



Wisconsin Compensation Rating Bureau

WISCONSIN WORKERS COMPENSATION STATISTICAL PLAN MANUAL

WORKER'S COMPENSATION AND EMPLOYERS LIABILITY INSURANCE

Effective: January 1, 1996

SUMMARY OF CHANGES

issued by:

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WI STATISTICAL PLAN MANUAL
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[SUMMARY OF CHANGES](#)

I. INTRODUCTION

This Plan contains the necessary instructions for the reporting of experience on the direct business, (voluntary and assigned risk), written by the data provider for Worker's Compensation and Employers Liability Insurance in Wisconsin. While this Manual refers to electronic filing, instructions for electronic filing of unit statistical reports can be found in the WCIO Workers Compensation Data Specifications Manual located on the Workers Compensation Insurance Organizations ([WCIO website](#)).

The Wisconsin Compensation Rating Bureau will hereinafter be referred to as "the Bureau", or "WCRB".

Schedule for Filing Unit Report Data

The instructions set forth in this Plan are applicable to all reports for policies effective on or after January 1, 1996 for experience on:

- 1st reports due on and after July 1, 1997
- 2nd reports due on and after July 1, 1998
- 3rd reports due on and after July 1, 1999
- 4th reports due on and after July 1, 2000
- 5th reports due on and after July 1, 2001

Expanded reporting to add 6th through 10th reports for policies effective on or after January 1, 1999:

- 6th reports due on and after July 1, 2005
- 7th reports due on and after July 1, 2006
- 8th reports due on and after July 1, 2007
- 9th reports due on and after July 1, 2008
- 10th reports due on and after July 1, 2009

The following table outlines the valuation month and report month for each policy effective month.

Policy Effective Month	Valuation Month 18 Months After Policy Effective Month	Report Month 20 Months After Policy Effective Month
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

Bureau Correspondence

Delinquent Letter

Delinquent letters are created when a unit report is due and the report is not in WCRB's database in an "Accepted" status.

NOTE: The requirement for filing a unit statistical report is met only when the report is in an "Accepted" status in Manage Data.

Reject Letter

The Reject Letter identifies the edit failures causing the unit report to fail in WCRB's database, as well as the type of report (correction or replacement) required to fix the error.

NOTE: This documentation serves as the 1st Notice that we expect to receive another unit report to resolve the documented edit failures.

Estimated Unit Report Letter

The Estimated Unit Report Letter is created when a unit report is received and in an "Accepted" status in Manage Data and the Policy Condition Indicator-Estimated Audit Code is a "Y". (See section II. A. 2 for filing requirements)

Electronic notification of Bureau correspondence can be obtained by completing and submitting the [Unit Statistical Letter Notification Preference](#) form, found in the Forms tab of the WCRB website.

All letter types are posted on the WCRB website (www.wcrb.org) in Manage Data.

Schedule of Statistical Plan Fines

WCRB is authorized to levy fines for delinquent and estimated unit reports. The schedule for fining is as follows:

Notice	Amount
1 st	\$ 0
2 nd	\$ 150
3 rd	\$ 250
4 th	\$ 350
5 th and all subsequent	\$ 500

Failure to comply may result in a letter of complaint being issued to the Office of the Commissioner of Insurance for the State of Wisconsin.

The fine schedule was approved by the Office of the Commissioner of Insurance for the State of Wisconsin to be effective January 1, 1998.

Statistical Plan Summary of Changes

Changes to the Wisconsin Statistical Plan Manual will be listed in the "Summary of Changes" document released with each Manual revision.

GENERAL RULES/DEFINITIONS

A. Scope of Report

Final audited statistical data must be filed for every policy insuring liability under Wisconsin Worker's Compensation and Employers Liability Insurance. Two reporting options exist when reporting unit statistical data for Wisconsin effective July 1, 2001. All unit reports must be filed using either Option 1 or Option 2 as defined below:

Option 1: Electronically file all unit statistical report data directly with the WCRB through CDX (Compensation Data Exchange), found on the [CDX website](#). Prior to submitting unit statistical data directly to WCRB, a "[Filing Option Election Form](#)" must be completed and sent to WCRB for approval. (Copy of form in V. Sample Forms) Contact WCRB directly for questions regarding reporting requirements and the method for submission.

Option 2: If you are not approved to file directly with WCRB, all reports must be filed electronically with the National Council on Compensation Insurance Inc. (NCCI), Data Center Processing Team, 901 Peninsula Corporate Circle, Boca Raton, FL 33487.

B. Recording of Statistics

Unit statistical reports consist of experience comprising exposure and loss data for Wisconsin businesses. Electronic reporting specifications are published in the WCIO Workers Compensation Data Specifications Manual found on the WCIO website at [wcio.org](#). These specifications are maintained and published by the WCIO.

The Bureau Entry and Edit Package (BEEP) is available for the electronic reporting of unit statistical data for Wisconsin. Additional information regarding BEEP can be found on the [CDX website](#).

C. Multiple Year Policies

Multiple year policies, other than three-year fixed rate policies, shall be considered as separate annual 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. Losses shall be valued as of the 18th month after the month in which each unit of experience became effective and at annual periods thereafter.

Examples:

1. The reports on a three-year policy effective January 1, 2006 shall be filed with regular reports on policies effective January 1, 2006, January 1, 2007, and January 1, 2008. First report valuations shall be as of July 2007, July 2008, and July 2009, respectively.
2. The reports on a policy covering the period January 1, 2006 to July 1, 2007, with the first six months considered as a unit, shall be filed with the regular reports on policies effective January 1, 2006 and July 1, 2006. Losses shall be valued as of July 2007 and January 2008, respectively.

3. The reports on a policy covering the period January 1, 2006 to July 1, 2008, with the last six months considered as a unit, shall be filed with the regular reports on policies effective January 1, 2006, January 1, 2007, and January 1, 2008. Losses shall be valued as of July 2007, July 2008, and July 2009, respectively.

D. Uncollectible Premiums and Corresponding Losses

All earned premiums, whether collectible or not, shall be reported. Likewise, the corresponding exposure and losses shall be reported.

E. Radiation Exposure-Other Than Government Agency Atomic Energy Projects

Experience in connection with Atomic Energy Projects performed for, or under the direction of, any government agency shall be excluded from the experience reported under this Plan.

This Manual provides that a supplemental rate, subject to the approval of the Bureau, may be applied to operations involving research, manufacturing, handling, transportation, use of or exposure to radioactive materials, where such operations are not performed for or under the direction of any government agency. The payroll to which such supplemental rate is applicable, together with the premium derived from such charge, shall be reported under **Classification Code 9985**. The payroll reported for **Classification Code 9985** shall be reported in the Exposure Amount field and shall not be added to payrolls shown for other manual classifications in determining the risk's Exposure Amount Total amount.

The Exposure Amount, Manual/Charged Rate, and Premium Amount are not subject to experience modification and only the premium shall be included in the risk total. Similarly, radiation losses on risks where a supplemental loading has been applied shall be assigned to **Classification Code 9985**. If no supplemental radiation loading has been applied, any radiation losses shall be assigned to the appropriate classification. Note, however, that any radiation loss, whether reported under **Classification Code 9985** or a regular classification, must be identified as a disease loss in the field named "Loss Conditions". Refer to section III. C.4. Loss Conditions.

F. Reinsurance

No deductions shall be made from earned premiums and incurred losses for, or on account of, reinsurance ceded. Premiums earned and losses incurred on account of reinsurance received by the reporting data provider shall be excluded from the experience.

G. Excess Insurance

Experience on Excess Insurance policies must be excluded from the experience reported under this Plan.

H. Experience Under the National Defense Projects Rating Plan

Any portion of exposure resulting from experience written under the National Defense Projects Rating Plan shall not be included as audited exposure in the insured's statistical filing.

I. Admiralty and Federal Employers Liability

The Bureau has no jurisdiction over the rates and classifications for Admiralty or Federal Employers Liability exposure. Admiralty and Federal Employers Liability exposure shall be excluded from the experience reported under this Plan.

J. Loss Rules

1. Occupational Disease Incurred Losses

- a. Disease losses shall be identified in the “Loss Conditions Codes/Type of Loss” field by the appropriate code for Disease Loss according to section III. C.4. Loss Conditions. The total losses reported shall be the total of traumatic losses and disease losses incurred and shall exclude any allocated claim expense, but shall include allocated claim expense for Part II Employers Liability losses.
- b. Dust disease losses incurred in connection with payrolls reported under **Classification Code 0066** shall likewise be assigned to the same code and shall be further identified by the appropriate code for Disease Loss in the “Loss Conditions Codes/Type of Loss” field. These losses shall also be included in the total losses reported.

2. Interest on Awards

Interest on awards for delayed payments of compensation due, for which the data provider is liable and which accrue as benefits to the injured worker or his dependents, shall be chargeable to losses and so reported. No penalties or fines are to be charged to losses.

3. Medical on Compensable Cases

Medical losses shall include all payments to doctors and hospitals as well as physical rehabilitation costs and reserves for future payments but shall not include any claim expense. In this connection, see the instructions contained in J.7. of this section.

4. Subrogation Claims

- a. For subrogation cases, the net liability shall be determined by deducting from the incurred cost prior to recovery the amount recovered through subrogation less any expenses incurred in connection with such recovery. However, in cases where the expenses incurred in connection with such recovery exceed the amount recovered, the net amount of losses reported shall not exceed the gross amount of loss prior to recovery. Furthermore, the net liability incurred shall be apportioned to indemnity and medical as recovered in the settlement. If apportionment of the credit to the claim is not identified, a suggested method for apportionment is given below.

Subrogation correction reports are required to be filed for all report levels where the subrogation claim has been previously reported. Each report level should be corrected to reflect the change in loss due to the subrogation recovery.
- b. When a subrogation recovery is received by the data provider subsequent to the first reporting of the claim, a correction report must be filed with the Bureau reducing the incurred loss on the claim by the amount of the subrogation recovery received.

A suggested method for these calculations is given in the following example:

	<u>Total</u>	<u>Ind</u>	<u>% of Total</u>	<u>Med</u>	<u>% of Total</u>
Gross Incurred Loss	\$20,000	\$17,000	85	\$3,000	15
Subrogation Received	\$ 7,000				
Claim Expense	<u>\$ 500</u>				
Net Recovery	\$ 6,500				
Net Loss	\$13,500	\$11,475	85	\$2,025	15

- c. When subrogation is final and claim is closed, report the net loss. In the event the net loss is greater than what was previously reported, no correction may be filed.

5. Aircraft Operation Losses

Losses incurred in connection with employees of the risk, other than members of the flying crew, shall not be reported by classification but shall be assigned to **Statistical Code 9108**, provided such losses arise out of the operation of aircraft subject to a passenger seat surcharge.

NOTE: The passenger seat surcharge is not applicable for policies effective January 1, 2015 and subsequent.

6. Subsequent Reports

The rules of this section apply to any second through tenth report involving

- (1) claim reported "open" on the previous report,
- (2) any re-opened claim reported "closed" on the previous report,
- (3) any claim previously unreported, or
- (4) any other change in the valuation of losses.

The data reported for each claim shall be the previously reported and the revised values.

It shall not be permissible to revise loss values between two valuation dates because of departmental or judicial decision, or because of developments in the nature of the injury.

7. Medical or Legal Expense

Medical or legal expenses incurred for the benefit of the data provider to secure evidence for presentation before an official body shall be treated as adjusting expenses and not reported except as respects Employers Liability, Part II, of the Worker's Compensation Policy.

The following are a few examples that should be charged to expenses rather than to losses:

- a. Medical examination of a claimant on behalf of the data provider to determine liability.
- b. Cost of securing birth and death certificates.
- c. Cost of performing autopsies.
- d. Expert testimony of physicians on behalf of the data providers or fees paid to the claimant's physician called in by the data provider.

NOTE: When the claimant calls in the attending physician to give medical testimony on the claimant's behalf, or where the data provider is required to produce the claimant's physician at the hearing and the employee or the data provider is required to pay such a physician's fee, the payment of the fee shall be reported as a medical loss.

When an award to a claimant includes the cost of witness fees, attorney fees, and other court costs, the amount so awarded shall be considered as part of the cost of the benefit and shall be included with the indemnity reported. With respect to claims brought by persons against whom an employee has brought a third party common law action, such special costs shall be reported as an indemnity loss whether or not a recovery is made against the third party by the employee. See section IV. Glossary for more information.

8. Incurred Losses

Report the total of all paid plus outstanding compensation in the fields captioned Incurred Indemnity Amount and Incurred Medical Amount. Report the total of all paid compensation in the fields captioned Paid Indemnity Amount and Paid Medical Amount. The outstanding costs shall be the company's individual case estimates of future payments as of the date of valuation.

- a. When a final award has been made, the total incurred compensation must be in agreement with such award, except under the following circumstances:
 - (1) When a claimant has appealed for a higher award for a compensable claim, the data provider shall 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.
 - (2) In cases where a claim has been officially declared non-compensable by a law judge, if the appeal has been taken and is undetermined on the valuation date, the data provider shall report the incurred cost that would have been reported had the claim not been declared non-compensable. It should not be reported as non-compensable during the appeals process.
 - (3) In cases where a claim has been officially declared non-compensable, if the period during which an appeal may be taken has not expired by the valuation date, the data provider may report the incurred cost that would have been reported had there been no declaration of non-compensability. It shall be permissible to eliminate from the report the reserve for the non-compensable claim in any case where the period for taking an appeal has expired subsequent to the date of valuation, but prior to the date of filing of the report, without an appeal having been taken.
- b. The closing of a claim shall be regarded for the purpose of this rule as the equivalent of a specific official declaration of non-compensability under the following circumstances:
 - (1) No claim was filed during the period provided by law and the data provider, therefore, closes the case.

- (2) The data provider has raised the issues of accident prior to the valuation date and continues to contest the claim on any such issues; and the claim is officially closed because of the claimant's non-appearance or failure to prosecute his claim without a ruling on the question of accident, notice or causal relation.
- c. Where the data provider has appealed against an award, it shall report the full amount of such award. Cases on which the data provider has filed a petition to terminate must not be reported as closed or non-compensable until the petition has been granted by a referee or the Bureau of Worker's Compensation of the Department of Workforce Development and all appeals are final.
- d. If the final award has not been made, but compensation for the injury is subject to a definite schedule of benefits, the provisions of the Law shall be reflected in the amount of compensation reported. In all other cases the amount reported should reflect the data provider's estimate of incurred cost in the light of all information available on the date of valuation.
- e. Expenses, any general allowances for contingencies, and any supplemental non-statutory benefits not otherwise provided for in this Plan must be excluded. Precautionary reserves in excess of the amount shown on the final settlement receipt as filed, at completion of all compensation payments, with the Wisconsin Department of Workforce Development, or other body having jurisdiction over worker's compensation claims shall not be included in the amount of losses reported under the Statistical Plan. Vocational Rehabilitation costs and reserves for future payments shall be included as part of the amount reported as incurred indemnity.

In all cases where a claim has been determined to be eligible for reimbursement to the data provider from a special fund (such as Second Injury Fund, etc.) the gross incurred cost of the claim (i.e., prior to any reimbursement) shall be reduced by the amount of any paid or anticipated recovery from such fund and the net incurred cost of the claim shall be reported. Anticipated recovery is defined for this purpose as the amount of recovery expected to be recovered from such funds based on the rules governing such funds or a binding agreement between such funds and the data provider on an amount, or percentage of the incurred cost, to be reimbursed to the data provider on a particular claim.

When such an anticipated recovery becomes known by the data provider or when a recovery is paid to the data provider subsequent to the first reporting of the claim on the 18th month valuation date of the policy, a correction report must be filed with the Bureau reducing the incurred cost on the claim by the amount of the paid or anticipated recovery.

K. Special Reportings—Three-Year Fixed Rate Policies

1. The rules in this section relate to the reporting of experience incurred under three-year fixed rate policies, written in accordance with [Part 1, Rule XI of the WI Basic Manual](#).

- A. Second through tenth reports on three-year fixed rate policies or per capita policies reported in accordance with this section are not required.
- B. The rules of this Manual apply to the reporting of the experience, except as supplemented by the following rules in this section.

2. Three-Year Fixed Rate Unit Reporting Instructions

- a. The complete three-year experience incurred under each policy shall be reported. For electronic submission instructions see [WCIO Workers Compensation Data Specifications Manual](#).
- b. Losses included in the reporting of a given policy shall be valued as of the 42nd month after the month in which the policy became effective, and the reports shall be filed not later than 44 months after the month in which the policy became effective. These reportings shall be specifically identified as three-year fixed rate policy experience (this must be done by reporting code "Y" in the Three-Year Fixed Rate Policy Indicator of the Policy Conditions Indicators field in the Header Record) and shall be segregated and reported independently of the reportings of one-year policies.
- c. The data required shall be the data specified in this Manual.

Expense Constant premium shall be assigned to **Statistical Code 0900**. If the Deposit Premium has been paid in advance, report only the net amount, i.e. the amount of one Expense Constant; if the premium has been paid in annual installments, report the amount of two Expense Constants. Cancellation penalty premium shall be assigned to **Statistical Code 0931**.

L. Estimated Audit

Where it is not possible to obtain audited exposure figures due to the policyholder's refusal to provide the carrier access to the payroll and other required records, the carrier shall use the Estimated Audit Code "U". A "U" means that the carrier has made a good faith effort to complete the final audit.

When the exposure reported on the 1st report is based on estimated exposure, because the insured has not responded to the request for audited data and has been deemed uncooperative, report as follows:

- "U" for the Estimated Audit Code-Policy Conditions
- The estimated exposure and class/stat code(s) corresponding to the estimated premium, and associated losses.

When the exposure reported on the 1st report includes Statistical Code 9757, Audit Noncompliance Charge, report the Estimated Audit Code as a "U" in the applicable Policy Condition Indicator field. Refer to [Circular Letter 3134, March 18, 2016](#).

If subsequent to reporting an estimated unit report audited exposure amounts are obtained in accordance with the [Basic Manual](#) rules, an exposure correction must be submitted as soon as the revised figures are available. If Statistical Code 9757 was reported, this code and its accompanying charge must be removed. Additionally, the Estimated Audit Code must be reported as "N", and the exposure records must reflect the final audit.

II. WISCONSIN REPORTING REQUIREMENTS

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A. Rules Common to Premiums and Losses

1. Form of Report

WCSTAT files, as found in the [WCIO Data Specifications Manual](#), consist of data comprising Header, Name, Address (optional), Exposure, Loss, and Total records.

Unit report data must be submitted electronically to WCRB. For further information regarding electronic reporting, please contact the WCRB or NCCI, Inc. Additional information can be found in section I. A. Scope of Report.

Carriers who have never reported WCSTAT files electronically are required to test their electronic submissions with WCRB and receive approval prior to submitting their first electronic file of production data. [WCSTAT Submission Instructions](#) can be found on the WCRB website.

2. Estimated Audits

If for any reason data is unavailable to the data provider before the filing date, an estimated audit must be filed with the Bureau and the Policy Condition Indicators-Estimated Audit Code shall be reported with the symbol "Y". A multiple correction report must be filed when final audited data becomes available. This report will update the header and exposure record detail. If a final audit cannot be obtained, the WCRB must be notified and the estimated audit will be used as the final audit.

3. Fraction of Dollars

Report all monetary amounts in whole dollars only.

4. Method of Transmittal

- a. WCSTAT files shall be submitted on a monthly basis, except that the data provider may submit electronic files more frequently if the data provider so desires.
- b. WCSTAT files shall be transmitted to WCRB via CDX with an electronic letter of transmittal by a responsible official of the data provider.

5. Dates

All dates shall be reported using a numeric designation, e.g. April 1, 2009 should appear as 040109.

B. Header Data Elements and Definitions

ASWG Unit Format Submission Code

This code identifies a unit statistical report that is being reported in the ASWG format. All unit reports with effective dates 1/1/96 and later must be reported in the ASWG format. (Refer to section III. A.7 for list of ASWG Unit Format Submission Codes.)

BEEP Use Edit Bypass Code (Applicable to BEEP submissions only)

BEEP (Bureau Entry & Edit Package) uses this field to indicate when a unit statistical report has been forced onto the submission file without passing all of the validations. (Refer to section III. A.6 for list of BEEP Use Edit Bypass Codes.)

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Only unit statistical reports in a Passed Status can be submitted to WCRB. For previously reported ("Update Type" equal to "P"), some data field edits will be bypassed. These edits are still processed as warnings, but do not cause a unit statistical report to fail validation.

Carrier Code

The code assigned to the reporting carrier by NCCI, Inc.

Correction Sequence Number

The sequential number that corresponds to the number of correction reports submitted within a particular report level. (Refer to section II. H. b. for conditions requiring a correction report.)

Correction Type Code

The code that indicates the type of correction report being submitted. Applicable only to correction reports. (Refer to section III. A.2 for the list of Correction Type Codes.)

Exposure State Code

The code that represents the state in which coverage has been provided. (Refer to section I.A.3 for the valid Exposure State Code.)

Federal Employer ID Number (FEIN)

The federal identification number of the person or business with whom an insurance contract is made and who is specifically designated by name in item 1 of the policy information page or as endorsed. The Federal Employer Identification Number is optional.

Policy Number Identifier

The complete policy number must be reported AND MUST AGREE WITH THE NUMBER SHOWN ON THE POLICY INFORMATION PAGE. The complete policy number including prefixes and suffixes, if used, must remain the same throughout the life of the policy.

Policy Effective Date

The effective date should correspond exactly with that shown on the policy information page or endorsements attached thereto.

Policy Expiration or Cancellation Date

The expiration date shall be the expiration date shown on the policy information page unless the policy is canceled. In that event, the cancellation date shall be recorded as the expiration date. In the case of a multi-state policy, the policy expiration date shall be the expiration date shown on the policy information page or the date operations ceased in Wisconsin.

Policy Conditions Indicators

Indicators of various policy conditions. Indicate with a "Y" in the appropriate field for each condition that applies, and an "N" in the appropriate field for each condition code that does not apply. (Refer to section III. A.5 for list of Policy Conditions.)

Policy Type ID Codes

Identifies the type of coverage, plan indicator and non-standard provisions of the policy. (Refer to section III. A. 4 for list of Policy Type ID Codes.)

Previous Report Level Code/Report Number

The report number code that was previously reported.

Previous Correction Sequence Number

The correction sequence number that was previously reported.

Previous Carrier Code

The carrier code that was previously reported.

Previous Policy Number Identifier

The policy number identifier that was previously reported.

Previous Policy Effective Date

The policy effective date that was previously reported.

Previous Exposure State Code

The exposure state code that was previously reported.

Replacement Report Code

For data providers electing to file data directly with WCRB, report an R to identify a Replacement Report being submitted in response to a unit report in a “Rejected” status in WCRB’s Web product, [Manage Data](#). Otherwise, leave this field blank. Carriers not reporting unit statistical data directly with WCRB must contact NCCI, Inc. for reporting procedures.

Report Level Code/Report Number

The code that corresponds to the valuation date. (Refer to section III. A.1 for list of report numbers and valuation dates.)

First Reports are valued as of the 18th month after the month in which the policy became effective, and the report shall be filed not later than 20 months after the effective month of the policy.

Subsequent Reports:

Second reports are valued exactly 30 months from the policy effective month.

Third reports are valued exactly 42 months from the policy effective month.

Fourth reports are valued exactly 54 months from the policy effective month.

Fifth reports are valued exactly 66 months from the policy effective month.

Sixth reports are valued exactly 78 months from the policy effective month.

Seventh reports are valued exactly 90 months from the policy effective month.

Eighth reports are valued exactly 102 months from the policy effective month.

Ninth reports are valued exactly 114 months from the policy effective month.

Tenth reports are valued exactly 126 months from the policy effective month.

Risk ID Number

The identification number assigned to the risk by the bureau issuing the experience rating. The Risk ID Number is optional.

State Effective Date

The date coverage begins in Wisconsin on a multi-state policy where Wisconsin has been added mid-term.

C. Name Record Data Elements and Definitions**Insured Name**

The name of the person or business with whom an insurance contract is made and who is specifically designated by name in item 1 of the policy information page or as endorsed.

D. Address Record Data Elements and Definitions**Insured Address**

The address of the person or business with whom an insurance contract is made and who is specifically designated by name in item 1 of the policy information page or as endorsed. The Address of the Insured is optional.

E. Exposure Record Data Elements and Definitions**Classification Code**

The code corresponding to the insured's classification determined according to classification rules of the Bureau and published in the Basic Manual for Worker's Compensation and for Employers Liability Insurance.

Experience Modification Effective Date

Normally, this is the effective date of the policy. However, if the experience modification changes during the policy period, in accordance with Experience Rating Manual rules, this is the effective date of the experience modification that applies to the exposure reported in this detail record.

If the anniversary rating date is different from the policy effective date, then the modification effective date equals the anniversary rating date.

NOTE: The Experience Modification Effective Date for split 0 must always equal the policy effective date on the unit report's Header Record. The Experience Modification Effective Date is a required data element when reporting electronically.

Policies effective September 1, 2013, the note above is no longer applicable.

Experience Modification Factor

The experience modification is used to develop charged premium, expressed as a decimal, (e.g., .95 for 5% credit, 1.00 for a "neutral" modification, or 1.05 for a 5% debit) shall be reported on every classification for a risk that is subject to experience rating. If a change in the experience modification occurs subsequent to inception date of the policy, the Exposure Amounts, Manual/Charged Rates, and corresponding Premium Amount shall be split and reported with unique split dates. The period covered by each report shall be shown by appropriate notation in the Experience Modification Effective Date and/or Rate Effective Date fields

NOTE: A "neutral" modification may not be used for a non-rated risk and must be reported as 0000.

Exposure Act/Exposure Coverage Code

The code indicating the Act (Law) under which the exposure for this record's Classification Code is associated. (Refer to section III. B.2 for list of Exposure Act/Exposure Coverage Codes.)

Exposure Amount

Exposure Amounts (payroll) reported is audited payrolls, even on minimum premium risks.

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

The total payroll for all classifications is to be reported in the Exposure – Payroll Total field.

The payroll exposures for non-ratable (supplemental and catastrophe loading) portions are not to be included in the Exposure–Payroll Total field.

The Manual rules provide that the payroll of all employees exposed to a foundry, abrasive, sand blasting hazard, carcinogen, radiation or federal black lung (except those rated under a classification where the Bureau Rates provide coverage for silicosis) will have a special supplementary disease rate charge. Such payroll, together with the manual premium derived from the supplemental rate charge, shall be assigned to the appropriate Classification Code. Refer to section III. B. 3. Premium Codes of this Plan for a complete list. The payroll reported for these codes shall be reported but shall not be used in determining the risk's Exposure–Payroll Total. However, the premium resulting from the application of the supplemental disease rates shall be included in the Standard Premium Total.

The Manual rules provide that the payroll of all employees exposed to or engaged in the following hazards will have a mandatory catastrophe reserve rate, which is not subject to experience or retrospective rating.

Such payroll, together with the Manual premium from the mandatory catastrophe reserve rate charge, shall be assigned to the appropriate Classification Code:

<u>Class</u>	<u>Hazard</u>	<u>Code</u>
4771	Explosives or Ammunition Mfg NOC & Drivers	0771
7405	Air Carrier Scheduled or Supplemental: Flying Crew	7445
7431	Aircraft or Helicopter Operation: Air Carrier Commuter—Flying Crew	7453

Reporting Instructions for Policies Where No Exposure Was Developed

When a policy is issued on an “if any” basis, or as estimated coverage in Wisconsin, and upon audit no exposure developed, two methods of reporting the unit statistical data can be used:

Method 1: Report the Classification Codes with zeros in the Exposure Amount and Premium Amount fields. Report the applicable rate for the Classification Code in the Manual/Charged Rate field. Report any other statistical codes that are policy related, such as the Expense Constant, Waiver of Subrogation, and Premium for Increased Liability codes, as identified on the policy.

Method 2: Report statistical code 1111 with zeros in the Exposure Amount, Premium Amount, and Manual/Charged Rate fields. Report any other statistical codes that are policy related such as the Expense Constant, Waiver of Subrogation, and Premium for Increased Liability codes, as identified on the policy.

No losses should be reported on unit statistical reports for policies where no exposure developed.

Manual/Charged Rate

The rates as approved for use in Wisconsin shall be shown against the classifications and Exposure Amounts to which they are applicable.

Premium Amount

Premium by Classification. The premium reported by Classification Code shall be that obtained by extension of the payroll or other exposure at the rates, and shall be reported in the field captioned Premium Amount. Where a classification includes a non-ratable element or supplemental loading, only the ratable portion of the premium should be reported with the policy's experience modification factor. The non-ratable portion is not reported with an experience modification factor.

Miscellaneous Premium. The Bureau rules provide for additional premium charges for various special conditions or additional coverage, such as Aircraft Seat Surcharge, Excess Limits under Part II, etc. These additional premium charges are reported in the field captioned Premium Amount. (See E.1. of this section). The exposure items if any shall be reported in the field captioned Exposure Amount.

NOTE: The passenger seat surcharge is not applicable for policies effective January 1, 2015 and subsequent.

Rate Effective Date

Normally, this is the effective date of the rate that corresponds to the classification code and exposure. However, if the rate changes during the policy period, in accordance with Basic Manual rules, this is the rate effective date that applies to the classification code and exposure reported in this detail record.

NOTE: The Rate Effective Date for split 0 must always equal the policy effective date on the unit report's Header Record. The Rate Effective Date is a required data element when reporting electronically. For policies effective September 1, 2013, the note above is no longer applicable.

Split Period Code

This code is used to indicate change in manual/charged rates or modification factors during life of policy. For policies with no change in manual/charged rates or modification factors this field will be zero filled. For policies with changes in manual/charged rates or modification factors, report "0" for the first period, "1" for the second period, "2" for the third period, etc., through "9".

Update Type Code

The code that identifies the activity of an Exposure Record. (Refer to section III. B. 1 for list of Update Type Codes.)

Miscellaneous Premium and Credits

a. Premium Subject to Experience Modification

Premium for Increased Limits under Part II of the policy to be reported in the aggregate in the Premium Amount field, assigned to the appropriate code. (Refer to section III. B. 3. for limits and percentages).

The [Basic Manual](#) rules provide that the premium for limits shall be determined by applying the appropriate factors to the total premium, before any applicable experience modification.

These codes should not be used in connection with the reporting of excess premium developed for higher limits on voluntary compensation policies. For such cases, the [Basic Manual](#) rules contemplate that the premium for coverage in excess of standard limits is provided by an appropriate increase in the Manual/Charged Rate.

In those cases where the additional premium resulting from the application of the appropriate limit factor to total premium is less than the corresponding minimum premium established by the data provider for such increased limits, the corresponding minimum premium shall be shown opposite the appropriate **Statistical Code 9848**.

Per Capita Classifications. Experience on per capita classifications (**Classification Codes 0908 and 0913**) shall be reported in the Exposure Amount field by the number of persons exposed. An employee covered under a per capita classification for a period of one year shall be reported as an exposure of 10. Similarly, if coverage is terminated before the expiration of a year, the exposure reported per person shall be that decimal part of a year, expressed to the nearest tenth, for which the coverage was in effect. For example, an employee covered for four months should be reported as an exposure of 3. Exposure shall be governed by the duration of the coverage and not by the number of days worked.

Exposure Amounts for these Classification Codes are not included in the Exposure – Payroll Total Field.

Volunteer Firemen—**Classification Code 7709**. Where the policy provides coverage for Volunteer Firemen, report the total premium from the chart in Wisconsin rate pages. No Exposure Amount or Manual/Charged Rate should be reported.

Work-Study Program—**Classification Code 9428**. Report the total premium charge incurred when the policy provides coverage for students under this program. No Exposure Amount or Manual/Charged Rate should be reported.

Additional Premium Resulting From Flat Increase on Outstanding Policies—**Statistical Code 0998**. For policies where the effect of a law amendment has been applied during the term of the policy as a flat increase on total premium for the unexpired portion, the additional aggregate premium resulting from the flat increase shall be reported on a manual rate basis and shall be assigned to **Statistical Code 0998** and reported in the Premium Amount field. The Exposure Amount and Manual/Charged Rate fields shall be zero filled.

Premium Credit Resulting From Flat Decrease on Outstanding Policies—**Statistical Code 0994**

For policies where the effect of a law amendment has been applied during the term of the policy as a flat decrease on total premium for the unexpired portion, the premium credit resulting from the flat decrease shall be reported on a manual rate basis and shall be assigned to **Statistical Code 0994** and reported in the Premium Amount field. The Exposure Amount and Manual/Charged Rate field shall be zero filled.

Additional premium for Admiralty or FELA coverage—refer to section III. B.3. for limits and codes.

Waiver of Subrogation—Report the premium charged for the waiver of subrogation under **Statistical Code 0930**.

NOTE: **Statistical Code 0930** is applicable for policies with an effective date prior to October 26, 2001. Refer to [Circular Letter 2885—December 7, 2001](#).

Statistical Code 0930 is not applicable for policies effective October 1, 2006 through September 30, 2008.

Statistical Code 0930 is applicable for policies effective October 1, 2008 and current. Refer to [Circular Letter 3026—April 10, 2008](#).

Statistical Code 0930 is applicable for policies effective July 12, 2013 and current. Refer to [Circular Letter 3104—July 16, 2013](#).

Short Rate Penalty Premium—**Statistical Code 0931** Where policies are canceled prior to normal expiration, the cancellation date shall be reported in the block captioned Policy Expiration Date and the symbol "Y" reported in the Policy Condition Field Canceled Mid-Term. When a policy is canceled short rate, the Exposure Amount and Manual premium by classification shall be reported on the basis of the actual exposure. The experience mod, if any, shall then be applied to the Manual premium to determine the total modified premium. The additional premium resulting from application of the short rate cancellation table to such modified premium extended to full annual basis shall be assigned to **Statistical Code 0931** and reported in the Premium Amount field. The Exposure Amount and Manual Rate fields shall be zero filled.

b. Premium Not Subject to Experience Modification

Aircraft Operation—Passenger Seat Surcharge. Passenger seat surcharge premiums shall be reported separately on the basis of each aircraft owned or operated by the risk during the policy period and shall be assigned to **Statistical Code 9108**. The number of seats shall be reported as 10 per seat. The Exposure Amount is not included in the Exposure – Payroll Total Field.

NOTE: The passenger seat surcharge is not applicable for policies effective January 1, 2015 and subsequent.

Contractor's Premium Adjustment Credit—**Statistical Code 9046**. Report the contracting credit modification factor in the rate field, and the amount of premium credit.

Waiver of Subrogation—**Statistical Code 9115**. Report the premium charged for the waiver of subrogation for policies with an effective date of October 26, 2001 and after.

Statistical Code 9115. Report the premium charged for the waiver of subrogation for policies with an effective date of July 12, 2013 and after. Refer to [Circular Letter 3104—July 16, 2013](#).

Work-Study Program—For policies effective 10-1-13 and subsequent. Refer to [Circular Letter 3097, January 3, 2013](#)

Secondary Schools—**Statistical Code 9428**. Report the total premium charge incurred when the policy provides coverage for students under this program. No Exposure Amount or Manual/Charged Rate should be reported.

Post Secondary Schools—**Statistical Code 9447**. Report the total premium charge incurred when the policy provides coverage for students under this program. No Exposure Amount or Manual/Charged Rate should be reported.

See Basic Manual for instructions when applying Work Study Program Codes.

Non-Ratable Statistical Codes. Refer to II. E. Exposure Amount of this section.

Statistical Code 0771—Explosives or Ammunition Mfg NOC & Drivers

Statistical Code 7445—Air Carrier Scheduled or Supplemental: Flying Crew

Statistical Code 7453—Aircraft or Helicopter Operation: Air Carrier Commuter – Flying Crew.

Apprenticeship Credit Program – **Statistical Code 9777** – effective 10-1-18 applicable to new, renewal and outstanding policies. Does not apply to policies cancelled or expired prior to 10-1-18. Refer to [Circular Letter 3166 – September 28, 2017](#).

Statistical code 0012 – Paid Furloughed Workers During A Governmental Emergency Order Impacting Employment. Refer to [Circular Letter 3209 – March 30, 2020](#).

c. Non-Standard Premium Codes—not included in the Total Standard Premium Premium Discount—Statistical Code 0063 or 0064. If premium discount is applied, the total amount of the discount shall be assigned to **Statistical Code 0063** for Type A carrier discount plan or **Statistical Code 0064** for Type B carrier discount plan. Do not include the premium discount in the Standard Premium Total.

Expense Constant—**Statistical Code 0900**. On each policy where an expense constant has been charged, the amount so charged shall be assigned to **Statistical Code 0900** for all industry groups. Do not include the expense constant in the Standard Premium Total.

Terrorism Risk Insurance Act (TRIA)—**Statistical Code 9740**. On each policy where a premium is charged for TRIA, the amount charged shall be assigned to **Statistical Code 9740**. Do not include the premium in the Standard Premium Total Amount.

Code 9740 Catastrophe Provisions for Terrorism—Not Part of Standard Premium (TRIPRA). Refer to [Circular Letter 3031—July 22, 2008](#).

Domestic Terrorism and Earthquake Coverage (DTEC)—**Statistical Code 9741**.

On each policy where a premium is charged for DTEC, the amount charged shall be assigned to **Statistical Code 9741**. Do not include the premium in the Total Standard Premium. Code 9741 Catastrophe Provisions for Catastrophe (other than Certified Acts of Terrorism). Refer to [Circular Letter 3031—July 22, 2008](#).

Code 9757 Audit Non-Compliance Charge Refer to [Circular Letter 3134—March 18, 2016](#).

F. Loss Record Data Elements and Definitions

Accident Date

Report the month, day and year on which the injury occurred.

In cases involving disease, the claim shall be assigned to the policy in force at the time the data provider became aware of the claim. In the event the data provider no longer insures the risk, the claim shall be assigned to the last policy issued by the data provider. The selected and indicated date of accident shall fall within the policy period, and not beyond the last full date of coverage.

Catastrophe Number

Any accident resulting in two or more reported claims must be reported as a catastrophe. In reporting catastrophes, all claims (compensable as well as non-compensable) resulting from this accident shall be designated by placing the numeral "01" in the field captioned Catastrophe Number. If there is more than one catastrophe under the policy, each succeeding catastrophe should be designated by means of a separate serial number "02", "03", etc. A separate series of catastrophe numbers shall be used for each policy. Catastrophe codes 01-10 have been reserved for reporting all non-Extraordinary Loss_Event (ELE) catastrophes.

Extraordinary Loss Event Catastrophe Numbers

Catastrophe codes between 11 and 99 are assigned for each qualifying extraordinary loss event. This unique code provides the industry a standard for reporting associated losses and is used by the insurance industry to fulfill internal needs and bureau reporting purposes. The accident date range is based on each specific catastrophic event and is determined on a case-by-case basis.

Claim Count

Number of claims is reported as "1" for individually listed claims.

Claim Number

The number that uniquely identifies the claim excluding blanks, punctuation marks, and special characters. The complete claim number, including suffixes and prefixes, if used, must remain the same throughout the life of the claim.

For policies effective 12-31-11 and prior: At the option of the data provider, all other medical only claims may be listed individually or may be grouped by Manual classification and by type of injury within each Manual classification. The number of claims within each group shall be reported in the field captioned Claim Count. In counting the number of claims, claims closed without payment shall be omitted. If one or more claims within the group are open, such a group shall be considered open and revised experience shall be reported in accordance with the rules of this Plan. If the grouping option is elected, claims must be grouped separately according to loss conditions codes as designated in section III. C.4. For policies with an effective date prior to 1-1-99, it was permissible to group indemnity claims under \$2,000 using the above criteria.

For policies effective 1-1-12 and after, the grouped claim reporting option is no longer a reporting option. All claims must be listed individually with the appropriate claim number.

Claim/Status Code

The code that indicates the status of the claim. (Refer to section III. C.3 for list of Claim/Status Codes.)

Classification Code

The classification code number to which the claim has been assigned. Report the code corresponding to the insured's classification determined according to the classification rules of the Bureau. No claims may be assigned to any classification unless premium also has been reported for that class.

Injury Code (Injury Type)

The code that identifies under which provision of the law benefits are paid or expected to be paid.

Death Cases Code—01

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

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

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

Permanent Total Disability Code—02

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Report as permanent total each claim which has been adjudged to constitute permanent total disability or which is defined as such under the law, or which in the judgment of the data provider will result in permanent total disability.

In general, permanent total disability includes cases involving the loss or loss of use of both hands, arms, feet, legs, eyes, or any combination of such members.

Temporary Total or Temporary Partial Disability Code—05

Report as temporary every case, which involves or is expected to involve indemnity benefits but which does not constitute a case of death, permanent total or permanent partial as defined in this section.

Medical Only Claims Code—06

When reporting claims involving medical losses only, make no entry in the field captioned indemnity and report the medical amount with the appropriate injury type code and classification code.

Permanent Partial Disability Code—09

A permanent partial loss is defined as:

- Any permanent injury which does not involve permanent total disability.
- Any temporary injury which satisfies any one of the following criteria:

The duration of disability benefits exceeds or is expected to exceed one full year. No loss is to be reported as temporary total if the duration of total disability exceeds or is expected to exceed 52 weeks.

A lump sum settlement is made or, in the judgment of the data provider, will be required to settle future benefits.

The extent of liability for future payments cannot be determined. The amount reported as indemnity incurred shall include specific benefits and compensation for temporary disability as well as loss of earning capacity.

NOTE: For ALAE only claims, report the injury code used to set up the claim's reserve. If there was no reserve, report Injury Code 06- Medical Only Claims Code.

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

The whole dollar amount of loss adjustment expense allocated and paid or reserved for the claim as of the loss valuation.

Incurred Indemnity Amount

The whole dollar amount of incurred indemnity as of the loss valuation. The loss consists of all paid and outstanding reserve benefits due to an employee's lost wages or inability to work, including compensation paid to the deceased prior to death, burial expenses, claimant's attorney fees, vocational rehabilitation benefits, payments to the state, and employers liability losses and expenses.

NOTE: Allocated Loss Adjustment Expenses for other than Employers Liability coverage must be excluded from indemnity losses.

Incurred Medical Amount

The whole dollar amount of incurred medical as of the loss valuation date. These losses consist of all paid and outstanding reserve benefits.

Injury Description Codes

The codes that represent the part of body, nature of injury, and cause of injury for a given claim. The codes are published on the [WCIO website](#).

Jurisdiction State Code

The 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 different from the exposure state.

Loss Condition Codes

The code for each loss condition. (Refer to section III. C.4 for list of Loss Condition Codes.)

Lump Sum Indicator

The code that indicates the inclusion of a lump sum settlement in the losses. (Refer to section III. C.6 for list of Lump Sum Indicators.)

Managed Care Organization Type Code)

The type of organization that will administer the applicable medical losses of a claim. (Refer to section III. C.7 for list of Managed Care Organization Type Codes.)

Paid Allocated Loss Adjustment Expense (ALAE) Amount

The whole dollar amount of loss adjustment expense allocated and paid for this claim as of the loss valuation date.

Paid Indemnity Amount

The whole dollar amount of paid indemnity loss for the claim as of the loss valuation date. The loss consists of all paid benefits due to an employee's lost wage or inability to work, including compensation paid to a deceased prior to death, burial expense, claimant's attorney fees, vocational rehabilitation benefits, payments to the state, and employers liability losses and expenses.

Paid Medical Amount

The whole dollar amount of paid medical for the claim as of the loss valuation date.

Update Type Codes

The code that identifies the activity of a loss record. (Refer to section III. C.1 for list of Update Type Codes.)

Vocational Rehabilitation Indicator

The code that indicates the inclusion of vocational rehabilitation costs in the losses. (Refer to section III. C.5 for list of Vocational Rehabilitation Indicators.)

G. Total Record Data Elements and Definitions Claim Count Total

The sum total number of claims reported for the state within the policy. In the case of corrections and subsequent reports, this must be the revised total. Individually listed claims count as "1".

Exposure—Payroll Total

The sum of all dollar value exposures to be included in standard exposure. In those cases where correction reports are being reported the Exposure—Payroll Total amount shall be the revised total amounts.

Incurred Allocated Loss Adjustment Expense (ALAE) Amount Total

(Optional) The sum total of the incurred ALAE amounts reported. In the case of corrections and subsequent reports, this must be the revised total.

Incurred Indemnity Amount Total

The sum total of the incurred indemnity amounts reported. In the case of corrections and subsequent reports, this must be the revised total.

Incurred Medical Amount Total

The sum total of the incurred medical amounts reported. In the case of corrections and subsequent reports, this must be the revised total.

Paid Indemnity Amount Total

The sum total of the paid indemnity amounts reported. In the case of corrections and subsequent reports, this must be the revised total.

Paid Medical Amount Total

The sum total of the paid medical amounts reported. In the case of corrections and subsequent reports, this must be the revised total.

Paid Allocated Loss Adjustment Expense (ALAE) Amount Total

The sum of the total paid ALAE amounts reported. In the case of corrections and subsequent reports, this must be the revised total.

Standard Premium Total

The sum of all premium dollars, both subject and not subject to modification, which are to be included in standard premium. In those cases where correction reports are being reported the Standard Premium Total amount shall be the revised total amounts.

Subject Premium Total

The sum total of the Exposure Record's Premium Amount fields that are subject to experience modification. In those cases where correction reports are being reported the Subject Premium Total amount shall be the revised total amounts.

Records In Unit Report Total

The total number of records including the unit total record reported for the unit report

H. Correction Reports**1. When Required**

Correction reports must be filed whenever a revision is necessary to update a previously filed report. Correction reports must be filed as soon as the changes are known.

a. Exposure Corrections. A correction of an exposure report must be filed when any of the following occur:

- (1) A final audit has been made of previously reported estimated exposures.
- (2) A clerical error in a classification, exposure amount, premium amount, or experience modification has been discovered.
- (3) The experience modification has been revised.
- (4) The exposure of the claimant has been reassigned to another classification through the revision of an audit.

- (5) Any other adjustment affecting a classification, exposure amount, or premium amount.
- b. Loss Corrections. A correction of a loss report must also be filed when any of the following occur between valuation dates.
- (1) Loss values are found to have been included or excluded through a mistake other than error of judgment.
 - (2) One or more claims are declared non-compensable as defined in section III. D.4.d of the [Experience Rating Plan Manual](#). When reporting non compensable claims, the indemnity and medical amounts must be reported as zero. Expense dollars may be reported.
 - (3) The carrier has obtained a subrogation recovery in an action against a third party or has received, or anticipates receiving, reimbursement from the Second Injury Fund.
 - (4) A clerical error in either the classification assignment or the injury code assignment of a given claim has been discovered.
 - (5) The determination of an aggravated inequity as defined in section III, D.4.f of the [Experience Rating Plan Manual](#).

NOTE: Correction reports shall NOT be filed to revise values because of developments in the claim amounts and/or injury type between two valuation dates except in cases involving an aggravated inequity.

2. Method of Reporting

a. Header Information

- (1) Report number, carrier code, policy number, effective date, and expiration date may be changed via the correction process.
- (2) When correcting header information data elements, all required policy information, including data not changing, MUST BE reported.

- b. When changing the policy conditions, policy type ID, or expiration date, only the revised data shall be reported.

c. Exposure Information

- (1) Exposures. When there is a change in any of the data previously reported for a particular classification code, the corrected report shall include all of the data previously reported for the Classification Code (indicated by the Update Type Code "P"), as well as all of the data, including those data which do not change, on a corrected basis (indicated by the Update Type Code "R").

In the case of split period reports, both the changed and unchanged data must always be reported for all split periods.

- (2) Experience Modification. If the exposure does not change but the risk total standard premium previously reported is revised due solely to a change in the experience modification, it shall be necessary to submit a revised report showing only each item affected by the modification change on a previously reported and revised basis. Premiums by Classification are not required.

In the case of split periods, only report the previous and revised data elements changing.

- (3) Statistical Codes. Revised values for applicable statistical codes (e.g., premium discount, flat increase on outstanding policies) as a result of changes in exposure information must also be reported. The corrected report shall include all of the data previously reported for the statistical code (indicated by the Update Type Code "P"), as well as all of the data, on a corrected basis (indicated by the Update Type Code "R").
- d. Loss Information. When there is a change in any of the data previously reported for a particular claim number, the corrected report shall include all of the data previously reported for the claim record (indicated by the Update Type Code "P"), and all of the revised data, including the data which does not change, on a corrected basis (indicated by the Update Type Code "R").
- e. Total Information. Report the revised risk totals resulting from any changes to the exposure and/or loss information.

3. Procedure for Correction of Unit Reports after Subsequent Reports have been Filed

When submitting a correction to a unit report for which a subsequent report has been filed, it is also necessary to submit a correction report for each associated unit report with a higher report level.

I. Replacement Reports

Carriers reporting directly with WCRB have the option of filing a replacement report for any unit report in a rejected status.

The data provider is to report an "R" in the Replacement Report Code field to identify a Replacement Report being submitted in response to a unit report that has been rejected by WCRB. The "R" is to be reported in the header record for any report that is being replaced.

This filing option applies only to carriers approved to file directly with WCRB.

III. CODES (Applicable in Wisconsin)

A. Codes Common to Premium and Losses

1. Report Level Code/Report Number and Valuation Date

<u>Code</u>	<u>Description</u>
1	Valued 18 months after the policy effective month
2	Valued 30 months after the policy effective month
3	Valued 42 months after the policy effective month
4	Valued 54 months after the policy effective month
5	Valued 66 months after the policy effective month
6	Valued 78 months after the policy effective month
7	Valued 90 months after the policy effective month
8	Valued 102 months after the policy effective month
9	Valued 114 months after the policy effective month
10	Valued 126 months after the policy effective month

2. Correction Type Codes

<u>Code</u>	<u>Description</u>
H	Header Record Correction
E	Exposure Record Correction
L	Loss Record Correction
T	Total Record Correction
M	Multiple Record Corrections
A	Loss Record Correction Due to Aggravated Inequity

3. Exposure State Code

The following state code number must be used. Wisconsin—
48

4. Policy Type ID Codes

Type of Coverage ID Code

<u>Code</u>	<u>Description</u>
01	Standard Worker's Compensation Policy
05	Large Risk Rated Option

NOTE: Report code 05 on Large Risk Alternative Rating Option Program policies.

Type of Plan Indicator ID Code

<u>Code</u>	<u>Description</u>
1	Voluntary Policy
2	Normal Assigned Risk Policy

Type of Non-Standard Type ID Code

<u>Code</u>	<u>Description</u>
01	Non-Standard Code Does Not Apply

5. Policy Conditions Indicators

- 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 Rated 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 result of the audit.
 - "U" = Insured has not responded to request for audited data and has been deemed uncooperative. Exposures expressed on unit report are estimated.
- e. Retrospective Rated Indicator
 - "Y" = Policy is retrospective rated. "N"
 - = Policy is not retrospective rated.
- f. Canceled Mid-Term Indicator
 - "Y" = Policy has been canceled mid-term.
 - "N" = Policy has not been canceled mid-term.
- g. MCO Indicator
 - "Y" = Policy has provisions for the administration of losses under an approved managed care organization.
 - "N" = Policy does not have provisions for the administration of losses by an approved managed care organization.

6. BEEP Use Edit Bypass Code

<u>Code</u>	<u>Description</u>
F	Forced leave
Blank	No edit bypass

7. ASWG Unit Format Submission Code

<u>Code</u>	<u>Description</u>
A	ASWG Format

B. Exposure Information Codes

1. Update Type Code

<u>Code</u>	<u>Description</u>
P	Previously Reported
R	Revised

2. Exposure Act/Exposure Coverage Code

<u>Code</u>	<u>Description</u>
0	For Use with Statistical Codes
1	State or Federal Act, excluding USL&HW and Federal Mine Safety and Health Act (Act)
2	USL&HW"F" or USL&H coverage on Non "F" classes
3	Coverage under the Federal Mine Safety and Health Act (Act) only
4	Coverage under the Federal Mine Safety and Health Act (Act) and the State Act

3. Premium Statistical Codes

a. Premium Subject to Experience Modification Factor

(1) Premium for Increased Limits
Table for Increased Limits

<u>Limits of Liability</u> <u>(000's omitted)</u>	<u>Codes</u>
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
All other increased limits	9837

(2) Premium for Increased Limits—Admiralty or FELA

<u>Limits of Liability</u>	<u>Codes</u>
\$50,000	9817
\$100,000	9818
\$200,000	9819
\$300,000	9820
\$400,000	9821
\$500,000	9822
Over \$500,000	9840

- (3) Amount Required to Balance Increased Limits Minimum Premium—**Code 9848**
- (4) Additional Premium from Flat Increase on Outstanding Policies—**Code 0998**
- (5) Premium Credit Resulting From Flat Decrease on Outstanding Policies—**Code 0994**
- (6) Short rate penalty premium—**Code 0931**
- (7) Waiver of Subrogation—**Code 0930**
- (8) Work Study Programs—**Code 9428**

b. Premium Not Subject to Experience Modification Factor

- (1) Aircraft Seat Surcharge—**Code 9108**
NOTE: The passenger seat surcharge is not applicable for policies effective January 1, 2015 and subsequent.
- (2) Risk Minimum Premium—**Code 0990**
See Basic Manual for instructions when applying **Code 0990**.
- (3) Contractors Premium Credit—**Code 9046**
- (4) Optional Supplemental Loadings
For Radiation Experience—**Code 9985**
- (5) Non-Ratable Statistical
Codes: For Class 4771—
Code 0771 For Class 7405—
Code 7445 For Class 7431—
Code 7453
- (6) Waiver of Subrogation—**Code 9115**
- (7) Additional premium required to balance to minimum for Admiralty and/or FELA increased limits—**Code 9849**
- (8) Work Study Programs
For policies effective 10-1-13 and subsequent: Secondary Schools—
Code 9428
Post Secondary Schools—**Code 9447**
- (9) Apprenticeship Credit Program—**Code 9777**
- (10) Paid Furloughed Workers During A Governmental Emergency Order Impacting Employment—**Code 0012**

c. Non-Standard Premium Codes:

- Expense Constant **Code 0900**
- Premium Discount—Type A **Code 0063**
- Premium Discount—Type B **Code 0064**
- TRIA **Code 9740**
- Catastrophe Provisions for Terrorism-Not Part of Standard Premium
DTEC **Code 9741**
- Catastrophe Provisions for Catastrophe (other than Certified Acts of Terrorism)
ANC **Code 9757**
- Audit Non-Compliance Charge

C. Loss Information Codes

1. Update Type

<u>Code</u>	<u>Description</u>
P	Previously Reported
R	Revised

2. Injury Code (Injury Type)

<u>Code</u>	<u>Description</u>
1	Death
2	Permanent Total Disability
5	Temporary Total or Temporary Partial Disability
6	Medical Only Claims
09	Permanent Partial Disability

3. Claim/Status Code

<u>Code</u>	<u>Description</u>
0	Open
1	Closed

4. Loss Condition Codes

Loss Coverage Act

<u>Code</u>	<u>Description</u>
1	State or Federal Act, excluding USL&H and Federal Mine Safety and Health Act (Act)
2	USL&H"F" or USL&H coverage on Non "F" classes
3	Coverage under the Federal Mine Safety and Health Act (Act) only
4	Coverage under the Federal Mine Safety and Health Act (Act) and the State Act

Type of Loss

<u>Code</u>	<u>Description</u>
1	Trauma
2	Occupational Disease (OD)
3	Cumulative Injury other than Disease

Type of Recovery

<u>Code</u>	<u>Description</u>
1	No Recovery
2	Second Injury Only
3	Subrogation Only (Third Party)
4	Subrogation with Second Injury

Type of Claim

<u>Code</u>	<u>Description</u>
01	Worker's Compensation Only
03	Worker's Compensation & Employers' Liability

Type of Settlement

<u>Code</u>	<u>Description</u>
00	Claim Not Subject to Settlement
3	Stipulated Award (Carrier/Claimant Settlement)
4	Findings and Award (Judicial Award)
5	Dismissal (Non-Compensable)
6	Compromise Settlement
09	All Other Settlements

5. Vocational Rehabilitation Indicator

<u>Code</u>	<u>Description</u>
Y	Claim includes Vocational Rehabilitation Costs
N	Claim does not include Vocational Rehabilitation Costs

6. Lump Sum Indicator

<u>Code</u>	<u>Description</u>
Y	Claim was settled by Lump Sum
N	Claim was not settled by Lump Sum

7. Managed Care Organization Type Code

<u>Code</u>	<u>Description</u>
0	MCO is not applicable
1	MCO is applicable
2	Medical Losses are administrated by HMO
3	Medical Losses are administrated by PPO
4	Medical Losses are administrated by EPO
5	Medical Losses are administrated by IPA

IV. GLOSSARY

Assigned Risk Plan—Plan ID

The insured was unable to secure a worker's compensation insurance policy in the voluntary market and obtains coverage under the Worker's Compensation Assigned Risk Plan.

Bureau Rates

All parameters filed by the Bureau and approved by the Wisconsin Insurance Commissioner and which are used mandatorily for purpose of pricing worker's compensation and employers liability coverages. Such Bureau rates include experience rating plan values such as Expected Loss Factors, Credibility, Maximum Value of One Accident, and Credibility Weighted Maximum Value Charge, retrospective rating plan values such as the Expected Loss Ranges, Excess Loss Pure Premium Factors, Retrospective Pure Premium Development Factors, and expense parameters applicable to USL&HW coverages such as Premium Discounts, Expected Loss Ratio, Expense Ratios, Tax Multipliers and Loss Conversion Factors.

Contractor's Premium Adjustment Program

The Contractor's Premium Adjustment Program (CPAP) provides for premium credit for a qualifying policy which contains one or more contracting classifications and which has at least 50% of its exposure in the contracting classifications. If an applicant does not have more than 50% of its payroll in contracting classes, but does have more than 50% of its estimated annual premium in contracting classes, it will also be deemed eligible for the program.

Cumulative Injury

An injury which results in a disability or death and is not traceable to a definite compensable accident occurring during the employees present or past employment. The injury is understood to have occurred from and has been aggravated by an employment-related repetitive (physical or mental) activity. For example, a cement mason, carpet installer or tile man presents a claim for injury to the knee caused by repetitive bending and kneeling on the job.

Employers Liability

If an injured employee is not covered under any worker's compensation law, he or she may seek recovery by suing the employer under employers liability.

Expense Constant

A premium charge which may apply to a policy in addition to the premium. The expense constant covers expenses such as issuing, recording, and auditing, which are common to all worker's compensation policies regardless of size.

Expenses—Excluded from Losses

Expenses must be excluded from losses except as noted below. Medical or legal expenses incurred for the benefit of the data provider shall be treated as loss adjustment expense. For expenses developed for the benefit of the claimant, refer to **Expenses—Included in Losses**.

- a. Allocated Loss Adjustment Expenses. Allocated Loss Adjustment Expenses encompass the following costs of a data provider, which can be directly allocated to a particular claim:

- (1) Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside or staff representative.
 - (2) Court, Alternate Dispute Resolution and other specific items of expense such as:
 - Medical examinations of a claimant to determine the extent of the liability, degree of permanency or length of disability,
 - Expert medical or other testimony,
 - Autopsy,
 - Witnesses and summonses,
 - Copies of documents such as birth and death certificates, medical treatment records,
 - Arbitration fees,
 - Surveillance,
 - Appeal bond costs and appeal filing fees.
 - (3) Medical cost containment expenses incurred with respect to a particular claim, whether by an outside vendor or done internally by an employee 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, medical or vocational rehabilitation vendor bills.
 - Hospital and other treatment utilization reviews, including pre-certification/pre-admission, concurrent or retrospective reviews.
 - Preferred provider network/organization expenses.
 - Medical fee review panel expenses.
 - (4) Expenses which are not defined as losses and are directly related to and directly allocated to the handling of a particular claim for services which are required to be performed by statute or regulation.
- b. Unallocated Loss Adjustment Expenses. Unallocated Loss Adjustment Expenses are loss adjustment expenses that are not defined above. These include but are not limited to:
- (1) Data provider employees' salaries, overhead and traveling expenses which are considered loss adjustment expense and are not incurred while doing activities previously listed as allocated expenses.
 - (2) Fees paid to independent claims professionals or attorneys (hired to perform the function of claim investigation normally performed by claim adjusters), for developing and investigating a claim so that a determination can be made of the cause, extent of responsibility for the injury or disease, including evaluation and settlement of covered claims.

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 data provider is required to produce for the benefit of the claimant, shall be reported as either an indemnity or medical loss depending upon the nature of the expense.
- b. Employers Liability Loss Adjustment Expenses—Indemnity. Employers' liability losses include allocated loss adjustment expenses as defined above. The entire amount of losses and allocated loss adjustment expenses shall be reported as incurred losses on the unit report.
- c. Impartial Examinations by Industrial Board—Medical. Expenses for impartial examinations ordered by an industrial board are to be considered as incurred losses and reported on the unit report.
- d. Awards. When an award to a claimant includes the cost of witness fees, attorney fees and other court costs, the amount so awarded shall be considered as part of the cost of benefit and shall be included with the indemnity reported. With respect to claims brought by persons against whom an employee has brought a third party common law action, such special costs shall be reported as an indemnity loss whether or not a recovery is made against the third party by the employee.
- e. Vocational Rehabilitation Evaluation/Testing Expense. Evaluation expenses (which are defined as costs incurred in testing and evaluating the claimant's ability, aptitude or attitude in determining suitability for vocational rehabilitation or placement) shall be reported as incurred indemnity loss if such evaluation services are purchased from outside vendors.

Evaluation expenses incurred by data provider personnel may be reported as incurred loss if such expenses are related to the activities of individuals (other than claims supervisors or claims adjusters engaged in efforts to return an injured worker to gainful employment) that, at a minimum, satisfy the qualifications established by the state having jurisdiction over a particular claim.

- f. Physical Rehabilitation Expenses. Expenses incurred by the data provider due to the purchase of physical rehabilitation services from outside vendors shall be reported as incurred medical loss.

Expenses incurred by the data provider for physical rehabilitation activities listed below may be included in Incurred losses if performed by data provider personnel (other than claims supervisors and claims adjusters engaged in efforts to return an injured worker to gainful employment) who are medically trained:

- (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 claimant's medical condition.

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

For such expenses associated with the above, the data provider personnel performing the activities must be trained in one of the following:

- physicians
- licensed registered nurses
- licensed speech therapists
- registered physical therapists
- dentists and dental technicians
- occupational therapists
- chiropractors
- podiatrists
- licensed physician assistants
- licensed cardio-pulmonary technicians

Experience Modification

A factor used to modify the computed premium based on an insured's payroll and loss record. The modification factor is determined by comparing actual losses to expected losses, and can be a debit (>1.00) or a credit (<1.00).

Exposure

The extent of exposure to loss as measured by payroll, or, for per capita classes, number of employees per year.

Exposure Coverage Act - Loss Conditions—Loss Coverage Act

- a. State Act. Coverage benefits paid to employees or injured workers as the result of a workplace accident under State Worker's Compensation Law or Federal Compensation Laws.
- b. USL&HW"F" or Non "F". Coverage for benefits paid to employees or injured workers as the result of a workplace accident under the United States Longshore and Harbor Worker's Compensation Act.
- c. Federal Mine Safety and Health Act (Act) Only. Coverage for benefits paid to employees or injured workers as the result of a workplace accident under the Federal Mine Safety and Health Act (Act).
- d. Federal Mine Safety and Health Act (Act) and the State Act. Coverage for benefits paid to employees or injured workers as the result of a workplace accident under both Federal Mine Safety and Health Act (Act) and the State Act.

Jurisdiction State

The governing state that will administer the claim, and whose statute will apply to the claim adjustment process when that state is different from the exposure state.

Loss Ratio

The ratio of losses to premiums.

Lump Sum

A claim settled by the agreement of the insurer and claimant to redeem the liability for compensation by payment from insurer to the claimant of a specified amount representing a discounted or commuted value of a specific award or benefit.

Managed Care Organization

- a. HMO. The claim will be administered by an HMO (Health Maintenance Organization). Generally restricts employee's choice of health care providers in exchange for reduced out-of-pocket costs and more extensive preventive care. Generally requires only minimal co-payments and no deductibles. Directs patients to a network of providers and requires authorization for many specialist and hospital services.
- b. PPO. The claim will be administered by a PPO (Preferred Provider Organization). Retains many elements of indemnity plans, but provides employees with a choice of whether or not to use managed care network providers. Financial incentives are offered for those who receive care from providers selected by employers or insurers.
- c. EPO. The claim will be administered by an EPO (Exclusive Provider Organization). A network where coverage is confined to the provider network. If enrollees go outside of the network for care, they get no reimbursement.
- d. IPA. The claim will be administered by an IPA (Individual Practice Association). A network of individual physicians who also serve non-network patients covered by other insurance. An IPA's contract with a large number of physicians and enrollees represent only a small portion of physicians' practices.

Manual Rate

The amount per unit of exposure charged for Worker's Compensation and Employers Liability Insurance.

Minimum Premium

The lowest premium amount for which a single risk can be insured for a policy period. Minimum premiums are not subject to experience modifications.

Non-Ratable Element

A portion of the rating value which is not subject to experience or retrospective rating.

Occupational Disease Loss

Occupational Disease Loss is any abnormal condition resulting in disability or death, which is not traceable to a definite compensable accident occurring during the employee's present or past employment. The injury is understood to have been caused by repeated exposure extending over a period of time to a disease producing agent or agents present in the worker's occupational environment. For example, a granite worker presents a claim for the occupational disease of silicosis due to exposure to the disease agent silica.

Per Capita

One employee working for one year. For example, an employee working for one year is insured for 1.0-year. An employee working for nine months is insured for 0.8 years.

Per Capita Classification

A classification where the exposure base is the number of employees rather than payroll.

Premium Discount

For policies with a Standard Premium Total Amount in excess of a specified amount, the premium discount recognizes that the relative expense of issuing and servicing larger premium policies is less than for smaller premium policies.

Provision for Claim Payment

Historical aggregate losses projected through development to their ultimate value and through trending to a future point in time, but excluding all loss adjustment or claim management expenses, other operating expenses, assessments, taxes, and profit or contingency allowances.

Rating Value

A parameter or number used in pricing worker's compensation or Employers Liability Insurance coverages. Rates will be established by the Bureau.

Reinsurance

Acceptance by an insurer (called a reinsurer) of all or part of the risk of loss of another insurer.

Risk ID#

The identification number assigned to the risk by the bureau issuing the experience rating.

Second Injury Fund

The Second Injury Fund is a trust established to reimburse carriers when a subsequent injury is caused by, or made substantially greater due to the combined effects of physical impairment, or previous accident, disease or congenital condition.

Standard Type of Coverage

Coverage contemplated by the manual rate and classification to which the exposure has been assigned under the provisions of the Worker's Compensation and Employer's Liability policy.

Subrogation

A recovery action in which losses incurred by a carrier due to the injury of an employee are reimbursed either in part or in whole by a third party deemed primarily responsible for the injury.

Subsequent Report

A report that updates the loss information and is filed as of the second, through tenth valuation dates. (Refer to section III., A.1. for valuation dates.)

Supplemental Non-Ratable Loading

A supplement to be added to the rating value for certain risks within a classification which have a hazard not shared by all members of the classification. The supplemental loading is not subject to experience or retrospective rating.

Type of Claim—Loss Conditions

- a. Worker's Compensation Only. The entire loss is incurred under provisions of Part I of the Worker's Compensation and Employers Liability Insurance Policy.
- b. Worker's Compensation and Employers Liability. The loss is incurred under provisions of both Part I and Part II of the Worker's Compensation and Employers Liability Insurance Policy.

Type of Loss—Loss Conditions

- a. Trauma. An injury caused by a work related accident.
- b. Cumulative Injury Other than Disease. An injury occurring from repetitive mental or physical traumatic activities extending over a period of time, the combined effect of which caused disability or need for medical treatment (other than disease).
- c. Occupational Disease. An abnormal condition or disorder other than a workplace injury caused by extended exposure to environmental factors associated with employment, including acute and chronic illness or disease caused by inhalation, absorption, ingestion or direct contact.

Type of Recovery—Loss Conditions

- a. Second Injury Fund Only. The data provider has received reimbursements from the Second Injury Fund. The Second Injury Fund is a trust established to reimburse data providers when a subsequent injury is caused by or made substantially greater due to the combined effects of physical impairment or previous accident, disease or congenital condition.
- b. Subrogation Only. The data provider has received reimbursements from an entity other than the employer with legal liability due to circumstances for the injury.
- c. Subrogation with Second Injury Fund. The data provider has received reimbursement from both the Second Injury Fund and a third party.
- d. Joint Coverage. Coverage furnished by other than the one policy for which experience is being reported is pertinent to a division of the total incurred loss. Such claims usually result from one of the following causes:
 - (1) The injured party has co-employers.
 - (2) Overlapping coverage on the same employer.

Type of Recovery—Loss Conditions, d. Joint Coverage (cont'd)

- (3) Injury developed over an extended period. When a data provider has determined that the loss is chargeable to two or more policies written by such data provider or when two or more data providers have accepted liability for a part of the total incurred loss, it shall be considered the equivalent of a determination by adjudication that the coverage furnished by other than the one policy for which experience is being reported is pertinent to the division of the total incurred loss.

Type of Settlement—Loss Conditions

- a. Stipulated Award (data provider/claimant settlement). An award which has been drawn up between the data provider and claimant and submitted to the worker's compensation appeals board for review.
- b. Findings and Award (judicial award). An award which has been issued by a judge based on evidence presented in the process of litigation.
- c. Dismissal or Take Nothing Non-Compensable. The claim will generate no payments or reserves due to one of the following:
 - (1) Official ruling denying benefits.
 - (2) Claimant's failure to file for benefits.
 - (3) Claimant's failure to prosecute claim following data provider's denial of the claim.
- d. Compromise and Release. A settlement over the issues of applicability, extent of injury, or future benefits.

Vocational Rehabilitation

Indemnity losses including non-medical services to restore a disabled employee to suitable employment. Such services may include vocational evaluation, counseling, education, work place modification and retraining, including on the job training for alternative employment with the same employer and job placement assistance. It shall also include reasonably necessary related expenses such as tuition, books, tools, transportation and additional living expenses.

V. SAMPLE FORMS

Form

Number

Description

FOE Form v1

[Filing Option Election Form](#)

VI. ELECTRONIC SUBMISSION

The Worker's Compensation Data Reporting Specifications Manual has been modified to provide for the Advisory Statistical Work Group (ASWG) changes. Wisconsin has adopted the Workers Compensation Insurance Organizations (WCIO) changes to WCSTAT. The Bureau requires electronic submissions. The WCIO Workers Compensation Data Reporting Specifications Manual is available on the WCIO website at www.wcio.org.

SUMMARY OF CHANGES—WI WORKERS COMP STAT PLAN MANUAL

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April 2024

Section	Field Name/Item	Reason for Update
I. Introduction	Bureau Correspondence	Changed “Manage USR” to “Manage Data”
II. Wisconsin Reporting Requirements	B. Header Data Elements and Definitions	Changed “Manage USR” to “Manage Data”

April 2021

Section	Field Name/Item	Reason for Update
II. Wisconsin Reporting Requirements	b. Premium Not Subject to Experience Modification	Corrected the identification of codes 9428 and 9447 from “Classification” to “Statistical”

March 17, 2020

Section	Field Name/Item	Reason for Update
II. Wisconsin Reporting Requirements	b. Premium Not Subject to Experience Modification	Paid Furloughed Workers During A Governmental Emergency Order Impacting Employment
III. Codes Applicable in Wisconsin	b. Premium Not Subject to Experience Modification Factor	Paid Furloughed Workers During A Governmental Emergency Order Impacting Employment

December 2017

Section	Field Name/Item	Reason for Update
II. Wisconsin Reporting Requirements	b. Premium Not Subject to Experience Modification	Apprenticeship Program reporting
III. Codes Applicable in Wisconsin	b. Premium Not Subject to Experience Modification Factor	Apprenticeship Program Reporting

March 2016

Section	Field Name/Item	Reason for Update
I. Introduction Page 11	<u>L. Estimated Audit</u>	New filing requirement.

II.E.1.c. Non-Standard Premium Codes Page 21	<u>Code 9757</u> Audit Noncompliance Charge	New filing requirement.
III.B.c. Premium Statistical Codes Non-Standard Premium Codes Page 31	Code 9757 Audit Noncompliance Charge	New filing requirement.

May 2015

Section	Field Name/Item	Reason for Update
I. Valuation table		Changed “date” to “month” to be consistent with reporting requirements.
II.B. Header Data Elements and Definitions	First Report	Changed “date” to “month” to be consistent with reporting requirements.
II.B. Header Data Elements and Definitions	Subsequent Reports	Changed “date” to “month” to be consistent with reporting requirements.
II.E.1.a. Premium Subject to Experience Modification	Statistical Code 0930	Added the reporting instruction for policies effective July 12, 2013 and current.
II.E.1.b. Premium Not Subject to Experience Modification	Statistical Code 9115	Added the reporting instruction for policies effective July 12, 2013 and current.
II. F. Injury Codes		Added a reporting note for ALAE only claims.
III.A.1 Report Level Code/Report Number and Valuation Date		Changed “date” to “month” to be consistent with reporting requirements.

May 2014

Section	Field Name/Item	Reason for Update
I. J. Loss Rules	5 Aircraft Operation Losses	Eliminated the Passenger Seat Surcharge on policies effective 1-1-15.
II. E. Exposure Record Data Elements and Definitions	Premium Amount	Eliminated the Passenger Seat Surcharge on policies effective 1-1-15.
II.E.1.b. Premium Not Subject to Experience Modification	Aircraft Operation— Passenger Seat Surcharge.	Eliminated the Passenger Seat Surcharge on policies effective 1-1-15.
III.B.2. Exposure Act/Exposure Coverage Code	Codes 01, 03, 04	Amended title to comply with the Federal Mine Safety and Health Act (Act).
III.B.3.b.(1) Premium Not Subject to Experience Modification	Aircraft Seat Surcharge-Code 9108	Eliminated the Passenger Seat Surcharge on policies effective 1-1-15.
III.C.4.b.(1) Loss Coverage Act	Codes 01, 03, 04	Amended title to comply with the Federal Mine Safety and Health Act (Act).

IV. Glossary	Exposure Coverage Act-Loss Conditions-Loss Coverage Act	Amended title to comply with the Federal Mine Safety and Health Act (Act).
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November 2013

Section	Field Name/Item	Reason for Update
INTRODUCTION	BUREAU CORRESPONDENCE	Removed the reference to the Unmatched Letter. This letter is no longer provided by WCRB.
GENERAL RULES/DEFINITIONS	A. Scope of Report Option 2	Updated the NCCI reporting instruction. They only accept electronic reports.
GENERAL RULES/DEFINITIONS	E. Radiation Exposure-Other Than Government Agency Atomic Energy Projects	Removed note. This code is applicable.
II.E.1.b. Premium Not Subject to Experience Modification	Aircraft Operation— Passenger Seat Surcharge.	Clarified reporting instruction.
II.E.1.b. Premium Not Subject to Experience Modification	Work-Study Program	Added a link to the circular announcement.
II.E.1.b. Premium Not Subject to Experience Modification	Non-Ratable Statistical Codes	Bolded the statistical codes.

December 2012

Section	Field Name/Item	Reason for Update
I.E. Radiation Exposure-Other Than Government Agency Atomic Energy Projects		Added a note. Classification code is no longer applicable as of 12-31-10.
II.1.b. Premium Not Subject to Experience Modification	Aircraft Operation—Passenger Seat Surcharge— Classification Code 9108	Corrected reporting instruction.
II.1.b. Premium Not Subject to Experience Modification	Work Study Programs	Effective 10-1-13, added class code phraseology and reporting instructions for Work Study Codes 9428 and 9447.
II. G. Total Record Data Elements and Definitions	Claim Count Total	Removed reference to grouped claims. Grouping of claims is no longer valid in WI.
II. H.1.b.(4) Correction Reports	Loss Corrections—Clerical Error	Removed reference to grouped claims. Grouping of claims is no longer valid in WI.
III.B.2. Exposure Act/ Exposure Coverage Codes		Added code 00 and phraseology. Inadvertently deleted on a prior version.
III.B.3.a.(8) Premium Statistical Codes	Work Study Program	Added code for existing program.
III.B.3.b.(8) Premium Statistical Codes	Work Study Programs	Effective 10-1-13, added class code phraseology and reporting instructions for Work Study Codes 9428 and 9447.

June 25, 2012

Section	Field Name / Item	Reason for Update
I. A. Scope of Report	Option 2	Removed NCCI's hard copy reporting instructions. Announced in Item filing U-1398.
II. E. Exposure Record Data Elements and Definitions	Hazard Class and Stat Codes	Corrected class code phraseology and deleted class 7327 from the list of applicable codes. Class 7327 does not have a matching stat code.
II.1.a. Premium Subject to Experience Modification	Aircraft Operation— Passenger Seat Surcharge—Classification Code 9108	Moved the reporting instructions for stat code 9108 to the list of stat codes that are not subject to experience modification.
II.1.b. Premium Not Subject to Experience Modification	Aircraft Operation— Passenger Seat Surcharge—Classification Code 9108	Moved the reporting instructions for stat code 9108 to the list of stat codes that are not subject to experience modification.
II.1.b. Premium Not Subject to Experience Modification	Non-Ratable Element Class and Stat Codes	Added the list of codes for the non-ratable element codes to the list of stat codes that are not subject to experience modification.
II. H.1.b.(2) Correction Reports	Loss Corrections—Non- Compensable Claims	Added wording to the reporting instructions for non-compensable claims. When reporting non-compensable claims, the indemnity and medical amounts must be reported as zero. Expense dollars may be reported. This amendment was made per the direction of the WCRB Governing Board.
III.B.3.b.(5) Exposure Information Codes	Premium Not Subject to Experience Modification Factor—Non-Ratable Statistical Codes	Corrected the name from Mandatory Supplemental Loadings to Non-Ratable Statistical Codes. Deleted class 7327 from the list of applicable codes. Class 7327 does not have a matching stat code.

June 11, 2012

Section	Field Name / Item	Reason for Update
II., E.	Reporting Instructions for Policies Where No Exposure Was Developed.	Updated the reporting instruction to provide clearer understanding of the reporting options available, and to include the types of codes allowable, when reporting "No Exposure" unit reports.

April 17, 2012

Section	Field Name / Item	Reason for Update
I.,A.	Option 1	Removed the reporting instruction that referenced the hard copy reporting. This reporting note is outdated.
II.,E.	Experience Modification Effective Date	Modified the reporting instruction and removed the reporting note to comply with the change announced in Circular Letter 1139, dated 12-28-11. Policies effective September 1, 2013, the note is no longer applicable.
II.,E.	Exposure Amount	Corrected an expired non-ratable class code.
II.,E.	Rate Effective Date	Modified the reporting instruction and removed the reporting note to comply with the change announced in Circular Letter 1139, dated 12-28-11. Policies effective September 1, 2013, the note is no longer applicable.
II.,E.,1.,a.	Premium Subject to Experience Modification	Carriers are reporting first reports for policies effective in 2010. This reporting note is outdated and has been removed.
II.,E.,1.,c.	Non-Standard Premium Codes	Carriers are reporting first reports for policies effective in 2010. The reporting note for TRIA and DTEC dates are outdated.
II.,F.	Claim Number	The removal of this text eliminates redundancy.
II.,F.	Injury Code (Injury Type) Medical Only Claims Code - 06	Removed the reporting instruction that referenced the governing class. This was an old reporting rule that was part of the grouped claim option. For policies effective 1-1-12 and after this reporting option is no longer applicable in WI.
II.,F.	Injury Description Codes	This reporting note is outdated.
II.,F.	Lump Sum Indicator	This reporting note is outdated.
II.,F.	Managed Care Organization Type Code	This reporting note is outdated.
III.,A.,4.	Policy Type ID Codes / Type of Coverage ID Code	Added a reporting note to clarify that code 05 should be reported for the Large Risk Alternative Rating Plans (LRARO).
III.,A.,5.,g.	Managed Care Organization Type Code	This reporting note is outdated.
III.,B.,3.,b.	Non-Ratable Class Code	Corrected the expired class code.
III.,B.,3.,c.	Non-Standard Premium Codes	These reporting notes are redundant.
III.,C.,7.	Managed Care Organization Type Code	This reporting note is outdated.

July 29, 2011

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Section	Field Name/Item	Reason for Update
III.,A.,4.	Policy Type ID Codes/ Type of Coverage ID Code	Added code 05 for identifying Large Risk Alternative Rating Plan (LRARO).

March 24, 2011

Section	Field Name/Item	Reason for Update
I. Bureau Correspondence	Estimated Unit Report Letter	Updated the data element name to coincide with the WCIO Data Specifications Manual change.
I.,J.,4.	Subrogation Claims	Added a reporting instruction to clarify the reporting procedure.
II.,A.,2.	Estimated Audits	Updated the data element name to coincide with the WCIO Data Specifications Manual change.
II.,F.	Loss Record Data Elements and Definitions: Accident Date	Updated the reporting instruction to remove the reference to grouped claims.
II.,F.	Loss Record Data Elements and Definitions: Claim Count	Updated the reporting instruction to remove the reference to grouped claims.
II.,F.	Loss Record Data Elements and Definitions: Claim Number	Updated the reporting instruction to remove the reporting option for grouped claims.
III.,A.,5.	Estimated Audit Code	<ul style="list-style-type: none"> Updated the data element name to coincide with the WCIO Data Specifications Manual change. Added code "U" for designation of uncooperative insured.
III.,B.	Exposure Information Codes 3. Premium Statistical Codes	<ul style="list-style-type: none"> Corrected reference for stat code 9849 to show as a Premium Not Subject to Experience Modification Factor code. Corrected class and stat codes for Mandatory Supplemental Loadings.
III.,C.	Loss Condition Codes 4. Type of Claim	Corrected data element name.
Glossary	Type of Claim—Loss Conditions	Corrected data element name.

February 26, 2010

Section	Field Name / Item	Reason for Update
II.,F.	Loss Record Data Elements and Definitions; Catastrophe Number	Added reporting instructions for Extraordinary Loss Events. Removed reference to individual ELEs.