WCIRB Data Reporting Handbook

September 2023

Unit Statistical Reporting

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Notice

This *WCIRB Data Reporting Handbook – Unit Statisical Reporting* was developed by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) for the convenience and guidance of its users. It does not bear the official approval of the California Insurance Commissioner and is not a regulation.

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Section 1 — Introduction

A. Scope

This WCIRB *Data Reporting Handbook – Unit Statistical Reporting* (Handbook) provides information regarding the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP), Part 4, *Unit Statistical Reporting Requirements*, and on the reporting instructions in the Workers Compensation Insurance Organizations (WCIO) Workers Compensation Statistical Reporting Specifications (WCSTAT) as applicable in California, which is incorporated by reference into the USRP. This Handbook compiles the regulations and reporting instructions into a single document and provides examples for various reporting scenarios.

The Handbook is located on the WCIRB website at wcirb.com.

B. Overview of Unit Statistical Reporting

Unit statistical data refers to specific data elements, including payroll (exposure) and loss information, which must be submitted for every workers' compensation insurance policy providing coverage under the workers' compensation laws of California, including California coverage by endorsement on a policy primarily covering another state. On multi-state policies, data pertaining only to California coverage is to be submitted.

A Unit Statistical Report (USR) must be submitted for every policy, even if written on an "if any" basis. Data must be filed in accordance with Part 4, *Unit Statistical Reporting Requirements,* of the USRP.

The first time that a claim must be valued for unit statistical reporting is 18 months after the policy inception month. This 18-month valuation is required to be reported on a "first report level" USR and submitted to the WCIRB no later than 20 months after the policy inception date. The first report level also includes exposure data. Claims that are still open as of the first report are required to be valued and reported again 12 months later (30-month valuation, submitted to the WCIRB no later than 32 months after the policy inception date) on a "second report level". This process continues until either all claims are closed or 10 report levels are reached, whichever comes first.

Report Number	Report Level	Date of Valuation (number of months after the month in which policy incepted)	Date of Reporting (number of months after the inception date of the policy)
1	First Level	18	20
2	Second Level	30	32
3	Third Level	42	44
4	Fourth Level	54	56
5	Fifth Level	66	68
6	Sixth Level	78	80
7	Seventh Level	90	92
8	Eighth Level	102	104
9	Ninth Level	114	116
10 reported as "A"	Tenth Level	126	128

C. Submission Creation and Transmission

All unit statistical data must be reported electronically and transmitted via the Compensation Data Exchange (CDX) web-based service. Hard copy USRs are not accepted.

The format for electronic reporting of unit statistical data is WCSTAT, which consists of 250-byte records with fixed field positions. If any record within the file is greater or less than 250 bytes, the

WCIRB's system will not accept the file. USR data must be submitted in accordance with the USRP and the specifications set forth in WCSTAT as applicable in California.

Insurers may use the web-based Bureau Edit and Entry Package (BEEP) on the CDX website to create and/or validate USRs before submitting them to the WCIRB.

See the CDX page on our website for information on obtaining a user account for CDX and BEEP.

D. Submission Testing

Each insurer and authorized third-party entity (TPE) must submit a test file for approval by the WCIRB prior to submitting production files. Please review the guidelines on the *USR Submission Test Requirements* page on our website, and then contact the WCIRB Data Reporting Analysts at datasubmissions@wcirb.com to arrange the test.

E. Resources

See the *Data Reporting*, *Unit Statistical Data* page of our website for links to these resources:

WCIRB Manuals and Plans including:

- *California Workers' Compensation Uniform Statistical Reporting Plan—1995*
- WCIRB Connect® Information
- WCIO website including the WCIO's WCSTAT specifications
- CDX website cdxworkcomp.org (BEEP is also accessible here)

F. WCIRB Unit Statistical Reporting Contacts

If you have any questions about unit statistical reporting requirements, please email datasubmissions@wcirb.com.

Section 2 — General Reporting Requirements

A. WCSTAT Records: Requirements by USR Type

The chart below describes the WCSTAT records that are required for each USR.

USR Type	Header Record (Record 1)	Name Record (Record 2)	Address Record (Record 3)	Exposure Record (Record 4)	Loss Record (Record 5)	Unit Totals Record (Record 6)
First Report	**Required.** Must have only one	**Required.** Must have only one	Optional. If reported, must have only one	**Required.** Must have at least one; no maximum	Optional. Report if appropriate. No maximum	**Required.** Must have only one.
Subsequent Reports	**Required.** Must have only one	**Required.** Must have only one	Optional. If reported, must have only one	None allowed	**Required.** Must have at least one; no maximum	**Required.** Must have only one.
Correction Type H - Header	**Required.** Must have only one	Optional. If reported, must have only one	Optional. If reported, must have only one	None allowed	None allowed	None allowed.
Correction Type E - Exposure	**Required.** Must have only one	**Required.** Must have only one	Optional. If reported, must have only one	**Required.** Must have at least one; no maximum	None allowed	**Required.** Must have only one.
Correction Type L - Loss	**Required.** Must have only one	**Required.** Must have only one	Optional. If reported, must have only one	None allowed	**Required.** Must have at least one; no maximum	**Required.** Must have only one.
Correction Type T - Total	**Required.** Must have only one	**Required.** Must have only one	Optional. If reported, must have only one	None allowed	None allowed	**Required.** Must have only one.
Correction Type M - Multiple	**Required.** Must have only one	**Required.** Must have only one	Optional. If reported, must have only one	Optional. Report if appropriate; no maximum	Optional. Report if appropriate; no maximum	**Required.** Must have only one.

B. Subsequent Reports and Correction Reports

The USRP provides the following rules regarding subsequent and correction reports.

1. Subsequent Reports

In order to reflect changes in loss records subsequent to the valuation date of the first report because of developments in the nature of the claims and departmental or judicial decisions, losses must be revalued, and subsequent reports filed, in accordance with the USRP, Part 4, *Unit Statistical Reporting Requirements,* Section I, *General Instructions,* Rule 2, *Date of Valuation,* and Rule 3, *Date of Reporting.* A subsequent (second through tenth) revaluation must be filed when one or more claims meet any of the following conditions as of the scheduled date of the valuation:

a. previously reported as open at the most recent prior report level valuation,

b. incurred but not reported at the most recent prior report level valuation,

c. previously reported as closed at any prior report level valuation, but are now open, or

d. previously reported as closed at any prior report level valuation, but have been subsequently reopened and reclosed with the incurred indemnity and/or incurred medical amounts different from the last reported amounts.

The revaluation shall include a reporting of every claim described in a through d, above, in the same detail as set forth in Section V, *Loss Information.* Claims reported as closed on the earlier report level may be reported again on the revaluation. Second through tenth reports shall be identified by the appropriate code in the "Report Level Code / Report Number" field (see the USRP, Part 4, Section III, *Link Data and Header Record Information,* Rule 3, *Report Level Code / Report Number*).

2. Correction Reports

a. Policy Information (Header) Corrections

i. Corrections or changes involving key data elements ("Report Level Code/Report Number", "Correction Sequence Number", "Insurer Code", "Policy Number Identifier", "Policy Effective Date", "Exposure State Code") are to be made through a Header (Correction Type Code "H") correction by indicating all previous key data above.

ii. Corrections or changes involving non-key data elements, such as "Policy Expiration Date" or "Cancellation Date", "Estimated Audit Code", etc., are also to be made using Header (Correction Type Code "H") corrections; however, only the changed non-key data elements along with all key data elements shall be reported.

b. Exposure, Standard Classification, Experience Modification and Final Premium Corrections

i. Whenever exposure amounts, standard classification(s), experience modification(s), or the final premium previously reported is changed, a correction report must be submitted as soon as the revised figures are available

ii. A correction report must be filed if:

(1) a final audit has been made of estimated figures previously submitted to the WCIRB;

(2) a clerical error in the exposure or final premium has been discovered, either by the insurer or by the WCIRB;

(3) a change in the experience modification has been made;

(4) a revision in exposure has been made as a result of a test audit of a policyholder for which experience has been submitted; or

(5) any other adjustment affecting previously reported exposure, final premium or standard classification.

iii. Corrections to exposure amounts, standard classifications, experience modifications, and final premium are to be made through an Exposure (Correction Type Code "E") correction. Corrections only to the "Final Premium Total" field are to be made through a Total (Correction Type Code "T") correction.

c. Loss Corrections

i. Subsequent to the first reporting, a loss correction, when required, must be filed between two valuation dates or within thirty (30) months after the final valuation of losses. Except for loss corrections due to mistake other than error of judgment, should a loss correction coincide with a normal valuation of losses, only the normal valuation of losses should be filed. If a loss correction is not required, losses shall be revalued, and subsequent reports filed, in accordance with the USRP, Part 4, Section I, Rule 2, *Date of Valuation*, and Rule 3, *Date of Reporting*.

ii. Notwithstanding the foregoing, if an employer notified its insurer that a claim is non-compensable pursuant to California Labor Code Section 3761 and such claim is determined to be non-compensable by the Workers' Compensation Appeals Board, a loss correction shall be filed within ninety (90) days after final adjudication of the determination of non-compensability.

iii. A loss correction must be filed under the following circumstances:

(1) A loss record detail was incorrectly reported through mistake other than error of judgment.

(2) One or more claims are non-compensable.

(3) The insurer has recovered in an action against a third party through subrogation or where a claim is determined to be partially fraudulent.

(4) A death claim has been compromised over the sole issue of the applicability of the workers' compensation laws of California, i.e., Compromised Death or "S" claim.

(5) A claim is determined to be a joint coverage claim.

(6) Exposure has been reassigned to another standard classification through the revision of an audit. A loss correction should be filed with the exposure correction, reassigning all claims to the appropriate standard classification.

(7) A clerical error in either the standard classification assignment or the type of injury assignment of a given claim, or a group of claims, has been discovered by the insurer.

(8) A clerical error in either the standard classification assignment or the type of injury assignment of a given claim has been discovered by the WCIRB.

Under these circumstances, the insurer shall, when notified by the WCIRB, file a loss correction or make satisfactory explanation.

(9) A correction is made in a standard classification assignment of a given claim, or a group of claims, as a result of a WCIRB test audit of a policyholder for which experience has been submitted.

iv. Corrections to losses are to be made through a Loss (Correction Type Code "L") correction. Corrections only to loss totals are to be made through a Total (Correction Type Code "T") correction.

3. Reporting Totals on Subsequent and Correction Reports

The USRP provides the following rules on reporting totals:

a. The revised risk totals are required to be reported. The Exposure – Payroll Total should be the sum of <u>all</u> payroll for the policy, not just the sum of the revised payroll records. To the extent that exposure records are revised, report the revised Final Premium based on the latest exposure information of the entire policy. The Incurred Indemnity Amount Total and Incurred Medical Amount Total should be the sum of incurred indemnity and incurred medical amounts for all of the claims for the policy as of the reported report level, not just the sum of the loss records being revised or added.

C. WCSTAT Reporting Methods for Exposure and Loss Records: Previous / Revised and Add / Change / Delete

There are two methods for reporting USR exposure and loss records: the Previous/Revised method and the Add/Change/Delete method. The code reported in the Update Type Code field (position 121 on both the exposure and loss records) identifies the method being used.

Section 2 — General Reporting Requirements

- The Previous/Revised (P/R) method requires the codes "P" or "R" to be reported as appropriate in the Update Type Code field on all exposure or loss records;

  Or

- the Add/Change/Delete (A/C/D) method requires the codes "A," "C," or "D" to be reported as appropriate in the Update Type Code field on all exposure or loss records **(Note: Restrictions apply on the use of the "C" (Change) update type; see below for more details).**

Following the instructions below will ensure optimal matching of incoming data.

1. Key Data

Certain fields on exposure and loss records are designated as "key data" and are used for matching incoming records to previously reported data.

To change or delete previously reported exposure or loss data, you must report the key data on "Previous" or "Delete" records so that the WCIRB system can locate the previously-reported record and either apply the new incoming changes to it or delete it. The key data must exactly match the data previously reported or an error will occur.

KEY DATA	
Type of Data	**Key Data for Matching Incoming Record to Existing Data**
Exposure Records	• **Classification Code - Primary field for matching** • Rate Effective Date • Exposure Act / Exposure Coverage Code • Exposure Amount
Loss Records – Individual Claims	• **Claim Number - Only field for matching**
Loss Records – Grouped Claims *(policies effective prior to 1/1/2011 only)*	• **Classification Code** • **Injury Code (Injury Type)** • **Loss Coverage Act Code** } **Primary fields for matching** • Incurred Indemnity Amount • Incurred Medical Amount

2. Reporting New Exposure or Loss Data

All new exposure or loss data must be reported with an Update Type Code field value of "R" or "A." The same instructions apply whether you are submitting an original first report level, adding a new exposure record on a first report correction, or adding a new claim on a subsequent report or a correction report.

New exposure or loss records are reported as follows:

a. **P/R method:** Report one "R" record with the new data. All reported data is added.

b. **A/C/D method:** Report one "A" record with the new data. All reported data is added.

3. Deleting Previously-Reported Exposure or Loss Data

Exposure and loss records are not deleted in the WCIRB system, but are instead deactivated as follows:

a. **P/R method:** Report one "P" record that includes the key data for matching and all other required data elements. The key data on the "P" record must match the existing data or an error will result. If a match is successful, the following will occurs:

   i. Exposure: The existing data is deactivated. The exposure is excluded from experience rating and displays in WCIRB Connect as "grayed out."

ii. Loss: The matched record is deactivated and an audit error (L125) is raised. The WCIRB will query the data submitter to confirm whether the intent was to deactivate the entire claim. If confirmed, the claim is deactivated at all report levels and the entire claim history, at all report levels, is excluded from experience rating. The claim displays in WCIRB Connect as "grayed out." If the data submitter instead responds that the intent was to "delete" the claim at only a single report level, the single matched record is considered inactive (excluded from experience rating), and the prior record for that claim becomes the active record for experience rating purposes.

b. **A/C/D method:** Report one "D" record that includes the key data for matching and all other required data elements. The key data on the "D" record must match the data previously reported or an error will result. If a match is successful, the following will occurs:

i. Exposure: The existing data is deactivated. The exposure is excluded from experience rating, and displays in WCIRB Connect as "grayed out."

ii. Loss: The matched record is deactivated and an audit error (L125) will be raised. The same process will be followed as described above in Item 3, *Deleting Previously – Reported Exposure or Loss Data*, a., *P/R Method*, ii., *Loss*.

4. Revising Previously-Reported Exposure or Loss Data

Revisions to existing data are reported as follows:

a. **P/R method:** Report two records (on both correction reports and subsequent reports): a "P" record that includes the key data for matching and all other required data elements, and an "R" record with the revised data and all other required data elements. The key data on the "P" record must match exactly the data previously reported or an error will result.

b. **A/C/D method:** There are two distinct ways to change data using this method:

i. Report two records (on both correction reports and subsequent reports): a "D" record that includes the key data for matching and all other required data elements, and an "A" record with the revised data and all other required data elements. The key data on the "D" record must match exactly the data in previously reported or an error will result.

ii. Report one "C" (Change) record. The "C" update type offers the benefit of requiring a single record to report a change. However, **"C" records can ONLY be used to change individual claims and cannot be used for changes to exposure records or grouped claims. Additionally, the "C" record cannot be used to change the Claim Number field on individual claims since this is the key data for individual claim records.** To change exposure records, grouped claims, or the Claim Number on an individual loss record, use "A" and "D" (or "P" and "R") records instead.

iii. Summary of Reporting Methods
The tables on the next two pages summarize both reporting methods.

Section 2 — General Reporting Requirements

Previous / Revised Method – P/R

Add Exposure	Delete Exposure	Revise Exposure
Report one "R" record with all exposure data elements. *Notes:* "R" records are required for original first reports. Do not report "P" records on original first reports or with any new exposure record.	Report one "P" record that includes the key data and all other required data elements. *Notes:* The key data must match to the previously reported data in the WCIRB system or an error will result. If a match is successful, the existing record is deactivated.	Report a set of two records consisting of one "P" and one "R" record. *Notes:* The "P" record includes the key data and all other required data elements. The key data must match to the previously reported data in the WCIRB system or an error will result. If a match is successful, the changes reported in the "R" record will be processed. The "R" record must include ALL exposure data elements, both changed and unchanged. **<u>If key data is changing</u>:** The Classification Code field is the primary key data field for matching. When reporting a class code revision, ensure that all other key data fields on the incoming "P" record are unchanged from the previously submitted record. If changes to more than one key data field are necessary, submit them in separate USRs (for example, submit a change to the Classification Code as one set of "P" and "R" records in report level 1, and a change to Exposure Amount as a separate set of "P" and "R" records in correction 1 to report level 1).

Add Loss	Delete Loss	Revise Loss
Report one "R" record with all loss data elements. *Notes:* "R" records are required for newly-reported losses. Do not report "P" records on original first reports or with any new exposure record.	Report one "P" record that includes the key data and all other required data elements. *Notes:* The key data must match to the previously reported data in the WCIRB system or an error will result. If a match is successful, the matched record is deactivated, and an audit error (L125) is raised. The WCIRB will query the data submitter to confirm whether the intent was to deactivate the entire claim. If confirmed, the claim is deactivated at all report levels.	Report a set of two records consisting of one "P" and one "R" record. *Notes:* The "P" record includes the key data and all other required data elements. The key data must match to the previously reported data in the WCIRB system or an error will result. If a match is successful, the changes reported in the "R" record are processed. The "R" record must include ALL loss data elements, both changed and unchanged. **<u>Individual losses where key data (Claim Number) is changing</u>:** The Claim Number field should not be changed, because it is the only key data field for matching. If it is changed, the old claim is deactivated and the data submitter must "rebuild" the entire claim history under the new claim number by submitting corrections for all prior report levels. **<u>Grouped losses where key data is changing</u>:** The Classification Code, Injury Code (Injury Type), and Loss Coverage Act fields are the primary key data field for matching. When reporting a class code revision, ensure that all other key data fields on the incoming "P" record are unchanged from the previously submitted record. If changes to more than one key data field are necessary, submit them in separate USRs (for example, submit a change to the Classification Code as one set of "P" and "R" records in report level 2, and a change to Injury Code (Injury Type) as a separate set of "P" and "R" records in correction 1 to report level 2). When converting grouped claims to individual claims and also changing key data, first convert the grouped claim to individual claims, with no changes to any key data. Once the claims are converted, submit key data changes in a separate USR. See Appendix 3 for examples of converting grouped claims.

Section 2 — General Reporting Requirements

Add / Change / Delete Method – A/C/D

Add Exposure	Delete Exposure	Revise Exposure
Report one "A" record with all exposure data elements. *Notes:* "A" records are required for original first reports. Do not report "D" records on original first reports or with any new exposure record.	Report one "D" record that includes the key data and all other required data elements. *Notes:* The key data must match to the previously reported data in the WCIRB system or an error will result. If a match is successful, the existing record is deactivated.	Report a set of two records consisting of one "A" and one "D" record. ***Do not use the "C" (Change) record for exposure revisions.*** *Notes:* The "D" record includes the key data and all other required data elements. The key data must match to the previously reported data in the WCIRB system or an error will result. If a match is successful, the changes reported in the "A" record are processed. The "A" record must include ALL exposure data elements, both changed and unchanged. **<u>If key data is changing</u>:** The Classification Code field is the primary key data field for matching. When reporting a class code revision, ensure that all other key data fields on the incoming "D" record are unchanged from the previously submitted record. If changes to more than one key data field are necessary, submit them in separate USRs (for example, submit a change to the Classification Code as one set of "A" and "D" records in report level 1, and a change to Exposure Amount as a separate set of "A" and "D" records in correction 1 to report level 1).

Add Loss	Delete Loss	Revise Loss
Report one "A" record with all loss data elements. *Notes:* "A" records are required for newly-reported losses. Do not report "D" records on original first reports or with any new exposure record.	Report one "D" record that includes the key data and all other required data elements. *Notes:* The key data must match to the previously reported data in the WCIRB system or an error will result. If a match is successful, the matched record is deactivated and an audit error (L125) is raised. The WCIRB will query the data submitter to confirm whether the intent was to deactivate the entire claim. If confirmed, the claim is deactivated at all report levels.	Report a set of two records consisting of one "A" and one "D" record. Alternatively, use the "C" (Change) record for revisions to individual losses where the Claim Number is NOT changing. Report one "C" record including the key data and all other loss data, changed or not. If the key data matches, all changed data is processed. ***Do not use the "C" (Change) record for grouped loss revisions.*** *Notes:* The "D" record includes the key data and all other required data elements. The key data must match to the previously reported data in the WCIRB system or an error will result. If a match is successful, the changes reported in the "A" record are processed. The "A" record must include ALL loss data elements, both changed and unchanged. **<u>Individual losses where key data (Claim Number) is changing</u>:** ***Do not use the "C" (Change) record.*** The Claim Number field should not be changed, because it is the only key data field for matching. If it is changed, the old claim is deactivated and the data submitter must "rebuild" the entire claim history under the new claim number by submitting corrections for all prior report levels. **<u>Grouped losses where key data is changing</u>:** ***Do not use the "C" (Change) record.*** The Classification Code, Injury Code (Injury Type), and Loss Coverage Act fields are the primary key data field for matching. When reporting a class code revision, ensure that all other key data fields on the incoming "D" record are unchanged from the previously submitted record. If changes to more than one key data field are necessary, submit them in separate USRs (for example, submit a change to the Classification Code as one set of "P" and "R" records in report level 2, and a change to Injury Code (Injury Type) as a separate set of "P" and "R" records in correction 1 to report level 2). When converting grouped claims to individual claims and also changing key data, first convert the grouped claim to individual claims, with no changes to any key data. Once the claims are converted, submit key data changes in a separate USR. See Appendix 3 for examples of converting grouped claims.

Section 3 — Field-by-Field Reporting Guidelines for California

All fields below are required to be reported in California as indicated. Refer to WCSTAT for all technical field attributes (position, field class, number of bytes).

Per the WCIO Data Reporting Handbook, the following are the attributes applicable to each field class:

Field Class	Description	Field justification	Field fill
Alpha (A)	A field that contains only alphabetical characters	left-justified	right blank-filled
Alphanumeric (AN)	A field that contains alphabetic and numeric characters	left-justified	right blank-filled
Numeric (N)	A field that contains only numeric characters	right-justified	left zero-filled

A. Link Data Fields

Link Data is a collection of data elements that are common to all records in a particular USR. These common data elements allow the applicable records to be joined. The WCIRB system does not allow duplicate instances of link data in the same submission, meaning that the same USR cannot be reported twice in a submission.

1. Carrier Code

WCSTAT Reporting Instructions
Report the code assigned to the reporting company by NCCI or other DCO.

Additional Information/Examples for California Reporting
California accepts either the California Insurer Code or the NCCI carrier code. The submission is rejected if it is not valid.

2. Policy Number Identifier

WCSTAT Reporting Instructions
Report the unique identifier used for identifying the policy.

This number identifier must be identical to the number identifier set forth on the policy information page or as endorsed.

The complete policy number identifier must remain the same throughout the life of the policy and for all experience reporting.

Do not report embedded blanks or marks of punctuation.

3. Exposure State Code

USRP Reporting Instructions
Report code “04”.

4. Policy Effective Date

USRP Reporting Instructions
Report the inception date that corresponds exactly to that shown on the policy information page or the inception date changed by endorsement.

a. Interstate Policies
For interstate policies that are endorsed after the inception date to provide coverage for California, the effective date shall be the inception date of the interstate policy.

Section 3 — Field-by-Field Reporting Guidelines for California

b. Continuing Form and Fixed Term Policies
For each successive annual period, treat the policy in the same manner as though it were an annual policy effective in the same month and on the same day of the month as the inception date of the annual period. If there has been a first period or last period of coverage, which has been treated as a short-term policy in accordance with Part 2, Section II, Rule 2, *Continuing Form Policies or Fixed-Term Policies Written in Excess of One Year and Sixteen (16) Days*, of the USRP, such period shall also be treated as a separate short-term policy for reporting purposes under the USRP.

5. Report Level Code/Report Number

USRP Reporting Instructions
Report the code that corresponds to the report level based on the policy valuation date. (See the USRP, Part 4, Section I, Rule 2, *Date of Valuation*, and Rule 3, *Date of Reporting*, to determine the policy valuation dates and required reporting dates.)

Report Number	Level
1	First Report
2	Second Report
3	Third Report
4	Fourth Report
5	Fifth Report
6	Sixth Report
7	Seventh Report
8	Eighth Report
9	Ninth Report
A	Tenth Report

6. Correction Sequence Number

WCSTAT Reporting Instructions
Report the number that corresponds to the number of correction reports submitted within a particular report level.

Exposure and loss corrections on the same report level must be numbered consecutively.

This field is the most current/correct value for this data element.

Example: Third correction to a first report = Report Level Code 1, Correction Sequence Number 3. This is the revised correction sequence number on header corrections to change the correction sequence number.

For noncorrections, report “0”.

The proper sequencing for numbering consecutively is “1” through “9” and then “A” through “Z”. This number sequence will accommodate up to 35 corrections.

Additional Information/Examples for California Reporting
The WCIRB system can accommodate the reporting of more than 35 corrections. If a data submitter reports up to Correction Sequence Number “Z” and then needs to report a 36th correction, the data submitter should continue to use Correction Sequence Number “Z” on all future correction reports. The incoming correction will be placed at the top of the hierarchy of USRs and will display the incoming correction report’s Correction Sequence Number as “Z” (as reported). This is considered the active record.

Starting over with Correction Sequence Number “1” is NOT recommended because the WCIRB system does not consider the incoming record to be the active record.

Section 3 — Field-by-Field Reporting Guidelines for California

B. Header Record Fields

1. Record Type Code

WCSTAT Reporting Instructions
Report "1".

Additional Information/Examples for California Reporting
Per WCSTAT specifications, all USRs must have one and only one header record.

Policy Expiration or Cancellation Date

USRP Reporting Instructions
Report the expiration date as the expiration date shown on the policy information page unless the policy is cancelled. In that event, the cancellation date shall be reported as the expiration date.

a. Interstate Policies
For interstate policies, report the expiration or cancellation date of the interstate policy.

b. Continuing Form Policies
For each successive annual period, treat the policy in the same manner as though it were an annual policy expiring twelve (12) months after the inception date shown, unless the policy is cancelled. In that event, the cancellation date shall be reported as the expiration date.

Additional Information/Examples for California Reporting
The Policy Expiration or Cancellation Date must be greater than the Policy Effective Date. The Policy Expiration or Cancellation Date cannot be equal to the Policy Effective Date.

2. Risk ID Number

WCSTAT Reporting Instructions
Report the unique risk identification number assigned by the state where applicable.

Additional Information/Examples for California Reporting
In California, you can use this field to report the Bureau Number (up to 7 digits), which is the number assigned by the WCIRB for a risk. If you do not know the Bureau Number, leave the field blank.

3. Business Segment Identifier

WCSTAT Reporting Instructions
Report the series of identifying codes maintained and reported by the data provider.

4. Correction Type Code

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

This field is applicable only to correction reports.

Code	Description
E	Exposure Record Correction (First Reports Only)
H	Header Record Correction (Including Link Data)
L	Loss Record Correction Not Due to Aggravated Inequity
M	Corrections to Multiple Record Types
T	Total Record Correction

Additional Information/Examples for California Reporting
Report one of the valid codes above if a USR's Correction Sequence Number is greater than 0. Leave the Correction Type Code blank if the Correction Sequence Number equals 0.

Section 3 — Field-by-Field Reporting Guidelines for California

See the table in Section 2, *General Reporting Requirements*, Subsection A, *WCSTAT Records: Requirements by USR Type*, for reporting requirements and a description of the record requirements for each Correction Type.

5. Federal Employer Identification Number (FEIN)

WCSTAT Reporting Instructions
Report the number of the insured as shown on the policy Information Page.

The primary FEIN is used when multiple FEIN numbers are on the policy.

Additional Information/Examples for California Reporting
This field is optional for California.

6. Estimated Audit Code

USRP Reporting Instructions
Report whether the exposure is audited or estimated. If an audit was not conducted pursuant to the USRP, Part 3, Section VI, Rule 4, *Audit of Payroll*, the exposure shall be considered estimated. Report Estimated Audit Code "U" if estimate is due to an uncooperative policyholder; report Estimated Audit Code "Y" for all other reasons.

Code	Description
N	Exposure is audited
U*	Exposure is estimated due to an uncooperative policyholder
Y**	Exposure is estimated—other

* Where it is not possible to obtain audited exposure figures due to the policyholder's refusal to provide the insurer access to the payroll and other required records, the insurer shall use the Estimated Audit Code "U". A "U" Estimated Audit Code means that the insurer has made a good faith effort to complete the audit and inform the policyholder of the possible consequences of not permitting the insurer to complete the final audit, which may result in the exclusion of the payroll from the policyholder's experience modification in accordance with Section III, *Eligibility and Experience Period*, Rule 3, *Experience to be Used for Rating California Workers' Compensation Insurance Risks*, Subrule g, of the *California Workers' Compensation Experience Rating Plan—1995* (ERP).

** Where it is not possible to obtain audited exposure figures, for reasons other than an uncooperative policyholder, the insurer shall submit a statement indicating the reasons why audited exposure figures cannot be obtained. See the USRP, Part 4, Section II, *Definitions,* for the definition of "Audited Exposure." (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

Additional Information/Examples for California Reporting
When a "U" value is reported for a policyholder eligible for experience rating, the WCIRB sends correspondence directly to the policyholder indicating that the insurer has advised that the policyholder has been uncooperative in completing the payroll audit and notifying the policyholder that the failure to permit the insurer to complete the audit may result in the exclusion of the payroll from the policyholder's experience modification. See Subsection E, *Exposure Record Fields*, Item 6. *Exposure Amount*, for the reporting of estimated exposure amounts on policies that charge additional premium pursuant to California Insurance Code 11760.1.

When a "Y" value is reported for a policyholder eligible for experience rating, the WCIRB requires the insurer to provide a written explanation as to why audited exposure figures cannot be obtained. Acceptable explanations are confined to situations when the insurer has determined that the requisite payroll records no longer exist (in either hard copy or electronic form) or have been seized by a court, or when the policyholder is no longer in

business and the insurer's efforts to contact the policyholder have been unsuccessful. Absent a WCIRB concurrence that the records are not obtainable, the WCIRB will continue to pursue the issue until the insurer submits a corrected USR with audited exposure amounts or revises the estimated audit code to indicate that the exposure amounts cannot be obtained as a result of an uncooperative policyholder.

7. Type of Coverage ID Code

WCSTAT Reporting Instructions

Report the code that indicates the Type of Coverage.

Code	Description
01	Standard Workers Compensation Policy
05	Large Risk Rated Option/Large Risk Alternative Rating Option

8. Type of Plan ID Code

WCSTAT Reporting Instructions

Report the code that defines the type of plan used to underwrite the coverage.

Code	Description
01	Voluntary Policy

9. Type of Non-Standard ID Code

WCSTAT Reporting Instructions

Report the code that indicates the type of workers compensation policy.

Code	Description
01	Non-Standard Code Does Not Apply

10. Losses Subject to Deductible Code

WCSTAT Reporting Instructions

Report the code that identifies the losses subject to deductible.

Code	Description
00	No Deductible
01	Medical Losses Only
02	Indemnity Losses Only
03	Medical and Indemnity Losses – Deductible applies proportionately to the medical and indemnity portions of the loss.

11. Basis of Deductible Calculation Code

WCSTAT Reporting Instructions

Report the code that identifies the type of deductible being reported.

Code	Description
00	No Deductible
01	Per Claim Deductible Amount
02	Per Accident Deductible Amount
03	Per Policy Deductible Aggregate Limit
04	Percent of Claim Cost
05	Percent of Premium
06	Coinsurance Only Percent With Per Claim Amount Limit
07	Coinsurance Percent With Per Claim Deductible Amount and Coinsurance Limit
08	Coinsurance Percent With Per Accident Deductible Amount and Coinsurance Limit
09	Per Accident Deductible Amount With Per Policy Deductible Aggregate Limit

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10	Per Claim Deductible Amount With Per Policy Deductible Aggregate Limit
11	Coinsurance Percent With Per Claim Deductible Amount Limit With Per Policy Aggregate Limit
12	Variable – as per ASWG decision to allow flexibility for reporting deductible programs not otherwise defined.

12. Deductible Percentage

WCSTAT Reporting Instructions
Report the whole percentage of the deductible to be paid by the insured, if applicable, as defined by the deductible program.

This field is applicable only when the Basis of Deductible Calculation Code (position 167-168 of this record) is 04 through 08 or 11.

13. Deductible Amount per Claim/Accident

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

This field is applicable only when the Basis of Deductible Calculation Code (position 167-168 of this record) is 01, 02, 06, 07, 08, 09, 10, 11, 12 or 13.

14. Deductible Amount – Aggregate

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

This field is applicable only when the Basis of Deductible Calculation Code (position 167-168 of this record) is 03, 08, 09, 10, 11, 12 or 13.

15. Previous Report Level Code/Report Number

WCSTAT Reporting Instructions
Report the report number code that was previously reported.

This field is to be used only when correcting link data.

16. Unit Format Submission Code

WCSTAT Reporting Instructions
Report the code that defines the filing format.

Code	Description
E	Expanded ASWG report

Additional Information/Examples for California Reporting
All USRs reported to California must be in Expanded ASWG format, which includes four additional fields on the loss record: Weekly Wage Amount, Scheduled Indemnity – Percentage of Disability, Total Incurred Vocational Rehabilitation and Total Gross Incurred Amount.

C. Name Record Fields

1. Record Type Code

WCSTAT Reporting Instructions
Report “2”.

A Name Record is required for all DCOs.

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Additional Information/Examples for California Reporting
Per WCSTAT specifications, a Name Record is required on all USR types except it is optional on Header Corrections.

2. Name of Insured

WCSTAT Reporting Instructions
Report 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 Fields

1. Record Type Code

WCSTAT Reporting Instructions
Report "3".

Additional Information/Examples for California Reporting
Per WCSTAT specifications, the Address Record is optional on all USR types.

2. Address of Insured

WCSTAT Reporting Instructions
Report the street address, city, state and zip code of the insured as shown in Item 1 of the policy information page or as endorsed.

E. Exposure Record Fields

1. Record Type Code

WCSTAT Reporting Instructions
Report "4".

Additional Information/Examples for California Reporting
Per WCSTAT specifications, at least one exposure record is required on original first reports and exposure corrections. Exposure records are reported on multiple corrections only if necessary. They are not allowed on any other USR types.

2. Classification Code

USRP Reporting Instructions
Report the appropriate 4-digit California standard classification code. Report code 0012 for payments excluded from remuneration pursuant to Part 3, *Standard Classification System*, Section III, *General Classification Procedures*, Rule 7, *Coronavirus Disease 2019 (COVID-19)*, subrule b. All records containing "Exposure Amount" must be assigned to a standard classification code developed in accordance with the provisions of the USRP or code 0012.

Also, report statistical code 9740, *Catastrophe Provisions for Terrorism*, if applicable. Other statistical codes need not be reported. See the USRP, Part 4, Section II, Definitions, for the definition of "Statistical Code." (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

Additional Information/Examples for California Reporting
Classification Code is the primary key data field for matching incoming exposure records to exposure data already in the WCIRB system. Rate Effective Date, Exposure Act/Exposure Coverage Code, and Exposure Amount are secondary matching criteria. When reporting a class code revision, ensure that all other key data fields on the incoming "P" record are unchanged from the previously submitted record. If changes to more than one key data field are necessary, submit them in separate USRs.

Insurers may use statistical code 1200, *COVID-19 premium charges not included in insurer's filed rates*, to assist in tracking and reporting COVID-19 premium charges that are not included in the insurer's rates. (All COVID-19 related premium charges are required to be reported in the

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WCIRB's aggegrate financial data calls.) Insurers may choose to report statistical codes but are not required to report statistical codes other than codes 0012 and 9740, as applicable. See Appendix 2 for guidelines for BEEP users regarding applying statistical codes appropriately for purposes of computing Final Premium Total. Exposure Amount should not be reported on exposure records with statistical codes. See Section 3, *Field-by-Field Reporting Guidelines for California*, Subsection E, *Exposure Record Fields*, Item 3, *Experience Modification Factor*, for instructions on reporting split exposure.

3. Experience Modification Factor

WCSTAT Reporting Instructions

Report the factor based on the past experience of the insured that is used to modify an insured's premium.

Multiple experience modification factors may apply.

Enter the experience modification factor that applies to the exposure reported in this detail record.

For nonrated exposures, report "0000".

If a change in experience modification factor occurs subsequent to the policy effective date due to an Anniversary Rating Date change, the payrolls must be split.

If reporting an experience modification greater than 999%, report zeros in this field and report the experience modification factor in the Excessive Experience Modification Factor field in positions 94-97.

There is an assumed decimal point between positions 51 and 52.

Additional Information/Examples for California Reporting

When more than one experience modification applies to a single policy (commonly known as "split exposure"), report a separate set of exposure records for each experience modification, including all of the fields below in each record. Note: The WCIRB does not use the field Split Period Code to identify split exposure; however, BEEP does require and use the field for its split consistency validations on import.

- Classification Code
- Exposure Amount
- Exposure Act/Exposure Coverage Code
- Experience Modification Factor – In BEEP, this value should be identical in all records in a split, except those records with statistical codes that are not subject to experience modification. Note: the WCIRB does not require reporting of statistical codes.
- Experience Modification Effective Date – In BEEP, this value should be identical in all records in a split.
- Rate Effective Date – In BEEP, this value should be identical in all records in a split.

Below is an example of a correct "split exposure" on an exposure correction report. Non-numeric characters such as decimals, commas, and slashes are shown in the example below for clarity only; these non-numeric values are not permitted in WCSTAT reporting.

Split	Experience Mod. Factor	Experience Mod. Effective Date	Rate Effective Date	Class. Code	Exposure Act/ Coverage Code	Exposure Amount	Update Type Code
1st split	**1.080**	**01/01/10**	**01/01/10**	8810	01	169,426	P
1st split	**1.080**	**01/01/10**	**01/01/10**	8810	01	189,303	R
1st split	**1.080**	**01/01/10**	**01/01/10**	3165	01	128,475	P

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Split	Experience Mod. Factor	Experience Mod. Effective Date	Rate Effective Date	Class. Code	Exposure Act/ Coverage Code	Exposure Amount	Update Type Code
1st split	**1.080**	**01/01/10**	**01/01/10**	3165	01	160,005	R
1st split	**1.080**	**01/01/10**	**01/01/10**	4150	01	57,498	R
2nd split	**1.250**	**04/15/10**	**04/15/10**	8810	01	44,567	P
2nd split	**1.250**	**04/15/10**	**04/15/10**	8810	01	62,101	R
2nd split	**1.250**	**04/15/10**	**04/15/10**	3165	01	23,547	P
2nd split	**1.250**	**04/15/10**	**04/15/10**	3165	01	25,972	R
2nd split	**1.250**	**04/15/10**	**04/15/10**	4150	01	15,611	R

4. Experience Modification Effective Date

USRP Reporting Instructions

Report the California experience modification effective date. When more than one modification applies to a single policy, report the corresponding standard classification codes and exposures for each experience modification period separately, with the appropriate effective date of each modification. If no experience modification applies to the policy, report the policy effective date.

Additional Information/Examples for California Reporting

See Section 3, *Field-by-Field Reporting Guidelines for California*, Subsection E, *Exposure Record Fields*, Item 3, *Experience Modification Factor,* for information regarding reporting exposure for more than one experience modification (commonly known as “split exposure”).

5. Rate Effective Date

USRP Reporting Instructions

Report the rate (exposure) effective date. If the rate effective date precedes the policy effective date, report the policy effective date.

Additional Information/Examples for California Reporting

The Rate Effective Date field is used to report exposure effective date. It is a secondary key data field for matching incoming exposure records to exposure data already in the WCIRB system, particularly in cases where there is split exposure (Classification Code is the primary field for matching). See Section 3, *Field-by-Field Reporting Guidelines for California*, Subsection E, *Exposure Record Fields*, Item 3, *Experience Modification Factor,* for information regarding reporting split exposure.

6. Exposure Amount

USRP Reporting Instructions

Report the total audited exposure for each standard classification code. (See the USRP, Part 4, Section II, *Definitions,* for the definition of “Audited Exposure.”) (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.) Report payment excluded from remuneration pursuant to Part 3, *Stanard Classification System*, Section III, *General Classification Procedures*, Rule 7, *Coronavirus Disease 2019 (COVID-19)*, subrule b. Report payroll dollars rounded to the nearest whole dollar amount. Report non-payroll exposures to the nearest tenth of a unit. Payrolls or other applicable exposure amounts reported shall be obtained in accordance with the provisions of the USRP.

If pursuant to Section III, *Link Data and Header Record Information*, Rule 5, *Estimated Audit Code*, the exposure is considered estimated, report the current estimated exposure. Do not adjust

the estimated exposure to reflect any additional premium the insurer has charged in accordance with California Insurance Code Section 11760.1.

For a number of standard classifications, the USRP provides for a basis of exposure other than payroll. A list of these standard classifications and the applicable unit of exposure is given in the table below.

Code No.	Standard Classification	Unit of Exposure
8278	Jockeys	Per Race
7707	Fire Fighters, Volunteers	Per Capita, Per Year
7722	Police, etc., Volunteers	Per Capita, Per Year
8631	Racing Stables	Per Occupied Stall, Per Day (eff. 1/1/16)

For each such standard classification that applies, report the total number of exposure units.

Additional Information/Examples for California Reporting

- **No exposure on a first report.** The WCSTAT specification requires at least one exposure record on an original first report. In cases where there is no exposure on a first report, report an exposure record using statistical code “1111” as the Classification Code and report zeros in the Exposure Amount field.
- **Exposure other than payroll:**
  - For non-payroll exposure amounts, there is an assumed decimal point between positions 75 and 76 (the last two digits of this 10-digit field).
  - **Example 1.** Where coverage for volunteer police or fire fighters has been extended for less than the full unit indicated, count such fractional exposures to the nearest tenth of a unit. Thus, a volunteer fire fighter covered for four (4) months should be included in the total exposure for Classification 7707 at 0.3 (reported as “0000000003”).
  - **Example 2.** For jockeys in Classification 8278, report the total number of races in whole units. Thus, a total of 23 jockey races should be included in the total exposure for Classification 8278 as 23.0 (reported as “0000000230”).
- **Premium charge pursuant to California Insurance Code Section 11760.1.** If additional premium is charged pursuant to California Insurance Code Section 11760.1, do not increase the estimated Exposure Amounts on exposure records with standard classification codes to reflect this additional premium. If it is necessary to increase the estimated Exposure Amounts to derive the corresponding premium charge pursuant to Section 11760.1, report the additional estimated Exposure Amounts attributable to the premium charge under Exposure Act Code 00 and statistical code 9757.
- **Statistical codes.** California does not require the reporting of statistical codes when reporting Exposure Amount, and an error is generated if an amount greater than zero is reported in the Exposure Amount field of an exposure record with a statistical code other than 9740 (to report terrorism premium amounts) and 9757 (to report additional premium charged pursuant to California Insurance Code Section 11760.1). Statistical code 1200 may be used to report COVID-19 premium charges that are not included in insurer’s rates, but exposure should not be reported with this statistical code.
- **Split exposure.** Exposure Amount is a secondary key data field for matching incoming exposure records to exposure data already in the WCIRB system, particularly in cases where there is split exposure (Classification Code is the primary field for matching). Section 3, *Field-by-Field Reporting Guidelines for California*, Subsection E, *Exposure Record Fields*, Item 3, *Experience Modification Factor,* for information regarding reporting split exposure.

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7. Premium Amount

USRP Reporting Instructions

Report the premium amount for statistical code 9740, *Catastrophe Provisions for Terrorism*. (Note that the premium amount for statistical code 9740 is not to be included in the "Final Premium Total (Standard Premium Total)" amount in USRP, Part 4, Section VI, *Unit Total Record Data*. See the definition of "Final Premium(s)" in USRP, Part 4, Section II, *Definitions*.) The premium amounts for standard classification codes and other statistical codes need not be reported.

Additional Information/Examples for California Reporting

Insurers may use statistical code 1200, *COVID-19 premium charges not included in insurer's filed rates*, to assist in tracking and reporting COVID-19 premium charges that are not included in the insurer's rates. **Premium charges related to COVID-19 are to be included in the "Final Premium Total (Standard Premium Total)" amount in USRP, Part 4, Section VI, *Unit Total Record Data*.** See the definition of "Final Premium(s)" in USRP, Part 4, Section II, *Definitions*.)

8. Split Period Code

WCSTAT Reporting Instructions

Report the code 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, enter "0".

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".

Code	Description
0	First Period
1	Second Period
2	Third Period
3	Fourth Period
4	Fifth Period
5	Sixth Period
6	Seventh Period
7	Eighth Period
8	Ninth Period

Additional Information/Examples for California Reporting

California does not use the Split Period Code field for determining or matching split exposure. The field is applicable to California only because it is a required field for BEEP users and omitting it in BEEP results in the inability to import USRs.

See Section 3, *Field-by-Field Reporting Guidelines for California*, Subsection E, *Exposure Record Fields*, Item 3, *Experience Modification Factor,* for information regarding reporting split exposure.

9. Excessive Experience Modification Factor

Report the factor that applies to the subject premium if the factor is greater than 999%.

Update Type Code

USRP Reporting Instructions

Report the alphabetic code that identifies the activity of an exposure record. Exposure records can be reported using either the "Previous/Revised" method or the "Add/Change/Delete" method. Refer to the USRP, Part 4, Section VII, *Subsequent Reports, Correction Reports, and Reporting Methods*, Rule 3, *Reporting Methods*, for instructions.

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Code	Description
A	Add Record
D	Delete Record
P	Previously Reported
R	Revised

Additional Information/Examples for California Reporting
See Section 2, *General Reporting Requirements*, Subsection C, *WCSTAT Reporting Methods for Exposure and Loss Records: Previous/Revised and Add/Change/Delete,* for instructions on using the Update Type Code field.

10. Exposure Act/Exposure Coverage Code

WCSTAT Reporting Instructions
Report the code that indicates the Act (Law) under which the exposure for the class record is associated.

Regardless of the Act (Law) governing the policy, statistical codes must be reported as 00.

Code	Description
00	For Use with Statistical Codes
01	State Act or Federal Act Excluding USL&HW and Federal Coal Mine Health and Safety Act
02	USL&HW “F”

Additional Information/Examples for California Reporting

- **Reporting the correct Exposure Act/Exposure Coverage Code.** The WCIRB system identifies the type of Classification Code based on the Exposure Act/Exposure Coverage Code value. For example, if exposure is reported with standard Classification 8810, but with the incorrect Exposure Act/Exposure Coverage Code of 00 (which is for statistical codes), 8810 is assumed to be a statistical code. If Exposure Amount was reported on the 8810 record, an audit error is generated since a non-zero Exposure Amount is not allowed on exposure records with statistical codes.
- **No reporting of Exposure Amount with statistical codes**. Exposure Amount should be reported only on exposure records that include standard Classification Codes. California does not require the reporting of statistical codes and an error will generate if a non-zero Exposure Amount is reported on an exposure record with a statistical code.

Split exposure. Exposure Act/Exposure Coverage Code is a secondary key data field for matching incoming exposure records to exposure data already in the WCIRB system, particularly in cases where there is split exposure (Classification Code is the primary field for matching). See Section 3, *Field-by-Field Reporting Guidelines for California*, Subsection E, *Exposure Record Fields*, Item 3, *Experience Modification Factor,* for information regarding reporting split exposure.

F. Loss Record Fields

Any and all claims, including those involving first aid as defined in California Labor Code Section 5401(a), in which Indemnity Losses or Medical Losses are incurred or Allocated Loss Adjustment Expenses are paid must be reported individually.

All loss amounts are on a direct basis (excluding reinsurance assumed and adjustment for reinsurance ceded) and must be reported on a gross basis prior to the application of any deductibles.

See the USRP, Part 4, Section I, Rule 2, *Date of Valuation*, to determine the valuation dates for losses.

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Supplemental Claim Fields (Conditional)

There are four supplemental claim information fields that are reported on only certain types of claims:

- Weekly Wage Amount
- Total Incurred Vocational Rehabilitation Amount
- Total Gross Incurred Amount
- Scheduled Indemnity — Percentage of Disability

Total Gross Incurred Amount must be reported on subrogation claims, joint coverage claims, and partially fraudulent claims. Additionally, these fields must be reported based on the Injury Code (Injury Type) of the claim. See the table below for an overview, and see the individual field sections for details.

Report this field…	**if the injury type on the claim is…**								**OR if any of these claim conditions exist, regardless of injury type:**		
	01 Death	02 Perm. Total Disability	03 Major Perm. Partial Disability	04 Minor Perm. Partial Disability	05 Temp. Total or Temp. Partial Disability	06 Medical Claims Only	07 Contract Medical or Hospital Allowance	08 Compromised Death or "S" Claim	Subrogation Claim Type of Recovery Code 03	Joint Coverage Claim Type of Recovery Code 05 or 06	Partially Fraudulent Claim Fraudulent Claim Code 01
Weekly Wage Amount	✓	✓	✓	✓	✓			✓			
Total Incurred Vocational Rehabilitation Amount	✓	✓	✓	✓	✓			✓			
Total Gross Incurred Amount								✓	✓	✓	✓
Scheduled Indemnity — Percentage of Disability		✓	✓	✓							

1. Record Type Code

WCSTAT Reporting Instructions

Report "5".

Additional Information/Examples for California Reporting

Per WCSTAT specifications, report at least one loss record on all subsequent reports and loss corrections. Loss records are reported only if claims exist on first reports and multiple corrections, and loss records are not allowed on header, exposure, and total corrections.

2. Classification Code

USRP Reporting Instructions

Report the 4-digit California standard classification code to which the claim has been assigned. With respect to contract medical, costs shall be apportioned by standard classification. (See the

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USRP, Part 4, Section II, *Definitions,* for the definition of "Contract Medical.") (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.) No claims may be assigned to any standard classification unless payroll or other appropriate exposure also has been reported for that standard classification. In cases where losses have been incurred under the benefits of a state other than where the payroll is assigned, report the claim in the state where the payroll is assigned.

3. Claim Count

WCSTAT Reporting Instructions
Report the number of claims reported as a grouped loss, or as defined by the respective statistical plan.

Individually listed claims are reported as either "0001" or "0000".

For policies effective 1/1/2011 and after, reporting of grouped claims will no longer be accepted.

Zeros are accepted for claims with claim numbers.

Additional Information/Examples for California Reporting
During USR submission preprocessing, the Claim Count, Accident Date, and Claim Number fields are validated for consistency. Report a valid date in the Accident Date field and a value (not blank) in the Claim Number field if the Claim Count for a loss record equals 0000 or 0001 (an individual claim).

For policies incepting on or after 1/1/2011, the reporting of grouped claims (Claim Count greater than 0001) was discontinued. Currently, almost all reported claims are individual and thus require an Accident Date and Claim Number. However, insurers are allowed to continue reporting grouped claims on policies incepting prior to 1/1/2011. For those remaining grouped claims, leave the Accident Date Field blank or report zeros and leave the Claim Number field blank if the Claim Count for a loss record is greater than 0001 (a grouped claim).

4. Accident Date

WCSTAT Reporting Instructions
Report the date on which the injury occurred.

This field applies only to individually listed losses.

Format YYMMDD.

Additional Information/Examples for California Reporting
Accident Date is not reported for contract medical claims (Injury Code (Injury Type) 07 – Contract Medical or Hospital Allowance).

See Section 3, *Field-by-Field Reporting Guidelines for California*, Subsection F, *Loss Record Fields*, Item 3, *Claim Count,* for information on the submission of the Claim Count, Accident Date, and Claim Number fields.

5. Claim Number

WCSTAT Reporting Instructions
Report the number that uniquely identifies the claim.

The complete claim number must remain the same throughout the life of the claim.

Claim number is not reported if the insurer elects the claim grouping option.

Do not include embedded blanks or marks of punctuation.

Claim number of every individually listed loss must be reported as right-justified and with leading blanks if claim number is less than 12 positions.

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Additional Information/Examples for California Reporting
The Claim Number field is the only key data field for matching incoming individual claim data to existing data in the WCIRB system. The Claim Number should not change after a loss is initially reported. See Section 2, *General Reporting Requirements*, Subsection C, *WCSTAT Reporting Methods for Exposure and Loss Records: Previous/Revised and Add/Change/Delete,* for more information on this.

For policies effective 1/1/2011 and after, reporting of grouped claims will no longer be accepted.

Claim Number is not reported for contract medical claims (Injury Code (Injury Type) 07 – Contract Medical or Hospital Allowance).

See Section 3, *Field-by-Field Reporting Guidelines for California*, Subsection F, *Loss Record Fields*, Item 3, *Claim Count,* for information on the submission of the Claim Count, Accident Date, and Claim Number fields.

6. Claim/Status Code

WCSTAT Reporting Instructions
Report the code that indicates the status of the claim.

Code	Description
0	Open Claim
1	Closed Claim

Additional Information/Examples for California Reporting
See the USRP, Part 4, Section II, *Definitions*, for definitions of the above. (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

7. Weekly Wage Amount

USRP Reporting Instructions
Report the whole dollar amount of the injured worker's weekly wage. See the USRP, Part 4, Section II, *Definitions,* for the definition of "Weekly Wage Amount." (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

This field must be reported on only claims meeting the following criteria:

- Injury Code (Injury Type) on the claim is:
  - 01 Death
  - 02 Permanent Total Disability
  - 03 Major Permanent Partial Disability
  - 04 Minor Permanent Partial Disability
  - 05 Temporary Total or Temporary Partial Disability
  - 08 Compromised Death or "S" Claim

Additional Information/Examples for California Reporting
For California reporting, Weekly Wage Amount refers to **average** weekly wages. See the USRP, Part 4, Section II, *Definitions,* for the complete definition of "Weekly Wage Amount."

8. Injury Code (Injury Type)

USRP Reporting Instructions
Report the code that identifies the injury type giving rise to the claim. See the USRP, Part 4, Section II, *Definitions,* for assistance in determining the "Injury Code (Injury Type)." (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.) All claims shall be assigned to an injury type even if the data in the file on the date of valuation is not sufficient to form a conclusive determination of the duration or extent of disability.

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Code	Description
01	Death
02	Permanent Total Disability
03	Major Permanent Partial Disability
04	Minor Permanent Partial Disability
05	Temporary Total or Temporary Partial Disability
06	Medical Claims Only
07	Contract Medical or Hospital Allowance
08	Compromised Death or "S" Claim

Additional Information/Examples for California Reporting
See the USRP, Part 4, Section II, *Definitions*, for definitions of the above. (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

9. Catastrophe Number

USRP Reporting Instructions
Report the 2-digit sequential number for two or more claims resulting from the same occurrence. For each policy, all claims resulting from the first such occurrence shall be assigned a "Catastrophe Number" of 01, all claims resulting from the second occurrence shall be 02, etc. When an occurrence results in only one claim being reported, report zero.

Example

Claim No.	Policy No.	Date of Injury	Cat. No.
123	WC-1	2/15/yy	01
456	WC-1	2/15/yy	01
321	WC-1	4/23/yy	00
789	WC-1	6/14/yy	02
987	WC-1	6/14/yy	02

With respect to unit statistical report data with a required date of valuation on or after March 1, 2002, report "Catastrophe Number" 48 for all claims directly arising from the commercial airline hijackings of September 11, 2001 and the resulting subsequent events with accident dates of September 11, 2001 through September 14, 2001. (This applies to both single and multiple claims.) (See the USRP, Part 4, Section II, *Definitions,* for the definition of "Catastrophe.") (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

With respect to unit statistical report data with a required date of reporting on or after August 1, 2020, report "Catastrophe Number" 12 for all claims directly arising from a diagnosis of Coronavirus disease 2019 (COVID-19) and an accident date on or after December 1, 2019.

10. Incurred Indemnity Amount

There are general reporting instructions and special loss reporting instructions for this field.

WCSTAT Reporting Instructions (General) for Incurred Indemnity Amount
Report the amount of incurred indemnity, including 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 as of the loss valuation date.

Enter in whole dollars only.

Section 3 — Field-by-Field Reporting Guidelines for California

USRP Reporting Instructions (Special) for Incurred Indemnity Amount
See the USRP, Part 4, Section V, *Loss Information*, Subsection C, *Special Loss Reporting Instructions,* for information on reporting the Incurred Indemnity Amount for the following types of claims (for your convenience, Appendix 4 to this Handbook is a copy of the USRP, Part 4, Section V, Subsection C):

- Subrogation Claims (Type of Recovery Code “03”)
- Partially Fraudulent (Fraudulent Claim Code “01”)
- Joint Coverage (Type of Recovery Code “05” or “06”)
- Non-Compensable Claims (Type of Settlement Code “05”)
- Cumulative Injury Claims (Type of Loss Code “03”)
- Employers’ Liability Claims (Type of Claim Code “02” or “03”)
- Compromised Death or “S” Claims (Injury Code (Injury Type) Code “08”)

Additional Information/Examples for California Reporting
See the USRP, Part 4, Section II, *Definitions*, for the definitions of the above. (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

11. Incurred Medical Amount

There are general reporting instructions and special loss reporting instructions for this field.

WCSTAT Reporting Instructions (General) for Incurred Medical Amount
Report the amount of incurred medical, including all paid and outstanding reserve benefits as of the loss valuation date.

Enter in whole dollars only.

USRP Reporting Instructions (Special) for Incurred Medical Amount
See the USRP, Part 4, Section V, *Loss Information*, Subsection C, *Special Loss Reporting Instructions,* for information on reporting the Incurred Medical Amount for the following types of claims (for your convenience, Appendix 4 to this Handbook is a copy of the USRP, Part 4, Section V, Subsection C):

- Subrogation Claims (Type of Recovery Code “03”)
- Partially Fraudulent (Fraudulent Claim Code “01”)
- Joint Coverage (Type of Recovery Code “05” or “06”)
- Non-Compensable Claims (Type of Settlement Code “05”)
- Cumulative Injury Claims (Type of Loss Code “03”)
- Employers’ Liability Claims (Type of Claim Code “02” or “03”)
- Compromised Death or “S” Claims (Injury Code (Injury Type) Code “08”)

Additional Information/Examples for California Reporting
See the USRP, Part 4, Section II, *Definitions,* for the definition of the above. (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

12. Update Type Code

USRP Reporting Instructions
Report the alphabetic code that identifies the activity of the loss record. Loss records can be reported using either the “Previous/Revised” method or the “Add/Change/Delete” method. Refer to the USRP, Part 4, Section VII, *Subsequent Reports, Correction Reports, and Reporting Methods*, Rule 3, *Reporting Methods*, for instructions.

Code	Description
A	Add Record
C	Change Record

Section 3 — Field-by-Field Reporting Guidelines for California

D	Delete Record
P	Previously Reported
R	Revised

Additional Information/Examples for California Reporting
See Section 2, *General Reporting Requirements*, Subsection C, *WCSTAT Reporting Methods for Exposure and Loss Records: Previous/Revised and Add/Change/Delete,* for information on using the Update Type Code field.

13. Loss Coverage Act

WCSTAT Reporting Instructions
Report the code that identifies the basis of liability for the claim.

Code	Description
00	Reserved For Future Use
01	State Act or Federal Act Excluding USL&HW and Federal Coal Mine Health and Safety Act
02	USL&HW “F” Coverage or USL&HW Coverage on Non-F-Classes

14. Type of Loss

WCSTAT Reporting Instructions
Report the code that identifies the circumstances of the injury.

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

Additional Information/Examples for California Reporting
See the USRP, Part 4, Section II, *Definitions,* for definitions of the above. (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

15. Type of Recovery

WCSTAT Reporting Instructions
Report the code that corresponds to the type of recovery received or anticipated.

Code	Description
01	No Recovery
03	Subrogation Only (Third Party)
05	Joint Coverage – Without Subrogation
06	Joint Coverage – With Subrogation

Additional Information/Examples for California Reporting
See the USRP, Part 4, Section II, *Definitions,* for definitions of the above. (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

16. Type of Claim

WCSTAT Reporting Instructions
Report the code that corresponds to the type of claim.

Code	Description
01	Workers Compensation Only
02	Employers Liability Only
03	Workers Compensation Including Employers Liability

Section 3 — Field-by-Field Reporting Guidelines for California

Additional Information/Examples for California Reporting
See the USRP, Part 4, Section II, *Definitions,* for the definition of Employers' Liability Claim(s). (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

17. Type of Settlement

USRP Reporting Instructions
Report the code that identifies the certain settlement situation for the claim.

Code	Description
00	Claims Not Subject to Settlement
03	Stipulated Award
04	Findings and Award
05	Non-Compensable
06	Compromise and Release
09	All Other Settlements

Additional Information/Examples for California Reporting

- See the USRP, Part 4, Section II, *Definitions,* for definitions of the above. (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)
- See the USRP, Part 4, Section II, *Definitions,* for definition of a non-compensable claim. The insurer shall submit a statement to the WCIRB when a non-compensable claim meets the requirements of California Labor Code Section 3761(d).

18. Total Incurred Vocational Rehabilitation Amount (CA Only)

WCSTAT Reporting Instructions
Report the amount of incurred cost of 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). See the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP), Part 4, Section II, *Definitions*, for the definition of "Supplemental Job Displacement Benefit Voucher(s)".

Enter in whole dollars only.

Additional Information/Examples for California Reporting
Report this field only on claims that meet the following criteria:

- Injury Code (Injury Type) on the claim is:
  - 01 Death
  - 02 Permanent Total Disability
  - 03 Major Permanent Partial Disability
  - 04 Minor Permanent Partial Disability
  - 05 Temporary Total or Temporary Partial Disability
  - 08 Compromised Death or "S" Claim

(For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

If you report an amount in "Total Incurred Vocational Rehabilitation Amount", a "Y" should be reported in the Vocational Rehabilitation Indicator field.

Section 3 — Field-by-Field Reporting Guidelines for California

19. Jurisdiction State Code

WCSTAT Reporting Instructions
Report 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 code is different from the exposure state code.

20. Part of Body

USRP Reporting Instructions
Report the code that identifies the part of body injured. (See the USRP, Appendix IV for the applicable codes.)

Additional Information/Examples for California Reporting
For your convenience, Appendix 5 to this Handbook is a copy of Appendix III from the USRP containing the list of codes applicable for California.

21. Nature of Injury

USRP Reporting Instructions
Report the code that identifies the nature of injury. (See the USRP, Appendix III for the applicable codes.)

Additional Information/Examples for California Reporting
For your convenience, Appendix 5 to this Handbook is a copy of Appendix III from the USRP containing the list of codes applicable for California.

22. Cause of Injury

USRP Reporting Instructions
Report the code that identifies the cause of injury. (See the USRP, Appendix III for the applicable codes.)

Additional Information/Examples for California Reporting
For your convenience, Appendix 5 to this Handbook is a copy of Appendix III from the USRP containing the list of codes applicable for California.

23. Vocational Rehabilitation Indicator

WCSTAT Reporting Instructions
Report the applicable indicator code.

This indicator identifies the inclusion of vocational rehabilitation costs in the losses.

These costs may include supplemental job displacement benefits issued in the form of vouchers. See the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP), Part 4, Section II, *Definitions*, for the definition of "Supplemental Job Displacement Benefit Voucher(s)."

Code	Description
N	Claim does not include Vocational Rehabilitation costs
Y	Claim includes Vocational Rehabilitation costs

Additional Information/Examples for California Reporting

If you report an amount in "Total Incurred Vocational Rehabilitation Amount", report "Y" in the Vocational Rehabilitation Indicator field.

24. Fraudulent Claim Code

USRP Reporting Instructions
Report the appropriate code from the list below to indicate whether a claim is partially fraudulent or not.

Section 3 — Field-by-Field Reporting Guidelines for California

Code	Description
00	Not Partially Fraudulent
01	Partially Fraudulent

Additional Information/Examples for California Reporting

- See the USRP, Part 4, Section II, *Definitions,* for definition of "Partially Fraudulent." (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)
- The WCIRB's use of code 00 differs from other DCOs. There is no applicable California code for "fully fraudulent;" therefore, Code 00 is designated as "Not **Partially** Fraudulent."

25. Paid Indemnity Amount

WCSTAT Reporting Instructions

Report the amount of paid indemnity for the claim as of the loss valuation date.

These losses consist of all paid benefits due to an employee's lost wages or inability to work, including compensation paid to a deceased prior to death, burial expense, claimant's attorney fees, vocational rehabilitation benefits, payments to the state and employers liability losses and expenses.

ALAE for other than employers liability coverage must be excluded from indemnity losses.

Enter in whole dollars only.

26. Paid Medical Amount

WCSTAT Reporting Instructions

Report the amount of medical losses paid for the claim as of the loss valuation date.

Enter in whole dollars only.

27. Total Gross Incurred Amount (CA Only)

USRP Reporting Instructions

Report the total gross incurred amount in whole dollars.

This field is only required to be reported on claims that are either subrogated (Type of Recovery Code "03"), partially fraudulent (Fraudulent Claim Code "01"), joint coverage (Type of Recovery Code "05" or "06"), or Compromised Death or "S" claim (Injury Code (Injury Type) "08").

a. Subrogation Claims — See the USRP, Part 4, Section V, *Loss Information*, Subsection C, *Special Loss Reporting Instructions,* Rule 1, *Subrogation Claims*.

b. Partially Fraudulent Claims — See the USRP, Part 4, Section V, *Loss Information*, Subsection C, *Special Loss Reporting Instructions,* Rule 2, *Partially Fraudulent Claims*.

c. Joint Coverage Claims — See the USRP, Part 4, Section V, *Loss Information*, Subsection C, *Special Loss Reporting Instructions,* Rule 3, *Joint Coverage Claims*.

d. "S" Claims — See the USRP, Part 4, Section V, *Loss Information*, Subsection C, *Special Loss Reporting Instructions,* Rule 7, Compromised Death or *"S" Claims*.

Additional Information/Examples for California Reporting

For your convenience, Appendix 4 to this Handbook is a copy of the USRP, Part 4, Section V, Subsection C.

28. Paid Allocated Loss Adjustment Expense (ALAE) Amount

USRP Reporting Instructions

Report the amount of loss adjustment expense allocated and paid by an insurance company when handling a claim as of the loss valuation date.

Enter in whole dollars only.

Additional Information/Examples for California Reporting
See the USRP, Part 4, Section II, *Definitions,* for the definition of "Paid Allocated Loss Adjustment Expense (ALAE) Amount." (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

29. Scheduled Indemnity – Percentage of Disability (CA Only)

WCSTAT Reporting Instructions
Report the permanent disability rating upon which the claim has been adjudicated.

If the claim has not been adjudicated, the insurer's best estimate of the permanent disability rating shall be reported.

Enter the nearest whole percentage.

Additional Information/Examples for California Reporting
Report this field only on claims that meet the following criteria:

- Injury Code (Injury Type) on the claim is:
  - 02 Permanent Total Disability
  - 03 Major Permanent Partial Disability
  - 04 Minor Permanent Partial Disability

Additional Information/Examples for California Reporting
See the USRP, Part 4, Section II, *Definitions,* for definitions of the above. (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

G. Unit Total Record Fields

The Unit Total Record contains fields for both exposure and loss totals. When corrections are processed, the type of correction (using the Correction Type Code field in the Header Record) and, in some cases, the report level is evaluated to determine which of the Unit Total Record fields to process.

For example, for an exposure correction, the loss total fields (Claim Count Total, Incurred Indemnity Amount, and Incurred Medical Amount Total) are not be processed because the correction type indicates that only exposure details and corresponding totals have changed. You do not need to report loss totals on an exposure correction.

For multiple corrections, however, there is no indication of what has changed in the correction – it could be exposure, loss, or both. Therefore, **all** fields on the Unit Total Record are processed. If a multiple correction is revising only the loss and header information, for instance, you must still report the latest exposure totals. If you do not report the latest exposure totals, and instead zero-fill those fields, the previously-reported exposure totals in the WCIRB system are overwritten with the incoming zero values.

Totals corrections can be reported either on a first report level (changing exposure and/or loss totals) or on a subsequent report level (changing loss totals only). If a totals correction is reported on the first report level, report the latest values on all Unit Total Record fields. If a totals correction is reported on a subsequent report level, only the loss totals need to be reported.

The table below provides an overview of the processing of Unit Total Record fields by USR type.

✓ = Required – the latest values must be reported
— = Not applicable; field can be zero-filled
c = Conditional; if claims exist, the latest values are required to be reported

Section 3 — Field-by-Field Reporting Guidelines for California

USR Type		WCSTAT Fields on Unit Total Record						
		Record Type Code	**Exposure – Payroll Total**	**Final Premium Total**	**Claim Count Total**	**Incurred Indemnity Amount Total**	**Incurred Medical Amount Total**	**Records in Unit Report Total**
First Report		✓	✓	✓	C	C	C	✓
Subsequent Report		✓	—	—	✓	✓	✓	✓
Correction Type H **Header**		n/a – Unit Total Record (record 6) is not allowed on header corrections.						
Correction Type E **Exposure**		✓	✓	✓	—	—	—	✓
Correction Type L **Loss**		✓	—	—	✓	✓	✓	✓
Correction Type T **Total**	RL 1	✓	✓	✓	✓	✓	✓	✓
	RLs 2-10	✓	—	—	✓	✓	✓	✓
Correction Type M **Multiple**		✓	✓	✓	✓	✓	✓	✓

1. **Record Type Code**

   WCSTAT Reporting Instructions
   Report "6".

2. **Exposure – Payroll Total**

   USRP Reporting Instructions
   Report in whole dollars the sum of all payroll exposures. Do not include per capita or per race exposure units in this total.

   Additional Information/Examples for California Reporting
   For 1st Reports, report the sum of all payroll exposure amounts.

   For Exposure Correction Reports, report the revised exposure payroll total.

   For Subsequent Reports and/or Loss Correction Reports, report zeros.

3. **Final Premium Total (Standard Premium Total)**

   USRP Reporting Instructions
   Report the whole dollar amount of the final premium for the policy. (See the USRP, Part 4, Section II, *Definitions,* for the definition of "Final Premium.") (For your convenience, Appendix 1 to this Handbook includes the definitions from Part 4, Section II of the USRP.)

   Additional Information/Examples for California Reporting
   Premium discount and expense constant should be reflected in Final Premium.

   For 1st Reports, report the final premium total.

   For Exposure Correction Reports, report the revised final premium total.

   For Subsequent Reports and/or Loss Correction Reports, report zeros.

Section 3 — Field-by-Field Reporting Guidelines for California

4. Claim Count Total

WCSTAT Reporting Instructions
Report the total number of claims reported for California within the policy.

For 1st Reports, report individually listed claims as one claim.

For Exposure Correction Reports, report zeros.

For Subsequent Reports and/or Loss Correction Reports, report the revised number of claims.

Claims reported using the grouping option will include the number of claims grouped.

For policies effective 1/1/2011 and after, reporting of grouped claims will no longer be accepted.

5. Incurred Indemnity Amount Total

USRP Reporting Instructions
Report the sum of the amounts reported for "Incurred Indemnity" as of the valuation date. In the case of subsequent reports and correction reports, the totals shown must be the revised totals for all of the claims for the policy and not just the sum of the loss records being revised or added in the correction report.

Additional Information/Examples for California Reporting
For 1st Reports, report the total of the incurred indemnity amounts on this report.

For Exposure Correction Reports, report zeros.

For Subsequent Reports and/or Loss Correction Reports, report the revised incurred indemnity total of all claims for the policy.

6. Incurred Medical Amount Total

USRP Reporting Instructions
Report the sum of the amounts reported for "Incurred Medical" as of the valuation date. In the case of subsequent reports and correction reports, the totals shown must be the revised totals for all of the claims for the policy and not just the sum of the loss records being revised or added in the correction report.

Additional Information/Examples for California Reporting
Report the total of the incurred medical amounts reported for the state within the policy.

For 1st Reports, report the total of the incurred medical amounts on this report.

For Exposure Correction Reports, report zeros.

For Subsequent Reports and/or Loss Correction Reports, report the revised incurred medical total of all claims for the policy.

7. Records in Unit Report Total

WCSTAT Reporting Instructions
Report the total number of records including the unit total record reported for this unit report.

This includes ALL records reported for the USR. Both 'previous' and 'revised' records should be included in this total.

For example, 1 header record, 1 name record, 1 address record, 2 exposure records, 10 loss records and 1 unit total record = 16 records.

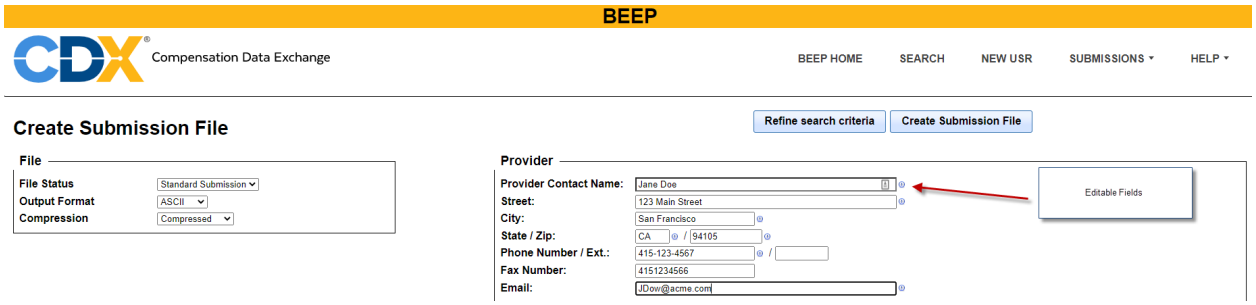
H. Electronic Transmittal Record (ETR)

The Electronic Transmittal Record (ETR) is the first record in every submission and includes identifying information about the submitter of the file and its data. The WCIO's specifications for the ETR are located in the document titled *Electronic Transmittal Record Specifications (ETR).*

Section 3 — Field-by-Field Reporting Guidelines for California

One, and only one, ETR is required for each file submitted and the ETR must be the first record in every submission file.

Changing ETR values if you use BEEP to create submission files. If you create submission files in BEEP, the ETR is automatically generated by BEEP when the file is created. BEEP populates some of the ETR fields by pulling information from your CDX user profile. During the submission file creation, BEEP allows you to edit those fields for the current submission:



To permanently change these fields, however, requires editing your CDX user profile. Contact your company's CDX administrator (IGA) for assistance with your CDX account.

Changing ETR values if you use a proprietary system to create submission files. If you use a proprietary system to generate your WCSTAT submissions, please contact your IT department for information on changing ETR values.

1. **Label**

   WCIO ETR Reporting Instructions
   Report the first 14 characters as $!+WORKCOMP+!$. This is a constant.

   This will be used to determine that this is a transmittal record for workers' compensation.

2. **Data Provider Contact Email Address**

   WCIO ETR Reporting Instructions
   Report the email address of the individual who should be contacted regarding submission or transmission problems and questions and error reports.

   Additional Information/Examples for California Reporting
   This should be the email address of the data provider contact identified in Item 9, *Name of Data Provider Contact*.

3. **Record Type Code**

   WCIO ETR Reporting Instructions
   Report "__" (fill with two (2) blanks).

4. **Data Type Code**

   WCIO ETR Reporting Instructions
   Report the code that defines the type of information contained in the submission.

   The first two (2) bytes are always "WC". The third byte defines the type of information contained in the submission.

Code	Description
S	Unit Report (WCSTAT)

5. **Data Receiver Code**

Section 3 — Field-by-Field Reporting Guidelines for California

WCIO ETR Reporting Instructions
Report the state code of the DCO receiving the information.

When used as electronic confirmation of receipt and processing of electronic submission, this field will contain the code assigned to the data provider that originated the submission.

Code	Description
00004	California

6. Transmission Version Identifier

WCIO ETR Reporting Instructions
Report the series of characters used to sequence file transmissions.

Example: “96281V01” is the first transmission of data on October 7, 1996.

For file transmissions, the Julian date is in the first five positions followed by the constant letter “V” in the sixth position, followed by the version number of the transmission in the seventh and eighth positions.

For each subsequent transmission sent with the same date to the same DCO, the version is incremented by 1 (e.g., “96281V02”).

7. Submission Type Code

WCIO ETR Reporting Instructions
Report the code describing the type of submission.

Code	Description
S	Standard Submission
T	Test Submission

8. Data Provider Code

WCIO ETR Reporting Instructions
Report the code applicable to the data provider.

For group submissions, report the group code.

For single submissions, report the individual carrier code.

Additional Information/Examples for California Reporting
If the Data Provider Code is not valid, the submission will be rejected.

The Carrier Code for each USR in the submission must be part of the same NAIC group as the Data Provider Code or a permissions error will result and the submission will be rejected.

9. Name of Data Provider Contact

WCIO ETR Reporting Instructions
Report the name of the individual who should be contacted regarding submission or transmission problems and questions and error reports.

10. Phone Number

WCIO ETR Reporting Instructions
Report the phone number of the data provider contact.

11. Phone Number Extension

WCIO ETR Reporting Instructions
Report the phone number extension of the data provider contact.

12. Fax Number

WCIO ETR Reporting Instructions

Section 3 — Field-by-Field Reporting Guidelines for California

Report the fax number of the data provider contact.

13. **Processed Date**

WCIO ETR Reporting Instructions
Report the date the file was created by the data provider.

Format CCYYMMDD.

14. **Address of Contact – Street**

WCIO ETR Reporting Instructions
Report the street number and name, post office box or other description of the contact person.

15. **Address of Contact – City**

WCIO ETR Reporting Instructions
Report the name of the city of the contact person.

16. **Address of Contact – State**

WCIO ETR Reporting Instructions
Report the US Postal Service abbreviation for the state or the abbreviation for the Canadian province of the contact person.

17. **Address of Contact – ZIP Code**

WCIO ETR Reporting Instructions
Report the zip code of the physical address of the contact person.

18. **Data Provider Type Code**

WCIO ETR Reporting Instructions
Report the code identifying the data provider type.

Code	Description
C	Data Provider is Insurance Carrier
T	Data Provider is Third Party Entity (TPE/TPA/MGA) (on behalf of the Insurance Carrier)

Additional Information/Examples for California Reporting
This field (position 239 of the ETR) is required. If you are a submitting insurer, you must report "C" in this field. If you are an authorized Third-Party Entity (TPE), you must report "T" in this field. Each TPE is also required to report its Federal Employer Identification Number (FEIN) in positions 240-248 of the ETR.

Changing the Data Provider Type Code if you use BEEP to create submission files. If you create submission files in BEEP, the ETR is automatically generated by BEEP when the file is created. BEEP automatically populates the Data Provider Type Code based on the user's CDX profile. If you are an insurer, BEEP should automatically report "C" in this field. If not, contact your company's CDX administrator (IGA) for assistance with your CDX account. If you are a TPE, BEEP should automatically report "T" in this field. If not, contact the insurer's CDX administrator (IGA) for assistance with your CDX account and to ensure that your user account is set up as a TPE account type.

19. **Third Party Entity (TPE/TPA/MGA) Federal Employer Identification Number (FEIN)**

WCIO ETR Reporting Instructions
Report the Federal Employer Identification Number (FEIN) corresponding to the Third Party Entity (TPE/TPA/MGA) Data Provider (on behalf of the Insurance Carrier).

Additional Information/Examples for California Reporting

Section 3 — Field-by-Field Reporting Guidelines for California

If a "T" is reported in the Data Provider Type Code field, a valid FEIN must be reported in this field. If a "C" is reported in the Data Provider Type Code field, this field must be left blank or zero-filled.

If the TPE is not authorized to report USRs for the associated Carrier Codes, the submission will be rejected.

I. File Control Record (FCR)

The File Control Record (FCR) is the last record in every submission and includes a summary about the file.

One, and only one, FCR is required for each file submitted and the FCR must be the last record in every submission file.

The FCR specifications are included in WCSTAT.

1. Filler

WCSTAT Reporting Instructions
These positions of this record are to be filled with 9s.

2. Record Type Code

WCSTAT Reporting Instructions
Report "9".

3. Detail Record Count Total

WCSTAT Reporting Instructions
Report the total number of records on the submission.

This field will show the total number of records on the submission including the Electronic Transmittal Record if used, but excluding the File Control Record.

4. Unit Reports Submitted Total

WCSTAT Reporting Instructions
Report the total number of unit reports submitted.

5. Primary Effective Year

WCSTAT Reporting Instructions
Report the primary effective year of this submission.

6. Primary Effective Month

WCSTAT Reporting Instructions
Report the primary effective month of this submission.

Appendix 1 — Definitions

All definitions are listed as they appear in Part 4, Section II, *Definitions*, of the USRP.

1. **Accident Date**
   a. For specific injuries, it is the date on which the accident or injury occurred.
   b. For cumulative injury or occupational disease cases, it is the date during the policy period to which the claim is assigned.
2. **Allocated Loss Adjustment Expense(s)**
   See Loss Adjustment Expense(s).
3. **Audited Exposure**
   Payroll or other basis of exposure reported from an audit conducted pursuant to USRP, Part 3, Section VI, Rule 4, *Audit of Payroll*. See also USRP, Part 1, Section II, *General Definitions*, for the definition of "Audit" and "Exposure(s)".
4. **Catastrophe**
   Any single accident resulting in a compensable injury to two or more persons. Accident includes incidents where multiple claims have been consolidated for hearing by the Workers' Compensation Appeals Board.
5. **Closed or Closed Claim**
   Any claim for which final payment has been made.
6. **Compromise and Release**
   A settlement over the issues of compensability, extent of injury, and/or past, present and/or future benefits.
7. **Compromised Death Claim(s)**
   A closed death claim that has been compromised over the sole issue of the applicability of the workers' compensation laws of California.
8. **Contract Medical**
   The actual costs incurred by the insurer under medical contracts with physicians, hospitals, and others that cannot be allocated to a particular claim, e.g., a contract for medical services provided on a per-head or "capitated" basis.
9. **Cumulative Injury or Cumulative Injury Claim(s)**
   An injury having occurred from repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which caused any disability or need for medical treatment.
10. **Death or Death Claim**
    Any industrial death claim, unless it has been established that the insurer incurred no liability for the death, the injured worker died from natural causes, or the claim was compromised over the sole issue of the applicability of the workers' compensation laws of California. (See the definition for "Compromised Death Claim(s)".)
11. **Employers' Liability Claim(s)**
    A claim with an Allocated Loss Adjustment Expense or an incurred loss amount under the employers' liability provision of the workers' compensation insurance policy.
12. **Final Premium(s)**
    Reported in the "Standard Premium Total" field on the unit statistical report, this is the total premium charged to the policyholder, EXCEPT that it does not include the following:
    a. Reinsurance assumed,
    b. Adjustment for reinsurance ceded,
    c. Retrospective rating adjustments,

Appendix 1 — Definitions

d. Policyholder dividends,

e. Application of deductible credits,

f. Premium charges arising from the Terrorism Risk Insurance Program established by the Terrorism Risk Insurance Act of 2002 and any amendments thereof.

g. The costs incurred by the insurer in unsuccessfully attempting to perform a payroll audit that are reimbursable pursuant to Insurance Code Section 11760.1, and

h. Policy assessments, including but not limited to California Insurance Guarantee Association (CIGA) assessments, California Workers' Compensation Revolving Fund assessments, California workers' compensation fraud surcharges, Uninsured Employers Benefits Trust Fund assessments, Occupational Safety and Health Fund assessments, Labor Enforcement and Compliance Fund assessments, and Subsequent Injuries Benefits Trust Fund assessments.

The following hypothetical examples illustrate how final premiums on two large policies are to be determined (assuming, for simplicity, that retrospective rating adjustments and policyholder dividends do not apply to these two policies, but a charge arising from the Terrorism Risk Insurance Program and any amendments thereof, does apply):

		Example One	Example Two
(1)	Subject Premium (Based on exposure and insurer's rates)	$ 5,000	$ 200,000
(2)	Experience Rating Credit	—	20,000
(3)	Experience Rating Debit	—	—
(4)	Deductible Credit	—	50,000
(5)	Premium Discount	—	10,000
(6)	Expense Constant	50	—
(7)	Other Credit Adjustments*	100	2,000
(8)	Other Debit Adjustments**	75	3,000
(9)	Charge for the Terrorism Risk Insurance Program and any amendments thereof	40	1,500
(10)	Actual Premium Charged [(1) + (3) + (6) + (8) + (9)] – [(2) + (4) + (5) + (7)]	5,065	122,500
(11)	**Final Premium to be Reported** [(1) + (3) + (6) + (8)] – [(2) + (5) + (7)], or simply (10) + (4) – (9)	**$ 5,025**	**$ 171,000**

* schedule rating credits, merit rating credits, Insolvent Insurer Rating Adjustment Factor credits, etc., if applicable.

** schedule rating debits, surcharge for waiver of subrogation, surcharge for Coverage B increased limits, surcharge for policyholder audits authorized by Insurance Code Section 11665, additional premium estimated pursuant to Insurance Code Section 11760.1, Insolvent Insurer Rating Adjustment Factor debits, premium charges not included in insurer's filed rates related to Coronavirus 2019 (COVID-19)[1] etc., if applicable.

13. Findings and Award
An award that has been issued by a workers' compensation judge based on evidence presented in the process of litigation.

14. Incurred Indemnity
The sum of all paid indemnity losses and the outstanding indemnity losses on a claim. (See the definitions for "Indemnity Loss(es)" and "Outstanding Indemnity".)

[1] The WCIRB has submitted recommended changes to be effective September 1, 2021.

Appendix 1 — Definitions

15. Incurred Loss(es)
The sum of incurred indemnity and incurred medical losses. (See the definitions for "Incurred Indemnity" and "Incurred Medical".)

16. Incurred Medical
The sum of all paid medical losses and the outstanding medical on a claim. (See the definitions for "Medical Loss(es)" and "Outstanding Medical".)

17. Indemnity Loss(es)
All indemnity costs including, but not limited to:

a. On a claim closed by a single sum settlement, that portion assignable to indemnity. (See the definition for "Single Sum Settlement".)

b. The following legal expenses for the claimant if they are included in the award to, or incurred on behalf of, a claimant:

(1) Witness fees.

EXCEPTION: Expert medical witness fees shall be included in medical loss.

(2) Attorney fees.

(3) Other court costs.

(4) Reimbursement for expenses incurred in attending a hearing or deposition, including interpreter fees.

(5) Cost of copies of documents such as birth and death certificates.

c. The cost of all supplemental job displacement benefit vouchers as well as any additional vocational rehabilitation-type benefits (including those provided on a voluntary basis).

d. Allocated Loss Adjustment Expenses incurred for employers' liability claims.

Note:
Indemnity losses do not include automatic increases to late indemnity payments made pursuant to California Labor Code Section 4650, penalties for unreasonable delay determined by the Workers' Compensation Appeals Board pursuant to California Labor Code Section 5814, reimbursement of lien filing fee or lien activation fee made pursuant to California Labor Code Section 4903.07 or reimbursement of independent bill review fee made pursuant to California Labor Code Section 4603.6(c).

18. Insolvent Insurer Rating Adjustment Factors
See the definition for "Insolvent Insurer Rating Adjustment Factor" located in Part 1, *General Provisions,* Section II, *General Definitions,* of the *Miscellaneous Regulations for the Recording and Reporting of Data—1995*, approved by the Insurance Commissioner of the State of California, Title 10, California Code of Regulations, Section 2354.

19. Joint Coverage or Joint Coverage Claim(s)
A claim for which it has been determined by adjudication that the coverage furnished by other than the one policy for which experience is being reported is pertinent to a division of the total incurred loss which usually results from the injured party having co-employers, overlapping coverage on the same employer, or the injury developing over an extended period. When an insurer has determined that the loss is chargeable to two or more employers insured by such insurer, or when a written agreement has been executed between two or more insurers which specifies a sum specific or percentage of contribution as to each insurer's liability for the claim, 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.

Appendix 1 — Definitions

20. Loss Adjustment Expense(s)

Loss adjustment expense(s) includes two components, **Allocated Loss Adjustment Expense(s)** and **Unallocated Loss Adjustment Expense(s)**, each of which is defined below:

a. Allocated Loss Adjustment Expense(s)

Allocated Loss Adjustment Expenses includes of the following costs:

(1) Fees, salary and overhead (including support staff) of individuals whose primary or predominant job function is to perform representation before the Workers' Compensation Appeals Board or other legal services. This shall include costs incurred by outside or in-house counsel, non-attorney hearing representatives and their related support personnel.

EXCEPTION: Costs associated with occasional or incidental legal work performed by individuals hired primarily or predominantly to perform the function of claim operations shall be considered as Unallocated Loss Adjustment Expenses (see Subrule 20b, below).

(2) The cost of legal services incurred in pursuing subrogation recoveries.
EXCEPTION: If a subrogation reimbursement is obtained, the reported cost of legal services incurred in pursuing the recovery shall be reduced by the amount reimbursed. If the reimbursement exceeds the cost of such legal services, the excess shall be applied to reduce the reported incurred losses.

(3) Court, alternate dispute resolution and other specific costs listed below that are not included in the award to or incurred on behalf of the claimant:

(If any costs listed below are included in the award to or incurred on behalf of the claimant, they shall be reported as indemnity loss.)

(a) Expert testimony.

EXCEPTION: The cost of all expert testimony related to medical-legal shall be reported as medical loss.

(b) Witnesses and summonses.

(c) Copies of documents such as birth and death certificates.

EXCEPTION: The cost of procuring copies of medical treatment records shall be reported as medical loss.

(d) Alternate dispute resolution fees, such as arbitration fees.

(e) Surveillance, including activity checks, performed by either in-house personnel or outside services.

EXCEPTION: The cost of incidental surveillance or activity checks performed by individuals hired primarily or predominantly to perform the function of claim operations shall be considered as Unallocated Loss Adjustment Expenses (see Subrule 20b, below).

(f) The cost of field investigations related to the compensability of claims, potential fraud or the potential for future subrogation, performed by either dedicated in-house personnel or outside services.

EXCEPTION: The cost of incidental field investigations performed by individuals hired primarily or predominantly to perform the function of claim operations shall be considered as Unallocated Loss Adjustment Expenses (see Subrule 20b, below).

(g) Court costs, such as appeal bond costs and appeal filing fees.

Appendix 1 — Definitions

(h) Interpreter fees.

EXCEPTION: Interpreter fees related to medical-legal or medical treatment shall be reported as medical loss. Interpreter fees related to vocational rehabilitation or included in the award to, or incurred on behalf of, the claimant, other than those related to medical-legal or medical treatment, shall be reported as indemnity loss.

(4) The cost of medical cost containment programs incurred with respect to a particular claim or which can be allocated to a particular claim, whether by an outside vendor or done internally by an employee, to ensure that only reasonable and necessary costs of services are paid, shall be included in the allocated loss adjustment expense amount. (The cost of medical cost containment programs that cannot be allocated to a particular claim shall be considered unallocated loss adjustment expenses.)

These costs include, but are not limited to:

(a) Bill auditing expenses for any medical services rendered, such as hospital bills, nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills and medical vendor bills.

(b) Hospital and other treatment utilization reviews, including precertification/preadmission, and concurrent or retrospective reviews. This includes fees and costs, including the cost of procuring copies of medical records, associated with independent medical review conducted pursuant to Labor Code Sections 4610.5 and 4610.6 or 4616.4.

(c) Access fees and other expenses incurred with respect to the utilization of managed care organizations, such as preferred provider networks/organizations (PPOs), medical provider networks (MPNs), and Health Care Organizations (HCOs).

(d) Costs of medical management except for nurse case management or case management that directly interacts and is coordinated with the injured employee and others, who are all parties to the employee's need for medical care.

(5) The fees and costs, including the cost of procuring copies of medical records, associated with independent bill review conducted pursuant to Labor Code Section 4603.6 or independent medical review conducted pursuant to Labor Code Sections 4610.5 and 4610.6 or 4616.4.

b. Unallocated Loss Adjustment Expense(s)

The costs of an insurer, in connection with the handling of claims, which are not defined as Allocated Loss Adjustment Expenses, indemnity loss or medical loss. These include, but are not limited to:

(1) Fees, salary and overhead (including support staff) of individuals hired primarily or predominantly to perform the function of claim operations. This includes costs incurred by in-house personnel or outside services.

EXCEPTION: Costs related to individuals whose primary or predominant function is to perform legal services or field investigations related to the compensability of claims, potential fraud or the potential for future subrogation shall be considered as Allocated Loss Adjustment Expenses (see Subrule 20a, above).

(2) The costs of medical cost containment programs that cannot be allocated to a particular claim. (The costs of medical cost containment programs that can be allocated to a particular claim shall be reported as allocated loss adjustment expenses.)

(3) The cost of benefit increases or penalty awards made pursuant to California Labor Code Sections 4650, 5814, 4603.2, 4610.6 and 4622.

Appendix 1 — Definitions

(4) The cost of the reimbursement to the lien claimant of the lien filing fee or lien activation fee when ordered or awarded by the Workers' Compensation Appeals Board (WCAB) or arbitrator pursuant to Labor Code Section 4903.07.

21. Major Permanent Partial Disability
An injury resulting in a permanent partial disability, not constituting permanent total disability, which has been adjudicated to constitute a permanent disability rating of 25% or more (but less than 100%) or which, in the opinion of the insurer, will result in a permanent disability rating of 25% or more (but less than 100%).

22. Medical Evaluation
An examination of a worker's injury, performed by an independent medical examiner, agreed medical evaluator, treating physician, consulting physician or qualified medical evaluator, for purposes of assessing the worker's eligibility for benefits, ability to return to work, extent of permanent disability and/or need for new and further medical treatment. This does not include independent medical review conducted pursuant to Labor Code Sections 4610.5 and 4610.6 or 4616.4 or independent bill review conducted pursuant to Labor Code Section 4603.6.

23. Medical Loss(es)
All medical costs including, but not limited to:

a. On a claim closed by a single sum settlement, that portion assignable to medical. (See the definition for "Single Sum Settlement".)

b. The cost of all medical evaluations and medical-legal evaluations shall be included in the medical amount. This includes all evaluations to determine eligibility for benefits, such as ability to return to work, extent of permanent disability, and/or the need for new and further medical treatment. This also shall include the cost of procuring copies of medical records and interpreter fees related to medical evaluations and medical-legal evaluations. This does not include costs associated with independent medical review conducted pursuant to Labor Code Sections 4610.5, and 4610.6 or 4616.4 or independent bill review conducted pursuant to Labor Code Section 4603.6.

c. Contract medical. (See the definition for "Contract Medical".)

d. Interpreter fees related to medical treatment.

e. All fees or costs related to Medicare Set-aside Arrangements.

Note:
Medical losses shall not include increases due to late payments for medical and medical-legal services made pursuant to California Labor Code Sections 4603.2 or 4622.

24. Medical Only or Medical Claims Only
A claim or injury for which no indemnity is incurred, but for which medical treatment costs are incurred is a "medical only" claim or injury, regardless of whether the cost of medical treatment, including first aid, is paid by an employer or insurer, or regardless of whether a Workers' Compensation Claim Form (DWC 1) is filed. "Medical Only" claims or injuries include but are not limited to all compensable injuries in which the disability does not extend beyond the waiting period specified in the workers' compensation laws of California, or injuries for which immediate medical treatment has been provided prior to a determination of compensability pursuant to Labor Code Section 5402(c).

25. Minor Permanent Partial Disability
An injury resulting in a permanent partial disability, not constituting permanent total disability, which has been adjudicated to constitute a permanent disability rating of less than 25% (but greater than 0%) or which, in the opinion of the insurer, will result in a permanent disability rating of less than 25% (but greater than 0%).

Appendix 1 — Definitions

26. Net Incurred (Loss)
In the computation of experience modifications, the amount used for Subrogation, Partially Fraudulent, Joint Coverage or Compromised Death Claims that is determined as described for each such claim in Section V, *Loss Information*, Subsection C, *Special Loss Reporting Instructions*.

27. Non-Compensable Claim(s)
Any claim where:

a. There is a ruling by the Workers' Compensation Appeals Board (WCAB), or other court of competent jurisdiction, specifically holding that a claimant is not entitled to benefits under the workers' compensation laws of California, even though the claimant may have been awarded reimbursement for expenses incurred by the claimant in presenting his/her case;

b. The insurer rejects the claim for benefits under the workers' compensation laws of California and the claim is dismissed by a ruling by the WCAB or other court of competent jurisdiction, because of the claimant's failure to prosecute his/her claim; or

c. The insurer rejects the claim for benefits and no application for adjudication of claim was filed during the period of limitation provided by the workers' compensation laws of California.

28. Nontransferable Education-Related Voucher(s)
See the definition for "Supplemental Job Displacement Benefit Voucher(s)".

29. Occupational Disease
Any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment. It includes acute and chronic illnesses or disease that may be caused by inhalation, absorption, ingestion or direct contact.

30. Open or Open Claim(s)
Any claim that is not closed.

31. Outstanding Indemnity
The insurer's individual case estimate of all future indemnity payments on the claim.

32. Outstanding Medical
The insurer's individual case estimate of all future medical payments on the claim.

33. Partially Fraudulent Claim(s)
A claim where the Workers' Compensation Appeals Board (WCAB) declares a portion of the claim costs invalid, unnecessary or excessive, such as, but not limited to, cases where medical liens are deemed excessive.

34. Permanent Total Disability
An injury that has been adjudicated to constitute a permanent disability rating of 100% or which, in the judgment of the insurer, will result in a 100% permanent disability rating.

35. "S" Claim(s)
See the definition for "Compromised Death Claim(s)".

36. Single Sum Settlement
The closing amount of a claim representing the discounted or commuted value of a specific award or benefit. These could include compromise and release settlements, stipulated awards, findings and awards or summary ratings.

37. Statistical Code
A code, not a standard classification code, normally used by insurers to report premium credits and debits resulting from rating plans, discounts, surcharges, etc., on unit statistical reports submitted to other jurisdictions.

Appendix 1 — Definitions

38. **Stipulated Award**
    An award that has been drawn up between the insurer and claimant and submitted to the Workers' Compensation Appeals Board (WCAB) for review.

39. **Subrogated, Subrogation or Subrogation Claim(s)**
    A claim where an insurer received monetary reimbursement either in part or in whole under subrogation rights.

40. **Supplemental Job Displacement Benefit Voucher(s)**
    Supplemental job displacement benefits in the form of vouchers issued pursuant to Labor Code Sections 4658.5 and 4658.7.

41. **Temporary Total or Temporary Partial Disability**
    A claim or compensable injury that is not classified as permanent and that extends beyond the waiting period specified in the workers' compensation laws of California.

42. **Trauma**
    An injury resulting in disability or death that is traceable to a definite accident occurring during the worker's present or past employment and cannot be classified as either a cumulative injury or an occupational disease claim.

43. **Unallocated Loss Adjustment Expense(s)**
    See Loss Adjustment Expense(s).

44. **Weekly Wage Amount**
    Average weekly wages upon which the indemnity benefits are based pursuant to the California Labor Code (but not the maximum or minimum weekly earnings specified in the California Labor Code).

Appendix 2 — Statistical Codes in California Reporting (for BEEP Users)

Although California does not require the reporting of statistical codes other than statistical code 0012 and 9740, if applicable, insurers may choose to report statistical code details since the correct application of statistical code details is necessary for the calculation of the Final Premium Total (reported under the Total Standard Premium field in BEEP).

The WCIRB system does not capture any premium information associated with exposure records that include a statistical code in the Classification Code field other than those reported with stastical code 9740. For purposes of calculating Final Premium, however, below is some helpful information for BEEP users.

In BEEP, each DCO has defined its statistical codes along with attributes for the premium associated with each code, including whether or not the premium:

- **Must have the employer's experience modification applied to it**
  "Above the mod" is the common term in BEEP reporting for statistical codes with associated premium to which the experience modification is applied. "Below the mod" and "Non-standard" in BEEP reporting refer to statistical codes with associated premium to which the experience modification is not applied.

- **Is to be included in the Final Premium calculation**
  For California, premium associated with "above the mod" and "below the mod" statistical codes is included in the Final Premium calculation, while premium associated with "non-standard" statistical codes is not.

- **Should be treated as a debit or a credit in the Final Premium calculation.**

California has also defined code attributes for purposes of BEEP calculations. If you use BEEP and choose to report statistical codes in USRs submitted to the WCIRB, you will need to ensure that experience modifications are applied correctly depending on the code attributes as defined by California.

In general, California expects experience modifications to be applied ONLY to standard classification codes, not to statistical codes:

> Section I, Rule 4, *Applicability*, of the ERP defines how the WCIRB-promulgated experience modification is to be applied:
>
> > An experience modification promulgated in accordance with this Plan shall be applied to the base premium developed in connection with the coverage provided during the effective period of the experience modification.
>
> Base Premium is defined in Section II, Rule 2 of the ERP as:
>
> > The amount derived from summing the application of the insurer classification rates to the payroll or other basis of exposure, excluding any premium charges arising from the Terrorism Risk Insurance Act of 2002 and any amendments thereof.

Based on the rules of the ERP, BEEP considers all statistical codes with associated premiums that contribute to the derivation of Final Premium Total on California policies as "below the mod"; that is, BEEP will not apply an employer's experience modification to premiums emanating from these statistical

Appendix 2 — Statistical Codes in California Reporting (for BEEP Users)

codes. See Section G, *Unit Total Record Fields,* Subsection 3, *Final Premium Total (Standard Premium Total),* for more information regarding how to calculate Final Premium.

The WCIRB has developed some generic statistical codes which may be used solely to represent premium credits and debits for purposes of determining the Final Premium amount by BEEP:

Generic Credit Statistical Codes for use in BEEP

- 9722
- 0222
- 0522

Generic Debit Statistical Codes for use in BEEP

- 9724
- 0224
- 0524

Appendix 3 — Grouped Claim Conversion Examples

Appendix 3 — Grouped Claim Conversion Examples

The WCIRB discontinued grouped claim reporting for policies incepting on or after January 1, 2011. However, insurers are allowed to continue grouped claim reporting on policies incepting prior to January 1, 2011 and some insurers convert older claims that were grouped to individual claims. The examples below demonstrate how to convert claims that were grouped to individual claims so that the updates are processed accurately. It is important to note that in some cases the primary key data fields for grouped claim reporting (Classification Code, Injury Code (Injury Type), and Loss Coverage Act Code) must remain the same until the claims that were grouped are initially converted to individual claims. After the conversion is processed, later corrections can be submitted to change key data fields as needed.

Example 1: Extracting an individual claim.
Extract one individual claim that was previously reported as part of a group and change key data on the individual claim.

Existing grouped claim:

Claim Count	Claim Number	Accident Date	Class Code	Loss Coverage Act	Injury Type	Inc. Medical	Inc. Indemnity
10	*blank*	*blank*	5183	01	6	5000	0

Report the following:

USR 1 – All changes can be done in one USR.

Update Type Code	Claim Count	Claim Number	Accident Date	Class Code	Loss Coverage Act	Injury Type	Inc. Medical	Inc. Indemnity	Comments
P or D	10	*blank*	*blank*	5183	01	6	5000	0	Update the existing grouped claim count and loss information to 'subtract' the individual claim. **The Class Code, Loss Act, and Injury Type must remain the same on the P and R records or on the D and A records.**
R or A	**9**	*blank*	*blank*	5183	01	6	4500	0	
R or A	1	**XXXXX1**	**YYMMDD**	5183	01	5	500	200	Add the new individual claim. The Class Code, Loss Act, and Injury Type can change on this record.

Red = Changed fields
Gray shading = Fields that must remain the same as previously reported

Resulting claim hierarchy in WCIRB Connect:

- Grouped Claim with Claim Count of 9
  - Grouped Claim with Claim Count of 10 (inactive)
- Ind. Claim XXXXX1

Appendix 3 — Grouped Claim Conversion Examples

Example 2: Converting to individual claims.
Convert claims previously-reported as grouped to multiple individual claims and change key data.

Existing grouped claim:

Claim Count	Claim Number	Accident Date	Class Code	Loss Coverage Act	Injury Type	Inc. Medical	Inc. Indemnity
10	*blank*	*blank*	5183	01	6	5000	0

Report the following:
Report the following in two separate USR submissions.

USR 1 – Convert to individual claims

Update Type Code	Claim Count	Claim Number	Accident Date	Class Code	Loss Coverage Act	Injury Type	Inc. Medical	Inc. Indemnity	Comments
P or D	10	*blank*	*blank*	5183	01	6	5000	0	One P record to delete the grouped claim
R or A	1	**XXXXX1**	**YYMMDD**	5183	01	6	476	0	10 new individual claims are added. **The Class Code, Loss Act, and Injury Type must remain the same as the original grouped claim.**
R or A	1	**XXXXX2**	**YYMMDD**	5183	01	6	128	0	
R or A	1	**XXXXX3**	**YYMMDD**	5183	01	6	1122	0	
R or A	1	**XXXXX4**	**YYMMDD**	5183	01	6	785	0	
R or A	1	**XXXXX5**	**YYMMDD**	5183	01	6	146	0	
R or A	1	**XXXXX6**	**YYMMDD**	5183	01	6	956	0	
R or A	1	**XXXXX7**	**YYMMDD**	5183	01	6	610	0	
R or A	1	**XXXXX8**	**YYMMDD**	5183	01	6	220	0	
R or A	1	**XXXXX9**	**YYMMDD**	5183	01	6	260	0	
R or A	1	**XXXX10**	**YYMMDD**	5183	01	6	297	0	

USR 2 – Change key data

Update Type Code	Claim Count (No. of Claims)	Claim Number	Accident Date	Class Code	Loss Coverage Act	Injury Type	Inc. Medical	Inc. Indemnity	Comments
P or D	1	XXXXX4	YYMMDD	5183	01	6	785	0	Change any details on the new individual claims.
R or A	1	XXXXX4	YYMMDD	**8810**	01	6	**811**	0	
P or D	1	XXXXX9	YYMMDD	5183	01	6	260	0	Change any details on the new individual claims.
R or A	1	XXXXX9	YYMMDD	5183	01	**5**	260	**157**	

Red = Changed fields
Gray shading = Fields that must remain the same as previously reported

Resulting claim hierarchy in WCIRB Connect:

- Ind. Claim XXXXX3 *(highest incurred loss)*
  - Grouped claim with Claim Count of 10 (inactive)
- Ind. Claim XXXXX1
- Ind. Claim XXXXX2
- Ind. Claim XXXXX4
- Ind. Claim XXXXX5
- Ind. Claim XXXXX6
- Ind. Claim XXXXX7
- Ind. Claim XXXXX8
- Ind. Claim XXXXX9
- Ind. Claim XXXX10

Appendix 3 — Grouped Claim Conversion Examples

Example 3: Grouped claim (with Claim Count = 1) to one individual claim.
Convert a claim previously-reported as a grouped claim with Claim Count = 1 to a single individual claim and change key data.

(Note: Technically, all grouped claims should have a Claim Count greater than one, but some instances of grouped claims with Claim Count = 1 have been reported).

Existing grouped claim:

Claim Count	Claim Number	Accident Date	Class Code	Loss Coverage Act	Injury Type	Inc. Medical	Inc. Indemnity
1	*blank*	*blank*	5183	01	6	5000	0

Report the following:
Report the following in two separate USR submissions.

USR 1 – Convert the grouped claim to individual claims

Update Type Code	Claim Count (No. of Claims)	Claim Number	Accident Date	Class Code	Loss Coverage Act	Injury Type	Inc. Medical	Inc. Indemnity	Comments
P	1	*blank*	*blank*	5183	01	6	5000	0	Convert the grouped claim to individual. Change only the Claim Number and Accident Date fields. **The Class Code, Loss Act, and Injury Type must remain the same on the P and R records.**
R	1	**XXXXX1**	**YYMMDD**	5183	01	6	5000	0	

USR 2 – Change key data

Update Type Code	Claim Count (No. of Claims)	Claim Number	Accident Date	Class Code	Loss Coverage Act	Injury Type	Inc. Medical	Inc. Indemnity	Comments
P	1	XXXXX1	YYMMDD	5183	01	6	5000	0	Change any other loss details on the newly-converted individual claim.
R	1	XXXXX1	YYMMDD	**8810**	01	**5**	5000	**2500**	

Red = Changed fields
Gray shading = Fields that must remain the same as previously reported

Resulting claim hierarchy in WCIRB Connect:

- Ind. Claim XXXXX1
  - Grouped claim with Claim Count of 1 (inactive)

Appendix 4 — Special Loss Reporting Instructions and Examples

1. **Subrogation Claims**

For a subrogation claim reported on a normal valuation of losses, the gross incurred shall be the estimated liability for the claim as of the normal valuation as if there had been no subrogation. For a subrogation claim reported on a correction filed between valuation dates, the gross incurred shall be the estimated liability for the claim at the time of subrogation reimbursement as if there had been no subrogation.

In reporting subrogation claims, the net incurred amount is the sum of the net paid and net outstanding amounts. The net paid is equal to the gross paid less the amount of the subrogation reimbursement that exceeds the expense incurred in obtaining the subrogation. The net outstanding is equal to the gross outstanding less the subrogation credit allowed, and is subject to a minimum of zero. (In other words, Net Incurred = [Gross Paid – (Reimbursement – Expense Incurred in Obtaining Subrogation)*] + [Gross Outstanding – Subrogation Credit Allowed]*).

* Amount is limited to be no less than zero.

The following hypothetical examples illustrate how net and gross incurred on subrogation claims are to be determined:

		Example One	Example Two	Example Three	Example Four
(1)	Total Paid (Gross)	$ 15,000	$ 15,000	$ 15,000	$ 30,000
(2)	Amount Reimbursed	12,000	15,000	6,000	30,000
(3)	Expense Incurred in Subrogation	2,000	4,000	7,000	0
(4)	Total Net Paid [(1) – ([2] – [3])*]	$ 5,000	$ 4,000	$ 15,000	$ 0
(5)	Total Outstanding (Gross)	$ 0	$ 20,000	$ 15,000	$ 20,000
(6)	Credit Allowed	$ 0	$ 10,000	$ 0	$ 20,000
(7)	Total Net Outstanding [(5) – (6)]*	$ 0	$ 10,000	$ 15,000	$ 0
(8)	Total Gross Incurred [(1) + (5)]	$ 15,000	$ 35,000	$ 30,000	$ 50,000
(9)	Total Net Incurred [(4) + (7)]	$ 5,000	$ 14,000	$ 30,000	$ 0

* Amount is limited to be no less than zero.

When the allocation of the subrogation to indemnity and medical is not known, the subrogation shall be allocated as indicated below for purposes of reporting the net incurred. The amount by which the monetary reimbursement exceeds the expense incurred in obtaining the subrogation recovery, if any, shall be apportioned to the paid indemnity and paid medical based on the ratios of gross paid indemnity and gross paid medical to the total gross paid, respectively. The credit allowed, if any, shall be apportioned to the outstanding indemnity and outstanding medical based on the ratios of the gross outstanding indemnity and the gross outstanding medical to total gross outstanding, respectively.

The following hypothetical examples illustrate how recoveries are to be reflected in the net incurred indemnity and net incurred medical amounts.

Appendix 4 — Special Loss Reporting Instructions and Examples

(1)	Paid Indemnity (Gross)	$ 15,000
(2)	Paid Medical (Gross)	25,000
(3)	Total Gross Paid [(1) + (2)]	$ 40,000
(4)	Outstanding Indemnity (Gross)	$ 15,000
(5)	Outstanding Medical (Gross)	15,000
(6)	Total Gross Outstanding [(4) + (5)]	$ 30,000

Example A — Subrogation Reimbursement and Credits — Medical Losses Only

(7A)	Amount Reimbursed Indemnity	$ 0
(8A)	Amount Reimbursed Medical	15,000
(9A)	Expense Incurred in Subrogation	5,000
(10A)	Net Paid Indemnity [(1) – (7A)]	$ 15,000
(11A)	Net Paid Medical [(2) – ([8A] – [9A])*]	$ 15,000
(12A)	Credit Allowed Indemnity	$ 0
(13A)	Credit Allowed Medical	$ 10,000
(14A)	Net Outstanding Indemnity [(4) – (12A)]*	$ 15,000
(15A)	Net Outstanding Medical [(5) – (13A)]*	$ 5,000
(16A)	Net Incurred Indemnity (10A) + (14A)]	$ 30,000
(17A)	Net Incurred Medical [(11A) + (15A)]	$ 20,000

Example B — Subrogation Reimbursement and Credits Apportionment to Medical and Indemnity Not Known

(7B)	Amount Reimbursed (Unapportioned)	$ 15,000
(8B)	Expense Incurred in Subrogation	5,000
(9B)	Total Net Reimbursement [(7B) – (8B)]*	$ 10,000
(10B)	Net Paid Indemnity [(1) – ([9B] x [1]/[3])]	$ 11,250
(11B)	Net Paid Medical [(2) – ([9B] x [2]/[3])]	$ 18,750
(12B)	Credit Allowed (Unapportioned)	$ 10,000
(13B)	Net Outstanding Indemnity [(4) – ([12B] x [4]/[6])]*	$ 10,000
(14B)	Net Outstanding Medical [(5) – ([12B] x [5]/[6])]*	$ 10,000
(15B)	Net Incurred Indemnity [(10B) + (13B)]	$ 21,250
(16B)	Net Incurred Medical [(11B) + (14B)]	$ 28,750

* Amount is limited to no less than zero.

Appendix 4 — Special Loss Reporting Instructions and Examples

2. **Partially Fraudulent Claims**
In reporting partially fraudulent claims, report all loss details (i.e., medical costs, etc.) apportioned as existed in the gross loss. The gross incurred shall be the estimated cost of the claim if it had not been found to be partially fraudulent. The net incurred is the estimated cost of the claim after it is found to be partially fraudulent.

3. **Joint Coverage (Type of Recovery Code "05" or "06")**
In reporting joint coverage claims, report as the net incurred only that amount which has been apportioned to the claim of the policyholder. The amount apportioned to the claim of the particular policyholder shall be that proportion of the total incurred loss (gross incurred*) assignable by adjudication to the policy for which the experience is being reported.

All loss details shall be apportioned as existed in the gross incurred loss. The gross incurred shall be that amount for which the insurer would have been liable had the insurer incurred the entire loss. In reference to the example below, if it is determined through adjudication or an executed written agreement that Insurer A is responsible for 40% of the claim and Insurer B is responsible for 60% of the claim, and each insurer's estimate** of the total cost of the claim* is as shown below, the gross and net incurred amounts are to be reported as follows:

		Insurer A	Insurer B
(1)	Estimated Total Incurred Indemnity	$ 50,000	$ 50,000
(2)	Estimated Total Incurred Medical	50,000	70,000
(3)	Gross Incurred to be Reported* [(1) + (2)]	$100,000	$120,000
(4)	Share of Liability for Claim	40%	60%
(5)	Net Incurred Indemnity to be Reported [(1) x (4)]	$ 20,000	$ 30,000
(6)	Net Incurred Medical to be Reported [(2) x (4)]	$ 20,000	$ 42,000

***** These are reserves, which are estimated by each insurer. At claim close, paid amounts will true up.

4. **Non-Compensable Claims**
Loss amounts incurred on non-compensable claims are to be reported. (These loss amounts are not used in experience rating.)

Additional Information/Examples for California Reporting
Per the USRP, Part 4, Section II, Rule 26, the definition of a non-compensable claim is any claim where:

a. There is a ruling by the Workers' Compensation Appeals Board (WCAB), or other court of competent jurisdiction, specifically holding that a claimant is not entitled to benefits under the compensation laws of California, even though the claimant may have been awarded reimbursement for expenses incurred by the claimant in presenting his/her case;

b. The insurer rejects the claim for benefits under the workers' compensation laws of California and the claim is dismissed by a ruling by the WCAB or other court of competent jurisdiction, because of the claimant's failure to prosecute his/her claim; or

Appendix 4 — Special Loss Reporting Instructions and Examples

c. The insurer rejects the claim for benefits and no application for adjudication of claim was filed during the period of limitation provided by the workers' compensation laws of California.

Reporting

When a claim is deemed non-compensable pursuant to the above definition, correct only the latest report level by changing the Type of Settlement Code to "05." This is the only reporting action that is necessary to indicate that the claim is non-compensable. Once the correction is processed, current and prior experience modifications in which the claim was used are reviewed to remove the claim and its loss amounts from the experience modifications and issue rerates where applicable. It is not necessary to correct prior report levels or delete any previously reported loss values on non-compensable claims since the values are disregarded in experience rating.

Timing

If an employer notified its insurer that a claim is non-compensable pursuant to California Labor Code Section 3761 and such claim is determined to be non-compensable by the Workers' Compensation Appeals Board, a loss correction must be filed within ninety (90) days after final adjudication of the determination of non-compensability.

Special Requirement for Non-compensable Claims Meeting the Requirements of California Labor Code Section 3761(d)

When a non-compensable claim also meets the requirements of California Labor Code Section 3761(d), the insurer shall submit a statement to the WCIRB.

5. **Cumulative Injury Claims**
The incurred loss amounts reported for a cumulative injury claim shall not reflect the incurred loss amounts, if any, for benefits due to a specific injury. (Claims for benefits due to a specific injury shall be reported separately.) A cumulative injury claim with liability limited to a single employer covered by a single insurer during the period of liability shall be reported on the most current policy providing coverage during that period.

6. **Employers' Liability Claims**
If reported as a single claim, an "03" shall be reported for "Type of Claim". If reported as separate claims, an "02" shall be reported for "Type of Claim".

7. **Compromised Death or "S" Claims**
To report Compromised Death or "S" claims, the gross incurred shall be the amount for which the insurer would have been liable had there been no compromise over the applicability of the claim to the workers' compensation laws of California. The net incurred indemnity and net incurred medical amounts shall be reported as the incurred indemnity and incurred medical amounts for which the insurer is liable. The net incurred is the sum of the net incurred indemnity and net incurred medical.

Appendix 5 — Injury Description Codes

Appendix 5 — Injury Description Codes

All codes are listed as they appear in the USRP.

Injury Description Codes

A. Part of Body (Positions 1-2)

Code	Narrative Description
I. Head	
10. Multiple Head Injury	Any Combination of Below Parts
11. Skull	
12. Brain	
13. Ear(s)	Includes: Hearing, Inside Eardrum
14. Eye(s)	Includes: Optic Nerves, Vision, Eyelids
15. Nose	Includes: Nasal Passage, Sinus, Sense of Smell
16. Teeth	
17. Mouth	Includes: Lips, Tongue, Throat, Taste
18. Soft Tissue	
19. Facial Bones	Includes: Jaw
II. Neck	
20. Multiple Neck Injury	Any Combination of Below Parts
21. Vertebrae	Includes: Spinal Column Bone, “Cervical Segment”
22. Disc	Includes: Spinal Column Cartilage, “Cervical Segment”
23. Spinal Cord	Includes: Nerve Tissue, “Cervical Segment”
24. Larynx	Includes: Cartilage and Vocal Cords
25. Soft Tissue	Other Than Larynx or Trachea
26. Trachea	
III. Upper Extremities	
30. Multiple Upper Extremities	Any Combination of Below Parts, Excluding Hands and Wrists Combined
31. Upper Arm	Humerus and Corresponding Muscles, Excluding Clavicle and Scapula
32. Elbow	Radial Head
33. Lower Arm	Forearm — Radius, Ulna and Corresponding Muscles
34. Wrist	Carpals and Corresponding Muscles
35. Hand	Metacarpals and Corresponding Muscles – Excluding Wrist or Fingers
36. Finger(s)	Other than Thumb and Corresponding Muscles
37. Thumb	
38. Shoulder(s)	Armpit, Rotator Cuff, Trapezius, Clavicle, Scapula
39. Wrist(s) and Hand(s)	

Appendix 5 — Injury Description Codes

Code	Narrative Description
IV. Trunk	
40. Multiple Trunk	Any Combination of Below Parts
41. Upper Back Area	(Thoracic Area) Upper Back Muscles, Excluding Vertebrae, Disc, Spinal Cord
42. Lower Back Area	(Lumbar and Lumbo Sacral) Lower Back Muscles, Excluding Sacrum, Coccyx, Pelvis, Vertebrae, Disc, Spinal Cord
43. Disc	Spinal Column Cartilage Other Than Cervical Segment
44. Chest	Including Ribs, Sternum, Soft Tissue
45. Sacrum and Coccyx	Final Nine Vertebrae-Fused
46. Pelvis	
47. Spinal Cord	Nerve Tissue Other Than Cervical Segment
48. Internal Organs	Other Than Heart and Lungs
49. Heart	
60. Lungs	
61. Abdomen Including Groin	Excluding Injury to Internal Organs
62. Buttocks	Soft Tissue
63. Lumbar and/or Sacral Vertebrae (Vertebra NOC Trunk)	Bone Portion of the Spinal Column
V. Lower Extremities	
50. Multiple Lower Extremities	Any Combination of Below Parts
51. Hip	
52. Upper Leg	Femur and Corresponding Muscles
53. Knee	Patella
54. Lower Leg	Tibia, Fibula and Corresponding Muscles
55. Ankle	Tarsals
56. Foot	Metatarsals, Heel, Achilles Tendon and Corresponding Muscles, Excluding Ankle or Toes
57. Toes	
58. Great Toe	
VI. Multiple Body Parts	
64. Artificial Appliance	Braces, etc.
65. Insufficient Info to Properly Identify — Unclassified	Insufficient Information to Identify Part Affected
66. No Physical Injury	Mental Disorder
90. Multiple Body Parts (Including Body Systems and Body Parts)	Applies When More Than One Major Body Part Has Been Affected, Such As an Arm and a Leg, and Multiple Internal Organs
91. Body Systems and Multiple Body Systems	Applies to the Functioning of an Entire Body System that Has Been Affected Without Specific Injury to Any Other Part, as in the Case of Poisoning, Corrosive Action, Inflammation, Affecting Internal Organs, Damage to Nerve Centers, etc. Does Not Apply When the Systemic Damage Results from an External Injury Affecting an External Part Such As a Back Injury Which Includes Damage to the Nerves of the Spinal Cord

Appendix 5 — Injury Description Codes

B. Nature of Injury (Positions 3-4)

Code	Narrative Description
I. Specific Injury	
01. No Physical Injury	i.e., Glasses, Contact Lenses, Artificial Appliance, Replacement of Artificial Appliance
02. Amputation	Cut Off Extremity, Digit, Protruding Part of Body, Usually by Surgery, i.e., Leg, Arm
03. Angina Pectoris	Chest Pain
04. Burn	(Heat) Burns or Scald. The Effect of Contact with Hot Substances (Chemical) Burns. Tissue Damage Resulting from the Corrosive Action Chemicals, Fumes, etc. (Acids, Alkalies)
07. Concussion	Brain, Cerebral
10. Contusion	Bruise — Intact Skin Surface Hematoma
13. Crushing	To Grind, Pound or Break into Small Bits
16. Dislocation	Pinched Nerve, Slipped/Ruptured Disc, Herniated Disc, Sciatica, Complete Tear, HNP Subluxtion, MD Dislocation
19. Electric Shock	Electrocution
22. Enucleation	Removal of Organ or Tumor
25. Foreign Body	
28. Fracture	Breaking of a Bone or Cartilage
30. Freezing	Frostbite and Other Effects of Exposure to Low Temperature
31. Hearing Loss or Impairment	Traumatic Only. A Separate Injury, Not the Sequelae of Another Injury
32. Heat Prostration	Heat Stroke, Sun Stroke, Heat Exhaustion, Heat Cramps and Other Effects of Environmental Heat. Does Not Include Sunburn
34. Hernia	The Abnormal Protrusion of an Organ or Part Through the Containing Wall of its Cavity
36. Infection	The Invasion of a Host by Organisms such as Bacteria, Fungi, Viruses, Mold, Protozoa or Insects, With or Without Manifest Disease
37. Inflammation	The Reaction of Tissue to Injury Characterized Clinically by Heat, Swelling, Redness and Pain
38. Adverse Reaction to a Vaccination or Inoculation[2]	
40. Laceration	Cuts, Scratches, Abrasions, Superficial Wounds, Calluses. Wound by Tearing
41. Myocardial Infarction	Heart Attack, Heart Conditions, Hypertension. The Inadequate Blood Flow to the Muscular Tissue of the Heart
42. Poisoning — General (Not OD or Cumulative Injury)	A Systemic Morbid Condition Resulting from the Inhalation, Ingestion, or Skin Absorption of a Toxic Substance Affecting the Metabolic System, the Nervous System, the Circulatory System, the Digestive System, the Respiratory System, the Excretory System, the Musculoskeletal System, etc. Includes Chemical or Drug Poisoning, Metal Poisoning, Organic Diseases, and Venomous Reptile and Insect Bites. Does NOT Include Effects of Radiation, Pneumoconiosis, Corrosive Effects of Chemicals; Skin Surface Irritations, Speticemia or Infected Wounds

[2] The WCIRB anticipates submitting recommended changes effective September 1, 2022.

Appendix 5 — Injury Description Codes

Code		Narrative Description
43.	Puncture	A Hole Made by the Piercing of a Pointed Instrument
46.	Rupture	
47.	Severance	To Separate, Divide or Take Off
49.	Sprain or Tear	Internal Derangement. A Trauma or Wrenching of a Joint, Producing Pain and Disability Depending Upon Degree of Injury to Ligaments
52.	Strain or Tear	Internal Derangement. The Trauma to the Muscle or the Musculotendinous Unit from Violent Contraction or Excessive Forcible Stretch
53.	Syncope	Swooning, Fainting, Passing Out, No Other Injury
54.	Asphyxiation	Strangulation, Drowning
55.	Vascular	Cerebrovascular and Other Conditions of Circulatory Systems, NOC. Excludes Heart and Hemorrhoids. Includes Strokes, Varicose Veins — Non Toxic
58.	Vision Loss	
59.	All Other Specific Injuries, NOC	
II. Occupational Disease or Cumulative Injury		
60.	Dust Disease, NOC	All other Pneumoconiosis
61.	Asbestosis	Lung Disease. A Form of Pneumoconiosis, Resulting from Protracted Inhalation of Asbestos Particles
62.	Black Lung	The Chronic Lung Disease or Pneumoconiosis Found in Coal Miners
63.	Byssinosis	Pneumoconiosis of Cotton, Flax and Hemp Workers
64.	Silicosis	Pneumoconiosis Resulting from Inhalation of Silica (Quartz) Dust
65.	Respiratory Disorders	Gases, Fumes, Chemicals, etc.
66.	Poisoning — Chemical (Other Than Metals)	Man-Made or Organic
67.	Poisoning — Metal	Man-Made
68.	Dermatitis	Rash, Skin or Tissue Inflammation Including Boils, etc. Generally Resulting from Direct Contact with Irritants or Sensitizing Chemicals Such As Drugs, Oils, Biologic Agents, Plants, Woods or Metals Which May Be in the Form of Solids, Pastes, Liquids or Vapors and Which May Be Contacted in the Pure State or in Compounds or in Combination with Other Materials. Does Not Include Skin Tissue Damage Resulting from Corrosive Action of Chemicals, Burns from Contact with Hot Substances, Effects of Exposure to Radiation, Effects of Exposure to Low Temperatures or Inflammation or Irritation Resulting from Friction or Impact
70.	Radiation	All Forms of Damage to Tissue, Bones or Body Fluids Produced by Exposure to Radiation
71.	All Other Occupational Disease Injury, NOC	
72.	Loss of Hearing	
73.	Contagious Disease	
74.	Cancer	
76.	VDT-Related Diseases	Video Display Terminal Diseases Other Than Carpal Tunnel Syndrome
77.	Mental Stress	

Appendix 5 — Injury Description Codes

Code	Narrative Description
78. Carpal Tunnel Syndrome	Soreness, Tenderness and Weakness of the Muscles of the Thumb Caused by Pressure on the Median Nerve at the Point at Which It Goes Through the Carpal Tunnel of the Wrist
79. Hepatitis Losses	
80. All Other Cumulative Injury, NOC	
83. COVID-19	Coronavirus Disease 2019 (COVID-19) is a Respiratory Disease Caused by a Coronavirus
III. Multiple Injuries	
90. Multiple Physical Injuries Only	
91. Multiple Injuries Including Both Physical and Psychological	

C. Cause of Injury (Positions 5-6)

Code	Narrative Description
I. Burn or Scald — Heat or Cold Exposures — Contact With	
01. Chemicals	Includes Hydrochloric Acid, Sulfuric Acid, Battery Acid, Methanol, Antifreeze
02. Hot Objects or Substances	
03. Temperature Extremes	Non-Impact Injuries Resulting in a Burn Due to Hot or Cold Temperature Extremes. Includes Freezing or Frostbite
04. Fire or Flame	
05. Steam or Hot Fluids	
06. Dusts, Gases, Fumes or Vapors	Includes Inhalation of Carbon Dioxide, Carbon Monoxide, Propane, Methane, Silica (Quartz), Asbestos Dust and Smoke
07. Welding Operations	Includes Welder's Flash (Burns to Skin or Eyes as a Result of Exposure to Intense Light from Welding)
08. Radiation	Includes Effects of Ionizing Radiation Found in X-Rays, Microwaves, Nuclear Reactor Waste, and Radiating Substances and Equipment. Includes Non-Ionizing Radiation Such as Sunburn
11. Cold Objects or Substances	
14. Abnormal Air Pressure	
84. Electrical Current	Includes Electric Shock, Electrocution and Lightning
09. Contact With, NOC	Not Otherwise Classified in Any Other Code. Includes Cleaning Agents and Fertilizers
II. Caught In, Under or Between	
10. Machine or Machinery	Running or Meshing Objects, a Moving and a Stationary Object, Two or More Moving Objects
12. Object Handled	Includes Medical Hospital Bed and Parts, Wheelchair, Clothespin Vise
20. Collapsing Materials (Slides of Earth)	Either Man-Made or Natural
13. Caught In, Under or Between, NOC	Not Otherwise Classified in Any Other Code

Appendix 5 — Injury Description Codes

Code	Narrative Description
III. Cut, Puncture, Scrape Injured by	
15. Broken Glass	
16. Hand Tool, Utensils; Not Powered	Includes Needle, Pencil, Knife, Hammer, Saw, Axe, Screwdriver
17. Object Being Lifted or Handled	Includes Being Cut, Punctured or Scraped by a Person or Object Being Lifted or Handled
18. Powered Hand Tool, Appliance	Includes Drill, Grinder, Sander, Iron, Blender, Welding Tools, Nail Gun
19. Cut, Puncture, Scrape, NOC	Not Otherwise Classified in Any Other Code. Includes Power Actuated Tools
IV. Fall, Slip or Trip Injury	
25. From Different Level (Elevation)	Includes Collapsing Chairs, Falling from Piled Materials, Off Wall, Catwalk, Bridge
26. From Ladder or Scaffolding	
27. From Liquid or Grease Spills	
28. Into Openings	Includes Mining Shafts, Excavations, Floor Openings, Elevator Shafts
29. On Same Level	
30. Slip, or Trip, Did Not Fall	Slip or Trip and Did Not Come in Contact with the Floor or Ground
32. On Ice or Snow	
33. On Stairs	
31. Fall, Slip or Trip, NOC	Not Otherwise Classified in Any Other Code. Includes Tripping Over Object, Slipping on Organic Material
V. Motor Vehicle	
40. Crash of Water Vehicle	
41. Crash of Rail Vehicle	
45. Collision or Sideswipe with Another Vehicle	Vehicle Collision, Both Vehicles in Motion
46. Collision with a Fixed Object	Collision Occurring with Standing Vehicle or Stationary Object
47. Crash of Airplane	
48. Vehicle Upset	Includes Overturned or Jackknifed
50. Motor Vehicle, NOC	Not Otherwise Classified in Any Other Code. Includes Injuries Due to Sudden Stop or Start, Being Thrown against Interior Parts of the Vehicle and Vehicle Contents Being Thrown against Occupants
VI. Strain or Injury by	
52. Continual Noise	Injury to Ears or Hearing Due to the Cumulative Effects of Constant or Repetitive Noise
53. Twisting	Free Bodily Motion That Imposes Stress or Strain on Some Part of Body. Includes Assumption of Unnatural Position, Involuntary Motions Induced by Sudden Noise, Fright or Loss of Balance
54. Jumping or Leaping	
55. Holding or Carrying	Applies to Objects or People. Includes Restraining a Person
56. Lifting	Includes Objects or People
57. Pushing or Pulling	Includes Objects or People
58. Reaching	
59. Using Tool or Machinery	
61. Wielding or Throwing	Physical Effort or Overexertion from Attempts to Resist a Force Applied by an Object Being Handled

Appendix 5 — Injury Description Codes

Code	Narrative Description
97. Repetitive Motion	Cumulative Injury or Condition Caused by Continual, Repeated Motions; Strain by Excessive Use. Includes Carpal Tunnel Syndrome
60. Strain or Injury by, NOC	Not Otherwise Classified in Any Other Code
VII. Striking Against or Stepping on	**NOTE: Applies to Cases in Which the Injury Was Produced by the Impact Created by the Person, Rather than by the Source**
65. Moving Part of Machine	
66. Object Being Lifted or Handled	
67. Sanding, Scraping, Cleaning Operation	Include Scratches or Abrasions Caused by Sanding, Scraping, Cleaning Operations
68. Stationary Object	
69. Stepping on Sharp Object	
70. Striking Against or Stepping on, NOC	Not Otherwise Classified in Any Other Code
VIII. Struck or Injured by	**NOTE: Applies to Cases in Which the Injury Was Produced by the Impact Created by the Source of Injury, Rather than by the Injured Person**
74. Fellow Workers, Patient or Other Person	Struck by Co-Worker, Either on Purpose or Accidentally. Includes Being Struck by a Patient While Lifting or Moving Them Not in Act of a Crime
75. Falling or Flying Object	
76. Hand Tool or Machine in Use	
77. Motor Vehicle	Applies When a Person is Struck by a Motor Vehicle, Including Rail Vehicles, Water Vehicles, Airplanes
78. Moving Parts of Machine	
79. Object Being Lifted or Handled	Includes Dropping Object on Body Part
80. Object Handled by Others	Includes Another Person Dropping Object on Injured Person's Body Part
85. Animal or Insect	Includes Bite, Sting or Allergic Reaction
86. Explosion or Flare Back	Rapid Expansion, Outbreak, Bursting, or Upheaval. Includes Explosion of Cars, Bottles, Aerosol Cans, or Buildings. "Flare back" Involves Superheated Air and Combustible Gases at Temperatures Just Below the Ignition Temperature
81. Struck or Injured, NOC	Not Otherwise Classified in Any Other Code. Includes Kicked, Stabbed, Bitten
IX. Rubbed or Abraded by	
94. Repetitive Motion	Caused by Repeated Rubbing or Abrading; Applies to Non-Impact Cases in Which the Injury Was Produced by Pressure, Vibration or Friction between the Person and the Source of Injury. Includes Callous, Blister
95. Rubbed or Abraded, NOC	Not Otherwise Classified in Any Other Code. Includes Foreign Body in Ears

Appendix 5 — Injury Description Codes

Code	Narrative Description
X. Miscellaneous Causes	
82. Absorption, Ingestion or Inhalation, NOC	Not Otherwise Classified in Any Other Code. Applies Only to Non-Impact Cases in Which the Injury Resulted from Inhalation, Absorption (Skin Contact), Ingestion of Harmful Substances, or Vaccinations[3]
83. Pandemic	A Disease Outbreak Affecting Large Populations or a Whole Region, Country or Continent
87. Foreign Matter (Body) in Eye(s)	Injury to Eyes Resulting from Foreign Matter That is Not Otherwise Classified in Any Other Code
88. Natural Disasters	Injury Resulting from Natural Disaster. Includes Hurricane, Earthquake, Tornado, Flood, Forest Fire
89. Person in Act of a Crime	Specific Injury, Other than Gunshot, Caused as a Result of Contact between Injured Person and Another Person in the Act of Committing a Crime. Includes Robbery or Criminal Assault
90. Other than Physical Cause of Injury	Stress, Shock, or Psychological Trauma That Develops in Relation to a Specific Incident or Cumulative Exposure to Conditions
91. Mold	Includes Mildew
93. Gunshot	Injury Is Caused by the Discharge of a Firearm. Includes Instances Where Injury Arises from Being Struck by the Fired Projectile, Burned by Muzzle Blast or Deafened by Report of Gunshot
96. Terrorism (for use with assigned Catastrophe Code only)	An Act That Causes Injury to Human Life, Committed by One or More Individuals as Part of an Effort to Coerce a Population Group(s) or to Influence the Policy or Affect the Conduct of Any Government(s) by Coercion
98. Cumulative, NOC	Cumulative, Not Otherwise Classified in Any Other Code. Involves Cases in Which the Cause of Injury Occurred over a Period of Time, Any Condition Increasing in Severity over Time
99. Other — Miscellaneous, NOC	Not Otherwise Classified in Any Other Code

[3] The WCIRB anticipates submitting recommended changes effective September 1, 2022.

Appendix 6 – Coronavirus Disease 2019 (COVID-19) Reporting

Appendix 6 – Coronavirus Disease 2019 (COVID-19) Reporting

1. **Exposure**

Payments made to an employee excluded from remuneration as a result of COVID-19 pursuant to Part 3, Section III, *General Classification Procedures*, Rule 7, *Coronavirus Disease 2019 (COVID-19)*, of the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* must be reported as either a Classification Code **or** Statistical Code 0012. There is no requirement that the exposure be reported on the policy in order to be reported as exposure on the USR. When reporting as either a Classification Code or Statistical Code, the exposure may either be reported in the Exposure Totals or excluded. Note this exposure will be omitted from the experience rating calculations.

2. **Claims**

a. When reporting COVID-19 claims, report the following:

Nature of Injury: Report "83" (COVID-19)
Cause of Injury: Report "83" (Pandemic)
Catastrophe Number: Report "12" for all claims directly arising from a diagnosis of COVID-19

These rules apply to reporting COVID-19 claims with accident dates on or after December 1, 2019 and with a required date of reporting on or after August 1, 2020.

b. When reporting an adverse reaction to a COVID-19 vaccine claim, report the following:

Nature of Injury: Report "38" (Adverse Reaction to a Vaccination or Innoculation)
Cause of Injury: Report "83" (Pandemic)

These codes have been adopted by the DWC for purposes of FROI reporting and will be proposed for inclusion in the Insurance Commissioner's regulations as part of the September 1, 2022 Regulatory Filing.

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