DELAWARE INDEMNITY DATA CALL IMPLEMENTATION GUIDE

Issued January 14, 2019

DELAWARE COMPENSATION RATING BUREAU, INC.

TABLE OF CONTENTS

INTRODUCTION
- A. Overview
- B. Purpose of Indemnity Data Call
- C. Indemnity Data Call Contact Information

SECTION I. INDEMNITY DATA CALL GENERAL RULES
- A. Scope and Effective Date
- B. General
- C. Participation / Eligibility
- D. Reporting Frequency
- E. Data Submission Procedures
- F. Insurer User Management Group (UMG) Primary Administrator Application
- G. Business Exclusion Options

SECTION II. INDEMNITY DATA CALL STRUCTURE
- A. Record Descriptions
- B. Key Fields and Processing Data Elements (Transactional and Quarterly)

SECTION III. RECORD LAYOUTS
- A. Overview
- B. File Control Record Layout
- C. Transactional Record Layout
- D. Quarterly Record Layout

SECTION IV. DATA DICTIONARY
- A. Overview
- B. Data Dictionary

SECTION V. REPORTING RULES
- A. File Control Records
- B. Transactional Records
- C. Quarterly Records

SECTION VI. EDITING PROCEDURES
- A. Editing Process
- B. Validating a Submission
- C. Aggregate Record Level Editing Per File
- D. Quarter-End Validation

SECTION VII. APPENDIX
- A. Overview
- B. Business Exclusion Request Form Example
- C. Premium Verification Worksheets and Instructions
- D. Compensation Data Exchange (CDX) Information

INDEMNITY DATA CALL IMPLEMENTATION GUIDE

A. Overview

The information contained in this Indemnity Data Call Implementation Guide contains the reporting guidelines for the Call. The current web-based guide is located on the DCRB's website at www.dcrb.com.

The Indemnity Data Call Implementation Guide applies to data submitted to DCRB. Data providers are required to comply with the instructions and guidelines contained in this guide in conjunction with DCRB's ***Statistical Plan.*** Each data provider should develop its own internal methods for how to apply the information contained in these guides. However, the end result must meet DCRB's criteria.

This guide is your source for DCRB's Indemnity Data Call reporting rules and requirements, as well as additional information and examples to assist you in meeting your reporting requirements.

B. Purpose of Indemnity Data Call

The Governing Board voted unanimously on April 25, 2018, to authorize the DCRB to begin collecting indemnity data on a transactional and quarterly basis. The vote followed careful consideration of the potential importance and utility of detailed indemnity data, as well as available methods for accomplishing the collection of such information. Factors addressed in the Governing Board's discussion included the following points:

- Indemnity Data Call would assist and augment the DCRB's ability to respond to legislative pricing. DCRB would be able to opine with greater authority on a variety of possible proposals to change the payment system for workers compensation in Delaware.
- Indemnity Data Call could enhance DCRB's ability to explain filings and better understand cost drivers.
- The ability to compare data with other jurisdictions will emerge with the common collection of this data elsewhere.

The National Council on Compensation Insurance, Inc. (NCCI) has, through an extended and rigorous process, established a construct for the reporting and collection of indemnity detail information. That process has been accepted by carriers for use in NCCI states and is being implemented in those states. The NCCI refers to the collection of this indemnity detail as the Indemnity Data Call. The NCCI has shared the formats, timelines and related collateral for the Indemnity Data Call with all independent bureaus and has advised those organizations that they are at liberty to adopt and use any portion(s) of that intellectual property as seen fit.

The DCRB, with Governing Board support, believes that using and conforming as much as possible to the NCCI standards for the collection of indemnity detail information will be the most beneficial and effective means of expanding our database to include indemnity transactional and quarterly information.

C. Indemnity Data Call Contact Information

If you have any questions about the Indemnity Data Call, please contact the DCRB via one of the following:

Mail: Indemnity Data Reporting Department
Delaware Compensation Rating Bureau, Inc.
30 South 17th Street – Suite 1500
Philadelphia, PA 19103-4007

Phone: (215) 568-2371
Website: www.dcrb.com
E-mail: Indemnitycall@dcrb.com

SECTION I – GENERAL RULES

A. Scope and Effective Date

All indemnity claim activities with jurisdiction state of Delaware or federal claims associated with a Delaware policy as well as employers' liability claims are reportable. This includes all workers compensation claims for which an indemnity payment has been made or indemnity reserve established. This does not include medical-only claims (i.e., workers compensation claims in which there are no incurred indemnity losses reported and no anticipation of an indemnity payment in the future). The Jurisdiction State corresponds to the state or federal workers compensation act under which the claimant's benefits are being paid.

All transactions must be submitted electronically to the Delaware Compensation Rating Bureau, Inc., 30 S. 17th Street, Suite 1500, Philadelphia, PA 19103.

The Call begins with indemnity claim activities occurring in Second Quarter 2020, to be reported to the Delaware Compensation Rating Bureau, Inc., by September 30, 2020, regardless of the Accident Date or Policy Effective Date.

The Call includes the detailed indemnity benefit payments made to claimants at a transactional level, reported to the DCRB as individual Transactional records, and summarized Paid-To-Date totals reported as Quarterly records. Indemnity payments (refer to the DCRB's ***Statistical Plan Manual*** for rules regarding what is included in the indemnity loss) are defined as payments made for items such as:

- Wage loss
- Disfigurement
- Vocation rehabilitation
- Death and burial
- Claimant attorney
- Employer's Liability

1. Claims Included in the Indemnity Data Call

The Indemnity Data Call applies to direct workers compensation, voluntary compensation, and employers liability indemnity claims where the claim's jurisdiction state is Delaware or federal act (Jurisdiction State Code 59). Therefore, medical-only claims and claims where the jurisdiction state is not Delaware or federal act (Jurisdiction State Code 59) are not included in the Indemnity Data Call for Delaware.

Regarding reinsurance, do not submit claim data for assumed policies (e.g., exclude losses paid to other carriers on account of reinsurance assumed by the data provider). No deductions should be made by the data provider for losses recovered from other data providers due to ceded reinsurance.

Claims with indemnity incurred greater than zero that are determined to be noncompensable or fraudulent, as defined by DCRB's ***Statistical Plan Manual***, are to be reported in the Indemnity Data Call.

B. General

This implementation guide contains copyrighted material of National Council on Compensation Insurance, Inc. (NCCI), used with permission.

C. Participation / Eligibility

Participation is limited to carrier groups with at least 1% market share in the state of Delaware over the most recent three years (overall average equals 1% or more). Once a carrier group meets the eligibility criteria, the group will be required to report even if the carrier group's market share drops below the threshold. Participation is re-evaluated every three years. Questions regarding participation/eligibility of a carrier should

be addressed to the DCRB.

1. Carrier Group Participation

When a carrier group is included in the Call, all companies that are aligned within that group are required to report under the Call. The carrier group is identified based on NAIC group code.

2. Reporting Responsibility

Participants in the Call will have the flexibility of meeting their reporting obligation in several ways, including:

(a) Submitting all of their Call data directly to the DCRB
(b) Authorizing their vendor business partners (TPAs, etc.) to report the data directly to DCRB

Regardless of who submits the Call to the DCRB, the data provider must report the standard record layout in its entirety with all data elements populated. Refer to **Section III—Record Layouts** section of this guide.

Note: Although data may be provided by an authorized vendor on behalf of a carrier or carrier group, quality and timeliness of the data is the responsibility of the carrier.

3. Mergers and Acquisitions

If a carrier/group is required to report the Call prior to a merger or acquisition, the obligation to continue to report the Call remains. If a carrier/group that was not previously required to report the Call merges with or becomes acquired by a reporting carrier/group, the acquired carrier/group is required to report the Call as part of that carrier/group. DCRB will provide lead time for the acquired carrier/group to begin reporting the Call.

Example:

Mergers and Acquisition Scenarios

If. . .	And. . .	Then. . .
Carrier A currently reports the Call	Merges with Carrier B, that does not report the Call	Carrier A will continue to report the Call; Carrier B will be provided lead time to report the Call
Carrier A does not currently report the Call	Merges with Carrier B, that currently reports the Call	Carrier B will continue to report the Call; Carrier A will be provided lead time to report the Call
Carrier A currently reports the Call	Merges with Carrier B, that currently reports the Call	Both Carrier A and Carrier B will continue to report the Call
Carrier A currently reports the Call as part of reporting Group B	Leaves Group B	Both Carrier A and Group B will continue to report the Call
Carrier A does not currently report the Call	Merges with Carrier B, that does not currently report the Call	Neither Carrier A nor B reports the Call unless a future participation evaluation deems AB eligible

D. Reporting Frequency

The Indemnity Data Call will begin with indemnity claim activities occurring in Second Quarter 2020. Data will be due by the close of the following quarter.

Transactional Record Reporting Table

For each quarter, the following table displays the Quarter, the corresponding Transaction Date Range, and the Due By Date:

Quarter	Transaction Date Range	Due By Date
1st	01/01–03/31	06/30
2nd	04/01–06/30	09/30
3rd	07/01–09/30	12/31
4th	10/01–12/31	03/31 (following year)

Example: Transactional date range of 01/01-03/31 is due by June 30.

Quarterly Record Reporting Table

For each quarter, the following table displays the Quarter, Claim Valuation Date, and Due By Date:

Quarter	Claim Valuation Date	Due By Date
1st	03/31	06/30
2nd	06/30	09/30
3rd	09/30	12/31
4th	12/31	03/31 (following year)

Example: Second quarter claim data is valued as of June 30 and is due by September 30.

E. Data Submission Procedures

Indemnity Data Call transactions are to be submitted electronically to the DCRB through Compensation Data Exchange (CDX).

CDX is a self-administered service offered to carriers who are members of one or more of the ACCCT members. (Please refer to the appendix for a list of ACCCT members.) The use of CDX for the submission or retrieval of data and to provide access to other services or products is subject to availability and the terms and conditions of use established by ACCCT, Compensation Data Exchange, LLC., or individual DCOs. These guidelines may be accessed through the ACCCT website at www.accct.org. ACCCT disclaims all liability, direct or implied, and all damages, whether direct, incidental, or punitive, arising from the use or misuse of the CDX site or services by any person or entity.

Before data providers can send Indemnity Data Call production files using **CDX,** a completed Insurer User Management Group (UMG) Primary Administrator Application for each carrier/group must be on file, and each submitter's electronic data submissions must pass Certification Testing. Refer to the **Insurer User Management Group (UMG) Primary Administrator Application** section of this manual for details and the **Appendix** of this manual for a copy of the digital (online) form.

If a carrier group has already established an UMG primary administrator and currently submits policy data, unit statistical data or medical data to the DCRB via CDX, a carrier does not need to submit an additional application to submit Indemnity Data Call transactions.

F. Insurer User Management Group (UMG) Primary Administrator Application

Each applicant is required to designate an **Insurer User Management Group (UMG) Primary Administrator** for the entire Group. The UMG primary administrator shall be solely responsible for the following activities: (a) establishing, controlling, and maintaining Applicant's access to CDX and its products and services; (b) creating and maintaining accounts for the Applicant; (c) establishing and maintaining all Carrier User account levels; and (d) assessing and responding to all security issues and breaches.

1. Application Instructions

The digital (online) application form must be filled out in its entirety and submitted online.

2. Submission of Application

Once you have successfully submitted the application, click the hyperlink labeled 'Click here to print this application for submission' to launch a printable version. You will receive an e-mail titled "Insurer UMG Primary Administrator Application Received", which also includes a link to print the application.
The printable copy will include instructions on how to complete the application process.

This printed application must be signed by the Primary Administrator and an Authorizing Officer of the Applicant who shall be fully authorized to bind the Applicant to the Terms and Conditions of Use at www.accct.org. The completed application with the signatures, along with a copy of the authorizing officer's business card or letter head, must be mailed, faxed, or e-mailed to:

CDX Central Support
c/o Farragut Systems
2775 Meridian Pkwy
Durham, NC 27713

E-mail: CDXCentralSupport@farragut.com
Fax: 919-572-0783

If a method other than mailing is used, a signed original must also be mailed to CDX Central Support.

Once your account has been created, the Applicant's Primary Administrator will receive an e-mail notifying an account has been established and informing them of the temporary password. A copy of this e-mail, without the password, will be sent to the Applicant's Authorizing Officer.

3. Third Party Administrator Requirement

For carriers or carriers groups that use a Third Party Administrator (TPA), bill review vendor, or pharmacy vendor, the DCRB requires the CDX permission(s) to be handled through the TPA Request function within CDX. It will take 2 to 3 business days for CDX to review and approve the request. Once you are notified that the request has been approved, then the Primary Administrators for the carrier/group and the TPA will complete the set-up and data transfer permissions in CDX.

4. User Request Changes

In the event there is a need to modify TPA access to CDX, it is the responsibility of the data submitter to notify the carriers' UMG Primary Administrator immediately in order to restrict a user from having access to CDX.

G. Business Exclusion Options

It is expected that 100% of indemnity transactions from workers compensation claims in the state of Delaware will be reported in the Indemnity Data Call. The DCRB does recognize that in certain limited circumstances this can be very difficult, if not impossible, for participants (carrier groups) to comply with reporting 100% of the expected claims data.

Accordingly, a carrier group participating in the Call may exclude data for claims that represent up to 15% of gross premium (direct premium gross of deductibles) for the state of Delaware from its reporting requirement. This option may be utilized for small subsidiaries and/or business segments (e.g., coverage providers, branches, TPAs) where it may be more difficult for these entities to establish the required reporting infrastructure. The exclusion option must be based on a business segment, not claim type or characteristics. All requests for such exclusions must be presented to the DCRB for acceptance. Refer to **Requests for Business Exclusion** in this section.

The 15% exclusion does **not** apply to selection by:

- Policy types (e.g., large deductible policies)
- Claim characteristics such as claim status (e.g., open, closed)
- Claim types such as specific injury types (death, permanent total disability, etc.)

DCRB will annually review previously filed exclusion requests to determine if a reexamination is warranted based upon changes in market share. Additionally, business exclusions will be reviewed when participation/eligibility is re-evaluated.

Once a claim has been reported under the Call, all data pertaining to the Indemnity Data Call must be reported according to the reporting requirements of the Call.

Example: The need to exercise the Business Exclusion Option

A carrier group has a TPA that does not process indemnity payments electronically. The premium associated with this TPA represents less than 15% of the participant's gross premium. The carrier group may request to exclude the TPA's transactions from Call reporting.

Note: If a participant has unique circumstances that cannot be accounted for within the exclusion option, contact the DCRB's Indemnity Data Reporting Department to submit documentation describing these circumstances. The DCRB will address these situations on a case-by-case basis.

1. Requests for Business Exclusion

Participants in the Call are required to submit their basis for exclusion to the DCRB for review. The requests can be submitted to the DCRB starting in Third Quarter 2019.

All exclusion requests must include the following documentation:

- The nature of what data is to be excluded (e.g., any vendors or entities).
- An explanation as to why you are requesting the exclusion.
- Output used to demonstrate that the excluded segment(s) will be less than 15% of premium. Refer to **Method of Determining Gross Premium for Business Exclusion** in this section of the guide for an example of premium determination.
- Contact information for the individual responsible for the review documentation.

2. Methods of Determining Gross Premium for Business Exclusion

The measurement of the 15% business exclusion is based on direct workers compensation premiums, gross of deductibles. The measurement should be made across the states where the Indemnity Data Call applies. Below are four methods for estimating the proportion of business excluded; any of these four are acceptable to the DCRB.

Some methods use the NAIC Direct Premium, which is reported in the Exhibit of Premium and Losses (Statutory Page 14) in the NAIC Annual Statement. This premium can either be written or earned premium, whichever is more convenient, and is net of deductibles.

Method 1—Carriers with Large Deductible Direct Premium less than 0.3% of their total premium (NAIC Direct Premiums) may determine their estimated exclusion using Direct Premium, without adjustment. The information to be submitted to the DCRB for review must include the premium for the excluded entities in each applicable state(s) in comparison to the carrier's total premium in the state(s).

A participant with Large Deductible Direct Premium less than 0.3% of its total needs to exclude business for two small subsidiaries. The participant determines the exclusion on January 1, 2020, utilizing Direct Written Premium to determine the percentage of excluded premium.

Column A Entities for Proposed Exclusion	Column B Entities' Calendar Year Written Premium	Column C Carrier Group Calendar Year Written Premium	Column D Entities' Written Premium as % of Carrier Group (Col. B/Col. C)
Subsidiary #1	$1,500,000		
Subsidiary #2	$2,000,000		
TOTAL	$3,500,000	$357,500,000	1.0%

The following steps are performed to determine whether the proposed exclusions are less than 15% of the total gross written premium.

1. Based on premium data that it maintains, the carrier group determines the Calendar Year Direct Premiums Written in Delaware or Federal Act for each subsidiary to be excluded. It enters the information in Column B.
2. Add up the data in Column B to get the Delaware premium proposed to be excluded.
3. Determine the 2018 Calendar Year Direct Premiums Written in Delaware—the participant finds this information on Schedule T of its 2018 NAIC Annual Statement (due on April 1, 2019). This information is entered on the Total line in Column C.
4. Calculate percentages for Column D (equals Column B divided by Column C).
5. Compare the Total line percentage to the 15% requirement. In this case the proposed exclusion is less than 15% so it is allowable.

Refer to Appendix of this manual for Premium Verification Worksheet and Instructions – Method 1 and submission instructions.

Method 2—Carrier Groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums) may use the table **Large Deductible Net to Gross Ratio**, included in this section, to determine their estimated exclusion using Direct Premium.

Determine the Large Deductible Net Ratio by calculating the ratio of excluded Large Deductible Direct Premium to total Direct Premium for Delaware. Use this net ratio to look up the gross ratio using the **Large Deductible Net to Gross Ratio** table below. Calculate the ratio of excluded non-Large Deductible Direct Premium to total Direct Premium. Add the corresponding Gross Ratio found in the table to the ratio of excluded non-Large Deductible Direct Premium (if any) to determine the percentage of excluded Direct Premium.

Large Deductible Net to Gross Ratio	
Net Ratio	**Gross Ratio**
0.0%	0.0%
0.1%	0.5%
0.2%	1.0%
0.3%	1.5%
0.4%	2.0%
0.5%	2.5%
0.6%	2.9%
0.7%	3.4%
0.8%	3.9%
0.9%	4.3%
1.0%	4.8%
1.1%	5.3%
1.2%	5.7%
1.3%	6.2%
1.4%	6.6%
1.5%	7.1%
1.6%	7.5%
1.7%	8.0%
1.8%	8.4%
1.9%	8.8%
2.0%	9.3%
2.1%	9.7%
2.2%	10.1%
2.3%	10.5%
2.4%	10.9%
2.5%	11.4%
2.6%	11.8%
2.7%	12.2%
2.8%	12.6%
2.9%	13.0%
3.0%	13.4%
3.1%	13.8%
3.2%	14.2%
3.3%	14.6%
3.4%	15.0%
3.5%	15.4%

Example: Premium Determination—Method 2

A participant with Large Deductible Direct Premium greater than 0.3% of its total must exclude one of its data providers. The participant had the following premium values:

- Total Direct Premium in Delaware is $1,000,000
- Large Deductible Direct Premium to be excluded for Delaware is $20,000
- Non-Large Deductible Direct Premium to be excluded for Delaware is $40,000

The following steps are performed to determine whether the proposed exclusion is less than 15% of the total gross written premium:

1. Calculate the Large Deductible Net Ratio—$20,000 (Large Deductible Direct Premium to be excluded) divided by $1,000,000 (Total Direct Premium), multiplied by 100 equals a Large Deductible Net Ratio of 2.0% ($20,000 / $1,000,000 x 100 = 2.0%)
2. Use the Large Deductible Net Ratio of 2.0% and the table to determine the corresponding gross ratio of 9.3%
3. Calculate the excluded Non-Large Deductible Ratio--$40,000 (non-Large Deductible Direct Premium to be excluded) divided by $1,000,000 (Total Direct Premium), multiplied by 100 equals an excluded non-Large Deductible ratio of 4.0% ($40,000 / $1,000,000 x 100 = 4.0%)
4. Determine the percentage of excluded premium—4.0% (excluded non-Large Deductible ratio) added to 9.3% (Large Deductible gross ratio) equals excluded premium of 13.3% (4.0% + 9.3% = 13.3%)
5. Compare the excluded premium percentage to the 15% requirement; in this case, the proposed exclusion is less than 15%, so it is allowable

Refer to Appendix of this manual for Premium Verification Worksheet and Instructions – Method 2 and submission instructions.

Method 3—This is another option for carrier groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums) is to use the following Gross Premium Estimation Worksheet.

Fill in items A, B, C, and D, and use the formulas to complete the worksheet. Only include premium from Delaware.

Premium Verification Worksheet—Method 3			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total including Large Deductible		
B	Large Deductible		
C	Large Deductible to be excluded		
D	Non-Large Deductible to be excluded		
	Estimated Gross Premium:		
E	Large Deductible to be excluded	5 times C (5 x C)	
F	Total Excluded	Sum of D and E (D + E)	
G	Add-on for Large Deductible business	4 times B (4 x B)	
H	Estimated Total	Sum of A and G (A + G)	
I	Ratio	F divided by H (F / H)	

Example: Premium Determination—Method 3

A participant with Large Deductible Direct Premium greater than 0.3% of its total must exclude one of its data providers. The participant has the following premium values:

- Total Direct Premium including Large Deductible for Delaware is $1,000,000
- Large Deductible Direct Premium for Delaware is $300,000
- Large Deductible Direct Premium to be excluded for Delaware is $20,000
- Non-Large Deductible Direct Premium to be excluded for Delaware is $40,000

Premium Verification Worksheet—Method 3			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total including Large Deductible		$1,000,000
B	Large Deductible		300,000
C	Large Deductible to be excluded		20,000
D	Non-Large Deductible to be excluded		40,000
	Estimated Gross Premium:		
E	Large Deductible to be excluded	5 times C (5 x C)	100,000
F	Total Excluded	Sum of D and E (D + E)	140,000
G	Add-on for Large Deductible business	4 times B (4 x B)	1,200,000
H	Estimated Total	Sum of A and G (A + G)	$2,200,000
I	Ratio	F divided by H (F / H)	6.4%

The following steps are performed to determine whether the proposed exclusions are less than 15% of the total gross written premium:

1. From its records, the carrier group determines its Direct Written Premium for all Large Deductible policies, excluded Large Deductible policies, excluded non-Large Deductible policies, and the total for all policies including Large Deductibles
2. Input these values into the Amount column of the applicable row (Items A through D) of the Premium Verification Worksheet
3. Calculate Items E through I of the Premium Verification Worksheet
4. Compare the excluded premium percentage (Item I) to the 15% requirement; in this case, the proposed exclusion is less than 15%, so it is allowable

Refer to Appendix of this manual for Premium Verification Worksheet and Instructions – Method 3 and submission instructions.

Method 4—Use the gross (of deductible) premium in Unit Statistical Plan data (reported in the Premium Amount field of the Exposure Record). Calculate the ratio of total gross premium on business to be excluded to total gross premium on all business and compare the excluded premium percentage to the 15% requirement. Only include premium from the state of Delaware or Federal Act.

Example: Premium Determination—Method 4

A participant needs to exclude business for two subsidiaries that represent 1% of total gross premium. The participant determines the exclusion on July 1, 2018, utilizing gross premium to determine the percentage of excluded premium.

Column A Entities for Proposed Exclusion	Column B Entities' Gross Premium	Column C Affiliate Group Gross Premium	Column D Entities' Gross Premium as % of Affiliate Group (Col. B / Col. C)
Subsidiary #1	$1,500,000		
Subsidiary #2	$2,000,000		
TOTAL	**$3,500,000**	**$357,500,000**	**1.0%**

The following steps are performed to determine whether the proposed exclusions are less than 15% of the total gross written premium:

1. Based on premium data that it maintains, the affiliate group determines the gross premiums for Delaware or Federal Act for each subsidiary to be excluded. It enters the information in Column B.
2. Add up the data in Column B to get the premium proposed to be excluded.
3. Determine the 2017 workers compensation gross premiums for the entire affiliate group for Delaware or Federal Act. This information is entered on the Total line in Column C.
4. Calculate the percentage for Column D (equals Column B divided by Column C).
5. Compare the Total line percentage to the 15% requirement. In this case, the proposed exclusion is less than 15%, so it is allowable.

Refer to Appendix of this manual for Premium Verification Worksheet and Instructions – Method 4 and submission instructions.

3. Other Premium Determination Methods

Contact the DCRB for guidance if the methods described in this section are not appropriate for determining the exclusion percentage. The methods are not appropriate if they do not closely approximate prospective premium distribution in the current calendar year (e.g., a significant shift has occurred in a participant's book(s) of business since the last NAIC reporting; or the participant writes a significant number of large deductible policies).

4. Business Exclusion Request Form

An example of the Business Exclusion Request Form is provided in the **Appendix** of this manual.

SECTION II – INDEMNITY DATA CALL STRUCTURE

A. Record Descriptions

The Indemnity Data Call includes the following three separate record layouts:

- File Control Record—The File Control Record identifies the carrier, the quarter that the data represents, and the number of Transactional or Quarterly records being submitted. The File Control Record contains nine data elements. The File Control Record Data Elements are provided in **Section III—Record Layouts** and in **Section IV—Data Dictionary.**

  Note: A separate file and File Control Record are required for transactional records and a separate file and File Control Record are required for quarterly records.

- Transactional Record—The Transactional record provides the details of each indemnity payment transaction and includes five key fields, four processing data elements, and nine Transactional claim data elements. These records are to be created for each payment transaction and are due by the end of the following quarter. The Transactional data elements are provided in **Section III—Record Layouts** and in **Section IV—Data Dictionary**.

- Quarterly Record—The Quarterly record provides the inception-to-date aggregated details of each indemnity claim and includes five key fields, two Processing data elements, and thirty Quarterly claim data elements. These records are to be valued as of the end of each quarter (3/31, 6/30, 9/30, and 12/31) and are due to be reported by the end of the following quarter. The Quarterly record data elements are provided in **Section III—Record Layouts** and in **Section IV—Data Dictionary.**

B. Key Fields and Processing Data Elements (Transactional and Quarterly)

Key fields identify unique claims. These elements are required to be reported the same for all records related to a claim (refer to Section V—Reporting Rules in this guide for details regarding deleting and changing records).

Key fields include:

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Accident Date

Key fields must be reported consistently within the Indemnity Data Call as well as across data types (i.e., Unit Statistical data and Medical data). Correctly reporting the key fields ensures the accurate linking and unique identification of claims. Accurate linking of claims across data types enables DCRB to use fields for the same claim, across data types, thereby reducing the number of elements that would be duplicated. The key fields are also used to link the cancellation or replacement Transactional record to the original Transactional record. If a record is reported with one or more of the key fields either missing or invalid, this record would be deemed unusable.

Processing data elements are used to ensure the proper handling of the transactions.

Processing data elements include:

- Record Type Code
- Transaction Code*
- Transaction Date
- Transaction Identifier*

Correctly reporting the processing data elements ensures the accurate processing of the record. If a record is reported with one or more of the processing data elements either missing or invalid, the record could be deemed unusable.

*Only applicable to the Transactional Record

SECTION III –RECORD LAYOUTS

A. Overview

In order for the DCRB to properly receive data submissions, data providers are required to comply with specific requirements regarding record layouts, data elements, and link data when reporting Call data. Data files are transmitted in specific record layouts to allow for efficient processing. This allows the data contained within the record layouts to be formatted, sorted, and customized according to the user's specifications.

The record layouts that comprise the Indemnity Data Call are provided in this section of the guide.

B. File Control Record Layout

Field No.	Field Title/ Description	Class	Position	Bytes
1	Record Type Code	N	1-2	2
2	Submission File Type Code	A	3	1
3	Carrier Group Code	N	4-8	5
4	Reporting Quarter Code	N	9	1
5	Reporting Year	N	10-13	4
6	Submission File Identifier	AN	14-43	30
7	Submission Date	N	44-51	8
8	Submission Time	N	52-57	6
9	Record Total	N	58-68	11
10	**RESERVED FOR FUTURE USE**		69-300	232

C. Transactional Record Layout

Field No.	Field Title/ Description	Class	Position	Bytes
Processing Data Elements (Fields 1-4)				
1	Record Type Code	N	1-2	2
2	Transaction Code	N	3-4	2
3	Transaction Date	N	5-12	8
4	Transaction Identifier	AN	13-32	20
Key Data Elements (Fields 5-9)				
5	Carrier Code	N	33-37	5
6	Policy Number Identifier	AN	38-55	18
7	Policy Effective Date	N	56-63	8
8	Claim Number Identifier	AN	64-75	12
9	Accident Date	N	76-83	8
Transactional Data Elements (Fields 10-18)				
10	Jurisdiction State Code	N	84-85	2
11	Transaction From Date	N	86-93	8
12	Transaction To Date	N	94-101	8
13	Transaction Amount	N	102-113	12
14	Benefit Type Code	N	114-115	2
15	Lump-Sum Indicator	A	116	1
16	Benefit Offset Code	N	117	1

17	Benefit Offset Amount	N	118-128	11
18	Weekly Benefit Amount	N	129-137	9
19	**RESERVED FOR FUTURE USE**		138-300	163

D. Quarterly Record Layout

Field No.	Field Title/ Description	Class	Position	Bytes
Processing Data Elements (Fields 1-2)				
1	Record Type Code	N	1-2	2
2	Transaction Date	N	3-10	8
Key Data Elements (Fields 3-7)				
3	Carrier Code	N	11-15	5
4	Policy Number Identifier	AN	16-33	18
5	Policy Effective Date	N	34-41	8
6	Claim Number Identifier	AN	42-53	12
7	Accident Date	N	54-61	8
Quarterly Indemnity Claim Data Elements (Fields 8-37)				
8	Jurisdiction State Code	N	62-63	2
9	Claimant Gender Code	N	64	1
10	Birth Year	N	65-68	4
11	Hire Date	N	69-76	8
12	Employment Status Code	AN	77	1
13	Closing Date	N	78-85	8
14	Reopen Date	N	86-93	8
15	Maximum Medical Improvement (MMI) Date	N	94-101	8
16	Reported to Insurer Date	N	102-109	8
17	Accident State Code	N	110-111	2
18	Attorney or Authorized Representative Indicator	A	112	1
19	Method of Determining Pre-Injury/Average Weekly Wage Code	N	113	1
20	Impairment Percentage Basis Code	N	114	1
21	Impairment Percentage	N	115-117	3
22	Disability/Loss of Earnings Capacity (LOEC) Percentage	N	118-120	3
23	Pre-Existing Disability Percentage	N	121-123	3
24	Part of Body Code—Injury Description	N	124-125	2
25	Nature of Injury Code—Injury Description	N	126-127	2
26	Cause of Injury Code—Injury Description	N	128-129	2
27	Act—Loss Condition Code	N	130-131	2
28	Type of Settlement—Loss Condition Code	N	132-133	2
29	Medical Extinguishment Indicator	A	134	1
30	Temporary Disability Benefit Extinguishment Code	N	135	1
31	Indemnity Paid-To-Date	N	136-144	9
32	Medical Paid-To-Date	N	145-153	9
33	Incurred Indemnity Amount	N	154-162	9
34	Incurred Medical Amount	N	163-171	9
35	Employer Legal Amount Paid	N	172-180	9

36	Allocated Loss Adjustment Expense (ALAE) Paid	N	181-189	9
37	Pre-Injury/Average Weekly Wage Amount	N	190-194	5
38	**RESERVED FOR FUTURE USE**		195-300	106

SECTION IV –DATA DICTIONARY

A. Overview

The Data Dictionary provides information on each data element. Coding Values are also included in this section.

All data elements should be reported, except for a Transaction Identifier, which should only be reported if a data provider is going to use Option 1 (refer to Section V—Reporting Rules for details) for changing or deleting Transactional records. However, many of the data elements are conditional and would only be reported when they are applicable to a Transactional or Quarterly record.

Except for the key fields (which are always required to be reported), when the appropriate value is not available to the data provider or is unknown, do NOT provide defaulted values. Rather, leave the field blank/zero-filled as per the element details below:

- Alpha and alphanumeric fields—Leave Blank
- Numeric fields (including data fields)—Zero Fill

Example 1: Attorney or Authorized Representative Indicator (Alpha field)

Scenario	Valid Format
Claimant is known to have an attorney	Y
Claimant is known to not have an attorney	N
It is unknown whether the claimant has an attorney or authorized representative	Leave Blank

Example 2: Employment Status Code (Alphanumeric field)

Scenario	Report
Claimant's work status is known to be Regular Full-Time	1
Claimant's work status is known but is not one of the four specified codes; i.e., Other	X
Claimant's work status is unknown	Leave Blank

Example 3: Benefit Offset Code (Numeric field)

Scenario	Report
There is no Benefit Offset; i.e., None	1
A Benefit Offset exists and is based upon SSDI	2
A Benefit Offset exists and is based on something other than SSDI	3
It is unknown whether a Benefit Offset exists	Zero-Fill

B. Data Dictionary

1. Accident Date

Record Type: Quarterly and Transactional (Key)
Field(s): 7 (Quarterly) and 9 (Transactional)
Position(s): 54-61 (Quarterly) and 76-83 (Transactional)
Class: Numeric (N) – Field contains only numeric characters
Bytes: 8
Format: YYYYMMDD
Definition: The date the claimant was injured.
Reporting Requirement: The Accident Date must be reported for all Transactional and Quarterly records. This date must be within the policy period. The Accident Date must match the Unit Statistical data Accident Date reported for this claim.

For all claims where the accident date is known, report the date on which the claim occurred. For Occupational Disease and Cumulative Injury Other Than Disease claims where the Accident Date is not known, report the Accident Date as the claimant's last date of exposure to the conditions causing or aggravating the injury.

2. Accident State Code

Record Type: Quarterly
Field No.: 17
Position(s): 110-111
Class: Numeric (N) – Field contains only numeric characters
Bytes: 2
Format: N 2
Definition: The code that corresponds to the state or foreign location where the claimant was injured or contracted an occupational disease.
Reporting Requirement: Report the code that corresponds to the state or foreign location where the claimant was injured or contracted a disease. Zero-fill if unknown.

Coding Values

State and Province Code Table

State or Province	Code	State or Province	Code	State or Province	Code
Alabama	01	Louisiana	17	Oklahoma	35
Alaska	54	Maine	18	Ontario	67
Alberta	61	Manitoba	63	Oregon	36
Arizona	02	Maryland	19	Pennsylvania	37
Arkansas	03	Massachusetts	20	Philippine Islands	57
British Columbia	62	Michigan	21	Prince Edward Islands	66
California	04	Minnesota	22	Puerto Rico	58
Canadian Provinces (NOC—Not Otherwise Classified)	55	Mississippi	23	Quebec	68
Canada Zone	56	Missouri	24	Rhode Island	38
Colorado	05	Montana	25	Saskatchewan	69
Connecticut	06	Nebraska	26	South Carolina	39
Delaware	07	Nevada	27	South Dakota	40
District of Columbia	08	New Brunswick	64	Tennessee	41
Florida	09	New Hampshire	28	Texas	42

Foreign Territory (Not Otherwise Classified)	80	New Jersey	29	Utah	43
Georgia	10	New Mexico	30	Vermont	44
Hawaii	52	New York	31	Virginia	45
Idaho	11	Newfoundland/Labrador	72	Virgin Islands	51
Illinois	12	North Carolina	32	Washington	46
Indiana	13	North Dakota	33	West Virginia	47
Insular Possession	53	Northwest Territories	60	Wisconsin	48
Iowa	14	Nova Scotia	65	Wyoming	49
Kansas	15	Nunavut	70	Yukon	71
Kentucky	16	Ohio	34		

3. Act—Loss Condition Code

Record Type Quarterly
Field(s) 28
Position(s) 130-131
Class Numeric (N)—Field contains only numeric characters
Bytes 2
Format N 2
Definition The code that identifies the act or law governing the basis of liability for the claim
Reporting Requirement Report the code that corresponds to the act or law governing the basis of the liability for the claim. Zero-fill if unknown.

Coding Values

Code	Act	Description
01	State Act or Federal Act excluding USL&HW and Federal Mine Safety and Health Act	A claim with benefits determined according to the workers compensation law or federal compensation laws, excluding United States Longshore and Harbor Workers Compensation Act and excluding coverage under the Federal Mine Safety and Health Act
02	USL&HW F-Classes and USL&HW coverage on Non-F-Classes	A claim with benefits determined according to the United States Longshore and Harbor Workers Compensation Act
03	Federal Mine Safety and Health Act Only	A claim with benefits determined according to the Federal Mine Safety and Health Act
04	Federal Mine Safety and Health Act and the State Act	A claim with benefits determined according to the Federal Mine Safety and Health Act and state workers compensation law

4. Allocated Loss Adjustment Expense (ALAE) Paid

Record Type Quarterly
Field No.: 37
Position(s): 181-189
Class: Numeric (N) – Field contains only numeric characters
Bytes: 9
Format: N 9—Amount is rounded to the nearest whole dollar; data field is to be right-justified and left zero-filled
Definition: The cumulative amount of all ALAE paid for the specific claim, net of recoveries.

Reporting Requirement: Report the whole-dollar amount of ALAE that has been paid for the claim as of the loss valuation date. Employers Liability ALAE and claimant attorney fees are excluded from ALAE Paid and must be included in the Indemnity Paid-To-Date and Indemnity Incurred Amount. For additional details on what to include in ALAE paid, please refer to the Expenses section provided in DCRB's ***Statistical Plan Manual***, Section 1—General Rules/Definitions, Part N—General Rules and Definitions. The reporting must be consistent with the reporting of ALAE for this same claim for Unit Statistical data.

5. Attorney or Authorized Representative Indicator

Record Type: Quarterly
Field No.: 18
Position(s): 112
Class: Alpha (A)—Field contains only alphabetic characters
Bytes: 1
Format: Y/N
Definition: Indicates whether the claimant has an attorney or authorized representative.
Reporting Requirement: Report "Y" or "N" to indicate whether the claimant has an attorney or authorized representative. Report "Y" if the claimant has obtained attorney representation regardless of whether the claim is litigated. Leave blank if unknown.

Coding Values

Indicator	Description
Y	Claimant has an attorney or authorized representative
N	Claimant does not have an attorney or authorized representative

6. Benefit Offset Amount

Record Type: Transactional
Field No.: 17
Position(s): 118-128
Class: Numeric (N)—Field contains only numeric characters
Bytes: 11
Format: N 11—Amount includes dollars and cents; data field is to be right-justified and left zero-filled
Definition: The amount of the benefit offset applied because of payments from another source (i.e., the statutory payment amount had there not been any offsets for payments/contributions from other source, such as social security disability insurance, employer-paid disability plans, retirement plans, and unemployment insurance, less the Transactional Amount).
Reporting Requirement: This data element is a conditional field and is only required to be reported when applicable to the Transactional record. The amount reported includes dollars and cents. Offsetting amounts do not include penalties and liens or subrogation recoveries. There is an implied decimal between positions 126 and 127. If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount. Reporting examples:

- $123.45 is reported as 00000012345
- $123 is reported as 00000012300

Zero-fill if unknown or not applicable.

Refer to **Benefit Offset Code** below for an example.

7. Benefit Offset Code

Record Type: Transactional
Field No.: 16
Position(s): 117
Class: Numeric (N) – Field contains only numeric characters
Bytes: 1
Format: N 1
Definition: The code that indicates that the claim had an offset for payments/contributions from another source. That is, a code that indicates whether the statutory payment amount has been explicitly reduced to reflect payments/contributions from other sources such as social security disability insurance (SSDI), employer-paid disability plans, retirement plans, and unemployment insurance.
Reporting Requirement: Report the applicable Benefit Offset Code. Zero-fill if unknown.

Coding Values

Code	Description
1	None
2	SSDI
3	Other

Example: Reporting a Benefit Offset for SSDI

An injured worker is awarded statutory workers compensation indemnity benefits of $500 per week. However, this particular state allows for an offset against the statutory workers compensation benefit for SSDI benefits received. Given an allowable SSDI offset amount of $200 per week, the resulting transactional fields would be reported as follows for the applicable weekly period:

- Transaction Amount ($500-$200=$300) = 000000030000
- Weekly Benefit Amount ($300) = 000030000
- Benefit Offset Amount ($200) = 00000020000
- Benefit Offset Code = 2

Additional examples will be added in subsequent publications of this guide.

8. Benefit Type Code

Record Type: Transactional
Field No.: 14
Position(s): 114-115
Class: Numeric (N) – Field contains only numeric characters
Bytes: 2
Format: N 2
Definition: The code that corresponds to the type of benefits paid to the claimant, including recovery reimbursement amounts paid
Reporting Requirement: At least one Benefit Type Code must be reported for all claims for which a benefit payment has been made. Zero-fill if unknown.

Coding Values

Code	Description	Additional Rules and/or Exceptions (If Applicable)
01	**Death Benefits**—The transactional amount of indemnity benefits paid for the death of the claimant resulting from a work-related accident or occupational injury or disease.	Includes burial expenses
02	**Permanent Total Disability Benefits**—The transactional amount of indemnity benefits paid for permanent total disability as defined by statute.	
03	**Scheduled Permanent Partial Disability Benefits**—The transactional amount of indemnity permanent partial disability benefits paid as established by a statutory list (schedule) of weeks for specific parts of body.	
04	**Unscheduled Permanent Partial Disability Benefits**—The transactional amount of indemnity benefits paid for injuries to parts of the body not specifically listed in a statutory schedule.	
05	**Temporary Total Disability Benefits—**The transactional amount of indemnity benefits paid for the period that the claimant is temporarily but totally disabled as defined by statute.	
09	**Disfigurement Benefits—**The transactional amount of indemnity benefits paid for any scarring or cosmetic defect as defined by statute.	
11	**Temporary Partial Disability Benefits—**The transactional amount of indemnity benefits paid for the period that the claimant is temporarily but partially disabled as defined by statute.	
12	**Employers Liability—**The transactional amount of all indemnity benefits and expense (ALAE) paid under the Employers Liability portion of the Workers Compensation policy.	
20	**Claimant Legal Amount Paid—**The transactional amount paid by the employer or insurer for the fee of the claimant's attorney or authorized representative as specified in an award or paid without an award.	Report only when a separate payment is made to the claimant attorney (i.e., separate checks).
30	**Indemnity Recovery Reimbursement Amount—Third Party Actions—**The transactional amount of indemnity recovery reimbursed to the carrier from a third-party action less recovery expenses.	
31	**Indemnity Recovery Reimbursement Amount—State Administered Funds—**The transactional amount of indemnity recovery reimbursed to the carrier from a state-administered fund (e.g., Second Injury Fund) less recovery expenses.	
48	**Penalties, Assessments, Interest**—The transactional amount of all penalties, assessments, and/or interest accrued.	

49	**Indemnity and Medical Combined**—The transactional amount of benefits paid for indemnity and medical on a combined basis which cannot be separated out.	
50	**Other Specified Indemnity Benefits—**The transactional amount of indemnity benefits paid for specific injuries in addition to previously defined indemnity benefits.	
60	**Vocational Rehabilitation—Evaluation Benefit Costs**—The transactional amount paid for testing and evaluating the claimant's ability, aptitude, and/or attitude in determining suitability for vocational rehabilitation or placement.	
61	**Vocational Rehabilitation—Education Benefit Costs**—Transactional amounts paid for education/training costs including tuition, books, and tools.	Transaction From and To Dates are required for these payments. Refer to the Transaction From/To Date fields in this section of the guide for examples.
62	**Vocational Rehabilitation—Maintenance Benefit Costs**—Transactional amount paid for any expense, such as transportation, lodging, and meal costs, that enables the claimant to receive or participate in vocational rehabilitation services.	Temporary disability benefits that are paid while the claimant receives vocational rehabilitation services are excluded from this field and reported in the appropriate Benefit Type Code (i.e., 05 or 11).
63	**Vocational Rehabilitation—Payment NOC**—Transactional amount paid for vocational rehabilitation services that is not classified as either evaluation, educational, or maintenance costs.	
79	**Lump Sum Including Multiple Indemnity**—The transactional amount paid via lump sum for multiple indemnity benefit types that cannot be reasonably separated out.	If payment included medical benefits that cannot be reasonably separated from the indemnity portion of the payment, then use Benefit Type Code 49.
99	**Other Indemnity Benefits Not Otherwise Specified**—The transactional amount of indemnity benefits paid, not otherwise classified by DCRB.	It is expected that this benefit type will be used infrequently.

9. Birth Year

Record Type:	Quarterly
Field No.:	10
Position(s):	65-68
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	4
Format:	YYYY
Definition:	The actual or estimated year the claimant was born.
Reporting Requirement:	Report the year the claimant was born. If the claimant's birth year is unknown but the claimant's age is known, then report the estimated birth year (accident year minus claimant age). The Birth Year must be before the Accident Date year. Zero-fill if neither the birth year nor age is known.

10. Carrier Code

Record Type: Quarterly and Transactional (Key)
Field No.: 3 (Quarterly) and 5 (Transactional)
Position(s): 11-15 (Quarterly) and 33-37 (Transactional)
Class: Numeric (N) – Field contains only numeric characters
Bytes: 5
Format: N 5
Definition: The carrier code assigned to the carrier by NCCI.
Reporting Requirement: Report the 5-digit NCCI assigned Carrier Code. The Carrier Code must match the Unit Statistical Carrier Code reported for this claim.

11. Carrier Group Code

Record Type: File Control
Field No.: 3
Position(s): 4-8
Class: Numeric (N) – Field contains only numeric characters
Bytes: 5
Format: N 5
Definition: The carrier group code assigned to the carrier by NCCI.
Reporting Requirement: Report the 5-digit NCCI assigned Carrier Group Code that corresponds to the Reporting Group for which the data provider has been certified to report on its behalf.

12. Cause of Injury Code—Injury Description

Record Type: Quarterly
Field No.: 26
Position(s): 128-129
Class: Numeric (N) – Field contains only numeric characters
Bytes: 2
Format: N 2
Definition: The code that corresponds to the cause of injury sustained by the claimant.
Reporting Requirement: Report the applicable code that corresponds to the cause of injury sustained by the claimant using the Injury Description. Zero-fill if unknown.

Coding Values

Cause of Injury	Code	Specific Cause of Injury	Description (If Applicable)
Burn or Scald—Heat or Cold Exposures—Contact With	01	Chemicals	
	02	Hot Objects or Substances	
	11	Cold Objects or Substances	
	03	Temperature Extremes	
	04	Fire or Flame	
	05	Steam or Hot Fluids	
	06	Dust, Gases, Fumes, or Vapors	
	07	Welding Operation	
	08	Radiation	
	14	Abnormal Air Pressure	
	84	Electrical Current	
	09	Contact With, NOC	

Caught In, Under, or Between	10	Machine or Machinery	
	12	Object Handled	
	20	Collapsing Materials (Slides of Earth)	Either Man-Made or Natural
	13	Caught In, Under or Between, NOC	
Cut, Puncture, or Scrape—Injured By	15	Broken Glass	
	16	Hand Tool, Utensil; Not Powered	
	17	Object Being Lifted or Handled	
	18	Powered Hand Tool, Appliance	
	19	Cut, Puncture, Scrape, NOC	
Fall, Slip, or Trip Injury	25	From Different Level (Elevation)	Off Wall, Catwalk, Bridge, etc.
	26	From Ladder or Scaffolding	
	27	From Liquid or Grease Spills	
	28	Into Openings	Shafts, Excavations, Floor Openings, etc.
	29	On Same Level	
	30	Slipped, Did Not Fall	
	32	On Ice or Snow	
	33	On Stairs	
	31	Fall, Slip, or Trip, NOC	
Motor Vehicle	40	Crash of Water Vehicle	
	41	Crash of Rail Vehicle	
	45	Collision or Sideswipe With Another Vehicle	Both Vehicles in Motion
	46	Collision With a Fixed Object	Standing Vehicle or Stationary Object
	47	Crash of Airplane	
	48	Vehicle Upset	Overturned or Jackknifed
	50	Motor Vehicle, NOC	
Strain Or Injury By	52	Continual Noise	
	53	Twisting	
	54	Jumping	
	55	Holding or Carrying	
	56	Lifting	
	57	Pushing or Pulling	
	58	Reaching	
	59	Using Tool or Machinery	
	61	Wielding or Throwing	
	97	Repetitive Motion	Carpal Tunnel Syndrome
	60	Strain or Injury By, NOC	
Striking Against or Stepping On	65	Moving Part of Machine	
	66	Object Being Lifted or Handled	
	67	Sanding, Scraping, Cleaning Operation	
	68	Stationary Object	
	69	Stepping on Sharp Object	
	70	Striking Against or Stepping on, NOC	

Struck or Injured By—Includes Kicked, Stabbed, Bit, etc.	74	Fellow Worker; Patient	Not in Act of a Crime
	75	Falling or Flying Object	
	76	Hand Tool or Machine in Use	
	77	Motor Vehicle	
	78	Moving Parts of Machine	
	79	Object Being Lifted or Handled	
	80	Object Handled by Others	
	85	Animal or Insect	
	86	Explosion or Flare Back	
	81	Struck or Injured, NOC	Includes Kicked, Stabbed, Bit, etc.
Rubbed or Abraded By	94	Repetitive Motion	Callous, Blister, etc.
	95	Rubbed or Abraded, NOC	
Miscellaneous Causes	82	Absorption, Ingestion, or Inhalation, NOC	
	87	Foreign Matter (Body) in Eye(s)	
	88	Natural Disasters	Earthquake, Hurricane, Tornado, etc.
	89	Person in Act of a Crime (Other Than Gunshot)	Robbery or Criminal Assault
	90	Other Than Physical Cause of Injury	
	91	Mold	
	93	Gunshot	
	96	Terrorism (for use with an assigned Catastrophe Code only)	
	98	Cumulative, NOC	All Other
	99	Other—Miscellaneous, NOC	

13. Claim Number Identifier

Record Type: Quarterly and Transactional (Key)
Field No.: 6 (Quarterly) and 8 (Transactional)
Position(s): 42-53 (Quarterly) and 64-75 (Transactional)
Class: Alphanumeric (AN) – Field contains alphabetic and numeric characters
Bytes: 12
Format: A/N 12, letters A–Z and numbers 0–9 only (if the Claim Number Identifier is less than 12 bytes, this field must be left justified, and blanks in all spaces to the right of the last character).
Definition: The unique set of numbers and/or letters that identify the specific claim that the report/transaction applies to.
Reporting Requirement: Report the unique set of numbers and/or letters that identify the specific claim. **The Claim Number Identifier must match the Unit Statistical data claim number reported for this claim.** This number must be used consistently for all future reporting of the claim transactions.

The Claim Number Identifier can neither be all zeros nor all blanks nor a combination of zeros and blanks.

14. Claimant Gender Code

Record Type: Quarterly
Field No.: 9
Position(s): 64
Class: Numeric (N)—Field contains only numeric characters
Bytes: 1
Format: N 1
Definition: The code that corresponds to the claimant's gender.
Reporting Requirement: Report the code that corresponds to the claimant's gender. If the claimant's gender is unknown, do NOT report 3 (Other); leave this field blank. Zero-fill if unknown.

Coding Values

Code	Description
1	Male
2	Female
3	Other

15. Closing Date

Record Type: Quarterly
Field No.: 13
Position(s): 78-85
Class: Numeric (N)—Field contains only numeric characters
Bytes: 8
Format: YYYYMMDD
Definition: The date that the claim was closed (i.e., further indemnity or medical payments are not expected), the judgment date, or the date an agreement was made regarding the final amount paid.
Reporting Requirement: This data element is a conditional field and is only required to be reported when applicable to the Quarterly record. DCRB will derive a claim's status (Open/Closed) based on the population of the Closing Date and Reopen Date fields.

A claim will be deemed to be Open if any of these conditions are true:
1. Both the Closing Date and the Reopen Date fields are zero-filled
2. The Reopen Date is greater than the Closing Date
3. The Closing Date is zero-filled and the Reopen date is populated

A claim will be deemed to be Closed if either of these conditions are true:
1. The Closing Date is populated and the Reopen Date is zero-filled
2. The Closing Date is greater than the Reopen Date

The following example illustrates how claim status will be derived using the Closing Date field. See the **Reopen Date** section for details on reporting the Reopen Date field.

Example: Deriving claim status using Closing Date and Reopen Date fields

A claim with an Accident Date of January 1, 2020, was settled on February 15, 2025. Subsequently, the claim was reopened due to a change in condition on July 5, 2025. After additional medical treatment was received, the claim was closed again on December 31, 2025.

Scenario	Accident Date	Closing Date	Reopen Date	Derived Claim Status
Claim is open	20200101	00000000	00000000	Open
Claim is closed	20200101	20250215	00000000	Closed
Claim reopens *	20200101	00000000	20250705	Open
Claim is closed again**	20200101	20251231	20250705	Closed

*Do not zero-out the Closing Date field when a claim reopens
**Do not zero-out the Reopen date field when the claim closes again

16. Disability/Loss of Earnings Capacity Percentage (For Federal Act Coverages Only)

Record Type: Quarterly
Field No.: 22
Position(s): 118-120
Class: Numeric (N)—Field contains only numeric characters
Bytes: 3
Format: N 3—Data field is to be right justified and left zero-filled. Enter the percentage as a whole number with a leading zero or zeros (for example, 50% is reported as 050)
Definition: In jurisdictions where permanent partial disability (PPD) benefits are based on a formal assessment of the claimant's loss of earnings capacity (LOEC) post maximum medical improvement, this is the actual, final LOEC of a claim, expressed as a percentage, which underlies the benefits paid.

In jurisdictions where additional factors beyond impairment rating are considered in determining disability (e.g., LOEC, age, education, ability to be retrained, residual physical capacity), this is the actual final disability rating of a claim, expressed as a percentage, which underlies the benefits paid.

Reporting Requirement: This data element is a conditional field and is only required to be reported when applicable to the Quarterly record. Disability/LOEC percentage will only be applicable to Quarterly records with a Jurisdiction State Code of 59 - Federal Act (USL&HW Act, FELA, Jones Act, Admiralty Law, and Federal Mine Safety and Health Act). If applicable, report the final LOEC or disability of a claim as a percentage, which underlies the permanent benefits paid. The Disability/LOEC percentage field is to be reported on a whole-body basis. If a Disability/LOEC percentage is on a part-of-body basis, then convert it to a whole-body basis. Zero-fill if not applicable.

The disability rating percentage and LOEC percentage are mutually exclusive. That is, for the particular jurisdiction/benefit type combination, there would be either one or the other. In jurisdictions where PPD benefits are strictly based on impairment rating, it is expected that the LOEC/Disability Percentage field will be left blank.

Example 1: Reporting Disability/LOEC Percentage with a Single Impairment

An injured worker has an impairment rating of 30% to the arm and is determined to suffer a loss of earning capacity of 25%. The resulting quarterly fields would be:

- Impairment Percentage = 030
- Impairment Percentage Basis Code = 2 (impairment percentage based on part of body)
- Part of Body Code = 31 (Arm)
- Disability/LOEC Percentage = 025

Example 2: Reporting a Disability/LOEC Percentage with Multiple Impairments

A worker has sustained an injury to two body parts. The physician has provided two separate impairment ratings: 50% of arm and 20% of leg. The combination of these impairment ratings results in a whole-body impairment of 38%. If the claim is ultimately determined to have a disability rating of 50%, the quarterly fields would be reported as follows:

- Impairment Percentage = 038
- Impairment Percentage Basis Code = 1 (impairment percentage based on the whole body)
- Part of Body Code = 91 (multiple body parts)
- Disability/LOEC Percentage = 050

17. Employer Legal Amount Paid

Record Type:	Quarterly
Field No.:	35
Position(s):	172-180
Class:	Numeric (N)—Field contains only numeric characters
Bytes:	9
Format:	N 9—Amount is rounded to the nearest whole dollar; data field is to be right-justified and left zero-filled
Definition:	The cumulative amount paid by the employer or insurer for the services of an attorney or authorized representative to defend against a proceeding brought under the workers compensation or employer's liability laws, net of recoveries received.
Reporting Requirement:	Report the whole dollar amount paid by the employer or insurer for the services of an attorney or authorized representative. If a special fund (e.g., Second Injury Fund) has or will reimburse the insurer for a claim, or where the recovery was received due to subrogation; report the Employer Legal Amount Paid gross of the recovery, report the recovery reimbursement amount separately in the Transaction Amount field, and use the Benefit Type Code related to the type of recovery (Benefit Type 30 or 31).

18. Employment Status Code

Record Type:	Quarterly
Field No.:	12
Position(s):	77
Class:	Alphanumeric (AN)—Field contains only numeric characters
Bytes:	1
Format:	A/N 1—Letter X and numbers 1, 2, 8,and 9 only
Definition:	The code that indicates the employee's primary work status at the time of the injury with the covered employer.
Reporting Requirement:	Report the code that indicates the employee's primary work status at the time of the injury with the covered employer as used in the statutory calculation of pre-injury wages. Leave blank if unknown.

Coding Values

Code	Description	Hierarchy
9	Volunteer—Indicates that the injured worker is a volunteer for the covered employer and sustained a compensable injury, but the claim administrator will make no indemnity payments unless indemnity benefits are required based on concurrent employment.	1
8	Seasonal—Indicates that the claimant was employed in a position dependent on or controlled by the season of the year.	2
1	Regular Full-Time—Indicates that the injured worker was employed on a full-time basis. (Schedule is comparable to other employees of the company and/or other employees in the same business or vicinity that are considered full-time). This status is NOT used when reporting experience for full-time seasonal, volunteer, apprenticeship, or piece workers.	3
2	Part-Time—Indicates that the injured worker was employed on a part-time basis and their work history in the preceding months shows that the person worked on less than a full-time basis. This status is NOT used when reporting experience for part-time seasonal, volunteer, apprenticeship, or piece workers.	4
X	Other—Indicates that the claimant had an employment status other than those listed above.	5

Example 1: Reporting employment status when multiple employment status apply in the same time period

An injured worker was employed as a part-time seasonal worker at the time of a workplace accident. In this case, two Employment Status Codes would apply (Code 2 for part-time worker and Code 8 for seasonal worker); however, based on the hierarchy provided in the table above, report Employment Status Code 8 (seasonal worker).

Example 2: Reporting employment status when multiple employment status apply in the different time periods

An injured worker was employed on a full-time basis for the first three quarters of the year preceding a workplace accident and on a part-time basis for the quarter directly preceding the workplace accident.

- If statutory indemnity benefits are based on the injured worker's average weekly wage for the 13 weeks preceding the workplace accident, report Employment Status Code 2 (part-time worker).
- If statutory indemnity benefits are based on the injured worker's average weekly wage for the 52 weeks preceding the workplace accident, two employment status codes would apply (Code 2 for part-time worker and Code 1 for full-time worker); however, based on the hierarchy in the table above, report Employment Status Code 1 (full-time worker).

19. Hire Date

Record Type: Quarterly
Field No.: 11
Position(s): 69-76
Class: Numeric (N)—Field contains only numeric characters
Bytes: 8
Format: YYYYMMDD
Definition: The date that the claimant began his or her most recent employment with the employer.
Reporting Requirement: This data element is a conditional field and is only required to be reported when the hire date or hire year is known. When available, report the claimant's hire date. The hire date must be on or before the accident date. If the hire date is unknown but the hire year is available, report the hire year followed by four zeros. Zero-fill if both the Hire Date and the hire year are not available.

Example: Reporting Hire Date when only hire year is known

The claimant was hired in 1996, but the exact date in 1996 is unknown. Report 19960000 in the Hire Date field.

20. Impairment Percentage

Record Type: Quarterly
Field No.: 21
Position(s): 115-117
Class: Numeric (N)—Field contains only numeric characters
Bytes: 3
Format: N 3—Data field is to be right-justified and left zero-filled; enter the percentage as a whole number with a leading zero or zeros (for example, 50% is reported as 050 and not 50)
Definition: The actual, final impairment rating of a claim (I.e., medical assessment of claimant's post-MMI functionality) expressed as a percentage.
Reporting Requirement: This data element is a conditional field and is only required to be reported when applicable to the Quarterly record. When applicable, report the percentage of impairment when the following three conditions occur:

- The Jurisdiction State has established calculations that use an impairment rating or allow the ratings to be used in benefit determination
- An impairment rating was used to determine the claimant's benefits
- One of the following benefit types has been paid or is expected to be paid:
  - Benefit Type Code 02
  - Benefit Type Code 03
  - Benefit Type Code 04
  - Benefit Type Code 09

Zero-fill if not applicable.

If an impairment percentage is required to be reported in this field, then the basis for the percentage (whole body or part of body) is required to be reported in the Impairment Percentage Basis Code field. The reported impairment percentage must correspond to the reported Impairment Percentage Basis Code.

For single impairment ratings, the data provider can choose to use the whole body or part of body to determine the impairment percentage.

For multiple impairment ratings, convert each one to a whole-body rating, then add together to find the impairment percentage and indicate the conversion to whole body in the Impairment Percentage Basis Code.

21. Impairment Percentage Basis Code

Record Type: Quarterly
Field No.: 20
Position(s): 114
Class: Numeric (N)—Field contains only numeric characters
Bytes: 1
Format: N 1
Definition: The code that corresponds to whether the reported Impairment Percentage was based on the whole body or part of body.

Coding Values

Code	Description
1	Impairment percentage based on the whole body (Applicable to Federal Act Coverage Claims only)
2	Impairment percentage based on part of body (Applicable in Delaware)

Examples will be added in a subsequent publication of this guide.

22. Incurred Indemnity Amount

Record Type: Quarterly
Field No.: 33
Position(s): 154-162
Class: Numeric (N)—Field contains only numeric characters
Bytes: 9
Format: N 9—Amount is rounded to the nearest whole dollar; data field is to be right-justified and left zero-filled
Definition: The Incurred Indemnity Amount is the total of paid-to-date and outstanding reserves, as of the quarter-end valuation date. This definition is equivalent to the rules for unit statistical reporting in accordance with DCRB's ***Statistical Plan Manual***.
Reporting Requirement: Report the total of indemnity paid-to-date and outstanding reserves as of the quarter-end valuation date.

Incurred Indemnity Includes:

- Reserves for future payments, which may include benefits subject to pension table valuation
- All paid benefits for the employee's lost wages or inability to work, including compensation paid to the deceased prior to death, burial expenses, payments to the state or to special funds, and claimant's attorney fees
- Vocational rehabilitation
- Employers liability losses including Allocated Loss Adjustment Expenses (ALAE)
- Subrogation recoveries and special fund reimbursements
- Awards
- Penalties for delays in making compensation payments for reasons beyond the carrier's control
- Expenses incurred for the benefit of the claimant (must be reported as either an indemnity or medical loss depending upon the nature of the expense)

Refer to the DCRB's ***Statistical Plan Manual*** for information on allocating subrogation recoveries between indemnity and medical.

Incurred Indemnity Excludes:

- Legal expenses incurred for the benefit of the carrier
- ALAE, excluding Employers Liability ALAE
- Unallocated Loss Adjustment Expenses (ULAE)
- Penalties for any reason within the carrier's control that accrue as benefits to the injured worker or to his or her dependents
- Deductible reimbursements

23. Incurred Medical Amount

Record Type: Quarterly
Field No.: 34
Position(s): 163-171
Class: Numeric (N)—Field contains only numeric characters
Bytes: 9
Format: N 9—Amount is rounded to the nearest whole dollar; data field is to be right-justified and left zero-filled

Definition: The Incurred Medical Amount is the total of paid-to-date and outstanding reserves as of the quarter-end valuation date. This definition is equivalent to the rules for unit statistical reporting in accordance with DCRB's ***Statistical Plan Manual***.

Reporting Requirement: Report the total of medical paid-to-date and outstanding reserves as of the quarter-end valuation date.

Incurred Medical Includes:

- Reserves for future payments
- All payments to doctors and hospitals
- Drugs
- Physical rehabilitation
- Impartial examinations
- Clinical medical
- Medical loss items, such as transportation expenses associated with medical treatment
- Bonuses or return-to-work incentives paid by the carrier to the medical care provider when the policy is written with contract medical
- Expenses incurred for the benefit of the claimant (must be reported as either an indemnity or medical loss, depending upon the nature of the expense)
- Subrogation recoveries and special fund reimbursements

Refer to the DCRB's ***Statistical Plan Manual*** for information on allocating subrogation recoveries between indemnity and medical.

Incurred Medical Excludes:

- Legal expenses incurred for the benefit of the carrier
- Employers Liability losses
- Allocated Loss Adjustment Expenses (ALAE)
- Unallocated Loss Adjustment Expenses (ULAE)
- Penalties for any reason within the carrier's control that accrue as benefits to the injured worker or to his or her dependents
- Deductible reimbursements

24. Indemnity Paid-To-Date

Record Type: Quarterly
Field No.: 31
Position(s): 136-144
Class: Numeric (N)—Field contains only numeric characters
Bytes: 9
Format: N 9—Amount is rounded to the nearest whole dollar; data field is to be right-justified and left zero-filled
Definition: The paid-to-date amount of all indemnity payments for the claim as of the quarter-end valuation date. This definition is equivalent to the rules for unit statistical reporting in accordance with DCRB's ***Statistical Plan Manual***.
Reporting Requirement: Report the paid-to-date amount of all indemnity payments for the claim as of the quarter-end valuation date.

Indemnity Paid-To-Date Includes:

- All paid benefits for the employee's lost wages or inability to work, including compensation paid to the deceased prior to death, burial expenses, payments to the state or to special funds, and claimant's attorney fees
- Vocational rehabilitation
- Employer's Liability losses including Allocated Loss Adjustment Expenses (ALAE)
- Subrogation recoveries and special fund reimbursements
- Awards
- Penalties for delays in making compensation payments for reasons beyond the carrier's control
- Expenses incurred for the benefit of the claimant (must be reported as either an indemnity or medical loss depending upon the nature of the expense.

Refer to the DCRB's ***Statistical Plan Manual*** for information on allocating subrogation recoveries between indemnity and medical.

Indemnity Paid-To-Date Excludes

- Legal expenses incurred for the benefit of the carrier
- ALAE, excluding Employers Liability ALAE
- Unallocated Loss Adjustment Expenses (ULAE)
- Penalties for any reason within the carrier's control that accrue as benefits to the injured worker or to his or her dependents
- Deductible reimbursements

25. Jurisdiction State Code

Record Type:	Quarterly and Transactional (Key)
Field No.:	8 (Quarterly) and 10 (Transactional)
Position(s):	62-63 (Quarterly) and 84-85 (Transactional)
Class:	Numeric (N) – Field contains only numeric characters
Bytes:	2
Format:	N 2
Definition:	The code that corresponds to the governing jurisdiction that would administer the claims and whose statutes will apply to the claim adjustment process.
Reporting Requirement:	Report the code that corresponds to the state under whose Workers Compensation Act or Employers Liability Act the claimant's benefits are being paid or Federal Act (Jurisdiction State Code 59.) For the Transactional record, report the Jurisdiction State Code that underlies the transaction amount (i.e., benefit payable). The code could be a state jurisdiction in some instances and federal jurisdiction in others, For the Quarterly record, if the incurred losses include both state and federal benefits payable, report the Federal Jurisdiction State Code. In the event that, after reporting one or more Transactional or Quarterly records to the DCRB, the Jurisdiction State for a claim changes and is no longer applicable to the Indemnity Data Call state, a new Quarterly record with the new Jurisdiction State should be submitted. No additional records, Quarterly or Transactional, would need to be reported.

Jurisdiction	State Code
Delaware	07
Federal Act (USL&HW)	59

26. Lump-Sum Indicator

Record Type	Transactional
Field(s)	15
Position(s)	116
Class	Alpha (A)—Field contains only alphabetic characters

Bytes 1
Format Y/N
Definition The code that identifies whether an indemnity lump-sum payment to the claimant has been made.
Reporting Requirement: Report "Y" or "N" to indicate whether or not the benefit payment was made in the form of a lump sum. A "Y" represents all lump-sum payments.

Coding Values

Indicator	Description
Y	Indicates when an indemnity benefit payment to a claimant is made in the form of a lump sum
N	Indicates when an indemnity benefit payment to a claimant is not made in the form of a lump sum

27. Maximum Medical Improvement (MMI) Date (For Federal Act Coverages Only)

Record Type Quarterly
Field(s) 15
Position(s) 94-101
Class Numeric (N)—Field contains only numeric characters
Bytes 8
Format YYYYMMDD
Definition The date after which further recovery from, or lasting improvements to, an injury or disease can no longer be anticipated based on reasonable medical probability, or as defined in the state by statute or case law.
Reporting Requirement: This data element is a conditional field and is only required to be reported when applicable to the Quarterly record. Report the Maximum Medical Improvement (MMI) Date for those claims where permanent benefits (including lump-sum amounts) have been paid or are expected to be paid after final determination of MMI. Examples of permanent benefits include:

- Permanent Total benefit (Benefit Type Code 02)
- Permanent Partial benefit (Benefit Type Code 03 or 04)

Zero-fill if not applicable or if MMI has not been determined as of the quarter-end valuation date.

28. Medical Extinguishment Indicator

Record Type Quarterly
Field(s) 29
Position(s) 134
Class Alpha (A)—Field contains only alphabetic characters
Bytes 1
Format Y/N
Definition The code that indicates if future medical liabilities are extinguished based on a lump-sum settlement agreement.
Reporting Requirement: This data element is a conditional field and is only required to be reported when a transaction with a Lump-Sum Indicator equal to "Y" has been reported as of the quarter-end valuation date and the Type of Settlement—Loss Condition Code is not equal to 00. When applicable, report "Y" or "N" to indicate whether medical liabilities are extinguished based on a lump-sum settlement agreement. Leave blank if unknown or not applicable.

This flag should be set to "Y" if there has been at least one lump-sum settlement of benefits for the claim and the insurer has a reasonable expectation that it will not be obligated to make any further medical payments on the claim. In particular, if a medical settlement is made for a particular injury and, at the time of settlement, no other injuries to the claimant are known, this flag should be set to "Y."

Coding Values

Indicator	Description
Y	Medical payments are extinguished by a lump-sum settlement
N	Medical payments are not extinguished by a lump-sum settlement

Note: Do not report N when medical benefits have not been extinguished; in this case, leave the field blank. Only report N when there has been a lump-sum settlement made and medical payments are still ongoing.

Examples will be added in subsequent publications of this guide.

29. Medical Paid-To-Date

Record Type Quarterly
Field(s) 32
Position(s) 145-153
Class Numeric (N)—Field contains only numeric characters
Bytes 9
Format N 9—Amount is rounded to the nearest whole dollar; data field is to be right-justified and left zero-filled
Definition The paid-to-date of all medical payments for the claim as of the quarter-end valuation date. This definition is equivalent to the rules for unit statistical reporting in accordance with the DCRB's ***Statistical Plan Manual.***
Reporting Requirement: Report the paid-to-date amount of all medical payments for the claim as of the quarter-end valuation date.

Medical Paid-To-Date Includes:

- All payments to doctors and hospitals
- Drugs
- Physical rehabilitation
- Impartial examinations
- Clinical medical
- Medical loss items, such as transportation expenses associated with medical treatment
- Bonuses or return-to-work incentives paid by the carrier to the medical care provider when the policy is written with contract medical
- Expenses incurred for the benefit of the claimant (must be reported as either an indemnity or medical loss depending upon the nature of the expense)
- Subrogation recoveries and special fund reimbursements

Refer to the DCRB's ***Statistical Plan Manual*** for information on allocating subrogation recoveries between indemnity and medical.

Medical Paid-To-Date Excludes:

- Legal expenses incurred for the benefit of the carrier
- Employers Liability losses
- Allocated Loss Adjustment Expenses (ALAE)
- Unallocated Loss Adjustment Expenses (ULAE)
- Penalties for any reason within the carrier's control that accrue as benefits to the injured worker or to his or her dependents
- Deductible reimbursements

30. Method of Determining Pre-Injury/Average Weekly Wage Code

Record Type	Quarterly
Field(s)	19
Position(s)	113
Class	Numeric (N)—Field contains only numeric characters
Bytes	1
Format	N 1
Definition	The code that corresponds to the method used to determine the Pre-Injury/Average Weekly Wage.
Reporting Requirement:	Report the code that corresponds to the method used to determine the Pre-Injury/Average Weekly Wage Amount. Zero-fill if unknown.

Coding Values

Code	Method	Description
1	**Actual Wage**	When the claimant's actual average weekly wage is known, report the actual wage amount in the Pre-Injury/Average Weekly Wage Amount.
2	**Minimum Weekly Benefit**	When the claimant's average weekly wage is not known but is below the wage required by statute for receiving minimum benefits, report the wage required for the minimum weekly benefit in the Pre-Injury/Average Weekly Wage Amount.
3	**Maximum Weekly Benefit**	When the claimant's actual average weekly wage is not known but is above the wage required by statute for receiving benefits, report the wage required for the maximum weekly benefit in the Pre-Injury/Average Weekly Wage Amount.

31. Nature of Injury Code—Injury Description

Record Type	Quarterly
Field(s)	25
Position(s)	126-127
Class	Numeric (N)—Field contains only numeric characters
Bytes	2
Format	N 2
Definition	The code that corresponds to the nature of the injury sustained by the claimant.
Reporting Requirement:	Report the code that corresponds to the nature of the injury sustained by the claimant. **Zero-fill if unknown.**

Coding Values

Nature of Injury	Code	Specific Nature of Injury	Description (If Applicable)
Specific Injury	01	No Physical Injury	i.e., Glasses, Contact Lenses, Artificial Appliance, Replacement of Artificial Appliance
	02	Amputation	Cut Off Extremity, Digit, Protruding Part of Body, usually by Surgery, i.e., Leg, Arm
	03	Angina Pectoris	Chest Pain
	54	Asphyxiation	Strangulation, Drowning
	04	Burn	(Heat) Burns or Scald; the effect of contact with Hot Substances; (Chemical) Burns; Tissue Damage resulting from the Corrosive Action Chemicals, Fumes, etc. (Acids & Alkalis)
	07	Concussion	Brain, Cerebral
	10	Contusion	Bruise—Intact Skin Surface Hematoma
	13	Crushing	To Grind, Pound, or Break into Small Bits
	16	Dislocation	Pinched Nerve, Slipped/Ruptured Disc, Herniated Disc, Sciatica, Complete Tear, HNP Subluxation, Medical Doctor Dislocation
	19	Electric Shock	Electrocution
	22	Enucleation	Removal of Organ or Tumor
	25	Foreign Body	
	28	Fracture	Breaking of a Bone or Cartilage
	30	Freezing	Frostbite and Other Effects of Exposure to Low Temperature
	31	Hearing Loss or Impairment	Traumatic Only; a separate Injury, not the Sequelae of another Injury
	32	Heat Prostration	Heat Stroke, Sun Stroke, Heat Exhaustion, Heat Cramps and Other Effects of Environmental Heat; does not include Sunburn
	34	Hernia	The Abnormal Protrusion of an Organ or Part through the Containing Wall of its Cavity
	36	Infection	The Invasion of a Host by Organisms such as Bacteria, Fungi, Viruses, Mold, Protozoa or Insects, with or without Manifest Disease
	37	Inflammation	The reaction of Tissue to Injury characterized clinically by Heat, Swelling, Redness, and Pain
	40	Laceration	Cut, Scratches, Abrasions, Superficial Wounds, Calluses; Wound by Tearing
	41	Myocardial Infarction	Heart Attack, Heart Conditions, Hypertension; the Inadequate Blood Flow to the Muscular Tissue of the Heart

	42	Poisoning—General (NOT OD or Cumulative Injury)	A Systemic Morbid Condition resulting from the Inhalation, Ingestion, or Skin Absorption of a Toxic Substance affecting the Metabolic System, the Nervous System, the Circulatory System, the Digestive System, the Respiratory System, the Excretory System, the Musculoskeletal System, etc.; includes Chemical or Drug Poisoning, Metal Poisoning, Organic Diseases, and Venomous Reptile and Insect Bites; does NOT include effects of Radiation, Pneumoconiosis, Corrosive Effects of Chemicals; Skin Surface Irritations, Septicemia or Infected Wounds
	43	Puncture	A Hole made by the piercing of a pointed instrument
	46	Rupture	
	47	Severance	To Separate, Divide, or Take Off
	49	Sprain	Internal Derangement, a Trauma or Wrenching of a Joint, producing pain and disability depending upon degree of injury to ligaments
	52	Strain	Internal Derangement, the Trauma to the Muscle or the Musculotendinous Unit from Violent Contraction or Excessive Forcible Stretch
	53	Syncope	Swooning, Fainting, Passing Out, no other Injury
	55	Vascular	Cerebrovascular and Other Conditions of Circulatory Systems, NOC; excludes Heart and Hemorrhoids; includes Strokes, Varicose Veins—Nontoxic
	58	Vision Loss	
	59	All Other Specific Injuries, NOC	
Occupational Disease or Cumulative Injury	60	Dust Disease, NOC	All Other Pneumoconiosis
	61	Asbestos	Lung Disease, a form of Pneumoconiosis, resulting from Protracted Inhalation of Asbestos Particles
	62	Black Lung	The Chronic Lung Disease or Pneumoconiosis found in Coal Miners
	63	Byssinosis	Pneumoconiosis of Cotton, Flax, and Hemp Workers
	64	Silicosis	Pneumoconiosis resulting from Inhalation of Silica (Quartz) Dust
	65	Respiratory Disorders	Gases, Fumes, Chemicals, etc.
	66	Poisoning—Chemical (Other Than Metals)	Man-Made or Organic
	67	Poisoning—Metal	Man-Made
	68	Dermatitis	Rash, Skin, or Tissue Inflammation including Boils, etc., generally resulting from direct contact with Irritants or Sensitizing Chemicals such as Drugs, Oils, Biologic Agents, Plants, Woods, or Metals, which may be in the form of Solids, Pastes, Liquids, or Vapors and which may be

			contacted in the Pure State, or in Compounds, or in Combination with Other Materials; does NOT include Skin Tissue Damage resulting from Corrosive Action of Chemicals, Burns from Contact with Hot Substances, Effects of Exposure to Radiation, Effects of Exposure to Low Temperatures, or Inflammation or Irritation resulting from Friction or Impact
	69	Mental Disorder	A Clinically Significant Behavioral or Psychological Syndrome or Pattern typically associated with either a Distressing Symptom or Impairment of Function, e.g., Acute Anxiety, Neurosis, Stress, Nontoxic Depression
	70	Radiation	All forms of damage to Tissue, Bones, or Bodily Fluids produced by Exposure to Radiation
	71		
	72	Loss of Hearing	
	73	Contagious Disease	
	74	Cancer	
	75	AIDS	
	76	VDT-Related Disease	Video Display Terminal Diseases other than Carpal Tunnel Syndrome
	77	Mental Stress	
	78	Carpal Tunnel Syndrome	Soreness, Tenderness, and Weakness of the Muscles of the Thumb caused by pressure on the Median Nerve at the point at which it goes through the Carpal Tunnel of the Wrist
	79	Hepatitis C	
	80	All Other Cumulative Injury, NOC	
Multiple Injuries	90	Multiple Physical Injuries Only	
	91	Multiple Injuries Including Both Physical and Psychological	

32. Part of Body Code—Injury Description

Record Type	Quarterly
Field(s)	24
Position(s)	124-125
Class	Numeric (N)—Field contains only numeric characters
Bytes	2
Format	N 2
Definition	The code that corresponds to the part of the claimant's body that sustained the injury.

Reporting Requirement: Report the Part of Body Code that identifies the specific body part affected by the injury that is the most significant contributor to the expected overall cost of the claim. Part of Body Code changes (excluding Part of Body Code 65) are considered loss development and are reported on a going-forward basis. When the specific body part affected by the injury cannot be determined, Part of Body Code 65 (Insufficient Information to Properly Identify—Unclassified) must be reported. When the specific Part of Body Code is determined subsequently, report the appropriate Part of Body Code in the next Quarterly reporting. Zero-fill if unknown.

Coding Values

Part of Body Region	Code	Specific Part of Body	Description (If Applicable)
Head	10	Multiple Head Injury	Any combination of below parts
	11	Skull	
	12	Brain	
	13	Ear(s)	Includes Hearing, Inside Eardrum
	14	Eyes	Includes Optic Nerves, Vision, Eyelids
	15	Nose	Includes Nasal Passage, Sinus, Sense of Smell
	16	Teeth	
	17	Mouth	Includes Lips, Tongue, Throat, Taste
	18	Soft Tissue	
	19	Facial Bones	Includes Jaw
Neck	20	Multiple Neck Injury	Any combination of below parts
	21	Vertebrae	Includes Spinal Column Bone, Cervical Segment
	22	Disc	Includes Spinal Column Cartilage, Cervical Segment
	23	Spinal Cord	Includes Nerve Tissue, Cervical Segment
	24	Larynx	Includes Cartilage and Vocal Cords
	25	Soft Tissue	Other than Larynx or Trachea
	26	Trachea	
Upper Extremities	30	Multiple Upper Extremities	Any combination of below parts, excluding Hands and Wrists combined
	31	Upper Arm	Humerus and Corresponding Muscles, excluding Clavicle and Scapula
	32	Elbow	Radial Head
	33	Lower Arm	Forearm—Radius, Ulna, and Corresponding Muscles
	34	Wrist	Carpals and Corresponding Muscles
	35	Hand	Metacarpals and Corresponding Muscles—excluding Wrist or Fingers

	36	Finger(s)	Other than Thumb and Corresponding Muscles
	37	Thumb	
	38	Shoulder(s)	Armpit, Rotator Cuff, Trapezius, Clavicle, Scapula
	39	Wrist(s) and Hand(s)	Any combination of below parts
Trunk	40	Multiple Trunk	(Thoracic Area) Upper Back Muscles, excluding Vertebrae, Disc, and Spinal Cord
	41	Upper Back Area	(Lumbar Area and Lumbo Sacral) Lower Back Muscles, excluding Sacrum, Coccyx, Pelvis, Vertebrae, Disc, and Spinal Cord
	42	Lower Back Area	
	43	Disc	
	44	Chest	Including Ribs, Sternum, Soft Tissue
	45	Sacrum and Coccyx	Final Nine Vertebrae—Fused
	46	Pelvis	
	47	Spinal Cord	Nerve Tissue other than Cervical Segment
	48	Internal Organs	Other than Heart and Lungs
	49	Heart	
	60	Lungs	
	61	Abdomen	Excluding Injury to Internal Organs including Groin
	62	Buttocks	Soft Tissue
	63	Lumbar and/or Sacral Vertebrae (Vertebra NOC Trunk)	Bone Portion of the Spinal Column
Lower Extremities	50	Multiple Lower Extremities	Any combination of below parts
	51	Hip	
	52	Upper Leg	Femur and Corresponding Muscles
	53	Knee	Patella
	54	Lower Leg	Tibia, Fibula, and Corresponding Muscles
	55	Ankle	Tarsals
	56	Foot	Metatarsals, Heel, Achilles Tendon, and Corresponding Muscles—excluding Ankle or Toes
	57	Toes	
	58	Great Toe	

Multiple Body Parts	64	Artificial Appliance	Braces, etc.
	65	Insufficient Info to Properly Identify—Unclassified	Insufficient information to identify part affected
	66	No Physical Injury	Mental Disorder
	90	Multiple Body Parts (Including Body Systems and Body Parts)	Applies when more than one Major Body Part has been affected, such as an Arm and a Leg and Multiple Internal Organs
	91	Body Systems and Multiple Body Systems	Applies when functioning of an Entire Body System has been affected without specific injury to any other part, as in the case of Poisoning, Corrosive Action, Inflammation, Affecting Internal Organs, Damage to Nerve Centers, etc.; does NOT apply when the systemic damage results from an External Injury affecting an External Part such as a Back Injury that includes damage to the Nerves of the Spinal Cord
	99	Whole Body	

33. Policy Effective Date

Record Type	Quarterly and Transactional (Key)
Field(s)	5 (Quarterly) and 7 (Transactional)
Position(s)	34-41 (Quarterly) and 56-63 (Transactional)
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD
Definition	The date that the policy under which the claim occurred became effective.
Reporting Requirement:	Report the effective date that corresponds to the date shown on the policy. The Policy Effective Date reported must be before, or the same as, the Accident Date. The Policy Effective Date must match the Unit Statistical data Policy Effective Date reported for this claim.

34. Policy Number Identifier

Record Type	Quarterly and Transactional (Key)
Field(s)	4 (Quarterly) and 6 (Transactional)
Position(s)	16-33 (Quarterly) and 38-55 (Transactional)
Class	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes	18
Format	A/N 18—Letters A–Z and numbers 0–9 only (if the Policy Number Identifier is less than 18 bytes, this field must be left-justified and have blanks in all spaces to the right of the last character)
Definition	The unique set of numbers and/or letters that identify the policy under which the claim occurred.
Reporting Requirement:	Report the unique set of numbers and/or letters that identify the policy under which the claim occurred. **The Policy Number Identifier must match the Unit Statistical data Policy Number reported for this claim including any prefixes or suffixes.** The policy number identifier can neither be all zeros nor all blanks nor a combination of zeros and blanks.

35. Pre-Existing Disability Percentage (For Federal Act Coverages Only)

Record Type	Quarterly
Field(s)	23
Position(s)	121-123
Class	Numeric (N)—Field contains only numeric characters
Bytes	3
Format	N 3—Data field is to be right-justified and left zero-filled; enter the percentage as a whole number with a leading zero or zeros (for example, 50% is reported as 050)
Definition	The pre-existing disability percentage that directly affects the amount of benefits payable and is contemplated in the determination of a claimant's permanent disability benefits (i.e., compensation is reduced to reflect a pre-existing impairment or disability).
Reporting Requirement:	This data element is a conditional field and is only required to be reported when applicable to the Quarterly record. Report the percentage of the pre-existing disability when it directly impacts the disability rating for the claim. Zero-fill if not applicable. The Pre-Existing Disability Percentage field is to be reported on a whole-body basis.

Example: Reporting a Pre-Existing Disability Percentage (Disability/LOEC Basis)

An injured worker has a 12% permanent disability rating due to a compensable lower-back injury. However, the jurisdiction allows for the explicit reduction for pre-existing conditions in determining the compensation payable, and the claimant has a pre-existing lumbar degenerative joint disease which contributed to the compensable lower-back injury. If the physician determines that 4% of the permanent disability was due to the pre-existing condition, the permanent disability award would be based on the remaining disability rating of 8% (12% – 4% = 8%). The resulting quarterly fields would be reported as follows:

- Disability/LOEC Percentage = 008
- Pre-Existing Disability Percentage = 004

36. Pre-Injury/Average Weekly Wage Amount

Record Type	Quarterly
Field(s)	37
Position(s)	190-194
Class	Numeric (N)—Field contains only numeric characters
Bytes	5
Format	N 5—Amount is rounded to the nearest whole dollar; data field is to be right-justified and left zero-filled; if greater than $99,999, report 99999
Definition	The average weekly wage of the claimant or deceased worker prior to injury, as defined by state or federal law.
Reporting Requirement:	Report the pre-injury average weekly wage of the claimant or deceased worker computed in accordance with statutes and rules of the applicable jurisdiction. Zero-fill if unknown. This field should be reported in conjunction with the Method of Determining Pre Injury/Average Weekly Wage Code.

Examples will be added in subsequent publications of this guide.

37. Record Total

Record Type	File Control
Field(s)	9
Position(s)	58-68
Class	Numeric (N)—Field contains only numeric characters
Bytes	11
Format	N 11
Definition	The total number of records (Transactional or Quarterly) in the file.

Reporting Requirement: Report the total number of records in the file, excluding the File Control Record.

Note: Blank rows will be removed during processing and not counted. If blank rows are included in the Record Total, the file will appear out of balance and reject.

38. Record Type Code

Record Type: Quarterly, Transactional (Processing), and File Control Record
Field(s): 1 (Quarterly), 1 (Transactional), and 1 (File Control Record)
Position(s): 1–2 (Quarterly), 1–2 (Transactional), and 1–2 (File Control Record)
Class: Numeric (N)—Field contains only numeric characters
Bytes: 2
Format: N 2
Definition: The code that identifies the record being submitted is a Transactional, Quarterly, or File Control record.
Reporting Requirement: Report the code that identifies the record being submitted as a Quarterly, Transactional, or File Control Record.

Coding Values

Code	Description
01	Transactional
02	Quarterly
03	File Control

39. Reopen Date

Record Type: Quarterly
Field(s): 14
Position(s): 86-93
Class: Numeric (N)—Field contains only numeric characters
Bytes: 8
Format: YYYYMMDD
Definition: The date a claim is reopened as defined by the carrier.
Reporting Requirement: This data element is a conditional field and is only required to be reported when applicable to the Quarterly record. When applicable, report the date that a closed claim was last reopened for additional benefits. Payments made after the closing date that purely reflect adjustments or modifications to prior benefit paid amounts would not be considered a claim reopening. When a claim closes again, leave the Reopen Date field filled with the most recent Reopen Date and update the Closing Date field accordingly.

Refer to the **Closing Date** section for an example of how the Closing Date and Reopen Date are used to derive claim status.

40. Reported To Insurer Date

Record Type: Quarterly
Field(s): 16
Position(s): 102-109
Class: Numeric (N)—Field contains only numeric characters
Bytes: 8
Format: YYYYMMDD
Definition: The date that a claim was originally reported by the insured.
Reporting Requirement: Report the date that the claim was originally reported to the insurer. If the claim is first reported to a third-party claim administrator, then this is the Reported To Insurer Date. The Reported To Insurer Date must be on or after the Accident Date. Zero-fill if unknown.

41. Reporting Quarter Code

Record Type	File Control
Field(s)	4
Position(s)	9
Class	Numeric (N)—Field contains only numeric characters
Bytes	1
Format	N 1
Definition	The code that corresponds to the quarter when the claim activity being reported occurred.
Reporting Requirement:	Report the code that corresponds to the quarter using the code values below. **Note:** Only one quarter's worth of records can be submitted per file.

Coding Values

Code	Description
1	First Quarter
2	Second Quarter
3	Third Quarter
4	Fourth Quarter

42. Reporting Year

Record Type	File Control
Field(s)	5
Position(s)	10-13
Class	Numeric (N)—Field contains only numeric characters
Bytes	4
Format	YYYY
Definition	The code that identifies the year in which the payments or claim changes occurred.
Reporting Requirement:	Report the year in which the payments or claim changes occurred.

43. Submission Date

Record Type	File Control
Field(s)	7
Position(s)	44-51
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD
Definition	The date that the file was generated and/or submitted.
Reporting Requirement:	Report the date that the file was generated and/or submitted. For files containing Quarterly records, the submission date must be greater than the Quarterly records valuation date.

44. Submission File Identifier

Record Type	File Control
Field(s)	6
Position(s)	14-43
Class	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes	8
Format	A/N 30—Letters A–Z and numbers 0–9 only (if the Submission File Identifier is less than 30 bytes, this field must be left-justified and have blanks in all spaces to the right of the last character)
Definition	A unique identifier created by the data provider that is used to distinguish the file being submitted from previously submitted files.
Reporting Requirement:	Report the unique identifier created by the data provider to distinguish the file being submitted from previously submitted files.

45. Submission File Type Code

Record Type	File Control
Field(s)	2
Position(s)	3
Class	Alpha (A)—Field contains only alphabetic characters
Bytes	1
Format	A 1
Definition	The code that identifies the type of file being submitted.
Reporting Requirement:	Report the code that identifies the type of file being submitted.

Coding Values

Code	Description
O	Original
R	Replacement

46. Submission Time

Record Type	File Control
Field(s)	6
Position(s)	52-57
Class	Numeric (N)—Field contains only numeric characters
Bytes	6
Format	HHMMSS (HH = Hours, MM = Minutes, SS = Seconds)
Definition	The time that the file was generated noted in military time.
Reporting Requirement:	Report the time that the file was generated in military time.

47. Temporary Disability Benefit Extinguishment Code

Record Type	Quarterly
Field(s)	30
Position(s)	135
Class	Numeric (N)—Field contains only numeric characters
Bytes	1
Format	N 1
Definition	The code that corresponds to the reason why temporary disability benefits were terminated.
Reporting Requirement:	This data element is a conditional field and is only required to be reported when applicable to the Quarterly record. When applicable, report the code that corresponds to the reason why temporary disability benefits were terminated. If benefits are reinstated at a later date (i.e., a future quarter), the value reported in this field should be reported as zero for the quarter in which benefits are reinstated and in all subsequent quarterly reports until such benefits are once again extinguished. Switching from Temporary Total Disability to Temporary Partial Disability (or vice versa) would not result in the reporting of this data element. Only when both temporary disability benefit types are extinguished would this field be required to be reported. When multiple codes apply, report the lowest in the hierarchy. Zero-fill if unknown.

Coding Values

Code	Description	Hierarchy	Applicable in DE
1	Return to Work (RTW)	1	Yes
2	Release RTW	2	Yes
3	Maximum Medical Improvement (MMI)	3	
4	Maximum Statutory Duration	4	Yes
5	Medical Noncompliance (e.g., missed medical appointments or refusal to be examined)	5	Yes
6	Other	6	Yes

Example: An injured worker reaches MMI and is released to return to work on 7/1/2018. On 7/14/2018, the injured worker returns to work.

- If RTW is used to terminate temporary benefits on 7/14/2018, report Temporary Disability Benefit Extinguishment Code 1 (RTW).
- If release to return to work is used to terminate temporary benefits on 7/1/2018, report Temporary Disability Benefit Extinguishment Code 2 (Release RTW).
- If MMI is used to terminate temporary benefits on 7/1/2018, report Temporary Disability Benefit Extinguishment Code 3 (MMI).
- If the earliest of RTW, Release to RTW and MMI are used, based on statutory requirements, to terminate temporary benefits on 7/1/2018, two benefit codes would apply. When two codes apply, use the lowest code value of the hierarchy. In this case, report Temporary Disability Benefit Extinguishment Code 2 (Release RTW) and not Code 3 (MMI).

48. Transaction Amount

Record Type	Transactional
Field(s)	13
Position(s)	102-113
Class	Numeric (N)—Field contains only numeric characters
Bytes	12
Format	N 12—Amount includes dollars and cents and may represent a positive or negative transaction amount
Definition	The amount of the financial transaction being submitted; may be negative (e.g., to correct overpayments).
Reporting Requirement:	Report the amount of the financial transaction being submitted. The amount reported includes dollars and cents and may represent a positive or negative transaction amount. If a negative transaction amount is reported, the negative (–) sign must be reported in position 102 prior to the transaction amount. This field must be right-justified and left zero-filled. There is an implied decimal between positions 111 and 112. If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount. Reporting examples: ▪ $123.45 is reported as 000000012345 ▪ Negative (-) $123.45 is reported as -00000012345 ▪ $123 is reported as 000000012300

49. Transaction Code

Record Type	Transaction (Processing)
Field(s)	2
Position(s)	3-4
Class	Numeric (N)—Field contains only numeric characters
Bytes	2
Format	N 2—Data field is to be right-justified and left zero-filled.
Definition	The code that identifies the type of transaction being submitted (e.g., Original, Cancellation/Void, or Replacement). Zero-fill if unknown.
Reporting Requirement:	Report the code that identifies the type of transaction of the record being submitted. This code should always be reported as 01 (Original) if you are not reporting the Transaction Identifier.

Coding Values

Code	Description
01	Original
02	Cancellation/Void
03	Replacement

50. Transaction Date

Record Type	Quarterly and Transactional (Processing)
Field(s)	2 (Quarterly) and 3 (Transactional)
Position(s)	3-10 (Quarterly) and 5-12 (Transactional)
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD
Definition	The date that the transaction was established by the source system of the claim administrator or the date that the Quarterly record was created.
Reporting Requirement:	The Transaction Date must be reported as follows: Transactional record—Report the date that the payment (check) was made or the recovery received. In the case of a cancellation or replacement, the Transaction Date would reflect the date the changes were made to the source system. Quarterly record—The date the record was created. The Transaction Date cannot be prior to the valuation date for the quarter.

51. Transaction From Date

Record Type	Transactional
Field(s)	11
Position(s)	86-93
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD
Definition	The first date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code.
Reporting Requirement:	Report the first date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code. The Transaction From Date represents the first day of the specific period of the transaction. For example, if a data provider is paying Temporary Total Disability (TTD) benefit payments every two weeks, the Transaction From Date for these periodic payments would be the first day of the specific two-week period. Zero-fill if unknown.

52. Transaction Identifier

Record Type	Transaction (Processing)
Field(s)	4
Position(s)	13-32
Class	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes	20
Format	A/N 20—Letters A–Z and numbers 0–9 only (if the Transaction Identifier is less than 20 bytes, this field must be left-justified and have blanks in all spaces to the right of the last character)
Definition	The Transaction Identifier is a unique identifier created by the data provider when using Option 1. It is a unique alphanumeric identifier for each transaction within a claim.
Reporting Requirement:	The Transaction Identifier is reported as follows:

- Option 1—Data providers reporting a Transaction Identifier for all Original transactions are able to report corresponding Cancellation and Replacement records. The Transaction Identifier must be unique for each transaction for a claim.
  - Example 1: Because the field is 20 bytes and alphanumeric, the data provider can create unique Transaction Identifiers so that no two transactions for a claim will ever have the same identifier.
  - Example 2: For each claimant, every Transaction Identifier is different but the identifiers are reusable; i.e., for every claim the identifier for the first transaction is 00000000000000000001, the second is 00000000000000000002, etc.
- Option 2—This option does not use the Transaction Identifier or the Cancellation and Replacement Transaction Codes; rather, it requires the data provider to report multiple Original records to allow DCRB to correctly process the changes to previously reported transactions. The Transaction Identifier should be left blank for this option.

Refer to Section V—Reporting Rules of this guide for examples on how the Transactional Identifier is used to report a cancelled or replaced transaction.

53. Transaction to Date

Record Type	Transactional
Field(s)	12
Position(s)	94-101
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD
Definition	The last date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code.
Reporting Requirement:	Report the last date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code. The Transaction To Date represents the last day of the specific period of the transaction. For example, if a data provider is paying Temporary Total Disability (TTD) benefit payments every two weeks, the Transaction To Date for these periodic payments would be the last day of the specific two-week period. Zero-fill if the Transaction To Date is not available. If the payment represents a single day, then the Transaction From and To Dates will be the same.

Examples will be added in subsequent publications of this guide.

54. Type of Settlement—Loss Condition Code

Record Type Quarterly
Field(s) 28
Position(s) 132-133
Class Numeric (N)—Field contains only numeric characters
Bytes 2
Format N 2—Data field is to be right-justified and left zero-filled
Definition The code that identifies the type of claim settlement, if applicable.
Reporting Requirement: Report the code that identifies the type of claim settlement, if applicable. Zero-fill if unknown.

Coding Values

Code	Type of Settlement	Description
00	Claim Not Subject to Settlement	The claim does not involve a settlement.
03	Stipulated Award (Data Provider/Claimant Settlement)	An award that has been agreed to between the carrier and claimant and submitted for approval to the applicable state workers compensation.
04	Findings and Award (Judicial Award)	An award that has been issued by a judge based on evidence presented in the process of litigation.
05	Dismissal or Take Nothing (Noncompensable)	The claim meets one or more of the following: ▪ Official ruling denying benefits ▪ Claimant's failure to file for benefits ▪ Claimant's failure to prosecute claim following carrier's denial of the claim
06	Compromise Settlement	Compromise and release. A settlement over the issues of applicability, extent of injury, and future benefits.
09	All Other Settlements	The claim involves a settlement other than Codes 03-06.

55. Weekly Benefit Amount

Record Type Transactional
Field(s) 18
Position(s) 129-137
Class Numeric (N)—Field contains only numeric characters
Bytes 9
Format N 9—Amount includes dollars and cents; data field is to be right-justified and left zero-filled
Definition The weekly benefit amount, per the applicable state's approved minimums and maximums, underlying the periodic payment to the claimant for the corresponding Benefit Type Code.
Reporting Requirement: Report the weekly benefit amount, per the applicable state's approved minimums and maximums, underlying the periodic payment to the claimant for the corresponding Benefit Type Code. The amount reported includes dollars and cents. This field must be right-justified and left zero-filled. There is an implied decimal between positions 135 and 136. If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount.

- $123.45 is reported as 000012345
- $123 is reported as 000012300

If a transaction includes multiple rates at which weekly benefits are paid, then report the transaction as a lump-sum payment (Lump Sum Indicator = Y) and report the most recent weekly benefit rate underlying the reported transaction amount as the weekly benefit amount.

Examples will be added in subsequent publications of this guide.

SECTION V – REPORTING RULES

A. File Control Records

The File Control Record identifies the carrier, the quarter that the data represents, and the number of Transactional and Quarterly records being submitted. A separate file and File Control Record are required for transactional records and a separate file and File Control Record are required for quarterly records.

The File Control Record should be placed at the end of the file.

1. File Control Record for Original File

The following illustrates how to submit a File Control Record for an original file. Submit using a Submission File Type Code "O" (Original) on the File Control Record (Record Type—03). For record layout and data element details, refer to Section III—Record Layouts—File Control Record Layout of this guide.

Example: Original file submitted

A carrier group (99990) submits an original file on September 21, 2020. The file contains 5,000 Transactional records for Second Quarter 2020. The File Control Record for the original file is completed as follows:

Field No.	Field Title/Description	Reported As
1	Record Type	03
2	Submission File Type Code	O (Original)
3	Carrier Group Code	99990
4	Reporting Quarter Code	2
5	Reporting Year	2020
6	Submission File Identifier	999902020TRANS
7	Submission Date	20200921
8	Submission Time	124233
9	Record Total	00000005000
10	Reserved for Future Use	

2. File Control Record for File Replacement

Data providers may replace an entire file that was previously submitted by using Submission File Type Code "R" (Replacement) on the File Control Record (Record Type—03). For record layout and data element details, refer to the File Control Record Layout section in Part 5—Record Layouts of this guide.

Example: Replacing a file submitted in error

A carrier group (99990) submitted an original file on September 21, 2020. The file contained 5,000 Transactional records for Second Quarter 2020. On September 23, 2020, the data provider realizes that 3,500 of the Transactional records were submitted with an incorrect Carrier Code. The data provider chooses to submit a replacement instead of submitting 3,500 individual replacement records in a new file. The File Control Record for the replacement file is completed as follows:

Field No.	Field Title/Description	Reported As
1	Record Type	03
2	Submission File Type Code	R (Replacement)
3	Carrier Group Code	99990 (Same as original file being replaced)
4	Reporting Quarter Code	2
5	Reporting Year	2020
6	Submission File Identifier	9999022020TRANS (Same as original file being replaced)
7	Submission Date	20200923
8	Submission Time	155702 (Time that this file was generated)
9	Record Total	00000005000
10	Reserved for Future Use	

File Control Record for File Deletion

To delete an entire file and all of its records from DCRB's database, submit a File Control Record using Submission File Type Code R with no other records in the file.

Example: Deleting a file

A carrier group (99990) submits an original file on January 3, 2022. This file contains 200 Quarterly records for Fourth Quarter 2021. On January 14, 2022, the data provider realizes that the Quarterly records were test records and were submitted in error. To delete all of the records in an individual file, submit a File Control Record as follows:

Field No.	Field Title/Description	Reported As
1	Record Type	03
2	Submission File Type Code	R (Replacement)
3	Carrier Group Code	99990 (Same as file being deleted)
4	Reporting Quarter Code	4 (Same as file being deleted)
5	Reporting Year	2022 (Same as file being deleted)
6	Submission File Identifier	9999042021QTR (Same as file being deleted)
7	Submission Date	20220114 (Date that this file was generated)
8	Submission Time	110000 (Time that this file was generated)
9	Record Total	00000000000 (Do not include the File Control Record in the count)
10	Reserved for Future Use	

B. Transactional Records

The Transactional record contains indemnity benefit payments for a specific claim that occurred in a given quarter. These are identified by Record Type Code 01—Transactional Record. For record reporting details, refer to Section III—Record Layouts and Section IV—Data Dictionary of this guide.

1. Reporting Frequency

As stated in Section I—Indemnity Data Call General Rules, Transactional records are due to the DCRB by the end of the quarter following the quarter in which the benefit was paid. However, since transactional records represent benefit payments that can occur at any time throughout the quarter, data providers can choose to report these records daily, weekly, monthly, or quarterly—whichever makes the most sense for the business processes of the data provider.

Example: An indemnity payment is paid on February 2. The Transactional record can be reported as early as February 3, but not later than June 30.

2. Reporting Triggers

All indemnity claim activities (new claims and existing claims) that occur within a specific quarter, based on the Transaction Date, must be reported by the end of the next quarter. For example, indemnity claim activities that occur in June are reported in the second quarter submission that is due to DCRB by September 30 of the reporting year. For details, refer to the Reporting Frequency section in Section I—General Rules of this guide.

3. Changes to Transactional Records

Data providers may need to change previously reported transactions, regardless of whether the transactions were reported in an earlier submission or as a prior transaction in the current submission. A few reasons for changing previously reported transactions may include:

- Voids—A payment made to the claimant in error
- Transactional records submitted to the DCRB in error
- Transactional records with incorrect codes reported to the DCRB
- Underpayments and overpayments

A data provider has two options for making changes to Transactional records.

- Option 1—Reporting With the Transaction Identifier (Using the Cancellation and Replacement Transaction Codes
- Option 2—Reporting Without the Transaction Identifier (Accounting Method)

DCRB recommends the use of Option 1—Reporting With the Transaction Identifier because this is the option that is common across most data types. Examples of how to report using both options are provided below.

a. Option 1—Reporting With the Transaction Identifier (Using Cancellation and Replacement Codes)

This option requires the use of the Transaction Identifier on every record and uses the Cancellation and Replacement Transaction Codes to process changes to previously reported transactions. The Transaction Identifier is a unique number that is assigned to each individual payment transaction. The Transaction Identifier is then used by DCRB to correctly process the different transaction types.

The Transaction Code (Positions 3–4) is used to identify changes to a Transactional record as follows:

- Deleting a record—Transaction Code 02—Cancellation
- Changing a record—Transaction Code 03—Replacement

Cancelling a Transactional Record—Voids and Transactional Records Submitted in Error

To cancel a previously submitted record, submit a Cancellation record with the following:

- Record Type Code 01—Transactional Record (Positions 1–2).
- Transaction Code 02—Cancellation (Positions 3–4).
- Transaction Date (Positions 5–12) reported as the date that the information was changed in the source system of the claim administrator.
- Transaction Identifier (Positions 13–32) as reported on the previous record being cancelled.
- All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, and Accident Date) must be populated. The key fields must match those reported on the previous record to which the cancellation applies.
- All other fields may be left blank or zero-filled.

Example:

Carrier 99990 made an erroneous payment to a claimant that was reported to DCRB (A) and later voided in the data provider's payment system. To cancel the Original record from the database, the data provider submits a Cancellation record (B) with all key fields reported the same as the previous record, Transaction Code (02 in lieu of 01), Transaction Date (the date when the cancellation was performed), and Transaction Identifier reported the same as the previous record.

	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20201201	AE1000001	99990	WC1001	20180925	0006	20190101	20201201	20201214	000000100000	03
B	01	02	20201217	AE1000001	99990	WC1001	20180925	0006	20190101				
	Not all data elements are shown. For each record of this example, the data in these elements can be blank or zero-filled.												

Replacing an Incorrect Code (Non-Key Fields)

Changes via a Replacement record can only be made to non-key fields. To change key fields, refer to **Key Field Changes** later in this section.

To change a non-key field for a previously reported record (Original or Replacement), submit a Replacement record with the following:

- Record Type Code 01—Transactional Record (Positions 1-2).
- Transaction Code 03—Replacement (Positions 3-4)
- Transaction Date (Positions 5-12) reported as the date that the information was changed in the source system of the claim administrator.
- Transaction Identifier (Positions 13-32) as reported on the previous record to which the replacement applies.
- All key fields (Policy Number Identifier, Policy Effective Date, Carrier Code, Claim Number Identifier, and Accident Date) populated. The key fields must match those reported on the previous record to which the change applies.
- The current transactional values for all non-key fields (not the change in values).

  Note: The Replacement record must include all data elements even if they do not change.

Example: Reporting a Benefit Code change

Carrier 99990 submits an Original record (A) with Benefit Type Code 03 in error. To change the Benefit Type Code, the data provider submits a Replacement record (B) using Transaction Code 03, Transaction Date as the date that the change was performed, and the correct Benefit Type Code.

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20201201	AE1000001	99990	WC1001	20180925	1006	20190101	20201201	20201214	000000001000	03
B	01	03	20201215	AE1000001	99990	WC1001	20180925	1006	20190101	20201201	20201214	000000001000	04
	Not all data elements are shown. For record B, all key fields must be identical.												

Example: Reporting a Transaction Amount change (Underpayment)

Carrier 99990 submits an original record (A) with a Scheduled Benefit payment of $1,000. The data provider realizes that they actually paid a Scheduled benefit payment of $1,500. To change the Transaction Amount, the data provider submits a replacement record (B) using Transaction Code 03, Transaction Date as the date the change was performed, and the revised Transaction Amount of $1,500. All fields other than the Transaction Amount as was reported on the original claim (especially the Transaction Identifier).

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20201201	AE1000001	99990	WC1001	20180925	1006	20190101	20201201	20201214	000000100000	03
B	01	03	20201215	AE1000001	99990	WC1001	20180925	1006	20190101	20201201	20201214	000000150000	03
	Not all data elements are shown. For record B, all key fields must be identical.												

Example: Reporting a Transaction Amount change (Overpayment)

Carrier 99990 submits an original record (A) with a Scheduled Benefit payment of $1,000. The data provider realizes that they actually paid a Scheduled benefit payment of $500. To change the Transaction Amount, the data provider submits a replacement record (B) using Transaction Code 03, Transaction Date as the date the change was performed, and the revised Transaction Amount of $500. All fields other than the Transaction Amount as was reported on the original claim (especially the Transaction Identifier).

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20201201	AE1000001	99990	WC1001	20180925	1006	20190101	20201201	20201214	000000100000	03
B	01	03	20201215	AE1000001	99990	WC1001	20180925	1006	20190101	20201201	20201214	000000050000	03
	Not all data elements are shown. For record B, all key fields must be identical.												

Key Field Changes via Cancellation

There is not a Key Field Change transaction in the Indemnity Data Call. In order to change a key field on a previously submitted record, a Cancellation record must first be submitted to remove the record from the database. Refer to **Cancelling a Transactional Record** in this section of the guide for details.

After deleting the previously reported record, submit a new record with the following:

- Record Type Code 01—Transactional Record (Positions 1-2)
- Transaction Code 01—Original (Positions 3-4)
- Transaction Date (Positions 5-12) reported as the date the information was changed in the source system of the claim administrator
- Transaction Identifier (Positions 13-32) as reported on the previous record to which the replacement applies
- All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, and Accident Date) populated with the correct information and the previously reported information for any key fields that are not being changed
- All other fields may be blank or zero-filled

Example: Changing a key field—via Cancellation (with Transaction Identifier)

Carrier 99990 submits an Original record (A) with an erroneous Claim Number Identifier of 1006. To change the Claim Number Identifier, the data provider first submits a Cancellation record (B), using Option 1, with all the key fields and Transaction Identifier as previously reported (including Claim Number Identifier 1006), Transaction Code 02, and Transaction Date as the date that the cancellation was performed. After submitting the cancellation, the data provider submits a new record (C) with the corrected Claim Number Identifier and all the other key fields as previously reported, Transaction Code 01, and Transaction Date as the date that the change was performed.

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20201201	AE1000001	99990	WC1001	20180925	1006	20190101	20201201	20201214	000000100000	03
B	01	02	20201215	AE1000001	99990	WC1001	20180925	1006	20190101	00000000	00000000	000000000000	00
C	01	01	20201215	AE1000001	99990	WC1001	20180925	0006	20190101	20201201	20201214	000000100000	03
	Not all data elements are shown. For record B, all non-processing and non-key fields can be blank or zero-filled.												

Option 2—Reporting Without the Transaction Identifier (Accounting Method)

This option does not use the Transaction Identifier or the Cancellation and Replacement Transaction Codes; rather, it requires the data provider to report multiple Original records to allow the DCRB to correctly process the changes to previously reported transactions.

Deleting a Transactional Record Without the Transaction Identifier—Voids and Transactional Records Submitted in Error

For DCRB to adjust a previously submitted record, the data provider must submit a new Original record with the following:

- Record Type Code 01—Transactional Record (Positions 1–2).
- Transaction Code 01—Original (Positions 3-4)
- Transaction Date (Positions 5-12) reported as the date that the information was changed in the source system of the claim administrator.
- Transaction Identifier (Positions 13-32) would be left blank.
- All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, and Accident Date) must be populated. The key fields must match those reported on the previous Original record being deleted.
- Transaction Amount (Positions 102–113) would be reported as the negative of the original reported amount.
- Because the Transaction Identifier is not being reported, all other data fields must be reported exactly as the previous Original record to which the adjustment applies; e.g., Jurisdiction State, Transaction From Date, Transaction To Date, Benefit Type Code, etc.

Example: Voids and Transactional Records submitted in error

Carrier 99990 made an erroneous payment to a claimant that was reported to DCRB (A) and later voided in the data provider's payment system. For DCRB to void the Original record, the data provider must submit a new Original record (B) with all the fields reported the same as the previous Original record except for the Transaction Date (the date when the cancellation was performed) and the Transaction Amount (which should be the negative of the original Transaction Amount reported).

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier (N/A)	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20201201		99990	WC1001	20180925	0006	20190101	20201201	20201214	000000100000	03
B	01	03	20201217		99990	WC1001	20180925	0006	20190101	20201201	20201214	–00000100000	03
	Not all data elements are shown. For each record of this example, the data in the unseen elements is identical.												

Replacing an Incorrect Code (Non-Key Fields)

For the data provider to report changes to non-key fields without the Transaction Identifier, they must first submit an Original record to offset the original transaction amount (as above), which nullifies the prior record, followed by a new Original record with the following:

- Record Type Code 01—Transactional Record (Positions 1–2).
- Transaction Code 01—Original (Positions 3-4)
- Transaction Date (Positions 5-12) reported as the date that the information was changed in the source system of the claim administrator.
- Transaction Identifier (Positions 13-32) would be left blank.
- Transaction Amount (Positions 102–113) would be reported with a new dollar amount.
- All key fields (Policy Number Identifier, Policy Effective Date, Carrier Code, Claim Number Identifier, and Accident Date) populated. The key fields must match those reported on the previous record to which the change applies.
- The current correct values for all non-key fields.

Example: Changing Benefit Type Code

Carrier 99990 submits an Original record (A) with Benefit Type Code 03 in error. To change the Benefit Type Code, the data provider would first submit an Original record (B) to offset the previous transaction. After submitting the offsetting Original record, the data provider would submit a new Original record (C) with the corrected Benefit Type Code, all the other key fields as previously reported, Transaction Code 01, and Transaction Date as the date that the change was performed.

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier (N/A)	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20201201		99990	WC1001	20180925	1006	20190101	20201201	20201214	000000100000	03
B	01	01	20201215		99990	WC1001	20180925	1006	20190101	20201201	20201214	–00000100000	03
C	01	01	20201215		99990	WC1001	20180925	1006	20190101	20201201	20201214	000000100000	04
	Not all data elements are shown. For record B, all non-processing and non-key fields must be identical to the Original record A.												

Correcting an Underpayment or an Overpayment

A data provider can report changes to the Transaction Amount only by reporting a new Original record with the Transaction Amount being either the additional amount paid or the offsetting amount. Submit the new original Transactional record as follows:

- Record Type Code 01—Transactional Record (Positions 1–2).
- Transaction Code 01—Original (Positions 3-4)
- Transaction Date (Positions 5-12) reported as the date that the information was changed in the source system of the claim administrator.
- Transaction Identifier (Positions 13-32) would be left blank.
- All key fields (Policy Number Identifier, Policy Effective Date, Carrier Code, Claim Number Identifier, and Accident Date) populated. The key fields must match those reported on the previous record to which the change applies.
- All other unaffected fields as originally reported.
- Transaction Amount (Positions 102–113)—report the additional amount as a positive number or the offset amount as a negative number.

Example: Reporting an Underpayment

Carrier 99990 submits an Original record (A) with a scheduled benefit payment of $1,000. Two weeks later, the data provider makes an additional payment of $500 for the same time period. To report this additional payment transaction, the data provider submits another Original record (B) with the same key fields as the record being changed, Transaction Code 01, and the additional payment value of $500. The Transaction Date for this new Original record is the date that the additional payment was made in the source system of the claim administrator.

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier (N/A)	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20201201		99990	WC1001	20180925	0006	20190101	20201201	20201214	000000100000	03
B	01	01	20201215		99990	WC1001	20180925	0006	20190101	20201201	20201214	000000050000	03
	Not all data elements are shown. For each record of this example, the data in the unseen elements is identical to the previous record.												

Example: Reporting an Overpayment

Carrier 99990 submits an Original record (A) with a Scheduled Benefit payment of $2,000. Two weeks later, the data provider realizes that they overpaid the claimant by $500. To correct this overpayment, the data provider submits another Original record (B) with the same key fields as the record being changed, Transaction Code 01, and the offset amount of –$500. The Transaction Date for this record is the date the overpayment was offset in the source system of the claim administrator.

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier (N/A)	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20181201		99990	WC1001	20180925	0006	20190101	20181201	20181214	000000200000	03
B	01	01	20181215		99990	WC1001	20180925	0006	20190101	20181201	20181214	–00000050000	03
	Not all data elements are shown. For each record of this example, the data in the unseen elements is identical to the previous record.												

Key Field Changes

For data providers that do not provide Transaction Identifiers to change a key field on a previously submitted record, an Original record must first be submitted to offset the previous record from the database. Refer to **Deleting a Transactional Record Without the Transaction Identifier** in this section of the guide for details.

After offsetting the previously reported record, submit a new Original record with the following:

- Record Type Code 01—Transactional Record (Positions 1–2)
- Transaction Code 01—Original (Positions 3–4)
- Transaction Date (Positions 5–12) reported as the date that the information was changed in the source system of the claim administrator
- Transaction Identifier (Positions 13–32) would be left blank.
- All key fields (Carrier Code, Policy Number Identifier, Policy Effective Date, Claim Number Identifier, and Accident Date) populated with the corrected information and the previously reported information for any key fields that are not being changed
- All other fields may be blank or zero-filled.

Example: Changing a key field

Carrier 99990 submits an Original record (A) with an erroneous Claim Number Identifier 1006. To change the Claim Number Identifier, the carrier first submits an Original record (B) with Transaction Code 01, Transaction Date as the date that the information was changed in the source system of the claim administrator, and all the other elements as previously reported (including Claim Number Identifier 1006), except for Transaction Amount, which would be reported as the negative of the original amount. After submitting the offsetting record, the data provider submits a new record (C) with Transaction Code 01, Transaction Date as the date that the change was performed, the corrected Claim Number Identifier, and all the other key fields as previously reported.

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifier (N/A)	(5) Carrier Code	(6) Policy Number Identifier	(7) Policy Effective Date	(8) Claim Number Identifier	(9) Accident Date	(11) Transaction From Date	(12) Transaction To Date	(13) Transaction Amount	(14) Benefit Type Code
A	01	01	20201201		99990	WC1001	20180925	1006	20190101	20201201	20201214	000000100000	03
B	01	01	20201215		99990	WC1001	20180925	1006	20190101	20201201	20201214	–00000100000	03
C	01	01	20201215		99990	WC1001	20180925	0006	20190101	20201201	20201214	000000100000	03
	Not all data elements are shown. For record B, the data in the unseen elements is identical to the previous record.												

C. Quarterly Records

The Quarterly record is the inception-to-date reporting of an indemnity claim, identified by Record Type Code 02—Quarterly record in the record layout. For record reporting details, refer to Section II—Indemnity Data Call Structure and Section IV—Data Dictionary of this guide.

1. Reporting Frequency

As stated in Section I—Indemnity Data Call General Rules, Quarterly records are due to DCRB by the end of the quarter following the valuation date. After the valuation date has passed, the Quarterly records can be submitted all together in a single file or in multiple files—whatever suits your business process, as long as they are all submitted on or before the due date.

2. Reporting Rule

For the following data elements, the Quarterly record reporting rules are based on the unit statistical reporting rules pursuant to DCRB's ***Statistical Plan***:

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Accident Date
- Jurisdiction State Code
- Injury Description Codes—Part of Body, Nature of Injury, and Cause of Injury
- Incurred Indemnity Amount
- Incurred Amount Paid-To-Date
- Incurred Medical Amount
- Medical Amount Paid-To-Date
- Employer Legal Amount Paid
- Allocated Loss Adjustment Expense (ALAE) Amount Paid
- Act—Loss Condition Code
- Type of Settlement—Loss Condition Code

3. Reporting Triggers

A Quarterly record would be reported to DCRB whenever any of the following circumstances occur during a reporting quarter:

- A new claim has been reported to the insurer and the incurred indemnity amount > 0
- A Transactional (Original, Replacement, or Cancellation) record is reported within a quarter
- Amounts for the following data elements change from the prior quarter:
    - Indemnity Amount Paid-To-Date
    - Incurred Indemnity Amount
    - Medical Amount Paid-To-Date
    - Incurred Medical Amount
    - Allocated Loss Adjustment Expense (ALAE) Amount Paid
- Changes in the Jurisdiction State for a previously reported claim, when the new jurisdiction state is not an applicable Indemnity Data Call state

If a claim becomes medical-only (i.e., the Incurred Indemnity Amount is reduced to zero), then report the Quarterly record corresponding to the quarter in which this change occurred. No additional quarterly records are required to be reported while the claim is medical-only.

For claims that were open prior to the implementation of the Indemnity Data Call, only report the Quarterly records if a new transaction occurs or the amounts for the fields noted above change from the prior quarter. Quarterly reporting is required for newly opened claims (i.e., no payment made or incurred amount established in the prior quarter[s]). Typically, if a Transactional (Original, Replacement, or Cancellation) record is reported within a quarter, a corresponding Quarterly record would be expected as well.

4. Deleting or Changing Quarterly Records

Data providers may delete or change previously reported Quarterly records.

a. Deleting a Quarterly Record

Reasons for deleting Quarterly records that were previously submitted may include that the claim is not a workers compensation claim.

To delete a previously submitted Quarterly record, submit a new Quarterly record with the following:

- All key fields (Policy Number Identifier, Policy Effective Date, Carrier Code, Claim Number Identifier, and Accident Date) populated. The key fields must match those reported on the Quarterly record to be deleted.
- Record Type Code 02—Quarterly record (Positions 1–2).
- Transaction Date (Positions 3–10) reported as the date that the information was deleted in the source system of the claim administrator.
- Zeros or blanks for all non-key fields.

Example: Deleting a Quarterly Record

Carrier 99990 submits a Quarterly submission which includes record (A). Two weeks after this submission, the data provider realizes that the claim was not a workers compensation claim. The data provider reports an updated version of the Quarterly record (B) to delete the original Quarterly record.

Scenario	(1) Rec Type Code	(2) Trans Date	(3) Carrier Code	(4) Policy Number Identifier	(5) Policy Effective Date	(6) Claim Number Identifier	(7) Accident Date	(32) Medical Paid-To-Date	(33) Incurred Indemnity Amount	(34) Incurred Medical Amount	(35) Employer Legal Amount Paid
A	02	20210101	99990	WC1001	20180925	0006	20190701	000001000	000001000	000025000	000001000
B	02	20210117	99990	WC1001	20180925	0006	20190701	000000000	000000000	000000000	000000000

b. Changing a Quarterly Record

To change a previously submitted Quarterly record, not including a future quarter's update, submit a single Quarterly record with the following:

- All key fields (Policy Number Identifier, Policy Effective Date, Carrier Code, Claim Number Identifier, and Accident Date) populated. The key fields must match those reported on the previous record to which the change applies.
- Record Type Code 02—Quarterly record (Positions 1–2).
- Transaction Date (Positions 3–10) reported as the date that the information was changed in the system of the claim administrator. The Transaction Date must be greater than any previously submitted record for that quarter.
- The current values for all non-key fields (not the change in value).

Example: Changing Indemnity Paid-To-Date

Carrier 99990 submits a Quarterly record (A) for a claimant that reflects the claimant's results as of the end of Fourth Quarter 2020. Two weeks later, the data provider realizes that an additional payment was made in Fourth Quarter 2020. The data provider reports an updated version of the Quarterly record (B) to reflect the additional amounts paid.

Scenario	(1) Rec Type Code	(2) Trans Date	(3) Carrier Code	(4) Policy Number Identifier	(5) Policy Effective Date	(6) Claim Number Identifier	(7) Accident Date	(32) Medical Paid-To-Date	(33) Incurred Indemnity Amount	(34) Incurred Medical Amount	(35) Employer Legal Amount Paid
A	02	20210101	99990	WC1001	20180925	0006	20190701	000005000	000001000	000025000	000001000
B	02	20210117	99990	WC1001	20180925	0006	20190701	000007000	000001000	000025000	000002000

SECTION VI – EDITING PROCEDURES

A. Editing Process

The DCRB's editing process is performed to ensure that the data provider's data is consistent with reporting requirements and meets quality standards. The edit process for the Indemnity Data Call is based on file acceptance and three quality components:

(a) Population test (e.g., are the data elements appropriately reported?)
(b) Validation test (e.g., are the data elements populated with valid values?)
(c) Reasonableness test (e.g., is the distribution of data elements reasonable?)

These tests will be performed within each data element and across Call elements where needed. Editing processes and procedures will be detailed in subsequent updates to this publication.

B. Validating a Submission

Call submissions are evaluated at the data element level based on File Submission level edits and authentication. File Submission level edits and authentication will either accept or reject the entire file.

File Acceptance submission level edits determine whether:

- The file name is valid per file naming conventions
- The data provider is authorized to report the Indemnity Data Call and to submit for the Carrier Group Code
- The record length is correct and contains only valid characters
- The file contains a File Control Record, there is only one File Control Record per file, and the File Control Record is not a duplicate
- A separate file and File Control Record are required for transactional records and a separate file and File Control Record are required for quarterly records
- The Submission File Type is valid
- The Reporting Quarter is valid
- The Submission Date is valid
- The Reporting Year is valid
- The Record Totals are valid and match the number of records in the file
- The replacement file matches a previously submitted file
- The Submission Date and Submission Time on a replacement file are later than those on the file it is intended to replace

To ensure the completeness and validity of the required fields, field and relational level edits will be performed during this stage on any field that is identified as "Required for Record Acceptance."

- Field edits ensure the population and validity of each data element. For example, the Carrier Code cannot be missing and must be a valid NCCI Carrier Code.
- Relational edits check for acceptable relationships between elements on different records, either within the submission or on DCRB's database. For example, a Cancellation record (Transaction Code 02) must have an associated Original record (Transaction Code 01) or Replacement record (Transaction Code 03) in the submission or on DCRB's database.

After a file passes the Record Acceptance stage, all records, except those returned, will be processed.

C. Aggregate Record Level Editing Per File

Record-level editing will be performed and results will be captured at the data element level in the aggregate. Using data elements categories, the editing process will determine the overall quality of the Indemnity Data Call. Each data element is evaluated against one or more edits and either passes or fails each edit. For each data element, if any edit fails, the transaction is counted. Varying thresholds will be created based on the specific data element within each of the element categories.

Data element categories are defined as follows:

- Record Acceptance (R)—Indicates that the data element is necessary for record acceptance.
- Critical (C)—Indicates that the data element is of critical importance
- Priority (P)—Indicates that the data element is very important
- Supplemental (S)—Indicates that the data element is important

Record	Field Type	Category	Conditional**
Both	Accident Date*	R	
Both	Carrier Code*	R	
Both	Claim Number Identifier*	R	
Both	Policy Effective Date*	R	
Both	Policy Number Identifier*	R	
Both	Record Type Code	R	
Both	Transaction Date	R	
Transactional	Transaction Code	R	
Transactional	Transaction Identifier	R	Yes
Both	Jurisdiction State Code	C	
Quarterly	Act—Loss Condition Code	C	
Quarterly	Attorney or Authorized Representative Indicator	C	
Quarterly	Cause of Injury Code—Injury Description	C	
Quarterly	Incurred Indemnity Amount	C	
Quarterly	Incurred Medical Amount	C	
Quarterly	Indemnity Paid-to-Date	C	
Quarterly	Medical Paid-to-Date	C	
Quarterly	Nature of Injury Code—Injury Description	C	
Quarterly	Part of Body Code—Injury Description	C	
Quarterly	Pre-Injury/Average Weekly Wage Amount	C	
Transactional	Benefit Type Code	C	
Transactional	Lump-Sum Indicator	C	
Transactional	Transaction Amount	C	
Quarterly	Disability/Loss of Earnings Capacity (LOEC) Percentage	C	Yes
Quarterly	Impairment Percentage	C	Yes
Quarterly	Impairment Percentage Basis Code	C	Yes
Quarterly	Maximum Medical Improvement (MMI) Date	C	Yes

Quarterly	Temporary Disability Benefit Extinguishment Code	C	Yes
Quarterly	Type of Settlement—Loss Condition Code	C	Yes
Transactional	Transaction From Date	C	Yes
Transactional	Transaction To Date	C	Yes
Quarterly	Accident State Code	P	
Quarterly	Birth Year	P	
Quarterly	Method of Determining Pre-Injury/Average Weekly Wage Amount	P	
Transactional	Weekly Benefit Amount	P	
Quarterly	Allocated Loss Adjustment Expense (ALAE) Paid	P	Yes
Quarterly	Employer Legal Amount Paid	P	Yes
Quarterly	Medical Extinguishment Indicator	P	Yes
Quarterly	Pre-existing Disability Percentage	P	Yes
Transactional	Benefit Offset Amount	P	Yes
Transactional	Benefit Offset Code	P	Yes
Quarterly	Claimant Gender Code	S	
Quarterly	Employment Status Code	S	
Quarterly	Hire Date	S	
Quarterly	Reported to Insurer Date	S	
Quarterly	Closing Date	S	Yes
Quarterly	Reopen Date	S	Yes

**Conditional—Indicates that the data element must be provided but is conditional on state-mandated criteria or dependent on a specific condition or set of conditions. This element must be valid if populated.
*This data element is considered a key field and is required to be reported the same as on the original record for all records related to a claim. Refer to key fields in Section II—Indemnity Data Call Structure of this guide.

D. Quarter-End Validation

During the Quarter-End Validation stage, edits for all of the data providers reporting for a carrier group are summarized for the entire quarter's data, developing quality statistics across all submissions. Editing processes and procedures will be provided in a future update to this guide.

SECTION VII – APPENDIX

A. Overview

The following examples are included in the Appendix:

- **Business Exclusion Request Form Example**
- **Premium Verification Worksheets** and Instructions - For use with Premium Determination Methods 1 - 3
- **Compensation Data Exchange (CDX) Information**
- **CDX Insurer User Management Group (UMG) Primary Administrator Application**

B. Business Exclusion Request Form Example

Participants in the Call are required to submit their basis for exclusion to the DCRB for review. All requests for review must include the output used to demonstrate that the excluded segment(s) will be less than 15% of gross premium. For details on the methods for premium determination and examples, refer to Business Exclusion Option in the **General Rules** section of this manual.

Date Prepared:
Carrier Group Name:
Carrier Group Number:
Preparer's Contact Information
Name:
Address:
Phone:
Email:

Exclusions – Complete the following steps:

1. Document the nature and reason for all proposed exclusions. If more space is needed, please attach a separate page with the explanation(s) to this form.

   Note: The exclusion option must be based on business segment, not on claim type or characteristics.

   The 15% exclusion does not apply to selection by:
   - Policy types (e.g., large deductible policies)
   - Claim characteristics such as claim status (e.g., open, closed)
   - Claim types such as specific injury types (death, permanent total disability, etc.)

2. Document the carriers (by carrier code) and states that are handled by each excluded business segment.

3. For each applicable carrier, provide an estimate of the percentage of paid losses handled by each excluded business segment.

4. If the method described is not appropriate for determining the exclusion percentage, contact the DCRB for guidance. The method is not appropriate if it would not closely approximate prospective premium distribution in the current calendar year (e.g., a significant shift has occurred in a participant's book(s) of business since the last NAIC reporting or the participant writes a significant number of large deductible policies).

5. Completed requests should be sent to the Delaware Compensation Rating Bureau, Inc., 30 S. 17th Street, Suite 1500, Philadelphia, PA 19103 or emailed to indemnitycall@dcrb.com.

C. Premium Verification Worksheet and Instructions

1. Worksheet – Method 1

Use this worksheet to determine if proposed exclusions are less than or equal to 15% of the group's total written premium when using Premium Determination Method 1. Only include premium from Delaware or Federal Act.

For details on Premium Determination Method 1 and all other premium determination methods, refer to Business Exclusion Option in the **General Rules** section of this manual.

Column A Entities for Proposed Exclusion	Column B Entities' Calendar Year Written Premium	Column C Carrier Group Calendar Year Written Premium	Column D Entities' Written Premium as % of Carrier Group (Col. B / Col. C)
TOTAL			

2. Worksheet Instructions – Method 1

1. In Column A, list the entities excluded from Delaware or Federal Act.
2. In Column B, enter the Calendar Year Written Premium for Delaware or Federal Act for each excluded entity.
3. In Column B of the Total row, enter the sum of the premium for the excluded entities.
4. In Column C of the Total row, enter the Carrier Group's Calendar Year Written Premium for Delaware or Federal Act (as reported in the NAIC Annual Statement—Statutory Page 14).
5. In Column D of the Total row, divide Column B by Column C, and enter the result as a percentage. Round to one decimal. This value must be equal to or less than 15%.

3. Worksheet – Method 2

Use this worksheet to determine whether proposed exclusions are less than or equal to 15% of the group's total written premium when using Premium Determination Method 2. This method is an option for affiliate groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums.) Only include premium from Delaware or Federal Act.

For details on Premium Determination Method 2 and all other premium determination methods, refer to Business Exclusion Option in the **General Rules** section of this manual.

Premium Verification Worksheet – Method 2			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total		
B	Large Deductible to be excluded		
C	Non-Large Deductible to be excluded		
	Estimated Gross Premium:		
D	Net Ratio	B divided by A (B / A)	
E	Gross Ratio	From table (Refer to Business Exclusion Option in the **General Rules** section of this manual	
F	Non-Large Deductible Ratio	C divided by A (C / A)	
G	Ratio	Sum of E and F (E+F)	

4. Worksheet Instructions – Method 2

1. Fill in Items A, B and C.
2. Determine the Net Ratio (D).
3. Use the Net Ratio to determine the Gross Ratio (E) from the table. Refer to Business Exclusion Option in the **General Rules** section of this manual.
4. Use the formulas to complete the worksheet.
5. If the ratio (G) is 15% or less, the exclusion is acceptable.

5. Worksheet – Method 3

Use this worksheet to determine if proposed exclusions are less than or equal to 15% of the group's total written premium when using Premium Determination Method 3. This method is an option for affiliate groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums.) Only include premium from Delaware or Federal Act.

For details on Premium Determination Method 3 and all other premium determination methods, refer to Business Exclusion Option in the **General Rules** section of this manual.

Premium Verification Worksheet – Method 3			
Item	**Description**	**Formula**	**Amount**
	NAIC Direct Written Premium:		
A	Total including Large Deductible		
B	Large Deductible		
C	Large Deductible to be excluded		
D	Non-Large Deductible to be excluded		
	Estimated Gross Premium:		
E	Large Deductible to be excluded	5 times C (5 x C)	
F	Total Excluded	Sum of D and E (D + E)	
G	Add-on for Large Deductible business	4 times B (4 x B)	
H	Estimated Total	Sum of A and G (A + G)	
I	Ratio	F divided by H (F / H)	

6. **Worksheet Instructions – Method 3**
   1. Fill in Items A, B, C. D.
   2. Use the formulas to complete the worksheet.
   3. If the ratio (I) is 15% or less, the exclusion is acceptable.

7. **Worksheet – Method 4**

   Use this worksheet to determine if proposed exclusions are less than or equal to 15% of the group's total gross premium when using Premium Determination Method 4. This method uses the gross (of deductible) premium in Unit Statistical data (reported in the Premium Amount field of the Exposure Record). Calculate the ratio of total gross premium on business to be excluded to total gross premium on all business, and compare the excluded premium percentage to the 15% requirement. Only include premium from Delaware or Federal Act.

Column A Entities for Proposed Exclusion	Column B Entities' Gross Premium	Column C Affiliate Group Gross Premium	Column D Entities' Gross Premium as % of Affiliate Group (Col. B / Col. C)
TOTAL			

8. **Worksheet Instructions – Method 4**

   1. In Column A, list the entities excluded from the Affiliate Group.
   2. In Column B, enter the gross (of deductible) premium for Delaware or Federal Act for each excluded entity.
   3. In Column B of the Total row, enter the sum of the premium for the excluded entities.
   4. In Column C of the Total row, enter the Affiliate Group's gross premium for Delaware or Federal Act as applicable.
   5. In Column D of the Total row, divide Column B by Column C, and enter the result as a percentage. Round to one decimal. This value must be equal to or less than 15%.

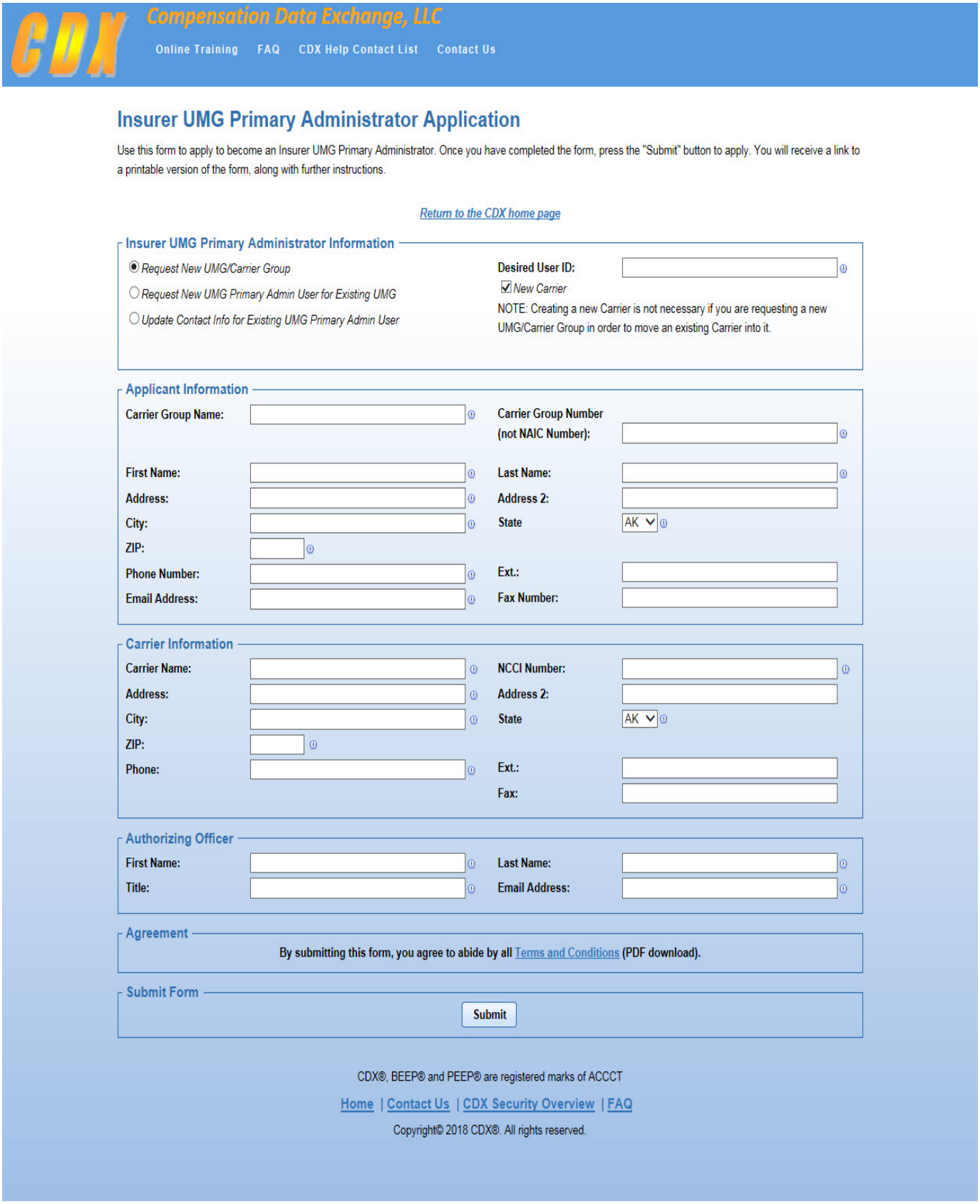
D. Compensation Data Exchange (CDX) Information

CDX is a service of Compensation Data Exchange, LLC which is owned by the following data collection organization members of the American Cooperative Council on Compensation Technology (ACCCT):

- Workers' Compensation Insurance Rating Bureau of California
- Delaware Compensation Rating Bureau, Inc.
- Insurance Services Office, Inc.
- Workers' Compensation Rating and Inspection Bureau of Massachusetts
- Compensation Advisory Organization of Michigan
- Minnesota Workers' Compensation Insurers Association, Inc.
- New York Compensation Insurance Rating Board
- North Carolina Rate Bureau
- Pennsylvania Compensation Rating Bureau
- Wisconsin Compensation Rating Bureau

CDX *Insurer User Management Group (UMG) Primary Administrator Application* (see subsequent page)

The *Insurer User Management Group (UMG) Primary Administrator Application* form is a digital (online) form. The following page contains a screen shot of the form, which is available on the CDX website. Please visit www.accct.org to complete this application.



Compensation Data Exchange, LLC

Online Training FAQ CDX Help Contact List Contact Us

Insurer UMG Primary Administrator Application

Use this form to apply to become an Insurer UMG Primary Administrator. Once you have completed the form, press the "Submit" button to apply. You will receive a link to a printable version of the form, along with further instructions.

Return to the CDX home page

Insurer UMG Primary Administrator Information

- (•) Request New UMG/Carrier Group
- ( ) Request New UMG Primary Admin User for Existing UMG
- ( ) Update Contact Info for Existing UMG Primary Admin User

Desired User ID:

[✓] New Carrier

NOTE: Creating a new Carrier is not necessary if you are requesting a new UMG/Carrier Group in order to move an existing Carrier into it.

Applicant Information

Carrier Group Name: | Carrier Group Number (not NAIC Number):

First Name: | Last Name:

Address: | Address 2:

City: | State AK

ZIP:

Phone Number: | Ext.:

Email Address: | Fax Number:

Carrier Information

Carrier Name: | NCCI Number:

Address: | Address 2:

City: | State AK

ZIP:

Phone: | Ext.:

Fax:

Authorizing Officer

First Name: | Last Name:

Title: | Email Address:

Agreement

By submitting this form, you agree to abide by all Terms and Conditions (PDF download).

Submit Form

Submit

CDX®, BEEP® and PEEP® are registered marks of ACCCT

Home | Contact Us | CDX Security Overview | FAQ

Copyright© 2018 CDX®. All rights reserved.