Indemnity Data Call Implementation Guide

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CHANGE TRACKING GUIDE

LATEST PUBLICATION UPDATES *Issued 21 Nov 2018*

The Change Tracking Guide identifies each change to the ***Indemnity Data Call Implementation Guide*** since the last update. Changes are indicated by underlined text, and deleted sections are indicated by a ~~strikethrough~~ in the title, while deleted subsections are removed entirely. There may be underlined text in this manual from previous updates; please use the Change Tracking Guide to identify the most current updates.

- **Part** column—Lists the specific part of the manual that changed.
- **Section** column—Lists the specific section within the ***Indemnity Data Call Implementation Guide*** that changed.
- **Change** column—Summarizes the specific language that has been updated.
- **Reason** column—Provides a description for the change.

If applicable, please refer to the Reason column below for information on the effective date of a particular section.

Part	Section	Change	Reason
Global	Global	Updated verbiage from data submitter/carrier to data provider.	For clarity.
		Updated verbiage from key data elements to key fields.	For uniformity.
1	A—Overview	Updated verbiage to include reference to independent bureaus.	For completeness.
2	A—Scope and Effective Date	• Added numbering for subsection and reference to NCCI's ***Statistical Plan*** • Clarified the scope regarding medical claims and where claims were included in the Call • Deleted Claims Excluded From the Indemnity Data Call section	For ease of use and clarity.
	B—Applicable Jurisdictions	• Added Minnesota, North Carolina, and Wisconsin to Jurisdictions Applicable to the Indemnity Data Call table • Updated footnotes	For completeness and clarity.
	C—Participation/ Eligibility	• Added numbering for subsection • Moved Affiliate Group Participation • Updated Mergers and Acquisitions and added a note	For ease of use and clarity.
	D—Reporting Time Frames	• Added numbering for subsections • Updated table names	For ease of use.
	F—NCCI Setup Forms	Added Data Provider Profile Form and Service Provider Forms information.	To assist with data provider setup.

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Part	Section	Change	Reason
	G—Business Exclusion Option	• Added numbering for subsections and references to Part 11 • Updated the Business Exclusion Options and Premium Determination Methods, and added examples	For ease of use and clarity.
4	A—File Control Records	• Added numbering for subsections • Emphasized that the File Control Record must be the first record in the file • Updated how to submit File Control Records for Original File, File Replacement, and File Deletion	For completeness and ease of use.
	B—Transactional Records	• Added numbering for subsections and a Reporting Frequency subsection • Updated Reporting Triggers section and Option 1 and 2 verbiage and examples	For completeness and clarity.
	C—Quarterly Records	• Added numbering for subsections, a Reporting Frequency subsection, and an example of Deleting a Quarterly Record • Clarified Reporting Triggers	
5	C—Transactional Record Layout	Updated Transaction Identifier Class.	For accuracy.
6	A—Overview—Global	• Revised Data Dictionary references on how to report the data element if unknown • Updated example titles	For ease of use.
	A-4—Allocated Loss Adjustment Expense (ALAE) Paid	Added Oregon Exception.	For completeness.
	A-6—Benefit Offset Amount	Updated the Format information in table.	For accuracy.
	A-7—Benefit Offset Code	• Updated the Reporting Requirement • Clarified Reporting Example 1 • Added Reporting Example 2	For completeness.
	A-8—Benefit Type Code	• Clarified Additional Rules • Added Florida Exceptions	For accuracy.

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Part	Section	Change	Reason
	A-13—Claim Number Identifier	Updated the Reporting Requirement.	For clarity.
	A-15—Closing Date	Updated table and notes in the example.	For accuracy.
	A-16—Disability/Loss of Earnings Capacity Percentage	• Updated the Reporting Requirement • Added North Carolina and Wisconsin to the Jurisdiction table and revised the formatting	For accuracy and uniformity.
	A-19—Hire Date Change	Updated the Reporting Requirement.	For clarity
	A-20—Impairment Percentage	Updated the Format information in table.	For accuracy.
	A-22—Incurred Indemnity Amount	Added reference to Part 4 of the ***Statistical Plan Manual***.	For ease of use.
	A-23—Incurred Medical Amount		
	A-24—Indemnity Paid-To-Date		
	A-25—Jurisdiction State Code	• Enhanced the Reporting Requirement • Updated the Record Type in table and the Jurisdiction State Code Table name	For accuracy and completeness.
	A-28—Medical Extinguishment Indicator	Added a note on how to report.	For clarity.
	A-29—Medical Paid-To-Date	Added reference to Part 4 of the ***Statistical Plan Manual***.	For ease of use.
	A-30—Method of Determining Pre-Injury/Average Weekly Wage Code	• Updated the Format information in table and Coding Value description for Maximum Weekly Benefit • Deleted the word “illustrative” in reference	For clarity.
	A-34—Policy Number Identifier	Updated the Reporting Requirement.	
	A-36—Pre-Injury/ Average Weekly Wage Amount	• Moved verbiage regarding statutory compensation • Updated Example 2	For completeness.
	A-39—Reopen Date	Deleted the word “illustrative” in reference.	For uniformity.
	A-42—Reporting Year	Updated the Format information in table.	For accuracy.
	A-43—Submission Date		

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Part	Section	Change	Reason
	A-47—Temporary Disability Benefit Extinguishment Code	Updated the Reporting Requirement.	For completeness.
	A-49—Transaction Code		
	A-50—Transaction Date		For completeness and accuracy.
	A-51—Transaction From Date	Deleted the word “illustrative” in reference.	For uniformity.
	A-52—Transaction Identifier	• Updated the Definition and Reporting Requirement • Added examples	For completeness and accuracy.
	A-54—Type of Settlement—Loss Condition Code	Updated the Oregon Exception.	For uniformity.
	A-55—Weekly Benefit Amount	Updated the Reporting Requirement.	For completeness.
9	A—Editing Process	Updated name of test from Completeness test to Population test.	For clarity.
	B—Validating a Submission File	• Updated “completeness” to “population” • Changed verbiage from File Acceptance to Record Acceptance	
	C—Aggregate Record-Level Editing per File	Added data element categories and table.	For completeness.
11	A—Data Provider Profile Form	Added definition of the Indemnity Data Provider Profile Form.	
	B—Business Exclusion Request Form and Premium Determination Worksheets	• Updated title of section and the definition • Added Premium Determination Methods and Worksheets	
	C—Secure FTP Preinstallation Questionnaire	• Updated section title • Added a definition and a reference to the ***Electronic Transmission User’s Guide***	

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PART 1—INTRODUCTION

A. OVERVIEW

The *Indemnity Data Call Implementation Guide* is your source for reporting rules and requirements. The guide applies to data submitted to the National Council on Compensation Insurance (NCCI), Inc. for all applicable Indemnity Data Call jurisdictions (Refer to Part 2-B). Data providers are required to comply with the instructions and requirements contained in this guide in conjunction with NCCI's ***Statistical Plan*** or the statistical plan designated by the independent bureau.

One of NCCI's core activities is the analysis and evaluation of legislation impacting workers compensation system costs. NCCI collects the Indemnity Data Call to support legislative pricing and research related to indemnity benefits.

B. YOUR NCCI DATA TEAM

NCCI's Customer Service Center is available for any questions about the Indemnity Data Call program or for access to any data reporting resources.

Mail:	Customer Service Center National Council on Compensation Insurance, Inc. 901 Peninsula Corporate Circle Boca Raton, FL 33487-1362
Phone:	800-**NCCI**-123 (800-622-4123)
Web:	From **ncci.com**, click **Contact Us**, then click **Customer Service Center** to access our online form
Email:	data@ncci.com

The hours of operation are Monday–Friday (except holidays), 8:00 a.m.–8:00 p.m. ET.

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PART 2—GENERAL RULES

A. SCOPE AND EFFECTIVE DATE

All indemnity claim activities within an Indemnity Data Call jurisdiction state 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. Refer to **Applicable Jurisdictions** in this part of the guide.

The Call begins with indemnity claim activities occurring in Second Quarter 2020, to be reported to NCCI 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 NCCI as individual Transactional records, and summarized Paid-To-Date totals reported as Quarterly records. Indemnity payments (refer to NCCI'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

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 an applicable Call state or federal act (Jurisdiction State Code 59). Therefore, medical-only claims and claims where the jurisdiction state is not an applicable Call state are not included in the Indemnity Data Call. For a list of states where the Indemnity Data Call is applicable, refer to the **Applicable Jurisdictions** listed below.

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 NCCI's ***Statistical Plan***, Part 4—Loss and Expense Information, Item A.1.c (Fraudulent Claims) and Item A.1.d (Noncompensable Claims), are to be reported in the Indemnity Data Call.

B. APPLICABLE JURISDICTIONS

The Indemnity Data Call applies as follows:

Jurisdictions Applicable to the Indemnity Data Call

Alabama	Hawaii	Maryland	North Carolina*	Vermont
Alaska	Idaho	Minnesota*	Oklahoma	Virginia
Arizona	Illinois	Mississippi	Oregon	West Virginia
Arkansas	Indiana*	Missouri	Rhode Island	Wisconsin*
Colorado	Iowa	Montana	South Carolina	Federal Act (USL&HW Act, FELA, Jones Act, Admiralty Law, and Federal Mine Safety and Health Act)**
Connecticut	Kansas	Nebraska	South Dakota	
District of Columbia	Kentucky	Nevada	Tennesee	
Florida	Louisiana	New Hampshire	Texas	
Georgia	Maine	New Mexico	Utah	

* At the discretion of the independent bureau, this is an applicable Indemnity Data Call state. Report the Indemnity Data Call in conjunction with the designated statistical plan.

** For applicable jurisdictions only.

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C. PARTICIPATION/ELIGIBILITY

Participation will be limited to affiliate groups with at least 1% market share in any one applicable state over the most recent three years (overall average equals 1% or more). Once an affiliate group meets the eligibility criteria, the group will be required to report for all applicable jurisdictions in which it writes, even if an individual state's market share drops below the threshold. Refer to the **Applicable Jurisdictions** table above.

1. Reporting Responsibility

Affiliate Group Participation

When an affiliate group is included in the Indemnity Data Call, all companies that are aligned within that group are required to report.

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

- Submitting all their Call data directly to NCCI
- Authorizing their vendor business partners (such as third party administrators) to report the data directly to NCCI

Regardless of who submits the Call to NCCI, the data provider must report the standard record layout in its entirety with all data elements populated. Refer to Part 5—Record Layouts in this guide.

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

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. NCCI 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 currently 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 deems AB eligible

Note: Applies to NCCI states only. Questions regarding participation/eligibility of an independent bureau state should be addressed to the bureau.

D. REPORTING TIME FRAMES

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.

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1. 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.

2. 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. AVAILABLE MEDIA

Indemnity Data Call transactions are to be submitted electronically to NCCI through ***Data Transfer via the Internet***.

Before data providers can send Indemnity Data Call production files using ***Data Transfer via the Internet***, each submitter's electronic data submissions must pass certification testing. Refer to Part 7—Certification Process for certification testing information in this guide.

The following is the communication configuration for ***Data Transfer via the Internet:***

Communication Configuration:

- Internet connection (HTTP, FTPS, and SFTP)
- Data encryption uses SSL 3.2 (Secure Sockets Layer) 128-bit standard

Software and Browser:

- Microsoft Internet Explorer 11.0 or Google Chrome with the most recent Service Pack applied

F. NCCI SETUP FORMS

1. Data Provider Profile Form—Indemnity Data Call

The Data Provider Profile Form is used for a carrier to request user access to submit data files electronically for the Indemnity Data Call.

This form identifies the carrier codes and specific users that will submit data files and must be completed by the carrier. If a third party administrator (TPA) or other vendor (also known as a service provider) is reporting on a carrier's behalf, the Service Provider Attachment and Service Provider Data Tool Addendum are also required. Refer to **Service Provider Forms** below for details.

View and update the Data Provider Profile Form, and email the form as an attachment to data@ncci.com.

Complete the following form sections:

- Requestor's Information

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- Request Type
- Carrier Information
- Reporting Company Information
- Reporting Company User Information

For additional information, refer to Part 11—Forms of this guide.

2. Service Provider Forms

If a service provider is used to report data on a carrier's behalf, the following forms must also be completed:

- Service Provider Attachment—authorizes the TPA or other vendors to report data on the carrier's behalf
- Service Provider Data Tool Addendum—grants the TPA or other vendors access to the carrier's data via NCCI's online data reporting tools and identifies the level of access

These forms are part of the carrier's affiliation agreement. To access the Service Provider Attachment and Service Provider Data Tool Addendum, contact Customer Service.

The service providers must be identified on the Data Provider Profile Form to submit data. After NCCI receives all completed forms, the user ID and password information will be sent directly to the service provider.

G. BUSINESS EXCLUSION OPTION

It is expected that 100% of indemnity claims data in applicable jurisdictions will be reported in the Indemnity Data Call. NCCI does recognize that in certain limited circumstances, it may be difficult, if not impossible, for participants (affiliate groups) to comply with reporting 100% of the expected claims data.

Accordingly, an affiliate group participating in the Call may exclude data for claims that represent up to 15% of gross premium (direct premium gross of deductibles) for all states combined from its reporting requirement. This option may be utilized for small subsidiaries and/or business segments (e.g., coverage providers, branches, and 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 NCCI for acceptance. Refer to the **Requests for Business Exclusion** section below.

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

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

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

An affiliate 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 affiliate group may request to exclude the TPA's transactions from Call reporting.

1. Requests for Business Exclusion

Participants in the Call are required to submit their basis for exclusion to NCCI for review. The requests can be submitted to NCCI's Customer Service Center beginning 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.

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Refer to Part 11—Forms in this guide for premium determination worksheets and submission instructions. The Business Exclusion Request Form is available and downloadable/fillable on **ncci.com**.

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 (refer to Part 2-B—General Rules—Applicable Jurisdictions of this guide). Below are four methods for estimating the proportion of business excluded; any of these four are acceptable to NCCI.

Some methods use the NAIC Direct Premium, which is reported in the Exhibit of Premiums and Losses (Statutory Page 14) in the NAIC Annual Statement. This premium can be either 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 NCCI 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).

Premium Determination—Method 1

Participants may use the Calendar Year Direct Written Premium most recently reported to the National Association of Insurance Commissioners (NAIC) to determine whether the gross premium associated with the business segment(s) intended for exclusion does not exceed 15% of gross premium in applicable jurisdictions. Applicable jurisdictions are the state(s) for which a carrier is required to submit indemnity claim activities related to the Call (refer to the **Applicable Jurisdictions** section in this part of the guide).

The information to be submitted to NCCI 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).

Example: Premium determination

A participant needs to exclude business for two small subsidiaries. Subsidiary #1 does business in GA, FL, and IL, and Subsidiary #2 does business in IL. The affiliate group only wants to exclude GA and IL transactions. The participant determines the exclusion on January 1, 2020.

Column A Entities for Proposed Exclusion	Column B State	Column C Entities' Calendar Year Written Premium 2018—State	Column D Affiliate Group Calendar Year Written Premium 2018—State	Column E Entities' Written Premium as Percentage of Affiliate Group 2018—State
Subsidiary #1	IL	$1,000,000	n/a	
Subsidiary #2	IL	2,000,000	n/a	
Subtotal	IL	3,000,000	$ 50,000,000	6.0%
Subsidiary #1	GA	500,000	7,500,000	6.7%
	All Others	n/a	300,000,000	n/a
TOTAL		**$3,500,000**	**$357,500,000**	**1.0%**

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

1. Determine the 2018 Calendar Year Direct Premiums Written by state—the participant finds this information on Schedule T of its 2018 NAIC Annual Statement. This information is entered in Column D.
2. Based on premium data that it maintains, the affiliate group determines the Calendar Year Direct Premiums Written by state for each subsidiary. It enters the information in Column C.

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3. Sum the data in Columns C and D to get the premium proposed to be excluded and the total premium for the affiliate group.
4. Calculate percentages for Column E (equals Column C divided by Column D).
5. Compare the Total line percentage to the 15% requirement. In this case, the proposed exclusions are less than 15%, so they are allowable.

Refer to Part 11 of this guide for the Premium Verification Worksheet and Instructions—Method 1.

Method 2—Affiliate 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 the states where the Indemnity Data Call applies (refer to Part 2-B—General Rules—Applicable Jurisdictions of this guide). Use this net ratio to look up the gross ratio using the **Large Deductible Net to Gross Ratio** table. 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%

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Net Ratio	Gross Ratio
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%

Premium Determination—Method 2

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

- Total Direct Premium in the states where the Indemnity Data Call applies is $1,000,000
- Large Deductible Direct Premium to be excluded in the states where the Indemnity Data Call applies is $20,000
- Non-Large Deductible Direct Premium to be excluded in the states where the Indemnity Data Call applies 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 Part 11 of this guide for Premium Verification Worksheet and Instructions—Method 2.

Method 3—This is another option for affiliate groups with Large Deductible Direct Premium greater than 0.3% of their total premium (NAIC Direct Premiums).

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 the states where the Indemnity Data Call applies is $1,000,000

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- Large Deductible Direct Premium for the states where the Indemnity Data Call applies is $300,000
- Large Deductible Direct Premium to be excluded for the states where the Indemnity Data Call applies is $20,000
- Non-Large Deductible Direct Premium to be excluded for the states where the Indemnity Data Call applies 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 affiliate 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 Part 11 of this guide for Premium Verification Worksheet and Instructions—Method 3.

Method 4—Use 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 the states where the Indemnity Data Call applies (refer to Part 2-B—General Rules—Applicable Jurisdictions of this guide).

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.

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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 the states where the Indemnity Data Call applies (refer to Part 2-B—General Rules—Applicable Jurisdictions of this guide) for each subsidiary to be excluded and 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 in the states where the Indemnity Data Call applies (refer to Part 2-B—General Rules—Applicable Jurisdictions of this guide). 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 Part 11 of this guide for Premium Verification Worksheet and Instructions—Method 4.

3. Other Premium Determination Methods

Contact NCCI's Customer Service Center 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 because the participant has written a significant number of large deductible policies).

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PART 3—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 Part 5—Record Layouts and in Part 6—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 Part 5—Record Layouts and in Part 6—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 30 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 Part 5—Record Layouts and in Part 6—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 Part 4—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 NCCI to use data elements 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.

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PART 4—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 must be the first record in 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 Part 5-B—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	9999022020TRANS
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 Part 5–B—Record Layouts—File Control Record Layout 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 file 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

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Field No.	Field Title/Description	Reported As
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	

3. File Control Record for File Deletion

To delete an entire file and all of its records from NCCI'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 Part 5—Record Layouts and Part 6—Data Dictionary of this guide.

1. Reporting Frequency

As stated in Part 2-D, Transactional records are due to NCCI 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 chose 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

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that occur in June are reported in the second quarter submission that is due to NCCI by September 30 of the reporting year. For details, refer to Part 2-D—General Rules—Reporting Time Frames 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 a claimant in error
- Transactional records submitted to NCCI in error
- Transactional records with incorrect codes reported to NCCI
- 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)

NCCI 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 NCCI 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 NCCI (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.

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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	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 should be as they were reported on the original claim (especially the Transaction Identifier).

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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 should be as they were reported on the original claim (especially the Transaction Identifier).

Scenario	(1) Rec Type Code	(2) Trans Code	(3) Trans Date	(4) Transaction Identifer	(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 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 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.

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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 nonprocessing and non-key fields can be blank or zero-filled.												

b. 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 NCCI 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 NCCI 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 previous 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 NCCI (A) and later voided in the data provider's payment system. For NCCI 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).

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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	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 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 nonprocessing 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).

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- 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)

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- 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 data provider 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 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 Part 3—Indemnity Data Call Structure and Part 6—Data Dictionary of this guide.

1. Reporting Frequency

As stated in Part 2-D, Quarterly records are due to NCCI 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 NCCI'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

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- Incurred Indemnity Amount
- Indemnity 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 NCCI 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.

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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) Indemnity Paid-To-Date	(34) Incurred Indemnity Amount	(35) Incurred Medical Amount
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

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PART 5—RECORD LAYOUTS

A. OVERVIEW

For NCCI 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 quick 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 part of the guide.

B. FILE CONTROL RECORD LAYOUT

Field No.	Field Title	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	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 Fields (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

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Field No.	Field Title	Class	Position	Bytes
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	Class	Position	Bytes
Processing Data Element (Fields 1–2)				
1	Record Type Code	N	1–2	2
2	Transaction Date	N	3–10	8
Key Fields (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

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Field No.	Field Title	Class	Position	Bytes
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

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PART 6—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 Part 4—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 Date 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

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 month, day, and year on which the injury occurred.

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.

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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(s)	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.

The Accident State does not have to be one of the states included in the list of applicable Indemnity Data Call jurisdictions contained in Part 2—General Rules of this guide.

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 Island	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

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State and Province Code Table (Cont'd)

State or Province	Code	State or Province	Code	State or Province	Code
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		

Zero-fill if unknown.

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.

Coding Values

Code	Act	Description	Additional Rules and/or Exceptions (If Applicable)
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	

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Code	Act	Description	Additional Rules and/or Exceptions (If Applicable)
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	
05	Oil, Gas, and Other Mineral Operations On or Over Water	A claim with benefits determined according to the state workers compensation law, excluding the United States Longshore and Harbor Workers' Compensation Act and the Federal Mine Safety and Health Act	Applicable in Texas only, effective 06/01/2014
08	USL&HW Act for Oil, Gas, or Other Mineral Operations On or Over Water	A claim with benefits determined according to the United States Longshore and Harbor Workers' Compensation Act or extension of the USL&HW Act	Applicable in Texas only, effective 06/01/2014

Zero-fill if unknown.

4. Allocated Loss Adjustment Expense (ALAE) Paid

Record Type	Quarterly
Field(s)	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 list provided in NCCI's ***Statistical Plan Manual***, Part 4—Loss and Expense Information, Item D.1.a (ALAE Paid Amount).

The reporting must be consistent with the reporting of ALAE for this same claim for Unit Statistical data.

Oregon Exception: The reporting of ALAE is optional in Oregon.

5. Attorney or Authorized Representative Indicator

Record Type	Quarterly
Field(s)	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.

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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.

Coding Values

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

Leave blank if unknown.

6. Benefit Offset Amount

Record Type	Transactional
Field(s)	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 the **Benefit Offset Code** section below for an example.

7. Benefit Offset Code

Record Type	Transactional
Field(s)	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 has 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.

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Coding Values

Code	Description
1	None
2	SSDI
3	Other

Zero-fill if unknown.

Example 1: Reporting a Benefit Offset for SSDI (weekly basis)

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

Example 2: Reporting a Benefit Offset for SSDI (bi-weekly basis)

An injured worker is awarded statutory workers compensation indemnity benefits of $500 per week, payable on a bi-weekly basis. 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 bi-weekly period:

- Transaction Amount ([$500 x 2] – [$200 x 2] = $600) = 000000060000
- Weekly Benefit Amount ($500 – $200 = $300) = 000030000
- Benefit Offset Amount ($200 x 2 = $400) = 00000040000
- Benefit Offset Code = 2

8. Benefit Type Code

Record Type	Transactional
Field(s)	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.

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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 in the applicable jurisdiction.	GA—Defined as Catastrophic Injury Benefits TX—Defined as Lifetime Income Benefits
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.	AK, KY, MN, MT, OR, TN (accidents occurring on or after 7/1/2014), and VT—Not applicable FL—Defined as Impairment Income Benefits NH—Defined as Permanent Impairment Awards TX—Defined as Supplemental Income Benefits
04	**Unscheduled Permanent Partial Disability Benefits**—The transactional amount of indemnity permanent partial disability benefits paid for injuries to parts of the body not specifically listed in a statutory schedule.	FL—Not applicable NH—Defined as Compensation for Permanent Partial Disability TX—Defined as Impairment Income Benefits
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 in the applicable jurisdiction.	TX—Defined as Temporary Income Benefits/Temporary Total Benefits
09	**Disfigurement Benefits**—The transactional amount of indemnity benefits paid for any scarring or cosmetic defect as defined by statute in the applicable jurisdiction.	AK, FL, GA, ID, KS, KY, ME, MI, MN, NE, NJ, NV, OR, TX, UT, VT, and WV—Not applicable
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 in the applicable jurisdiction.	KY and LA—Not applicable TX—Defined as Temporary Income Benefits/Temporary Partial Benefits
12	**Employers Liability**—The transactional amount of all indemnity benefits and expense (ALAE) paid under the Employers Liability portion of the Workers Compensation policy.	
15	**Supplemental Benefits**—The transactional amount of wage-loss benefits, usually based on the difference between pre-injury wage and post-injury wage. Supplemental benefits are defined by statute in the applicable jurisdiction.	LA and SD—Only applicable in these states

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Code	Description	Additional Rules and/or Exceptions (If Applicable)
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). FL—This field must always be reported when claimant legal expenses are paid by the employer or insurer, regardless of whether a separate payment is made.
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, as defined in NCCI's ***Statistical Plan***.	
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.	CT, FL, LA, and RI—Only applicable in these states CT—Defined as Discretionary Benefits FL—Defined as PTD Supplemental Benefits LA and RI—Defined as Additional 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.	FL—Defined as Reemployment Assessment costs
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. FL—Defined as Reemployment Services
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).

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Code	Description	Additional Rules and/or Exceptions (If Applicable)
63	**Vocational Rehabilitation—Payment NOC**—Transactional amount paid for vocational rehabilitation services that is not classified as either evaluation, educational, or maintenance costs.	FL—Includes Medical Care Coordination 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 NCCI.	It is expected that this benefit type will be used infrequently.

Zero-fill if unknown.

9. Birth Year

Record Type	Quarterly
Field(s)	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(s)	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 five-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(s)	3
Position(s)	4–8
Class	Numeric (N)—Field contains only numeric characters

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Bytes	5
Format	N 5

Definition: The Carrier Group Code assigned to the carrier by NCCI.

Reporting Requirement: Report the NCCI 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(s)	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.

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	

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Cause of Injury	Code	Specific Cause of Injury	Description (If Applicable)
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	

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Cause of Injury	Code	Specific Cause of Injury	Description (If Applicable)
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	

Zero-fill if unknown.

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13. Claim Number Identifier

Record Type	Quarterly and Transactional (Key)
Field(s)	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 have 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 (and prior) 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(s)	9
Position(s)	64
Class	Numeric (N)—Field contains only numeric characters
Bytes	1
Format	N1

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).

Coding Values

Code	Description
1	Male
2	Female
3	Other

Zero-fill if unknown.

15. Closing Date

Record Type	Quarterly
Field(s)	13
Position(s)	78–85
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD

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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. NCCI 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 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 Data 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 example below illustrates how claim status will be derived using the Closing Date field. Refer to 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

Record Type	Quarterly
Field(s)	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 listed in the table below. 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

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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.

Disability/LOEC Percentage Applies in the Following Jurisdictions:

Alabama	Hawaii	Maine	New Hampshire	South Carolina
Arizona	Idaho	Maryland	New Mexico	South Dakota
Arkansas	Illinois	Mississippi	North Carolina	Tennessee
Colorado	Iowa	Missouri	Oklahoma	Virginia
Connecticut	Kansas	Montana	Oregon	Wisconsin
District of Columbia	Kentucky	Nebraska	Rhode Island	Federal Act (USL&HW Act, FELA, Jones Act, Admiralty Law, and Federal Mine Safety and Health Act)

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% (for details on how to convert multiple impairment ratings to a whole-body basis, refer to the example provided in the **Impairment Percentage Basis Code** section). 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(s)	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

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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(s)	12
Position(s)	77
Class	Alphanumeric (AN)—Field contains alphabetic and 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.

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

Leave blank if unknown.

Example 1: Reporting employment status when multiple employment statuses 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).

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Example 2: Reporting employment status when multiple employment statuses 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(s)	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.

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.

Zero-fill if both the hire date and the hire year are not available.

20. Impairment Percentage

Record Type	Quarterly
Field(s)	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:

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- 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. Refer to Example 3 in the **Impairment Percentage Basis Code** section below for an example.

21. Impairment Percentage Basis Code

Record Type	Quarterly
Field(s)	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.

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 whether the impairment percentage was reported based on the whole body or part of body. This field must be completed when an impairment percentage is reported in the Impairment Percentage field. With a single impairment, the data provider can choose either whole body or part of body for the basis code. Multiple impairments must be reported based on a whole-body basis.

Coding Values

Code	Description
1	Impairment percentage based on the whole body
2	Impairment percentage based on part of body

Zero-fill if not applicable.

Example 1: Reporting Impairment Percentage based on the whole body (single impairment)

An injured worker has an impairment rating of 30% to the arm based on part of body. If benefits for the injured worker are based on the whole-body impairment and the arm is considered 60% of the whole body, multiply the impairment rating for the arm (30%) by the whole-body percentage (60%) for an impairment percentage of 18% (30% x 60% = 18%). The resulting quarterly fields would be:

- Impairment Percentage = 018
- Impairment Percentage Basis Code = 1 (impairment percentage based on the whole body)
- Part of Body Code = 31 (Arm)

Example 2: Reporting Impairment Percentage based on part of body (single impairment)

An injured worker has an impairment rating of 30% to the arm based on part of body. If benefits for the injured worker are based on the part of body, the resulting quarterly fields would be:

- Impairment Percentage = 030

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

Example 3: Reporting Impairment Percentage based on the whole body (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. If the arm is considered 60% of the whole body, multiply the impairment rating for the arm (50%) by the whole-body percentage (60%) as 0.5 × 0.6 = 0.3. If the leg is considered 40% of the whole body, multiply the impairment rating for the leg (20%) by the whole-body percentage (40%) as 0.2 × 0.4 = 0.08. Now that the impairment ratings are converted to whole-body percentages, they are added together for an impairment percentage of 38% (30% + 8% = 38%). 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)

Multiple impairment ratings are converted to a whole-body rating and reported as "1" in this field. For instructions on converting multiple impairment ratings to a whole-body rating, refer to the example in the **Impairment Percentage** section.

22. Incurred Indemnity Amount

Record Type	Quarterly
Field(s)	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 NCCI's ***Statistical Plan Manual***, Part 4—Loss and Expense Information, Section A—General Incurred Loss Information and Section C—Indemnity Losses.

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 Part 4, Items A-1-a and A-1-b of NCCI's ***Statistical Plan Manual*** for information on allocating subrogation recoveries and special fund reimbursements between indemnity and medical.

Incurred Indemnity Excludes:

- Legal expenses incurred for the benefit of the carrier
- ALAE, excluding Employers Liability ALAE

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- 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(s)	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 NCCI's ***Statistical Plan Manual***, Part 4—Loss and Expense Information, Section A—General Incurred Loss Information and Section B—Medical Losses.

Reporting Requirement: Report the total of the 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 Part 4, Items A-1-a and A-1-b of NCCI's ***Statistical Plan Manual***, for information on allocating subrogation recoveries and special fund reimbursements 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(s)	31

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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 NCCI's ***Statistical Plan Manual***, Part 4—Loss and Expense Information, Section C—Indemnity Losses.

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
- 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 Part 4, Items A-1-a and A-1-b of NCCI's ***Statistical Plan Manual*** for information on allocating subrogation recoveries and special fund reimbursements 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
Field(s)	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 workers compensation law, employers liability law, or the federal law under which the claimant's benefits are being paid. 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.

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In the event that, after reporting one or more Transactional or Quarterly records to NCCI, 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.

Coding Values

Jurisdiction State Code Table

State	Code	State	Code	State	Code
Alabama	01	Kentucky	16	Ohio	34
Alaska	54	Louisiana	17	Oklahoma	35
Arizona	02	Maine	18	Oregon	36
Arkansas	03	Maryland	19	Pennsylvania	37
California	04	Massachusetts	20	Puerto Rico	58
Colorado	05	Michigan	21	Rhode Island	38
Connecticut	06	Minnesota	22	South Carolina	39
Delaware	07	Mississippi	23	South Dakota	40
District of Columbia	08	Missouri	24	Tennessee	41
Florida	09	Montana	25	Texas	42
Foreign Territories (NOC—Not Otherwise Classified)	80	Nebraska	26	Utah	43
Georgia	10	Nevada	27	Vermont	44
Hawaii	52	New Hampshire	28	Virginia	45
Idaho	11	New Jersey	29	Washington	46
Illinois	12	New Mexico	30	West Virginia	47
Indiana	13	New York	31	Wisconsin	48
Iowa	14	North Carolina	32	Wyoming	49
Kansas	15	North Dakota	33	Federal Act (USL&HW Act, FELA, Jones Act, Admiralty Law, and Federal Mine Safety and Health Act)	59

26. Lump-Sum Indicator

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

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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

Leave blank if unknown.

Refer to the **Transaction To Date** section for an illustrative example of reporting Transaction To and From Dates for lump-sum payments.

27. Maximum Medical Improvement (MMI) Date

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.

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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.

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

Leave blank if unknown or not applicable.

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.

Example: Reporting a Medical Extinguishment Indicator when medical payments are extinguished by a lump-sum settlement and subsequently reinstated

An injured worker receives a permanent impairment rating, and the claim is settled by a full and final lump-sum agreement. This settlement includes the permanent impairment award and all expected future medical costs. Subsequently, the injured worker's condition unexpectedly deteriorates and requires additional medical treatment. Regardless of whether the insurer makes additional payments for medical care after the settlement agreement, the Medical Extinguishment Indicator code should be set to "Y" because the lump-sum settlement included all further medical payments that the insurer reasonably expected.

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 amount 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 NCCI's ***Statistical Plan Manual***, Part 4—Loss and Expense Information, Section B—Medical Losses.

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

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- 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 Part 4, Items A-1-a and A-1-b of NCCI's ***Statistical Plan Manual*** for information on allocating subrogation recoveries and special fund reimbursements 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.

Coding Values

Code	Method	Description
1	**Actual Wage**	When the claimant's 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 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.

Zero-fill if unknown.

Refer to the **Pre-Injury/Average Weekly Wage Amount** section for examples.

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

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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.

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

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Nature of Injury	Code	Specific Nature of Injury	Description (If Applicable)
	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	

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Nature of Injury	Code	Specific Nature of Injury	Description (If Applicable)
Occupational Disease or Cumulative Injury	60	Dust Disease, NOC	All Other Pneumoconiosis
	61	Asbestosis	Lung Disease, a form of Pneumoconiosis, resulting from Protracted Inhalation of Asbestos Particles
	62	Black Lung	The Chronic Lung Disease or Pneumoconiosis found in Coal Miners
	63	Byssinosis	Pneumoconiosis of Cotton, Flax, and Hemp Workers
	64	Silicosis	Pneumoconiosis resulting from Inhalation of Silica (Quartz) Dust
	65	Respiratory Disorders	Gases, Fumes, Chemicals, etc.
	66	Poisoning—Chemical (Other Than Metals)	Man-Made or Organic
	67	Poisoning—Metal	Man-Made
	68	Dermatitis	Rash, Skin, or Tissue Inflammation including Boils, etc., generally resulting from direct contact with Irritants or Sensitizing Chemicals such as Drugs, Oils, Biologic Agents, Plants, Woods, or Metals, which may be in the form of Solids, Pastes, Liquids, or Vapors and which may be contacted in the Pure State, or in Compounds, or in Combination with Other Materials; does NOT include Skin Tissue Damage resulting from Corrosive Action of Chemicals, Burns from Contact with Hot Substances, Effects of Exposure to Radiation, Effects of Exposure to Low Temperatures, or Inflammation or Irritation resulting from Friction or Impact
	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	All Other Occupational Disease Injury, NOC	
	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	

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Nature of Injury	Code	Specific Nature of Injury	Description (If Applicable)
	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	

Zero-fill if unknown.

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.

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

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Part of Body Region	Code	Specific Part of Body	Description (If Applicable)
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)	
Trunk	40	Multiple Trunk	Any combination of below parts
	41	Upper Back Area	(Thoracic Area) Upper Back Muscles, excluding Vertebrae, Disc, and Spinal Cord
	42	Lower Back Area	(Lumbar Area and Lumbo Sacral) Lower Back Muscles, excluding Sacrum, Coccyx, Pelvis, Vertebrae, Disc, and Spinal Cord
	43	Disc	Spinal Column Cartilage other than Cervical Segment
	44	Chest	Including Ribs, Sternum, Soft Tissue
	45	Sacrum and Coccyx	Final Nine Vertebrae—Fused
	46	Pelvis	
	47	Spinal Cord	Nerve Tissue other than Cervical Segment
	48	Internal Organs	Other than Heart and Lungs
	49	Heart	
	60	Lungs	
	61	Abdomen	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

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Part of Body Region	Code	Specific Part of Body	Description (If Applicable)
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	

Zero-fill if unknown.

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.

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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

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 (refer to the **Impairment Percentage Basis Code** section for details on how to convert a part-of-body rating to 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

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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.

For jurisdictions where the compensation is statutorily determined on a monthly basis (e.g., AZ and NV), the monthly benefit amount must be converted to a weekly amount by dividing the monthly benefit amount by 4.35 for the reporting of this data element.

Zero-fill if unknown.

This field should be reported in conjunction with the Method of Determining Pre-Injury/Average Weekly Wage Code.

Example 1: Reporting the Pre-Injury/Average Weekly Wage when actual wages are known

An executive officer sustains a compensable workplace injury. The annual wage of the executive officer is $300,000. Per the statutes in the applicable jurisdiction, this is converted to a weekly wage by multiplying $300,000 by (1/52) which results in a weekly wage of $5,769. The resulting quarterly fields would be reported as follows:

- Pre-Injury/Average Weekly Wage Amount = 05769
- Method of Determining Pre-Injury/Average Weekly Wage = 1 (Actual Wage)

  Note: Even if weekly benefits are limited by the statutory maximum weekly benefit, the actual wages should be reported if known.

Example 2: Reporting the Pre-Injury/Average Weekly Wage when actual wages are unknown

An executive officer sustains a compensable workplace injury. The average weekly wage of the executive officer is unknown but it is assumed to exceed the wage required for the maximum weekly benefit. If the rate of compensation is 66 2/3% of the injured worker's pre-injury average weekly wage, limited to a statutory maximum weekly benefit of $800, then the resulting quarterly fields would be reported as follows:

- Pre-Injury/Average Weekly Wage Amount = 01200 ($800 / 66 2/3% = $1,200)
- Method of Determining Pre-Injury/Average Weekly Wage = 3 (Maximum Weekly Benefit)

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.

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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—Data field is to be right-justified and left zero-filled

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

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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.

Coding Values

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

Note: Only one quarter's worth of records can be submitted per file.

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

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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	30
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

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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.

Coding Values

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

Zero-fill if unknown.

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).

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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).

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

Field is to be right-justified and left zero-filled.

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)

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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.

Refer to the **Transaction To Date** section below for an example.

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 Cancellation and Replacement records.

  The Transaction Identifier must be unique for each transaction for a claim.

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- 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 NCCI to correctly process the changes to previously reported transactions. The Transaction Identifier must be left blank for this option.

Refer to Part 4—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.

Example 1: Reporting Transaction To and From Dates for a lump-sum payment

An injured worker reaches maximum medical improvement (MMI) and receives a permanent impairment rating on March 30, 2020. The insurer makes a lump-sum payment of $54,600 on April 1, 2020, to settle the claim.

If the lump-sum payment is based on 104 weeks for which benefits are payable post-MMI (i.e., the time period from March 30, 2020, to March 30, 2022), then the resulting transactional fields would be reported as follows:

- Lump-Sum Indicator = Y
- Transaction Amount = 00005460000
- Transaction Date = 20200401
- Transaction From Date = 20200330
- Transaction To Date = 20220330

If the lump-sum payment is not based on a specific number of weeks for which benefits are payable, then the Transaction From Date and the Transaction To Date should have the same value as the Transaction Date (i.e., the date that the lump-sum payment was made).

Example 2: Reporting Transaction To and From Dates for vocational rehabilitation—education benefit costs

An injured worker, who is participating in a vocational rehabilitation program, attends a six-week job retraining course January 6, 2020, to February 18, 2020. The cost of this course, including tuition, books, and tools, is $5,000. The insurer pays for the cost of this rehabilitation program up-front on January 1, 2020. The resulting transactional fields would be reported as follows:

- Benefit Type Code = 61 (Vocational Rehabilitation—Education Benefit Costs)

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- Transaction Amount = 000000500000
- Transaction Date = 20200101
- Transaction From Date = 20200106
- Transaction To Date= 20200218

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.

Oregon Exception: The reporting of the Type of Settlement is required in Oregon for policies effective January 1, 2013, and subsequent.

Coding Values

Code	Type of Settlement	Description	Additional Rules and/or Exceptions (If Applicable)
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.	Not applicable in Texas
04	Findings and Award (Judicial Award)	An award that has been issued by a judge based on evidence presented in the process of litigation.	Not applicable in Texas
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.	Not applicable in Texas
07	No Safety Devices	A type of liability resulting from the employer's failure to provide safety devices as required by the New Mexico Workers' Compensation Act.	Applicable in New Mexico only
08	Exemplary Damages	Exemplary damages means any damages awarded as a penalty or by way of punishment, but not for compensatory purposes. Exemplary damages are neither economic nor noneconomic damages. "Exemplary damages" includes punitive damages.	Applicable in Texas only

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Code	Type of Settlement	Description	Additional Rules and/or Exceptions (If Applicable)
09	All Other Settlements	The claim involves a settlement other than Codes 03–08 and 10.	Not applicable in Texas
10	Aggravation of Prior Work-Related Injuries	The claim is eligible for exclusion from experience rating under Maine Rule 450.	Applicable in Maine only

Zero-fill if unknown.

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.

Example: Reporting the Weekly Benefit Amount for part-time employment

A part-time employee sustains an injury due to a work-related accident. Based on the applicable state statutes, the pre-injury/average weekly wage for part-time work is computed as the average daily wage ($75.00 per day) times the average number of days worked per week (3) which results in a pre-injury/average weekly wage of $225 ($75.00 x 3 = $225). The weekly rate of compensation for temporary total disability benefits for this employee in this jurisdiction is $150 ($225 x 66 2/3% = $150), which is not limited by the state minimum or maximum weekly benefit. The resulting transactional fields would be reported as follows:

- Benefit Type Code = 05 (Temporary Total Disability Benefits)
- Employment Status Code = 2 (Part-Time)
- Pre-Injury/Average Weekly Wage Amount = 00225
- Method of Determining Pre-Injury/Average Weekly Wage Amount = 1 (Actual Wage)
- Weekly Benefit Amount = 000015000

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PART 7—CERTIFICATION PROCESS

A. OVERVIEW

The certification process includes the testing of Indemnity Data Call, file structure, and connections before initially submitting data files to production. The Certification Process is divided into three parts:

- Setup
- Testing
- Approval

B. SETUP

The first step in the setup process is the completion and receipt of the Data Provider Profile form. This form will be available on **ncci.com** in future updates to the Indemnity Data Call section.

After all the necessary forms are received by NCCI, a representative will contact the requester and the Indemnity Data Call provider (if different from requester) to:

- Confirm that the information provided on the form is accurate and complete.
- Establish testing contact(s).
- Review expectations for testing. This allows the opportunity for the Indemnity Data Call provider to go over any preliminary questions.
- Verify that the customer is set up with all necessary resources for reporting Indemnity Data Call.
- Provide access to ***Data Transfer via the Internet (DTVI)*** to submit a certification file.

C. TESTING

Certification Testing is comprised of:

- Creation of a Test File—Components for creating an Indemnity Data Call test file
- Parameters—Requirements for sequence and frequency of submission
- File Acceptance—Upfront checks for file acceptance or rejection
- Quality—NCCI edits that check the quality of data

After submission of the test data, NCCI will review each file and provide feedback.

The tester should notify NCCI, in advance, of the date and approximate time when files will be transmitted.

D. APPROVAL

After the test submission is approved, NCCI will grant access to submit in production and will notify the Indemnity Data Call provider of this approval via email.

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PART 8—FILE SUBMISSION REQUIREMENTS

A. OVERVIEW

Upon submission of a production file, NCCI's process includes a series of editing stages to ensure acceptance of the file and the quality of the data. As the file passes through each of these stages, confirmations and notifications will be sent to help manage submissions.

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.

For each data type, there is a proper file naming convention that must be used for the file to be accepted into NCCI's database. If the file name is incorrect, the file will be rejected.

B. FILE NAMING CONVENTION

Indemnity Data Call file naming convention:

Record Type	File Name	File Name Description
Transactional	IDCTRANS*.TXT	• Prefix = "idctrans*" • (*) = Up to 30 additional characters (no spaces) can be included • Extension = ".txt" • Valid characters include 0 through 9, A through Z, - (dash), _ (underscore), or . (period) • No special characters, e.g., ampersand (&) or comma (,) Example: idctrans1052020.txt
Quarterly	IDCQTRLY*.TXT	• Prefix = "idcqtrly*" • (*) = Up to 30 additional characters (no spaces) can be included • Extension = ".txt" • Valid characters include 0 through 9, A through Z, - (dash), _ (underscore), or . (period) • No special characters, e.g., ampersand (&) or comma (,) Example: idcqtrly1052020.txt

- Data must not contain binary zeros [NULL]
- The number of records must match the File Control Record
- An email notification is sent to confirm acceptance or rejection
- A Rejected Records file is sent to provide any rejected Indemnity Data Call transactions that were submitted to NCCI
- A copy of the original file will be stored in the ***DTVI*** mailbox for eight calendar days

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PART 9—EDITING PROCEDURES

A. EDITING PROCESS

NCCI'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:

- Population test (e.g., Are the data elements appropriately reported?)
- Validity test (e.g., Are the data elements populated with valid values?)
- Reasonableness test (e.g., Is the distribution of data elements reasonable?)

These tests will be performed on each data element and across Call elements where needed.

Editing processes and procedures will be detailed in subsequent updates to the *Indemnity Data Call Implementation Guide*.

B. VALIDATING A SUBMISSION FILE

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 population 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 NCCI'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 NCCI'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:

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- 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 Title	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	Y
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	Y
Quarterly	Impairment Percentage	C	Y
Quarterly	Impairment Percentage Basis Code	C	Y
Quarterly	Maximum Medical Improvement (MMI) Date	C	Y
Quarterly	Temporary Disability Benefit Extinguishment Code	C	Y
Quarterly	Type of Settlement—Loss Condition Code	C	Y

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Record	Field Title	Category	Conditional**
Transactional	Transaction From Date	C	Y
Transactional	Transaction To Date	C	Y
Quarterly	Accident State Code	P	
Quarterly	Birth Year	P	
Quarterly	Method of Determining Pre-Injury/ Average Weekly	P	
Transactional	Weekly Benefit Amount	P	
Quarterly	Allocated Loss Adjustment Expense (ALAE) Paid	P	Y
Quarterly	Employer Legal Amount Paid	P	Y
Quarterly	Medical Extinguishment Indicator	P	Y
Quarterly	Pre-existing Disability Percentage	P	Y
Transactional	Benefit Offset Amount	P	Y
Transactional	Benefit Offset Code	P	Y
Quarterly	Claimant Gender Code	S	
Quarterly	Employment Status Code	S	
Quarterly	Hire Date	S	
Quarterly	Reported to Insurer Date	S	
Quarterly	Closing Date	S	Y
Quarterly	Reopen Date	S	Y

** 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 Part 3—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.

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PART 10—DATA QUALITY

A. OVERVIEW

Data Quality processes and procedures will be detailed in a subsequent update to this guide.

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PART 11—FORMS

All forms listed below are available and downloadable/fillable on **ncci.com**.

A. DATA PROVIDER PROFILE FORM

The Indemnity Data Provider Profile form identifies the carrier codes and specific users that will submit data files and must be completed by the carrier. If a third party administrator (TPA) or other vendor (also known as a service provider) is reporting on a carrier's behalf, the Service Provider Attachment and Service Provider Data Tool Addendum are also required.

B. BUSINESS EXCLUSION REQUEST FORM AND PREMIUM DETERMINATION WORKSHEETS

The **Business Exclusion Request** form is used when a carrier requests to be excluded from the Indemnity Data Call.

Participants in the Call are required to submit their basis for exclusion to NCCI 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. To determine if proposed exclusions are less than or equal to 15% of the group's total written premium, use the following methods:

1. Premium Determination—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 the states where the Indemnity Data Call applies (refer to Part 2-B—General Rules—Applicable Jurisdictions of this guide).

For details on Premium Determination Method 1 and all other premium determination methods, refer to Part 2-G—General Rules—Business Exclusion Option of this guide.

Premium Verification Worksheet—Method 1

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

Worksheet Instructions—Method 1

1. In Column A, list the entities excluded from that state.
2. In Column B, enter the Calendar Year Written Premium for the states where the Indemnity Data Call applies 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 Calendar Year Written Premium for that state (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%.

2. Premium Determination—Method 2

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 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 the states where the Indemnity Data Call applies (refer to Part 2-B—General Rules—Applicable Jurisdictions of this guide).

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For details on Premium Determination Method 2 and all other premium determination methods, refer to Part 2-G—General Rules—Business Exclusion Option of this guide.

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 Part 2-G—General Rules—Business Exclusion Option of this guide)	
F	Non-Large Deductible Ratio	C divided by A (C / A)	
G	Ratio	Sum of E and F (E + F)	

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 Part 2-G—General Rules—Business Exclusion Option of this guide.
4. Use the formulas to complete the worksheet.
5. If the ratio (G) is 15% or less, the exclusion is acceptable.

3. Premium Determination—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 the states where the Indemnity Data Call applies (refer to Part 2-B—General Rules—Applicable Jurisdictions of this guide).

For details on Premium Determination Method 3 and all other premium determination methods, refer to Part 2—General Rules—Business Exclusion Option of this guide.

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		

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Item	Description	Formula	Amount
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)	

Worksheet Instructions—Method 3

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

For details on the methods for premium determination and examples, refer to Part 2-G—General Rules—Business Exclusion Option in this guide.

4. Premium Determination—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 the states where the Indemnity Data Call applies (refer to Part 2-B—General Rules—Applicable Jurisdictions of this guide).

Premium Verification Worksheet—Method 4

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			

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 the states where the Indemnity Data Call applies 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 the state where the Indemnity Data Call applies.
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%.

For details on the methods for premium determination and examples, refer to Part 2-G—General Rules—Business Exclusion Option in this guide.

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C. SECURE FTP PREINSTALLATION QUESTIONNAIRE

The Secure FTP Preinstallation Questionnaire provides the technical staff of your company, and that of NCCI, with detailed information required for your company to utilize NCCI's Secure FTP services. If you are not familiar with all required information, technical assistance may be necessary to complete the form. After we receive your completed questionnaire, an NCCI representative will contact you to establish testing of the FTP connection.

Refer to Part 2 of the ***Electronic Transmission User's Guide*** for additional information and the Secure FTP Preinstallation Questionnaire.

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