Instructions
Call for Direct California Workers' Compensation

Annual Call For Direct California Workers' Compensation
Aggregate Indemnity and Medical Costs (CA-IM-20xx)

FOR ALL PARTS OF THIS CALL, information reported must be in accordance with the following:

a) All data reported on this call must be on a calendar year basis, which means that premiums and losses from all transactions that occurred during year xx must be included, regardless of the effective year of policies or year of accident of claims involved.

b) Include experience (premium and losses) from:
- Deductible policies on a gross (first dollar) basis
- Standard workers' compensation policies
- Employers liability increased limits
- Minimum premiums
- Salvage and subrogation

c) Exclude experience (premium and losses) from:
- Ceded reinsurance
- Reinsurance assumed
- Excess insurance
- USL&H insurance
- Private residence employee insurance
- National Defense Project insurance

d) Earned Premium (line 1 on Page 1 of this Call) must be identical to the earned premium reported on Part b, Column (1) Total of Section III, Calendar Year Exhibit of the Call for Direct California Workers' Compensation Experience, Fourth Quarter of Calendar Year 20xx (CA-QT-4Qxx). (Please refer to the definition of "Final Premium" in Part 4, Section II of the *California Workers' Compensation Uniform Statistical Reporting Plan – 1995* (USRP), available on the WCIRB website at http://www.wcirb.com/document/123, for a more detailed definition of premium to be reported to the WCIRB.)

e) Earned but not billed or booked (EBUB) premium must be included in Earned Premium.

f) Exclude the impact of the following items from all reported premiums:
- Application of any deductible credits
- Application of any retrospective rating plan adjustments
- California Insurance Guarantee Association (CIGA) assessments
- California Workers' Compensation Revolving Fund assessments
- California Workers' Compensation fraud surcharges
- Uninsured Employers Trust Fund Assessment
- Subsequent Injuries Benefits Trust Fund Assessment
- Occupational Safety & Health Fund assessments
- Labor Enforcement & Compliance Fund assessments
- Any charge for terrorism coverage pursuant to the Terrorism Risk Insurance Act of 2002 as amended by the Terrorism Risk Insurance Extension Act of 2005, or the Terrorism Risk Insurance Program Reauthorization Act of 2007 and 2015.

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g) Insurers who are members of an affiliated group are encouraged to file on a combined group ("consolidated") basis. However, all members of the group must be individually listed. All data calls for the same evaluation period submitted to the WCIRB must be made under the same grouping structure. Any changes to the reporting group must be communicated to and approved by WCIRB prior to reporting data under the new grouping.

h) Use of the eSCAD® web-based application to submit data is highly encouraged. Insurers with access to the eSCAD® web-based application should submit this data call online via eSCAD®. Non-eSCAD submissions using only WCIRB forms and/or templates are permitted for insurers who do not yet have access to eSCAD®, subject to a $250 processing fee for each submission of this data call. For all non-eSCAD submissions: (i) reported amounts must be rounded to whole dollars; (ii) negative amounts must be displayed enclosed within parentheses; (iii) the horizontal and vertical totals must equal their corresponding sum of rounded details shown on the forms, not the rounded sum of actual details.

i) This data call is subject to the SCAD Program (program for Submission of California Aggregate Data). Refer to the SCAD Program effective July 1, 2010 for details. A comprehensive listing of the edits used to check the accuracy of submitted call data is available by clicking on the Help link in eSCAD.

For PART B (Paid Indemnity), information reported must be in accordance with the following:

a) "Payments for Death Benefits" must be reported payments for death benefits. It must include payments for burial allowance. Payments for temporary, permanent partial and/or permanent total benefits made prior to the death of the injured worker must be excluded. Portions of single sum settlements, which can be allocated to this benefit type, must be included.

b) "Payments for Permanent Total Benefits" must be reported payments for permanent total benefits. Payments for temporary, permanent partial and/or death benefits paid on a claim which had permanent total benefits paid must be excluded. Supplemental vocational rehabilitation maintenance allowances paid to claimants who elect to supplement vocational rehabilitation maintenance benefits by an advance from permanent disability benefits must be included. Portions of single sum settlements, which can be allocated to this benefit type, must be included.

c) "Payments for Permanent Partial Benefits" must be reported payments for permanent partial disability benefits. Payments for temporary, permanent total and/or death benefits paid on a claim which had permanent partial benefits paid must be excluded. Permanent partial benefits paid on death and permanent total claims must be included. Supplemental vocational rehabilitation maintenance allowances paid to claimants who elect to supplement vocational rehabilitation maintenance benefits by an advance from permanent disability benefits must be included. Portions of single sum settlements, which can be allocated to this benefit type, must also be included.

d) "Payments for Temporary Disability Benefits" must be reported payments for temporary disability benefits, including temporary disability benefits paid on claims which had death,

permanent total and/or permanent partial payments. Portions of single sum settlements, which can be allocated to this benefit type, must also be included.

e) "Payments for Vocational Rehabilitation Benefits" must include reported payments for all supplemental job displacement benefits issued in the form of vouchers as well as any additional vocational rehabilitation-type benefits (including those provided on a voluntary basis. (Please refer to the definitions of "Indemnity Loss(es)" and "Supplemental Job Displacement Benefit Voucher(s)" in Part 4, Section II of the California Workers' Compensation Uniform Statistical Reporting Plan – 1995 (USRP), available on the WCIRB website at http://www.wcirb.com/document/123, for ~~a~~ more detail~~sed definition of premium to be reported to the WCIRB~~.) Portions of single sum settlements, which can be allocated to this benefit type, must be included.

f) "Other Indemnity Payments" must include other indemnity items, such as payments for workers' compensation life pension benefits, claimants' legal expenses, defense expenses on employers' liability claims, and mileage reimbursements. Portions of single sum settlements, which can be allocated to this benefit type, must also be included.

g) "Single Sum Settlement Indemnity Payments" must be the amounts in indemnity benefits paid as single amounts and which cannot be allocated to a specific indemnity type on this Call.

h) "Total Aggregate Indemnity Payments" must be identical to the paid indemnity losses reported on Column (1), Line (e), "YTD Change," in Section II, Accident Year Exhibit of CA-QT-4Qxx.

For PART C (Paid Medical), information reported must be in accordance with the following:

a) "Physicians" means physicians as defined in Section 3209.3(a) of the California Labor Code. Payments to physicians must include all clinic and office visits, diagnostic testing and physical therapy. Industrial medicine must be included in the Occupational Medicine category, and thoracic medicine must be included in the Chest Diseases category. The following specialties must be included in the "Unknown or Not Otherwise Classified" category:

allergy and immunology
aviation medicine
cardiology
digestive
endocrinology
gastroenterology
immunology
infectious diseases
neuromuscular medicine
nuclear medicine
obstetrics and gynecology
oncology
otolaryngology – head and neck surgery

otorhinolaryngology (ear, nose and throat)
pediatrics
preventative medicine and public health
proctology
rheumatology
urology

The "Total Payments Made to Physicians" from page 2 of this call must equal the "Payments Made to Physicians on page 1 of this call.

b) "Payments Made to Hospitals" must be reported payments made to hospitals, <u>including</u> payments for medications used in hospitals.

c) "Payments for Drugs" must be reported payments for medications, <u>excluding</u> those made to hospitals.

d) "Reimbursements to Medicare" must include direct reimbursement payments made to Medicare related to conditional liens intended to recover payments for past medical services. This would <u>exclude</u> medical payments related to Medicare Set-aside accounts.

e) "Other Payments for Medical Treatment" must include reported payments for medical treatment not made to treating physicians, hospitals or for drugs. This would <u>include</u> payments such as those made for custodial care, prosthetic devices, etc.

f) "Capitated Medical Payments Not Otherwise Classified" must include reported payments made on a capitated or "per covered individual" basis rather than for a specific medical procedure on a specific injury. Capitated medical payments must <u>include</u> amounts contemplated for payments to physicians, hospitals, drugs and other payments for medical treatment.

g) "Medical Payments Made Directly to Injured Workers" (except for those related to Medicare Set-aside accounts) must include the amounts paid directly to injured workers of such lump sum settlements apportioned to medical in recognition of future medical expenses. This must <u>exclude</u> any medical payments related to Medicare Set-aside accounts.

h) "Medical Payments Related to Medicare Set-aside Accounts" must include: costs relating to the evaluation of potential future medical care to determine the amount of the Medicare Set-aside for submission and approval by the Center for Medicare and Medicaid Services (CMS); the cost of the Medicare Set-aside itself (that is paid to a fund to be administered by the injured worker or a third party); and costs involved in the administration of the Medicare Set-aside account. This shall <u>exclude</u> medical reimbursement payments made directly to Medicare related to conditional liens.

i) "Payments for Medical Evaluations" must include reported payments for medical and medical-legal evaluations performed to assess the workers' eligibility for benefits, ability to return to work, extent of permanent disability, or need for new or further medical treatment. These <u>include</u> evaluations performed by agreed medical

evaluators/independent medical evaluators, evaluations performed by qualified medical evaluators on litigated claims, and evaluations performed by qualified medical evaluators selected from panels established for non-represented workers.

j) "Payments for Medical Cost Containment Programs" must include reported payments included as paid medical for medical cost containment programs incurred with respect to particular claims or which can be allocated to specific claims and which can be identified from company records, whether by an outside vendor or done internally. Include only the cost of medical cost containment programs paid during calendar year xx on claims covered by policies incepting **prior to** July 1, 2010.
(The paid cost of medical cost containment programs, including costs of Independent Bill Review (IBR) and Independent Medical Review (IMR), arising from claims covered by policies incepting on **or after** July 1, 2010 are included as allocated loss adjustment expenses. For more information on costs that are considered part of medical cost containment programs, please refer to the definition of "Allocated Loss Adjustment Expenses in Part 4, Section II of the USRP, available on the WCIRB website at http://www.wcirb.com/document/123).

k) "Total Aggregate Medical Payments" must be identical to the paid medical losses reported on Column (3), Line (e), "YTD Change," in Section II, Accident Year Exhibit of CA-QT-4Qxx.