



New York State Workers' Compensation Board



Employers' Handbook

*A Guide to the Workers' Compensation System
for the New York State Business Owner*

*Governor George E. Pataki
Chairman David P. Wehner*



A Message from Governor George E. Pataki

The New York Workers' Compensation Law was enacted in 1914 to ensure that workers who suffered injuries or illnesses on the job received timely medical treatment and wage replacement assistance.

Through the years this fundamental protection had been weakened by an increasingly unresponsive bureaucracy — a bureaucracy that was no longer meeting the needs of its primary customers — injured workers and their employers. At the same time, the costs of workers' compensation grew out of control.

In 1996, we began to address this problem with the passage of the New York Employment, Safety and Security Act. The fundamental reforms of this legislation led to rate reductions exceeding 30 percent, returned balance and efficiency to the process, promoted greater safety in the workplace, created new health care choices and arrangements and ensured the fiscal integrity of the system.

Today, New Yorkers see the Workers' Compensation Board in a whole new light as the speed, quality and consistency of Board decisions continues to improve. Our commitment to restoring confidence in workers' compensation can be readily seen through investments in technology and common sense administrative reforms. These investments are yielding impressive results as more than one million paper case files have been converted into computer images, as full-time, customer service centers across the state are serving injured workers every day, and as cutting-edge management techniques are introduced into the claims process with each passing day.

This comprehensive Employers Handbook — *A Guide to the Workers' Compensation System for the New York State Business Owner* — should serve as the most up-to-date reference guide for all employers, big and small, to provide a better understanding the workers' compensation system.

As part of my Administration's continued commitment to assist and protect the rights of employers and injured workers I am pleased to provide New York's citizens with this comprehensive handbook.



A Message from Chairman David P. Wehner

The Workers' Compensation Board is committed to providing fair and efficient services for employers who finance the system, providing benefits to workers injured through the course of their employment. As Chairman, I am dedicated to achieving this goal.

This manual provides detailed information that an employer needs when considering his or her responsibilities under the workers' compensation law. It has been produced by Board staff, including the Office of the Advocate for Business, and is a step by step manuscript for prospective employers as well as those who have operated businesses in New York State over an extended period of time.

If you have additional questions that are not addressed in this manual, please do not hesitate to contact the Office of the Advocate for Business at 1-800-628-3331.

Table of Contents

CHAPTER ONE – HOW THE WORKERS’ COMPENSATION SYSTEM BEGAN.....	3
CHAPTER TWO – THE PLAYERS IN THE SYSTEM	5
CHAPTER THREE – WHO IS COVERED BY THE LAW?	7
CHAPTER FOUR – EMPLOYERS’ RIGHTS AND RESPONSIBILITIES	11
CHAPTER FIVE – COMPLYING WITH THE LAW	13
CHAPTER SIX – DISABILITY BENEFITS COVERAGE	17
CHAPTER SEVEN - UNDERSTANDING INSURANCE	19
CHAPTER EIGHT – WHAT TO DO WHEN AN ACCIDENT HAPPENS	25
CHAPTER NINE – RETURN TO WORK PROGRAMS	31
CHAPTER TEN – WORKERS’ COMPENSATION FRAUD.....	35
CHAPTER ELEVEN – RESOURCES FOR EMPLOYERS	39
CHAPTER TWELVE - GLOSSARY OF COMMON WORKERS’ COMPENSATION TERMS	41

This booklet is intended to provide New York employers with general information regarding their rights and responsibilities under the state's workers' compensation program. It includes information that is not within the purview of the Workers' Compensation Board in an effort to inform employers about these areas. This booklet does not represent legal advice and is not a complete description of the law.

How the Workers' Compensation System Began

The Triangle Shirtwaist Factory Fire

The Workers' Compensation system in New York State was born out of a great tragedy – the worst factory fire in the history of New York City. On March 25, 1911, on the top three floors of a ten-story building, a fire broke out at the Triangle Shirtwaist Factory. The fire spread quickly among the reams of fabric, and 146 women died in less than 15 minutes.

In order to keep the women, mostly Jewish immigrants between the ages of 13 and 23, at the sewing machines, the owners had locked the exit doors.

At the time of the Triangle Shirtwaist tragedy, the only way an injured worker could recover damages sustained in a work-related accident was by suing the employer. It was the responsibility of the worker to prove that the employer was negligent. This standard of proof often led to lengthy court proceedings, and made it difficult for workers to obtain compensation and medical care quickly. At the same time, this system left employers open to costly lawsuits.

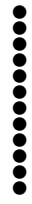
The Historic Agreement

By the early 1900's, most industrialized countries in Europe had regulatory systems and insurance programs which brought into place a "no-fault" exchange of protections between employers and workers. This new concept was first established in Germany in 1856, and adopted soon after in England and most of Western Europe. New York was the first state to establish a workers' compensation system, and by 1920 most states had workers' compensation laws.

Created in 1914 as the result of an historic agreement between employers and workers, the New York State Workers' Compensation Board ensures that in exchange for guaranteed medical coverage and compensation for lost earnings, employees would not sue their employers in the event of an on-the-job injury. This no-fault system is designed to eliminate the uncertainty of litigation associated with the courts. This reduces the employer's exposure to costly lawsuits and provides benefits to all injured workers.

The principles of workers' compensation laws are similar throughout the United States, but each state has unique laws with different benefits.





The Players in the System

Mission Statement of the Workers' Compensation Board

“The mission of the Workers’ Compensation Board is to equitably and fairly administer the provisions of the New York State Workers’ Compensation Law, including Workers’ Compensation Benefits, Disability Benefits, Volunteer Firefighters’ Benefits, Volunteer Ambulance Workers’ Benefits & Volunteer Civil Defense Workers’ Benefits Law on behalf of our customers, New York’s injured workers and their employers.”

To understand the workers’ compensation system, an employer or employee must first understand all the players that are responsible for the process.

Workers' Compensation Board

The first major player, the Workers’ Compensation Board, was established to administer the workers’ compensation law. It is responsible for the adjudication of claims and ensuring that employers provide the required coverage. The Workers’ Compensation Board administers the programs and laws of New York State in a fair and equitable fashion. The Board receives and processes claims and initially seeks to facilitate expedient agreements between injured workers and employers.

When a consensus cannot be reached through administrative measures, it becomes necessary for the Board to conduct hearings before a Workers’ Compensation Law Judge. Evidence and testimony are gathered and analyzed prior to the rendering of a decision by the Judge. Decisions by Law Judges are binding. Parties may appeal the Judge’s decision to the Appeals Unit. In such a case, a panel of three Board Commissioners will rule on the validity of the Judge’s decision. Failing a unanimous decision by the panel, a full Board review by all thirteen Commissioners may be requested. The decision of the Full Board may be further appealed to the State Appellate Division, Third Department.

State Insurance Fund (SIF)

Because of the compulsory nature of the workers’ compensation law, the Legislature created the State Insurance Fund to provide insurance to employers. The State Insurance Fund has two types of customers – employers who cannot obtain coverage elsewhere, and those that find the premiums more competitive. Private insurance carriers are also authorized to provide workers’ compensation insurance to employers.

The State Insurance Fund is a quasi-public agency that provides workers’ compensation insurance to approximately one-third of the eligible employers in New York State. The purpose of the Fund is to provide insurance to any employer in the state, without regard to experience or size. (see Chapter Five for more information on SIF).

Compensation Insurance Rating Board (CIRB)

The third major player in the system is the New York Compensation Insurance Rating Board (CIRB). CIRB is a non-profit, unincorporated association of insurance carriers, including the State Insurance Fund.

In conjunction with the Workers' Compensation Law, the Insurance Law provides for the Superintendent of Insurance to designate a statistical organization to collect the loss, premium and payroll data from each carrier, summarize this information and develop an adequate rate structure. Since the enactment of the Workers' Compensation Law in 1914, CIRB has been licensed as the official organization for the collection of data and development of workers' compensation rates.

CIRB analyzes that data and recommends annual reductions or increases in premium rates to the State Insurance Department. Other important functions of CIRB include:

- To determine manual rates for each classification and experience modification rates for employers with premiums in excess of \$5,000.
- To establish the rules and procedures, classifications and rates governing the underwriting of workers' compensation insurance and employer liability insurance.



Who is Covered by the Law?

Virtually all employers in New York State must provide workers' compensation coverage for their employees. Employers must post notice of coverage in their place of business.

Who is Covered?

- Workers in all employments conducted for profit. Part-time employees, family members and volunteers are also included under the workers' compensation law.
- Employees of counties and municipalities engaged in work defined by the law as "hazardous".
- Public school teachers, excluding those employed by New York City, and public school aides, including New York City.
- Employees of the State of New York, including some volunteer workers.
- Domestic workers employed forty or more hours per week by the same employer (including full-time sitters or companions, and live-in maids).
- Farm workers whose employer paid \$1200 or more for farm labor in the preceding calendar year.
- Any other worker determined by the Board to be an employee.
- All corporate officers if the corporation has more than two officers.
- Officers of one-or-two person corporations if there are other individuals in employment. These officers may choose to exclude themselves from coverage (see page 8).

Who is Not Covered?

- Clergy and members of religious orders.
- People engaged in a teaching or non-manual capacity in or for a religious, charitable or educational institution.
- People employed in certain maritime trades, interstate railroad employees, federal government employees and others covered under federal workers' compensation laws.

- People, including minors, doing yard work or casual chores in and about a one-family, owner-occupied residence. Casual means occasionally, without regularity, without foresight, plan or method. Coverage is required if the minor handles power-driven machinery, including a power lawnmower.
- Certain employees of foreign governments.
- New York City police officers, firefighters, and sanitation workers. Uniformed police officers and firefighters in other municipalities may also be excluded.
- Certain real estate salespersons who sign a contract with a broker stating that they are independent contractors.
- Sole proprietors, partners, and one/two person corporate officers with no employees (although coverage may be obtained voluntarily).

Corporate Officers

Corporate Officers with Employees

Any two executive officers of a corporation who each own at least one share of stock and between them own all the shares of stock and have employees are included in the law. One or both of the officers may choose to exclude themselves by filing an exclusion form with their insurance carrier at the time the policy is written or renewed.

Corporate Officers with No Employees

Any two executive officers of a corporation who each own at least one share of stock and between them own all the shares of stock and have no other persons in their employ are automatically excluded from the law. One or both of the officers may choose to be included by filing the appropriate form with their insurance carrier at the time the policy is written or renewed.

Business Permits/Licenses and the Workers' Compensation Law

Sections 57 and 220 Subd. 8 of the Workers' Compensation Law (WCL) requires the heads of all municipal and State entities to ensure that businesses applying for permits, licenses or contracts have appropriate workers' compensation and disability benefits insurance coverage. This requirement applies to both original issuances and renewals, and also applies whether the governmental agency is having the work done or is simply issuing the permit, license or contract.

The Workers' Compensation Board is working to make it as easy as possible for businesses, their insurance carriers, municipalities and State agencies to comply with the Law. Accordingly, we have streamlined the process so that government entities only have to check on compensation and disability insurance coverages once annually for businesses awarded contracts, licenses or permits.

Ensuring that businesses, receiving permits, licenses or contracts from municipal and State agencies, comply with the Workers' Compensation Law protects both injured workers and employers. In addition, such oversight helps to level the playing field, by strictly enforcing the requirement that all businesses maintain mandatory insurance coverages. Municipal and State agency cooperation in enforcing Sections 57 and 220 Subd. 8 of the Workers' Compensation Law is a critical component of encouraging business compliance.

***Section 57 — Restriction on Issue of Permits
and the Entering of Contracts Unless Compensation Is Secured***

Section 57 of the Workers' Compensation Law (WCL) requires the heads of all State and municipal entities, prior to issuing any permits, licenses or entering into contracts, to ensure that businesses applying for those permits, licenses or entering into contracts have appropriate workers' compensation insurance coverage.

To comply with coverage provisions of the Workers' Compensation Law, businesses must:

- be legally exempt from obtaining workers' compensation insurance coverage;
- obtain such coverage from insurance carriers; or
- be self-insured.

To assist State and municipal entities in enforcing Section 57 of the Workers' Compensation Law, businesses requesting permits, licenses or seeking to enter into contracts must provide ONE of the following forms to the entity issuing the permit or entering into a contract:

- WC/DB-100, Affidavit for New York Entities and any Out of State Entities with No Employees, that New York State Workers' Compensation and/or Disability Benefits Insurance Coverage Is Not Required; OR
- WC/DB-101 — Affidavit that an Out-of-State or Foreign Employer Working in New York State Does Not Require Specific New York State Workers' Compensation and/or Disability Benefits Insurance Coverage; OR

(Affidavits must first be notarized and then be stamped as received by the NYS Workers' Compensation Board)

Forms WC/DB-100 and WC/DB 101 are available on the Board's website under the heading "Common Forms Online." They may also be obtained by writing or visiting any District Office of the Workers' Compensation Board.

- C-105.2 — Certificate of Workers' Compensation Insurance (the business' insurance carrier will send this form to the government entity upon request) Please Note: The State Insurance Fund provides its own version of this form, the U-26.3; OR
- SI-12 — Certificate of Worker's Compensation Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247), OR GSI-12 — Certificate of Group Worker's Compensation Self-Insurance (the business' Group Self-Insurance Administrator will send this form to the government entity upon request).

(Please note: ACORD forms are NOT acceptable proof of workers' compensation coverage!)

Businesses that are unsure as to whether they are required to obtain a New York State workers' compensation insurance policy should call the Workers' Compensation Board's Enforcement Unit in the nearest district office:

Albany — (518) 486-3349
Binghamton — (607) 721-8333
Brooklyn — (718) 802-6870
Buffalo — (716) 842-2057
Hauppauge — (631) 952-6698
Hempstead — (516) 560-7742

Manhattan — (212) 932-7576
Peekskill — (914) 788-5804
Queens — (718) 523-8409
Rochester — (585) 238-8335
Syracuse — (315) 423-1140

How a Business Requests a SI-12 Form or a GSI-12 Form

Businesses should call the Workers' Compensation Board's Self-Insurance Office to obtain a SI-12 —Certificate of Worker's Compensation Self-Insurance at (518) 402-0247 or contact their Group Self-Insurance Administrator for a copy of the GSI-105.2 — Certificate of Group Workers' Compensation Self-Insurance.

Please call the Bureau of Compliance at (518) 486-6307 with any general questions regarding Section 57 of the Workers' Compensation Law.

Section 220 Subd. 8 — Restriction on Issue of Permits and the Entering of Contracts Unless Disability Benefits Is Secured

Section 220 Subd. 8 of the Disability Benefits Law (DBL) requires the heads of all State and municipal entities, prior to issuing any permits, licenses or entering into contracts, to ensure that businesses applying for those permits, licenses or entering into contracts have appropriate disability benefits insurance coverage.

To comply with coverage provisions of the Disability Benefits Law , businesses may:

- be legally exempt from obtaining workers' compensation insurance coverage;
- obtain such coverage from insurance carriers; or
- be self-insured.

Accordingly, to assist State and municipal entities in enforcing Section 220 Subd. 8 of the Disability Benefits Law, **businesses** requesting permits or seeking to enter into contracts must provide ONE of the following forms to the entity issuing the permit or entering into a contract:

- WC/DB-100, Affidavit for New York Entities and any Out of State Entities with No Employees, that New York State Workers' Compensation and/or Disability Benefits Insurance Coverage Is Not Required; OR
- WC/DB-101 — Affidavit that an Out-of-State or Foreign Employer Working in New York State Does Not Require Specific New York State Workers' Compensation and/or Disability Benefits Insurance Coverage; OR

(Affidavits must first be notarized and then be stamped as received by the NYS Workers' Compensation Board)

Forms WC/DB-100 and WC/DB 101 are available on the Board's website under the heading "Common Forms Online." They may also be obtained by writing or visiting any District Office of the Workers' Compensation Board.

- Either the DB-120.1 — Certificate of Disability Benefits Insurance OR the DB-820/820 — Certificate/ Cancellation of Insurance (the business' carrier will send one of these forms to the government entity upon request); OR
- DB-155 — Certificate of Disability Benefits Self-Insurance.

How a Business Requests a DB-155 Form

Businesses should call the Workers' Compensation Board's Self-Insurance Office at (518) 402-0247 to obtain a DB-155 form — Certificate of Disability Benefits Self-Insurance.

Please call the Bureau of Compliance at (518) 486-6307 with any general questions regarding Section 220 Subd. 8 of the Disability Benefits Law.

Employers' Rights and Responsibilities

Employers' Responsibilities

- Employers must obtain and keep in effect workers' compensation coverage for their employees; there must be no lapse in coverage even when switching insurance carriers.

The law requires almost all employers operating in New York State to have workers' compensation coverage for their employees. This requirement can be fulfilled by purchasing insurance coverage through an insurance carrier or by obtaining authorization from the Board to be self-insured.

- Employers must post a notice of workers' compensation coverage and employee rights.

This notice is in a form prescribed by the Workers' Compensation Board. Employers obtain the notice from their insurance carrier or, if self-insured, from the Board. The notice includes the name and address of the insurance carrier and the policy number of the employer. It must be posted in a conspicuous place in the employer's place of business. Violations of this requirement can result in a fine of up to \$250 per violation.

- An employer may not discriminate against an employee or applicant because he or she has claimed or attempted to claim workers' compensation.

- An employer must report most injuries to the Board and the insurance company, if insured, on Form C-2 within 10 days after an accident. An employer shall furnish a report of an occupational disease incurred by an employee on the same form.

A C-2 report must be filed with the Board and carrier if the accident results in personal injury which has caused or will cause a loss of time from regular duties of one day beyond the working day or shift on which the accident occurred, or which has required or will require medical treatment beyond ordinary first aid or more than two treatments by a person rendering first aid. Failure to file a C-2 or failure to file it timely may result in a penalty of up to \$2,500.

- C-2 forms (Employer's Report of Work-Related Accident/ Occupational Disease) must be maintained by the employer or designated third party for at least 18 years and are subject to review by the Board at any time.

- A record must be made and maintained on Form C-2 of any injury or illness incurred by an employee in the course of employment, even if the extent of the injury does not require that the C-2 be filed with the Board or carrier.

- An employer must report an injured worker's wages or other compensation to the Board.

Form C-240, Employer's Statement of Wage Earnings.

- An employer must report any changes in an injured worker's pay or work status to the Board.
Form C-11, Employer's Report of Injured Employee's Change in Employment Status Resulting from Injury.
- Certain employers must undergo safety consultations if directed to do so.
If an employer has an experience modification factor of greater than 1.2 and a payroll in excess of \$800,000, they must participate in a mandatory safety and loss prevention program, as outlined by the New York State Department of Labor.
- An employer must provide the Workers' Compensation Board with access to all books, records and payrolls related to employees upon request.

Employers' Rights

- An employer has the right to request that the insurance carrier contest the compensability of a claim.
A claim can be contested for a variety of reasons, including, for example, that the injury was not related to work or that the employee is not injured to the extent he or she is claiming. An employer can request that the insurance carrier contest the claim, but since the carrier has assumed liability for the claim, it is not required to comply with the employer's request. In addition, employers or carriers who engage in dilatory tactics will be penalized.
- An employer has the right to attend any hearings related to a claim filed by one of the employer's workers.
- An employer has the right to electronically access the Board's case file for a claim filed by the employer's worker by visiting one of the Board's customer service centers.
The Board's Electronic Case Folder (ECF) allows parties of interest to view the documents in the claim file electronically. Employers should go to one of the eleven district offices or 30 Customer Service Centers with identification to obtain a password to access the files. Based on the confidentiality of workers' compensation records, please be prepared to offer proof that you are the employer of record in the claim.
- A self-insured employer, or an employer who has failed his or her obligation to secure workers' compensation coverage, has the right to participate in the hearing and present relevant evidence about disputed issues at a hearing.
Employers may request that a hearing be scheduled on a particular issue by writing to the appropriate district office in a timely manner. Corporations must be represented by counsel in proceedings before the Board. Certain defenses will be waived if they are not promptly raised or if the employer or carrier does not timely file a Form C-7, Notice that Right to Compensation is Controverted.
- An employer has the right to report suspected workers' compensation fraud to the Fraud Inspector General.
Fraud Referral Hotline: 1-888-363-6001.
- An employer has the right to appeal or, if insured, to request that the insurance carrier appeal on appropriate grounds a decision of a Workers' Compensation Law Judge regarding a claim filed by an employee.
Any party may appeal a notice of decision within 30 days by writing to the Board requesting Board review; however, a party filing a frivolous appeal will be penalized.

Complying with the Workers' Compensation Law

New York State Law

The New York State Workers' Compensation Law requires that employers obtain and continuously keep in effect workers' compensation coverage for all their employees.

Businesses meet this requirement of the law by:

- Obtaining and maintaining a workers' compensation insurance policy; or
- Being self-insured for workers' compensation; or
- Being legally exempt from having to obtain workers' compensation coverage.

Are Any Businesses Exempt?

There are only very limited situations where businesses are exempt from providing workers' compensation coverage, including:

- the business is owned by one individual with no employees and is not a corporation; or
- the business is a partnership under the laws of New York State, and there are no employees; or
- the business is a one-or-two person owned corporation, with those individuals owning all of the stock and holding all offices of the corporation and there are no employees.

Obtaining Insurance Coverage

Employers may obtain workers' compensation insurance coverage in the following manner:

- purchasing a workers' compensation insurance policy from one of the approximately 800 private sector insurance carriers authorized to write such insurance in New York State (contact your insurance broker or insurers listed in the yellow pages of your telephone directory);
- purchasing a workers' compensation insurance policy from the State Insurance Fund, a quasi-public insurance carrier in New York State (contact your insurance broker or look for State Insurance Fund listed in the business or NYS government pages of your telephone directory);
- becoming authorized by the Workers' Compensation Board to be self-insured for workers' compensation (only very large corporations have the financial ability to become self-insured);

- becoming part of a group self-insurance plan authorized by the Workers' Compensation Board (such plans are offered as part of safety groups for certain industries).

Your firm's Federal Employer Tax Identification Number (FEIN) is the Workers' Compensation Board's primary identification for your business. PLEASE give your FEIN # to your insurance carrier when obtaining or modifying your workers' compensation coverage.

If you have any questions, please call the Office of Compliance at (518) 474-6967 or the Self-Insurance Office at (518) 402-0247.

What Does Workers' Compensation Insurance Buy?

When purchasing workers' compensation insurance, an employer is buying the following protections:

- Medical services needed to treat the job injury or illness
- Temporary disability payments to the employee to help replace lost wages
- Permanent disability payments to the employee to compensate for permanent effects of the injury
- A death benefit for the employee's survivors in the event of a fatal injury
- Legal representation for the employer by the insurance carrier
- Protection for the employer against most lawsuits for on-the-job injuries/illnesses

The employer must pay for the cost of insurance coverage; it is illegal to require employees to pay any of the costs associated with workers' compensation premiums or injuries.

Private Insurance

Generally, private insurance is purchased through a broker or agent. Different insurance carriers cater to different markets and offer different incentives to policy holders. It is important for an employer to "shop around" to make sure that they are buying the coverage that is best for them. Some insurance carriers may choose to not write insurance for a particular industry or size of employer. If an employer finds themselves in this situation, they should contact their agent and ask them to look around for other coverage. The costs can and do vary between insurance carriers due to discounts, dividends and incentive programs.

State Insurance Fund (SIF)

The State Insurance Fund is a not-for-profit agency of the State of New York that was established in 1914 to provide a guaranteed source of workers' compensation insurance coverage at the lowest possible cost to employers within New York State. The premiums are required by law to be fixed at the lowest possible rates, since SIF must provide coverage to any employer who seeks it, regardless of type of business, safety record or size. However, if an employer owes SIF money from a previous bill or account, coverage can be denied.

Despite its quasi-public status, SIF is a self-supporting insurance carrier that competes with private insurers. It is the largest provider of workers' compensation coverage in New York State, specializing only in workers' compensation and disability benefits insurance.

Safety Group Plans

The State Insurance Fund offers an alternative called Safety Groups, which are available to certain industries. These are plans designed for employers in the same trade or industry who, by cooperative effort, seek to curtail accidental injuries or occupational disease, thereby reducing their insurance costs. Qualified participants receive an advance discount. Based upon the safety performance of the members of the group, each group member receives a proportionate share of any dividend earned.

Self-Insurance and Group Self-Insurance

Employers who wish to self-insure for either workers' compensation or disability benefits must apply to and be approved by the Board's Office of Self Insurance. As part of this process, each approved self-insurer must post with the Board a security deposit (cash, securities, letter of credit and/or surety bond), which will be used in the event that the self-insurer defaults on their obligation to provide benefits to their employees.

What is Self-Insurance?:

Self-insurance is one of the three methods of providing coverage under the workers' compensation law. Self-insured employers pay for all medical care and indemnity benefits out of pocket, rather than through an insurance carrier. The resulting costs can be less than traditional insurance, if an employer predicts future costs and exercises extensive loss control programs. The employer's costs are more directly related to their own loss experience, and do not reflect the losses and liabilities of other employers.

Why should a company become self-insured?:

- If there is a potential to reduce the cost and number of claims by:
 - a. Increased commitment to safety.
 - b. Loss control techniques such as return to work or light duty programs.
- If there is a potential for improved labor relations by exercising direct control over the administration of claims.
- To improve cash flow.
- To avoid the carrier overhead expenses included in the cost of a policy.

How does an employer become self-insured?:

An employer qualifies as a self-insurer by filing an application for self-insurance and by furnishing satisfactory proof to the Chairman of the Workers' Compensation Board of its financial ability to pay claims. All applicants must file an independently audited financial statement, and if a publicly-held corporation, SEC Form 10-K.

How are claims handled for a self-insured company?:

- In-house, by employees of the self-insurer
- Through an attorney, licensed to practice in NYS
- Through a licensed self-insurers representative

What is Group Self-Insurance?:

Group self-insurance allows employers engaged in similar activities in a given industry to pool their assets (and losses), and thereby spread the costs among a group of employers. This allows employers that are not large enough to self-insure an opportunity to obtain the benefits of self insurance.

All members of a group self-insured trust are jointly and severally liable for the payments the trust must make including indemnity benefits, medical payments and assessments. Joint and several liability means that each member is liable not only for the benefits, losses and assessments associated with his own employees, but also for those of the other members.

How Does a Group Become Self-Insured?:

Employers interested in forming a new group self-insurer should first engage the services of a property and casualty actuary to explore the viability of the proposed group. To apply, the employer group is required to file an application for group self-insurance. There must be at least two members of the group that perform related activities in a given industry; they must have and maintain an aggregate net worth of members that is at least \$1 million; and they must have and maintain a combined annual payroll of members, which when multiplied by the CIRB rates, is at least \$500,000.

Getting the Right Coverage

Workers' Compensation insurance can be an expensive cost of doing business. However employers can take responsibility for those costs by following some of the tips below:

- Start getting quotes from a variety of insurance carriers through your agent. Do this several months before you need the policy.
- Make sure that the underwriter is using the proper classification of employees. If you are misclassified to get an initial lower rate, an audit will catch this and you will be charged retroactively.
- Discuss what types of alternative plans are available (deductibles, premium credits, safety programs)

Research the insurer's claims handling practices. A carrier that either automatically pays every claim or controverts many claims can directly affect your premium in the future.



Disability Benefits Coverage

What are Disability Benefits?

New York is one of a handful of states that require employers to provide disability benefits coverage to employees for an off-the-job injury or illness. Coverage for disability benefits can be obtained through an insurance carrier or by becoming authorized by the Workers' Compensation Board to self-insure.

Disability benefits are temporary cash benefits paid to an eligible wage earner, when he/she is disabled by an **off the job** injury or illness. The Disability Benefits Law provides weekly cash benefits to replace, in part, wages lost due to injuries or illnesses that do not arise out of or in the course of employment. Disability benefits are also paid to an unemployed worker to replace unemployment insurance benefits lost because of illness or injury.

An employer is allowed, but not required, to collect contributions from its employees to offset the cost of providing benefits. An employee's contribution is computed at the rate of one-half of one percent of his/her wages, but no more than sixty cents a week.

If an employee has more than one job at the same time, with combined wages of more than \$120 per week, the employee may request each employer to adjust the contributions in proportion to the earnings of each employment. The combined contributions may not exceed 60 cents per week. The request should be made as soon as the employee enters a second job.

Disability benefits include cash payments only. Medical care is the responsibility of the claimant. It is not paid for by the employer or insurance carrier. Cash benefits are 50 percent of a claimant's average weekly wage, but no more than the maximum benefit allowed, currently \$170 per week.

Benefits are paid for a maximum of 26 weeks of disability during 52 consecutive weeks. For employed workers, there is a 7-day waiting period for which no benefits are paid. Benefit rights begin on the eighth consecutive day of disability. An employer must supply a worker who has been disabled more than seven days with a Statement of Rights under the Disability Benefits Law (**form DB-271**), within five days of learning that the worker is disabled.

Who is Covered Under the Disability Benefits Law?

- Employees or recent employees of a “covered” employer, who have worked at least four consecutive weeks.
- An employer of one or more persons on each of 30 days in any calendar year becomes a “covered” employer four weeks after the 30th day of such employment.
- Employees of an employer who elects to provide benefits by filing an Application for Voluntary Coverage.
- Employees who change jobs from one “covered” employer to another “covered” employer are protected from the first day on the new job. Generally, an eligible employee does not lose protection during the first 26 weeks of unemployment, provided he/she is eligible for and is claiming unemployment insurance benefits.
- Domestic or personal employees who work 40 or more hours per week for one employer.

Who is Not Covered Under the Disability Benefits Law?

- A minor child of the employer.
- Government, railroad, maritime or farm laborers, ministers, priests, rabbis, members of religious orders, sextons, Christian Science readers.
- Corporate officers and persons engaged in a professional or teaching capacity in or for a religious, charitable, or educational institution of a “non-profit” character, and persons receiving rehabilitation services in a sheltered workshop operated by such institutions under a certificate issued by the U.S. Department of Labor.
- Persons receiving aid from a religious or charitable institution, who perform work in return for such aid.
- One or two corporate officers who either singly or jointly own all of the stock and hold all of the offices of a corporation that employs no other employees.
- Golf caddies.
- Daytime students in elementary or secondary school, who work part-time during the school year or their regular vacation period.
- Employees who change to jobs in an exempt employment or with a “non-covered” employer, and work in such employment for more than four weeks, lose protection until they work four consecutive weeks for a “covered” employer.

Note: A “noncovered” employer may elect at any time to provide disability coverage by filing an Application for Voluntary Coverage with the Chairman of the Workers’ Compensation Board.



Understanding Insurance

New York State Law

New York State Workers' Compensation Law requires that employers either insure their liability with an insurance carrier or be authorized by the Workers' Compensation Board to be self insured, either individually or as part of a group.

The cost of the insurance must be paid entirely by the employer, no amount can be charged to the employees.

The Workers' Compensation Board has the legal authority to require employers to provide coverage and can penalize those that do not. The Board does not, however, provide any insurance, pay claims, set rates or oversee the insurance carriers. Yet many employers turn to the Board with questions and assistance regarding these matters, so this chapter provides a brief overview of insurance. Self insurance is discussed in another chapter.

When employers buy workers' compensation insurance, the insurer is assuming the employer's statutory obligation to pay medical, indemnity and death benefits under the law. Premiums reflect the employer's potential liability for claims based on individual experience, wages paid to employees and the type of industry in which they are engaged.

Manual Rates

Rates for workers' compensation coverage are established by the New York State Insurance Department, upon recommendation from the Compensation Insurance Rating Board (CIRB). Based upon New York State employers' experience and future projections, the CIRB recommends a percentage increase or decrease in the rates to the Insurance Department each year.

There are more than 500 classifications of workers, each carrying a different manual rate for determining workers' compensation premiums. A classification code assigned to an employer is based on the actual work being performed, or the classification that most closely represents the type of work being performed if there is not an exact match. The manual rate that is assigned to the employer will reflect the most hazardous classification in the business, and all but a few employees will be grouped in that classification. Those standard exceptions involve occupations common to many businesses, including clerical, office employees, drivers, outside salespersons and messengers.

Therefore, the payroll for the secretary in a construction firm will be included in the clerical class, and not a more expensive construction classification like the remainder of the payroll.

Because they entail similar risks, certain varied businesses are grouped together within the same classification. Each classification is assigned its own manual rate based upon its contribution to total workers' compensation costs. The manual rate is based upon the average loss experience of all the members of the class taken as a whole, meaning the likelihood of injuries in that occupation, not the accident history of the individual company.

Each manual rate also is assigned a minimum premium, which is the lowest premium that an insurance company will accept to provide the workers' compensation insurance. In 2003, the most common minimum premium was \$850.

Manual rates are based on per hundred dollars of payroll, and change every year.

Experience Rating

The employer's own loss experience is a predictor of the likelihood of future losses for that employer. Therefore, premiums must take into account the individual risk, based on the experience of each particular company. Experience modification factor or rate (EMR) compares a company with others in its classification, and is a means of allocating premium among employers within a classification according to their relative contribution to class cost. It is applied to all policy holders with an annual premium of at least \$5,000. An insured's experience rating, or modification, compares its loss experience to the average for its class, and is used to increase or decrease the manual rates of insurance.

If a company has fewer, less costly accidents, it will receive a credit off the manual rate. If a company has more frequent or expensive accidents, it will receive a surcharge on the manual rate. It is important to note that frequency of accidents is weighted more heavily than severity when calculating an experience modification factor.

Normally, the average experience modification rate is 1.00. Therefore, an employer who is assigned an EMR of .85 would receive a 15 percent credit, while an EMR of 1.15 would result in a 15 percent surcharge. An accident is charged against a company's EMR for three full policy years following the injury.

Assessments

The final amount that is calculated into an insurance policy is the assessment. The assessment is based on a set percentage of premium for every employer, and the percentage changes every year.

The NYS Workers' Compensation Board is classified as a Revenue Agency within state government, and does not receive any funding through general tax revenue. Therefore, the Board itself must fully recover all the costs it incurs in the delivery of its services through its own revenue sources.

Assessments also fund several ancillary programs that reimburse carriers or claimants under special circumstances, including the Second Injury Fund, Special Disability Fund, Fund for Reopened Cases, Uninsured Employers Fund, and Special Fund for Disability Benefits.

By law, the recovery of the Board's administrative costs, which includes the cost of personnel, plant, supplies, travel, etc. is done through a series of general administrative assessments levied against insurance carriers and self-insured employers. The assessments against carriers are passed on to employers through the annual premiums. As the losses and liabilities for these programs rise and fall, so does the assessment charged to carriers.

Payroll

When an insurance company writes a policy for an employer, the manual rate, EMR and assessment are all used to calculate premium. The insurance carrier requests an estimate of total annual payroll from the employer. The premium cost is the manual rate for a classification multiplied by every \$100 of payroll, and the EMR and assessment are added to the total.

Since the premium is based in part on payroll that is estimated at the beginning of the policy year, the final premium could be more or less, depending on the actual payroll at the end of the policy year. Adjustments are made at that time, resulting in either a refund or an additional charge. An employer who understates their payroll at the beginning of the policy may receive a smaller bill for a year or two, but once the policy is audited, the error will be caught and the employer will receive a large bill after the policy expires. If the understatement was intentional, it could be classified as fraud, a class E felony.

The Audit

Every carrier has the right to audit a policy at least every three years, some are audited several times a year. During an audit, the employer must provide copies of canceled checks, payroll, general ledgers and other financial information.

The estimated payroll is often much higher than the actual payroll, resulting in a higher premium at the beginning of the policy period. Some policies are too small to be physically audited, and are instead based upon payroll report statements submitted by the employer. If the employer fails to submit the payroll report, the carrier will use an estimate, which is often much higher than the previous year's payroll. It is in the financial interest of the employer to comply with the payroll reports and audits.

Independent Contractors

The Workers' Compensation Law does not require sole proprietors or officers or one or two-person corporations to provide coverage for themselves. However, sometimes, an independent contractor is injured while working and files a claim stating that they were actually an employee.

There is case law (State Insurance Fund vs. Rivington Farm Dairy) that allows insurance carriers to protect themselves against such claims by charging an additional premium for any policyholder that uses independent contractors.

During an audit, the insurance carrier may charge premium based upon payments made to independent contractors/subcontractors that do not carry their own workers' compensation insurance. The Workers' Compensation Board does not make advance determinations regarding independent contractor status, and only makes such decisions on an individual basis in the event a claim is filed.

Policy Cancellations

The Workers' Compensation Law requires insurance carriers to notify the employer by certified mail 10 days prior to the cancellation of an insurance policy for nonpayment. When cancellation is due to any reasons other than nonpayment of premiums, the carrier must provide at least 30 days notice to the employer by certified mail and to the Chair of the Workers' Compensation Board. If an employer currently insured by the State Insurance Fund wishes to place coverage elsewhere, they must give 30 days written notice to SIF.

If an employer receives a notice of cancellation for nonpayment and does not pay the balance within several days, the policy will generally not be reinstated, even if the bill is paid in full at a later date. The employer will be without insurance and subject to penalties from the Workers' Compensation Board. The employer must get new insurance coverage immediately and appeal any penalties that they have for noncompliance. In addition, they should arrange an audit with the insurance carrier as soon as possible to determine the final bill. Since the policy would not have been in effect for a full year, it is possible the employer will receive a credit once the audit is complete.

When a policy is cancelled by either party (nonpayment or the employer chooses another carrier) on a date other than the anniversary date of the policy, a short rate penalty will be charged by the insurance carrier. This penalty, which is a percentage based on the amount of time the policy was in effect for the policy year, is in addition to any premium due. Therefore, the bill for a policy that was in effect for only six months of policy year could actually be more than a full year's premium.

The high cost of going without workers' compensation insurance-

An employer's failure to provide workers' compensation coverage is a crime, punishable by fines and/or imprisonment. Add onto that the legal cost of a defending and possibly losing a civil suit for an injury of an employee, and the cost of workers' compensation insurance seems very reasonable.

Penalties for noncompliance

The law requires employers operating in New York State to have workers' compensation coverage for their employees, with limited exceptions. Employers are required to obtain and keep in effect workers' compensation coverage for all employees, even part-time employees and family members that are employed by the company. (See Chapter Five for more about obtaining coverage)

The Board is notified when a workers' compensation insurance policy is written, modified or canceled by the insurance carrier. The Department of Labor notifies the Board of the number of employees that are employed. If the Board receives notice of a cancellation of a policy without new coverage taking effect for a company that has employees, the following will occur:

- The Board will send a notice asking if a new policy has been secured, or if the employer is now legally exempt from the workers' compensation coverage requirement.
- If no response is received, the first penalty notice will be sent. The penalties for non-compliance are \$250 for every ten-day period without coverage. By the time that an employer receives their first penalty notice, the penalty is already \$1000. The penalty accrues for the time period in which they had no workers' compensation coverage and had employees.

Appealing a Penalty

Employers have 30 days from the date of the initial penalty to make an application for redetermination review of such penalty, explaining why there was a lapse in coverage and asking for the penalty to be reduced. Information about how to appeal is located on the back of the penalty notice.

Uninsured Employers Fund

If an employee is hurt when there is no workers' compensation policy in effect and that employee chooses to file a workers' compensation claim, the employer will be liable for the actual cost of medical care and compensation payments, in addition to penalties. If a corporation has failed to secure workers' compensation coverage, the President, Secretary and Treasurer of a corporation are personally liable for the medical care, compensation payments and penalties.

Claims arising out of the Uninsured Employers Fund are overseen by the Board's Office of Compliance. The UEF is the funding mechanism for compensation and medical payments to injured employees whose employer was not properly insured at the time of the accident. These claims are processed by staff, who collect all evidence, prepare the claim for hearings and administer the payment of all compensation and medical benefits. The Office also has a team of lawyers who maintain the integrity of the UEF by representing the Fund at Board hearings to ensure that only valid claims are compensated.



What to Do When an Accident Happens

The First Steps

Everyone has probably heard the old adage “The least expensive accident is one that never occurs.” But accidents do happen, and employers need to become involved before the first form is filed.

Obtaining Medical Treatment

The employee should obtain medical treatment and notify his or her supervisor about the accident and how it occurred. In addition, the employee should submit written notice within 30 days to his or her employer.

Employers in New York State cannot direct their employees to a particular health care provider, unless they participate in the Preferred Provider Program or the Alternative Dispute Resolution Program. Employers can recommend care providing they inform employees of their rights to choose providers of their choice (Form C-3.1).

Investigation and Communication

All accidents should be investigated fully to ensure that all the facts are gathered. The health care provider may be contacted to make sure that the injured worker is receiving the appropriate care. In addition, the employer should contact the insurance carrier and maintain those communications throughout the claim.

Any written contact with the claimant’s health care provider should be copied to the claimant and the claimant’s legal representative, if any. Any attempt to influence the health care provider in any way may be considered interference with the claimant’s treatment.

Minor Injuries

If the injury is minor, requiring two or fewer treatments by a person rendering first aid, and with lost time of less than one day beyond the end of the working shift on which the accident occurred, the employer may choose to pay for the first aid treatments directly. In this instance, the employer completes a C-2 “Employer’s First Report of Injury” form, but does not send it to the Board or the insurance carrier. Instead, the employer maintains the form in their files for the statutory 18-year period. C-2 forms are available from the insurance carrier, a Board office or online at <http://www.wcb.state.ny.us>.

Reporting Injuries

All other injuries not fitting the above criteria must be reported to the Board and insurance carrier. Failure to file within 10 days after the occurrence of the accident is a misdemeanor and punishable by a fine. In addition, the Board may impose a penalty of up to \$2,500.

When completing a C-2 form, it is important to remember that statements can be binding. The employer should note on the C-2 if they believe the claim to be questionable or fraudulent. The insurance carrier can also be contacted for assistance with completing the form. The C-2 can be filed by a third party designated by the employer, however the employer is ultimately responsible for ensuring it is filed.

Filing the C-2 form is not necessarily an admission that you agree with the facts of an accident. It is a statement that an employee reported a work-related injury or illness to the employer.

The Path of a Claim

Immediately: The worker obtains the necessary medical treatment and notifies his/her supervisor about the accident and how it occurred.

The employee notifies the employer of the accident in writing, as soon as possible, but within 30 days. The Board can excuse if notice couldn't be given, employer had knowledge, or if the employer is not harmed by lack of notice.

The employee may file a claim with the Board on Form C-3 by filing the form with the appropriate District Office. This must be done within two years of the accident, or within two years after the employee knew or should have known, that the injury was related to employment. A C-3 form is not always necessary to adjudicate a claim.

Within 48 hours of the accident: The doctor completes a preliminary medical report on Form C-4 and mails it to the appropriate District Office. Copies must also be sent to the employer or its insurance carrier, the injured worker, and his/her representative, if any.

Within 10 days of the occurrence of the accident: The employer, or its third party designee, reports the injury to the Board and the insurance company on Form C-2.

Within 14 days of receipt of Form C-2: The insurer provides the injured worker with a written statement of his/her rights under the law. This must be done within 14 days after receipt of the C-2 from the employer or with the first check, whichever is earlier.

Within 15 days of initial treatment: The doctor completes a 15-day report of the injury and treatment on Form C-4 and mails it to the District Office.

Within 18 days after the first day of disability or 10 days after the employer first has knowledge of the alleged accident, or within 10 days after the carrier receives the Form C-2, whichever is greater: The insurer begins the payment of benefits if lost time exceeds seven days. If the claim is being disputed, the insurer must inform the Workers' Compensation Board (and the claimant and his/her representative, if any). If the claim is not disputed, but payment is not being made for specific reasons stated on the notice, (e.g. that there is no lost time or that the duration of the disability is less than the 7-day waiting period), the insurer must also notify all the parties.

The insurer files Form C-669 or Form C-7 with the Board indicating either that payment has begun or the reasons why payments are not being made. A copy of the Form C-669 or Form C-7 must be transmitted to the claimant and his/her attorney/licensed representative, if any, simultaneously with the filing with the Board. If the employee does not notify the employer timely, this notice may be filed within 10 days of learning of the accident.

Within 25 days of the notice of indexing: Where controverted – When the Board notifies an employer or its insurance carrier that a workers’ compensation case has been indexed against the employer, and the employer or insurance carrier decides to controvert the claim, a notice of controversy (Form C-7) shall be filed with the Board within 25 days from the date of mailing of the notice of indexing. Failure to file the notice of controversy within the prescribed 25 day time limit could bar the employer and its carrier from pleading certain defenses to the claim.

Where not controverted – If the right to compensation is not controverted but payment has not begun because no compensation is presently due, prescribed Form C-669 shall be filed with the Board not later than 25 days after the Board has transmitted a notice of indexing a case to the employer or its insurance carrier.

Every 2 weeks: The insurer continues to make payments of benefits to the injured employee (if the case is not being disputed). The carrier must notify the Board on Form C-8/8.6 when compensation is stopped or modified within 16 days after the date on which payments were stopped or modified.

Every 45 days: The doctor submits progress reports on Form C-4 to the Board.

After 8 weeks: The insurer considers the necessity of rehabilitation treatment for the injured employee.

Hearings: Notices of hearings will ordinarily be sent by The Workers’ Compensation Board to the carrier for the employer, or directly to the employer if self-insured. An employer having knowledge of a hearing is not obligated to attend unless a hearing notice is sent to the employer, specifically requesting attendance, or unless a representative of insurance carrier requests attendance.

Responsibilities of the Insurance Carrier

The insurance carrier has 18 days from the date of disability or 10 days after the employer first has knowledge of the alleged accident or within 10 days after the carrier receives Form C-2, whichever is greater, to determine whether to pay benefits or controvert all or part of a claim. Until such controversy is resolved, the carrier does not have to pay indemnity or medical benefits, although the health care provider must continue to treat during this period.

If the insurance carrier agrees with the claim, payment of benefits must begin within 10 days of receiving the C-2 form, or 18 days after the date of disability or 10 days after the employer first has knowledge of the alleged accident.

Controverting a Claim

The insurance carrier can contest the claim for a variety of reasons, including that the injury was not related to work, or the employee is not injured to the extent that he or she is claiming. An employer can also request that the insurance carrier contest the claim. However, since the insurance carrier has assumed the liability for the claim, it is not required to comply with the employer’s request.

Once a claim is controverted, a hearing will be scheduled to give a law judge the opportunity to hear both sides of a disputed issue. The Board may hold a hearing or hearings before a Workers' Compensation Law Judge. The Judge may take testimony, order depositions, review medical and other evidence and will decide whether the claimant is entitled to benefits. If the claim is determined to be compensable, the Judge determines the amount and duration of the compensation award.

Settling a Claim

Under Section 32 of the Workers' Compensation Law, parties may enter into a binding agreement settling upon and determining the compensation and other benefits due to the claimant. If approved by the Board, the settlement is binding on all the parties and not subject to appeal. Section 32 agreements can expedite the adjudication of issues or entire claims, while assuring the rights of the claimant and all other parties.

Another method that can be utilized to settle a claim is the Board's WISK Program (Walk-In Stipulation Kalendar). When interested parties wish to settle matters quickly and equitably, the WISK program allows them to stipulate to certain findings and resolve claims. Upon reaching agreements, the parties may request time on the Walk In Kalendar to seek approval of the agreed upon terms from a Workers' Compensation Law Judge.

A third option of settling a claim is through a lump-sum settlement, which allows the parties to agree to a lump-sum amount to be paid to the claimant. A lump-sum settlement is considered closed unless there is a change in the claimant's condition that was not contemplated at the time of the agreement.

Appealing A Decision

Either side may appeal the decision within 30 days of the filing of the Judge's decision. This is done by applying in writing for Board review. If the application is granted, a panel of three Board Members will review the case. This panel may affirm, modify or rescind the Judge's decision, or restore the case to the Law Judge for further development of the record. In the event the panel is not unanimous, any interested party may make application in writing for a full Board Review. The full Board must review and either affirm, modify or rescind such decision.

Appeals of Board Panel decisions may be taken to the Appellate Division, Third Department, Supreme Court of the State of New York, within 30 days. The decision of the Appellate Division may be appealed to the Court of Appeals.

Note: If a case is being contested, the carrier does not have to pay weekly benefits while the case is being reviewed by a Board Panel. However, payment of compensation and physician's bills must be made if the claimant's award is upheld by the Board Panel, even if an appeal is made to the Appellate Division. In addition, the uncontested portion of a Judge's award is paid even if an application for review is filed.

Keeping a Claim Moving

Immediately following a work-related injury or illness, most employees become very fearful about their financial future and ability to return to work. The longer an employee stays out of work, the more difficult it becomes to return, both physically and psychologically. Following these tips can help to keep a claim moving:

- Keep in touch with the employee, letting them know that you care about them and what happened to them. Contact them periodically to let them know what is going on at work.
- Contact the health care provider to make sure that the employee is receiving the treatment necessary to recover. Discuss light duty positions if that is an option. Make such positions available if possible (see Chapter 6 – Return to Work). Any contact with the claimant’s health care provider, however, must not violate Section 13-a (6) of the Workers’ Compensation Law, which provides in part that the “improper influencing or attempt to influence the medical opinion of any physician who has treated or examined an injured employee shall be a misdemeanor.”
- Make sure that the claims administrator has all the necessary information, and keep in touch with the insurance carrier.

Avoiding Future Accidents

Accident frequency, not severity, is what drives up insurance costs. Employers should evaluate every accident, particularly the smaller, more frequent ones, to determine how to avoid them in the future.

Ideally, the time to work on preventing accidents is before they occur. If safety rules and equipment are not enforced or used or worse yet, nonexistent, a careless attitude toward safety will surely develop.

Developing a safety culture is an important aspect to reducing or avoiding altogether lost-time accidents. Following these rules consistently and reminding employees of them on a regular basis, is a strong step toward that goal:

- Remind employees of the rules and encourage them to make suggestions regarding safety.
- Educate new employees about the safety program and requirements of the job. Knowing how to do the job the right way, whether it is heavy lifting or work at a keyboard, can eliminate some of the common workplace injuries, repetitive strain and low back injuries.
- Keep records of training and safety meetings.
- Make the use of safety equipment second nature. Make ample use of reminders and incentives to encourage the correct use of the equipment.
- Interview employees after each injury to determine not only the facts, but if the injury could have been avoided.
- Collect physical evidence such as equipment logs and photographs of the location where the injury occurred.
- Learn from these accidents. Once a problem area has been identified and analyzed, steps can be taken to eliminate hazards. Ergonomics, better lighting, improved ventilation, machine guarding or a change in process may be all that is necessary.

Employer's Rights During a Claim

An employer has the right to request that the insurance carrier contest the compensability of a claim. *A claim can be contested for a variety of reasons, including, for example, that the injury was not related to work or that the employee is not injured to the extent he or she is claiming. An employer can request that the insurance carrier contest the claim, but since the carrier has assumed liability for the claim, it is not required to comply with the employer's request. In addition, employers or carriers who engage in dilatory tactics will be penalized.*

- An employer has the right to attend any hearings related to a claim filed by one of the employer's workers.
- An employer has the right to electronically access the Board's case file for a claim filed by the employer's worker by visiting one of the Board's customer service centers. *The Board's Electronic Case Folder (ECF) allows parties of interest to view the documents in the claim file electronically. Employers should go to one of the 11 district offices or 30 Customer Service Centers with identification to obtain a password. Based on the confidentiality of workers' compensation records, please be prepared to offer proof that you are the employer of record in the claim.*
- A self-insured employer, or an employer who has failed his or her obligation to secure workers' compensation coverage, has the right to participate in the hearing and present relevant evidence about disputed issues at a hearing. *Employers may request that a hearing be scheduled on a particular issue by writing to the appropriate district office in a timely manner. Corporations must be represented by counsel in proceedings before the Board. Certain defenses will be waived if they are not timely raised or if the employer or carrier does not timely file a Form C-7, Notice that Right to Compensation is Controverted.*
- An employer has the right to report suspected workers' compensation fraud to the Fraud Inspector General. *Fraud Referral Hotline: 1-888-363-6001.*
- An employer has the right to appeal or, if insured, to request that the insurance carrier appeal on appropriate grounds a decision of a Workers' Compensation Law Judge regarding a claim filed by an employee. *Any party may appeal a notice of decision within 30 days by writing to the Board requesting Board review; however, a party filing a frivolous appeal will be penalized.*

Privacy of Case Records

Workers' Compensation Law section 110-a limits access to an individual's workers' compensation file to the claimant, the claimant's attorney or licensed representative (upon filing of an OC-400 form), and the employer/insurance carrier or their agents acting within the scope of their duties in evaluating, processing, and settling the claim.

Access can be gained by other parties by securing authorization from the claimant by filing OC-110A, a notarized authorization from the claimant or a court ordered subpoena or court order from a court of competent jurisdiction, and then submitting it to the Board. The original authorization, subpoena or court order must be filed with the Board, copies of the original are not sufficient to gain access.

The law prohibits authorization by the claimant directing disclosure of records to a prospective employer, or in connection with assessing fitness or capability for employment. It is unlawful for any employer to inquire into, or to consider for the purpose of assessing fitness or capability for employment, whether a job applicant has filed for or received workers' compensation benefits.



Return to Work Programs

Why Have A Return to Work Program?

Return to work programs can assist businesses in controlling expenses while helping the injured workers to return to work as quickly as medically possible. Many injured workers expect the workers' compensation system to replace all their wages and benefits, and are often dissatisfied by the realization that it cannot.

Who Can Benefit By A Return to Work Program?

Experience shows that injured workers recover faster when they return to work. Experience also shows that the longer an injured worker remains away from work, the more difficult it is to return. Returning to regular work usually occurs more quickly when modified duty is offered to the injured employee.

Some injuries are so severe that a return to any type of work is impossible. Yet with new advances in assistive technologies, there are fewer and fewer instances where job modifications cannot be made to accommodate even the most severe injuries.

The employer also benefits from a return to work program because the indemnity benefit that an employee receives is offset by the amount he or she is receiving in wages. The less money that an insurance company is spending to pay benefits, the better the experience modification factor, and ultimately, the lower the premium costs. In fact, according to the State Insurance Fund, companies that have return to work programs have seen savings up to 20-40 percent or more in workers' compensation costs.

The Most Important Player – The Employee

Two of the most important factors in considering the workers' response to the injury are motivation and pre-morbid personality. Motivation, or the worker's expectation of his or her performance, is probably one of the biggest predictors of success in any return to work program. The worker's expectation of his or her performance is a predictor of how well he or she will perform.

The second major factor is pre-morbid personality – the worker's level of self-esteem and self-confidence will have a major impact on how he or she deals with disability. If a person was already prone to anxiety and depression, these factors will impact his or her acceptance of the injury and view of the future.

The Return to Work Team

In larger firms, the return to work program is comprised of a number of individuals that function as a team. But what about a small employer that cannot afford a staff with such diverse expertise? The small employer can still look at each of the tasks to determine what is necessary to return an injured employee back to work safely.

- Determine the nature and extent of the disability and overall health, to determine capacities and limitations for the extent and type of work that the injured worker can perform.
- Look at the existing job and analyze it from the viewpoint of skills required and its physical demands. Based on existing claims information and medical reports, look at work history, education, training, skills, licenses, etc. to determine how the worker's existing skills fit into the requirements of the job.
- Focus on removing the barriers preventing a successful return to work, with a special focus on environmental barriers, family issues, psychological barriers and economic disincentives. A Workers' Compensation Board social worker can assist the injured worker with accepting the severity of the disability and the occupational limits it imposes and the need to make reasonable plans and decisions for economic security.
- Review job descriptions with a knowledge of the skills and other requirements that are necessary to satisfactorily perform a given job.
- Understand the detailed description of the actual job, including the requirements and skills to perform it effectively. The supervisor can also be given realistic expectations as to what to expect from the worker upon returning.
- Utilize the expertise of the insurance company claims examiner, who pays the bills, has detailed information about the injury and medical treatment, and a wealth of experience in dealing with a variety of workplace injuries.

The Various Steps to Return to Work

The ultimate goal is to return an employee to his or her same job at the same pay. But that does not mean the employment relationship has to end.

The other options an employer can utilize during the recovery period include:

- Modified job
- Part-time job
- Different job
- Job sharing
- On-the-job training

For the vast majority of injured workers, the lost time is minimal, the physician authorizes return to work and the worker goes back to the same job. For the more serious injuries, the physician still does the physical capacity evaluation, but also needs some vocational evaluation and understanding of the physical demands of the job to give informed opinions.

If the physical capacities are compatible with the physical demands of the job, then the injured worker can go back to the same job with the same employer. Where there is a discrepancy between the physical demands and the capacity to do the work, the next step is to assess whether some type of job modification or restructuring could enable the worker to return to the same job. It might be possible that some unessential functions could be eliminated, or essential tasks could be rearranged to accommodate the worker.

In one instance, a parts inspector sustained a back injury from constantly having to pick up three to five pound parts from cases on the floor. His physician stated that he could not continue to do this job without risking further deterioration of his condition. A Workers' Compensation Board counselor went to the site and analyzed the job. After recommending that the cases of parts be stacked on pallets, so the employee would not have to bend over, the problem was solved at minimal cost.

If job modification is not workable then alternative work must be considered. The first option is to look for a different job utilizing transferable skills. Here the skills analysis is critical to determine which skills may be transferable to keep the learning curve short. The employer needs to do a thorough job of skill assessment and analyzing the worker's potential for training and learning new skills. For example, a drill press operator with a back injury could no longer work for eight hours while standing on a concrete floor. A Workers' Compensation counselor visited the job site and found a position for the injured worker doing grinding and burring, a job that utilized existing skills and allowed him to sit on a high stool. This transfer was accomplished with the cooperation of the union and the Human Resource Manager.

The next level of alternative work entails on-the-job training with the same employer. In this case the emphasis is on aptitudes and learning capacity for new skills and training. Attention also needs to be focused on vocational interests and career goals.

When the injured worker cannot return to the employer, it may be because the injuries are so severe that there has been extensive lost time and the job could not be held open, or that the injuries prevent the worker from performing his or her usual job, or there is a poor match between transferable skills and existing jobs. When cases are more complex, that is, as lost time becomes more extensive (more than three months) the costs escalate and the odds for a successful return to work begin to decline.

Employers are prohibited from terminating an employee because the employee has filed a claim for compensation or received compensation pursuant to WCL §120. However, this is not a job security provision. To be a valid discriminatory claim, the employer must be retaliating against the employee for filing the claim or receiving benefits. If an employer terminates an employee for a valid business reason, without any retaliation, then there is no discrimination.

The Workers' Compensation Law does not prevent an employer from taking reasonable steps to secure a steady, reliable and adequate work force. Employers may terminate employees who have filed workers' compensation claims and/or are receiving benefits if the termination is for a valid business reason, such as

insubordination, lack of work/economic reasons, misconduct, lengthy absence from work, inability to perform the job, or poor job performance, and is not retaliatory. The determination of whether a discharge is discriminatory or for a valid business reason will be made by the Board if a discrimination claim is made. Employers may wish to seek legal advice on this issue, and with respect to any other State or Federal laws or collective bargaining agreements that may apply to termination of employees.

In summary, many variables go into crafting a successful return to work program. There are no easy answers or solutions. Developing a good plan early helps everyone to clearly see their role and to be able to work together effectively to bring about a win/win situation.



Workers' Compensation Fraud

In the simplest terms, insurance fraud occurs when someone knowingly and with intent to defraud, presents or causes to be presented, any written statement that is materially false and misleading to obtain some benefit or advantage, or to cause some benefit that is due to be denied. If there is no material, written lie, there may be abuse, but it is not fraud. However, workers' compensation fraud may be committed by a false statement, which could be verbal.

What is Workers' Compensation Fraud?

One of the costs of workers' compensation doesn't involve providing medical care or cash benefits to claimants. These are the costs associated with losses from fraudulent claims. Attorneys, employees, employers, health care providers, and insurance carriers can all be parties to fraud, bogging down the system for legitimate claims that would otherwise be paid in a timely manner.

People who inflate or misrepresent a claim or submit a false claim are committing fraud. People who get hurt participating in a leisure activity on Sunday and report it on Monday as a work-related accident are committing fraud. Employers who misclassify their employees or payroll are committing fraud. Health care providers who submit false medical reports or inflated bills are committing fraud. Attorneys who solicit a person to file a false claim, or insurance carriers who alter evidence to support a denial of benefits are committing fraud. Fraud hurts everyone. Fraud affects a company's bottom line, and therefore it affects all the employees. Money that could finance additional staff or increase employee wages must be diverted to pay for increased premiums. Employers pass these increases on to their customers in the form of higher prices. In the end, it is the taxpayers that pay for fraud.

Workers' compensation fraud occurs when someone knowingly, with intent to defraud, makes a false, material statement to obtain or deny a benefit. The law imposes tough criminal penalties for workers' compensation fraud by making such crimes a Class E felony, punishable by fines and/or prison time.

The Office of the Fraud Inspector General is charged with investigating allegations of fraud by any party to the workers' compensation system, including attorneys, employees, employers, health care providers, and insurance carriers.

Common Forms of Workers' Compensation Fraud

Attorney Fraud

Occurs when an attorney/licensed representative knowingly participates in misrepresentation of the truth in order to either secure or deny compensation for their clients and/or themselves.

Examples of Attorney Fraud

- Knowingly assisting a client in pursuing a false claim.
- Soliciting a person to file a false claim.

Employee Fraud

Occurs when an employee knowingly, either verbally or in writing, lies about, or causes another to lie about, a material fact for the purpose of obtaining workers' compensation benefits to which he or she is not entitled. The lie must be knowingly made. An inadvertent or unintentional misstatement is not fraud. The lie must be made for the purpose of obtaining or denying benefits, and important enough to impact the benefits.

Examples of Employee Fraud

- Filing a claim for an injury that did not occur on, or has no relation to the job.
- Lying about work status when questioned directly, such as at a deposition or a hearing, while receiving temporary disability benefits.

Employer Fraud

Occurs when an employer knowingly misrepresents the truth in order to avoid, deny or obtain compensation on behalf of employees, or knowingly lies about entitlement to benefits to discourage an injured employee from pursuing a claim. Occurs when an employer knowingly lies in order to obtain a workers' compensation insurance policy at less than the proper premium rate.

Examples of Employer Fraud

- Lying about the job risk or exposure by: underreporting payroll; misclassifying payroll; or lying about company ownership to avoid a higher experience modification.
- Telling an employee that workers' compensation benefits are only available if he or she has been employed for six months or more.

Health Care Provider Fraud

Includes any verbal or written lie that forms the basis of any billing for services or benefits in the workers' compensation system. Can be perpetrated by any provider in the system, such as doctors, rehabilitation counselors, pharmacists, or chiropractors.

Examples of Provider Fraud

- Billing for exams of patients who were never examined, or for treatment never rendered.
- Duplicate billing and/or receiving payment from different insurance carriers for the same treatment — and not making restitution

Insurance Carrier Fraud

Occurs when a claims representative purposely misrepresents the truth in order to either deny or support a claim; or offers or accepts any form of consideration for the referral or settlement of a claim.

Examples of Carrier Fraud

- Accepting a gift from a doctor's office in exchange for an implied promise of patient referrals.
- Altering the evidence in a claim in order to support a denial of benefits.

The Difference Between Fraud and Abuse

Fraud vs. Abuse

What is fraud? What is abuse? What is the difference between them? Because abuse is a very broad term, it is easy to confuse the two.

Abuse Defined:

Workers' compensation abuse is any practice that uses the workers' compensation system in a way that is contrary to either the intended purpose of the system or the law. This includes some behavior that is not criminal and some that is, most significantly, fraud.

Insurance Fraud Defined:

Merely filing a claim that is not warranted or violating the rules of the workers' compensation system, in the absence of fraud (a lie) or kickbacks, may be abuse, but it is not criminal. The specific elements of fraud must be present. Similarly, over-treatment by a physician might represent a difference in opinion; although it could appear excessive and possibly abusive, it does not necessarily constitute fraud. Typical abuses of the system also include magnification of complaints or disability that fall short of an outright lie, or an over utilization of benefits. For example, soft tissue injuries give rise to subjective complaints that they cannot either prove or disprove.

The presence or absence of a specific, provable lie is the deciding factor. To separate fraud from abuse, it is necessary to look for the material, written lie that was presented or caused to be presented to or by an insurer. The New York Penal Law punishes written fraud only; the Workers' Compensation Law also prohibits oral fraud, in addition to written fraud.

For example, returning to work while receiving temporary disability payments might be abuse, or it might be fraud, depending upon the circumstances. If temporary disability benefits continue when the claimant has returned to work, and no one ever asks the claimant "are you working?", there is an abuse of temporary disability benefits, but there is no written lie and therefore no insurance fraud.

However, using the same example, if someone, such as the adjuster or the doctor, specifically asks the claimant "are you currently working?" - and the claimant replies "no" and thus lies, and that lie is transcribed in a written instrument (e.g., doctor's report or employer's claim form) there is insurance fraud and a possible action under the Workers' Compensation Law and Penal Law, if the lie is relied upon to determine the amount and payment of temporary disability.

The Workers' Compensation Reform Act of 1996 has made it easier for prosecutors to establish fraud cases. Under an amendment to Section 132 of the Workers' Compensation Law, every check issued directly to a benefit recipient or health care provider must contain a statement directly beneath the endorsement line indicating that in endorsing the check, the signatory certifies that s(he) is entitled to such payment and that the circumstances which would affect entitlement to payment have not changed. Thus, with every check that is presented, prosecutors potentially have the basis for the "written lie" that is essential to a fraud case.

Kickbacks

Though not legally a fraud, offering or accepting kickbacks for the referral or settlement of cases is a reportable and highly prosecutable crime. Kickbacks indirectly feed the problem of fraud and as a result, cause damage to our society and our economy. Consequently, the legislature has determined that paying and receiving kickbacks can contribute to fraud and are punishable criminal acts.

Insurance Fraud

In separating criminal insurance fraud from abuse, remember these key elements:

- There is always a false representation - the lie
- The lie must be intentional or knowingly made
- The lie must be made for the purpose of obtaining a benefit the claimant is not due, denying a benefit that is due, or obtaining insurance at less than the proper rate
- The lie must be material, that is, it must make a difference: "If the truth had been told, would you have done anything differently?"

Reporting Fraud

Any claims of suspected workers' compensation fraud should be referred to the Workers' Compensation Fraud Inspector General for investigation and development of the appropriate case for prosecution by the State Attorney General's Office, or local District Attorneys. The Fraud Inspector General may be contacted by writing to:

Inspector General - Fraud Investigations
NYS Workers' Compensation Board
20 Park St.
Albany, NY 12207
(518) 473-4839 or the Fraud Hotline at 1-888-363-6001



Resources for Employers

Workers' Compensation Board

Questions regarding:
Injury/Claims
Workers' Compensation Law
Compliance/Coverage
Corporate Officer Options
Enforcement
Penalties
Self-Insurance
Medical Provider Requirements
Disputed Medical Bills

NYS Workers' Compensation Board
20 Park St.
Albany, NY 12207
518-474-6674 (General Information)
1-800-628-3331 (Advocate for Business)
www.wcb.state.ny.us

Compensation Insurance Rating Board

Questions regarding:
Rates
Classifications
Experience Modification Factors
Endorsements
Underwriting Rules

New York Compensation Insurance Rating Board
200 E. 42nd St.
New York, NY 10017
212-697-3535
www.nycirb.org

State Insurance Fund

Policy Holders of the State Insurance Fund with questions regarding:

- Audits
- Corporate office exemptions
- Payroll Reporting
- Policy Cancellations
- Quotes for Insurance (for potential customers)

New York State Insurance Fund

199 Church St.

New York, NY 10007

1-888-875-5790

212-312-9000

www.nysif.com

Commonly Used Workers' Compensation Terms

Abey a Case: To suspend action on a case, with a notation that an Examiner is to review the case by a specified future date.

Abey an Issue: To postpone a decision on an issue in a case until a later date, when it is expected that additional pertinent information may or will be available.

Accident (Work-Related): (WCB) An event, arising out of and in the course of employment, that results in personal injury to a worker.

Accident, Notice and Causal Relationship (ANCR): (WCB) Minimal conditions that must be met before financial responsibility can be assigned to a claim for workers' compensation. Specifically, it must be established that

- a work-connected accident covered by the Workers' Compensation Law occurred;
- following the accident, the claimant notified his/her employer within the time limit required by the Workers' Compensation Law; and
- a causal relationship exists between the accident and a resulting injury or disability.

Adjourn (a Hearing): (WCB) To put off or suspend until a future time, without making any findings.

Adjudication: The act or process of adjudicating. A determination or decision by the Board.

Appeal: (WCB) A legal action taken by one of the parties to the Appellate Division, Third Department, to reverse or amend a decision or direction made by a Board Panel or the Chair of the Workers' Compensation Board.

Apportionment: (WCB) A proportionate division of all or part of the liability in a case between two or more sources of disability for the same claimant, based on an evaluation of the relative contribution that the sources of disability have made to the claimant's permanent disability.

Arising Out of and in the Course of Employment: (WCB) Two necessary conditions that must be met to establish a work-connected accidental injury; an injury that "arises out of" is one that results from a hazard of the employment, while an injury "in the course of employment" is one that occurred at a time, place and under circumstances related to the employment.

Average Weekly Wage (AWW): Wage used to calculate compensation and death benefit rates. Defined at 1/52nd of the injured worker's average annual earnings (200-300 times average daily wage, depending on work schedule), based on the prior year's payroll data. If an injured worker has not worked a substantial portion of the immediately preceding year, the average wage of a comparably employed worker is used in the Board's calculations.

Board Panel: (WCB) A panel, usually comprised of three Workers' Compensation Board members, that reviews requests to amend decisions made by Workers' Compensation Law Judges, reopens closed cases and considers applications for lump sum non-schedule adjustment awards.

Case: (WCB) A reported work injury or illness which has been assembled and assigned a case number (indexed) by an indexing unit of the Workers' Compensation Board.

Case Number: (WCB) A unique identifier assigned by the Workers' Compensation Board at the time a case is indexed. The case number consists of 8 characteristics and has two possible formats:

- for regular cases (not involving volunteer firefighters or volunteer ambulance workers), the format is DYYSSSSS, where D is a code for the WCB district office in which the case was indexed (0,1=Brooklyn, Manhattan, Queens; 2=Hempstead; 3=Peekskill; 4=Hauppauge; 5=Albany; 6=Syracuse; 7=Rochester; 8=Buffalo; 9=Binghamton); YY represents the last two digits of the year of indexing; and SSSSS is a 5-digit sequence number, beginning with 00001 on January 1.
- for cases involving volunteer firefighters or volunteer ambulance workers, the format is VDYSSSSS, where: V is a letter indicating a firefighter (F) or ambulance worker (A); D and YY are the same as for regular cases; and SSSS is a 4-digit sequence number beginning with 0001 on January 1.

Cause of Accident: (WCB) Object, substance or condition that directly contributed to the occurrence of an accident.

Causation/Causative Factor: The fact of being the cause of something produced or of happening. The act by which an effect is produced. An important doctrine in fields of negligence and criminal law.

Claim: (WCB) A request, on a prescribed Form C-3, for workers' compensation for work-connected injury, occupational disease, disablement, or death (Form C-62). A claimant must file a claim within a two-year period from the occurrence of the accidental injury, knowledge of occupational disablement, or death. Failure to file a claim may bar an award for compensation unless the employer has made advance benefit payment or fails to raise the issue, in which event the claim filing requirement is deemed waived.

(NYCIRB, Carriers) A demand for payment or recovery for loss under an insurance contract. Cases are counted as claims only when a payment is made (for indemnity and/or medical benefits) or a reserve is established.

Classification Code: (NCCI, NYCIRB) A system of insurance risk classification based on industrial or occupational categories, supported by the National Council on Compensation Insurance and in use in about 40 states where private insurance is available. The system, which includes several thousand 4-digit numeric codes (with more than 700 classifications in use in New York), is extensively used to identify an employer's rate making class(es) and establish basic pricing for workers' compensation insurance.

Conciliation: (WCB) A Workers' Compensation Board process established to resolve, in an expeditious and informal manner (e.g. through meetings or telephone conferences), issues involving non-controverted claims in which the expected duration of benefits is fifty-two weeks or less. Failure to reach an agreement through the conciliation process results in the case being scheduled for a hearing.

Contested: To bring an action at law. To make the subject of dispute, contention, or litigation.

Continue (a Case): (WCB) To complete a hearing on a case without closing the case, leaving additional matters to be resolved at a future hearing.

Controverted Claim: (WCB) A claim challenged by the insurer on stated grounds. The Board sets a pre-hearing conference for the determination of the grounds and directs the parties to appear and present their case.

C-2: A Board form titled "Employer's Report of Work-Related Accident or Occupational Disease" filed by employers within ten days after an accident occurs, as required by WCL Section 110. The form includes a section identifying the case and principal parties and additional sections labeled "Accident," "Injured Person," "Nature of Injury," "Cause of Accident," and "Fatal Cases." Failure to make timely C-2 filings subjects employers to potential administrative and criminal penalties.

C-3: A Board form titled "Employee's Claim for Compensation," that should be completed by the injured worker and submitted to the Board within two years of the accident or onset date. The C-3 form contains much of the same information as the C-2 (sections describing the Injured Person, Employer, Place and Time of accident, Injury, Nature and Extent of Injury, Medical Benefits received, Compensation Benefits received/claimed, etc.).

C-4: A Board form titled "Attending Doctor's Report," that requests information about claimant/claim identification, claim parties of interest, injury history, diagnosis, treatment, disability, causal relation of accident to disability, and degree of impairment. The form is to be filed by the doctor within two days of initial treatment, with additional reports during continued treatment, including a final report. [Also used as Carrier/Employer Billing Form.]

C-7: A Board form titled "Notice that Right to Compensation is Controverted," that a carrier (as appropriate) must file within (1) 18 days of the date disability begins, (2) ten days of the date the employer first had knowledge of the alleged injury, or (3) within 10 days after the receipt of a copy of the C-2, whichever is later. The form contains

- information identifying the claim, person (allegedly) injured, employer and carrier,
- a description of the alleged injury and town/county/state where alleged injury occurred,
- reasons why right to compensation is controverted,
- dates for start of alleged disability, employer/carrier first knowledge of injury, receipt of a C-2 from the employer and
- statement concerning whether notification has been given to the disability benefits insurance carrier, and date of notification

C-8/8.6: A Board form titled “Notice that Payment of Compensation for Disability has been Stopped or Modified,” that carriers are required to file within 16 days of the date on which benefit payments are stopped or modified. The form includes:

- information identifying the claim, injured person, employer and carrier,
- a summary of total disability benefits, partial disability benefits and disfigurement awards paid,
- a summary of the claimant’s return-to-work and earnings status and
- if appropriate, an explanation of why indemnity benefits have not been paid in full. Depending on circumstances cited by the carrier and the claimant’s response, the filing of a C-8/8.6 may or may not trigger an immediate hearing.

Decision: A determination arrived at after consideration. A report of a conclusion.

Dependent: A person eligible to receive death benefits in a fatal injury case; the regular receipt of contributions by the alleged dependent upon which he/she relies and needs to sustain his/her customary mode of living constitutes dependency. Surviving widows and children under age 18 years are eligible for benefits without proving dependency, and other eligible recipients (if dependency is established) may include dependent handicapped children over age 18 years of age, grandchildren, brothers and sisters under age 18, dependent parents and grandparents.

Exclusive Remedy: The premise on which the Workers’ Compensation system is based: workers gave up the right to sue the employer in exchange for medical care and wage replacement benefits for their injuries.

Experience Rating: A method for determining an employer’s workers’ compensation premiums that reflects a) a comparison of the employers recent loss experience with the amount the employer would have been expected to pay if it had been an average employer in the same industry with the same payroll and b) the credibility or confidence assigned to the employer’s loss experience. In practice, insurers assign no credibility to employers with average class premiums below a certain amount (e.g., \$5,000/yr).

Final Adjustment Hearing: (WCB) A hearing held in cases involving the loss or loss-of-use of a member or organ of the body in which the principal issue is the extent of loss or loss-of-use (e.g., claims normally involving schedule awards).

Hearing: (WCB) The WCL provides that no case may be closed without notice to all interested parties, with all such parties having an opportunity to be heard. Board hearings are held before Workers’ Compensation Law Judges who hear and determine claims for compensation, for the purpose of ascertaining the rights of the parties. The Board, upon receipt of an application for review of a judge’s decision, may also hold hearings.

Indemnity Benefits: Compensation paid to the workers’ compensation claimants for lost time resulting from an injury or illness. Six types of award are permitted by the WCL:

- temporary total disability benefits (for periods of total wage loss);
- temporary partial disability benefits (for periods of partial wage loss);
- facial disfigurement awards (at judge’s discretion but subject to a maximum, for cosmetic facial disfigurement resulting from the accident or exposure);

- permanent partial disability benefits (for loss of physical function or for periods of partial wage loss after a claimant has been classified as having a permanent partial disability);
- permanent total disability benefits (for loss of wage earning capacity after a claimant has been classified as having a permanent total disability); and
- death benefits (compensation benefits awarded to spouse, children or under certain circumstances, other family members following a work-related death).

Indexed Claim: (WCB) A claim case folder which has been assembled and assigned a case number by the Board's Claims Unit.

Judge: See Workers' Compensation Law Judge.

Jurisdiction: (WCB) The right to hear and determine a workers' compensation case. The Board has jurisdiction over most work-related injuries occurring in New York State. Notable exclusions from the Board' jurisdiction in New York State include: federal government workers and certain employees of local government, many NYC government occupations (civil service police, firefighters, sanitation workers), most NYC teachers, and casual employments (yard work by minors, baby-sitters, etc.). Workers covered by separate compensation systems under federal laws (maritime employments, merchant seafarers, interstate railroad employees, etc.) may elect to submit to NYS jurisdiction by waiving their federal rights and remedies.

Coverage for some worker classes in NYS is elective (e.g., part-time household workers, sole proprietors, corporate officers, certain musicians, and farm workers earning less than \$1,200 per year).

Licensed Representative: (WCB) (a) Any person other than an attorney who is authorized by the Board to represent claimants or insurance carriers before the Board and, in some instances, to receive a fee, fixed by the Board, for such services. (b) Any person other than an attorney who is authorized by the Board to represent self-insurers before it.

Lost Time: (WCB) A period of total wage loss and loss of earning capacity, beyond the statutory waiting period, caused by the claimant's work-connected disability. In workers' compensation cases only, if the disability period exceeds 14 days, compensation will be paid from the first day of disability. There is no waiting period for volunteer ambulance worker or volunteer firefighter cases.

Lump Sum Settlement: (WCB) A negotiated and Board-approved agreement, termed a "non-schedule adjustment," between a claimant with a non-schedule permanent partial disability and the insurer(s). As a result of the agreement the claimant receives a sum of money representing all future compensation for his/her disability, and the case is considered closed. Under WCL Section 15(5-b), granting of a settlement by the Board requires that (a) the right to compensation has been established and compensation has been paid for at least three months, (b) the continuance of disability and of future earning capacity cannot be ascertained with reasonable certainty, (c) there has been a physical examination of the claimant prior to approval, and (d) the Board considers the settlement "fair and in the best interest of the claimant." In practice, lump sum settlements are usually final, but the law provides for reopenings if the Board finds that there has been a change in condition or degree of disability not contemplated at the time of the settlement.

Manual Rates: The listed premium, stated as dollars per \$100 of weekly earnings for each employee, in a state's current schedule; in New York the manual rates are linked to the Classification Code system (i.e., rates are stated for each work classification code used in the state).

Maximum Medical Improvement (MMI): (WCB) An assessed condition of a claimant based on medical judgment that (a) the claimant has recovered from the work injury to the greatest extent that is expected and (b) no further change in his/her condition is expected. A finding of maximum medical improvement is a normal precondition for determining the permanent disability level of a claimant.

Medical Benefits: Medical treatment provided, under the Workers' Compensation Law, to injured workers as a result of injuries arising out of and in the course of employment.

Medical Fee Schedule: A schedule, established by the Chair of the Workers' Compensation Board, of charges and fees for medical treatment and care furnished to workers' compensation claimants.

Medical Treatment: (WCL) Care (other than first aid) administered by a physician, chiropractor or podiatrist or on a physician's referral, by a psychologist, or physical or occupational therapist.

New York Compensation Insurance Rating Board: A private, non-profit association of licensed insurance companies that provide workers' compensation insurance in New York; the organization is responsible (among other things) for collecting and reviewing compensation loss experience from carriers, developing policy forms and rating plans, conducting actuarial analyses and preparing rate filings with the New York State Insurance Department.

No Further Action (NFA): A claim classified as such, based on the determination that no further rulings by the Workers' Compensation Board can be made unless action is taken by Parties of Interest in the case.

Notice: Written notification from an employee to his/her employer, indicating that a work-connected injury or injury has occurred. For accidental injuries, notice must be given no later than 30 days after the accident; the Board may excuse a failure to give notice on the grounds that a) for some reason, notice could not have been given; b) the employer had knowledge of the accident; or c) the employer's case has not been prejudiced. In cases involving occupational diseases, the time period for notice is 2 years from the date of disablement or from the date when the employee knew, or should have known, that the disease was due to the nature of employment.

Occupational Disease (OD): A disease arising from employment conditions for a class of workers, with the disease occurring as a natural incident for particular occupations, distinct from and exceeding the ordinary hazards and risks of employment. To be considered an occupational disease, there must be some recognizable link between the disease and some distinctive feature of the workers' job.

Occupational Disease, Notice and Causal Relationship (ODNCR): (WCB) Minimal conditions that must be met before financial responsibility can be assigned to a claim for workers' compensation based on occupational disease. Specifically, it must be established that (a) the claimant has an occupational disease recognized by the WCL, (b) the claimant has, after the onset of the disease, notified his/her employer within the statutory time limit (two years from date of disablement or from date when claimant knew or should have known that the disease was due to the nature of the employment, whichever is greater), and (c) a causal relationship exists between work-related activities and exposure, the development of the occupational disease, and a subsequent disability.

Occupational Illness: 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 diseases which may be caused by inhalation, absorption, ingestion or direct contact.

Occupational Injury: Any injury, such as a fracture, sprain, amputation, etc. - which results from a work accident or other exposure involving a single accident in the work environment.

Party of Interest: The claimant, employer, carrier and any statutory fund that may be liable in the particular case.

Premium: The total amount paid for an insurance policy. For workers' compensation insurance, premiums are normally calculated using a rate per \$100 of the payroll for covered employees.

Prima Facie Medical Evidence: Medical evidence of a work-related accident or occupational disease. A medical report constitutes prima facie medical evidence if it includes a history of the precipitating causes of the injury, causal relationship between the claimant's work and the injury, and a diagnosis.

Reimbursement, Request for: A request by an employer for reimbursement for wages paid to an employee for a period during which the employee was eligible to receive workers' compensation or disability benefits. A request by a compensation carrier for reimbursement out of the Special Disability Fund. A request by a disability benefits carrier for reimbursement of benefits paid to a claimant while the workers' compensation case was being litigated.

Reopened Case: A workers' compensation case which had been determined to need no further action by a Workers' Compensation Law Judge or a Board Panel that is subsequently made active again to determine the claimant's eligibility for benefits.

Reopened Cases Fund: (WCB) A fund established to assume liability for additional awards in cases in which the application to reopen the case occurs more than seven years from the date of injury and more than three years from the payment of the last payment of compensation. The Fund is financed through payments in non-dependency death cases and through assessments made as needed against all carriers.

Request for Further Action: When a Party-of-Interest in a case requests Board intervention.

Rescind (a Decision): (WCB) A Board Panel memorandum of decision which voids or annuls a Workers' Compensation Law Judge decision. Decisions to rescind are usually issued without prejudice in order to allow the parties to present evidence or testimony not previously presented to a Workers' Compensation Law Judge.

Schedule Permanent Partial Disability: (WCB) Maximum benefit week schedules in the WCL are generally used in determining lifetime benefits for injuries to major body parts. Injuries amounting to less than a 100 percent functional loss are awarded a percentage of the scheduled weeks, and there are also provisions for additional weeks required for a protracted healing period.

Second Injury Fund: A special fund, technically known in New York as the Special Disability Fund, which assumes, in certain cases, part of the permanent disability liability resulting from injuries to previously handicapped workers. The fund, which is funded by assessments against carriers and self-insureds, was created to assure handicapped workers receive full workers' compensation benefits, while encouraging employers to hire physically handicapped persons by protecting them against disproportionate liability in the event of subsequent employment injury.

Self-Insurance: (WCB) In lieu of purchasing insurance from an insurance carrier, an employer or group of employers may assume the liability for the payment of workers' compensation benefits to employees by depositing securities or a surety bond in an amount required by the Board.

Special Funds: Funds established under the WCL to assure payments of benefits associated with claims, usually by transferring all or part of the liability to the Fund.

State Insurance Fund: A quasi-public agency whose activities include a) providing workers' compensation insurance coverage to private and public employers; b) providing other lines of insurance coverage; and c) acting as an agent in NYS in workers' compensation cases involving NYS employees. The State Insurance Fund must offer workers' compensation insurance to any employer requesting it, making the Fund an "insurer of last resort" for employers otherwise unable to obtain coverage.

Symptomatic Treatment: Medical treatments aimed at providing relief from the symptoms of a disease or injury, rather than providing a permanent remedy to the underlying condition.

Tentative Rate: A weekly rate assigned by the Workers' Compensation Board for carrier indemnity payments, pending final adjudication of outstanding issues relating to benefit rates.

Third Party Action: (WCB) This term refers to lawsuits against equipment manufacturers, facility owners and other non-employer parties whose products or services contributed to the occurrence of an accident. Under WCL, a compensation claim is a workers' sole remedy against the employer, but lawsuits may be initiated against third parties for contributory negligence, product defects, etc.

Total Disability: Within meaning of workers' compensation acts, means lack of ability to follow continuously some substantially gainful occupation without serious discomfort or pain and without material injury to health or danger to life.

Trial Calendar Hearing: (WCB) A regularly scheduled hearing on a case conducted by a WCLJ that is designed to permit the introduction of evidence and/or witnesses and the presentation of arguments by the parties.

Uninsured Employers' Fund: A special fund which provides for the payment of workers' compensation cases where the employer was not insured nor self-insured and has defaulted in the payment of workers' compensation.

Waiting Period: (WCB) Period covering the first seven days of disability resulting from a work-connected injury or illness. Workers' compensation indemnity benefits are not allowable for the first seven days of disability, except that (a) in cases where the disability period exceeds 14 days, indemnity awards are allowed from the date of disability, and (b) there is no waiting period for VAWBL/VFBL cases. There is also a seven day waiting period for disability benefits.

Workers' Compensation Board, New York State (WCB): (a) The agency charged with administering the Workers' Compensation Law, the Volunteer Ambulance Workers' Benefit Law and the Volunteer Firefighters' Benefit Law and the Disability Benefits Law. (b) The thirteen member Board responsible (directly or through review of delegated authority) for determining all issues involving claims under the WCL. Members are appointed to seven-year terms by the Governor, by and with the advice and consent of the Senate. The Governor designates the Chair and Vice-Chair.

Workers' Compensation Law (WCL): Chapter 67 of the Consolidated Laws, governing the workers' compensation system; separate laws cover compensation benefits for volunteer firefighters and volunteer ambulance workers.

Workers' Compensation Law Judge (WCLJ; Compensation Claims Referee): (WCB) An officer appointed by the Chair of the Workers' Compensation Board from a Civil Service competitive process to hear and determine claims and to conduct such hearings and investigations and make such orders, decisions and determinations as may be required in the adjudication of the claims. A Judge's decision is deemed the decision of the Board unless the Board modifies or rescinds such decision.

NOTES

