The damages thus incurred to the employer, if covered under his workers' compensation policy, are classified as liability-over, and are in addition to compensation payments made to the injured employee. |

**(e) Type of Settlement**

Identify the type of settlement for the claim.

- **Claim Not Subject to Settlement – Code 00**
- **Section 32 Settlement – Code 03**
  The claim has been settled under Section 32 of the New York State Workers' Compensation Law. Code 03 is applicable to both closed claims and to open claims even when only a portion of the claim is subject to a Section 32 settlement.
- ★ **Dismissal or Take Nothing (Non-compensable) – Code 05**
  The claim ~~will generate no payments or reserves due to~~meets one or more of the following:
  - Official ruling denying benefits on the entire claim.
  - Claimant's failure to file for benefits and no claim is established by the New York State Workers' Compensation Board.
  - Claimant's failure to prosecute claim following carrier's denial of the claim as of the valuation date of the claim.
  - No reimbursement is sought for care provided within six months of the date the claim is filed and the claim has not been established by the New York State Workers' Compensation Board.
- **All Other Settlements – Code 09**

## ~~17.~~18. JURISDICTION STATE CODE

★ Report the numeric 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~~.

Refer to Part VI of this Plan for Jurisdiction State Codes.

★ **Note:** State Code "00" will no longer be accepted on any Unit Stat claim.

## ~~18.~~19. CATASTROPHE NUMBER

A catastrophe is defined as any accident (one occurrence) resulting in two or more reportable claims.

Report the two-digit sequential number for two or more claims resulting from the same occurrence. For each policy, the claims from the first such occurrence must be assigned a Catastrophe Number of "01," claims from a second occurrence must be "02," etc. up to "10." After number "10" is assigned the next number in the sequence will reprocess to number "01". When an occurrence results in only one claim being reported, zero-fill this field.

**Exceptions:**

**(1)** Report Catastrophe Number 87 for all claims for a latent condition emanating from the rescue, recovery and clean-up operations at the World Trade Center site that were undertaken between September 11, 2001 and September 12, 2002, as defined in Article 8-A of the New York Workers' Compensation Law (Chapter 446 of the Laws of 2006).

**Note:** Catastrophe Number 87 will apply to both single and multiple claims.

**(2)** Report Catastrophe Number 12 for all claims occurring on or after December 1, 2019 that are due to the COVID-19 pandemic.

**Note:** Catastrophe Number 12 will apply to both single and multiple claims.

## ~~19.~~20. MANAGED CARE ORGANIZATION TYPE

Report the code that corresponds to the type of organization, if any, that administers the applicable medical loss on the claim.

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

## ~~20.~~21. INJURY DESCRIPTION CODE

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

★ • **Part of Body:** Report the code that identifies the injured body part for a given claim. The part of body that is injured and expected to be the most significant contributor to the cost of the claim.

★ • **Nature of Injury:** Report the code that represents the nature of injury for a given claim.

★ • **Cause of Injury:** Report the code that represents the cause of injury for a given claim.

Refer to Part VI of this Plan for the applicable codes.

## ~~21.~~22. OCCUPATION DESCRIPTION

★ Report the narrative description of the regular occupation of the claimant.

## ~~22.~~23. NEW YORK STATE WORKERS' COMPENSATION BOARD CASE NUMBER

Report the unique alphanumeric Case Number assigned to each claim by the New York State Workers' Compensation Board.

**Note:** The Case Number must be reported for every claim to which a number has been assigned by the New York State Workers' Compensation Board.

Case numbers are **not** required for:

- Jurisdiction State is not New York
- Medical-only claims
- Claims subject to the Volunteer Firefighters' Benefit Law
- Claims subject to the Volunteer Ambulance Workers' Law
- Claims that are only Employers' Liability – Type of Claim 02
- Claims that are only Liability-Over – Type of Claim 04
- Claims that are subject to Federal Coverage
- ALAE-only claims when no Case Number has been assigned

## ~~23.~~24. CLAIMANT'S WEEKLY WAGE

Report, in whole dollars, the claimant's **actual** weekly wage amount at the date of injury upon which the indemnity benefits are based.

**Note:** This amount is NOT the effective weekly wage underlying maximum or minimum statutory benefits.

## ~~24.~~25. CLAIMANT ATTORNEY FEES INCURRED (OPTIONAL)

Report the incurred dollar amount (paid plus outstanding reserves) for the claimant's legal representation during the settlement of the claim as of the valuation date.

## ~~25.~~26. EMPLOYER ATTORNEY FEES INCURRED (OPTIONAL)

Report the incurred amount (paid plus outstanding reserves) for the employer's legal representation during the settlement of the claim as of the valuation date.

| | ~~26.~~27. TOTALS |
|---|---|
| | Report the arithmetic totals of the amounts reported for Number of Claims, Incurred Indemnity, Incurred Medical, Paid Indemnity, Paid Medical, ALAE Paid and Claimant Attorney Fees and Employer Attorney Fees, if reported.<br><br>In the case of corrections and subsequent reports, the totals shown must be the revised totals. |

## 2. CORRECTION REPORTS

Correction reports must be filed **without delay** when any of the conditions outlined below occur:

- An error of any kind is made on a previously filed statistical report(s).
- When the exposure previously reported has been changed by reason of an audit, a re-audit or any other adjustment affecting classification codes, exposure or premiums.
  - If a classification code is revised for a claim on a subsequent report, correction reports must be submitted for all prior reports which include the claim.
- If the carrier performs a final audit on an employer subsequent to performing an estimated audit.
- If the carrier performs a revised final audit on an employer subsequent to performing a final audit.
- If the header/policy information was reported incorrectly.
- The experience modification has been revised.
- ★ Loss values are found to have been included or excluded through clerical errors.
- Corrections to the type of injury are required as defined in Part IV, Item (~~14~~15) of this Plan.
- ★ A claim, or any part thereof, is declared non-compensable as defined in Part IV, Item (~~16~~17)(e) of this Plan.
- If the claim number changes during the life of the claim as defined in Part IV, Item (3) of this Plan.
- A claim is ruled or declared to be partially or fully fraudulent subsequent to the 1st reporting. Refer to Part IV, Item (8) "Fraudulent Claims" of this Plan.
- ★ The carrier or the claimant has obtained a subrogation recovery in an action against a third party. Refer to Part IV, Item (~~9~~10) "Recoveries" of this Plan.
- A carrier recovers paid indemnity or medical on a partially fraudulent or fully fraudulent claim under the applicable state law. Refer to Part IV, Item (8) "Fraudulent Claims".
- The specific Part of Body Code is determined subsequent to reporting Part of Body Code 65, Insufficient Info to Property Identify – Unclassified".

Correction reports are **not** permissible under the following conditions:

- Any change in loss amounts due to development in loss values from one valuation to the next.
- Any change in injury type of a claim due to development from one valuation to the next.

Correction reports submitted in connection with 1st – 10th reports must be identified with a correction type and sequence number. Refer to Part II, Items (2) and (3) of this Plan for specific codes and instructions.

Correction reports must be filed as soon as the changes are known.

## RULE 4 – APPLICATION AND REVISION OF EXPERIENCE RATING MODIFICATIONS

### A. GENERAL EXPLANATION

**1.** Modifications for eligible risks generally are determined on an annual basis and are effective for a period of 12 months. However, as provided in this Plan, certain circumstances may result in a reduced or extended application of an modification. Refer to Section (4)(D) of this Rule.

**2.** Only one modification applies to a risk at any given time and it applies to all operations of the risk.

**3.** Modifications are applied to the premium developed by the use of the carrier's rates in force on the effective date of the modification.

### B. INCLUSION OF PAYROLL AND LOSSES

★ **1. Revision of Payroll**

An insurance provider may discover within the audit period (within three years of policy expiration) that previously reported payroll must be revised. When the Rating Board receives these corrections, it will revise the current and up to two preceding modifications. Refer to Part V~~I~~ of the Statistical Plan for circumstances under which revised payroll values are required.

**2. Revision of Losses**

Revised unit reports (correction reports) to 1st, 2nd, and 3rd reports may be submitted in accordance with the Statistical Plan. With limited exception as indicated below, the Rating Board will use all payroll and loss correction reports in the production of the appropriate modifications. Refer to Part V of the Statistical Plan for circumstances under which revised loss values are required.

**(a)** Submission of revised loss values on unit reports will result in the automatic recalculation of the current and, if applicable, up to **two** preceding modifications when:

**(i)** Originally reported loss values were incorrect due to clerical or processing error

★ **(ii)** An originally reported claim is non-compensable in its entirety as ~~determined by~~defined in Part IV (17)(e) of the Statistical Plan.~~:~~

- ~~Official ruling by a court or the Workers' Compensation Board denying benefits under the New York State Workers' Compensation Law~~
- ~~A claimant's failure to file for benefits during the period allowed by the New York State Workers' Compensation Law~~

~~• A claimant's failure to prosecute his/her claim when a carrier contends, prior to the valuation date, that the claimant is not entitled to benefits under the New York State Workers' Compensation Law~~

★ **(iii)** An originally reported claim is partially non-compensable and corrections are reported in accordance with Part IV, Item (9)(B) of the Statistical Plan.

★ ~~(iii)~~**(iv)** Data obtained from carriers, including insolvent carriers and insolvent carrier data obtained from third party sources, has been submitted later than the customary due date schedule for unit statistical reports.

**(b)** Submission of revised loss values when a subrogation recovery is applicable to a claim will result in the automatic recalculation of the current and up to six preceding modifications. If a subrogation recovery is obtained in an action against a third-party, the current modification is that which is in effect when the insurance provider determines the revised loss value.

**(c)** In cases where a claim has been officially determined by the courts or ruling by the Workers' Compensation Board to be fully or partially fraudulent, the submission of revised loss values will result in the automatic recalculation of the current and up to six preceding modifications. If a claim is officially declared fraudulent, the current modification is that which is in effect when the official declaration of fraud is made.

**Note:**

In cases where a claim involves a subrogation recovery, or is declared fully or partially fraudulent, the respective identifiers must be included on the revised unit statistical reports. Failure to properly identify these cases will result in no change in the modification. Refer to Part IV of the Statistical Plan for appropriate coding information.

**3. Corrections in Classifications**

**(a)** A risk's classification(s) may be corrected in accordance with the New York Workers' Compensation and Employers' Liability Manual. When a classification assigned to a risk is revised other than as a result of a change in risk operations, the modification may be recalculated by the Rating Board. The purpose of such recalculation is to produce a modification using rating values that correspond to the class rates charged on a policy.

# PART IV – LOSS INFORMATION

| | 1. REPORTING OF LOSSES |
|---|---|
| | **(a)** Losses must be reported with the classification code corresponding to the classification to which the employee's payroll was assigned for premium determination purposes. |
| | **(b)** All claims must be reported to the Rating Board when, as of the valuation date, there are loss values in paid losses, incurred losses and/or ALAE, including those with only paid allocated loss adjustment expense amounts. Refer to Item (5)(b) of this Part for specific medical loss exception. The medical portion of losses on policies providing Excluding Medical coverage in accordance with Rule VIII (E) of the New York Workers' Compensation and Employers' Liability Manual should not be reported. |
| | **(c)** A claim, initially reported, but subsequently closed without payment at a later valuation must be reported as a closed claim with $0 indemnity and $0 medical loss amounts at that later valuation. |
| ★ | **(d)** An accident resulting in an injury to one worker, but on which losses are incurred under different coverages of the policy (e.g., workers' compensation; employers' liability) must be reported as one claim and be identified with the appropriate Type of Claim Code. Refer to Item (17)(d) of this Part for Type of Claim codes. |
| ★ | **(e)** When an accident results in two or more reported claims, each claim must be reported separately, and an appropriate Catastrophe Number must be assigned. Refer to Item (19) of this Part for instructions on the use of Catastrophe Number. |
| ★ | **(f)** Recoveries from subrogation and fraud determination, but not from reinsurance or deductible reimbursement, must net down the claim amounts. Refer to Item (8) of this Part for instructions regarding Fraudulent Claims, and to Item (10) of this Part for instructions regarding Recoveries. |
| | **(g)** Claim Grouping Option: The grouping of claims for statistical reporting purposes is not permitted in New York for losses that occur on policies effective January 1, 2011 and subsequent. |

**(a) Incurred Indemnity Amount**

Report the total amount of incurred indemnity costs for each claim as of the valuation date. Incurred indemnity loss amounts consist of all paid and outstanding benefits, including compensation paid to the deceased prior to death, burial expenses, payments to the state and employers' liability losses, including related expenses as described in Item (7) of this Part. Allocated loss adjustment expenses for other than employers' liability coverage must be **excluded** from reported incurred indemnity amounts and must be reported separately as allocated loss adjustment expense.

**(i) Outstanding Benefits**

The outstanding indemnity costs are the carrier's individual case estimates of future indemnity payments, except in the case of pension claims where any outstanding loss valuation, as set forth in Article 3, Section 27 of the New York State Workers' Compensation Law, must be determined by use of the appropriate tables published by the New York State Workers' Compensation Board.

**(ii) Reporting Special Payments:**

Where the New York State Workers' Compensation Law specifies that, in conjunction with certain types of injury, a specified amount shall be paid into a special fund, and that such amounts are in addition to the compensation payable to the injured worker or the dependents, then the combined total amount must be reported as the incurred indemnity amount on the unit statistical report.

**Examples of Special Payments:**

- Payments in no-dependent death cases
- Specified percentage of permanent partial awards designated for assignment for the Aggregate Trust Fund

**Note:** Assessments on the basis of total premium or total incurred or paid losses, instead of on a per claim basis, must **not** be included on unit statistical reports.

★ **(iii) Reporting Recoveries**

Incurred indemnity amounts must be reported net of recoveries from subrogation, special funds, fraudulent activities and findings of non-compensability. Refer to Item (8) of this Part for instructions regarding Fraudulent Claims, and to Item (10) in this Part for instructions regarding Recoveries.

| | |
|---|---|
| | **(iv) Final Awards**<br><br>Where a final award has been made by the New York State Workers' Compensation Board, the total incurred compensation must be in agreement with such award, except under the following circumstances: |
| | **A.** Where a claimant has appealed for a higher award for a compensable claim, the carrier must report at least the amount of the award, but may report a higher amount if, in its judgment, the facts in the case indicate an additional reserve is advisable. |
| | **B.** In cases where a claim has been officially declared non-compensable, but an appeal has been filed and is pending as of the valuation date, the carrier must report the incurred cost that would have been reported had there been no declaration of non-compensability. |
| ★ | **C.** In cases where a claim has been deemed non-compensable as defined in Item (17)(e) of this Part, but the period during which an appeal may be filed has not expired by the valuation date, the carrier may report the incurred cost that would have been reported had there been no declaration of non-compensability. In any case where the period for filing an appeal has expired subsequent to the valuation date, but prior to the submission date of the next statistical report, without an appeal having been filed, refer to Item (9) of this Part for the reporting requirements.<br><br>**Note:** Where the carrier has appealed an award, it must report the full amount of such award until the appeal is decided. |

## 6. EXPENSES EXCLUDED FROM LOSSES

Expenses must be excluded from reported losses except as noted in Item (7) of this Part. Medical or legal expenses incurred for the benefit of the carrier are treated as loss adjustment expense. Refer to Item (7) of this Part for expenses developed for the benefit of the claimant.

Unallocated Loss Adjustment Expense (ULAE) is also excluded from losses. ULAE includes, but is not limited to:

- Carrier employee salaries and traveling expenses that are considered loss adjustment expenses and are not incurred while doing activities listed as allocated expenses.
- Fees paid to independent claims professionals or attorneys hired to perform the function of claim investigation normally performed by claim adjusters. Fees are paid for developing and investigating a claim so that a determination can be made of the cause or extent of responsibility for the injury or disease, including evaluation and settlement of covered claims.

## 7. EXPENSES INCLUDED IN LOSSES

**(a) Medical or Legal Expenses Incurred for the Benefit of the Claimant**

Medical or legal court expenses incurred for the benefit of the claimant, or that the carrier is required to produce for the benefit of the claimant, must be reported as either an indemnity or medical loss depending upon the nature of the expense.

★ **(b) Employers' Liability Loss Adjustment Expense (LAE)**

Employers' liability losses must include allocated loss adjustment expenses, as defined in Item 13 of this Part. The entire amount of losses and allocated loss adjustment expenses for an employers' liability claim **must be reported as incurred indemnity losses** on the unit statistical report. If a deductible program applies, both losses and loss adjustment expense must be reported on a **gross** basis.

**(c) Impartial Examinations Ordered by the New York State Workers' Compensation Board**

Expenses for impartial examinations ordered by the New York State Workers' Compensation Board are to be reported as incurred losses.

## 9. NON-COMPENSABLE REPORTING

### A. Entire Claim Non-Compensable

When the entire claim has been determined to be non-compensable, in accordance with Part IV – Section (17)(e) of this Plan:

- As of the 1st report valuation, and the claim does not include any paid losses, incurred losses, and/or ALAE, the claim must not be reported.
- As of the 1st report valuation, and the claim includes paid losses, incurred losses, and/or ALAE, the claim must be reported with these loss values. Report this claim with the Type of Settlement (Loss Condition) Code 05.
- After the 1st report valuation and prior to the 10th report valuation, correction report(s) are required for all previously submitted unit reports to report the Type of Settlement (Loss Condition) Code 05. The paid losses, incurred losses, and/or ALAE must continue to reflect the loss values as of each specific report level(s).

**Example #1**

At the 1st unit report level, the following claim was reported:

- Policy Number: W123456 (Exposure State New York)
- Claim Number: 12345 (Jurisdiction State New Jersey)
- Incurred Indemnity: $20,000; Incurred Medical: $20,000
- Paid Indemnity: $1,000; Paid Medical: $1,000
- Paid ALAE: $2,000
- Claim Status: 0 (Open)

Between the 1st and 2nd unit reports, there was an official ruling that determined the claim was non-compensable.

This claim requires a correction to be reported on a 1st unit report to update the Type of Settlement Code to 05 Dismissal or Take Nothing (Non-Compensable). The Claim Status remains 0 (Open) and the loss amounts remain unchanged as originally reported.

Since this claim was open as of the 1st report, it will continue to be reported with Type of Settlement Code 05 until the claim is closed.

**Example #2**

At the 1st unit report level, the following claim was reported:

- Policy Number: W123456 (Exposure State New York)
- Claim Number: 23456 (Jurisdiction State New York)
- Incurred Indemnity: $20,000; Incurred Medical: $20,000
- Paid Indemnity: $1,000; Paid Medical: $1,000
- Paid ALAE: $2,000
- Claim Status: 0 (Open)

At the 2nd unit report level, the following claim was reported:

- Policy Number: W123456 (Exposure State New York)
- Claim Number: 23456 (Jurisdiction State – New York)
- Incurred Indemnity: $45,000; Incurred Medial $55,000
- Paid Indemnity: $45,000; Paid Medical: $55,000
- Paid ALAE: $10,000
  Claim Status: 1 (Closed)

Between the 2nd and 3rd unit reports, there was an official ruling that determined the claim was non-compensable.

In response to this ruling, the carrier submitted a correction to the 1st and 2nd unit reports to code the claim as non-compensable with Loss Condition Code – Type of Settlement 05 Dismissal or Take Nothing (Non-compensable). All loss amounts and Claim Status remain unchanged on both the 1st and 2nd reports.

This claim requires a correction to be reported to the 1st unit report, to include the Type of Settlement Code 05. The Claim Status remains 0 (Open) and the loss amounts remain unchanged as originally reported.

This claim requires a correction to be reported to the 2nd unit report to include the Type of Settlement Code 05. The Claim Status remains 1 (Closed) and the loss amounts remain unchanged as originally reported.

**B. Portion of a Claim Non-Compensable**

When a portion of a claim has been determined to be non-compensable, the claim is not reported as a non-compensable claim. Only the compensable portion of the claim is reported as follows:

- As of the 1st report valuation, and the claim does not include any paid losses, incurred losses, and/or ALAE, the claim must not be reported.
- As of the 1st report valuation, claims that include paid losses, incurred losses, and/or ALAE, must be reported with these loss values. Report this claim with the Type of Settlement (Loss Condition) Code other than 05.
- After the 1st report valuation, correction report(s) are required for all previously submitted unit reports to report the Type of Settlement (Loss Condition) Code other than 05. The paid losses, incurred losses, and/or ALAE must be corrected to reflect only the compensable portion of the loss values as of each specific report level(s).

## 10. RECOVERIES – SUBROGATION, THIRD-PARTY CASES

### (a) Net Loss Reporting

Except as noted below, when there has been recovery of loss due to subrogation, the amount of incurred loss reported must be the net incurred loss, and the amount of paid loss reported should be the net paid loss.

The net incurred loss is the gross incurred loss (i.e., the gross evaluation of the claim prior to any actual or expected recovery on which the award was based, whether the claim is still open or not) minus the amount recovered less recovery expenses. The net paid loss is the gross paid loss minus the amount recovered less recovery expenses. When the allocation of recovery to indemnity and medical is unknown, the net incurred loss must be proportionally split between indemnity and medical losses in the same proportion as the original gross incurred indemnity and medical amounts, and the net paid loss must be proportionally split between indemnity and medical losses in the same proportion as the original gross paid indemnity and medical amounts.

**Exception:** When the recovery expenses exceed the amount recovered, report the gross incurred loss instead of the net incurred loss and the gross paid loss instead of the net paid loss.

A claim involving subrogation must be reported with Loss Condition Code — Type of Recovery Code 03 (Subrogation-Only).

### (b) Correction Reporting

When a subrogation recovery is received by the carrier at any point subsequent to the 1st unit report, but prior to the 10th report valuation date, correction report(s) must be filed for prior reports that reflected a total incurred amount higher than the net incurred loss.

If a correction is required:

Report the net incurred indemnity loss amount if it is lower than the originally reported amount.
Report the net incurred medical loss amount if it is lower than the originally reported amount.
Report the net paid indemnity loss amount if it is lower than the originally reported amount.
Report the net paid medical loss amount if it is lower than the originally reported amount.

It was determined above that a second report correction is required. The net incurred loss for the 2nd unit report is determined by comparing the originally reported loss amount at 2nd report to the net losses as of the 3rd report:

- Net Incurred Indemnity: Report $32,400 because it is less than the $35,000 reported on the 2nd report originally.
- Net Paid Indemnity: Report $22,000 (unchanged because it is less than the $32,400 net paid amount at 3rd report)
- Net Incurred Medical: Report $25,600 because it is less than the $40,000 reported on the 2nd report originally.
- Net Paid Medical: Report $25,600 because it is less than the $28,000 reported on the 2nd report originally.

Because the Paid Indemnity was less than the calculated Net Paid Indemnity, the Paid Indemnity on the 2nd report level remains at $22,000.

The above example shows this claim reported on a correction to a 2nd unit report to include the revised loss amounts and Type of Recovery Code 03. Because the claim was still open, the Claim Status remains 0 (Open).

## 11. 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 proportionally between indemnity and medical.

Report the applicable Lump-Sum Indicator on each claim as follows:

| Code | Description |
|---|---|
| Y | The claim has been settled by an agreement between the carrier and claimant for a specified amount representing a discounted or commuted value. |
| N | The claim has not been settled with a lump-sum agreement. |

## 12. PAID LOSSES

★ **(a) Paid Indemnity Amount**

Report the dollar amount of paid indemnity costs for the claim as of the 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 recoveries must be subtracted from paid indemnity if the recovery applies to the indemnity loss. Refer to Item (10) of this Part for instructions regarding recoveries.

Payments required by the New York State Workers' 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 dollar amount of medical losses paid for the claim as of the valuation date. Paid medical must not include any claim expense. Subrogation recoveries must be subtracted from paid medical if the recovery applies to the medical loss. Refer to Item (10) of this Part for instructions regarding recoveries.

Paid medical amounts must include surcharges on hospital and related services imposed pursuant to the New York State Health Care Reform Act ("HCRA").

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

## 13. ALLOCATED LOSS ADJUSTMENT EXPENSE ("ALAE") PAID AMOUNT

Report the dollar amount of loss adjustment expense allocated and paid for each claim as of the valuation date. ALAE encompass 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:

- **(i)** Medical examinations of a claimant to determine the extent of the carrier's liability, degree of permanency or disability
- **(ii)** Expert medical or other testimony
- **(iii)** Autopsy
- **(iv)** Witness and summonses
- **(v)** Copies of documents such as birth and death certificates, and medical treatment records
- **(vi)** Arbitration fees
- **(vii)** Surveillance
- **(viii)** 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:

- **(i)** 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
- **(ii)** Hospital and other treatment utilization reviews, including precertification/preadmission, concurrent or respective reviews
- **(iii)** Preferred provider network/organization expenses
- **(iv)** Medical fee review panel expenses
- **(v)** 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

## 14. CLASSIFICATION CODE

Report the classification code under which the injured worker's payroll or other exposure was assigned 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 classification.**

## 15. INJURY TYPE

Report the type of injury code as defined under provisions of the New York State Workers' Compensation Law corresponding to the carrier's estimate, as of the valuation date, of the ultimate injury type of the claim. The injury type does not have to correspond to the type of benefit being paid as of the valuation date; e.g., if temporary total payments are being made on a claim that is reserved as a permanent partial case, report the claim as a permanent partial injury type.

## 16. CLAIM STATUS

Report the code that indicates the status of the claim as of the valuation date.

| Code | Description |
|---|---|
| 0 | Claim is open |
| 1 | Claim is closed |
| 2 | Claim is reopened |

Open means that the carrier still expects to make further indemnity or medical payments on the claim (the exact nature of these payments is not known) or may not have determined as of the valuation date 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 the 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.

## 17. LOSS CONDITION CODE

Report the applicable code corresponding to the Act, Type of Loss, Type of Recovery, Type of Claim, and Type of Settlement for each individual claim.

An accident resulting in an injury to one worker with payments made under different coverages of the policy must be reported as **one** claim with all of the incurred amounts combined.

**Example:** If the entire loss is incurred under the provisions of both Part One and Part Two of the Workers' Compensation and Employers' Liability Insurance policy, the claim would be coded to Type of Claim (03) Workers' Compensation, including Employers' Liability. Refer to section (d) of this Part, Type of Claim, within this section.

| | |
|---|---|
| ★ | **(c) Type of Recovery**<br><br>• **No Recovery – Code 01**<br>• **Subrogation Only (Third Party) Code – 03**<br>A recovery that occurs when the carrier has received reimbursements from an entity, other than the employer, with legal liability due to circumstances for the injury.<br><br>Refer to Item (10) of this Part regarding recoveries from subrogation and other third parties. |
| | **(d) Type of Claim**<br><br>• **Workers' Compensation Only – Code 01**<br>The entire loss is incurred under the provisions of Part One of the Workers' Compensation and Employers' Liability Insurance Policy<br>• **Employers' Liability Only – Code 02**<br>The entire loss is incurred under the provisions of Part Two of the Workers' Compensation and Employers' Liability Insurance Policy.<br>• **Workers' Compensation Including Employers' Liability or Liability-Over – Code 03**<br>The loss is incurred under the provisions of Parts One and Two of the Workers' Compensation and Employers' Liability Insurance Policy.<br>• **Liability Over – Code 04**<br>A particular Employers' Liability coverage situation where a third party, who is being sued by an employee, in turn sues the employer on the grounds of negligence, or like theory.<br><br>**Example:** A person operating a drill press is injured, and, although the injury is compensable, the worker brings suit against the manufacturer of the drill press on the grounds of faulty design or manufacture. The manufacturer then succeeds in suing the employer for damages on the grounds of faulty installation or maintenance of the drill press. The damages thus incurred to the employer, if covered under his workers' compensation policy, are classified as liability-over, and are in addition to compensation payments made to the injured employee. |

**(e) Type of Settlement**

Identify the type of settlement for the claim.

- **Claim Not Subject to Settlement – Code 00**
- **Section 32 Settlement – Code 03**
  The claim has been settled under Section 32 of the New York State Workers' Compensation Law. Code 03 is applicable to both closed claims and to open claims even when only a portion of the claim is subject to a Section 32 settlement.
- ★ **Dismissal or Take Nothing (Non-compensable) – Code 05**
  The claim meets one or more of the following:
  - Official ruling denying benefits on the entire claim.
  - Claimant's failure to file for benefits and no claim is established by the New York State Workers' Compensation Board.
  - Claimant's failure to prosecute claim following carrier's denial of the claim as of the valuation date of the claim.
  - No reimbursement is sought for care provided within six months of the date the claim is filed and the claim has not been established by the New York State Workers' Compensation Board.
- **All Other Settlements – Code 09**

## 18. JURISDICTION STATE CODE

★ Report the numeric state code of the governing jurisdiction that will administer the claim and whose statutes will apply to the claim adjustment process.

Refer to Part VI of this Plan for Jurisdiction State Codes.

★ **Note:** State Code "00" will no longer be accepted on any Unit Stat claim.

## 19.CATASTROPHE NUMBER

A catastrophe is defined as any accident (one occurrence) resulting in two or more reportable claims.

Report the two-digit sequential number for two or more claims resulting from the same occurrence. For each policy, the claims from the first such occurrence must be assigned a Catastrophe Number of "01," claims from a second occurrence must be "02," etc. up to "10." After number "10" is assigned the next number in the sequence will reprocess to number "01". When an occurrence results in only one claim being reported, zero-fill this field.

**Exceptions:**

**(1)** Report Catastrophe Number 87 for all claims for a latent condition emanating from the rescue, recovery and clean-up operations at the World Trade Center site that were undertaken between September 11, 2001 and September 12, 2002, as defined in Article 8-A of the New York Workers' Compensation Law (Chapter 446 of the Laws of 2006).

**Note:** Catastrophe Number 87 will apply to both single and multiple claims.

**(2)** Report Catastrophe Number 12 for all claims occurring on or after December 1, 2019 that are due to the COVID-19 pandemic.

**Note:** Catastrophe Number 12 will apply to both single and multiple claims.

## 20. MANAGED CARE ORGANIZATION TYPE

Report the code that corresponds to the type of organization, if any, that administers the applicable medical loss on the claim.

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

## 21. INJURY DESCRIPTION CODE

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

★ • **Part of Body:** Report the code that identifies the injured body part for a given claim. The part of body that is injured and expected to be the most significant contributor to the cost of the claim.

★ • **Nature of Injury:** Report the code that represents the nature of injury for a given claim.

★ • **Cause of Injury:** Report the code that represents the cause of injury for a given claim.

Refer to Part VI of this Plan for the applicable codes.

## 22. OCCUPATION DESCRIPTION

★ Report the narrative description of the regular occupation of the claimant.

## 23. NEW YORK STATE WORKERS' COMPENSATION BOARD CASE NUMBER

Report the unique alphanumeric Case Number assigned to each claim by the New York State Workers' Compensation Board.

**Note:** The Case Number must be reported for every claim to which a number has been assigned by the New York State Workers' Compensation Board.

Case numbers are **not** required for:

- Jurisdiction State is not New York
- Medical-only claims
- Claims subject to the Volunteer Firefighters' Benefit Law
- Claims subject to the Volunteer Ambulance Workers' Law
- Claims that are only Employers' Liability – Type of Claim 02
- Claims that are only Liability-Over – Type of Claim 04
- Claims that are subject to Federal Coverage
- ALAE-only claims when no Case Number has been assigned

## 24. CLAIMANT'S WEEKLY WAGE

Report, in whole dollars, the claimant's **actual** weekly wage amount at the date of injury upon which the indemnity benefits are based.

**Note:** This amount is NOT the effective weekly wage underlying maximum or minimum statutory benefits.

## 25. CLAIMANT ATTORNEY FEES INCURRED (OPTIONAL)

Report the incurred dollar amount (paid plus outstanding reserves) for the claimant's legal representation during the settlement of the claim as of the valuation date.

## 26. EMPLOYER ATTORNEY FEES INCURRED (OPTIONAL)

Report the incurred amount (paid plus outstanding reserves) for the employer's legal representation during the settlement of the claim as of the valuation date.

| | 27. TOTALS |
|---|---|
| | Report the arithmetic totals of the amounts reported for Number of Claims, Incurred Indemnity, Incurred Medical, Paid Indemnity, Paid Medical, ALAE Paid and Claimant Attorney Fees and Employer Attorney Fees, if reported.<br><br>In the case of corrections and subsequent reports, the totals shown must be the revised totals. |

## 2. CORRECTION REPORTS

Correction reports must be filed **without delay** when any of the conditions outlined below occur:

- An error of any kind is made on a previously filed statistical report(s).
- When the exposure previously reported has been changed by reason of an audit, a re-audit or any other adjustment affecting classification codes, exposure or premiums.
  - If a classification code is revised for a claim on a subsequent report, correction reports must be submitted for all prior reports which include the claim.
- If the carrier performs a final audit on an employer subsequent to performing an estimated audit.
- If the carrier performs a revised final audit on an employer subsequent to performing a final audit.
- If the header/policy information was reported incorrectly.
- The experience modification has been revised.
- ★ Loss values are found to have been included or excluded through clerical errors.
- Corrections to the type of injury are required as defined in Part IV, Item (15) of this Plan.
- ★ A claim, or any part thereof, is declared non-compensable as defined in Part IV, Item (17)(e) of this Plan.
- If the claim number changes during the life of the claim as defined in Part IV, Item (3) of this Plan.
- A claim is ruled or declared to be partially or fully fraudulent subsequent to the 1st reporting. Refer to Part IV, Item (8) "Fraudulent Claims" of this Plan.
- ★ The carrier or the claimant has obtained a subrogation recovery in an action against a third party. Refer to Part IV, Item (10) "Recoveries" of this Plan.
- A carrier recovers paid indemnity or medical on a partially fraudulent or fully fraudulent claim under the applicable state law. Refer to Part IV, Item (8) "Fraudulent Claims".
- The specific Part of Body Code is determined subsequent to reporting Part of Body Code 65, Insufficient Info to Property Identify – Unclassified".

Correction reports are **not** permissible under the following conditions:

- Any change in loss amounts due to development in loss values from one valuation to the next.
- Any change in injury type of a claim due to development from one valuation to the next.

Correction reports submitted in connection with 1st – 10th reports must be identified with a correction type and sequence number. Refer to Part II, Items (2) and (3) of this Plan for specific codes and instructions.

Correction reports must be filed as soon as the changes are known.

# RULE 4 – APPLICATION AND REVISION OF EXPERIENCE RATING MODIFICATIONS

## A. GENERAL EXPLANATION

**1.** Modifications for eligible risks generally are determined on an annual basis and are effective for a period of 12 months. However, as provided in this Plan, certain circumstances may result in a reduced or extended application of an modification. Refer to Section (4)(D) of this Rule.

**2.** Only one modification applies to a risk at any given time and it applies to all operations of the risk.

**3.** Modifications are applied to the premium developed by the use of the carrier's rates in force on the effective date of the modification.

## B. INCLUSION OF PAYROLL AND LOSSES

★ **1. Revision of Payroll**

An insurance provider may discover within the audit period (within three years of policy expiration) that previously reported payroll must be revised. When the Rating Board receives these corrections, it will revise the current and up to two preceding modifications. Refer to Part V of the Statistical Plan for circumstances under which revised payroll values are required.

**2. Revision of Losses**

Revised unit reports (correction reports) to 1st, 2nd, and 3rd reports may be submitted in accordance with the Statistical Plan. With limited exception as indicated below, the Rating Board will use all payroll and loss correction reports in the production of the appropriate modifications. Refer to Part V of the Statistical Plan for circumstances under which revised loss values are required.

**(a)** Submission of revised loss values on unit reports will result in the automatic recalculation of the current and, if applicable, up to **two** preceding modifications when:

**(i)** Originally reported loss values were incorrect due to clerical or processing error.

★ **(ii)** An originally reported claim is non-compensable in its entirety as defined in Part IV (17)(e) of the Statistical Plan.

★ **(iii)** An originally reported claim is partially non-compensable and corrections are reported in accordance with Part IV, Item (9)(B) of the Statistical Plan.

★ **(iv)** Data obtained from carriers, including insolvent carriers and insolvent carrier data obtained from third party sources, has been submitted later than the customary due date schedule for unit statistical reports.

**(b)** Submission of revised loss values when a subrogation recovery is applicable to a claim will result in the automatic recalculation of the current and up to six preceding modifications. If a subrogation recovery is obtained in an action against a third-party, the current modification is that which is in effect when the insurance provider determines the revised loss value.

★ **(c)** In cases where a claim has been officially determined by the courts or ruling by the Workers' Compensation Board to be fully or partially fraudulent, the submission of revised loss values will result in the automatic recalculation of the current and up to six preceding modifications. If a claim is officially declared fraudulent, the current modification is that which is in effect when the official declaration of fraud is made.

**Note:**

In cases where a claim involves a subrogation recovery, or is declared fully or partially fraudulent, the respective identifiers must be included on the revised unit statistical reports. Failure to properly identify these cases will result in no change in the modification. Refer to Part IV of the Statistical Plan for appropriate coding information.

**3. Corrections in Classifications**

**(a)** A risk's classification(s) may be corrected in accordance with the New York Workers' Compensation and Employers' Liability Manual. When a classification assigned to a risk is revised other than as a result of a change in risk operations, the modification may be recalculated by the Rating Board. The purpose of such recalculation is to produce a modification using rating values that correspond to the class rates charged on a policy.