COMPLETION INSTRUCTIONS
LOSS SUMMARY DATA REPORT
(FORMS SI-7 AND SI-7-A)

PURPOSE: The Loss Summary Data Report (hereafter LSDR) is a filing required of all self-insured employers and group self-insurers. The purpose of this filing is to enable the Arkansas Workers' Compensation Commission (hereafter Commission) to evaluate the loss exposure of a self-insurer as a component of the process of renewing the self-insurance privilege. The LSDR must be completed and cleared by the Self-Insurance Division before the self-insurance privilege can be renewed. **The Loss Summary Data Report is due by February 1 for the preceding year.** The LSDR **must** be signed and dated by either the self-insurer's administrator, group manager, claim officer, or adjuster.

COMPLETION: The LSDR consists of two (2) parts, the SI-7 and the SI-7-A. The SI-7 or "front page" is the part of the LSDR that recaps claims by number, type of claim, type of payment, and pending reserves. The SI-7-A is an "itemized listing" of those claims individually filed with the Commission reflecting the nature of the injury, amounts paid for indemnity, medical, expenses, and amount of pending reserves, individually by claimant. Typically, it is easier to complete the LSDR if the itemized listing is completed first, as numbers from that portion are used to complete the front page.

Effective for the 2011 calendar year LSDR, we will be sending the LSDR via e-mail. It will include the SI-7 (front page) in a PDF file. We will be including an Excel spreadsheet that is to be used for the SI-7-A (detail listing of the claims). Additionally, we will include PDF files for the LSDR Bulletin and Reported Claims Listing. When submitting the LSDR to us, please scan the SI-7 (front page) and e-mail it along with the Excel spreadsheet. If it is not possible to scan the SI-7 (Front page), it may be faxed to us.

All claim information is calendar year specific. Amounts reflected are to be *all* payments paid during the calendar year for *all* claims that were open at any point during that year. Pending reserves are to be as of December 31, of the calendar year.

SI-7 - "FRONT PAGE"

The upper portion of the front page is provided for informational purposes. The Self-Insurer Administrator is the company designated Commission contact person responsible for the company's entire self-insurance program. The Self-Insurer Claim Officer is the contact person designated by the third party administrator's corporate contact person. In the event of self-administration of claims by the self-insurer, this person is designated by the Administrator. If there are changes to be made to this information, please contact the Commission's Self-Insurance Division. Please do not make corrections to this page.

CLAIM TYPES: All claims are to be segregated into one of the three following classifications:

1. Non-Filed Medical Only - All claims ***not*** individually filed with the Commission. These claims are those that do not involve indemnity benefits being paid to the claimant. Additionally, these are non-controverted (accepted) claims, and are reported monthly via the Monthly Medical Only Report (Form M).

2. Filed Death - Claims involving the death of the claimant as a result of the work related injury. These include accepted, as well as controverted, death claims.

3. Filed - All Other - These claims should include: a.) any medical only claim that has been filed with the Commission and a Commission file number issued; b.) any claim, or part of a claim, that is controverted (including medical only); c.) claims involving a change of physician or third party subrogation (when a Commission file number is necessary); d.) claims involving lump sum payments or Joint Petition settlements; e.) any claim filed by, or on behalf of, the claimant via a Form C; and f.) any claim involving payment of indemnity benefits to the claimant.

NUMBER OF CLAIMS: This should be the total number of claims, by type, that were open at any point during the calendar year (i.e., the number of claims being totaled to get the payment and reserve numbers).

PAYMENT TYPES: Within each claim type (above), *all* amounts charged to a claim are to be broken down into the following categories:

1. **Indemnity** - Any amounts paid to the claimant as indemnity benefits (or awarded as such under a Joint Petition).

2. **Medical -** Payments to medical providers.

3. **Expenses -** Any claim related expenses incurred.

Typically, these are the three (3) general payment types maintained by any claim system. How a particular item should be classed (medical payment versus expense payment) will be left to the discretion of the adjuster or Third Party Administrator (TPA). Such items may include, but not limited to, the following: bill review, mileage reimbursement, investigation, case management, legal, etc. The important thing here is that *ALL* payments charged to a claim are included.

RESERVES: For all claims open as of December 31 of the calendar year, indicate the amount of pending reserves. This amount should include *all* reserves (indemnity, medical, and expense).

SI-7-A - "ITEMIZED LISTING"

The itemized listing portion of the LSDR is an individual listing of each claim that has been filed with the Commission (Claim Types 2 and 3 above). An itemized listing of the claims classed as "Non-Filed Medical Only" is not required. Please do not include the Non-Filed claims on the itemized listing.

The listing of claims is to be alphabetical by claimant's last name then first (name should be listed Last Name, First MI.). **Each claim listed must have the Commission's file number.** Death claims are to be marked so that they are easily identifiable (bold face font or other marking; no highlighting please), or may be segregated in the listing. Subtotals (indemnity, medical, expenses, and reserves) for the death and the "all other" claims are required as well as grand totals of all claims for indemnity, medical, expenses, and reserves listed on the report.

In order to assist with the completion of this portion of the LSDR, we will include with the SI-7 and SI-7-A spreadsheet, a listing of claims the Commission shows as having been open at any time during the calendar year. **If a claim appears on the Commission's listing, it must be listed on the itemized listing.** If there were payments made on a filed claim that does *not* appear on the Commission's listing, that claim is still to be included on the itemized listing and the appropriate numbers reported.

IDENTIFY AND EXPLAIN DISCREPANCIES:

In addition to having a "one-to-one" match of claims lists, we will also be looking to match the claim status (open or closed) as well. A column has been added to the SI-7-A spreadsheet where comments/explanations may be provided to reduce or eliminate questions that we are likely to have regarding the report by identifying and explaining any discrepancy between the Commission's list and the LSDR. Before submitting the LSDR, please review the report taking the following into consideration:

One-to-One Matching of Claims:

1. If the claim is listed on the LSDR and is not listed on the Commission's list:
   a. the claim may have re-opened for a late bill or other payment;
      i. if still open, we will need re-open date;
      ii. if closed, we will need an updated Form 4 (if not previously sent).
   b. the claim may have been closed with the Commission, but not in your claim system;

   i. if open, provide a re-open date;
   ii. if closed, correct the report to reflect zero reserves. Also verify total claim payments to total on previously submitted Form 4. Provide an updated Form 4 if necessary.
c. the claim may have never been filed with the Commission;
   i. if open, file a Form 1 and Form 2 immediately;
   ii. if closed, file a Form 1, Form 2, Form 3 (medical), and a Form 4 immediately.

2. If the claim is on the Commission's list, but not on the LSDR:
   a. the claim may have been closed in the claim system, but not with the Commission;
      i. if still closed, file a Form 4;
      ii. if re-opened, indicate date re-opened.
   b. the claim may be incorrectly coded as a non-filed medical only in your system.
      i. correct the coding in your system and correct the LSDR accordingly.
   c. the claim may be "old" and handled by a previous TPA;
      i. contact the previous TPA and obtain the missing information.
   d. the claim may have been established or re-opened via a Form C and never established or re-opened with the adjuster
      i. if a claim was never established, contact the Commission for a copy of the Form C (any other documentation available), immediately prepare a Form 1, Form 2, and a letter stating your position on the claim. Submit all three items as soon as possible;
      ii. if a claim was previously established, contact the Commission for a copy of the Form C (any other documentation available), immediately prepare a Form 2 and a letter stating your position on the claim. Submit both items as soon as possible.

Matching Status of Claims (Open or Closed):

Once a one-to-one claim match has been made, we will then match claim status. Based on a status date of December 31, if you reflect zero in pending reserves, we assume the claim is closed in your system. If the reserves are not zero, we assume the claim is open in your system.

1. If your status is "open" and the Commission status is "closed":
   a. We will need the date the claim re-opened so we can reflect the proper status. Also, if the re-open date is on or before 12/31, we will require a reserve amount.

2. If the Commission Status is "open" and your status is "closed":
   a. we will need a Form 4 in order to close the claim at the Commission. We will need the date the claim closed in your system. if your closing date is after 12/31, we will need a reserve amount as of 12/31;
      i. if you previously sent a Form 4, contact us to discuss the matter. We may not have received the Form 4, or it may have been rejected.

Claims involving Permanent Total Disability or claims not subject to the time limitations of §11-9-702 [see §11-9-702(b)(2)], represent a continuing liability of the self-insurer. As such, these claims are to remain open for the life of the claimant and shall maintain an appropriate reserve amount regardless of whether the claim is in a dormant status or not.

SUBMITTING FORM 4s:

I**f a Form 4 will be required to clear the item, please include the Form 4 with the LSDR.** Please do not send a Form 4 separately. We will be unable to clear the item until the Form 4 has been received, accepted, and processed. If it is sent with the LSDR, we can review it and mark our records as received. Adjusters: If you are completing a Form 4 to clear an outstanding item on the LSDR, be advised that, if there is insufficient medical information in our file to close the claim, the Form 4 will be rejected and returned to you. If you have not previously sent the necessary documentation,

include it with the Form 4. If a Form 4 is rejected and returned, we will be unable to clear the outstanding item until such time as an acceptable Form 4 and/or required documentation is received.

QUESTIONS:

If you have any questions regarding the completion of the LSDR or are unable to submit the completed report to the Commission by the due date, please contact Sheila Clark in the Self-Insurance Division. She may be reached via phone at (501) 682-2780 or e-mail at Sheila.Clark@Arkansas.gov In Sheila's absence, you may contact Randy Clay at (501) 682-2210 or e-mail at Randy.Clay@Arkansas.gov

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