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B U L L E T I N

December 10, 2012

Contact: *Ziv Kimmel, VP & Actuary*
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R.C. 2321

To the Members of the Board

Re: New York Workers Compensation Statistical Plan – 2013 Edition

The New York State Department of Financial Services has approved a new version of the New York Workers Compensation Statistical Plan Manual, effective January 1, 2013. The new Edition of the Plan has been reformatted and designed to be more user friendly and explicit than the current manual in its statement of plan rules, and is in a format that is consistent with the Statistical Plans used in most other jurisdictions.

A summary describing the major changes that have been incorporated into the new Manual is attached to this bulletin, as well as a complete copy of the new Statistical Plan.

We are pleased to announce that the revised Statistical Plan has also been incorporated to the Rating Board's new Digital Library which is being made available on the Board's website.

Very truly yours,

Monte Almer

President

ZK/ab
Encl.

NEW YORK COMPENSATION INSURANCE RATING BOARD

Major Changes Contained in the 2013 New York Workers Compensation Statistical Plan

- General update, modernization and clarification of verbiage
- Restructure of the organization of the Plan
- Consistency with WCSTAT definitions and verbiage where possible
- Elimination of all references to hardcopy reporting
- Elimination of separate section for three-year fixed rate policies; replaced by rule
- Elimination of rule relating to 'advance special reporting' requirements for Retro policies
- Addition of Replacement Report capability for replacing previously submitted original 1st reports in their entirety
- Addition of Deductible Type Code 12, Variable
- Addition of two new optional data elements: Claimant Attorney Fees and Employer Attorney Fees
- Addition of requirement that claim numbers reported on USRs be the same as those reported in the annual NY Special Claim Calls (NY 131, NY 132 & NY 141)
- Addition of verbiage urging carriers to report the same claim number to the WCB as reported to NYCIRB on USRs
- Elimination of the entire Individual Case Report section; eliminate ICR reporting on all claims as of 1/1/2013
- Addition and explanation of NYCIRB's new product, Manage USR (MUSR)
- Addition of the requirement to submit a correction report when a specific Part of Body Code becomes known subsequent to the reporting of Part of Body Code 65, Insufficient Info to Properly Identify - Unclassified
- Summary of all standard report codes in a single section (Part VI)
- Creation of an on-line Statistical Plan Reporting Guidebook to provide more detailed information, examples and record layouts

NEW YORK

WORKERS COMPENSATION

STATISTICAL PLAN

2013 Edition

NEW YORK COMPENSATION INSURANCE RATING BOARD
733 THIRD AVENUE
NEW YORK, NY 10017
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INTRODUCTION

Scope and Effective Date of The Plan

The New York Workers Compensation Statistical Plan (Plan) is applicable for the reporting of New York data on direct business written for Workers Compensation, Voluntary Compensation and Employers Liability insurance. Acting under the direction of the Superintendent of Financial Services, and pursuant to Article 23 of the New York Insurance Law, each carrier's experience must be submitted to the New York Compensation Insurance Rating Board (NYCIRB) in accordance with all of the requirements specified in the Plan.

This Plan is applicable on a **mandatory** basis for the reporting of data for all policies effective January 1, 2013 and thereafter.

Organization of The Plan

The New York Statistical Plan is organized according to the following major parts:

I. General Rules

II. Header Data/Policy Information

III. Exposure/Premium Information

IV. Loss Information

V. Subsequent Reports and Corrections

VI. Codes

New York Statistical Plan Reporting Guidebook

The New York Statistical Plan Reporting Guidebook is available on the NYCIRB website, www.nycirb.org, to provide further instructions, guidelines and examples to assist users to accurately meet their reporting requirements.

PART I

GENERAL RULES

PART I—GENERAL RULES

1. Reporting of Statistics

Carriers or their authorized data providers may use any method they choose for the internal recording of statistical data submitted to the NYCIRB. This includes any type of format convenient to the carrier's statistical and accounting procedures and codes other than those set forth in the Plan, provided that the required data elements are submitted to the NYCIRB in accordance with the rules and timeframes specified in this Plan.

2. Preparation and Completion of Unit Statistical Reports

Summarized exposure, premium and loss data for each workers compensation policy is required under Item 6 below. Electronic format is the exclusive means of submitting this data to NYCIRB. For information regarding electronic reporting, refer to the Workers Compensation Statistical Reporting Specifications (WCSTAT) in the WCIO Data Specifications Manual at www.wcio.org.

3. Submission Control Record

A submission of statistical data must be accompanied by a submission control record as specified in the WCIO Data Specifications Manual, General Section, at www.wcio.org.

4. Auditing of Statistics Prior to Submission

The carrier must audit the statistics being reported prior to their submission to NYCIRB to detect any errors. Examples of such errors are: errors in the assignment of statistical codes; errors in the assignment of claims to policies and/or class codes; errors in dollar amounts being reported. If audited information is not available prior to the submission of statistics, the carrier must identify and report the estimated exposure and premium until the audited information becomes available.

5. Correction of Errors

Carriers are expected to correct any and all errors found in their data. Errors impact the quality and accuracy of ratemaking and experience rating and must be corrected to prevent delays in releasing these products. *Refer to Part V for detailed instructions.*

6. Filing Requirements

Exposure, premium and loss data must be filed for every workers compensation and employers liability policy providing coverage in New York, including New York coverage on interstate policies and coverage provided under any voluntary compensation endorsement.

Statistical reports are also required for any policies with New York exposure that are written on an "*If Any*" basis and do not develop exposure, provided that the policy was not cancelled flat. Refer to Part III, Item 6.g.

If more than one risk is written on a single policy, as provided in either Section 32 of the Volunteer Firefighters' Benefit Law or Section 32 of the Volunteer Ambulance Workers' Law, separate statistical reports must be submitted for each risk included within the policy.

Statistical data is not required for the following types of policies:

- Employers liability insurance on residence and farm employees in conjunction with other liability insurance
- Workers compensation on domestics provided in conjunction with homeowners insurance
- Policies providing coverage under the National Defense Projects Rating Plan or Nuclear Regulatory Commission projects (See Items 10 and 11, respectively)
- Policies providing excess coverage other than excess medical

7. Multi-State Policies

Statistical reports must be filed for each state of a multi-state policy. A report must be filed for each state on a policy with estimated exposure, including those for which no exposure was developed.

Statistical reports for New York coverage on a multi-state policy must be filed with the NYCIRB and also with the National Council on Compensation Insurance (NCCI).

8. Uncollectible Premiums

a. Audited Policies

Report all earned premiums for those policies on which an audit has been conducted and the earned premium is known, even if the premium is uncollectible. Likewise, report the corresponding exposure and loss data.

b. Policies on Which a Final Audit Is Not Possible

Report the estimated earned premium and exposure corresponding to the term of coverage for those policies on which a final audit is not possible and the audited earned premium and exposure is not known. Likewise, report the loss data for the corresponding term of coverage.

9. Reinsurance

Statistics are to be reported only for direct business. Do ***not*** submit unit statistical reports for workers compensation assumed policies (e.g., exclude premiums received from, or losses paid to, other carriers on account of reinsurance assumed by the carrier). Do not submit unit report statistics for workers compensation ceded policies (e.g., reductions should not be made for premiums ceded to, or for losses recovered from, other carriers due to ceded reinsurance).

10. National Defense Projects

Premium and loss data for policies written under the National Defense Projects Rating Plan shall ***not*** be reported on unit statistical reports. Instead, "Exhibit I-Computation of Earned Premium", form NDPRP-I, must be filed with the NYCIRB at the same time this form is submitted to the insured in accordance with the rules of the National Defense Projects Rating Plan. Such filing shall include only New York experience and must not include experience of any other state which may be included on the policy. *Refer to the "Forms" section on the NYCIRB website, www.nycirb.org, for a copy of form NDPRP-1.*

11. Radiation Exposure—Nuclear Regulatory Commission Projects

Premiums and losses for policies covering Nuclear Regulatory Commission projects under the direction of any government agency must ***not*** be reported under this Plan.

12. Radiation Exposure—Other Than Nuclear Regulatory Commission Projects

The New York Workers Compensation and Employers Liability Manual provides that a supplemental rate, subject to the approval of the NYCIRB, may be applied to operations involving research, manufacture, handling, transportation and use of, or exposure to, radioactive materials, where such operations are not performed for, or under the direction of, any government agency. The additional premium resulting from this supplemental rate, and radiation losses on risks where the supplemental rate has been applied, must be reported under Code 9985.

13. Coverage for Other Than Payroll Based Exposures

a. On Standard One-Year Workers Compensation Policies

Premium and loss data must be submitted on unit statistical reports in accordance with Part III, Items 6.b. through 6.f. of this Plan.

b. On Three-Year Workers Compensation Policies

1. Three - Year Fixed Rate Policies

For three-year fixed rate policies written in accordance with Rule XI of the New York Workers Compensation and Employers Liability Manual, report the premiums and loss data on these policies in accordance with Item 19 below.

2. Other Three-Year Policies

For three-year policies that are not fixed rate policies written in accordance with Rule III C.3 of the New York Workers Compensation and Employers Liability Manual, report the premiums and loss data in accordance with Item 18 below.

c. Statutory Workers Compensation Coverage Afforded Under Personal Liability Policies

(1) Experience to be Reported

Whenever workers compensation and employers liability coverage for domestic workers is required by the New York Workers' Compensation Law and afforded by endorsement under a personal liability policy, statistical reports must be filed in accordance with the preceding sections of this Plan. Premium and loss data must be reported only for workers compensation and related employers liability coverage and must not include any other liability coverage afforded under the personal liability policy.

(2) Time of Reporting

(a) If the personal liability policy is written for a three-year period, it shall be considered for reporting purposes as three consecutive annual policies having the same policy number, and three reports shall be filed at annual intervals.

Example: Three-year personal liability policy effective 7/01/12
7/01/12 - 7/01/13 report due 3/01/14
7/01/13 - 7/01/14 report due 3/01/15
7/01/14 - 7/01/15 report due 3/01/16

(b) If the workers compensation and employers liability coverage is endorsed on an outstanding personal liability policy, the time for reporting experience for such coverage must be determined on the basis of the policy anniversary date, not the endorsement date.

Example: Three-year personal liability policy effective 7/01/12; workers compensation and employers liability endorsed effective 4/01/14
4/01/14 - 7/01/14 report due 3/01/15
7/01/14 - 7/01/15 report due 3/01/16

14. Excess Coverage for Medical Payments (Per Claim or Per Accident Basis)—Ex-Medical Policies

a. The experience under this coverage shall be reported in the same manner as the experience for the basic coverage provided by the policy. The instructions contained in this Plan are applicable to the reporting of such excess coverage. Ex-medical policies that are written to provide excess coverage for medical payments must be coded with the following Policy Type ID codes:

Type of Coverage	09
Type of Plan	01
Type of Non-Standard Provisions	06

b. Each loss incurred under such coverage shall be listed individually under the same claim identifiers (i.e. claim number, class code, type of injury, etc.) as assigned to the experience for the basic coverage.

15. Date of Valuation and Filing

Losses included in the first reporting of a given policy must be valued as of 18 months after the month in which the policy became effective. Subsequent reporting of loss data (2nd-10th) must be valued 12 months after the valuation of the preceding report. Each report level must be filed with the NYCIRB no later than two months after the respective valuation date.

The table shown below displays the valuation and filing dates for all reportings:

Report Level	Valuation Date	Filing Due Date
1st	18th month	20th month
2nd	30th month	32nd month
3rd	42nd month	44th month
4th	54th month	56th month
5th	66th month	68th month
6th	78th month	80th month
7th	90th month	92nd month
8th	102nd month	104th month
9th	114th month	116th month
10th	126th month	128th month

Examples of Valuation and Filing Dates for First Reports

Effective Month Of the Policy	Valuation Month (18 Months after policy effective month)	Reporting Month (20 months after policy effective date
January	July	September
February	August	October
March	September	November
April	October	December
May	November	January
June	December	February
July	January	March
August	February	April
September	March	May
October	April	June
November	May	July
December	June	August

16. Late Filing Penalties

Statistical reports received by NYCIRB later than the twenty-second month after the effective date of the policy will incur a late charge per unit report per month for each report that is overdue. The late charge also applies to all subsequent reports submitted more than four months past the required month of valuation.

17. Classification Code

Report the insured's classification codes determined according to the rules of the New York Workers Compensation and Employers Liability Manual.

No claim may be assigned to any classification unless exposure has also been reported for that classification. For losses, report the classification code under which the injured worker's payroll is assigned even if, at the time of the injury, the worker may have been involved in an activity that could be classified differently.

18. Multiple Year Policies Other Than Three-Year Fixed Rate

Multiple year policies other than three-year fixed rate must be considered as separate policies for reporting purposes, and reports for each unit of 12 months or less shall be filed at the time all other reports on policies with the same effective date are being filed. If, however, a policy is written for a period that is more than one year, but not more than one year and sixteen days, such policy must be treated as a one-year policy for reporting purposes. The reports for such policy must be filed at the time all other reports on policies with the same effective date are being filed. Losses must be valued 18 months after the effective date of each unit of experience, and at annual periods thereafter.

Examples:

a. The statistical reports on a three-year policy effective July 1, 2012 must be filed at the same time as other reports on policies effective in July 2012, July 2013 and July 2014. Losses shall be valued January 1, 2014, January 1, 2015 and January 1, 2016, respectively.

b. The statistical reports on a policy covering the period July 1, 2012 to January 1, 2015, with the first six months considered as a unit, must be filed with other reports on policies effective in July 2012, January 2013 and January 2014. Losses shall be valued January 1, 2014, July 2014 and July 1, 2015, respectively.

c. The statistical reports on a policy covering the period July 1, 2012 to January 2015, with the last six months considered as a unit, must be filed with the other reports on policies effective in July 2012, July 2013 and July 2014. Losses shall be valued January 1, 2014, January 1, 2015 and January 1, 2016, respectively.

Note: A policy issued for a period not longer than one year and 16 days is treated as a one-year policy.

19. Three-Year Fixed Rate Policies

The complete three-year experience incurred under the policy must be reported as one complete policy.

a. Date of Valuation and Filing

Losses included in the reporting of a given policy must be valued as of 42 months after the inception month of the policy, and the statistical reports must be filed not later than 44 months after the effective month of the policy. These statistical reports must be specifically identified as three-year fixed rate policy experience by placing a “Y” in the Three-Year Fixed Rate indicator of the “Policy Conditions” field.

b. Subsequent Reports

Second and third statistical reports must be filed 12 and 24 months, respectively, after filing the original statistical report. Fourth and subsequent reports are not required for three-year fixed rate policies.

20. Whole Dollar Amounts Required

Report all dollar amounts in whole dollars only.

21. Application of Manual Rules

- Rules in this Plan apply separately to each unit statistical report, including any associated exposure and corresponding claims
- The effective date of a rule, or a change in a rule, is the date approved for use by the New York Department of Financial Services
- The application of payroll and losses used to calculate an employer’s experience modification is in accordance with the New York Experience Rating Plan Manual
- Classification code assignment and basis of premium are determined by the New York Workers Compensation and Employers Liability Manual

PART II

HEADER DATA / POLICY INFORMATION

PART II—HEADER DATA / POLICY INFORMATION

1. Report Number

Report the code that corresponds to the policy valuation date. This code indicates whether the report is a 1st or subsequent report.

Code	Report Level	Valuation Schedule
1	First Report	Valued 18 months from policy effective month
2	Second Report	Valued 30 months from policy effective month
3	Third Report	Valued 42 months from policy effective month
4	Fourth Report	Valued 54 months from policy effective month
5	Fifth Report	Valued 66 months from policy effective month
6	Sixth Report	Valued 78 months from policy effective month
7	Seventh Report	Valued 90 months from policy effective month
8	Eighth Report	Valued 102 months from policy effective month
9	Ninth Report	Valued 114 months from policy effective month
A	Tenth Report	Valued 126 months from policy effective month

2. Correction Sequence Number

Report the sequential code that corresponds to the number of correction reports submitted within a particular report level. Report "0" for original report level submissions. Report “1” through “9” and then “A” through “Z” as a correction number within a particular report level. Contact NYCIRB if additional numbers are required.

Example: 3rd correction to a first report = Report Number "1", Correction Sequence Number “3".

3. Correction Type

Report the code that indicates the type of correction report being submitted.

Code	Description
H	Header Record Correction (including link data)
E	Exposure Record Correction (First Reports Only) (includes associated total corrections)
L	Loss Record Correction (includes associated total corrections)
T	Total Record Correction Only
M	Multiple Record Type Corrections

Note: This field must be left blank for original report level submissions.

4. Replacement Report Code

Identify reports being submitted to replace an entire 1st report that was previously submitted and failed (rejected). The replacement indicator, “R”, may only be submitted for the first reporting of exposure, premium and loss data, valued no later than 18 months after the policy effective date. *Refer to Part V, Item 5 for detailed instructions for submitting replacement reports.*

5. Carrier Code

Report the 5-digit numeric code assigned to the reporting company by the NYCIRB or the NCCI. This numeric code must remain the same throughout the life of the policy, unless a correction has been submitted revising the carrier code previously reported.

6. Policy Number

Report the policy number (up to 18 positions) that uniquely identifies the policy under which the experience occurred, excluding blanks, punctuation marks, and special characters. This number must be identical to the number set forth on the Policy Information Page or as endorsed. The complete policy number including prefixes or suffixes, if used, must remain the same throughout the life of the policy and the reporting of experience under that policy, unless a correction report has been submitted to revise the policy number.

7. Policy Effective Date

Report, in the format (YYMMDD), the year, month and day upon which the policy became effective.

Report the effective date that corresponds exactly to the date shown on the Policy Information Page or to endorsements attached. In cases where an interstate policy was endorsed after the policy effective date to provide coverage for an additional state, report the effective date of the policy.

For the second and third annual periods of three-year variable rate policies, report the effective date as one and two years, respectively, subsequent to the policy effective date on the Policy Information Page. For the first period, report the policy effective date as shown on the Policy Information Page, or as endorsed. In the event the policy contains a Policy Period Endorsement (WC 00 04 05), then the effective date must coincide with the dates indicated on the schedule of that endorsement. Refer to Part I, Item 18 for additional information.

For the second annual period of extended-term policies, report the effective date as the date the second period began as shown in the Policy Period Endorsement (WC 00 04 05).

8. Policy Expiration Date

Report, in the format (YYMMDD), the year, month and day on which the policy expired.

If the policy was cancelled, report the cancellation date as the expiration date. For policies that are cancelled flat (e.g. policy effective date = policy expiration date), unit statistical reports are not required.

A policy issued no longer than one year and 16 days is treated as a one-year policy and the expiration date shown on the Policy Information Page is reported.

For the first and second annual periods of three-year variable rate policies, report the expiration date as one and two years, respectively, subsequent to the policy effective date set forth on the Policy Information Page. For the third period, report the policy expiration date as shown on the Policy Information Page, or as endorsed. In the event the policy contains a Policy Period Endorsement (WC 00 04 05), then the expiration date must coincide with the date indicated in the schedule of that endorsement.

For the first and second periods of extended-term policies, report the associated expiration date for each term shown in the Policy Period Endorsement (WC 00 04 05).

9. Exposure State

Report the state in which coverage is provided. The exposure state should always be "31" for New York. If New York is not the exposure state, a USR is not required to be submitted to NYCIRB.

10. State Effective Date

Report, in the format (YYMMDD)), the year, month and day of the endorsement effective date if the New York coverage was endorsed mid-term; otherwise, zero-fill this field.

11. Risk ID Number (Optional)

For interstate rated risks, report the 9-position Risk Identification Number assigned by the NCCI, if available. For intrastate risks, report the 7-position Coverage Identification Number assigned by NYCIRB, if available.

12. Insured Name

Report the primary name of the insured as shown on Item 1. of the Policy Information Page or as endorsed.

13. Insured Address

Report the street address, city, state and zip code of the insured as shown on Item 1. of the Policy Information Page or as endorsed.

14. Federal Employer Identification Number (FEIN)

Report the Federal Employer Identification Number of the insured shown on the Policy Information Page.

15. Policy Conditions

Report the 1-position alphabetical code for each of the policy conditions that apply to the statistical data being reported:

Indicator	Codes
Three-Year Fixed Rate Policy Indicator	Y = Policy is a three-year fixed rate policy. N = Policy is not a three-year fixed rate policy.
Multi-state Policy Indicator	Y = Policy is a multi-state policy. N = Policy is not a multi-state policy.
Interstate Rated Policy Indicator	Y = Policy is interstate rated. N = Policy is not interstate rated.
Estimated Audit Indicator	Y = Exposures on unit report are estimated. N = Exposures on unit report are not estimated. U = Exposures on unit report are estimated-Uncooperative Insured
Retrospective Rated Policy Indicator	Y = Policy is retrospectively rated. N = Policy is not retrospectively rated.
Cancelled Mid-Term Policy Indicator	Y = Policy has been cancelled mid-term. N = Policy has not been cancelled mid-term.
Managed Care Organization Indicator	Y = Policy has provisions for the administration of losses under a managed care organization (approved by the New York State Department of Health) or a Preferred Provider Organization (approved by the New York State Department of Health). N = Policy does not have provisions for the administration of losses under a managed care organization (approved by the New York State Department of Health) or a Preferred Provider Organization (approved by the New York State Department of Health).

16. Policy Type ID

Report the six-digit code that corresponds to the Type of Coverage, Plan Indicator and Non-Standard provisions of the policy.

a. Type of Coverage

Code	Description
01	Standard Workers Compensation Policy—Coverage determined by the manual rate and class code to which exposure has been assigned under the provisions of the standard Workers Compensation and Employers Liability policy.
09	Non-Standard Policy—The standard workers compensation policy has been endorsed to either provide additional coverage or to limit coverage (policies endorsed by WC 31 03 03, excess medical, or WC 31 03 10, excluding medical)

b. Type of Plan

Code	Description
01	Voluntary Policy—The policy was written voluntarily by the carrier.

c. Type of Non-Standard Provisions

Code	Description
01	Non-Standard Does Not Apply—Coverages as described under the standard Workers Compensation and Employers Liability policy without non-standard exclusions, endorsements or exceptions.
02	Excluding Medical—Insured pays all medical costs; applies to all policies endorsed by WC 31 03 10 that are not also endorsed by WC 31 03 03.
06	Excess Medical—Carrier reimburses insured for medical costs that exceed a specified per claim or per accident insured retention; applicable to policies endorsed by WC 31 03 03.

17. Deductible Type

Report the 4-position code that identifies the Type of Deductible and Type of Plan being reported.

a. Type of Deductible (first two positions)

Code	Description
00	No Deductible—No Deductible Applies.
01	Medical Losses Only—The deductible applies only to the medical portion of the loss.
02	Indemnity Losses Only—The deductible applies only to the indemnity portion of the loss.
03	Medical and Indemnity Losses Combined—The deductible applies to the total loss (medical plus indemnity portions).

b. Type of Plan (last two positions)

Code	Description
00	No Deductible—There is no applicable deductible program for this policy/state.
01	Per Claim—The deductible amount applies to each claim arising for the policy.
02	Per Accident—The deductible amount applies to each accident arising for the policy. If multiple claims arise from one accident, apply the deductible amount only once (to one claim). If the use of one claim is less than the deductible reimbursement, use more than one claim and proportionately distribute the deductible amount as a method.
03	Per Policy (Aggregate)—The insured is responsible for losses up to the aggregate limit.
04	Percent of Claim Cost—The insured is responsible for a pre-defined percentage of claim costs arising from the policy.
05	Percent of Premium—The insured is responsible for losses up to a percentage of premium as determined by the carrier.
06	Coinsurance Only—The insured is responsible for a certain percent of the claim and the carrier is responsible for the remaining percent of the claim. (Percentages may vary.)
07	Benefit Coinsurance—The deductible amount applies to each claim. For the remainder of the claim, the insured is responsible for a percentage and the carrier is responsible for the remaining percent. (Percentages may vary.)

08 Per Accident Coinsurance—The deductible amount applies to each accident. For the remainder of the claim, the insured is responsible for a certain percentage and the carrier is responsible for the remaining percent. (Percentages may vary.)

09 Per Policy and Accident (Aggregate)—The deductible amount applies to each accident up to an aggregate limit.

10 Per Claim and Policy (Aggregate)—The deductible amount applies to each claim up to an aggregate limit.

11 Coinsurance Percent With Per Claim and Policy Aggregate Limit—The insured is responsible for a percent of the claim, both a per claim and a policy aggregated deductible amount applicable to each claim and policy.

12 Variable—Carrier Program not described above.

18. Deductible Percent

Report the whole percent of the deductible to be paid by the insured, if applicable, as defined by the deductible program. Applicable only with deductible types 0104, 0105, 0111, 0204, 0205, 0211, 0304, 0305, and 0311. (Example: 15% must be reported as 15)

19. Deductible Amount Per Claim/Accident

Report the loss amount for each claim/accident to be paid by the insured, if applicable, as defined by the deductible program.

20. Deductible Amount Aggregate

Report the maximum loss amount for all claims to be paid by the insured, if applicable, as defined by the deductible program.

PART III

EXPOSURE / PREMIUM INFORMATION

PART III—EXPOSURE / PREMIUM INFORMATION

1. Experience Modification Effective Date

Report the experience modification effective date, YYMMDD, only when different from the policy effective date. If the experience modification changes in accordance with New York Experience Rating Plan Manual rules, report the effective date of the experience modification that applies to the reported class codes, exposures and premiums. If the anniversary rating date is different from the policy effective date, then the experience modification effective date equals the anniversary rating date.

Note: For the first split (split 0), the experience modification effective date must be equal to, or prior to, the policy effective date. For subsequent splits (splits1….), the experience modification effective date must be after the policy effective date, but prior to the policy expiration date.

2. Rate Effective Date

Report the rate effective date, YYMMDD, only when different from the policy effective date. If the rate changes in accordance with manual rules, report the effective date that applies to the reported class codes, exposures and premiums.

Note: The rate effective date must be prior to, or equal to, the effective date of the first split period.

3. Update Type

Report the 1-letter code that identifies the activity of the exposure data.

Code	Description
R	Original first reports and revised data on correction reports
P	Previously reported data (used only on correction reports)

Refer to Part V for further instructions.

4. Exposure Coverage Code

Report the exposure coverage for each class on the policy.

Code	Description
00	For use with Statistical Codes
01	State Act or Federal Act excluding USL&HW and Federal Coal Mine Health and Safety Act
02	USL&HW coverage on “F” and Non-"F" Classes

5. Classification Code

Report the 4-digit code corresponding to the classification assigned to the insured according to the rules of the New York Workers Compensation and Employers Liability Manual or the statistical code defined by the NYCIRB.

Refer to Part I, Item 17 for additional instructions.

6. Exposure Amount

a. Payroll Classification Codes

i. Payroll exposures are required for all classifications except those specifically indicated as exceptions in this section.

Payrolls must be appropriately separated as of the effective date of the change whenever there is a change in experience modification.

The exposure reported on the 1st report must be the audited exposure corresponding to the charged premium amount. When a final audit has not been made at the time of filing a statistical report, submit the estimated exposures and mark the Estimated Audit Indicator box in the Policy Conditions field with the symbol "Y". Without further request, correct the estimated exposure with a revised statistical report as soon as the audited payrolls are available.

ii. For eligible construction classifications subject to the Payroll Limitation Law, report the limited payroll amounts, if any, as determined in accordance with the Law.

Refer to Rule V.G. in the New York Workers Compensation and Employers Liability Manual for detailed information regarding the Payroll Limitation Law.

b. Other Than Payroll Classification Codes

An employee covered under a per capita classification for a period of one year must be reported as an exposure of 10. For coverage less than one year, the exposure reported must be that fraction part of a year, expressed to the nearest tenth (with an implied decimal point), for which the coverage is in effect. Refer to the following table:

Individual Durations of Coverage Between				Fraction of Year	To Be Reported As
	0 days	to	17 days	0 year	00
	18 days	to	1 month 23 days	.1 year	01
1 month	24 days	to	less than 3 months	.2 year	02
3 months		to	4 months 5 days	.3 year	03
4 months	6 days	to	5 months 11 days	.4 year	04
5 months	12 days	to	6 months 17 days	.5 year	05
6 months	18 days	to	7 months 23 days	.6 year	06
7 months	24 days	to	less than 9 months	.7 year	07
9 months		to	10 months 5 days	.8 year	08
10 months	6 days	to	11 months 11 days	.9 year	09
11 months	12 days	to	one year 16 days	1.0 year	10

Example: An employee covered for six months (.5 of a year) shall be reported as an exposure of 05. Exposure shall be governed by the duration of coverage and not by the number of days worked.

c. Aircraft Operation—Passenger Seat Exposure

Report the number of seats under Classification Code 9108. The exposure to be reported must be 10 per seat. This code is not subject to experience rating.

d. Per Location

The exposure under Code 9027 (Building Operation—Dwelling) must be reported in accordance with the rules specified above for Per Capita classifications, treating one location year as an exposure of 10.

e. Volunteer Firefighters

The population of the "home area" must be reported under Code 7711 in the exposure field and the corresponding premium shall be reported in the premium field.

Where there are separate charges for servicing other areas under contract, the statistical report must show as separate items the following:

(1) The number of contracts for servicing other “home areas” must be shown in the exposure field and the total of the charges must be shown in the premium column. It is not necessary to list each such charge separately.

(2) For each "outside area”, report the population in the exposure column and the corresponding premium in the premium field. For these items, report 1.00 in the manual rate field. Where only a proportionate share of the total premium for the "outside area" is paid because the "outside area" is covered by more than one contract, report in the manual rate field the ratio of the contract price for the "home area" to the contract price for all areas servicing such "outside area".

Example: If the contract price for the "home area" is 25% of the total contract price for all areas, show .25 in the manual rate field.

Note: WCSTAT requires the reporting of three positions after the decimal point. Therefore, in the above example, the 25% to be reported in the manual rate field must be reported as 0000250, with an implied decimal point before the “2”.

Note: Do ***not*** include the population reported in the exposure field in the Exposure-Payroll Total.

f. Volunteer Ambulance Workers

The number of ambulances or first response vehicles servicing the ambulance district must be reported under Code 7370 in the exposure field and the corresponding premium shall be reported in the premium field. The exposure must be reported in accordance with the rules specified above for Per Capita classifications, treating one ambulance year as an exposure of 1.0.

g. No Exposure Developed (1st Report)

Report no exposure developed/no payroll by using statistical Code 1111 for the entire policy period and zero-fill the exposure field.

7. Manual Rate

Report the carrier’s authorized rate corresponding to each classification code.

In the case of split rates due to:

a. A Flat Increase or Decrease on an Outstanding Policy

There are two means of reporting a flat increase or decrease on an outstanding policy:

i) Report the additional premium resulting from a flat increase under Code 0998. Report the premium credit resulting from a flat decrease under Code 0994, or

ii) The exposure, authorized rate and corresponding premium may be split. The inception date of each period covered must be shown in the “Rate Effective Date” field.

b. The Anniversary Rating Date Differing from the Policy Effective Date

The exposure, authorized rate and corresponding premium must be split. The effective date of each period must reflect the appropriate “Experience Modification Effective Date” and “Rate Effective Date”.

8. Split Period Code

Report the single digit code when indicating changes in authorized rates or experience modifications during a policy period. Valid values are “0” - “9” where “0” is reported for the first effective period, “1” is reported for the second effective period, and so on up to a ninth effective period (if applicable). This field is zero-filled for policies with no changes in rates or experience modification.

9. Premium Amount

a. **Extension of Exposure**

The premium obtained by extension of payroll or other exposure at the carrier's authorized rate must be reported under the appropriate classification codes.

b. **Flat Charges**

The premium obtained by flat charges does not vary by exposure and must be reported under the appropriate statistical codes.

10. Premium Amount Subject to Experience Modification Factor (Above Line "A")

Report the premium by classification as determined by:

a. **Extension of Exposure**

Report the premium obtained by the extension of payroll or other exposure bases at the applicable manual rate corresponding to the appropriate classification code.

b. **Other Than Extension of Exposure**

Report premium that does not vary by exposure separately under the appropriate statistical code as follows:

(1) **Construction Employment Territory Differential Premium**

Report the premium resulting from the application of territory differentials for construction employers subject to Rule V.G. of the New York Workers Compensation and Employers Liability Manual.

a. Code 9126 - Territory 1 Differential Premium—Counties of The Bronx, Kings, New York, Queens and Richmond

b. Code 9127 - Territory 2 Differential Premium—Counties of Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk and Westchester

c. Code 9128 - Territory 3 Differential Premium—All Other Counties

Note: Exposures are not applicable to these codes.

(2) **Drug-Free Workplace Premium Credits**

Report the premium credit amount under Code 9841 for policies written in conjunction with a carrier filed Drug-Free Workplace Program, when the program has been filed subject to experience rating.

(3) **Employers Liability Increased Limits**

Refer to Part VI for the appropriate statistical codes to report the premium charged for providing increased limits for Coverage B for employees not subject to the New York Workers' Compensation Law. In those cases where the calculated charge is less than any minimum charge for the selected limits, the additional premium required to balance to such minimum charge must be reported under Code 9848.

(4) **Flat Decrease / Increase on Outstanding Policies**

Refer to Item 7a of this Part.

(5) **Deductible Programs**

a. Report the premium credit for the New York small deductible program under Code 9664.

b. Report the premium credit for carrier deductible programs under Code 9664 when filed to be applicable prior to the application of the experience modification.

(6) **No Exposure/Premium Developed**

Zero-fill the premium field under Code 1111, when no exposure develops on the policy.

(7) **Premium for the Extension of Employers Liability Coverage to Additional Interests Under a Volunteer Ambulance Workers' Benefit Law (VAWBL) or Volunteer Firefighters' Benefit Law (VFBL) policy**

Report the premium charged for this additional coverage under Code 9851 for VAWBL policies endorsed by WC 31 06 13, and under Code 9850 for VFBL policies endorsed by WC 31 06 07.

(8) **Rate Deviations**

Not applicable in New York to policies effective October 1, 2008 and subsequent.

(9) **Repatriation Expense Premium**

Report the premium charged for repatriation expense on policies endorsed by WC 31 06 17, Foreign Voluntary Coverage, under Code 9606.

(10) **Uninsured Subcontractors Flat Policy Charge**

Report the premium charged for coverage provided for uninsured subcontractors as determined according to Rule IX.C.3. of the New York Workers Compensation and Employers Liability Manual under Code 0061.

(11) **Waiver of Subrogation Premium**

Report the premium charged for a waiver of subrogation on policies endorsed by WC 00 03 13, Waiver of Our Right to Recover from Others, under Code 0930.

11. Total Subject Premium Amount

Report the total premium amount subject to experience modification. This is the sum of class code and statistical code premium that is subject to experience rating.

12. Experience Modification Factor

Report the experience modification factor used to develop the charged premium.

Example: A .95 experience modification factor must be reported as 0950. There is an implied decimal between the first and second digit in this field.

If a change in experience modification occurs subsequent to the inception date of the policy, the exposures, manual rates and corresponding premiums must be split and reported separately with the corresponding mod factor and mod effective date.

Note: Zero-fill this field for policies not subject to experience modification and for policies subject to Merit Rating. *Refer to Item 13g of this Part for instructions on reporting Merit Rating credit and debit premium.*

13. Premium *Not* Subject To Experience Modification Factor (Lines "D", "E" and "F")

Report the classification codes and corresponding exposures, rates (if applicable) and premium amounts separately for those classifications not subject to experience modification.

a. **Aircraft Operation / Passenger Seat Surcharge**

Report the premium charged for this exposure under Code 9108.

b. **Atomic Energy Radiation Exposure**

Refer to Part I, Items 11 and 12.

c. **Construction Classification Premium Adjustment Program Premium Credit**

Report the premium credit amount as a result of this program under Code 9046.

d. **Drug-Free Workplace Premium Credit**

Report the premium credit amount under Code 9846 for policies written in conjunction with a carrier filed Drug-Free Workplace Program, when filed *not* subject to experience rating.

e. **Deductible Programs**

Report the premium credit amount for carrier filed and approved deductible programs under Code 9663 when filed *not* subject to experience rating.

f. **Managed Care / Preferred Provider Organization Premium Credit**

Report the premium credit amount under Code 9874 for policies written in conjunction with a carrier filed and approved Managed Care or Preferred Provider Organization program.

g. **Merit Rating Premium Amount**

Report the premium amount resulting from the application of New York merit rating factors as follows:

Merit Rating Factor	Code
.92	9885
1.00	9884
1.04	9896
1.08	9886

Note: Zero-fill the premium amount when Code 9884 applies.

h. **Minimum Premium Policies**

i. **Other than Maritime or FELA**

The additional premium necessary to bring the total standard premium up to the minimum premium must be reported separately from the classification code(s)' manual premium and the expense constant. The Balance to Minimum Premium must be reported under Code 0990. The amount reported under this statistical code should ***not*** include the expense constant.

> ***Note:*** If the minimum premium applies to a multi-state policy, the additional premium required to bring the total risk standard premium up to the minimum premium must be reported to the state with the highest minimum premium.

ii. **Maritime or FELA**

Report the additional premium required to equal the separate minimum premiums under Code 9849 when manual premium is developed under Maritime or FELA classifications and where such premium together with any Maritime or FELA increased limits charge is less than any Maritime or FELA minimum premiums.

i. **Non-Ratable Premium Elements**

Report the exposures, manual rates and premium amounts under the associated statistical codes listed in Part VI for classification codes containing non-ratable elements.

Note: Report the same exposure under the non-ratable codes as reported for the companion ratable classification codes.

j. **Rate Deviations**

Not applicable in New York to policies effective October 1, 2008 and subsequent.

k. **Reserved for Future Use**

l. **Short Rate Penalty Premium**

Report the additional premium resulting from the application of the Short Rate Cancellation Rule X.D. in the New York Workers Compensation and Employers Liability Manual under Code 0931.

m. **Workplace Safety and Loss Consultation Premium Surcharge**

Report the premium surcharge amount as a result of the New York Compulsory Workplace Safety and Loss Consultation Program under Code 9747.

n. **Workplace Safety and Loss Prevention Incentive Program (WSLPIP) Premium Credit Amounts**

i. Drug and Alcohol Prevention Program

Report the premium credit amount under Code 9753 for policies written in conjunction with New York's Drug and Alcohol Prevention Program.

ii. Return-To-Work Program

Report the premium credit amount under Code 9743 for policies written in conjunction with New York's Return-To-Work Program.

iii. Safety Incentive Program

Report the premium credit amount under Code 9748 for policies written in conjunction with New York's Safety Incentive Program.

14. Exposure - Payroll Total

Report the sum of all payroll exposures. Do *not* include exposures reported for the non-ratable codes.

Note: Total payroll exposure is only required on first reports and corrections to first reports.

15. Total Standard Premium Amount

Report the total premium amount charged for the policy, excluding any approved expense constants, premium discounts, terrorism and catastrophe charges, New York Security Fund surcharges and any New York assessments.

Note: The total standard premium amount is only required on first reports and corrections to first reports.

16. Premium Discount Amount

Report the premium amount resulting from the application of approved premium discount plans under Code 0063 (stock company or Type A) or Code 0064 (non-stock company or Type B). Do *not* include the premium discount amount in the total standard premium.

17. Expense Constant Amount

The premium amount resulting from the application of an approved expense constant must be reported under Code 0900 and must be reported separately from the classification code(s)' manual premium and any Balance to Minimum premium. Do *not* include the expense constant amount in the total standard premium.

Note: The expense constant on a multi-state policy must be allocated to the state with the highest applicable expense constant. If two or more states included on the policy have the same highest expense constant, the expense constant must be reported for the state developing the largest amount of standard premium.

18. Catastrophe Provision for Terrorism

Report the premium amount charged for terrorism under Code 9740.
Do not include the terrorism amount in the total standard premium.

19. Catastrophe Provision for Natural Disasters and Catastrophic Industrial Accidents

Report the premium amount charged for natural disasters and catastrophic industrial accidents under Code 9741.
Do not include the catastrophe amount in the total standard premium.

20. New York Workers Compensation Security Fund Surcharge

Report the surcharge amount under Code 9749 when the policy is subject to the Security Fund Surcharge.
Do not include the Security Fund surcharge amount in the total standard premium.

PART IV

LOSS INFORMATION

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 NYCIRB 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.*

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.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 of this part for instructions on the use of Catastrophe Number.*

f. Recoveries from subrogation, Special Funds 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 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.

2. Update Type

Report the code that identifies the activity of the loss data on subsequent and correction reports.

Code	Description
R	Original first reports and revised data on correction reports
P	Previously reported data (used only on subsequent and correction reports)

For details regarding correction and subsequent reports, refer to Part V of the Plan.

3. Claim Number

Report the 12 position alphanumeric code that uniquely identifies the specific claim, excluding blanks, punctuation marks and special characters and which will make it possible to locate the claim records in the carrier files. The claim number must be reported consistently throughout the life of the claim.

a. To the extent possible, the claim number reported to NYCIRB on unit statistical reports should be the same claim number provided to the New York State Workers' Compensation Board for the adjudication of the claim.

b. The claim number reported to NYCIRB on unit statistical reports must be the same claim number reported in the NYCIRB annual individual claim data calls (e.g., NY 131-Large Loss and Catastrophe Claim Call; NY 132-Section 32 Claim Call; NY 141-Employers Liability Claim Call).

4. Accident Date

Report, in the format (YYMMDD), the year, month and day on which the injury occurred. The accident date must be within the policy period. For a disease injury where the accident date is not specified, report the claimant's last date of exposure to the conditions causing or aggravating the disease injury.

Note: *The accident date cannot be the same as the expiration date of the policy.*

5. Incurred Losses

Report all loss amounts on **a gross basis** prior to any reimbursement of indemnity and/or medical payments by the insured if a deductible applies.

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. 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.

(1) 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 Workers' Compensation Law, must be determined by use of the appropriate tables published by the New York State Workers' Compensation Board.

(2) Reporting Special Payments

Where the 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.

(3) Reporting of 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 9 in this part for instructions regarding Recoveries.*

(4) Final Awards

Where a final award has been made by the 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 non-compensable, 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.

Note: The term "declared non-compensable", as used in this rule, refers to an official ruling by the Workers' Compensation Board, specifically holding that a claimant is not entitled to benefits under the provisions of the New York Workers' Compensation Law. If 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**, if 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 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.

Where the carrier has appealed an award, it must report the full amount of such award.

(d) If a final award has not been made, but compensation for the injury is subject to a definite schedule of benefits, the provisions of the Law must be reflected in the amount of compensation reported. In all other cases, the amount reported must reflect the carrier's estimate of incurred cost in the light of all information available on the date of valuation.

(5) Other Amounts

Expenses, any general allowances for contingencies and any supplemental non-statutory benefits not otherwise provided for in this Plan must be excluded from the amount of losses. Reserves in excess of the amount shown on the final settlement receipt must not be included in the loss amounts reported under this Plan. At the completion of all payments, losses must only include settlement amounts filed with the Workers' Compensation Board or other body having jurisdiction over workers compensation claims.

b. Incurred Medical Amount

Report the total incurred medical loss amount associated with each claim as of the valuation date. Incurred medical loss amounts consist of all paid and outstanding benefits.

Incurred medical amounts must include all payments to doctors and hospitals, as well as physical rehabilitation costs and prescription drug costs, and reserves for future payments, but must **not** include any claim expense.

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

Incurred medical amounts from claims not required to be reported to the Workers' Compensation Board, as defined in Section 110 of the New York Workers' Compensation Law, provided that the employer pays the claim in the first instance or reimburses the carrier for the treatment rendered to the employee, must **not** be reported to the Rating Board.

Note: An employer is not required to file a claim notice with the Workers' Compensation Board if the accident or illness requires ordinary first aid, or causes loss of time from work of only one day beyond the working day or shift on which the accident or illness occurred.

6. Expenses Excluded From Losses

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

Employers liability losses must include allocated loss adjustment expenses, as defined in Item 12 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 Workers' Compensation Board

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

d. Awards

When an award to a claimant includes the cost of witness fees, attorney fees and other court costs or expert medical witness fees, the amount so awarded must be considered as part of the cost of benefits and must be included with the incurred indemnity amount reported. With respect to claims brought by persons against whom an employee has brought a third party common law action, such costs must be reported as an incurred indemnity loss whether or not a recovery is made against the third party by the employee.

e. Penalties For Delays In Making Compensation Payments

If the carrier is liable for penalties for reasons beyond its control that accrue as benefits to the injured worker or his or her dependents, the penalties must be reported as indemnity losses; e.g., interest on awards or for penalties imposed upon the employer for improper controversion of awards. If the carrier is liable for penalties for any reason within the carrier's control, the penalties must be considered as unallocated loss adjustment expense and not reported as loss.

f. Physical Rehabilitation Expenses

Physical rehabilitation costs incurred due to the purchase of physical rehabilitation services from outside vendors must 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 must 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.

In addition, 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) must 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

8. Fraudulent Claims

A fraudulent claim is a claim that meets either of the following conditions:

- The claim has been ruled (or officially declared) fully fraudulent by a court decision or a ruling of the Workers' Compensation Board.

- The claim, or a portion of the claim, has been deemed to be partially fraudulent by a court decision or a ruling of the Workers' Compensation Board.

a. Reporting Fully Fraudulent Claims

When a claim has been ruled or declared to be fully fraudulent, the entire cost of the claim must be netted down to zero for unit statistical reporting.

- **Ruling or declaration of fraud prior to 1st Report:** The claim is considered non-compensable and is not to be reported.

- **Ruling or declaration of fraud subsequent to 1st Report:** A correction report(s) must be filed, reducing the incurred cost of the claim to zero. This must be done for reports impacting the current and up to six prior experience modifications.

b. Reporting Partially Fraudulent Claims

When a claim, in which a portion of the claim has been ruled or declared to be partially fraudulent, the cost of the claim must be netted down to reduce the net incurred loss by the declared fraudulent amount.

- **Ruling or declaration of fraud prior to 1st Report:** The net incurred cost of the claim on the 1st report must reflect the reduction of the claim by the partially fraudulent amount.
- **Ruling or declaration of fraud subsequent to 1st Report:** A correction report(s) must be filed and the cost of the claim must be netted down to reduce the net incurred loss by the declared fraudulent amount. This must be done for reports impacting the current and up to six prior experience modifications.

The "net incurred cost" is defined as the gross incurred loss (i.e., the gross evaluation of the claim whether the claim is still open or not) minus the amount declared to be partially fraudulent.

For example, consider a claim that has been reported as $10,000 (1st report), $40,000 (2nd report), and $60,000 (3rd report). Subsequent to the 3rd report, the claim was ruled partially fraudulent with the partially fraudulent amount set at $25,000. The net incurred cost of the claim is the latest value minus the partially fraudulent amount: $60,000 - $25,000 = $35,000. The net incurred cost ($35,000) is less than the claim value reported at the 2nd and 3rd reports. Correction reports must be submitted for the 2nd and 3rd reports. As the net incurred cost is higher than the $10,000 reported in the 1st report, no correction report is needed for the 1st report.

When the partially fraudulent amount has not been allocated into indemnity and medical components by the adjudicator, the net incurred loss must be divided between indemnity and medical losses in the same proportion as the original gross incurred indemnity and medical amount.

Report the code that identifies the involvement of fraud in the claim.

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

9. Recoveries – Subrogation, Third-Party Cases, Special Funds

(1) In all cases where there has been recovery of loss due to subrogation, or where the injured worker or his dependents have recovered from a third party, the loss amount reported must be the net incurred loss.

(2) For subrogation cases, the net incurred loss is defined as 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. When the recovery expenses exceed the amount recovered, report the gross incurred loss instead of the net incurred loss. When the allocation of the recovery to indemnity and medical is not known, the net incurred loss must be divided between indemnity and medical loss in the same proportion as the original gross incurred indemnity and medical amounts.

(3) For cases involving recovery by the injured employee or his dependents, the net incurred loss must be:

(a) the deficiency, if any, between the outstanding compensation provided by the Workers' Compensation Law and the net amount of recovery actually collected by the claimant, and

(b) any other incurred indemnity and medical losses not recovered by the carrier's lien on the proceeds of the claimant's third party recovery or by a third party action pursued by the insurance carrier.

(4) When recovery by the injured worker or his dependents relieves the carrier of the liability for further compensation benefits as, for example, in the case involving recovery without the consent of the carrier, or where the recovery exceeds all future compensation benefits due, the net incurred loss must be the sum of all amounts paid and any amounts payable into Special Funds (Special Disability Fund and Reopened Case Fund), less the net reimbursements, if any, received from the claimant or third party. Where reimbursement is received by the carrier, and the allocation of the reimbursement to indemnity and medical is not known, the net liability incurred must be apportioned to indemnity and medical in the same proportion as existed in the amounts paid and/or payable by the carrier prior to the recovery.

When the carrier is (1) relieved of liability for death benefits to dependents who have made a compromise settlement with a third party without the consent of the carrier, but (2) is liable for payments to the dependents not involved in such settlement, the sum of the net liabilities for dependency groups (1) and (2), each calculated separately in accordance with the forgoing rules, must be added to any other indemnity and medical incurred loss amounts to determine the total net liability for the case.

(5) When reimbursement by a third party or a subrogation recovery is received by the carrier subsequent to the first reporting of the claim, but within one year after the 5th report due date, a correction report(s) must be filed with the NYCIRB reducing the incurred cost on the claim to the net incurred loss as defined above. This must be done for reports which would impact the current and up to six prior experience modifications. If an anticipated recovery becomes known by the carrier, or a recovery is paid to the carrier as of the 6th report valuation date or subsequent, all adjustments are reported at the next valuation date. *Refer to Rule 4.B.2.c. of the New York Experience Rating Plan Manual.*

Correction reports are required only for prior reports that reflected an amount higher than the net incurred cost.

Example: Consider a claim that has been reported as $10,000 (1st report); $40,000 (2nd report); $60,000 (3rd report). A subrogation recovery is in the amount of $25,000 and recovery expense is $3,000. The net incurred cost of the claim is the latest value minus the recovery, plus recovery expenses ($60,000 - $25,000 + $3,000 = $38,000). The net incurred cost ($38,000) is less than the claim value reported at the 2nd and 3rd reports. A corrected 2nd and 3rd report must be submitted. As the net incurred cost is higher than the $10,000 reported in the 1st report, no correction report is needed for the 1st report. *Refer to Part V for further instructions regarding correction reports.*

(6) In all cases where a claim has been determined to be eligible for reimbursement to the carrier from a Special Fund (such as Special Disability Fund, Reopened Case Fund, etc.), the gross incurred costs of the claim (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) must be reduced by the amount of any payment or anticipated recovery from such fund. The net incurred cost of the claim must be reported on statistical reports that would impact the current and up to six prior experience modifications. *Refer to Rule 4.B.2.b. of the New York Experience Rating Plan Manual.*

Correction reports are required only for prior reports which reflected an amount higher than the net incurred cost.

Example: Consider a claim that has been reported as $10,000 (1st report); $40,000 (2nd report); $60,000 (3rd report). A recovery from the Special Disability Fund is in the amount of $25,000. The net incurred cost of the claim is the latest value, minus the recovery ($60,000 - $25,000 = $35,000). The net incurred cost ($35,000) is less than the claim value reported at the 2nd and 3rd reports. Corrected 2nd and 3rd reports must be submitted. As the net incurred cost is higher than the $10,000 reported in the 1st report, no correction report is needed for the 1st report.

10. 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 as follows:

Code	Description
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 has not been settled with a lump-sum agreement.

11. 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 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 dollar amount of medical losses paid for the claim as of the valuation date. Paid medical must not include any claim expense. Subrogation or Special Funds recoveries must be subtracted from paid medical if the recovery applies to the medical loss. *Refer to Item 9 of this part for instructions regarding recoveries.*

Paid medical amounts must 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, should **not** be reported to the Rating Board.

12 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 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 or 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

13. 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 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 and subject to a passenger seat surcharge, must be reported under Code 9108. Losses related to employees, other than members of the flying crew, arising out of the operation of an aircraft and not subject to a passenger seat surcharge must be reported under the designated aircraft operation code.

14. Injury Type

Report the type of injury code as defined under provisions of the New York 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.

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 must 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.

Refer to Section g. below for rules concerning the computation of death claim loss amounts that are payable to the Aggregate Trust Fund.

b. **Permanent Total Disability—Code 02**

Report as permanent total disability, each claim that constitutes permanent total disability under the New York Workers' Compensation Law, or that, in the judgment of the carrier, will result in permanent total disability.

Refer to Section g. below for rules concerning the computation of permanent total claim loss amounts that are payable to the Aggregate Trust Fund.

c. **Permanent Partial Disability—Code 09**

A permanent partial loss is defined as any permanent injury that does not involve permanent total disability.

The amount entered as incurred indemnity must include specific benefits and compensation for temporary disability, as well as loss of earning capacity.

Refer to Section g. below for rules concerning the computation of permanent partial claim loss amounts that are payable to the Aggregate Trust Fund.

d. **Temporary Injury—Code 05**

Report as temporary every case that involves, or is expected to involve, indemnity benefits, but does not constitute a death case, permanent total disability or permanent partial disability as defined above.

e. **Medical Only—Code 06**

Report as medical-only, claims that involve medical costs only and for which no indemnity costs have been incurred or are expected to be incurred as of the valuation date.

Medical losses must include surcharges on hospital and related medical services imposed pursuant to the New York Health Care Reform Act.

When reporting claims involving medical-only losses, incurred and paid indemnity loss amounts must be $0.

Incurred medical losses from claims not required to be reported to the Workers' Compensation Board, as defined in Section 110 of the New York Workers' Compensation Law, provided that the employer pays the claim in the first instance or immediately reimburses the carrier for the treatment rendered to the employee, should **not** be reported to the Rating Board.

> ***Note:*** An employer is not required to file a claim notice with the Workers' Compensation Board if the accident or illness requires ordinary first aid or causes loss of time from work of only one day beyond the working day or shift on which the accident or illness occurred.

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 must be reported in the aggregate as incurred medical, and must be assigned to the governing classification. Contract medical costs, or medical costs incurred outside of the contractual arrangement, that are allocated to individual claims must be reported in connection with these claims and must not be included in the amount otherwise reported as contract medical.

g. **Aggregate Trust Fund**

All death cases and designated permanent total and permanent partial disability cases are payable to the Aggregate Trust Fund as set forth in the Workers' Compensation Law. In determining the present value of the incurred loss amounts on these claims, the tables published by the Workers' Compensation Board must be used. Bulletin 222B must be used for cases with accident dates on and after September 1, 1983 and before January 1, 2001, and Bulletin 222C must be used for cases with accident dates on and after January 1, 2001. *Refer to the New York State Workers' Compensation Board for these bulletins.*

When an award directing such payment has been made, include in the indemnity loss amount the fee charged by the Aggregate Trust Fund for the handling of such cases. This fee must not be included in the calculation of the present value of any case in which the final 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 must be used in determining the present value for reporting under this Plan.

TABLE I
Life Awards—Permanent Total and Permanent Partial Disabilities

Age	Present Value	Age	Present Value	Age	Present Value	Age	Present Value	Age	Present Value	Age	Present Value
11	25.580	26	23.524	41	20.330	56	15.767	71	10.291	86	5.088
12	25.461	27	23.352	42	20.068	57	15.419	72	9.919	87	4.818
13	25.339	28	23.175	43	19.801	58	15.069	73	9.547	88	4.560
14	25.215	29	22.991	44	19.527	59	14.714	74	9.176	89	4.315
15	25.090	30	22.802	45	19.247	60	14.356	75	8.807	90	4.082
16	24.963	31	22.607	46	18.961	61	13.994	76	8.439	91	3.861
17	24.835	32	22.406	47	18.670	62	13.630	77	8.073	92	3.651
18	24.706	33	22.199	48	18.372	63	13.264	78	7.707	93	3.453
19	24.573	34	21.987	49	18.069	64	12.896	79	7.345	94	3.265
20	24.436	35	21.768	50	17.758	65	12.526	80	6.988	95	3.087
21	24.296	36	21.544	51	17.441	66	12.155	81	6.640	96	2.917
22	24.151	37	21.313	52	17.117	67	11.782	82	6.303	97	2.755
23	24.002	38	21.077	53	16.787	68	11.408	83	5.978	98	2.598
24	23.849	39	20.834	54	16.452	69	11.034	84	5.667	99	2.444
25	23.689	40	20.585	55	16.111	70	10.662	85	5.371	100	2.289

1999 United States Life Tables (U.S. Department of HHS)
3.5% Annual Rate of Interest

15. 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. 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 paragraph d., Type of Claim, within this section.*

General definitions of the loss conditions follow:

a. Act

- **State Act or Federal Act Excluding USL&HW—Code 01**
  A claim with benefits determined according to the state workers compensation law or federal compensation laws, excluding United States Longshore and Harbor Workers' Compensation Act.

- **USL&HW F-Classes and USL&HW Coverage on Non-F-Classes—Code 02**
  A claim with benefits determined according to the United States Longshore and Harbor Workers' Compensation Act.

b. Type of Loss

- **Trauma—Code 01**
  An injury resulting in disability or death that is traceable to a definite compensable accident occurring during the employee's present or past employment. A traumatic injury cannot be classified as either a Cumulative Injury or an Occupational Disease Loss as defined below.

- **Occupational Disease—Code 02**
  Any abnormal condition or disorder other than a workplace injury resulting in a disability or death that is not traceable to a definite compensable accident occurring during the employee's present or past employment. Any injury caused by repetitive exposure extending over time 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.

  In order for a claim to be coded as an occupational disease case, it must have resulted from repetitive exposure extending over time. Claims that arise from single identifiable incidents should be coded as Trauma even though they may have been caused by inhalation, absorption, ingestion or other environmental factors.

- **Cumulative Injury Other Than Disease—Code 03**
  An injury that results in a disability or death and is not traceable to a definite compensable accident occurring during the employee's present or past employment. The injury is understood to have occurred from, and has been aggravated by, a repetitive employment-related activity.

  Example: A cement mason or carpet installer presents a claim for injury to the knee caused by repetitive bending and kneeling on the job.

c. Type of Recovery

- **No Recovery—Code 01**

- **Special Disability Fund (Second Injury Fund) Only—Code 02**
  The Special Disability Fund provides for reimbursement to employers or carriers when a subsequent injury is caused by, or made substantially greater due to, the combined effects of physical impairment, previous accident, disease or congenital condition after a specified number of weeks are paid by the employer or carrier.

- **Subrogation Only (Third Party)—Code 03**
  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.

- **Subrogation With Special Disability Fund (Third Party)—Code 04**

  A recovery that occurs when the carrier receives reimbursement from both the Special Disability Fund and a third party.

  Refer to Item 9 in this Part regarding recoveries from subrogation, the Special Disability Fund and other third parties.

  Note: In any case for which the Special Disability Fund has been held legally liable for reimbursement of payments beyond the first 260 weeks, only the indemnity and medical corresponding to the first 260 weeks must be reported on the unit statistical report. If the Special Disability Fund has not been held legally liable for reimbursement of payments beyond the first 260 weeks, the full indemnity and medical losses incurred must be reported.

  Recovery from the Special Disability Fund only applies to an injury or illness with a date of accident or date of disablement prior to July 1, 2007.

d. Type of Claim

- **Workers Compensation Only—Code 01**
  The entire loss is incurred under the provisions of Part One of the Workers Compensation and Employers Liability Insurance policy.

- **Employers Liability Only—Code 02**
  The entire loss is incurred under the provisions of Part Two of the Workers Compensation and Employers Liability Insurance policy.

- **Workers Compensation Including Employers Liability or Liability-Over—Code 03**
  The loss is incurred under the provisions of Parts One and Two of the Workers Compensation and Employers Liability Insurance policy.

- **Liability Over—Code 04**
  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.

  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 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 one or more of the following:
  - Official ruling denying benefits
  - Claimant's failure to file for benefits
  - Claimant's failure to prosecute claim following carrier's denial of the claim
- **All Other Settlements—Code 09**

17. Jurisdiction State

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.

18. 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 2 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. When an occurrence results in only one claim being reported, zero-fill this field.

EXCEPTIONS: a. 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.

b. 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 Numbers 48 and 87 will apply to both single and multiple claims.

19. 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. 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. *Refer to Part VI for the applicable codes.*

21. 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 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

22. 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.

23. 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.

24. 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.

25. 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.

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

PART V

SUBSEQUENT REPORTS AND CORRECTIONS

PART V—SUBSEQUENT REPORTS AND CORRECTIONS

1. Subsequent Reports

a. Reporting Conditions

Subsequent reports (2nd - 10th reports) must be filed with the NYCIRB when:

- There are open or reopened claims as of the last report submitted, regardless of whether or not there are changes to the loss data.
- There are claims indicated as closed on a previous report that are reopened.
- There are claims that were previously not reported, or the claim did not exist at the time of the previous reporting.
- There are changes in loss values in the period between the prior and the current valuation, yet these claims were closed in both valuation periods.

Note: Losses are valued 12 months after the valuation date of the preceding report. *Refer to Part I for additional instructions on valuation and filing requirements.*

b. Revaluation of Losses

If a claim is closed and there is no change in the loss amount in that valuation period, it should not be reported at the next valuation. If a change in the loss value does occur, report the revised loss amounts for each open, reopened or closed claim on the 2nd – 10th reports.

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 class codes, exposure or premiums.
- If the carrier performs a final audit on an insured subsequent to performing an estimated audit.
- If the carrier performs a revised final audit on an insured subsequent to performing a final audit.
- If the header/policy information was reported incorrectly.
- The experience modification has been revised for either an intra or interstate rating.
- 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.
- A claim, or any part thereof, is declared non-compensable as defined in Part IV, Item 16.e.
- If the claim number changes during the life of the claim as defined in Part IV, Item 3.
- 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.*
- The carrier or the claimant has obtained a subrogation recovery in an action against a third party, or has received, or anticipates receiving, reimbursement from the Special Disability Fund or Reopened Case Fund. *Refer to Part IV, Item 9—Recoveries.*
- 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 Properly 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 for specific codes and instructions.*

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

3. Method of Reporting

a. Header Information

When correcting a policy information data element, all required policy information data elements, including those data not changing, must be reported. When correcting the report number, correction number, carrier code, policy number, or policy effective date, the original header information (previously reported) must be reported in the respective fields. When correcting any other policy information data elements, report the revised value for the field.

b. Exposure Information

(1) Exposures

Where there is a change in any of the data previously reported for a particular classification code, the corrected report must include all of the data previously reported for the class code (indicated by the Update Type "P"), as well as all of the data, including those data which do not change, on a corrected basis (indicated by the Update Type "R").

Where split policy periods are involved and data for a class code in one of the split periods are changing, the unchanged data in the other period(s) for that class code must also be reported.

(2) Experience Modification

If the revision involves a change in the experience modification, previously reported as well as revised data for each class code affected by the modification change *must* be reported as described in (1) above, *even if the exposures and premium amounts of all reported class codes are unchanged.* The previously reported and revised experience modifications, as well as the revised Total Subject Premium amount, must also be reported.

(3) Statistical Codes

Revised values for applicable statistical codes (e.g., premium discount, flat increase on outstanding policies, etc.) as a result of changes in exposure information must also be reported. The corrected report must include all of the data previously reported for the code (indicated by the Update Type "P"), as well as all of the data, including those data which do not change, on a corrected basis (indicated by the Update Type "R").

c. Loss Information

When there is a change in any of the data previously reported for a particular claim number, the correction report must include all of the data previously reported for the claim record (indicated by the Update Type "P"), as well as all of the data, including those data which do not change, on a corrected basis (indicated by the Update Type "R").

d. Totals

Report the revised report totals resulting from any changes to the exposure and/or loss information.

4. Link Data

Key fields must be the same across all report levels, including corresponding corrections. Key fields are Carrier Code, Policy Number, Policy Effective Date and Exposure State Code.

For changes to the carrier code, policy number and / or policy effective date, report a correction to the 1st report only. Report both the revised key field(s) and the previously reported value(s).

5. Replacement Reports

Replacement reports may be used in lieu of correction reports to replace original 1st reports that have already been submitted to NYCIRB but have a status of "failed". Replacement reports **cannot** be used to replace subsequent (2nd through 10th) or correction reports.

Instructions:

- Report the Replacement Report Code on the Header as "R" to indicate that this is a replacement report.
- Report the Header Record matching fields for the replacement report consistently with the original 1st report that you are replacing. A replacement report that does **not** match a unit report in NYCIRB's database will be rejected and will **not** be processed.
- Report all other exposure, premium, and/or loss data that are on the original 1st report, in addition to the corrected data.

For additional information on the rules and requirements, refer to Part II—Header/Policy Information.

6. Procedure For Correction Of Claims After Subsequent Reports Have Been Filed

In order to correct a unit statistical report for which a subsequent report has already been filed, it is also necessary to submit a correction report for each associated unit statistical report with a higher report level.

7. Manage USR (MUSR)

Manage USR (MUSR) is an online NYCIRB product that allows member carriers to:

- Create, view and correct unit statistical reports
- Prepare WCSTAT files for submission directly to NYCIRB or via Compensation Data Exchange (CDX)
- View Error Reports
- Manage the timely submission of data through the Unit Statistical Tracking System (USTS) feature

MUSR is updated each evening to include each day's WCSTAT submissions, thereby creating a complete and current database.

For more information on MUSR and registering for access to this application, use the following link to the Manage USR User Guide on the NYCIRB website:

http://musr.nycirb.org/ManageUSR/ManageUSR_UserGuide.pdf

PART VI

NEW YORK

UNIT STATISTICAL REPORT CODES

PART VI—CODES

A. Codes Common to Premium and Losses

1. Report Number and Valuation Date

Code	Description
1	Valued as of the 18th month after the month in which the policy became effective
2	Valued 30 months after the policy effective date
3	Valued 42 months after the policy effective date
4	Valued 54 months after the policy effective date
5	Valued 66 months after the policy effective date
6	Valued 78 months after the policy effective date
7	Valued 90 months after the policy effective date
8	Valued 102 months after the policy effective date
9	Valued 114 months after the policy effective date
A	Valued 126 months after the policy effective date

2. Correction Type

Indicates the type of correction report being submitted. Applicable only to correction reports.

Code	Description
H	Header Record Correction
E	Exposure Record Correction (First Reports Only)
L	Loss Record Correction
T	Total Record Correction Only
M	Multiple Record Corrections

3. Exposure State

The following state code number **must** be used: New York-31

4. Policy Conditions

Report the 1-position code for each policy condition.

a. Three Year Fixed Rate Indicator
“Y” = Policy is a three-year fixed rate policy
“N” = Policy is not a three-year fixed rate policy

b. Multi-state Policy Indicator
“Y” = Policy is a multi-state policy
“N” = Policy is not a multi-state policy

c. Interstate Policy Indicator
“Y” = Policy is interstate rated
“N” = Policy is not interstate rated

d. Estimated Audit Code
“Y” = Exposures expressed on unit report are estimated
“N” = Exposures expressed on unit report are not estimated
“U” = Exposures expressed on unit report are estimated – uncooperative insured

e. Retrospective Rated Policy Indicator
“Y” = Policy is retrospectively rated
“N” = Policy is not retrospectively rated

f. Cancelled Mid-Term Indicator
"Y" = Policy has been cancelled mid-term
"N" = Policy has not been cancelled mid-term

g. Managed Care Organization Indicator
"Y" = Policy has provisions for the administration of losses under an approved managed care organization or preferred provider organization
"N" = Policy does not have provisions for the administration of losses by an approved managed care organization or preferred provider organization

5. Policy Type ID

Identifies the type of coverage, plan indicator and non-standard provisions of the policy.

a. Type of Coverage

Code	Description
01	Standard Workers Compensation Policy
09	Non-Standard Policy

b. Plan Type

Code	Description
01	Voluntary Policy

c. Non-Standard Type

Code	Description
01	Non-Standard Code Does Not Apply
02	Excluding Medical
06	Excess Medical

6. Deductible Type

Identifies the type of deductible being reported.

a. Type of Deductible - First Two Positions

Code	Description
00	No Deductible
01	Medical Losses Only
02	Indemnity Losses Only
03	Medical & Indemnity Losses

b. Type of Plan - Second Two Positions

Code	Description
00	No Deductible
01	Per Claim
02	Per Accident
03	Per Policy (Aggregate)
04	Percent of Claim Cost
05	Percent of Premium
06	Coinsurance Only
07	Benefit Coinsurance
08	Per Accident Coinsurance
09	Per Policy & Accident (Aggregate)
10	Per Claim and Policy Aggregate
11	Coinsurance Percent With Claim and Policy Aggregate Limits
12	Variable

B. Exposure Codes

1. Update Type

Identifies the activity of an exposure record.

Code	Description
P	Previously Reported
R	Revised

2. Exposure Coverage

Indicates the Act (Law) under which the exposure for the record's class code is associated.

Code	Description
00	For use with Statistical Codes
01	State or Federal Act, Excluding USL&HW
02	USL&HW Coverage on "F" or non "F" Classes

3. Premium Codes

a. Premium Subject to Experience Modification (Reported Above Line "A")

(1) Premium for Increased Limits

Description	Code
Employers Liability Increased Limits (in 000's)	
With Workers Compensation	
$100/100/1,000	9803
$100/100/2,500	9804
$100/100/5,000	9805
$100/100/10,000	9806
$500/500/500	9807
$500/500/1,000	9808
$500/500/2,500	9809
$500/500/5,000	9810
$500/500/10,000	9811
$1,000/1,000/1,000	9812
$1,000/1,000/2,500	9813
$1,000/1,000/5,000	9814
$1,000/1,000/10,000	9815
Over $1,000/1,000/10,000	9816
Without Workers Compensation	
$100/100/1,000	9823
$100/100/2,500	9824
$100/100/5,000	9825
$100/100/10,000	9826
$500/500/500	9827
$500/500/1,000	9828
$500/500/2,500	9829
$500/500/5,000	9830
$500/500/10,000	9831
$1,000/1,000/1,000	9832
$1,000/1,000/2,500	9833
$1,000/1,000/5,000	9834
$1,000/1,000/10,000	9835
Over $1,000/1,000/10,000	9836
All Other Increased Limits	9837

For unpublished limits within the table, use the next highest limit code.

Employers Liability Increased Limits—Admiralty or FELA

	Code
$ 50,000	9817
$100,000	9818
$200,000	9819
$300,000	9820
$400,000	9821
$500,000	9822
Over $500,000	9840

Employers Liability Increased Limits—Additional Premium to Balance to Minimum 9848

Note: The increased limits premium applicable to non-ratable classification exposures should be reported as not subject to the experience modification.

(2) Construction Employment Territory Differential Premium

Description	Code
Territory 1	9126
Territory 2	9127
Territory 3	9128

	Code
(3) Premium Credit From Carrier Filed Drug-Free Workplace Program Before Experience Modification	9841
(4) Additional Premium From Flat Increase on Outstanding Policies	0998
(5) Premium Credit Resulting From Flat Decrease on Outstanding Policies	0994
(6) Deductible Applied to Manual Premium Before Experience Modification	9664
(7) No Exposure (“If Any”)	1111
(8) EL extension Under VFBL	9850
(9) EL extension under VAWBL	9851
(10) Repatriation Expense	9606
(11) Uninsured Subcontractor Charge	0061
(12) Waiver of Subrogation Premium	0930

b. Premium Not Subject to Experience Modification Lines “D”, “E” or “F”)

Description	Code
(1) Aircraft Seat Surcharge	9108
(2) Radiation Exposure	9985
(3) CPAP Premium Credit	9046
(4) Premium Credit From Carrier Filed Drug-Free Workplace Program After Experience Rating	9846
(5) Deductible Applied to Manual Premium From Carrier Filed Deductible Programs After Experience Modification	9663

(6) Premium Credit From Managed Care or Preferred Provider Organization Programs 9874

(7) New York Merit Rating Program

Factor = .92	9885
Factor = 1.00	9884
Factor = 1.04	9896
Factor = 1.08	9886

(8) Premium To Balance To Minimum Premium

Other Than Maritime or FELA	0990
Maritime or FELA	9849

(9) Non-Ratable Elements

For Class 4767	0767
For Class 4771	0771
For Class 7405	7445
For Class 7431	7453

(10) Compulsory Workplace Safety Program Surcharge 9747

(11) Workplace Safety & Loss Prevention Program (WSLPIP) Credits

Drug & Alcohol Prevention	9753
Return-To-Work	9743
Safety Incentive	9748

(12) Short Rate Penalty Premium 0931

c. Premium Not Subject to Experience Modification and Not to be Included in Standard Premium (Lines "H", "I" or "J").

(1)	Premium Discount Amount-Stock Company or Type A	0063
(2)	Premium Discount Amount-Non-Stock Company or Type B	0064
(3)	Expense Constant Amount	0900
(4)	Terrorism Premium Amount	9740
(5)	Natural Disaster & Catastrophic Industrial Accidents Premium	9741
(6)	New York WC Security Fund Surcharge	9749

C. Loss Information Codes

1. Injury Type

Code	Description
01	Death
02	Permanent Total Disability
05	Temporary Total Disability
06	Medical Only Claims
07	Contract Medical
09	Permanent Partial Disability

2. Claim Status

Code	Description
0	Open
1	Closed
2	Reopened

3. Loss Conditions

a. Act

Code	Description
01	State or Federal Act, excluding USL&HW
02	USL&HW “F” Classes or USL&HW Coverage on Non-“F” Classes

b. Type of Loss

Code	Description
01	Trauma
02	Occupational Disease (OD)
03	Cumulative Injury Other Than Disease

c. Type of Recovery

Code	Description
01	No Recovery
02	Special Disability Fund (Second Injury) Only
03	Subrogation Only (Third Party)
04	Subrogation with Special Disability Fund (Second Injury)

d. Type of Claim

Code	Description
01	Workers Compensation Only
02	Employers Liability Only
03	Workers Compensation & Employers Liability
04	Liability-Over

e. Type of Settlement

Code	Description
00	Claim Not Subject to Settlement
03	Section 32 Settlement
05	Dismissal (Non-Compensable)
09	All Other Settlements

4. Managed Care Organization Type

Code	Description
00	The claim is not administrated by an approved managed care or preferred provider organization
01	The claim’s medical losses are administrated by an approved managed care organization
03	The claim’s medical losses are administrated by a licensed preferred provider organization

5. Fraudulent Claim Codes

Code	Description
00	Not Fraudulent
01	Partially Fraudulent
02	Fully Fraudulent

6. Injury Description Codes

a. Part - identify the part of body injured
b. Nature - identify the nature of the injury
c. Cause - identify the specific cause of injury

Refer to the following Injury Description Codes:

Injury Description Codes – Part of Body

	Code	Part of Body	Narrative Description
I.	**Head**		
	10	Multiple Head Injury	Any combination of parts below.
	11	Skull	
	12	Brain	
	13	Ear(s)	Includes: hearing, inside eardrum
	14	Eye(s)	Includes: optic nerves, vision, eye lids
	15	Nose	Includes: nasal passage, sinus, sense of smell
	16	Teeth	
	17	Mouth	Includes: lips, tongue, throat, taste
	18	Soft Tissue	
	19	Facial Bones	Includes: jaw
II.	**Neck**		
	20	Multiple Neck Injury	Any combination of parts below.
	21	Vertebrae	Includes: spinal column bone, "cervical segment"
	22	Disc	Includes: spinal column cartilage, "cervical segment"
	23	Spinal Cord	Includes: nerve tissue, "cervical segment"
	24	Larynx	Includes: cartilage and vocal cords
	25	Soft Tissue	Other than larynx or trachea.
	26	Trachea	

Injury Description Codes – Part of Body (Cont'd)

Code	Part of Body	Narrative Description
III. Upper Extremities		
30	Multiple Upper Extremities	Any combination of parts below, excluding hands and wrists combined.
31	Upper Arm	Humerus and corresponding muscles, excluding clavicle and scapula.
32	Elbow	Radial head
33	Lower Arm	Forearm - radius, ulna and corresponding muscles.
34	Wrist	Carpals and corresponding muscles.
35	Hand	Metacarpals and corresponding muscles excluding wrist or fingers.
36	Finger(s)	Other than thumb and corresponding muscles.
37	Thumb	
38	Shoulder(s)	Armpit, rotator cuff, trapezius, clavicle, scapula.
39	Wrist(s) and Hand(s)	
IV. Trunk		
40	Multiple Trunk	Any combination of parts below.
41	Upper Back Area	(Thoracic area) upper back muscles, excluding vertebrae, disc, spinal cord.
42	Lower Back Area	(Lumbar area and lumbo sacral) lower back muscles, excluding sacrum, coccyx, pelvis, vertebrae, disc, spinal cord.
43	Disc	Spinal column cartilage other than cervical segment.
44	Chest	Including ribs, sternum, soft tissue.
45	Sacrum and Coccyx	Final nine vertebrae - fused.
46	Pelvis	

Injury Description Codes – Part of Body (Cont'd)

	Code	Part of Body	Narrative Description
	47	Spinal Cord	Nerve tissue other than cervical segment.
	48	Internal Organs	Other than heart and lungs.
	49	Heart	
	60	Lungs	
	61	Abdomen Including Groin	Excluding injury to internal organs.
	62	Buttocks Soft Tissue	
	63	Lumbar & or Sacral Vertebrae (Vertebra NOC trunk)	Bone portion of the spinal column
V.	**Lower Extremities**		
	50	Multiple Lower Extremities	Any combination of parts below.
	51	Hip	
	52	Upper Leg	Femur and corresponding muscles.
	53	Knee	Patella
	54	Lower Leg	Tibia, fibula and corresponding muscles.
	55	Ankle	Tarsals
	56	Foot	Metatarsals, heel, achilles tendon and corresponding muscles - excluding ankle or toes.
	57	Toes	
	58	Great Toe	
VI.	**Multiple Body Parts**		
	64	Artificial Appliance	Braces, etc.
	65	Insufficient Info to Properly Identify - Unclassified	Insufficient information to identity part affected.
	66	No Physical Injury	Mental disorder

Injury Description Codes – Part of Body (Cont'd)

Code	Part of Body	Narrative Description
90	Multiple Body Parts (including Body Systems & Body Parts)	Applies when more than one major body part has been affected, such as an arm and a leg and multiple internal organs.
91	Body Systems and Multiple Body Systems	Applies to the functioning of an entire body system. Has been affected without specific injury to any other part, as in the case of poisoning, corrosive action, inflammation, affecting internal organs, damage to nerve centers, etc. Does NOT apply when the systemic damage results from an external injury affecting an external part such as a back injury which includes damage to the nerves of the spinal cord.

Injury Description Codes – Nature of Injury

Code	Nature of Injury	Narrative Description
I. Specific Injury		
01	No Physical Injury	i.e., glasses, contact lenses, artificial appliance, replacement of artificial appliance.
02	Amputation	Cut off extremity, digit, protruding part of body, usually by surgery, i.e., leg, arm.
03	Angina Pectoris	Chest pain
04	Burn	(Heat burns or scald). The effect of contact with hot substances. (Chemical burns). Tissue damage resulting from the corrosive action. Chemicals, fumes, etc. (acids, alkalies)
07	Concussion	Brain, cerebral
10	Contusion	Bruise - intact skin surface. Hematoma
13	Crushing	Ground, pounded or broken into small bits.
16	Dislocation	Pinched nerve, slipped/ruptured disc, herniated disc, sciatica, complete tear, HNP subluxation, MD dislocation.
19	Electric Shock	Electrocution
22	Enucleation	Removal of organ or tumor.
25	Foreign Body	
28	Fracture	Breaking of a bone or cartilage.
30	Freezing	Frostbite and other effects or exposure to low temperature.
31	Hearing Loss or Impairment	Traumatic only. A separate injury, not the sequelae of another injury.
32	Heat Prostration	Heat stroke, sun stroke, heat exhaustion, heat cramps and other effects of environmental heat. Does not include sunburn.
34	Hernia	The abnormal protrusion of an organ or part through the containing wall of its cavity.

Injury Description Codes – Nature of Injury (Cont'd)

Code	Nature of Injury	Narrative Description
36	Infection	The invasion of a host by organisms such as bacteria, fungi, viruses, protozoa, insects or mold, with or without manifest disease.
37	Inflammation	The reaction of tissue to injury characterized clinically by heat, swelling, redness and pain.
40	Laceration	Cut, scratches, abrasions, superficial wounds, calluses. Wound by tearing.
41	Myocardial Infarction	Heart attack, heart conditions, hypertension; the inadequate blood flow to the muscular tissue of the heart.
42	Poisoning - General (Not OD or Cumulative Injury)	A systemic morbid condition resulting from the inhalation, ingestion, or skin absorption of a toxic substance affecting the metabolic system, the nervous system, the circulatory system, the digestive system, the respiratory system, the excretory system, the musculoskeletal system, etc. Includes chemical or drug poisoning, metal poisoning, organic diseases, and venomous reptile and insect bites. Does NOT include effects or radiation, pneumoconiosis, corrosive effects of chemicals, skin surface irritations, septicemia or infected wounds.
43	Puncture	A hole made by the piercing from a pointed instrument.
46	Rupture	
47	Severance	Separation, division or take off.
49	Sprain	Internal derangement, a trauma or wrenching of a joint, producing pain and disability depending upon degree of injury of ligaments.
52	Strain	Internal derangement, the trauma to the muscle or the musculotendinous unit from violent contraction or excessive forcible stretch.
53	Syncope	Swooning, fainting, passing out; no other injury.

Injury Description Codes – Nature of Injury (Cont'd)

	Code	Nature of Injury	Narrative Description
	54	Asphyxiation	Strangulation, drowning
	55	Vascular	Cerebrovascular and other conditions of circulatory systems, NOC. Excludes: heart and hemorrhoids. Includes: strokes, varicose veins - non-toxic.
	58	Vision Loss	
	59	All Other Specific Injuries, NOC	
II.	**Occupational Disease or Cumulative Injury**		
	60	Dust Disease, NOC	All other pneumoconiosis.
	61	Asbestosis	Lung disease, a form of pneumoconiosis, resulting from protracted inhalation of asbestos particles.
	62	Black Lung	The chronic lung disease or pneumoconiosis found in coal miners.
	63	Byssinosis	Pneumoconiosis of cotton, flax and hemp workers.
	64	Silicosis	Pneumoconiosis resulting from inhalation of silica (quartz) dust.
	65	Respiratory Disorders	Gasses, fumes, chemicals, etc.
	66	Poisoning - Chemical (Other Than Metals)	Man-made or organic
	67	Poisoning - Metal	Man-made
	68	Dermatitis	Rash, skin or tissue inflammation including boils, etc. Generally resulting from direct contact with irritants or sensitizing chemicals such as drugs, oils, biologic agents, plants, woods or metals which may be in the form of solids, pastes, liquids or vapors and which may be contacted in the pure state or in compounds or in combination with other materials. Do NOT include skin tissue damage resulting from corrosive action of chemicals, burns from contact with hot substances, effects of exposure to radiation, effects of exposure to low temperatures or inflammation or irritation resulting from friction or impact.

Injury Description Codes – Nature of Injury (Cont'd)

Code	Nature of Injury	Narrative Description
69	Mental Disorder	A clinically significant behavioral or psychological syndrome or pattern typically associated with either a distressing symptom or impairment of function i.e., acute anxiety, neurosis, stress, non-toxic depression.
70	Radiation	All forms of damage to tissue, bones or body fluids produced by exposure to radiation.
71	All Other Occupational Disease Injury, NOC	
72	Loss of Hearing	
73	Contagious Disease	
74	Cancer	
75	AIDS	
76	VDT - Related Diseases	Video display terminal diseases other than carpal tunnel syndrome.
77	Mental Stress	
78	Carpal Tunnel Syndrome	Soreness, tenderness and weakness of the muscles of the thumb caused by pressure on the median nerve at the point at which it goes through the carpal tunnel of the wrist.
79	Hepatitis C	
80	All Other Cumulative Injury, NOC	

III. Multiple Injuries

Code	Nature of Injury	Narrative Description
90	Multiple Physical Injuries Only	
91	Multiple Injuries Including Both Physical and Physiological	

Injury Description Codes – Cause of Injury

	Code	Cause of Injury	Narrative Description
I.	**Burn or Scald - Heat or Cold Exposures - Contact With**		
	01	Chemicals	
	02	Hot Objects or Substances	
	03	Temperature Extremes	
	04	Fire or Flame	
	05	Steam or Hot Fluids	
	06	Dust, Gases, Fumes or Vapors	
	07	Welding Operation	
	08	Radiation	
	11	Cold Objects or Substances	
	14	Abnormal Air Pressure	
	84	Electrical Current	
	09	Contact With, NOC	
II.	**Caught In, Under or Between**		
	10	Machine or Machinery	
	12	Object Handled	
	20	Collapsing Materials (Slides of Earth)	Either man-made or natural.
	13	Caught In, Under or Between, NOC	
III.	**Cut, Puncture, Scrape- Injured By**		
	15	Broken Glass	
	16	Hand Tool, Utensil; Not Powered	

Injury Description Codes – Cause of Injury (Cont'd)

	Code	Cause of Injury	Narrative Description
	17	Object Being Lifted or Handled	
	18	Powered Hand Tool, Appliance	
	19	Caught, Puncture, Scrape, NOC	
IV.	**Fall, Slip or Trip**		
	25	From Different Level (Elevation)	Off wall, catwalk, bridge, etc.
	26	From Ladder or Scaffolding	
	27	From Liquid or Grease Spills	
	28	Into Openings	Shafts, excavations, floor openings, etc.
	29	On Same Level	
	30	Slipped, Did Not Fall	
	32	On Ice or Snow	
	33	On Stairs	
	31	Fall, Slip or Trip, NOC	
V.	**Motor Vehicle**		
	40	Crash of Water Vehicle	
	41	Crash of Rail Vehicle	
	45	Collision or Sideswipe with Another Vehicle	Both vehicles in motion
	46	Collision with a Fixed Object	Standing vehicle or stationary object
	47	Crash of Airplane	
	48	Vehicle Upset	Overturned or jackknifed
	50	Motor Vehicle, NOC	
VI.	**Strain or Injury By**		
	52	Continual Noise	
	53	Twisting	
	54	Jumping	

Injury Description Codes – Cause of Injury (Cont'd)

	Code	Cause of Injury	Narrative Description
	55	Holding or Carrying	
	56	Lifting	
	57	Pushing or Pulling	
	58	Reaching	
	59	Using Tool or Machinery	
	61	Wielding or Throwing	
	97	Repetitive Motion	Carpal Tunnel Syndrome
	60	Strain or Injury By, NOC	
VII.	**Striking Against or Stepping On**		
	65	Moving Part of Machine	
	66	Object Being Lifted or Handled	
	67	Sanding, Scraping, Cleaning Operation	
	68	Stationary Object	
	69	Stepping on Sharp Object	
	70	Striking Against or Stepping On, NOC	
VIII.	**Struck or Injured By (includes Kicked, Stabbed, Bit, Etc.)**		
	74	Fellow Worker; Patient	Not in act of a crime.
	75	Falling or Flying Object	
	76	Hand Tool or Machine in Use	
	77	Motor Vehicle	
	78	Moving Parts of Machine	
	79	Object Being Lifted or Handled	
	80	Object Handled By Others	
	85	Animal or Insect	

Injury Description Codes – Cause of Injury (Cont'd)

	Code	Cause of Injury	Narrative Description
	86	Explosion or Flare Back	
	81	Struck or Injured, NOC	Includes kicked, stabbed, bit, etc.
IX.	**Rubbed or Abraded By**		
	94	Repetitive Motion	Callous, blister, etc.
	95	Rubbed or Abraded, NOC	
X.	**Miscellaneous Causes**		
	82	Absorption, Ingestion or Inhalation, NOC	
	87	Foreign Matter (Body) in (Eyes)	
	88	Natural Disaster	
	89	Person in Act of a Crime (Other Than Gunshot)	Robbery or criminal assault
	90	Other Than Physical Cause of Injury	
	93	Gunshot	
	91	Mold	
	96	Terrorism	
	98	Cumulative, NOC	All Other
	99	Other - Miscellaneous, NOC	

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