THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU

October 29, 2008

CIRCULAR LETTER NO. 2106

To All Members and Subscribers of the Bureau:

ELIMINATION OF INDIVIDUAL CASE REPORTS (ICR)
COLLECTION OF DETAILED CLAIM INFORMATION (DCI)
COLLECTION OF MEDICAL DATA CALL
REVISIONS TO PART I OF THE MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN

The Massachusetts Division of Insurance (DOI) recently approved the replacement of Section VIII – Individual Case Reports, in Part I of the Massachusetts Workers' Compensation Statistical Plan with Section VIII – Reporting of Information Regarding Individual Death and Permanent Total Disability Claims. The new section eliminates the reporting of Individual Case Reports, but retains Section VIII to ensure that specific data elements for Death and Permanent Total Claims continue to be available to the WCRIBMA through the participation of all of its member carriers in the National Council on Compensation Insurance, Inc.'s (NCCI) Redesigned Detailed Claim Information (DCI) Program announced in the NCCI Circular DCI-2008-01. The Circular can be found on NCCIs website with the following link.

https://www.ncci.com/manuals/circulars/countrywide/DCI-2008-01.htm

The DCI Reporting Guidebook can be found on NCCI's website in the online manual section with the following link.

https://www.ncci.com/onlinemanuals/default.aspx

Carriers will begin reporting DCI data for Massachusetts claims reported to the carrier on or after September 1, 2009 that will be valued in March 2011 and due to be reported by June 2011.

Attached for your information is a copy of the Division of Insurance's approval letter and the WCRIBMA's filing which includes the revised pages to the Massachusetts Statistical Plan. The revisions are shown in red, bold, italic, Times New Roman font and the elimination of text is indicated by gray highlight and strikes through the text.

The revised pages of the Massachusetts Statistical Plan will be posted on the web site in due course.

The WCRIBMA's Governing Committee has also approved WCRIBMA contracting with NCCI for the collection of Medical Data Call.

The Medical Data Call will begin with medical transactions occurring in 3rd quarter 2010, due to be reported by December 31, 2010. Refer to the NCCI's Medical Data Call Implementation Guidebook issued January 1, 2008 for reporting instructions. The Medical Data Call Guidebook can be found on NCCI's website in the online manual section with the link below.

https://www.ncci.com/nccimain/DataReporting/MedicalData/Pages/default.aspx

If you have any questions regarding these changes, please contact the undersigned at lkarvelis@wcribma.org or Erica Spicer at espicer@wcribma.org

Leah Karvelis
Manager Data Operations

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
One South Station • Boston, MA 02110-2208
(617) 521-7794 • FAX (617) 521-7475
TTY/TDD (617) 521-7490
http://www.mass.gov/doi

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

DANIEL O'CONNELL
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

DANIEL C. CRANE
DIRECTOR

NONNIE S. BURNES
COMMISSIONER OF INSURANCE

October 23, 2008

Paul Meagher, President
Workers' Compensation Rating and
Inspection Bureau of Massachusetts
101 Arch Street, 5th Floor
Boston, MA 02110

RE: REVISIONS TO PART I (UNIT STATISTICAL PLAN) OF THE MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN: ELIMINATION OF INDIVIDUAL CASE REPORTS ("ICRs")

Dear Mr. Meagher:

I am writing to advise you of the Division's approval of your request, as most recently amended in your October 1, 2008 filing, to eliminate ICRs in favor of utilization of the redesigned Detailed Claim Information Program ("DCI") of the National Council on Compensation Insurance. As set forth in your revised filing, all WCRIB members will continue to submit case-specific data on all permanent-and-total and death claims, but, as a result of the Bureau's adoption of the DCI, both the Industry and the Division will have access to a much richer fund of national data, including formerly uncollected information on medical services and cost. In addition, while Massachusetts adoption of the DCI will allow for discontinuance of the prior ICR system, which provided little usable data to any party, the revisions to your filing ensure that if the DCI is changed in such a way that key data requests are eliminated, it will no longer satisfy the Massachusetts Statistical Plan.

In accordance with your request, WCRIB members may begin reporting data in accordance with the DCI on claims reported to them on or after September 1, 2009.

Thank you for your work (and that of your staff) on this filing.

Sincerely,

Kevin P. Beagan
Deputy Commissioner and
Director, State Rating Bureau

THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU

October 1, 2008

The Honorable Nonnie S. Burnes
Commissioner of Insurance
Massachusetts Division of Insurance
One South Station
Boston, Massachusetts 02110-2208

Re: Revisions to the Massachusetts Workers' Compensation Statistical Plan
Part I: Unit Statistical Reporting - Elimination of Individual Case Reports

Dear Commissioner Burnes:

The Workers Compensation Rating and Inspection Bureau of Massachusetts ("WCRIBMA") is proposing to eliminate the collection of Individual Case Reports ("ICRs") and adopt the National Council on Compensation Insurance's ("NCCI") redesigned Detailed Claim Information Program ("DCI"), effective January 1, 2009. As explained herein, eliminating ICRs while adopting DCI will improve the quality and usefulness of the data received by the WCRIBMA for death and permanent total claims. Adopting DCI will also provide the WCRIBMA with data on temporary total and permanent partial claims which are not part of ICR data.

Individual Case Reports ("ICRs")

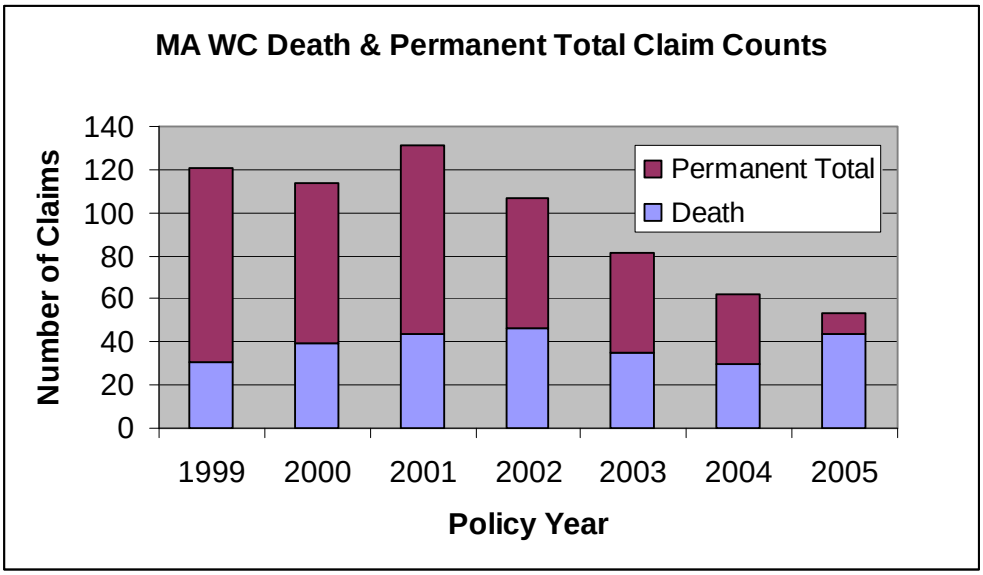
Carriers are required to file ICRs for all Massachusetts workers' compensation claims that involve death and permanent total benefits. The timing of ICR reporting coincides with the timing of the reporting of Unit Statistical Reports ("USRs"), which means that each death and permanent total claim is valued 18 months after policy inception and annually thereafter until the earlier of the claim's closing or the tenth valuation. Much of the information contained in an ICR duplicates the information that is included in the USRs. While the data from USRs is used extensively in the WCRIBMA's rate filings, the WCRIBMA did not utilize ICR data in its 2005, 2007 or 2008 rate filings.

At one time, the WCRIBMA used ICR data to adjust case reserves reported for death and permanent total claims on USRs submitted by WCRIBMA member carriers. The WCRIBMA adjusted such reserves to be consistent with the values suggested by the approved pension tables contained in the Massachusetts Workers Compensation Statistical Plan. The adjusted case reserves were then used by the WCRIBMA in its

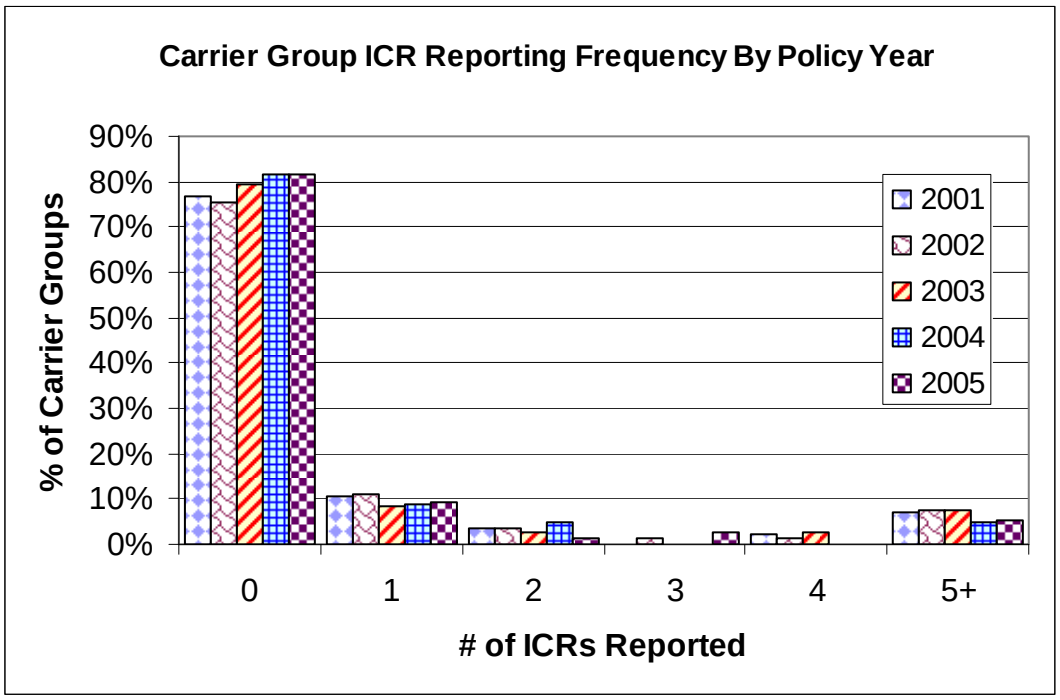
projection of the indicated rate change. The WCRIBMA stopped using ICRs to adjust carriers' case reserves because it was determined that usually there were legitimate reasons as to why case reserves reported by carriers for death and permanent total claims would vary from the values suggested by the pension tables. The reasons for such variations, however, are not reflected in the ICRs. Consequently, the WCRIBMA elected to defer to the judgment of carriers in setting their case reserves, given the carriers' more in depth knowledge of the details related to specific claims.

It had also been assumed that ICR data would be useful for purposes of estimating the cost impact associated with workers' compensation reform bills. This has proven not to be the case because of the sparseness of the ICR data. In fact, the WCRIBMA has looked for alternative sources of data, including prior versions of NCCI's DCI program, when asked to estimate the cost impact of proposed workers' compensation reforms.

A review of policy year data from 1999 through 2005 illustrates the sparseness of ICR data. As shown in the chart below, Massachusetts ICR reporting has resulted in the reporting of fewer than 140 claims in any recent policy year. This small collection of ICRs is submitted by the more than 80 carrier groups that write workers compensation in Massachusetts.



The following chart shows the actual number of Massachusetts ICR reports for policy years 2001 to 2005, during which 85% of carrier groups writing workers' compensation insurance in Massachusetts consistently reported one or fewer ICRs.



Massachusetts is one of only 6 states that require ICR reporting. One of these 6 states, New York, just recently approved the elimination of ICR reporting associated with all policies effective on or after January 1, 2008 (http://www.nycirb.org/rcb/rcb/rc2175.pdf). The WCRIBMA utilizes a data collection system called Spectrum, the development and maintenance of which is shared with 4 other rating bureaus. The elimination of ICR reporting in New York is significant because it means that Massachusetts is the only Spectrum Partner now required to collect ICRs. As such, the WCRIBMA estimates that the cost to the industry for future collaborative USR projects with Spectrum Partners will increase by about 25% due to the extra testing and system requirements that will be required to continue to accommodate ICR reporting for Massachusetts.

There is no sharing of ICR data among the states that require the collection of such data and the reporting requirements for ICRs are not uniform across those jurisdictions. As a consequence of the small volume of records and inconsistencies in the reporting rules by jurisdiction, ICR reporting is not an automated process for most member carriers. It is not cost effective for carriers to develop automated systems to submit just one to ten reports in a policy year and therefore, ICRs are often submitted to the WCRIBMA in hard copy form. The WCRIBMA has often found the hard copy reports to be unreliable. As a result, the WCRIBMA finds itself in the position of expending significant time and resources attempting to verify ICR data that is no longer used by the WCRIBMA for any rate making or other purpose.

Redesigned Detailed Claim Information ("DCI")

NCCI has collected DCI records since 1979. The DCI program is periodically reviewed by the NCCI and was modified in response to such reviews in 1991 and 1996. Recently, NCCI reviewed the DCI program again and NCCI is implementing a redesigned DCI program, which the WCRIBMA is proposing to adopt. See, Attachment A.

The DCI program collects data for workers' compensation claims involving indemnity benefits, otherwise known as lost time claims, including but not limited to death and permanent total claims. Forty-three states participate in the DCI program ("DCI states") and 4 of the states that do not participate have monopolistic state funds. Not all lost time claims are reported under the DCI program as the program employs a claims sampling mechanism. Under this sampling mechanism, DCI reporting is required of all carriers whose market shares exceed certain thresholds defined by the NCCI.

The redesigned DCI program applies to claims reported to carriers on or after September 1, 2009. Those carrier groups that are subject to the redesigned DCI reporting requirement meet one of the following criteria based on direct written premiums for calendar years 2004, 2005 and 2006:

- Average market share over three years of at least 1% for three or more DCI states.
- Calendar year 2006 market share of at least 5% in any one DCI state.

Once a carrier group has been designated to participate in the DCI program, DCI data is to be reported for all the DCI states in which the carrier group writes workers' compensation premium, even those states where the carrier group has minimal market shares. Additionally, carrier groups designated to report DCI records must continue to report indefinitely (unless granted a temporary reporting dispensation due to certain specific circumstances). Initially, more than 85% of the workers' compensation market of the 43 DCI states is expected to be represented by carriers reporting DCI records under the redesigned DCI program. For Massachusetts, the WCRIBMA estimates that 87% of the workers' compensation market would be subject to DCI reporting.

The redesigned DCI program requires carrier groups subject to the redesigned DCI program to report <u>all</u> death and permanent total claims, which is the same as Massachusetts' ICR reporting requirement. A sampling of the remaining lost time claims (temporary total and permanent partial claims) must also be reported. Currently, the redesigned DCI calls for 15% of temporary total and permanent partial claims to be reported. This additional sampling will provide the WCRIBMA with data that is not currently available on the Massachusetts ICRs.

All of the current ICR data fields that the WCRIBMA would expect to be significant for estimating the cost of workers' compensation reform bills will be collected as part of the redesigned DCI program, along with additional data that is not currently reported on the ICRs. The adoption of the DCI program would eliminate the requirement for some small market share carrier groups to report any data about death and permanent total claims,

aside from what is reported on USRs. However, given that the industry in total currently submits fewer than 140 ICRs annually to the WCRIBMA for a given policy year, the loss of data associated with these small carrier groups will be minimal.

The data available to the WCRIBMA as a consequence of adopting the redesigned DCI program dwarfs the sparse amount of ICR data that would no longer be reported. The WCRIBMA expects to receive 2100 to 2500 DCI records in future policy years, rather than just 140 or fewer clams reported on the Massachusetts ICRs. The WCRIBMA will also work with NCCI to supplement Massachusetts data with DCI information on approximately 50,000 claims per year as collected by NCCI from other DCI states. The mechanisms employed by carrier groups to collect and submit redesigned DCI data should be largely automated because most states will be subject to the redesigned DCI reporting requirements and those requirements are consistent from state to state. The automated submission of data coupled with standard reporting requirements will enhance the reliability of the data. The elimination of ICRs and adoption of the DCI Program provides an excellent opportunity for the WCRIBMA to increase the amount of data available for analysis while relieving the industry of the burdens and costs associated with the submission of ICRs from which the WCRIBMA and the industry derive no value.

Implementation

The WCRIBMA will immediately stop storing, editing, and summarizing ICR data. The last stored ICR data will be data which was due at the WCRIBMA in December 2008. The proposed revised manual pages are contained in Attachment B.

Carriers will begin reporting DCI data for claims reported to the carrier on or after September 1, 2009 that will be valued in March 2011 and due to be reported by June 2011. The data will be reported by the WCRIBMA's members to NCCI who will in turn make the data available to the WCRIBMA.

If you have any questions about this proposal, please contact me at (617)646-7519 or via email at pmeagher@wcribma.org

Sincerely,

Paul F. Meagher

Paul F. Meagher, Esquire
President

cc: Kevin Beagan, Deputy Commissioner and Director, State Rating Bureau
Walter Horn, PhD, State Rating Bureau
Caleb Huntington, State Rating Bureau

Attachments

Attachment A

DATA RESOURCES

Circular

JANUARY 18, 2008 **DETAILED CLAIM INFORMATION** **DCI-2008-01**

Detailed Claim Information–Redesigned Detailed Claim Information (DCI) Program–Initial Reporting in 2011

ACTION NEEDED

This circular announces a redesigned Detailed Claim Information (DCI) program that will require initial reporting in 2011. Our initial industry communication, which included a high-level overview of this new requirement, was posted to **ncci.com** in December 2007.

Accompanying this circular are:

- Attachment A—Redesigned DCI Reporting Overview
- Attachment B—Redesigned DCI Implementation Timeline

The industry lead time associated with the redesigned DCI program will not begin until the new ***Detailed Claim Information Reporting Guidebook*** is made available to the industry—targeted for release by March 2008. The industry will receive an 18-month implementation lead time from that point. This translates to the following activities:

- The initial claims will be those with a Reported to Insurer (RTI) Date of September 2009
- These claims (RTI September 2009) will be valued in March 2011
- Claims selected in the new sampling process will be reported to NCCI by June 2011
- Subsequent DCI reports will be due in one year intervals, up to the 11th report

In February 2008, we will send letters to affiliate groups that have a current and future DCI reporting obligation. We will utilize our current DCI reporting contact when available, and determine the company contact for newly identified reporters. The three types of letters are:

- Current DCI reporters that will have a continued reporting obligation under the redesigned DCI program. Included will be the DCI Participation Requirements attachment—customized to display each affiliate group's current DCI states and sample ratios, and the new sample ratios for all states.
- Current DCI reporters that will **not have** a future reporting obligation under the redesigned DCI program.
- Affiliate groups that will be new to DCI under the redesigned DCI program. Included with the letter will be the DCI Participation Requirements attachment displaying the new sample ratios for all states.

For affiliate groups with a current DCI reporting obligation, the letters will also address the transition plan, which includes the last reporting of current DCI claims in 2014.

BACKGROUND

Detailed Claim Information (DCI) was implemented in 1979 to streamline the data collection process needed for special claim studies. NCCI collects DCI in 43 states, and the data is used to fulfill a wide variety of purposes, including:

- **Pricing Proposed State Legislation** (Responding to proposed House/Senate Bills, Ballot Initiatives, Taskforces, Advisory Councils, Reforms, etc.)
- **Research Studies** (Carpal Tunnel, Study of Workplace Violence, etc.)
- **Statistical Agent Compliance** (State Insurance Department requirements)
- **Additional Analytical Needs** (***State Advisory Forums***, Focus Reports, etc.)

One of the unique features of DCI is that only a small sample of claims data is needed to fulfill the business uses defined above. This is accomplished by using a state sampling process, wherein data providers select claims according to the sampling rules. State sampling enables NCCI to collect approximately 1,200 new claims annually for each DCI state.

IMPACT

NCCI periodically reviews DCI reporting requirements both to ensure that the appropriate data providers are included in the program and that—from an overall perspective—the program continues to support the industry's business needs.

Earlier this year, we determined that a new DCI participation process should be conducted, utilizing 2004–2006 Direct Written Premium information. NCCI has also identified the need to redesign the DCI program, to include the reporting requirements, data elements, claims sampling process, and other requirements. Additional information on some of the more significant changes is provided in **Attachment A—Redesigned DCI Reporting Overview**. A summary of key changes is as follows:

DCI Participation—Affiliate group participation will be based on state market share using the following criteria:

- Three or more DCI states—State market share of at least 1% over the most recent three years (overall average = 1% or more)
- One DCI state—State market share of at least 5% in the latest year

DCI Data Elements—NCCI's analysis of current DCI data elements has identified the need to modify the data collected. The new DCI record layout will contain 6 policy/claim linking elements and 51 claim elements. Here's a comparison to the current DCI program:

- 42 of the existing data elements are being retained (7 of these are modified)
- 21 of the existing data elements are being eliminated
- 15 new data elements will be added

Claim Sampling Process—A new claims sampling methodology will be utilized. Unlike today's DCI program, all death and permanent total disability claims will be reportable and not subject to sampling. All other indemnity claims will be subject to a revised claims sampling process—utilizing separate sample ratios for open and closed claims. The total number of reportable claims per state will remain approximately the same as the current DCI program.

DCI Valuation and Reporting—The valuation of DCI claims will continue to be based on the Reported to Insurer Date (RTI). For DCI 1st reports, all claims will be valued and sampled at 18 months after RTI and are due to be reported to NCCI within three months, or by the 21st month.

DCI Report Levels—Subsequent DCI reports will be due in one-year intervals, up to the 11th report. This represents an increase in the total number of report levels from 9 (current) to 11 (redesigned DCI).

DCI States—The new DCI program will include all of the current states (43) and will add West Virginia (a new NCCI state).

NCCI ACTION

The redesigned DCI program was developed with the assistance of a data provider working group—all members of our Data Collections Procedures Subcommittee. These data managers contributed to all aspects of the project, including helping us develop the reporting requirements and reviewing the ***DCI Reporting Guidebook***, industry lead time, and other considerations.

The information provided in this communication is just the start of our redesigned Detailed Claim Information communication and training plan. Please refer to **Attachment B—Redesigned DCI Implementation Timeline**, which includes the planned industry communications and training opportunities.

PERSON TO CONTACT

If you have any questions, please contact our Customer Service Center at 800-**NCCI**-123 (800-622-4123). We're here to assist you Monday–Friday, 8:00 a.m.–8:00 p.m. ET. For faster service, use our simple online form on **ncci.com**.

National Council on Compensation Insurance, Inc.

Redesigned DCI Reporting Overview

CIRCULAR DCI-2008-01

ATTACHMENT A

DCI States

NCCI collects DCI in 43 states, including eight independent bureau states.

Carrier Participation

Carrier groups' participation is based on 2004-2006 Direct Written Premium, using the following criteria:

- At least 1% market share over the most recent three years (overall average = 1% or more), in at least three DCI states.
- Or, market share is >= 5% in any one DCI state in the latest year.

Once a carrier meets the eligibility criteria, they will be required to:

- Report for all states in which they write, even if an individual state's market share is below the threshold.
- Continue reporting indefinitely, even if they fall below the eligibility threshold. Carriers may request a temporary reporting dispensation.

Reportable Claims

All Death and Permanent Total disability claims with the State of Jurisdiction in DCI states are reportable, and not subject to sampling. All other indemnity claims will be subject to random sampling—utilizing separate sample ratios for open and closed claims. Medical-only claims are excluded.

Reporting Frequency

The valuation of DCI claims 1st reports are based on Reported to Insurer Date (RTI). All claims are to be valued and sampled at 18 months after RTI, and are due to be reported to NCCI by the 21st month.

Subsequent reports are submitted on a yearly basis until the claim:

- Is closed
- Becomes medical-only
- Reaches the 11th report level

DCI Record Layout

DCI utilizes a proprietary record layout that contains 6 policy/claim linking elements and 51 claim elements

Code Values

The code values used are industry standards defined by Workers Compensation Insurance Organizations' (WCIO) Advisory Statistical Work Group (ASWG), and Electronic Data Interchange (EDI) Committee.

Industry Lead-Time

There will be 18 months of lead-time for the redesigned DCI program, starting with the March 2008 availability of the DCI Reporting Guidebook.

Reported to Insurer Date (RTI)

The initial reportable claims under the redesigned DCI program will begin with RTI of September 2009, which are valued as of March 2011 and due to be reported to NCCI by June 2011.

Current DCI Program Run-Off

The final RTI for 1st reports under the current DCI program will be August 2009—with those 5th reports due in April 2014. Reporting is not required for **any reports** that would have been due after April 2014.

Industry Support

NCCI will support the industry to enable them to meet the reporting requirement via communication and training tools, as follows:

- Implementation Guide
- DCI Section on **ncci.com**
- DCI Circular Series
- Web-based training
- Regional Training
- Data Reporting Workshops

National Council on Compensation Insurance, Inc.

Redesigned DCI Implementation Timeline

CIRCULAR DCI-2008-01

ATTACHMENT B

2007 Activities

December

ncci.com—The initial Web article announcing the redesigned DCI program was posted.

2008 Activities

January

Redesigned DCI Circular—NCCI released Circular DCI-2008-01, which provided the initial "heads-up" communication of the redesigned DCI program to the industry.

NCCI Data Management Program—The Data Management program will be held on Wednesday, January 23, and will provide background, business needs, and further details on the redesigned DCI program.

2008 Data Reporting Workshop—The workshop, scheduled for January 24–25, 2008 includes a session on DCI. This training session will provide an overview of the reporting requirement changes (current and redesigned DCI programs).

February

Contact New DCI Reporting Companies—NCCI will contact the approximately 80 affiliate groups that meet the eligibility requirements for the newly redesigned DCI program. This will occur via individual letters, and will include the complete list of DCI states and state sample ratios (open claim ratios and closed claim ratios).

March

DCI Reporting Guidebook—The new ***DCI Reporting Guidebook*** will be available on **ncci.com**, in addition to hard copy format. This manual will include details for data providers to begin their implementation plans to meet the reporting requirements.

ncci.com—The DCI data reporting section on **ncci.com** will be updated with all information on the redesigned DCI program, and will continue to be updated as further information becomes available.

2nd Quarter

Web Training—NCCI will conduct the initial Web training sessions on the redesigned DCI program, which will be focused on implementation and systems considerations.

3rd Quarter

Regional Training—NCCI will conduct regional DCI training.

2009 Activities

1st Quarter

Data Reporting Workshop—The January workshop will include training sessions on the redesigned DCI program.

National Council on Compensation Insurance, Inc.

Redesigned DCI Implementation Timeline

CIRCULAR DCI-2008-01

ATTACHMENT B

2nd–3rd Quarter

Web Training—NCCI will conduct Web training sessions on the redesigned DCI program.

Regional Training—NCCI will conduct regional DCI training.

Redesigned DCI Implementation—Under the redesigned DCI program, reporting begins as follows:

- The initial Reported to Insurer (RTI) Date will be September 2009
- These claims (RTI September 2009) will be valued as of March 2011
- Claims selected in the new sampling process will be reported to NCCI by June 2011
- Subsequent DCI reports will be due in one-year intervals, up to the 11th report

Current DCI Program Run-Off—The final RTI for 1st reports under the current DCI program will be August 2009—with those 5th reports due in April 2014. Reporting is not required for any reports that would have been due after April 2014.

National
Council on
Compensation
Insurance, Inc.

Detailed Claim Information Reporting Guidebook

TABLE OF CONTENTS

PREFACE

NCCI's ***Detailed Claim Information Reporting Guidebook*** 2009 Edition contains the rules, requirements, and examples for reporting accurate and timely Detailed Claim Information to NCCI for claims with a Reported to Insurer Date of September 2009 and later.

For all claims with a Reported to Insurer Date prior to September 2009, data providers must use the ***Call for Detailed Claim Information Instruction Manual***.

CHANGE TRACKING GUIDE

NCCI's ***Detailed Claim Information Reporting Guidebook*** contains the rules, requirements, and examples for reporting accurate and timely detailed claim data to NCCI. The Change Tracking Guide in this guidebook identifies each change to the guidebook since the last update.

Change Tracking Guide Key

Part column—Lists the part of the ***Detailed Claim Information Reporting Guidebook*** that has changed.

No./Item column—Lists the specific section within the ***Detailed Claim Information Reporting Guidebook*** that has changed.

Change column—Summarizes the specific information that has changed.

Reason column—Provides the reason for the change.

MANUAL UPDATE

Part	No./Item	Change	Reason

RESERVED FOR FUTURE USE

PART 1—DCI REPORTING GUIDEBOOK

OVERVIEW

Part 1 of this guidebook contains a basic overview of the purpose for this publication, where it can be obtained, and how to contact NCCI for customer support.

A. PURPOSE OF THE MANUAL

The ***Detailed Claim Information Reporting Guidebook*** is your source for the rules and requirements for reporting Detailed Claim Information (DCI) to NCCI, as well as a source for helpful additional information and examples to assist you in meeting your reporting requirements.

The following is an overview of the information contained in this guidebook:

- DCI uses
- Participation process
- Claims included and excluded from DCI reporting
- Details of the claim selection and sampling process, including examples
- Instructions, examples, and record layouts for submitting DCI to NCCI for first reports, subsequent reports, and replacement reports
- Data element definitions, format, and reporting requirements
- Edits, error messages, and instructions for correcting errors
- DCI informational reports
- Tools and resources for reporting DCI
- Overview of the DCI Data Quality Program
- Glossary of terms included in this guidebook

B. CUSTOMER SUPPORT AND NCCI CONTACT INFORMATION

NCCI's Customer Service Center is available if you have any questions or require assistance such as:

- Requesting access to the online version of this guidebook at **ncci.com** (or ordering hard copies of this guidebook)
- Ordering any of the reports, data tools, or other products and services mentioned in this guidebook
- Requesting information regarding Detailed Claim Information (DCI) reporting, processing, edits, and data quality programs

Please contact NCCI at any of the following:

Address:	CUSTOMER SERVICE CENTER NATIONAL COUNCIL ON COMPENSATION INSURANCE INC 901 PENINSULA CORPORATE CIRCLE BOCA RATON FL 33487
Phone:	800-**NCCI**-123 (800-622-4123)
Web:	From our home page at **ncci.com**, click **Contact Us** to access our online form
E-Mail	customer_service@ncci.com

RESERVED FOR FUTURE USE

PART 2—GENERAL RULES

OVERVIEW

Detailed Claim Information (DCI) is a data collection program managed by NCCI whereby insurance companies furnish specific information on workers compensation indemnity claims (i.e., claims involving lost-time benefits). Part 2 of this guidebook explains the purpose of, and general rules that apply to, the DCI program.

A. PURPOSE OF DETAILED CLAIM INFORMATION

Detailed Claim Information (DCI) is designed to streamline the data collection process needed for claim studies. DCI data is used extensively for a variety of purposes, with five primary categories:

- State law pricing
- State insurance department reporting
- State advisory forums
- Research studies
- Information on **ncci.com**

B. SCOPE AND ISSUED DATE

Detailed Claim Information (DCI) applies to:

- Direct workers compensation (assigned risk and voluntary market)
- Voluntary compensation
- Employers liability business

DCI data may be submitted by insurance carriers, state funds, or third party administrators. This guidebook refers to these groups as:

- **Data providers** when the role is submitting data
- **Carriers** when the role is specific to the insurance carrier (i.e., participation criteria)
- **Insurers** when the role is specific to payments of a claim

Note: Although data may be provided by a third party administrator (TPA) on behalf of an affiliate carrier or affiliate carrier group, quality and timeliness of the data are the responsibility of the carrier.

1. Issued Date

This guidebook is being issued for the 2009 DCI participation program, which began with claims with a Reported to Insurer Date of September 2009 and later.

C. APPLICABLE STATES

NCCI STATES APPLICABLE TO DCI

Alabama	Hawaii	Mississippi	Rhode Island
Alaska	Idaho	Missouri	South Carolina
Arizona	Illinois	Montana	South Dakota
Arkansas	Iowa	Nebraska	Tennessee
Colorado	Kansas	Nevada	Utah
Connecticut	Kentucky	New Hampshire	Vermont
District of Columbia	Louisiana	New Mexico	Virginia
Florida	Maine	Oklahoma	West Virginia
Georgia	Maryland	Oregon	

INDEPENDENT BUREAU STATES APPLICABLE TO DCI

Indiana	New Jersey*	Pennsylvania
Massachusetts	New York	Texas**
Michigan	North Carolina	Wisconsin
Minnesota		

* New Jersey: NCCI collects DCI data, but it is not required.

** Texas: NCCI collects DCI data according to the Texas Detailed Claim Information Statistical Plan

STATES NOT APPLICABLE TO DCI

California	Ohio
Delaware	Washington
North Dakota	Wyoming

D. PARTICIPATION PROCESS

1. Participation Eligibility

Detailed Claim Information (DCI) carrier participation is mandatory for those NCCI affiliate carriers that meet ***either*** of the following:

- At least 1% market share over the most recent three years, in at least three DCI (NCCI and Independent Bureau) states. This is calculated by state, with the numerator being the carrier's total state premium for the three-year period and the denominator being the corresponding total state premium. For a list of DCI states, refer to Applicable States in the **General Rules** section (Part 2) of this guidebook.
- Market share is greater than or equal to 5% in any one DCI state in the latest year. For a list of NCCI states, refer to Applicable States in the **General Rules** section (Part 2) of this guidebook.

Participation is based on Direct Written Premium for the most recent three years in which NCCI has financial data.

Additionally, once a carrier meets the eligibility criteria, they are required to:

- Report for all applicable DCI states in which they write, even if an individual state's market share in an NCCI state is below the threshold.
- Continue reporting indefinitely, even if they fall below the eligibility threshold. In these cases, carriers may request a reporting waiver to be determined by NCCI at its sole discretion. Refer to Customer Support and NCCI Contact Information in the **DCI Reporting Guidebook** section (Part 1) of this guidebook.

2. NCCI Affiliate Group Participation

When an NCCI affiliate group is included in the DCI program, all companies that are aligned within that group are required to report DCI.

3. Mergers and Acquisitions

In the event a carrier/group was required to report DCI prior to a merger or acquisition, the obligation to continue to report DCI will remain. In the event a carrier/group that was not previously required to report DCI merges with or becomes acquired by a reporting carrier/group, the acquired carrier/group would not be required to report as part of that carrier/group until a future participation evaluation deems them eligible.

Example: Merger and Acquisition Scenarios

If ...	And ...	Then ...
Carrier A currently reports DCI	Merges with Carrier B, who does not currently report DCI	Only Carrier A reports DCI unless a future participation evaluation deems AB eligible
Carrier A does not currently report DCI	Merges with Carrier B, who currently reports DCI	Only Carrier B reports DCI unless a future participation evaluation deems AB eligible
Carrier A currently reports DCI	Merges with Carrier B, who currently reports DCI	Both Carrier A and Carrier B continue to report DCI
Carrier A currently reports DCI as part of reporting Group B	Leaves Group B	Both Carrier A and Group B continue to report DCI
Carrier A does not currently report DCI	Merges with Carrier B, who does not currently report DCI	Neither Carrier A nor B reports unless a future participation evaluation deems AB eligible

4. Participation Summary and Evaluation

NCCI publishes a Carrier Participation Summary for those NCCI affiliate carriers and NCCI affiliate groups that are required to participate in the DCI program.

This summary provides the applicable DCI states and the sample ratios for each state. An example of a Carrier Participation Summary is included in this part of the guidebook.

The Carrier Participation and state sample ratio evaluation will be conducted by NCCI at least every two years. This will enable NCCI to identify emerging writers and ensure that the number of new claims needed for each DCI state is maintained.

Example: Carrier Participation Summary

Jurisdiction State	Open Claims (%)	Closed Claims (%)
Alabama	52	2
Alaska	100	4
Arizona	24	1
Arkansas	72	3
Florida	6	1
Maine	100	4
South Carolina	21	2
South Dakota	100	7
Tennessee	16	1

E. DESIGNATED CARRIER COORDINATOR

Each NCCI affiliate carrier or NCCI affiliate group participating in the Detailed Claim Information (DCI) program is required to designate one individual as the coordinator for DCI within their organization. The coordinator is required to:

- Be a centrally located claims, statistical, or data management person with the group or carrier
- Receive and disperse all Request for Subsequents—Expected lists and Request for Subsequents—Overdue lists sent by NCCI
- Serve as central control for DCI within their organization

F. ELECTRONIC SUBMISSION

The 2009 Detailed Claim Information (DCI) program may only be reported electronically. DCI data must adhere to the record layouts found in this guidebook and in the WCCDCI section of the ***WCIO Workers Compensation Data Specifications Manual*** available on **ncci.com**.

Data providers may submit DCI data to NCCI using one of the electronic transmission options described in the **Data Reporting Resources and Tools** section (Part 9) of this guidebook.

Before data providers can submit production files to NCCI, their electronic data submissions must pass Electronic Certification Testing. This ensures that all connections, data files, and systems are functioning and processing correctly. For information on Electronic Certification Testing, refer to NCCI's ***Electronic Transmission User's Guide*** on **ncci.com**.

PART 3—DCI STRUCTURE

OVERVIEW

Part 3 of this guidebook explains the structure of Detailed Claim Information (DCI) and provides details of what claims are to be included or excluded from the claim selection process and when claims are to be valued and reported to NCCI.

A. CLAIMS INCLUDED IN DCI

Detailed Claim Information (DCI) applies to direct workers compensation, voluntary compensation, and employers liability indemnity claims where the claim jurisdiction state is an applicable DCI state. For a list of states where DCI is applicable, refer to Applicable States in the **General Rules** section (Part 2) of this guidebook.

All Death and Permanent Total Disability claims that meet the above criteria are required to be reported.

A percentage of all other indemnity claims, both open and closed, are sampled as identified in the Carrier Participation Summary. For an example of a Carrier Participation Summary, refer to Participation Process in the **General Rules** section (Part 2) of this guidebook.

A claim's eligibility for reporting is based on an incurred indemnity loss value greater than zero. Even if no lost-time payments have been made as of loss valuation but reserves have been set on the claim in anticipation of payment, the claim is still eligible for reporting.

B. CLAIMS EXCLUDED FROM DCI

Since Detailed Claim Information (DCI) includes only direct workers compensation, voluntary compensation, and employers liability indemnity claims where the claim jurisdiction state is an applicable DCI state, the following is excluded from DCI:

- Claims where the jurisdiction state is not an applicable DCI state
- Medical-only claims
- Losses paid to another insurer because of reinsurance assumed by the reporting insurer
- Claims that involve benefits payable under Federal Acts (i.e., Admiralty, USL&HW, FELA, Jones Act, or Coal Mine Acts)

  Note: For specific instructions on subsequent reporting of claims that become medical-only or have been reclassified as a Federal Act or a nonapplicable DCI state, refer to Subsequent Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

C. REPORTED TO INSURER DATE

Reported to Insurer Date is a key data element within the Detailed Claim Information (DCI) program and is defined for loss valuation and selection purposes as the month and year that a particular claim is registered with the insurer.

The Reported to Insurer Date triggers the first loss valuation of a claim and is also used through 11 report levels to determine what the report level should be when reporting claims that become Death or Permanent Total Disability claims. For details, refer to Death and Permanent Total Disability Claims in the **Claim Selection and Sampling** section (Part 4) of this guidebook.

Note: The DCI selection and sampling process is performed on a monthly basis for each state that the carrier/carrier group is required to report under the DCI program. For details, refer to the **Claim Selection and Sampling** section (Part 4) of this guidebook.

D. VALUATION OF CLAIMS

Detailed Claim Information (DCI) losses are valued at specific time frames corresponding to the report levels (1st through 11th). Losses are first valued during the 18th month after the Reported to Insurer Date. For details, refer to DCI Due Date Table in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Subsequent reporting of claims (2nd–11th report levels) must be valued 12 months after the loss valuation date of the preceding report, or until the claim has become:

- Closed
- Reclassified as medical only (i.e., no indemnity payments made or anticipated), Federal Act, or a nonapplicable DCI state

Note: For specific instructions on subsequent reporting of claims that close, reopen, become medical-only, or must otherwise be reclassified from what was originally reported, refer to Subsequent Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

E. RECOVERIES AND REIMBURSEMENTS

In accordance with the Statistical Plan, in all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund, etc.) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report amounts net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery.

For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

Refer to the appropriate Statistical Plan for details, including exceptions for reporting recoveries and reimbursements.

PART 4—CLAIM SELECTION AND SAMPLING

OVERVIEW

One of the unique features of Detailed Claim Information (DCI) is that only a small number of claims data is necessary to fulfill the business needs. In addition to collecting data for **all** Death and Permanent Total Disability claims, a sampling process where data providers select claims according to the sampling rules is used to obtain approximately 1,200 new claims annually for each DCI state. Part 4 of this guidebook provides instructions and examples for selecting and for sampling DCI claims.

A. TIMING OF SELECTION AND SAMPLING PROCESS

The Detailed Claim Information (DCI) selection and sampling process must occur 18 months after the Reported to Insurer Date (first loss valuation period). As noted in Death and Permanent Total Disability Claims in the **Claim Selection and Sampling** section (Part 4) of this guidebook, Death and Permanent Total Disability claims must be reported, regardless of when they are identified within 138 months of the Reported to Insurer Date.

Note: The DCI selection and sampling process is performed on a monthly basis for each state that the carrier/carrier group is required to report under the DCI program.

B. DEATH AND PERMANENT TOTAL DISABILITY CLAIMS

All eligible claims that are, or become, Death or Permanent Total Disability claims are required to be reported. This includes open and closed claims, regardless of when they become a Death or Permanent Total Disability claim.

A claim identified as Death or Permanent Total Disability based on the established indemnity reserve, must be reported even if no Death or Permanent Total Disability benefit payments have been made as of the loss valuation. Any claim reported as Death or Permanent Total Disability on a previous report that is reclassified to another Benefit Type must continue to be reported. For details, refer to Subsequent Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Although Death and Permanent Total Disability claims are not included in the sampling process, they are valued based on the Reported to Insurer Date. If a claim that was **not** designated for reporting when claims were originally valued (at 18 months) becomes a Death or Permanent Total Disability claim within 138 months of the Reported to Insurer Date, that claim must be added to the list of claims to be reported to NCCI.

- The Death or Permanent Total Disability claim is then reported at annual intervals at the same time as other claims reported, based on the month it was originally reported to the insurer.
- It is not necessary to report data for the Death or Permanent Total Disability claim for any loss valuation dates prior to the date the claim became a Death or Permanent Total Disability claim. Paid and Incurred Amounts are based on the total to date.

Example: Report Levels and Time Frames for Claims That Become a Death or Permanent Total Disability After Original Loss Valuation

If ...	And ...	Then ...
Claim WC3862354 is a reportable claim that is not selected in the sampling process at 18 months after Reported to Insurer Date	Becomes a Death Claim 19 months after Reported to Insurer Date	Report all loss values as of 30 months after Reported to Insurer Date (2nd report level) Do not submit a 1st report for this claim
OR		
Claim WC3862354 is a reportable claim that is not selected in the sampling process at 18 months after Reported to Insurer Date	Becomes a Permanent Total Disability Claim 136 months after Reported to Insurer Date	Report all loss values as of 138 months after Reported to Insurer Date (11th report level) Do not submit 1st–10th reports for this claim

C. RANDOM SAMPLING

Data providers are required to randomly select a specified percentage of open eligible claims, and also a specified percentage of closed eligible claims, reported to the insurer each month in the states included in the Detailed Claim Information (DCI) program. The Carrier Participation Summary provides a list of the applicable DCI states and the corresponding percentage of open claims and the percentage of closed claims required for each state. For an example of a Carrier Participation Summary, refer to Participation Process in the **General Rules** section (Part 2) of this guidebook.

Data providers are required to use a procedure to select a random sample from their eligible claims that has an expected probability of being selected equal to the applicable sampling ratio for their state. The sampling ratio for the state is provided on the Carrier Participation Summary.

NCCI recommends that data providers randomly assign three-digit numbers (i.e., a number ranging from 000 to 999) to potential indemnity claims. This must be done in such a way that each of the 1,000 possible numbers is equally likely (probability = 0.001) to be assigned to any given claim. A number can be selected more than one time.

It is acceptable to use a computerized random number generating function to meet this requirement.

Data providers that want to use an alternative sampling method must submit written documentation to NCCI's Customer Service Center prior to using the method. NCCI will review the data provider's method to make sure that it produces an acceptable sample.

The examples provided in Selection Hierarchy and Examples in the **Claim Selection and Sampling** section (Part 4) of this guidebook use a three-digit random sampling method based on the following:

For any integer n from 1 to 1000, the probability of selecting a number between 0 and $n-1$, inclusive, from the 1000 numbers from 0 to 999 is $n/1000$.

D. SELECTION HIERARCHY AND EXAMPLES

This section describes each step in the selection and sampling process and includes examples for each step. The examples provided here are for illustrative purposes only.

All of the steps listed in this section must be repeated for each Detailed Claim Information (DCI) state required to be reported based on the participation eligibility criteria. For details, refer to Participation Process in the **General Rules** section (Part 2) of this guidebook.

The claim selection and sampling process is performed 18 months after the Reported to Insurer Date. The following steps and examples will use:

- Georgia as the state to be reported
- September 2009 as the Reported to Insurer Date
- March 2011 (18 months after Reported to Insurer Date) as the claim selection and loss valuation date

1. Step #1—Select the Appropriate Jurisdiction State

From the population of claims that fall within the Reported to Insurer Date, select all claims within the jurisdiction state to be reported. If the jurisdiction state is not an applicable DCI state, do not include the claim in the selection. For a listing of applicable DCI states, refer to Scope and Issued Date in the **General Rules** section (Part 2) of this guidebook.

Example: Selecting the Appropriate Jurisdiction State

This example assumes there are 40 claims with a Reported to Insurer Date of September 2009. The jurisdiction state being sampled is Georgia (Jurisdiction State Code 10).

Claim Number	Jurisdiction State	Include in Selection for This Jurisdiction? Y/N
WC3658692	**10**	**Y**
WC3862354	**10**	**Y**
WC3876935	**10**	**Y**
WC3900522	**10**	**Y**
WC3915366	**10**	**Y**
WC3928655	**10**	**Y**
WC3939652	**10**	**Y**
WC4123456	01	N
WC3939766	**10**	**Y**
WC3942322	**10**	**Y**
WC4298765	**10**	**Y**
WC3943005	**10**	**Y**
WC3944022	**10**	**Y**
WC3952115	**10**	**Y**
WC3930023	**10**	**Y**
WC3945626	**10**	**Y**
WC4412392	**10**	**Y**
WC3232317	**10**	**Y**
WC3273931	**10**	**Y**
WC3900129	**10**	**Y**
WC3911443	**10**	**Y**

Claim Number	Jurisdiction State	Include in Selection for This Jurisdiction? Y/N
WC3922333	**10**	**Y**
WC4321987	39	N
WC3939312	**10**	**Y**
WC3939744	**10**	**Y**
WC4563721	39	N
WC3972355	**10**	**Y**
WC3973001	**10**	**Y**
WC4063255	**10**	**Y**
WC3125654	**10**	**Y**
WC3698520	**10**	**Y**
WC3652369	**10**	**Y**
WC3452653	**10**	**Y**
WC3860025	**10**	**Y**
WC4676859	39	N
WC3763260	**10**	**Y**
WC3880088	**10**	**Y**
WC3869201	**10**	**Y**
WC4765432	**10**	**Y**
WC4879675	01	N

Of our initial population of 40 claims, 35 claims have been identified with Jurisdiction State Code 10 (Georgia) and are eligible for the next step in the claim selection process.

Note: All of the steps listed in this section are repeated for each DCI state required to be reported based on the participation eligibility criteria. In this example, the carrier would repeat this step and the steps that follow for Alabama (Jurisdiction State Code 01) and South Carolina (Jurisdiction State Code 39).

2. Step #2—Exclude Non-DCI Claims

From the population of claims that fall within the appropriate jurisdiction state, exclude all claims that are not eligible DCI claims.

Claims excluded from DCI are:

- Medical-only claims
- Claims with losses paid to another insurer because of reinsurance assumed by the reporting insurer
- Claims where the benefits are payable under a Federal Act (i.e., Admiralty, USL&HW, FELA, Jones Act, or Coal Mine Acts)

Example: Excluding Non-DCI Claims

Using the 35 claims that remain after Step #1, this example identifies claims that are excluded from DCI reporting.

Claim Number	Benefit Type	Claim Status	Eligible for Selection Process? Y/N
WC3658692	**Temporary Total**	**Closed**	**Y**
WC3862354	**Death**	**Closed**	**Y**
WC3876935	**Temporary Total**	**Open**	**Y**
WC3900522	**Permanent Partial**	**Closed**	**Y**
WC3915366	**Temporary Partial**	**Closed**	**Y**
WC3928655	**Temporary Partial**	**Open**	**Y**
WC3939652	**Temporary Partial**	**Closed**	**Y**
WC3939766	**Temporary Partial**	**Closed**	**Y**
WC3942322	**Permanent Partial**	**Closed**	**Y**
WC4298765	Medical Only	Open	N
WC3943005	**Temporary Partial**	**Open**	**Y**
WC3944022	**Temporary Partial**	**Open**	**Y**
WC3952115	**Death**	**Open**	**Y**
WC3930023	**Temporary Total**	**Closed**	**Y**
WC3945626	**Permanent Total Disability**	**Open**	**Y**
WC4412392	**Temporary Partial**	**Closed**	**Y**
WC3232317	**Temporary Partial**	**Closed**	**Y**
WC3273931	**Temporary Partial**	**Open**	**Y**
WC3900129	**Temporary Partial**	**Closed**	**Y**
WC3911443	**Permanent Total Disability**	**Open**	**Y**
WC3922333	**Temporary Partial**	**Open**	**Y**
WC3939312	**Temporary Partial**	**Closed**	**Y**
WC3939744	**Permanent Partial**	**Closed**	**Y**
WC3972355	**Temporary Partial**	**Closed**	**Y**
WC3973001	**Permanent Total Disability**	**Open**	**Y**
WC4063255	**Temporary Partial**	**Closed**	**Y**

Claim Number	Benefit Type	Claim Status	Eligible for Selection Process? Y/N
WC3125654	**Permanent Total Disability**	**Open**	**Y**
WC3698520	**Temporary Partial**	**Closed**	**Y**
WC3652369	**Temporary Partial**	**Closed**	**Y**
WC3452653	**Temporary Partial**	**Open**	**Y**
WC3860025	**Permanent Partial**	**Closed**	**Y**
WC3763260	**Temporary Partial**	**Closed**	**Y**
WC3880088	**Temporary Partial**	**Closed**	**Y**
WC3869201	**Temporary Partial**	**Closed**	**Y**
WC4765432	Medical Only	Closed	N

From the population of 35 claims, two were identified as medical-only claims and, therefore, are not eligible DCI claims. We now have 33 claims that will proceed to Step #3.

3. Step #3—Select Death and Permanent Total Disability Claims

Once the appropriate claims have been excluded from the population of claims, identify **all** Death and Permanent Total Disability claims. This is the last step in the selection process. All claims remaining after this step will be subject to sampling. Since all Death and Permanent Total Disability claims are required to be reported, they will not go through the sampling process.

Example: Selecting Death and Permanent Total Disability Claims

This example uses the 33 claims remaining after Step #2 and based on Benefit Type identifies all Death and Permanent Total Disability claims.

Claim Number	Benefit Type	Claim Status	Subject to Sampling? Y/N
WC3658692	Temporary Total	Closed	Y
WC3862354	**Death**	**Closed**	**N**
WC3876935	Temporary Total	Open	Y
WC3900522	Permanent Partial	Closed	Y
WC3915366	Temporary Partial	Closed	Y
WC3928655	Temporary Partial	Open	Y
WC3939652	Temporary Partial	Closed	Y
WC3939766	Temporary Partial	Closed	Y
WC3942322	Permanent Partial	Closed	Y
WC3943005	Temporary Partial	Open	Y
WC3944022	Temporary Partial	Open	Y

Claim Number	Benefit Type	Claim Status	Subject to Sampling? Y/N
WC3952115	**Death**	**Open**	**N**
WC3930023	Temporary Total	Closed	Y
WC3945626	**Permanent Total Disability**	**Open**	**N**
WC4412392	Temporary Partial	Closed	Y
WC3232317	Temporary Partial	Closed	Y
WC3273931	Temporary Partial	Open	Y
WC3900129	Temporary Partial	Closed	Y
WC3911443	**Permanent Total Disability**	**Open**	**N**
WC3922333	Temporary Partial	Open	Y
WC3939312	Temporary Partial	Closed	Y
WC3939744	Permanent Partial	Closed	Y
WC3972355	Temporary Partial	Closed	Y
WC3973001	**Permanent Total Disability**	**Open**	**N**
WC4063255	Temporary Partial	Closed	Y
WC3125654	**Permanent Total Disability**	**Open**	**N**
WC3698520	Temporary Partial	Closed	Y
WC3652369	Temporary Partial	Closed	Y
WC3452653	Temporary Partial	Open	Y
WC3860025	Permanent Partial	Closed	Y
WC3763260	Temporary Partial	Closed	Y
WC3880088	Temporary Partial	Closed	Y
WC3869201	Temporary Partial	Closed	Y

Of the population of 33 claims, 2 claims were identified as Death claims and 4 were identified as Permanent Total Disability claims. These 6 claims will be included on the first report but will not be subject to the sampling process in Step #4

4. Step #4—Assign a Random Number

The population of claims that remain after Step #3 are subject to the sampling process. For this step, a random number is assigned to each claim.

Example: Assigning a Random Number

In this example, a three-digit random number is assigned to each of the 27 claims remaining after Step #3.

Claim Number	Random Number (000–999)	Claim Status
WC3658692	355	Closed
WC3876935	237	Open
WC3900522	475	Closed
WC3915366	586	Closed
WC3928655	987	Open
WC3939652	389	Closed
WC3939766	943	Closed
WC3942322	028	Closed
WC3943005	576	Open
WC3944022	456	Open
WC3930023	681	Closed
WC4412392	134	Closed
WC3232317	001	Closed
WC3273931	307	Open
WC3900129	721	Closed
WC3922333	264	Open
WC3939312	833	Closed
WC3939744	332	Closed
WC3972355	012	Closed
WC4063255	123	Closed
WC3698520	037	Closed
WC3652369	152	Closed
WC3452653	638	Open
WC3860025	288	Closed
WC3763260	972	Closed
WC3880088	849	Closed
WC3869201	184	Closed

5. Step #5—Apply Sampling Ratios to Open and Closed Claims

Once the three-digit random number is assigned to the claims subject to sampling, the separate sampling ratios for open indemnity claims and closed indemnity claims specified on the Carrier Participation Summary for each state will be used to determine which open and closed claims will be reported. For the following examples,

each sampling ratio is multiplied by 1000 and the result is subtracted by 1 to provide a range for selecting the open and closed claims.

Example: Applying Sampling Ratios to Open Claims

This example uses a sampling ratio of 30% for open claims for jurisdiction state Georgia. The sampling ratio is multiplied by 1000 and the result is subtracted by 1. So, 30% times 1000 minus 1 is 299 (0.30 × 1000 = 300 − 1 = 299). Open claims for which the random three-digit number is in the range 000 to 299 (including 000 and 299) to equal a range of 300 numbers are selected. Of the 6 open claims (out of 27) remaining after Step #4, 2 claims fall within the 000–299 range.

Note: Any range that includes 300 numbers would be acceptable here—for example, a range of 001–300, inclusive of 001 and 300, could also be used.

Claim Number	Random Number (000–299)	Claim Status	Report to NCCI? Y/N
WC3876935	**237**	**Open**	**Y**
WC3928655	987	Open	N
WC3943005	576	Open	N
WC3944022	456	Open	N
WC3273931	307	Open	N
WC3922333	**264**	**Open**	**Y**
WC3452653	638	Open	N

Example: Applying Sampling Ratios to Closed Claims

This example uses a sampling ratio of 2% for closed claims for jurisdiction state Georgia. The sampling ratio is multiplied by 1000 and the result is subtracted by 1. So, 2% times 1000 minus 1 is 19 (0.02 × 1000 = 20 − 1 = 19). Closed claims for which the random three-digit number is in the range 000 to 019 (including 000 and 019) to equal a range of 20 numbers are selected. Of the 20 closed claims (out of 27) remaining after Step #4, 2 claims fall within the 000–019 range.

Note: Any range that includes 20 numbers would be acceptable here—for example, a range of 001–020, inclusive of 001 and 020, could also be used.

Claim Number	Random Number (000–019)	Claim Status	Report to NCCI? Y/N
WC3658692	355	Closed	N
WC3900522	475	Closed	N
WC3915366	586	Closed	N
WC3939652	389	Closed	N
WC3939766	943	Closed	N
WC3942322	028	Closed	N
WC3930023	681	Closed	N
WC4412392	134	Closed	N

Claim Number	Random Number (000–019)	Claim Status	Report to NCCI? Y/N
WC3232317	**001**	**Closed**	**Y**
WC3900129	721	Closed	N
WC3939312	833	Closed	N
WC3939744	332	Closed	N
WC3972355	**012**	**Closed**	**Y**
WC4063255	123	Closed	N
WC3698520	037	Closed	N
WC3652369	152	Closed	N
WC3860025	288	Closed	N
WC3763260	972	Closed	N
WC3880088	849	Closed	N
WC3869201	184	Closed	N

6. Summary—Claims Reported on First Report for Jurisdiction

At loss valuation date (18 months after Reported to Insurer Date), claims selected for first reports are determined by:

- Jurisdiction State (Step #1)
- Exclusion Rules (Step #2)
- Benefit Type (Step #3)
- Sampling Rules (Steps #4 and #5)

These steps are repeated for each jurisdiction state required to be reported as indicated in the Carrier Participation Summary.

In the examples above, loss valuation and selection began March 2011 (18 months after the September 2009 Reported to Insurer Date) for Georgia (jurisdiction state). After completing all the steps, the following claims would be reported on the first report:

- 2 Death claims
- 4 Permanent Total Disability claims
- 2 open indemnity claims
- 2 closed indemnity claims

PART 5—REPORTING AND RECORD LAYOUTS

OVERVIEW

Part 5 of this guidebook provides the instructions and examples for First Reports, Subsequent Reports, and Replacement Reports including the record layouts. The DCI Due Date Table including loss valuation information and what action the data provider and NCCI will take at each loss valuation month is also included in Part 5.

A. FIRST REPORTS

NCCI must receive a First Report valued as of 18 months for all Death claims, Permanent Total Disability claims, and all eligible claims selected in the random sampling process for each given Reported to Insurer Date within a specific month. For information, instructions, and examples of the random sampling process, refer to the **Claim Selection and Sampling** section (Part 4) of this guidebook.

Submit the First Report (Report Level Code 01, Record Type Code 1) to NCCI within three months after the 18-month loss valuation date. For details on loss valuation and due dates, refer to DCI Due Date Table in the **Reporting and Record Layouts** sections (Part 5) of this guidebook.

B. SUBSEQUENT REPORTS

A Subsequent Report must be valued every 12 months after the original 18-month loss valuation until the claim has been reported as:

- Closed
- Reclassified as medical only (i.e., no indemnity payments made or anticipated), Federal Act, or a nonapplicable DCI state
- Valued at the 138th month

NCCI initiates the request for subsequent valuations. Approximately two months prior to the subsequent loss valuation date for a given Reported to Insurer Date within a specific month, NCCI generates a Request for Subsequents—Expected List. NCCI produces this report for each claim reported as open on its previous loss valuation. For information on the Request for Subsequents—Expected List, refer to Subsequent Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Submit Subsequent Reports (Report Level Code 02-11, Record Type Code 1) to NCCI within three months after the 12-month loss valuation date. For details on loss valuation and due dates, refer to DCI Due Date Table in the **Reporting and Record Layouts** section (Part 5) of this guidebook .

1. Subsequent Reporting of a Claim Reported as Closed on a Prior Report

Subsequent Reports are not required for a claim reported as closed (Claim Status Code 1—Closed) on a prior report level unless:

- The claim has reopened and remains open at a subsequent loss valuation—Report the claim at the next report due date with all data valued as of the subsequent loss valuation date and Claims Status Code 0—Open. Continue to report the claim at each subsequent report level until the claim is closed, valued at the 138th month, or is reclassified.
- Additional payments were made between valuations whether or not the claim has reopened—Report the claim at the next report due date with all data valued as of the subsequent loss valuation date and Claim Status Code 1—Closed. A claim is not considered reopened if only loss expense (ALAE or ULAE) payments are made except in the case of an employers liability claim (Type of Claim—Loss Conditions Code 02 or 03). No further reporting is required unless the claim reopens and remains open, or additional payments were made between valuations, whether or not the claim has reopened.

2. Subsequent Reporting of an Open Claim That Becomes Closed

A claim reported as open on a previous report that closes between valuations is reported at the next report due date with all data valued as of the subsequent loss valuation date and Claim Status Code 1—Closed.

No further reporting is required unless the claim reopens and remains open, or additional payments were made between valuations, whether or not the claim has reopened. Refer to Subsequent Reporting of a Claim Reported as Closed on a Prior Report in this section.

3. Subsequent Reporting of a Death or Permanent Total Disability Claim Reclassified as Another Benefit Type

A claim may be identified and reported as Death or Permanent Total Disability based on the established indemnity reserve, even if no Death or Permanent Total Disability benefit payments have been made as of the loss valuation. Any claim reported as Death or Permanent Total Disability on a previous report that is reclassified to another Benefit Type must be reported at the next report due date, with all data valued as of the subsequent loss valuation date and the appropriate Benefit Type assigned.

Continue to value and report the reclassified claim every 12 months until the claim has been reported as:

- Closed
- Reclassified as medical only (i.e., no indemnity payments made or anticipated), Federal Act, or a nonapplicable DCI state
- Valued at the 138th month

4. Subsequent Reporting of a Claim That Becomes Medical Only

A claim reported with an indemnity reserve on a previous report that becomes medical only (i.e., no indemnity payments made or anticipated, no indemnity reserves) between valuations is reported at the next report due date with all data valued as of the subsequent loss valuation date and Claim Status Code 5—Became Medical Only.

No further reporting is required unless indemnity payments are made or anticipated (i.e., indemnity reserves are established).

5. Subsequent Reporting of a Claim Reclassified to a Non-Eligible DCI State

A claim reported with an eligible DCI state (see Jurisdiction State) on a previous report that is reclassified to a non-eligible DCI state must be reported at the next report due date with all data valued as of the subsequent loss valuation date and Jurisdiction State Code 00—Non-Eligible DCI state.

No further reporting is required unless the jurisdiction state is determined to be an eligible DCI state.

6. Subsequent Reporting of a Claim Reclassified as Federal Act

A claim reported as a state Workers Compensation Act or Employers Liability Act on a previous report that is reclassified as Federal Act (i.e., Admiralty, USL&HW, FELA, Jones Act, or Coal Mine Acts) must be reported at the next report due date with all data valued as of the subsequent loss valuation date and Jurisdiction State Code 59—Federal Act.

No further reporting is required unless the claim is determined to be a state Workers Compensation Act or Employers Liability Act claim.

C. DCI DUE DATE TABLE

Detailed Claim Information (DCI) reports are due at NCCI within three months after the loss valuation date. For example, the First Report is valued 18 months after the Reported to Insurer Date and is due at NCCI by the 21st month. It can be received at NCCI between the beginning of the 18th month and the end of the 21st month, and still be considered on time.

DCI DUE DATE

Month	Data Provider Action	NCCI Action
18	Selects, samples, and values all reportable claims for the 1st Report	N/A
18–21	Submits the 1st Report by the last day of the 21st month	Edits and returns Reject and Error Report

DCI DUE DATE (Cont'd)

Month	Data Provider Action	NCCI Action
28	N/A	Distributes Request for Subsequents—Expected List
30	Values and updates all reportable claims for the 2nd Report	N/A
30–33	Submits the 2nd Report by the last day of the 33rd month	Edits and returns Reject and Error Report
40	N/A	Distributes Request for Subsequents—Expected List
42	Values and updates all reportable claims for the 3rd Report	N/A
42–45	Submits the 3rd Report by the last day of the 45th month	Edits and returns Reject and Error Report
52	N/A	Distributes Request for Subsequents—Expected List
54	Values and updates all reportable claims for the 4th Report	N/A
54–57	Submits the 4th Report by the last day of the 57th month	Edits and returns Reject and Error Report
64	N/A	Distributes Request for Subsequents—Expected List
66	Values and updates all reportable claims for the 5th Report	N/A
66–69	Submits the 5th Report by the last day of the 69th month	Edits and returns Reject and Error Report
76	N/A	Distributes Request for Subsequents—Expected List
78	Values and updates all reportable claims for the 6th Report	N/A
78–81	Submits the 6th Report by the last day of the 81st month	Edits and returns Reject and Error Report
88	N/A	Distributes Request for Subsequents—Expected List
90	Values and updates all reportable claims for the 7th Report	N/A
90–93	Submits the 7th Report by the last day of the 93rd month	Edits and returns Reject and Error Report
100	N/A	Distributes Request for Subsequents—Expected List
102	Values and updates all reportable claims for the 8th Report	N/A
102–105	Submits the 8th Report by the last day of the 105th month	Edits and returns Reject and Error Report
112	N/A	Distributes Request for Subsequents—Expected List

DCI DUE DATE (Cont'd)

Month	Data Provider Action	NCCI Action
114	Values and updates all reportable claims for the 9th Report	N/A
114–117	Submits the 9th Report by the last day of the 117th month	Edits and returns Reject and Error Report
124	N/A	Distributes Request for Subsequents—Expected List
126	Values and updates all reportable claims for the 10th Report	N/A
126–129	Submits the 10th Report by the last day of the 129th month	Edits and returns Reject and Error Report
136	N/A	Distributes Request for Subsequents—Expected List
138	Values and updates all reportable claims for the 11th Report	N/A
138–141	Submits the 11th Report by the last day of the 141st month	Edits and returns Reject and Error Report

D. DCI RECORD LAYOUTS

1. Detailed Claim Information Record

This record is for electronic reporting of all Detailed Claim Information (DCI) report levels (Report Level Code 1–11).

For data element descriptions, reporting format, allowable content, code tables, and reporting rules associated with the data elements in the DCI Record Layout, refer to the **Data Dictionary** section (Part 6) of this guidebook.

DCI RECORD

Field No.	Field Title/Description	Class	Position	Bytes
1	Record Type Code	N	1	1
2	Carrier Code	N	2–6	5
3	Carrier Group Code	N	7–11	5
4	Policy Number Identifier	AN	12–29	18
5	Policy Effective Date	N	30–37	8
6	Report Level Code	N	38–39	2
7	Replacement Type Code	N	40	1
8	Claim Number Identifier	AN	41–52	12
9	Reserved for Future Use		53–70	18
10	Jurisdiction State Code	N	71–72	2
11	Accident State Code	N	73–74	2
12	Accident/Injury Date	N	75–82	8
13	Reported to Insurer Date	N	83–90	8

DCI RECORD (Cont'd)

Field No.	Field Title/Description	Class	Position	Bytes
14	Classification Code	N	91–94	4
15	Type of Loss—Loss Condition Code	N	95–96	2
16	Type of Recovery—Loss Condition Code	N	97–98	2
17	Type of Claim—Loss Condition Code	N	99–100	2
18	Claimant Gender Code	N	101	1
19	Birth Year	N	102–105	4
20	Hire Year	N	106–109	4
21	Reserved for Future Use		110–113	4
22	Preinjury/Average Weekly Wage Amount	N	114–118	5
23	Method of Determining Preinjury/Average Weekly Wage Code	N	119	1
24	Part of Body Code—Injury Description	N	120–121	2
25	Nature of Injury Code—Injury Description	N	122–123	2
26	Cause of Injury Code—Injury Description	N	124–125	2
27	Claim Status Code	N	126	1
28	Closing Date	N	127–134	8
29	Total Incurred Indemnity Amount	N	135–143	9
30	Benefit Type Code	N	144–145	2
31	Benefit Amount Paid	N	146–154	9
32	Weekly Benefit	N	155–160	6
33	Benefit Type Code	N	161–162	2
34	Benefit Amount Paid	N	163–171	9
35	Weekly Benefit	N	172–177	6
36	Benefit Type Code	N	178–179	2
37	Benefit Amount Paid	N	180–188	9
38	Weekly Benefit	N	189–194	6
39	Benefit Type Code	N	195–196	2
40	Benefit Amount Paid	N	197–205	9
41	Weekly Benefit	N	206–211	6
42	Benefit Type Code	N	212–213	2
43	Benefit Amount Paid	N	214–222	9
44	Weekly Benefit	N	223–228	6
45	Reserved for Future Use		229–245	17
46	Vocational Rehabilitation Evaluation Expense Amount Paid	N	246–254	9
47	Vocational Rehabilitation Maintenance Benefit Amount Paid	N	255–263	9

DCI RECORD (Cont'd)

Field No.	Field Title/Description	Class	Position	Bytes
48	Vocational Rehabilitation Education Expense Amount Paid	N	264–272	9
49	Vocational Rehabilitation Other Amount Paid	N	273–281	9
50	Total Incurred Medical Amount	N	282–290	9
51	Total Paid Medical Amount	N	291–299	9
52	Post-Injury Weekly Wage Amount	N	300–308	9
53	Impairment/Disability Percentage	N	309–311	3
54	Impairment Percentage Basis Code	N	312	1
55	Maximum Medical Improvement Date	N	313–320	8
56	Attorney or Authorized Representative Indicator	A	321	1
57	Controverted/Disputed Case Indicator	A	322	1
58	Claimant Legal Amount Paid	N	323–331	9
59	Employer Legal Amount Paid	N	332–340	9
60	Benefits Covered by Lump Sum Settlement Code	AN	341–342	2
61	Lump Sum Settlement Amount Paid	N	343–351	9
62	Benefits Covered by Lump Sum Settlement Code	AN	352–353	2
63	Lump Sum Settlement Amount Paid	N	354–362	9
64	Benefits Covered by Lump Sum Settlement Code	AN	363–364	2
65	Lump Sum Settlement Amount Paid	N	365–373	9
66	Benefits Covered by Lump Sum Settlement Code	AN	374–375	2
67	Lump Sum Settlement Amount Paid	N	376–384	9
68	Benefits Covered by Lump Sum Settlement Code	AN	385–386	2
69	Lump Sum Settlement Amount Paid	N	387–395	9
70	Benefits Covered by Lump Sum Settlement Code	AN	396–397	2
71	Lump Sum Settlement Amount Paid	N	398–406	9
72	Medical Extinguishment Indicator	A	407	1
73	Return to Work Date	N	408–415	8
74	Return to Work Status Indicator	A	416	1
75	Extraordinary Loss Event Claim Indicator	A	417	1
76	Reserved for Future Use		418–425	8
77	Previous Carrier Code	N	426–430	5
78	Previous Carrier Group Code	N	431–435	5
79	Previous Policy Number Identifier	AN	436–453	18
80	Previous Policy Effective Date	N	454–461	8
81	Previous Reported to Insurer Date	N	462–469	8
82	Previous Claim Number Identifier	AN	470–481	12
83	Reserved for Future Use		482–500	19

2. Submission Control Record

This record provides information about the electronic submission such as the number of data records included in the submission. Every electronic submission must include a Submission Control Record (Record Type Code 9).

SUBMISSION CONTROL RECORD

Field No.	Field Title/Description	Class	Position	Bytes
1	**Record Type Code** Enter "9"	N	1	1
2	**Filler** Fill positions 2–41 of this record with nines.	N	2–41	40
3	**Submission Record Total** Report the total of all Record Type 1 records. Do not count the submission control record in this total. Field is right justified and left zero filled for totals less than 8 characters.	N	42–49	8
4	Reserved For Future Use		50–250	201

E. REPLACEMENT REPORTS

A Detailed Claim Information (DCI) Replacement Report allows data providers to fully replace any report (1st–11th) that resides on NCCI's database and:

- Contains rejected values that have been incorrectly reported (i.e., mistakenly excluded or misrepresented)
- Contains nonrejected values that have been incorrectly reported (i.e., mistakenly excluded or misrepresented)
- Requires key data element revision

Note: Do not use the DCI Replacement Report to submit loss valuation updates (i.e., changes in loss values due to development from one report to the next). For information on updating or reclassifying data at loss valuation date, refer to Subsequent Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

1. Replacement Due to Nonrejected Incorrect Values

Although NCCI uses edits to identify any data that is (or may be) in error, it is possible that incorrect values can go undetected. For example, a claimant hire year could be reported to NCCI as 1998 (a valid value per NCCI editing) when, in fact, the hire year was 1989.

When a data provider finds that a value has been mistakenly excluded or misrepresented, a Replacement Report should be submitted for each report level that contains the incorrect value.

To correct an incorrect value:

- Report the appropriate Report Level Code (Positions 38–39)
- Report "1" in Replacement Type Code (Position 40)
- Report **all** data elements—because this is a complete replacement, the corrected data and the data that is unchanged must be reported

2. Replacement Due to Key Data Element Revisions

The following elements are considered key data elements and are required to be reported the same for all report levels (1st–11th) unless a Replacement Report is submitted:

- Carrier Code (if applicable)
- Carrier Group Code (if applicable)
- Policy Number Identifier
- Policy Effective Date

- Reported to Insurer Date
- Claim Number Identifier

To change one or more of these data elements:

- Report "01" in Report Level Code (Positions 38–39), regardless of the most recently reported level
- Report "1" in Replacement Type Code (Position 40)
- Report **all** data elements—because this is a complete replacement, the revised data and the data that is unchanged must be reported
- Report the revised and previously reported data elements as follows:

If revision is to ...	**Report the revised information in** ...	**Report the previously reported information in** ...
Carrier Code	Carrier Code—Positions 2–6	Previous Carrier Code—Positions 426–430
Carrier Group Code	Carrier Group Code—Positions 7–11	Previous Carrier Group Code—Positions 431–435
Policy Number Identifier	Policy Number Identifier—Positions 12–29	Previous Policy Number Identifier—Positions 436–453
Policy Effective Date	Policy Effective Date—Positions 30–37	Previous Policy Effective Date—Positions 454–461
Reported to Insurer Date	Reported to Insurer Date—Positions 83–90	Previous Reported to Insurer Date—Positions 462–469
Claim Number Identifier	Claim Number Identifier—Positions 41–58	Previous Claim Number Identifier—Positions 470–487

Example: Replacement Report to Revise Claim Number Identifier

After submitting a 2nd Report, the data provider finds that claim number WC9322333 should have been reported as WC3922333. To revise the previously reported claim number identifier, a Replacement Report is submitted as follows:

Field No.	Field Title/Description	Position	Data Reported as ...
1	Record Type Code	1	1
6	Report Level Code	38–39	01
7	Replacement Type Code	40	1
8	Claim Number Identifier	41–58	WC3922333
82	Previous Claim Number Identifier	470–487	WC9322333

Because this is a complete replacement, the revised data and **all** of the data elements that are unchanged must be reported.

Once NCCI processes the Replacement Report, the data previously residing on the DCI database will be updated and all future requests for Subsequent Reports (Request for Subsequents—Expected List) will contain the correct key data elements.

PART 6—DATA DICTIONARY

OVERVIEW

To facilitate effective data planning, control, and use, the alphabetized Data Dictionary contained in Part 6 provides information associated with the data elements in the DCI Record Layout such as:

- Data element descriptions
- Reporting format
- Allowable content
- Code tables
- Relationships to other data
- Reporting rules

A. DATA DICTIONARY

1. Accident State Code

Field(s)	11
Position(s)	73–74
Class	Numeric (N)—Field contains only numeric characters
Bytes	2
Format	N 2

Definition: A code that corresponds to the state or foreign location where the claimant was injured or contracted disease.

Reporting Requirement: Report the code that corresponds to the state or foreign location where the claimant was injured or contracted disease. The Accident State does not have to be one of the states included in the list of applicable DCI states.

STATE AND PROVINCE CODE TABLE

State or Province	Code
Alabama	01
Alaska	54
Alberta	61
Arizona	02
Arkansas	03
British Columbia	62
California	04
Canada	55
Canada Zone	56
Colorado	05
Connecticut	06
Delaware	07
District of Columbia	08

STATE AND PROVINCE CODE TABLE (Cont'd)

State or Province	Code
Florida	09
Georgia	10
Hawaii	52
Idaho	11
Illinois	12
Indiana	13
Iowa	14
Kansas	15
Kentucky	16
Louisiana	17
Maine	18
Manitoba	63
Maryland	19
Massachusetts	20
Michigan	21
Minnesota	22
Mississippi	23
Missouri	24
Montana	25
Nebraska	26
Nevada	27
New Brunswick	64
New Hampshire	28
New Jersey	29
New Mexico	30
New York	31
Newfoundland/Labrador	72
North Carolina	32
North Dakota	33
Northwest Territories	60
Nova Scotia	65
Nunavut	70
Ohio	34
Oklahoma	35
Ontario	67
Oregon	36
Pennsylvania	37
Philippine Islands	57

STATE AND PROVINCE CODE TABLE (Cont'd)

State or Province	Code
Prince Edward Island	66
Puerto Rico	58
Quebec	68
Rhode Island	38
Saskatchewan	69
South Carolina	39
South Dakota	40
Tennessee	41
Texas	42
Utah	43
Vermont	44
Virginia	45
Virgin Islands	51
Washington	46
West Virginia	47
Wisconsin	48
Wyoming	49
Yukon	71

2. Accident/Injury Date

Field(s)	12
Position(s)	75–82
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD

Definition: The date the claimant was injured.

Reporting Requirement: Report the date the claimant was injured.

The Accident/Injury Date must be equal to or greater than the Policy Effective Date (Positions 30–37).

In the case of occupational disease or cumulative injury, use the last day that the claimant worked without the disability or the last day of coverage, whichever is earlier.

3. Attorney or Authorized Representative Indicator

Field(s)	56
Position(s)	321
Class	Alpha (A)—Field contains only alphabetic characters

Bytes	1
Format	Y/N

Definition: Indicates whether or not the claimant has an attorney or authorized representative.

Reporting Requirement: Report "Y" or "N" to indicate whether or not the claimant has an attorney or authorized representative.

INDICATOR	DESCRIPTION
Y	Claimant has an attorney or authorized representative
N	Claimant does not have an attorney or authorized representative

4. Benefit Amount Paid

Field(s)	31, 34, 37, 40, 43
Position(s)	146–154, 163–171, 180–188, 197–205, 214–222
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 indemnity amount paid to date (sum of previous and current payments) for the corresponding Benefit Type, excluding Lump Sum Settlement Amount Paid.

Reporting Requirement: Report the indemnity amount paid to date that corresponds with the Benefit Type Code, excluding Lump Sum Settlement Amount Paid. If there have been no benefits other than those covered by a lump sum settlement, zero-fill this field and report the dollar amount in Lump Sum Settlement Amount Paid (Positions 343–351, 354–362, 365–373, 376–384, 387–395, 398–406).

The amount reported should include any payments to special funds, compensation paid to a deceased claimant prior to death, burial expenses, and payments to the state. If a separate payment is made to the claimant attorney (i.e., separate checks), report the amount in Claimant Legal Amount Paid (Positions 323–331); otherwise, include the claimant legal amount paid in Benefit Amount Paid.

If Type of Claim (Position 99–100) is reported as 02—Employers Liability Only, then the entire loss amount paid including allocated loss adjustment expenses (ALAE) must be reported as Benefit Amount Paid.

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the Benefit Amount Paid net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

When reporting a claim for which an indemnity reserve has been established, but no payments have been made, zero-fill this field and report the Benefit Type Code (Positions 144–145, 161–162, 178–179, 195–196, 212–213) that reflects the type of benefit anticipated for the first indemnity payment.

Benefit Amount Paid is identified as an indemnity loss and must be included in Total Incurred Indemnity Amount (Positions 135–143).

Benefit Amount Paid must be consistent with the Benefit Type Code reported in the corresponding Benefit Type Code positions.

If reporting Benefit Amount Paid in Positions ...	Then the amount must correspond to Benefit Type Code in Positions ...
146–154	144–145
163–171	161–162
180–188	178–179
197–205	195–196
214–222	212–213

In cases of multiple or additional Benefit Type Codes, use multiple Benefit Amount Paid fields.

Example: Using Multiple Benefit Amount Paid Fields

The Benefit Type Code reported on the 1st report was Temporary Partial (Benefit Type Code 11), and at second loss valuation (30 months), the benefits now correspond to Scheduled Permanent Partial (Benefit Type Code 03). For this example, the Benefit Type Code and Benefit Amount Paid that were reported on the 1st report were reported in Positions 144–145 and 146–154, respectively. On the subsequent report, the additional Benefit Type Code and corresponding Benefit Amount Paid were reported in the next set of fields (Positions 161–162 and 163–171, respectively).

- 1st report

Valuation	Benefit Type	Report:	
18-month	Temporary Partial	Benefit Type Code = 11 (Positions 144–145)	Benefit Amount Paid = 4000 (Positions 146–154)

- 2nd report

Valuation	Benefit Type	Report:	
30-month	Temporary Partial	Benefit Type Code = 11 (Positions 144–145)	Benefit Amount Paid = 4200 (Positions 146–154)
	Scheduled Permanent Partial	Benefit Type Code = 03 (Positions 161–162)	Benefit Amount Paid = 951 (Positions 163–171)

Note: Since Benefit Amount Paid is the total indemnity amount paid to date associated with a benefit type, any additional payments for that benefit type are reported at the next loss valuation in the appropriate Benefit Amount Paid field. For this example, an additional $200 in Temporary Partial benefits was paid between the first (18-month) and second (30-month) valuations. Therefore, Positions 146–154—Benefit Amount Paid was increased from $4,000 to $4,200.

5. Benefit Type Code

Field(s)	30, 33, 36, 39, 42
Position(s)	144–145, 161–162, 178–179, 195–196, 212–213
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: A code that corresponds to the type of benefits paid to the claimant.

Reporting Requirement: At least one Benefit Type Code must be reported for all claims for which a benefit payment has been made that was not part of a Lump Sum Settlement. If there have been no benefits other than those covered by a lump sum settlement, zero-fill this field and report the benefit type in Benefits Covered by Lump Sum Settlement Code (Positions 341–342, 352–353, 363–364, 374–375, 385–386, 396–397).

When reporting a claim for which an indemnity reserve has been established, but no payments have been made, report the Benefit Type Code that reflects the type of benefit anticipated for the first indemnity payment.

If, at a later loss valuation, the actual indemnity payments are made under a Benefit Type Code other than what was anticipated, or the claim becomes medical only, then the Benefit Type Code associated with the payments should replace the anticipated benefit type that was previously reported.

Code	Description
01	**Death**—Benefits paid or payable for the death of the claimant resulting from a work-related accident or occupational injury or disease.
02	**Permanent Total Disability**—Benefits paid or payable for: • The loss of any body part or function that renders the claimant unable to engage in any employment or occupation, or • The permanent loss of use of any body part or function that renders the claimant unable to engage in any employment or occupation
03	**Scheduled Permanent Partial**—Benefits paid or payable as established by a statutory list (schedule) of payments for certain injuries. The benefit amount is determined by the part of the body that was injured subject to limitations set forth in the statute.
04	**Unscheduled Permanent Partial**—Benefits paid or payable for injuries to parts of the body not covered by a schedule. These benefits are payable for the claimant's actual wage loss or reduction in wage-earning ability, subject to limitations set forth in the statute.
05	**Temporary Total Injury**—Benefits paid or payable for the period that: • Claimant is unable to perform any work for pay as a result of disability from which that individual can be expected to fully recover, and • Precedes the date of maximum medical improvement (MMI)
09	**Disfigurement**—Benefits paid or payable for any scarring or cosmetic defect. Nonapplicable states: AK, AL, AZ, FL, GA, HI, IA, ID, KS, KY, MA, MD, ME, MI, MN, MS, NE, NH, NJ, NV, NY, OR, UT, VA, VT, WI, WV
11	**Temporary Partial**—Benefits paid or payable for the period that: • Claimant, as a result of disability from which that individual can be expected to fully recover, is unable to perform work for their regular pay, but is receiving a reduced rate of pay, and • Precedes the date of maximum medical improvement (MMI)
12	**Employers Liability**—Includes all loss and expense (ALAE)
15	**Supplemental (FL, LA, SD only)**—A wage-loss benefit, usually based on the difference between preinjury wage and postinjury wage, that is provided to injured employees in addition to Permanent Partial Disability benefits. Supplemental benefits are defined by statute in the applicable jurisdictions.

Code	Description
50	**Not Otherwise Classified (NOC)**—Benefits paid or payable that cannot be assigned to a specific Benefit Type listed above. • Discretionary Benefits (CT only) • Additional Benefits (LA, RI only) • Impairment Compensation (MN only)

Benefit Type Code must be consistent with the Benefit Amount Paid reported in the corresponding Benefit Amount Paid positions.

If reporting Benefit Type Code in Positions ...	Then the Benefit Type Code must correspond to the Benefit Amount Paid in Positions ...
144–145	146–154
161–162	163–171
178–179	180–188
195–196	197–205
212–213	214–222

In cases of multiple or additional Benefit Types, use multiple Benefit Type Code fields.

Example: Using Multiple Benefit Type Code Fields

The Benefit Type Code reported on the 1st report was Temporary Partial (Benefit Type Code 11), and at second loss valuation (30 months), the benefits now correspond to Scheduled Permanent Partial (Benefit Type Code 03). For this example, the Benefit Type Code and Benefit Amount Paid that were reported on the 1st report were reported in Positions 144–145 and 146–154, respectively. On the subsequent report, the additional Benefit Type Code and corresponding Benefit Amount Paid were reported in the next set of fields (Positions 161–162 and 163–171, respectively).

- 1st Report

Valuation	Benefit Type	Report:	
18-month	Temporary Partial	Benefit Type Code = 11 (Positions 144–145)	Benefit Amount Paid = 4000 (Positions 146–154)

- 2nd Report

Valuation	Benefit Type	Report:	
30-month	Temporary Partial	Benefit Type Code = 11 (Positions 144–145)	Benefit Amount Paid = 4000 (Positions 146–154)
	Scheduled Permanent Partial	Benefit Type Code = 03 (Positions 161-162)	Benefit Amount Paid = 951 (Positions 163–171)

6. Benefits Covered by Lump Sum Settlement Code

Field(s)	60, 62, 64, 66, 68, 70
Position(s)	341–342, 352–353, 363–364, 374–375, 385–386, 396–397
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: A code that corresponds to the type of benefits covered by the Lump Sum Settlement Amount Paid.

Reporting Requirement: Report the code that corresponds to the type of benefits covered by the Lump Sum Settlement Amount Paid (Positions 343–351, 354–362, 365–373, 376–384, 387–395, 398–406).

Zero-fill if no Lump Sum Settlement amount has been paid as of loss valuation.

Code	Description
01	**Death**—Lump Sum Settlement paid or payable for the death of the claimant resulting from a work-related accident or occupational injury or disease.
02	**Permanent Total Disability**—Lump Sum Settlement paid or payable for: • The loss of any body part or function that renders the claimant unable to engage in any employment or occupation, or • The permanent loss of use of any body part or function that renders the claimant unable to engage in any employment or occupation
03	**Scheduled Permanent Partial**—Lump Sum Settlement paid or payable as established by a statutory list (schedule) of payments for certain injuries. The benefit amount is determined by the part of the body that was injured subject to limitations set forth in the statute.
04	**Unscheduled Permanent Partial**—Lump Sum Settlement paid or payable for injuries to parts of the body not covered by a schedule. These benefits are payable for the claimant's actual wage loss or reduction in wage-earning ability, subject to limitations set forth in the statute.
05	**Temporary Total Injury**—Lump Sum Settlement paid or payable for the period that: • Claimant is unable to perform any work for pay as a result of disability from which that individual can be expected to fully recover, and • Precedes the date of maximum medical improvement (MMI)
06	**Medical Only**—Lump Sum Settlement includes only future medical payments
09	**Disfigurement**—Lump Sum Settlement paid or payable for any scarring or cosmetic defect. Nonapplicable states: AK, AL, AZ, FL, GA, HI, IA, ID, KS, KY, MA, MD, ME, MI, MN, MS, NE, NH, NJ, NV, NY, OR, UT, VA, VT, WI, WV
11	**Temporary Partial**—Lump Sum Settlement paid or payable for the period that: • Claimant, as a result of disability from which that individual can be expected to fully recover, is unable to perform work for their regular pay, but is receiving a reduced rate of pay, and • Precedes the date of maximum medical improvement (MMI)
12	**Employers Liability**—Lump Sum Settlement paid or payable under Employers Liability coverage. Includes all loss and expense (ALAE)

Code	Description
15	**Supplemental (FL, LA, SD only)**—A wage-loss benefit, usually based on the difference between preinjury wage and postinjury wage, that is provided to injured employees in addition to Permanent Partial Disability benefits. Supplemental benefits are defined by statute in the applicable jurisdictions.
49	**Indemnity and Medical Combined**—Lump Sum Settlement includes only future indemnity and medical payments combined
50	**Not Otherwise Classified (NOC)**—Lump Sum Settlement amount that cannot be assigned to a specific Benefits Covered by Lump Sum Settlement Code listed above. • Discretionary Benefits (CT only) • Additional Benefits (LA, RI only) • Impairment Compensation (MN only)

Benefits Covered by Lump Sum Settlement Code must be consistent with the Lump Sum Settlement Amount Paid reported in the corresponding Lump Sum Settlement Amount Paid positions.

If reporting Benefits Covered by Lump Sum Settlement Code in Positions ...	Then the Benefits Covered by Lump Sum Settlement Code must correspond to the Lump Sum Settlement Amount Paid in Positions ...
341–342	343–351
352–353	354–362
363–364	365–373
374–375	376–384
385–386	387–395
396–397	398–406

In cases of multiple or additional Benefit Types, use multiple Benefits Covered by Lump Sum Settlement Code fields.

Example: Using Multiple Benefits Covered by Lump Sum Settlement Code Fields

The Benefits Covered by Lump Sum Settlement Code reported on the 1st report was Medical Only (Benefit Type Code 06), and at second loss valuation (30 months), the benefits now correspond to Indemnity and Medical Combined (Benefit Type Code 49). For this example, the Benefits Covered by Lump Sum Settlement Code and Lump Sum Settlement Amount Paid that were reported on the 1st report were reported in Positions 341–342 and 343–351, respectively. On the subsequent report, the additional Benefits Covered by Lump Sum Settlement Code and corresponding Lump Sum Settlement Amount Paid were reported in the next set of fields (Positions 352–353 and 354–362, respectively).

- 1st report

Valuation	Benefits Covered by Lump Sum Settlement	Report:	
18-month	Temporary Partial	Benefits Covered by Lump Sum Settlement Code = 06 (Positions 341–342)	Lump Sum Settlement Amount Paid = 2000 (Positions 343–351)

- 2nd report

Valuation	Benefits Covered by Lump Sum Settlement	Report:	
30-month	Temporary Partial	Benefits Covered by Lump Sum Settlement Code = 06 (Positions 341–342)	Lump Sum Settlement Amount Paid = 2000 (Positions 343–351)
	Scheduled Permanent Partial	Benefits Covered by Lump Sum Settlement Code = 49 (Positions 352–353)	Lump Sum Settlement Amount Paid = 6000 (Positions 354–362)

7. Birth Year

Field(s)	19
Position(s)	102–105
Class	Numeric (N)—Field contains only numeric characters
Bytes	4
Format	YYYY

Definition: Claimant's actual or estimated year of birth.

Reporting Requirement: Report the year the claimant was born. The Birth Year must be before the Accident/Injury Date (Positions 75–82). If the Employer's First Report of Injury Form contains the claimant's age rather than an actual birth date, calculate the Birth Year by subtracting the claimant's age from the year of accident/injury.

Zero-fill if neither the birth year nor age is available.

8. Carrier Code

Field(s)	2
Position(s)	2–6
Class	Numeric (N)—Field contains only numeric characters
Bytes	5
Format	N 5

Definition: The carrier code assigned to the data provider by NCCI.

Reporting Requirement: Report Carrier Code only if your company participates in Detailed Claim Information (DCI) at the company level and performs the claim selection and claim sampling on an individual company basis. If your company participates in DCI on a group level and performs the claim selection and claim sampling on a group basis, zero-fill Carrier Code and report in Carrier Group Code (Positions 7–11).

Carrier Code is a key data element and must remain the same throughout DCI reporting (1st–11th reports), unless a revision to the Carrier Code previously reported has been submitted. For information on revising Carrier Code, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

9. Carrier Group Code

Field(s)	3
Position(s)	7–11
Class	Numeric (N)—Field contains only numeric characters
Bytes	5
Format	N 5

Definition: The code assigned by NCCI that corresponds to the dominant insurer in a carrier group.

Reporting Requirement: Report Carrier Group Code only if your company participates in Detailed Claim Information (DCI) at the group level and performs the claim selection and claim sampling on a group basis. If your company participates in DCI at the company level and performs the claim selection and claim sampling on an individual company basis, zero-fill Carrier Group Code and report in Carrier Code (Positions 2–6).

Carrier Group Code is a key data element and must remain the same throughout DCI reporting (1st–11th reports), unless a revision to the Carrier Group Code previously reported has been submitted. For information on revising Carrier Group Code, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

10. Cause of Injury Code—Injury Description

Field(s)	26
Position(s)	124–125
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: A code that corresponds to the cause of injury sustained by the claimant.

Reporting Requirement: Report the code that corresponds to the cause of injury sustained by the claimant.

CAUSE OF INJURY CODES—EFFECTIVE 1/1/96

Code	Cause of Injury	Narrative Description
a.	**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	

CAUSE OF INJURY CODES—EFFECTIVE 1/1/96 (Cont'd)

Code	Cause of Injury	Narrative Description
06	Dust, Gases, Fumes, or Vapors	
07	Welding Operation	
08	Radiation	
14	Abnormal Air Pressure	
84	Electrical Current	
09	Contact With, NOC	
b.	**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	
c.	**Cut, Puncture, 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	
d.	**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	

CAUSE OF INJURY CODES—EFFECTIVE 1/1/96 (Cont'd)

Code	Cause of Injury	Narrative Description
32	On Ice or Snow	
33	On Stairs	
31	Fall, Slip, or Trip, NOC	
e.	**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	
f.	**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	
g.	**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	

CAUSE OF INJURY CODES—EFFECTIVE 1/1/96 (Cont'd)

Code	Cause of Injury	Narrative Description
70	Striking Against or Stepping On, NOC	
h.	**Stuck 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.
i.	**Rubbed or Abraded By**	
94	Repetitive Motion	Callous, Blister, etc.
95	Rubbed or Abraded, NOC	
j.	**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	Robbery or Criminal Assault
90	Other Than Physical Cause of Injury	
91	Mold	
96	Terrorism (for use with an assigned Catastrophe Code only)	
98	Cumulative, NOC	All Other
99	Other—Miscellaneous, NOC	

11. Claim Number Identifier

Field(s)	8
Position(s)	41–52
Class	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes	12
Format	A/N 12, exclude blanks, punctuation marks, and special characters (if the Claim Number Identifier is less than 12 bytes, this field must be left justified, and blanks in all spaces to the right of the last character).

Definition: The unique set of numbers and/or letters that identify the specific claim that the report applies to.

Reporting Requirement: Report the unique set of numbers and/or letters that identify the specific claim that the report applies to.

The Claim Number Identifier must match the Unit Statistical claim number and must remain the same throughout DCI reporting (1st –11th reports), unless a revision to the Claim Number Identifier previously reported has been submitted. For information on revising Claim Number Identifier, refer to Replacement Reports in the **Reporting and Record Layouts** sections (Part 5) of this guidebook.

12. Claim Status Code

Field(s)	27
Position(s)	126
Class	Numeric (N)—Field contains only numeric characters
Bytes	1
Format	N

Definition: A code that corresponds to the current status of the claim at the time of loss valuation.

Reporting Requirement: Report the code that corresponds to the current status of the claim at the time of loss valuation. On 1st reports, the claim status must equal “0” (Open) or “1” (Closed).

Code	Description
0	**Open:** The insurer expects to make further indemnity and/or medical payments on the claim (the exact nature of these payments may not be known) or may not have determined whether payments will be made in the future.
1	**Closed:** The insurer does not expect to make any further indemnity or medical payments on the resolved claim.
5	**Became Medical Only:** The claim became a medical-only claim after originally being reported as an indemnity claim and, therefore, is no longer subject to DCI.

13. Claimant Gender Code

Field(s)	18
Position(s)	101
Class	Numeric (N)—Field contains only numeric characters
Bytes	1
Format	N

Definition: A code that corresponds to the claimant's gender.

Reporting Requirement: Report the code that corresponds to the claimant's gender.

CODE	DESCRIPTION
1	Male
2	Female
3	Other

14. Claimant Legal Amount Paid

Field(s)	58
Position(s)	323–331
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 amount paid to date 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.

Reporting Requirement: Report Claimant Legal Amount Paid only when a separate payment is made to the claimant attorney (i.e., separate checks); otherwise, zero-fill and include in Benefit Amount Paid (Positions 146–154, 163–171, 180–188, 197–205, 214–222).

If Type of Claim (Positions 99–100) is reported as 02—Employers Liability Only, zero-fill and include in Benefit Amount Paid (Positions 146–154, 163–171, 180–188, 197–205, 214–222).

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the Claimant Legal Amount Paid net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

Claimant Legal Amount Paid is identified as an indemnity loss and must always be included in Total Incurred Indemnity Amount (Positions 135–143).

Zero-fill if no Claimant Legal Amount has been paid as of loss valuation.

15. Classification Code

Field(s)	14
Position(s)	91–94
Class	Numeric (N)—Field contains only numeric characters
Bytes	4
Format	N 4, Data field is to be right justified and left zero-filled

Definition: A code that corresponds to the assigned classification of the injured employee's payroll or other exposure.

Reporting Requirement: Report the class code assigned to the injured employee's payroll or other exposure according to the rules of, or as defined by, the jurisdiction. Verify that the classification code is valid for the state and effective date of the policy.

Do not report statistical (premium only) codes or "company use only" codes in this field.

Use NCCI's ***Basic Manual for Workers Compensation and Employers Liability Insurance*** and ***Scopes®Manual*** to assign classification codes. Use NCCI's ***Classification Codes and Statistical Codes for Workers Compensation and Employers Liability Insurance*** to find classification codes and their descriptions, as well as to learn whether a code is a state special, a federal classification, or a statistical code, or whether it has been discontinued.

Exception: For Independent Bureau states: Use the manual designated by the Independent Bureau state to determine classification code assignment.

Exception: Pennsylvania: Report Pennsylvania's three-digit classification code as a four-digit code by inserting a zero before the code.

16. Closing Date

Field(s)	28
Position(s)	127–134
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD

Definition: The date the claim was closed (i.e., further indemnity or medical payments are not expected), the judgment date, or the date an agreement was made as to the final amount paid.

Reporting Requirement: Report the most recent date as of loss valuation that the claim was closed only if Claim Status Code (Position 126) is reported as "1"—Closed.

Zero-fill if the Claim Status Code (Position 126) is "0"—Open.

The Closing Date must be greater than or equal to the Reported to Insurer Date (Positions 83–90).

17. Controverted/Disputed Case Indicator

Field(s)	57
Position(s)	322

Class	Alpha (A)—Field contains only alphabetic characters
Bytes	1
Format	Y/N

Definition: Indicates whether this claim is or was ever contested or disputed for compensability and/or disability by the insurer.

Reporting Requirement: Report "Y" or "N" to indicate whether or not this claim is or was ever contested or disputed for compensability and/or disability by the insurer.

INDICATOR	DESCRIPTION
Y	This claim is or was contested or disputed for compensability and/or disability.
N	This claim is not or has not been contested or disputed for compensability and/or disability.

Examples of contests/disputes include:

- Compensability—whether the claim is a valid workers compensation claim
- Degree of disability or impairment
- Type of benefits that should apply
- Termination of benefits
- Medical treatment—what medical procedure is appropriate or what medical provider is used

The Controverted/Disputed Case Indicator should be reported as "Y" if any of the above apply, or if there is or has been any dispute that affects the total cost of the claim.

18. Employer Legal Amount Paid

Field(s)	59
Position(s)	332–340
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 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 employers liability law.

Reporting Requirement: Report the amount paid by the employer or benefit payer for the services of an attorney or authorized representative.

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the Employer Legal Amount Paid net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

Zero-fill if there has not been any Employer Legal Amount Paid as of loss valuation.

19. Extraordinary Loss Event Claim Indicator

Field(s)	75
Position(s)	417
Class	Alpha (A)—Field contains only alphabetic characters
Bytes	1
Format	Y/N

Definition: Indicates whether or not the claim is part of an Extraordinary Loss Event catastrophe.

Reporting Requirement: Report "Y" or "N" to indicate whether or not this claim is the result of an Extraordinary Loss Event catastrophe. An Extraordinary Loss Event (ELE) catastrophe is a significant loss event from a workers compensation perspective, which is determined by NCCI on a case-by-case basis.

INDICATOR	DESCRIPTION
Y	This claim is the result of an Extraordinary Loss Event (ELE) catastrophe.
N	This claim is not the result of an Extraordinary Loss Event (ELE) catastrophe.

20. Hire Year

Field(s)	20
Position(s)	106–109
Class	Numeric (N)—Field contains only numeric characters
Bytes	4
Format	YYYY

Definition: The year the claimant began his or her most recent employment with the employer.

Reporting Requirement: Report the year the claimant began his or her most recent employment with the employer.

Hire Year must be less than or equal to the year of the Accident/Injury Date (Positions 75–82).

If the Employer's First Report of Injury Form contains the claimant's number of years employed rather than the Hire Date, calculate the Hire Year by subtracting the number of years employed from the year of the Accident/Injury Date.

21. Impairment Percentage Basis Code

Field(s)	54
Position(s)	312
Class	Numeric (N)—Field contains only numeric characters
Bytes	1
Format	N

Definition: A code that corresponds to whether the impairment rating was based on the whole body or part of body.

Reporting Requirement: Report the code that corresponds to whether the impairment rating was based on the whole body or part of body only if an impairment percentage is reported in Impairment/Disability Percentage (Positions 309–311). If applicable, this field must be completed if Claim Status Code (Position 126) is reported as "1" (Closed).

Report "0" if benefits are based on a disability percentage.

CODE	DESCRIPTION
0	Benefits not based on impairment percentage
1	Impairment percentage based on the whole body
2	Impairment percentage based on part of body

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 Impairment/Disability Percentage (Positions 309–311).

22. Impairment/Disability Percentage

Field(s)	53
Position(s)	309–311
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 (for example: 50% is reported as 050)

Definition: The actual, final percentage of impairment or disability of a claim.

Reporting Requirement: Report the percentage of impairment or disability only for states where impairment rating or disability rating is used to determine benefits (see Impairment Rating/Disability Rating States) and then for those claims where an impairment rating or disability rating was used to determine benefits. If applicable, this field must be completed if Claim Status Code (Position 126) is reported as "1" (Closed).

Zero-fill if not applicable or if Claim Status Code (Position 126) is reported as "0" (Open) and a final impairment or disability rating has not been assigned as of loss valuation.

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 Impairment Percentage Basis Code (Position 312). This is not a requirement for disability percentage.

For multiple impairment ratings, convert each one to a whole body rating, then add together to find the impairment percentage.

Example: Converting Multiple Impairment Ratings to Whole Body Rating

A claim has two impairment ratings, 50% of arm and 20% of leg. If the arm is considered 40% of the whole body, multiply the impairment rating for the arm (50%) by the whole body percentage (40%) as 0.5 × 0.4 = 0.2. If the leg is considered 30% of the whole body, multiply the impairment rating for the leg (20%) by the whole body percentage (30%) as 0.2 × 0.3 = 0.06. Now that the impairment ratings are converted to whole body percentages, they are added together as 0.2 + 0.06 = 0.26 for an impairment percentage of 26%. Entered as a whole number with a leading zero or 026.

a. Impairment Rating/Disability Rating States

The following states have established benefit calculations that use an impairment rating or a disability rating, or allow impairment ratings to be used in benefit determination:

Alabama	Illinois	Mississippi	Oregon
Alaska	Indiana	Missouri	Pennsylvania
Arizona	Iowa	Montana	Rhode Island
Arkansas	Kansas	Nebraska	South Carolina
Colorado	Kentucky	Nevada	South Dakota
Connecticut	Louisiana	New Hampshire	Tennessee
District of Columbia	Maine	New Jersey	Utah
Florida	Maryland	New Mexico	Vermont
Georgia	Massachusetts	New York	Virginia
Hawaii	Michigan	North Carolina	West Virginia
Idaho	Minnesota	Oklahoma	Wisconsin

23. Jurisdiction State Code

Field(s)	10
Position(s)	71–72
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: A code that corresponds to the state under whose Workers Compensation Act or Employers Liability Act the claimant's benefits are being paid.

Reporting Requirement: Report the code that corresponds to the state under whose Workers Compensation Act or Employers Liability Act the claimant's benefits are being paid.

Only report loss experience if the jurisdiction state is an eligible Detailed Claim Information (DCI) state. For a list of DCI states, refer to Applicable States in the **General Rules** section (Part 2) of this guidebook. For information on loss experience included and excluded from DCI, refer to the **DCI Structure** section (Part 3) and the **Claim Selection and Sampling** section (Part 4) of this guidebook. If a claim that was previously reported to NCCI must be reclassified to a jurisdiction state that is not an eligible DCI state, use Jurisdiction State Code 00 on a subsequent report. For information on subsequent reports, refer to the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Claims reported to insurers that involve benefits payable under a Federal Act (i.e., Admiralty, USL&HW, FELA, Jones Act, or Coal Mine Acts) should not be considered DCI claims. If a claim that was previously reported to NCCI must be reclassified to Federal Act, use Jurisdiction State Code 59 on a subsequent report. For information on subsequent reports, refer to the **Reporting and Record Layouts** section (Part 5) of this guidebook.

JURISDICTION STATE CODE TABLE

Jurisdiction State	Code
Nonapplicable DCI State	00
Alabama	01
Alaska	54
Arizona	02
Arkansas	03
Colorado	05
Connecticut	06
District of Columbia	08
Florida	09
Georgia	10
Hawaii	52
Idaho	11
Illinois	12
Indiana	13
Iowa	14
Kansas	15
Kentucky	16
Louisiana	17
Maine	18
Maryland	19
Massachusetts	20
Michigan	21
Minnesota	22
Mississippi	23
Missouri	24
Montana	25
Nebraska	26
Nevada	27
New Hampshire	28
New Jersey	29
New Mexico	30
New York	31
North Carolina	32
Oklahoma	35
Oregon	36
Pennsylvania	37

JURISDICTION STATE CODE TABLE (Cont'd)

Jurisdiction State	Code
Rhode Island	38
South Carolina	39
South Dakota	40
Tennessee	41
Texas	42
Utah	43
Vermont	44
Virginia	45
West Virginia	47
Wisconsin	48
Federal Act (USL&HW, FELA, Jones Act, Admiralty, Coal Mine)	59

24. Lump Sum Settlement Amount Paid

Field(s)	61, 63, 65, 67, 69, 71
Position(s)	343–351, 354–362, 365–373, 376–384, 387–395, 398–406
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 lump sum settlement or annuity amount paid to date that corresponds to the code for type of benefits covered by lump sum settlement.

Reporting Requirement: Report the amount paid to date as a lump sum settlement or annuity for the corresponding Benefit Type Covered by Lump Sum Settlement Code (Positions 341–342, 352–353, 363–364, 374–375, 385–386, 396–397).

If claimant legal expenses are part of a lump sum settlement and separate payment is made to the claimant attorney (i.e., separate checks), report the amount in Claimant Legal Amount Paid (Positions 323–331), otherwise include the claimant legal amount paid in Lump Sum Settlement Amount Paid.

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the Lump Sum Settlement Amount net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

Lump Sum Settlement Amount Paid is identified as an indemnity loss and must be included in Total Incurred Indemnity Amount (Positions 135–143) **except** when Benefit Type Covered by Lump Sum Settlement Code (Positions 341–342, 352–353, 363–364, 374–375, 385–386, 396–397) is 06—Medical Only. Lump sum settlement amounts corresponding to Benefit Type Covered by Lump Sum Settlement Code 06—Medical Only are included in Total Incurred Medical Amount (Positions 282–290).

Zero-fill if no lump sum settlement amount has been paid as of loss valuation.

Lump Sum Settlement Amount Paid must be consistent with the Benefit Type Covered by Lump Sum Settlement Code (reported in the corresponding Benefit Type Covered by Lump Sum Settlement Code) positions.

If reporting Lump Sum Settlement Amount Paid in Positions ...	Then the amount must correspond to Benefit Type Covered by Lump Sum Settlement Code, in Positions ...
343–351	341–342
354–362	352–353
365–373	363–364
376–384	374–375
387–395	385–386
398–406	396–397

In cases of multiple or additional Benefit Type Covered by Lump Sum Settlement Codes, use multiple Lump Sum Settlement Amount Paid fields.

Example: Using Multiple Lump Sum Settlement Amount Paid Fields

The Benefits Covered by Lump Sum Settlement Code reported on the 1st report was Medical Only (Benefit Type Code 06), and at second loss valuation (30 months), the benefits now correspond to Indemnity and Medical Combined (Benefit Type Code 49). For this example, the Benefits Covered by Lump Sum Settlement Code and Lump Sum Settlement Amount Paid that were reported on the 1st report were reported in Positions 341–342 and 343–351, respectively. On the Subsequent Report, the additional Benefits Covered by Lump Sum Settlement Code and corresponding Lump Sum Settlement Amount Paid were reported in the next set of fields (Positions 352–353 and 354–362, respectively).

- 1st report

Valuation	Benefits Covered by Lump Sum Settlement	Report:	
18-month	Temporary Partial	Benefits Covered by Lump Sum Settlement Code = 06 (Positions 341–342)	Lump Sum Settlement Amount Paid = 2000 (Positions 343–351)

- 2nd Report

Valuation	Benefits Covered by Lump Sum Settlement	Report:	
30-month	Temporary Partial	Benefits Covered by Lump Sum Settlement Code = 06 (Positions 341–342)	Lump Sum Settlement Amount Paid = 2000 (Positions 343–351)
	Scheduled Permanent Partial	Benefits Covered by Lump Sum Settlement Code = 49 (Positions 352–353)	Lump Sum Settlement Amount Paid = 6000 (Positions 354–362)

25. Maximum Medical Improvement Date

Field(s)	55
Position(s)	313–320
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.

Reporting Requirement: Report the Maximum Medical Improvement (MMI) Date for those claims where a Permanent Total benefit (Benefit Type Code 02—Permanent Total Disability) or a Permanent Partial benefit (Benefit Type Code 03—Scheduled Permanent Partial, 04—Unscheduled Permanent Partial, or 09—Permanent Partial Disfigurement) has been paid or is expected to be paid after final determination of MMI. If applicable, this field must be completed if Claim Status Code (Position 126) is reported as “1” (Closed).

Zero-fill if not applicable or if MMI has not been determined as of loss valuation.

26. Medical Extinguishment Indicator

Field(s)	72
Position(s)	407
Class	Alpha (A)—Field contains only alphabetic characters
Bytes	1
Format	Y/N

Definition: Indicates if the medical payments are extinguished based on a lump sum settlement agreement.

Reporting Requirement: Report “Y” or “N” to indicate whether or not medical payments have been 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 settlement of medical 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.”

INDICATOR	DESCRIPTION
Y	Medical payments are extinguished.
N	Medical payments are not extinguished.

Leave blank if not applicable or if there has been no lump sum settlement of benefits as of loss valuation.

27. Method of Determining Preinjury/Average Weekly Wage Code

Field(s)	23
Position(s)	119

Class	Numeric (N)—Field contains only numeric characters
Bytes	1
Format	N

Definition: A code that corresponds to the method used to determine the preinjury/average weekly wage.

Reporting Requirement: Report the code that corresponds to the method used to determine the Preinjury/Average Weekly Wage Amount (Positions 114–118).

CODE	DESCRIPTION
1	Actual Wage
2	Estimated Wage
3	Minimum Weekly Benefit
4	Maximum Weekly Benefit

28. Nature of Injury Code—Injury Description

Field(s)	25
Position(s)	122–123
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: A 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.

NATURE OF INJURY CODES—EFFECTIVE 1/1/96

Code	Nature of Injury	Narrative Description
a.	**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 Plain
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, Alkalies)
07	Concussion	Brain, Cerebral
10	Contusion	Bruise—Intact Skin Surface Hematoma
13	Crushing	To Grind, Pound or Break into Small Bits

NATURE OF INJURY CODES—EFFECTIVE 1/1/96 (Cont'd)

Code	Nature of Injury	Narrative Description
16	Dislocation	Pinched Nerve, Slipped/Ruptured Disc, Herniated Disc, Sciatica, Complete Tear, HNP Subluxation, Medical Doctor Dislocation
19	Electric Shock	Electrocution
22	Enucleation	Removal of Organ or Tumor
25	Foreign Body	
28	Fracture	Breaking of a Bone or Cartilage
30	Freezing	Frostbite and Other Effects of Exposure to Low Temperature
31	Hearing Loss or Impairment	Traumatic Only; a separate Injury, not the Sequelae of another Injury
32	Heat Prostration	Heat Stroke, Sun Stroke, Heat Exhaustion, Heat Cramps and Other Effects of Environmental Heat; does not include Sunburn
34	Hernia	The Abnormal Protrusion of an Organ or Part through the Containing Wall of its Cavity
36	Infection	The Invasion of a Host by Organisms such as Bacteria, Fungi, Viruses, Mold, Protozoa or Insects, with or without Manifest Disease
37	Inflammation	The reaction of Tissue to Injury characterized clinically by Heat, Swelling, Redness and Pain
40	Laceration	Cut, Scratches, Abrasions, Superficial Wounds, Calluses; Wound by Tearing
41	Myocardial Infarction	Heart Attack, Heart Conditions, Hypertension; the Inadequate Blood Flow to the Muscular Tissue of the Heart
42	Poisoning—General (NOT OD or Cumulative Injury)	A Systemic Morbid Condition resulting from the Inhalation, Ingestion, or Skin Absorption of a Toxic Substance affecting the Metabolic System, the Nervous System, the Circulatory System, the Digestive System, the Respiratory System, the Excretory System, the Musculoskeletal System, etc.; includes Chemical or Drug Poisoning, Metal Poisoning, Organic Diseases, and Venomous Reptile and Insect Bites; does NOT include effects of Radiation, Pneumoconiosis, Corrosive Effects of Chemicals; Skin Surface Irritations, Septicemia or Infected Wounds
43	Puncture	A Hole made by the piercing of a pointed instrument
46	Rupture	
47	Severance	To Separate, Divide or Take Off
49	Sprain	Internal Derangement, a Trauma or Wrenching of a Joint, producing pain and disability depending upon degree of injury to ligaments
52	Strain	Internal Derangement, the Trauma to the Muscle or the Musculotendinous Unit from Violent Contraction or Excessive Forcible Stretch
53	Syncope	Swooning, Fainting, Passing Out, no other Injury

NATURE OF INJURY CODES—EFFECTIVE 1/1/96 (Cont'd)

Code	Nature of Injury	Narrative Description
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	
b.	**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; do 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, i.e., Acute Anxiety, Neurosis, Stress, Nontoxic Depression
70	Radiation	All forms of damage to Tissue, Bones or Body Fluids produced by Exposure to Radiation
71	All Other Occupational Disease Injury, NOC	
72	Loss of Hearing	
73	Contagious Disease	
74	Cancer	
75	AIDS	

NATURE OF INJURY CODES—EFFECTIVE 1/1/96 (Cont'd)

Code	Nature of Injury	Narrative Description
76	VDT-Related Disease	Video Display Terminal Diseases other than Carpal Tunnel Syndrome
77	Mental Stress	
78	Carpal Tunnel Syndrome	Soreness, Tenderness and weakness of the Muscles of the Thumb caused by pressure on the Median Nerve at the point at which it goes through the Carpal Tunnel of the Wrist
79	Hepatitis C	
80	All Other Cumulative Injury, NOC	
c.	**Multiple Injuries**	
90	Multiple Physical Injuries Only	
91	Multiple Injuries Including Both Physical and Psychological	

29. Part of Body—Injury Description

Field(s)	24
Position(s)	120–121
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: A code that corresponds to the part of the claimant's body that sustained the injury.

Reporting Requirement: Report the code that corresponds to the part of the claimant's body that sustained the injury.

PART OF BODY CODES—EFFECTIVE 1/1/96

Code	Part of Body	Narrative Description
a.	**Head**	
10	Multiple Head Injury	Any combination of below parts injury
11	Skull	
12	Brain	
13	Ear(s)	Includes: Hearing, Inside Eardrum
14	Eyes(s)	Includes: Optic Nerves, Vision, Eyelids
15	Nose	Includes: Nasal Passage, Sinus, Sense of Smell

PART OF BODY CODES—EFFECTIVE 1/1/96 (Cont'd)

Code	Part of Body	Narrative Description
16	Teeth	
17	Mouth	Includes: Lips, Tongue, Throat, Taste
18	Soft Tissue	
19	Facial Bones	Includes: Jaw
b.	**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	
c.	**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) & Hand(s)	
d.	**Trunk**	
40.	Multiple Trunk	Any combination of below parts
41.	Upper Back Area	(Thoracic Area) Upper Back Muscles, excluding Vertebrae, Disc, Spinal Cord
42.	Lower Back Area	(Lumbar Area and Lumbo Sacral) Lower Back Muscles, excluding Sacrum, Coccyx, Pelvis, Vertebrae, Disc, Spinal Cord
43.	Disc	Spinal Column Cartilage other than Cervical Segment

PART OF BODY CODES—EFFECTIVE 1/1/96 (Cont'd)

Code	Part of Body	Narrative Description
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
e.	**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	
f.	**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

PART OF BODY CODES—EFFECTIVE 1/1/96 (Cont'd)

Code	Part of Body	Narrative Description
90.	Multiple Body Parts (Including Body Systems & 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

30. Policy Effective Date

Field(s)	5
Position(s)	30–37
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD

Definition: The date the policy under which the claim occurred became effective.

Reporting Requirement: Report the effective date that corresponds to the date shown on the policy Information Page or to endorsements attached. The Policy Effective Date reported must be before or the same as Accident/Injury Date (Positions 75–82).

Policy Effective Date is a key data element and must remain the same throughout Detailed Claim Information (DCI) reporting (1st–11th reports), unless a revision to the Policy Effective Date previously reported has been submitted. For information on revising Policy Effective Date, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

The Policy Effective Date for a three-year variable-rate policy is the annual period being reported. For example, if you have a three-year variable-rate policy written effective 01/01/08 and expiring 01/01/11, the first year is reported as policy effective date 20080101, the second year is reported as policy effective date 20090101, and the third year is reported as policy effective date 20100101.

For the second and the third period of extended term policies (if applicable), the Policy Effective Date must equal the date that the second or third period began, as shown on the policy period endorsement.

31. Policy Number Identifier

Field(s)	4
Position(s)	12–29
Class	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes	18

Format	A/N 18, exclude blanks, punctuation marks, and special characters (if the Policy Number Identifier is less than 18 bytes, this field must be left justified, and blanks in all spaces to the right of the last character)

Definition: The unique set of numbers and/or letters that identify the 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.

Policy Number Identifier must match the Unit Statistical policy number and must remain the same, including any prefixes or suffixes, throughout Detailed Claim Information (DCI) reporting (1st–11th reports), unless a revision to the Policy Number Identifier previously reported has been submitted. For information on revising Policy Number Identifier, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

32. Postinjury Weekly Wage Amount

Field(s)	52
Position(s)	300–308
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 weekly wage amount that the claimant earns and that is used to determine the benefits when the claimant returns to work.

Reporting Requirement: Report the Postinjury Weekly Wage Amount for all Permanent Partial Disability claims (Benefit Type Code 03, 04, 09) with a jurisdiction state where wage loss is used to determine benefits (see Wage Loss States). This is the postinjury weekly wage that corresponds to the Benefit Amount Paid (Positions 146–154, 163–171, 180–188, 197–205, 214–222).

Zero-fill if not applicable or if the claimant has not returned to work as of loss valuation.

a. Wage Loss States

The following states have established benefit calculations that use wage loss:

Alabama	Georgia	Missouri	Rhode Island
Alaska	Illinois	Montana	South Carolina
Arizona	Iowa	Nebraska	South Dakota
Arkansas	Kansas	Nevada	Utah
Colorado	Louisiana	New Jersey	Vermont
Connecticut	Maine	New Hampshire	Virginia
District of Columbia	Maryland	New Mexico	West Virginia
Florida	Mississippi	North Carolina	

33. Preinjury/Average Weekly Wage Amount

Field(s)	22
Position(s)	114–118
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 at accident date.

Reporting Requirement: Report the average weekly wage of the claimant or deceased worker at Accident/Injury Date (Positions 75–82). This amount should include commissions, piecework earnings, and other forms of income converted to a normal scheduled workweek, plus the estimated value of lodging, food, laundry, and other payments in kind, as defined by state law.

34. Previous Carrier Code

Field(s)	77
Position(s)	426–430
Class	Numeric (N)—Field contains only numeric characters
Bytes	5
Format	N 5

Definition: The Carrier Code that was reported to NCCI on a previous report.

Reporting Requirement: Report the Carrier Code that was previously reported only if the Carrier Code in NCCI's system is being revised. If the Carrier Code is being revised, report the revised Carrier Code in Positions 2–6. For information on revising Carrier Code, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Zero-fill if Replacement Type Code (Position 40) is zero.

35. Previous Carrier Group Code

Field(s)	78
Position(s)	431–435
Class	Numeric (N)—Field contains only numeric characters
Bytes	5
Format	N 5

Definition: The Carrier Group Code that was reported to NCCI on a previous report.

Reporting Requirement: Report the Carrier Group Code that was previously reported only if the Carrier Group Code in NCCI's system is being revised. If the Carrier Group Code is being revised, report the revised Carrier Group Code in Positions 7–11. For information on revising Carrier Group Code, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Zero-fill if Replacement Type Code (Position 40) is zero.

36. Previous Claim Number Identifier

Field(s)	82
Position(s)	470–487
Class	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes	12
Format	A/N 12, exclude blanks, punctuation marks, and special characters (if the Previous Claim Number Identifier is less than 12 bytes, this field must be left justified, and blanks in all spaces to the right of the last character)

Definition: The Claim Number Identifier that was reported to NCCI on a previous report.

Reporting Requirement: Report the Claim Number Identifier that was previously reported only if the Claim Number Identifier in NCCI's system is being revised. If the Claim Number Identifier is being revised, report the revised Claim Number Identifier in Positions 41–58. For information on revising Claim Number Identifier, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Zero-fill if Replacement Type Code (Position 40) is zero.

37. Previous Policy Effective Date

Field(s)	80
Position(s)	454–461
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD

Definition: The Policy Effective Date that was reported to NCCI on a previous report.

Reporting Requirement: Report the Policy Effective Date that was previously reported only if the Policy Effective Date in NCCI's system is being revised. If the Policy Effective Date is being revised, report the revised Policy Effective Date in Positions 30–37. For information on revising Policy Effective Date, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Zero-fill if Replacement Type Code (Position 40) is zero.

38. Previous Policy Number

Field(s)	79
Position(s)	436–453
Class	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes	18
Format	A/N 18, exclude blanks, punctuation marks, and special characters (if the Previous Claim Number Identifier is less than 18 bytes, this field must be left justified, and blanks in all spaces to the right of the last character)

Definition: The Policy Number Identifier that was reported to NCCI on a previous report.

Reporting Requirement: Report the Policy Number Identifier that was previously reported only if the Policy Number Identifier in NCCI's system is being revised. If the Policy Number Identifier is being revised, report the revised Policy Number Identifier in Positions 12–29. For information on revising Policy Numbers, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Zero-fill if Replacement Type Code (Position 40) is zero.

39. Previous Reported to Insurer Date

Field(s)	81
Position(s)	462–469
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD

Definition: The Reported to Insurer Date that was reported to NCCI on a previous report.

Reporting Requirement: Report the Reported to Insurer Date that was previously reported only if the Reported to Insurer Date in NCCI's system is being revised. If the Reported to Insurer Date that was previously reported is being revised, report the revised Reported to Insurer Date in Positions 83–90. For information on revising Reported to Insurer Date, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

Zero-fill if Replacement Type Code (Position 40) is zero.

40. Record Type Code

Field(s)	1
Position(s)	1
Class	Numeric (N)—Field contains only numeric characters
Bytes	1
Format	N

Definition: A code that corresponds to the type of record being submitted.

Reporting Requirement: Report the code that corresponds to the type of record being submitted.

CODE	DESCRIPTION
1	Detailed Claim Information Record
9	Submission Control Record

41. Replacement Type Code

Field(s)	7
Position(s)	40
Class	Numeric (N)—Field contains only numeric characters

Bytes	1
Format	N

Definition: A code that corresponds to the type of replacement record being submitted.

Reporting Requirement: Report Replacement Type Code "0" if the record being submitted is:

- An original report (Report Level Code 01—First Report).
- Replaces a rejected original report (Report Level Code 01—First Report).
- A subsequent loss valuation update report (Report Level Code 02–11).
- Replaces a rejected subsequent loss valuation update report (Report Level Code 02–11). The appropriate report level being replaced must also be identified.

Report Replacement Type Code "1" if the record being submitted corrects a nonrejected data element that was previously reported with an incorrect value.

The appropriate report level being replaced must also be identified. For example, to replace a rejected 3rd report, enter "1" in Replacement Type Code and "03" in Report Level Code (Positions 38–39).

CODE	DESCRIPTION
0	Original or Subsequent Report
1	Replacement to a previous report due to incorrect value (not-rejected)

Always submit replacement reports with the same key data elements: Carrier Group Code (or Carrier Code, whichever is applicable), Policy Number Identifier, Policy Effective Date, Reported to Insurer Date, and Claim Number Identifier. If the replacement report being submitted is to revise a previously reported key data element, enter "1" in Replacement Type Code. For more information, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

42. Report Level Code

Field(s)	6
Position(s)	38–39
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: A code that corresponds to the report level based on the loss valuation date.

Reporting Requirement: Report the code that corresponds to the report level based on the loss valuation date.

	DESCRIPTION	
CODE	**Report Level**	**Valuation Schedule**
01	First Report	Valued 18 months from Reported to Insurer Date
02	Second Report	Valued 30 months from Reported to Insurer Date
03	Third Report	Valued 42 months from Reported to Insurer Date

CODE	DESCRIPTION	
	Report Level	**Valuation Schedule**
04	Fourth Report	Valued 54 months from Reported to Insurer Date
05	Fifth Report	Valued 66 months from Reported to Insurer Date
06	Sixth Report	Valued 78 months from Reported to Insurer Date
07	Seventh Report	Valued 90 months from Reported to Insurer Date
08	Eighth Report	Valued 102 months from Reported to Insurer Date
09	Ninth Report	Valued 114 months from Reported to Insurer Date
10	Tenth Report	Valued 126 months from Reported to Insurer Date
11	Eleventh Report	Valued 138 months from Reported to Insurer Date

43. Reported to Insurer Date

Field(s)	13
Position(s)	83–90
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD

Definition: The date the claim was originally reported to the insurer. The date used to determine loss valuation.

Reporting Requirement: Report the date the claim was originally reported to the insurer. The Reported to Insurer Date must be after or the same as Accident/Injury Date (Positions 75–82).

Use this date to determine 18-month and subsequent valuations by comparing it with the DCI Due Date Table in this guidebook.

The Reported to Insurer Date must remain the same throughout DCI reporting (1st–11th reports), unless a revision to the Reported to Insurer Date previously reported has been submitted. For information on revising Reported to Insurer Date, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this guidebook.

44. Return to Work Date

Field(s)	73
Position(s)	408–415
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD

Definition: The most recent date on which the claimant returned to work.

Reporting Requirement: Report the most recent date on which the claimant returned to work. The Return to Work Date must be after or the same as Accident/Injury Date (Positions 75–82).

Zero-fill if claimant has not returned to work as of loss valuation, or if Claim Status Code 5—Became Medical Only is reported.

45. Return to Work Status Indicator

Field(s)	74
Position(s)	416
Class	Alpha (A)—Data field
Bytes	1
Format	Y/N

Definition: Indicates whether or not the claimant's most recent return-to-work status is to the same or similar hours and pay as before the injury.

Reporting Requirement: Report "Y" or "N" to indicate whether or not the claimant's most recent return-to-work status is to the same or similar hours and pay as before the injury.

Leave blank if Return to Work Date (Positions 408–415) is zero.

INDICATOR	DESCRIPTION
Y	Returned to work at same or similar preinjury hours and pay.
N	Returned to work at something other than same or similar preinjury hours and pay.

46. Total Incurred Indemnity Amount

Field(s)	29
Position(s)	135–143
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 total amount to date of all paid and current outstanding (reserve) indemnity benefits excluding loss adjustment expenses (e.g., ALAE and ULAE).

Reporting Requirement: Report the total amount to date of all paid and current outstanding (reserve) indemnity benefits excluding loss adjustment expenses (e.g., ALAE and ULAE). If Type of Claim (Positions 99–100) is reported as 02, Employers Liability Only, then the entire amount of losses including allocated loss adjustment expenses (ALAE) must be reported as incurred indemnity.

The Total Incurred Indemnity Amount must include those items that are also identified separately:

- Benefit Paid Amounts (Positions 146–154, 163–171, 180–188, 197–205, 214–222)
- Claimant Legal Amount Paid (Positions 323–331)
- Lump Sum Settlement Amount (Positions 343–351, 354–362, 365–373, 375–384, 387–395, 398–406). This includes amounts with Benefits Covered by Lump Sum Settlement Amount Code 49—Indemnity and Medical Combined and **excludes** amounts with Benefits Covered by Lump Sum Settlement Amount Code 06—Medical Only. If Benefits Covered by Lump Sum Settlement Amount Code (Positions 341–342, 352–353, 363–364, 374–375, 385–386, 396–397) is 06—Medical Only, report the amount in Total Incurred Medical Amount (Positions 282–290).

- Vocational Rehabilitation Education Expense Amount Paid (Positions 264–272)
- Vocational Rehabilitation Evaluation Expense Amount Paid (Positions 246–254)
- Vocational Rehabilitation Maintenance Benefit Amount Paid (Positions 255–263)
- Vocational Rehabilitation Other Paid (Positions 273–281)

Note: Refer to the description for each of these elements for information on when and how these costs are reported in relation to Total Incurred Indemnity Amount.

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the incurred indemnity amount net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

47. Total Incurred Medical Amount

Field(s)	50
Position(s)	282–290
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 total to date of all paid and current outstanding (reserve) amounts for physicians, hospitals, drugs, physical rehabilitation, and other related services, excluding loss adjustment expenses (e.g., ALAE and ULAE).

Reporting Requirement: Report the total to date of all paid and current outstanding (reserve) amounts for physicians, hospitals, drugs, physical rehabilitation, and other related services, excluding loss adjustment expenses (e.g., ALAE and ULAE).

If Benefits Covered by Lump Sum Settlement Amount Code (Positions 341–342, 352–353, 363–364, 374–375, 385–386, 396–397) is 06—Medical Only, include the corresponding Lump Sum Settlement Amount (Positions 343–351, 354–362, 365–373, 375–384, 387–395, 398–406) in Total Incurred Medical Amount. All other Lump Sum Settlement Amounts including Benefits Covered by Lump Sum Settlement Amount Code 49—Indemnity and Medical Combined are reported in Total Incurred Indemnity Amount (Positions 135–143).

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the incurred medical amount net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

48. Total Paid Medical Amount

Field(s)	51
Position(s)	291–299
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 amounts to date for physicians, hospitals, drugs, physical rehabilitation, and other related services, excluding loss adjustment expenses (e.g., ALAE and ULAE) and medical-only lump sum settlement amounts.

Reporting Requirement: Report all paid amounts to date for physicians, hospitals, drugs, physical rehabilitation, and other related services, excluding loss adjustment expenses (e.g., ALAE and ULAE) and medical-only lump sum settlement amounts.

Medical-Only Lump Sum Settlement Amounts (Benefits Covered by Lump Sum Settlement Code 06—Medical Only) are reported in Lump Sum Settlement Amount Paid (Positions 343–351, 354–362, 365–373, 376–384, 387–395, 398–406).

Exception: Florida—Costs incurred for medical care coordination services for traumatic brain injuries, spinal cord injuries, amputations, loss of eye(s), and burns of 5% or more of the total body surface are included in Total Paid Medical Amount. Refer to Vocational Rehabilitation Education Expense Amount Paid.

Exception: Michigan—Vocational rehabilitation costs are included in Total Paid Medical Amount.

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the Total Paid Medical Amount net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

Zero-fill if no medical payments have been made as of loss valuation.

49. Type of Claim—Loss Conditions Code

Field(s)	17
Position(s)	99–100
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: A code that corresponds to the provision(s) of the policy under which the loss was incurred.

Reporting Requirement: Report the code that corresponds to the provision(s) of the policy under which the loss was incurred.

CODE	DESCRIPTION
01	Workers Compensation—The entire loss is incurred under the provisions of Part One of the Workers Compensation and Employers Liability Insurance policy.
02	Employers Liability Only—The entire loss is incurred under the provisions of Part Two of the Workers Compensation and Employers Liability Insurance policy. Nonapplicable state: WI
03	Workers Compensation Including Employers Liability—The loss is incurred under the provisions of Parts One and Two of the Workers Compensation and Employers Liability Insurance policy.
04	Liability Over—A particular Employers Liability coverage situation where a third party, who is being sued by an employee, in turn sues the employer on the grounds of negligence, or like theory. Nonapplicable states: NJ, WI

50. Type of Loss—Loss Conditions Code

Field(s)	15
Position(s)	95–96
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: A code that corresponds to the type of injury, condition, or disorder.

Reporting Requirement: Report the code that corresponds to the type of injury, condition, or disorder.

CODE	DESCRIPTION
01	Trauma—An injury resulting in disability or death that is traceable to a definite compensable accident occurring during the employee's present or past employment.
02	Occupational Disease—Any abnormal condition or disorder other than a workplace injury resulting in a disability or death that is not traceable to a definite compensable accident occurring during the employee's present or past employment. Any injury caused by repetitive exposure extending over time to a disease-producing agent or agents present in the worker's occupational environment. In order for a claim to be coded as an occupational disease case, it must have resulted from repetitive exposure extending over time.
03	Cumulative Injury Other Than Disease—An injury that results in a disability or death and is not traceable to a definite compensable accident occurring during the employee's present and past employment. The injury is understood to have occurred from, and has been aggravated by, a repetitive employment-related activity.

51. Type of Recovery—Loss Conditions Code

Field(s)	**16**
Position(s)	97–98
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: A code that corresponds to the type of recovery received or anticipated.

Reporting Requirement: Report the code that corresponds to the type of recovery received or anticipated.

CODE	DESCRIPTION
01	No Recovery

CODE	DESCRIPTION
02	Second Injury Fund Only—Insurer has received, or anticipates receiving, reimbursement from the Second Injury Fund. The Second Injury Fund is a trust established to reimburse insurers when a subsequent injury is caused by or made substantially greater due to the combined effects of physical impairment, previous accident, disease, or congenital condition.
03	Subrogation Only (Third Party)—Insurer has received reimbursement from an entity other than the employer, with legal liability due to circumstances for the injury.
04	Subrogation (Third Party) With Second Injury Fund—Insurer has received reimbursement from both a Second Injury Fund and a third party.

52. Vocational Rehabilitation Education Expense Amount Paid

Field(s)	48
Position(s)	264–272
Class	Numeric (N)—Data 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 amount paid to date for education/training costs including tuition, books, and tools.

Reporting Requirement: Report the amount paid to date for education/training costs including tuition, books, and tools. Do not include amounts identified as:

- Vocational Rehabilitation Evaluation Expense Amount Paid (Positions 246–254)
- Vocational Rehabilitation Maintenance Benefit Amount Paid (Positions 255–263)
- Vocational Rehabilitation Other Paid (Positions 273–281)

Exception: Florida—Report the first $2,500 paid for reemployment services, which are defined in Section 440.491 of Florida Workers' Compensation law as "services that include, but are not limited to, vocational counseling, job-seeking skills training, ergonomic job analysis, transferable skills analysis, selective job replacement, labor market surveys, and arranging other services such as education or training, vocational and on-the-job, which may be needed by the employee to secure employment." Any remaining amount over $2,500 is not reported, except for the following injuries:

- Traumatic Brain
- Spinal Cord
- Amputation (including loss of eye or eyes)
- Burns over 5% or more of the total body surface

For these injuries, report the full costs paid to date for reemployment services as Vocational Rehabilitation Education Expense Amount Paid. Report costs for medical care coordination services for these injuries as Total Paid Medical Amount (Positions 291–299).

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the Vocational Rehabilitation Education Expense Amount Paid net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

Vocational Rehabilitation Education Expense Amount Paid is identified as an indemnity loss and must be included in Total Incurred Indemnity Amount (Positions 135–143).

Exception: Michigan—Vocational Rehabilitation costs are included as Total Paid Medical Amount (Positions 291–299).

Zero-fill if no education payments have been made as of loss valuation.

53. Vocational Rehabilitation Evaluation Expense Amount Paid

Field(s)	46
Position(s)	246–254
Class	Numeric (N)—Data 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 amount paid to date for testing and evaluating the claimant's ability, aptitude, and/or attitude in determining suitability for vocation rehabilitation or placement.

Reporting Requirement: Report the amount paid to date for testing and evaluating the claimant's ability, aptitude, and/or attitude in determining suitability for vocation rehabilitation or placement. Do not include amounts identified as:

- Vocational Rehabilitation Education Expense Amount Paid (Positions 264–272)
- Vocational Rehabilitation Maintenance Benefit Amount Paid (Positions 255–263)
- Vocational Rehabilitation Other Paid (Positions 273–281)

Exception: Florida—Report all expenses paid to date for reemployment assessments, which are defined in Section 440.491 of Florida Workers' Compensation law as "a written assessment performed by a qualified rehabilitation provider which provides a comprehensive review of the medical diagnosis, treatment and prognosis; includes conferences with the employer, physician and claimant; and recommends a cost effective physical and vocational rehabilitation plan to assist the employee in returning to suitable gainful employment."

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the Vocational Rehabilitation Evaluation Expense Amount Paid net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

Vocational Rehabilitation Evaluation Expense Amount Paid is identified as an indemnity loss and must be included in Total Incurred Indemnity Amount (Positions 135–143).

Exception: Michigan—Vocational rehabilitation costs are included as Total Paid Medical Amount (Positions 291–299).

Zero-fill if no testing and evaluation payments have been made as of loss valuation.

54. Vocational Rehabilitation Maintenance Benefit Amount Paid

Field(s)	47
Position(s)	255–263
Class	Numeric (N)—Data 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 amount paid to date for any expense that enables the claimant to receive or participate in a Vocational Rehabilitation service. Refer to the Vocational Rehabilitation Maintenance Benefit example.

Reporting Requirement: Report the amount paid to date for any expense that enables the claimant to receive or participate in a Vocational Rehabilitation service. Temporary Total Disability benefits (Benefit Type Code 05) that are paid while the claimant receives vocational rehabilitation are excluded from Vocational Rehabilitation Maintenance Benefit Amount and reported in Benefit Amount (Positions 146–154, 163–171, 180–188, 197–205, 214–222).

Example: Vocational Rehabilitation Maintenance Benefit

- A claimant requires specialized tests to determine placement but they can only be obtained at an out-of-town medical center. The cost of the tests would be reported as Vocational Rehabilitation Evaluation Expense (Positions 246–254) and the transportation, short term lodging, and meal costs would be reported as a Vocational Rehabilitation Maintenance Benefit.
- A claimant resides in a college dormitory while attending a college program. Tuition, books, and tools are reported as Vocational Rehabilitation Education Expense (Positions 264–272), and the costs of the dormitory, standard meal plan, and the transportation between the student's home and the college at the beginning and end of the semester or trimester are reported as Vocational Rehabilitation Maintenance Benefit.

Do not include amounts identified as:

- Vocational Rehabilitation Education Expense Amount Paid (Positions 264–272)
- Vocational Rehabilitation Evaluation Expense Amount Paid (Positions 246–254)
- Vocational Rehabilitation Other Paid (Positions 273–281)

Exception: Florida—Report a zero in this field. Maintenance benefits are reported as temporary total disability benefits under Florida Workers' Compensation law. Continue to report these benefits as Benefit Type Code 05—Temporary Total Injury (Positions 144–145, 161–162, 178–179, 195–196, 212–213) with the corresponding Benefit Amount Paid field (Positions 146–154, 163–171, 180–188, 197–205, 214–222).

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the Vocational Rehabilitation Maintenance Benefit Amount Paid net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

Vocational Rehabilitation Maintenance Benefit Amount Paid is identified as an indemnity loss and must be included in Total Incurred Indemnity Amount (Positions 135–143).

Exception: Michigan—Vocational rehabilitation costs are included as Total Paid Medical Amount (Positions 291–299).

Zero-fill if no maintenance benefit payments have been made as of loss valuation.

55. Vocational Rehabilitation—Other Paid

Field(s)	49
Position(s)	273–281
Class	Numeric (N)—Data 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 amount paid to date for any other phases of the vocational rehabilitation program not reported as vocational rehabilitation education, evaluation, or maintenance expenses.

Reporting Requirement: Report the amount paid to date for any other phases of the vocational rehabilitation program not reported as:

- Vocational Rehabilitation Education Expense Amount Paid (Positions 264–272)
- Vocational Rehabilitation Evaluation Expense Amount Paid (Positions 246–254)
- Vocational Rehabilitation Maintenance Benefit Amount Paid (Positions 255–263)

In all cases where a special fund (e.g., Second Injury Fund, Handicapped Workers' Reserve Fund) has or will reimburse the insurer for a claim, or where recovery was received due to subrogation, report the Vocational Rehabilitation Other Paid net (value of the claim had there been no recovery minus [the amount recovered less recovery expenses]) of the recovery. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount).

Vocational Rehabilitation Other Paid is identified as an indemnity loss and must be included in Total Incurred Indemnity Amount (Positions 135–143).

Exception: Michigan—Vocational rehabilitation costs are included as Total Paid Medical Amount (Positions 291–299).

Zero-fill if no other vocational rehabilitation benefit payments have been made as of loss valuation.

56. Weekly Benefit Amount

Field(s)	32, 35, 38, 41, 44
Position(s)	155–160, 172–177, 189–194, 206–211, 223–228
Class	Numeric (N)—Data field contains only numeric characters
Bytes	6
Format	N 6, Amount is rounded to the nearest whole dollar; data field is to be right justified and left zero-filled

Definition: The most recent Weekly Benefit Amount, per applicable state's approved minimums/maximums, paid to the claimant for the corresponding Benefit Type.

Reporting Requirement: Report the most recent Weekly Benefit Amount, per applicable state's approved minimums/maximums, paid to the claimant for the corresponding Benefit Type Code (Positions 144–145, 161–162, 178–179, 195–196, 212–213).

Divide monthly benefit amounts by 4 to convert to weekly benefits.

When reporting a claim for which an indemnity reserve has been established, but no payments have been made, zero-fill this field and report the Benefit Type Code (Positions 144–145, 161–162, 178–179, 195–196, 212–213) that reflects the type of benefit anticipated for the first indemnity payment.

Weekly Benefit Amount must be consistent with the Benefit Type Code reported in the corresponding Benefit Type Code positions.

If reporting Weekly Benefit Amount in Positions ...	Then the amount must correspond to Benefit Type Code in Positions ...
155–160	144–145
172–177	161–162
189–194	178–179
206–211	195–196
223–228	212–213

Use multiple Weekly Benefit Amount fields in cases of multiple or additional Benefit Type Codes.

Example: Using Multiple Weekly Benefit Amount Fields

The Benefit Type Code reported on the 1st report was Temporary Partial (Benefit Type Code 11), and at second loss valuation (30 months) the benefits now correspond to Scheduled Permanent Partial (Benefit Type Code 03). For this example, the Benefit Type Code and Weekly Benefit Amount that were reported on the 1st report were reported in Positions 144–145 and 155–160, respectively. On the subsequent report, the additional Benefit Type Code and corresponding Weekly Benefit Amount were reported in the next set of fields (Positions 161–162 and 172–177, respectively).

- 1st Report

Valuation	Benefit Type	Report:	
18-month	Temporary Partial	Benefit Type Code = 11 (Positions 144–145)	Weekly Benefit Amount = 150 (Positions 155–160)

- 2nd Report

Valuation	Benefit Type	Report:	
30-month	Temporary Partial	Benefit Type Code = 11 (Positions 144–145)	Weekly Benefit Amount = 150 (Positions 155–160)
	Scheduled Permanent Partial	Benefit Type Code = 03 (Positions 161–162)	Weekly Benefit Amount = 275 (Positions 172–177)

RESERVED FOR FUTURE USE

PART 7—EDITS, ERROR MESSAGES, AND CORRECTIONS

OVERVIEW

THIS PART OF THE GUIDEBOOK IS CURRENTLY BEING DEVELOPED.
At a later date, information will be included in this section, and this guidebook will be updated on **ncci.com**.

Please ensure that your **ncci.com** Notification Preferences are set to automatically receive updates to this guidebook.

To update your **ncci.com** Notifications Preferences:

1. Sign into **ncci.com** with your user ID and password
2. Click the **Update Notifications Preferences** link, and select the **Data** option
3. Select **Detailed Claim Information Reporting Guidebook** and the other publications you'd like to receive automatically
4. Click **Save**

RESERVED FOR FUTURE USE

PART 8—REPORTS

OVERVIEW

THIS PART OF THE GUIDEBOOK IS CURRENTLY BEING DEVELOPED.
At a later date, information will be included in this section, and this guidebook will be updated on **ncci.com**.

Please ensure that your **ncci.com** Notification Preferences are set to automatically receive updates to this guidebook.

To update your **ncci.com** Notifications Preferences:

1. Sign into **ncci.com** with your user ID and password
2. Click the **Update Notifications Preferences** link, and select the **Data** option
3. Select **Detailed Claim Information Reporting Guidebook** and the other publications you'd like to receive automatically
4. Click **Save**

RESERVED FOR FUTURE USE

PART 9—DATA REPORTING RESOURCES AND TOOLS

OVERVIEW

NCCI provides Internet-based products and services that help data providers submit and receive Detailed Claim Information (DCI) data quickly, conveniently, and accurately.

Part 9 of this guidebook provides information on the resources and data tools accessible via NCCI's Web site at **ncci.com** in the **Data Reporting** section under **Detailed Claim Information**.

For more information on the tools and resources referenced in this guidebook, refer to the **Services & Tools** section on **ncci.com**.

A. SECURITY ACCESS PLAN

In order to use most of NCCI's online products and services, data providers need to have an **ncci.com** user identification (ID) number, password, and authorized access to the products/services they want for the specified users. NCCI's Customer Service Center will assist data providers in gaining this access.

NCCI follows specific procedures when data providers request access to electronic data products. Each data provider should develop, implement, and maintain a security access plan for NCCI's electronic products and implement company security procedures.

Company access procedures should be communicated to NCCI so that access to these electronic products can be monitored. NCCI should also be notified when there is a change on the list of people who have access to NCCI's electronic products.

Contact NCCI's Customer Service Center at 800-**NCCI**-123 (800-622-4123) about procedures, access changes, and access inquiries.

B. DATA MANUALS, CIRCULARS, WEB ARTICLES, AND GUIDES

NCCI provides the following data manuals to assist in reporting Detailed Claim Information (DCI) data:

- ***Detailed Claim Information Reporting Guidebook*** contains the rules and requirements for reporting DCI, as well as helpful additional information and examples to assist you in meeting your reporting requirements
- ***WCIO Workers Compensation Data Specifications Manual*** contains the Workers Compensation Insurance Organizations' specifications and record layout information for electronically submitting DCI data (WCCDCI section) to NCCI
- ***Electronic Transmission User's Guide*** contains the rules and requirements for preparing and submitting test and production files for DCI data and other NCCI data types to ensure that all connections, data files, and systems are functioning and processing correctly

NCCI's circulars and ***FYI Plus*** releases announce topics that require action and/or are especially time-sensitive and necessary for reporting timely and accurate DCI data. (Authorized access and an **ncci.com** user ID and password are required for access.)

Like circulars and ***FYI Plus*** releases, DCI data reporting Web articles provide notification of changes and other up-to-date information. However, Web articles include reference guides and other content that are available only online, and most articles can be accessed without a user ID and password.

C. DCI REPORTING TOOLS

To Be Announced

D. DATA TRANSFER VIA THE INTERNET

Data Transfer via the Internet (DTVI) facilitates the exchange of reports and data files between data providers and NCCI for cost-effective, fast, and easy transmission. Two transmission options are available: Secure Browser Mailbox and Secure FTP Software.

- Secure Browser Mailbox —The Secure Browser Mailbox option allows you to post and retrieve files through an online mailbox.

- Secure FTP Software—An option that users have to enhance their Secure Browser Mailbox. Secure FTP Software:
  - — Automates the posting and sending of data files to NCCI
  - — Allows you to define directories to retrieve and store files
  - — Allows you to set up your own transmission schedule

  Note: ***DTVI*** uses 128-bit encryption.

E. E–LEARNING CENTER

NCCI's eLearning Center features Web-based training designed to enhance your knowledge regarding NCCI's processes, requirements, products, tools, services, and key business relationships. These modules offer a flexible learning plan, are easy to use, and allow you to self-pace your training.

PART 10—DATA QUALITY COMPLIANCE PROGRAM

OVERVIEW

THIS PART OF THE GUIDEBOOK IS CURRENTLY BEING DEVELOPED.
At a later date, information will be included in this section, and this guidebook will be updated on **ncci.com**.

Please ensure that your **ncci.com** Notification Preferences are set to automatically receive updates to this guidebook.

To update your **ncci.com** Notifications Preferences:

1. Sign into **ncci.com** with your user ID and password
2. Click the **Update Notifications Preferences** link, and select the **Data** option
3. Select **Detailed Claim Information Reporting Guidebook** and the other publications you'd like to receive automatically
4. Click **Save**

RESERVED FOR FUTURE USE

PART 11—GLOSSARY

OVERVIEW

Part 11 defines key terms related to Detailed Claim Information (DCI) reporting that are used within the ***Detailed Claim Information Reporting Guidebook*** and DCI-related communications.

A. DEFINITIONS OF TERMS

Accident Date—See *Accident/Injury Date* in this guidebook's Data Dictionary.

Actuarial Analysis—NCCI's evaluation of claim costs, frequency, development, and other claim statistical values.

Admiralty—See *Admiralty Law.*

Admiralty Law—Also referred to as maritime law, a distinct body of law that governs maritime questions and offenses.

Advisory Statistical Work Group (ASWG)—A work group established by the WCIO to review and advise on the unit statistical coding structure for continuity and consistency; cost implications of using existing reporting vehicles; alternative approaches to defined data elements; expansion and/or modification of currently defined fields; state-specific data requirements; expansion and/or revision of report formats; and deletion and restructure of data elements.

Affiliate—See *NCCI Affiliates.*

ALAE—See *Allocated Loss Adjustment Expense.*

Allocated Loss Adjustment Expense—Expenses *incurred* while investigating and settling claims that can be directly allocated to a particular claim.

Assigned Risk—An *insured* that is unable to obtain insurance in the voluntary market and, consequently, obtains coverage through a state-assigned risk plan or pool, which specifies that each participating *insurer* must accept a proportionate share of assigned risk applicants. *Premiums* for assigned risks are sometimes higher, and coverage may be restricted.

ASWG—See *Advisory Statistical Work Group (ASWG).*

Basic Manual for Workers Compensation and Employers Liability Insurance—An NCCI manual that contains rules, classifications with descriptions, rates/loss costs for each classification, and state specific exceptions for writing *workers compensation insurance* in the *voluntary market*. It also includes the state assigned risk plan with rates/loss costs for each classification, and state special deviations from the voluntary market rules and rating plans.

Beneficiary—Person or persons whom an *insured* designates to receive the benefits outlined in an insurance policy following the insured's death.

Benefit—Monetary payments and other services provided by the *insurer*.

Byte—An 8-bit representation of a character (alpha or numeric) read as one unit by the computer. Bytes are contained within *record layouts*.

Carrier—See *Insurance Carrier.*

Ceding Company—An insurance company that places *reinsurance* on certain risks or coverages with other insurance companies authorized to write such coverages or other applicable entity, for the purpose of limiting its loss liabilities.

Certification Process—See *Electronic Certification Testing.*

Claim—Refers to either:

- A loss for an on-the-job injury appearing on a DCI claim that is identified by a claim number
- A demand to recover under a policy of insurance for loss or damage covered by the policy

Claimant—A person who makes a claim.

Claim Selection Process—A process by which carriers use specific eligibility criteria to determine whether a claim must be reported to NCCI as a DCI claim. Refer to the **DCI Structure** and **Claim Selection and Sampling** sections (Parts 3 and 4) of this guidebook for eligibility criteria and selection examples.

Classification Codes and Statistical Codes for Workers Compensation and Employers Liability Insurance—Also referred to as the ***Classification Codes Manual***, an NCCI publication providing classification code numbers, statistical code numbers, corresponding phraseology, and state special codes.

Coal Mine Act—See *Federal Coal Mine Health and Safety Act of 1969.*

Coverage—The extent of protection afforded by an insurance policy.

Coverage Provider—See *Insurance Carrier.*

Cumulative Injury—An injury that results in a disability or death and is not traceable to a definite compensable accident occurring during the employee's present or past employment.

Data Field—Also referred to as data element, the smallest unit of physical data defined by attributes.

Data Provider—The company that reports data to NCCI. Data provider types include private carriers, *state funds*, self-insured groups, *self-insured funds*, *third party administrators (TPAs)*, and managing general agents (MGAs).

Data Provider Group—An assembly of affiliated insurance companies.

Data Transfer via the Internet—NCCI's data tool for submitting and receiving data electronically via **ncci.com**.

Date Reported to Insurer—See *Reported to Insurer Date* in this guidebook's Data Dictionary.

DCI States—Any *jurisdiction state*, whether an *NCCI state* or an *independent bureau state*, where the Detailed Claim Information program is applicable.

Deductible—A clause in an insurance policy that relieves the insurer of responsibility in dollars (percentage of the total or percentage of the loss) before paying the loss.

Direct Workers Compensation—Policies issued directly by an *insurance carrier* to its policyholders.

Direct Written Premium—For carriers that submit NAIC Annual Statements, the *premium* reported on column 2 of the NAIC Exhibit of Premiums and Losses of the NAIC Annual Statement (commonly known as Statutory Page 14). Otherwise, the premiums for primary policies issued directly by an *insurance carrier* to its policyholders. This might include premiums from some pools and associations.

Edit—The quality check performed as part of NCCI's editing process that verifies the validity of the data submitted.

Edit Description—Explains the *edit* in detail, including how and under what conditions the edit will be processed.

Editing Process—NCCI's process designed to ensure that data submitted by data providers is consistent with reporting requirements and that the data submitted meets quality standards.

Effective Date—The date that a specific document or transaction goes into effect.

Electronic Certification Testing—NCCI's process for preparing data providers to submit data files electronically to NCCI. The ***Electronic Transmission User's Guide*** contains details on this process and the preparation required.

Electronic Submission—A media type for reporting data to NCCI. A *data provider* may submit DCI data to NCCI using one of the electronic transmission options described in the **Data Reporting Resources and Tools** section (Part 9) of this guidebook.

Electronic Transmission User's Guide—An NCCI manual that provides details on how to transmit data electronically to NCCI. It includes the necessary requirements for preparing and submitting test and production files to ensure that all connections, data files, and systems are functioning and processing correctly. It also includes details on the available electronic submission methods.

Employer—An individual, partnership, joint venture, corporation, limited liability company, association, other legal entity, or a fiduciary such as a trustee, receiver, or executor.

Employers Liability Business—See *Employers Liability Insurance.*

Employers Liability Insurance—Protects the employer against claims for occupational diseases or work-related injuries not covered under state compensation laws. Employers liability insurance is coverage against common law liability of an employer for accidents to employees, as distinguished from liability imposed by a workers compensation law. Details are contained in NCCI's ***Basic Manual for Workers Compensation and Employers Liability Insurance*** for NCCI states, and in the appropriate jurisdiction manual for *independent bureau* states.

Endorsement—A modification to a policy, typed or printed on the policy itself or on an additional document attached to the policy. An *Endorsement* changes the document by restricting, expanding, or otherwise modifying the standard *coverage*.

Extended Term Policy—A policy whose expiration date is greater than one year and 16 days but less than three years from the *effective date*.

Federal Acts—Federal programs that govern an injured worker's benefits. Claims that include benefits payable under the following Federal Acts are excluded from DCI:

- Admiralty—see *Admiralty Law*
- USL&HW—see *United States Longshore & Harbor Workers' Compensation Act (USL&HW)*
- FELA—see *Federal Employers' Liability Act (FELA)*
- Jones Act—see *Merchant Marine Act of 1920*
- Coal Mine Act—see *Federal Coal Mine Health and Safety Act of 1969*

Federal Coal Mine Health and Safety Act of 1969—Generally referred to as the Coal Mine Act, or Coal Act, includes specific procedures for the development of improved mandatory health and safety standards, and provides compensation for miners who are totally and permanently disabled by the progressive respiratory disease caused by the inhalation of fine coal dust pneumoconiosis, or "black lung."

Federal Employers' Liability Act (FELA)—A law that establishes benefits for certain employees, e.g., those engaged in interstate commerce by rail. An act that gives employees of interstate rail carriers an action in negligence against their employers.

FELA—See *Federal Employers' Liability Act (FELA)*

Field Position—The location on the *record layout* for data submitted electronically.

Format—The arrangement or layout of information on a data-recording medium; e.g., the format for Policy Effective Date is YYYYMMDD.

Impairment Rating—An estimate, based on acceptable medical standards, of the degree to which illness or injury diminishes an individual's capacity to daily activities.

Incurred—Paid plus reserves (expected to be paid). Incurred indemnity and incurred medical amounts are examples.

Indemnity—Compensation paid to an injured worker for lost wages due to a work-related injury.

Independent Bureau States—Write and enforce the regulations for their specific state's workers compensation system. The independent bureau states are California, Delaware, Indiana, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, Pennsylvania, and Wisconsin. All of these states—except California and Delaware—are included in NCCI's Call for Detailed Claim Information data collection program. Additionally, Texas has its own Detailed Claim Information program with reporting requirements different from those of the NCCI program. NCCI acts as the statistical agent for Texas and collects this Texas DCI data from all data providers.

Insurance Carrier—The company that issues the insurance policy. Also referred to as *coverage provider*, insurance carriers include private carriers, state funds, and self-insured groups.

Insured—The policyholder. In *workers compensation insurance*, the insured is the person or organization (employer) that is protected (covered) by the insurance policy and is entitled to recover benefits under its terms. The insured is designated in Item 1 of the policy Information Page.

Insurer—An *insurance carrier* or other organization, such as a syndicate, pool, or association, providing insurance coverage and services.

Jones Act—See *Merchant Marine Act of 1920.*

Jurisdiction State—The governing body/territory (either the exposure state or the *accident state*) whose *statutes* will apply to the payment of *benefits* for the claim.

Key Data Elements—Data elements that link the carrier's system and the DCI database. DCI key data elements are:

- Carrier Code (if applicable)
- Carrier Group Code (if applicable)
- Policy Number Identifier
- Policy Effective Date
- Reported to Insurer Date
- Claim Number Identifier

Loss—Refers to either:

- Claim from an on-the-job injury
- Dollar amount that includes money already paid to the claimant by the insurance company, such as expenses, plus money reserved for future payments

Loss Valuation—The time period for assessment of the dollar amounts of *incurred* losses for claims. For DCI reports, claims are valued based on the Reported to Insurer Date. This is the actual date (month/day/year) that the claim was reported to the insurance carrier providing the workers compensation *coverage* under the policy.

The following are the loss valuation dates for each DCI Report Type:

Report Level	Valuation Schedule
First Report	Valued 18 months from Reported to Insurer Date
Second Report	Valued 30 months from Reported to Insurer Date
Third Report	Valued 42 months from Reported to Insurer Date
Fourth Report	Valued 54 months from Reported to Insurer Date
Fifth Report	Valued 66 months from Reported to Insurer Date
Sixth Report	Valued 78 months from Reported to Insurer Date
Seventh Report	Valued 90 months from Reported to Insurer Date
Eighth Report	Valued 102 months from Reported to Insurer Date
Ninth Report	Valued 114 months from Reported to Insurer Date
Tenth Report	Valued 126 months from Reported to Insurer Date
Eleventh Report	Valued 138 months from Reported to Insurer Date

Lump Sum—A sum of money payable as a single payment to the *insured*, *beneficiary*, *claimant*, etc., generally referred to as a lump sum settlement. This one-time payment may be made in place of weekly wage compensation checks, and in some cases, certain other *benefits*.

Market Share—The percentage of total industry sales that is made up by a particular company's individual sales.

Media Type—The format or medium on which the data is submitted to NCCI. The two primary media are electronic and hard copy. Hard copy is **not** an available media type for the DCI program presented in this guidebook.

Medical—The dollar amount for medical or hospital treatment that is due an injured worker because of a work-related injury.

Medical Extinguishment—The termination of medical benefits as part of a *Lump Sum* settlement.

Merchant Marine Act of 1920—Commonly referred to as the *Jones Act*, a United States Federal *statute* that regulates maritime commerce in US waters and between US ports, and contains provisions regarding seamen's rights.

NCCI Affiliates—Companies or organizations that are members of NCCI.

NCCI Carrier Code—See *Carrier Code* in this guidebook's Data Dictionary.

NCCI States—Jurisdictions in which NCCI's ***Workers Compensation Statistical Plan*** applies. For information on the specific states that are NCCI states, see the State Reference Guide located at **ncci.com**.

Occupational Disease—An abnormal condition or disorder, other than a workplace injury, caused by extended exposure to environmental factors associated with employment, including acute and chronic illness or disease caused by inhalation, absorption, ingestion, or direct contact.

Participation Process—Identifies those data providers that are required to report DCI. NCCI performs this analytical process approximately every three years. The intent of this process is to ensure that NCCI collects DCI from those *data providers* that are active writers of *workers compensation insurance* in each DCI state.

Policy Data—Information submitted to NCCI in the form of policy Information Pages, *endorsements*, cancellations, and other relevant policy documents for all single and multistate workers compensation policies for which *coverage* is provided in one or more NCCI *jurisdiction states*.

Policy Period—The term of a policy defined by the policy *effective date* and the policy expiration date.

Policy Period Endorsement—See *Endorsement.*

Policy Term—Indicates the length of time that the policy is in effect and whether the policy is variable or fixed-rate (e.g., standard one-year policy, three-year fixed-rate policy, *three-year variable rate policy*, etc.).

Premium—The amount of money an insurance company charges to provide the *coverage* described in the policy (payroll/100 × manual rate).

Private Carrier—See *Insurance Carrier.*

Production—See *Production Database*.

Production Database—Collects, captures, and stores statistical data in one environment. Interrelated data is stored together to serve one or more organizational applications in optimal fashion. This makes it possible for NCCI's customers to benefit from many of the features available through our online data tools.

Record Layout—Defines the parameters for each *data field* contained in the record, including the data field's starting and ending positions on the record and the field's specific type/class (e.g., alpha, numeric, or alpha/numeric).

Record Type—The category to which a record belongs. The Detailed Claim Information record types are Detailed Claim Information Record and Submission Control Record.

Reinsurance—Refers to:

- A process in which a company shares its risks with another, paying to this sharing company a portion of the premium it receives
- A transaction in which a reinsurer, for a consideration, agrees to indemnify the *ceding company* against all or part of a loss, which may be sustained by the ceding company under the policy or policies that it has issued

  Detailed Claim Information (DCI) is reported only for *direct workers compensation*. Statistics for workers compensation assumed policies (e.g., premiums received from or losses paid to other carriers on account of reinsurance assumed by the data provider) are excluded from DCI. In addition, deductions should not be made by the data provider for premiums ceded to or for losses recovered from other data providers due to ceded reinsurance.

Reopen—See *Reopened Claims*.

Reopened Claims—DCI claims that were previously reported as closed, and were subsequently reopened and remain open at a subsequent loss valuation.

Replacement Report—The method used by *data providers* to make rejected, nonrejected, or *key data element* changes by fully replacing any report (1st through 11th) that resides on NCCI's database.

Report Level—Identifies the specific valuation for the DCI claim being reported. The initial reporting of the DCI claim is valued as of 18 months after *Reported to Insurer Date*, known as Report Level 1. Subsequent DCI reports are required for claims that remain open or have a data value that has changed, as of each subsequent valuation date, known as Report Levels 2 through 11.

Reserve—A sum set aside by the *insurer*, in accordance with state *statutory* insurance accounting, to meet future obligations to the *insured*. This includes claim reserves, which is an estimated amount of money set aside and used to pay *benefits* for unsettled claims or known future claims.

Risk—Refers to either of the following:

- The insured (employer) covered by the insurance policy. A risk can be a single entity, or it can be two or more entities qualifying for combination under the rules of the Experience Rating Plan.
- All operations of an employer in a state.

Sampling—A method used in the Detailed Claim Information program to identify those claims that are subject to reporting as part of the *claim selection process*. All Death and Permanent Total Disability claims must be reported and, therefore, are not subject to sampling.

Scopes® Manual—An NCCI manual that provides comprehensive descriptions of classification codes, cross-references, and state special classifications.

Second Injury Fund—A dedicated fund set up by some states to limit employers compensation costs in the event that an impaired employee sustains a workers compensation injury that leaves him/her more disabled than the same injury would leave a nonimpaired worker. Where workers with existing handicaps suffer further work-related injuries or diseases that result in total disability, the employer is responsible for the workers compensation benefit only for the second injury or disease. The fund makes up the difference between the *benefit* for total disability and the benefit for the second injury. Second-injury funds are financed through general state revenues or assessments on workers compensation insurers.

Selection—See *Claim Selection Process*.

Self-Insured Fund—An assembly of insureds that pool funds to cover workers compensation claims experienced by the assembly.

SIF—See *Second Injury Fund* or *Self-Insured Fund*.

State Chart—An NCCI guide, located at **ncci.com**, which lists all states, indicating whether they are NCCI states, monopolistic fund states, or *independent bureau states*. The State Chart also defines NCCI's data collection roles for each state.

State Fund—An insurer that is generally operated by state regulation. Some state funds are competitive, meaning that they write insurance in competition with private insurers. Others are monopolistic, meaning that competition by private insurers is prohibited by *statute*. State funds are one group of NCCI's *data providers*.

State of Accident—See *Accident/Injury Date* in this guidebook's Data Dictionary.

State of Jurisdiction—See *Jurisdiction State* in this guidebook's Data Dictionary.

State Sampling Ratios—The percentages of DCI claims (both open and closed) that are required to be reported for each state. These ratios enable NCCI to annually collect the targeted 1,200 claims for each DCI state from the industry.

Statistical Agent—Company associations that collect workers compensation data and prepare it according to rating regulation requirements on behalf of their members. Most state workers compensation laws permit companies to join together for this purpose.

Statute—A formal, written law of a country or state, written and enacted by its legislative authority.

Statutory—See *Statute*.

Subrogation—When a company pays a loss for which a person other than the policyholder is responsible, the company's right to recover its loss from the guilty party is the right of *subrogation*.

Subsequent Report—Required when an open claim exists on a previously submitted *report level*, or when any data that has changed since the previous report must be modified, and the current data must be entered for the current valuation (e.g., Report Level 2 updates Report Level 1). Subsequent reports follow Report Level 1 (First Report).

Texas DCI Program—NCCI is the statistical agent for the Texas Department of Insurance, and one component of that role is the collection of Texas DCI. For information regarding the Texas DCI Program and reporting requirements, refer to the Texas *Detailed Claim Information Statistical Plan* at http://www.tdi.state.tx.us/wc/regulation/index.html.

Third Party Administrator (TPA)—One *data provider group* that reports data to NCCI. A third party administrator reports data on behalf of an *insurance carrier* (e.g., private carrier, state fund, self-insured group, or a self-insured fund).

Three-Year Variable-Rate Policy—A policy issued for a period of three years in which the rate could vary from the first to the second year and from the second year to the third year.

TPA—See *Third Party Administrator*.

Transaction—In general, refers to a string of data that is transmitted to the central processor from a terminal, plus the associated response from the processor to the initiating terminal.

ULAE—See *Unallocated Loss Adjustment Expense*.

Unallocated Loss Adjustment Expense—Those expenses that are not specifically assignable to losses, such as home office claim activity. ULAE includes, but is not limited to, the following:

- Carrier employees' salaries, overhead, and traveling expenses that are considered loss adjustment expenses and are not incurred while doing activities listed as allocated expenses
- Fees paid to independent claims professionals or attorneys hired to perform the function of claim investigation normally performed by claim adjusters. Fees are paid for developing and investigating a claim so that a determination can be made of the cause or extent of responsibility for the injury or disease, including evaluation and settlement of covered claims.

Unit Statistical Data—Statistical documentation that *data providers* submit to NCCI for the purpose of reporting *workers compensation insurance* data. It includes *premium* and *losses* by state at a classification code level.

United States Longshore and Harbor Workers' Compensation Act (USL&HW Act)—A federal law that provides for payment of compensation and other *benefits* to employees injured while loading, unloading, repairing, or building a vessel. The law is applicable to employees working on or over navigable waters of the United States.

USL&HW Act—See *United States Longshore and Harbor Workers' Compensation Act.*

Valuation—Refers to when claim values are assessed for reporting purposes. The DCI Report Level 1 is valued as of 18 months after *Reported to Insurer Date*. Report Levels 2 through 11 are valued in one-year intervals after the first reporting of the DCI claim.

Valued—See *Valuation*.

Vocational Rehabilitation—A service provided by the employer or *insurance carrier* for training and education in an effort to return the injured worker to gainful employment.

Voluntary Compensation—Insurance that provides *coverage* for workers for whom workers compensation coverage is not required by law. Under many state *workers compensation insurance* laws, an employer is not required to provide *benefits* for certain types of employment, such as domestic, farm, and casual workers. Voluntary compensation insurance enables the employer to offer the equivalent of workers compensation and *employers liability insurance* for these types of employment. Coverage for volunteers is permitted only where allowed by state law.

Voluntary Market—The marketplace where an employer, either directly or through a licensed agent or broker, can obtain workers compensation coverage through a licensed workers compensation carrier.

Wage Loss—Temporary disability benefits that may be paid when an employee returns to work at less than full earnings.

WCCDCI Format—See *Workers Compensation Call for Detailed Claim Information (WCCDCI) Format.*

WCIO—See *Workers Compensation Insurance Organizations*.

Workers Compensation Call for Detailed Claim Information (WCCDCI) Format—Required for reporting Detailed Claim Information data electronically to NCCI. The required specifications and *record layouts* are included in the ***Workers Compensation Insurance Organizations (WCIO) Workers Compensation Data Specifications Manual***.

Workers Compensation Insurance—Statutory coverage for employers subject to the workers compensation law of a state. It provides *benefits* to employees who are injured during the course of their employment. NCCI's ***Basic Manual for Workers Compensation and Employers Liability Insurance*** contains rules, classifications with descriptions, rates/loss costs for each classification, and state-specific exceptions for writing workers compensation insurance.

Workers Compensation Insurance Organizations (WCIO)—A voluntary association of statutorily authorized or licensed rating, advisory, or data service organizations that collect *workers compensation insurance* information in one or more states. WCIO has developed standards for the electronic transmission of information between insurers and rating/advisory organizations, which are contained in the ***WCIO Workers Compensation Data Specifications Manual.*** These specifications are available for DCI, policy information, unit statistical reporting, experience modifications, and individual case reports.

Workers Compensation Insurance Organizations (WCIO) Workers Compensation Data Specifications Manual—Contains data reporting specifications that have been implemented under the direction of various data collection organizations. The specifications provide standard formats for exchanging information electronically to all the data collection organizations and their members, including WCPOLS, WCSTAT, and *WCCDCI formats*.

Workers Compensation Policy Data Reporting Manual—Provides the requirements and guidelines for submitting workers compensation policy documents. It also explains the various methods used for reporting data to NCCI.

Attachment B

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

B. ~~Form of Report~~

~~Reports ***are comprised of detail records*** of exposures, premiums and losses, together with individual claim reports. All reports MUST be submitted ***electronically*** subject to the provisions of this Plan.~~

~~Forms~~	~~Description~~
~~ICR-ASWG Form~~	~~Individual Case Report.~~

C Experience Rated Risks

For all interstate experience rated risks, a duplicate copy of the Massachusetts experience shall also be filed with the National Council on Compensation Insurance (NCCI).

D. Date of Valuation and Filing

1. First Reports

a. The premium and losses of each policy are first valued as of eighteen (18) months after the policy effective date and reported no later than twenty (20) months after the policy effective date.

b. Revisions to first reports are required:

i. Upon the identification of mistakes in previously reported exposures or loss information by either the Bureau or carrier.

ii. When a revision to the loss is required due to the reasons listed in Section II, Part D, Item 4 (Revision to Losses).

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

I. Method of Transmittal

All submissions must be accompanied by a transmittal record in the electronic submission**.**

J. Three-year Fixed Rate Policies

Experience incurred under three-year fixed rate policies written in accordance with Section XI of the Massachusetts Workers' Compensation & Employers' Liability Insurance Manual must be reported by the following method:

1. Unit Reporting Basis for Electronic Submissions:

   a. Form of Report: The complete three-year experience incurred under each policy shall be reported on the current appropriate unit report with "Y" entered in the three-year fixed rate policy indicator.

   b. Date of Valuation and Filing: Losses included in the reporting of a given policy shall be valued as of exactly 42 months after the inception date of the policy and the reports shall be filed no later than 44 months after the effective date of the policy. These reportings shall be specifically identified as three-year fixed rate policy experience (this may be done by entering "Y" in the "Three-year Fixed Rate Indicator).
   c. Data to be Reported: The data required shall be the data specified under the Statistical Plan, i.e., all data elements are required.

   d. Second, through tenth reports are not required on these three-year policies. However, all corrections and revisions to first reports are required as specified for reporting of information under the Statistical Plan.

   e. ~~Individual Case Reports: Individual Case Reports are required.~~

2. Summarized Basis:

   Beginning with policies effective on January 1, 2006 summarized reporting of three year fixed data is not permissible.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

5. Correction Type (Corr. Type)

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: A code for correction reports which indicates the record types that change.

d. Requirements: Report the 1-digit alphabetic code that indicates the type of correction report being submitted. Subsequent reports cannot be coded with correction types H or E.

Code	Description
H	Header Record Correction (link all reports, non-link elements first report only)
E	Exposure Record Correction (first reports only)
L	Loss Record Correction - Not an Aggravated Inequity
T	Total Record Correction
M	Corrections to Multiple Record Types - Combinations of corrections to header, exposure, loss, total records or ICRs**,** Aggravated inequity corrections must be reported separately.
A	Loss Record Correction due to an aggravated inequity. This type of correction can not be reported on a multiple record type.
~~C~~	~~Individual Case Report (ICR) included~~

Note: A loss correction due to an Aggravated Inequity is submitted upon the Bureau's request or when the carrier identifies the circumstances that qualify the experience rating for a revision under the Aggravated Inequity Rule of the Experience Rating Plan Manual.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

5. Incurred Indemnity

a. Characteristic: Numeric

b. Length: 9

c. Definition: The whole dollar amount paid or expected to be paid to an injured employee and/or dependents due to the employees lost wage benefits. The incurred indemnity losses encompass all paid and outstanding wage compensation, burial expenses, sums designated for specific injuries or disfigurements, claimants' attorney fees, vocational rehabilitation, employers' liability losses and employers' liability expenses.

Note: Since 1986 the MA Second Injury Fund has been funded through premium assessments paid by the insureds. These employer paid DIA assessments shall not be reported as part of the losses.

d. Requirement: Report the whole dollar amount of incurred indemnity losses as of the loss valuation date. Except for death and permanent total claims, incurred indemnity losses reported on unit statistical reports should consist of the sum of all paid losses and outstanding case reserves for benefits (such as employee's lost wages) due to an employee's inability to work caused by a work related accident. The outstanding case reserves are the company's estimates of future payments for individual claims.

Generally, for purposes of reporting death and permanent total claims, Section IX pension tables should be used to estimate the future payments component of the incurred indemnity loss. Consequently, the incurred indemnity loss should consist of the sum of all paid losses and the estimated future payments derived using the Section IX pension tables for benefits (such as employee's lost wages) due to an employee's inability to work caused by a work related accident.

~~***For any death and permanent total claim where the Section IX pension tables have not been used, a reserve type code other than "00" must be reported on the individual case report which must accompany the unit statistical report. The reserve type codes other than "00" identify situations that may impact the future payments on a claim and support the carrier's election***~~

~~***to not use the value derived by using the pension tables.***~~ ~~Consequently,~~ ***T***he incurred indemnity loss should consist of the sum of all paid losses and the carrier's best estimate of future payments for benefits (such as employee's lost wages) due to an employee's inability to work caused by a work related accident. ~~***For a list of reserve type codes, refer to Section VIII, page 13.***~~

e. ***NON USL&HW ACT*** DEATH AND PERMANENT TOTAL CLAIMS

1. In valuing a surviving spouse's benefits in death claims where benefits are payable to the surviving spouse (widow or widower) until death or remarriage, use TABLE IE-398.

2. In valuing the portion of the reserve for death claims where there is not a surviving spouse, but a parent, brother or sister where benefits are payable for life, use TABLE IIE-398.

3. In valuing the disabled life portion of the reserve for a permanent total claim where benefits are payable for life, TABLE IIIEM-398 shall be used for male claimants. TABLE IIIEF-398 shall be used for female claimants.

4. For Permanent Total claims present values are to be further adjusted to allow for survivorship benefits according to the following procedure:

i. Establish the pension value for the disabled worker based on the appropriate table.

ii. Determine the pension value for the spouses with surviving spouse benefits based on the appropriate table or for dependent other than spouse based on the appropriate table.

iii. Determine the pension value difference of item (ii) minus item (i). If this produces a negative result, there is no additional increment to be added to the reserve for survivorship benefits.

iv. Multiply the pension value difference from item (iii) by one-third(1/3) the annual benefit that would be payable to the worker's spouse or dependents if the worker dies. This produces the amount to be added to the reserve for survivorship.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~***5. For death and permanent total claims where the above referenced tables have not been used, a reserve type code must be reported on the individual case report which must accompany the unit statistical report of death and permanent total claims. The reserve type codes other than "00" identify situations that may impact the reserve on a claim and support the carrier's election to not use the value derived by using the pension tables. For a list of reserve type codes, refer to Section VIII, page 13.***~~

f. USL&HW ACT DEATH AND PERMANENT TOTAL CLAIMS

1. For all death claims incurred under the United States Longshoremen and Harbor Workers' Act, PENSION TABLE UI-USLH shall be used in valuing the surviving spouse's benefit. Additionally, in valuing the present value or the remarriage dowry TABLE UII-USLH shall be used. For claims where there is not a surviving spouse, TABLE UIV-USLH Present Value of Survivorship benefits shall be used.

2. For all permanent total claims incurred under the United States Longshoremen and Harbor Workers' Act and the benefits payable for life, PENSION TABLE UIIIM-USLH or UIIIF-USLH shall be used in valuing the claimant's benefits. Additionally, TABLE UIV-USLH shall be used in valuing the present value of the survivorship benefits.

~~***3. For death and permanent total claims where the above referenced tables have not been used, a reserve type code must be reported on the individual case report which must accompany the unit statistical report of death and permanent total claims. The reserve type codes other than "00" identify situations that may impact the future payments on a claim and support the carrier's election to not use the value derived by using the pension tables. For a list of reserve type codes, refer to Section VIII, page 13.***~~

g. REPORTING OF REIMBURSEMENT FROM A SPECIAL FUND

In all cases where a claim has been determined to be eligible for reimbursement to the carrier from a special fund (such as Second Injury Fund, Handicapped Workers' Reserve Fund, etc.) the gross incurred cost of the claim (i.e., prior to any reimbursement) shall be reduced by the amount of any paid or anticipated recovery from such Fund and the net incurred cost of the claim shall be reported. Anticipated recovery is defined, for this purpose, as the amount of recovery expected to be recovered from such funds based on the rules governing such

PART I

UNIT STATISTICAL REPORTING

SECTION VIII

~~INDIVIDUAL CASE REPORTS~~

REPORTING OF INFORMATION REGARDING INDIVIDUAL DEATH AND PERMANENT AND TOTAL DISABILITY CLAIMS

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

SECTION VIII - INFORMATION REGARDING DEATH OR PERMANENT TOTAL CLAIMS

A. Reporting Requirements

Every company shall maintain, store and be prepared to report at least the following information for every death claim and every permanent and total disability claim:

1. Identifying information listed below must match to the unit statistical report of the claim and is defined and coded as specified in the previous sections of this Statistical Plan.

    a. Accident Date
    b. Carrier Code
    c. Claim ID Number
    d. Class Code
    e. Policy Effective Date
    f. Policy ID Number
    g. Report Number
    h. Claim Status Code

2. The additional claim information listed below which is defined and coded as specified in the NCCI's Detailed Claim Information Reporting Guidebook, issued January 1, 2008. The information listed in this section shall be reported at such times and in such manner as is set forth in NCCI Circular DCI-2008-01, dated January 18, 2008.

    a. Accident State Code
    b. Attorney or Authorized Representative Indicator
    c. Benefit Amounts Paid
        i. Death Benefits Paid
        ii. Permanent Total Disability Benefits Paid
        iii. Scheduled Permanent Partial Benefits Paid
        iv. Unscheduled Permanent Partial Benefits Paid
        v. Temporary Total Injury Benefits Paid
        vi. Disfigurement Benefits Paid
        vii. Temporary Partial Benefits Paid
        viii. Employers Liability Paid
        ix. Supplemental Benefits Paid
    d. Birth Year
    e. Claim Closing Date
    f. Claimant Gender Code
    g. Controverted / Disputed Case Indicator
    h. Hire Date
    i. Impairment Percentage Basis Code
    j. Impairment / Disability Percent

k. Lump Sum Benefits Paid
    i. Death Benefits Lump Sum Settlement
    ii. Permanent Total Disability Benefits Lump Sum Settlement
    iii. Scheduled Permanent Partial Benefits Lump Sum Settlement
    iv. Unscheduled Permanent Partial Benefits Lump Sum Settlement
    v. Temporary Total Injury Benefits Lump Sum Settlement
    vi. Disfigurement Benefits Lump Sum Settlement
    vii. Temporary Partial Benefits Lump Sum Settlement
    viii. Supplemental Benefits Lump Sum Settlement
l. Maximum Medical Improvement Date
m. Medical Extinguishment Indicator
n. Average Weekly Wage
    i. Post-Injury Average Weekly Wage
    ii. Pre-Injury Average Weekly Wage
o. Reported to Insurer Date
p. Return to Work Date
q. Return to Work Status Indicator
r. Vocational Rehabilitation
    i. Education Expense Amount Paid
    ii. Evaluation Expense Amount Paid
    iii. Maintenance Expense Amount Paid
    iv. Other Amount Paid

3. The requirements under this section may be satisfied by participation in the NCCI's Redesigned Detailed Claim Information Program as set forth in NCCI Circular DCI-2008-01.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

SECTION VIII - INDIVIDUAL CASE REPORTS

A. Reporting Requirements

Individual Case Reports (ICR) shall be filed for the following:

1. Any permanent total claim.

2. Any death claim.

Individual case reports are filed concurrently with the submission of individual risk experience through the ***tenth*** report. Individual case reports in connection with subsequent reporting of experience are required while the claim remains open and until the final closed incurred amounts have been reported.

B. General Information

1. ALL INFORMATION ON THE INDIVIDUAL CASE REPORT MUST AGREE WITH THE CORRESPONDING INFORMATION SHOWN ON THE UNIT REPORT.

2. Forms: Use Individual Case Report Form as illustrated in Section XI.

3. Only claim identification, loss development, and pension reserve verification data elements are required on ICRs. The mandatory elements are:

a. Class
b. Report Number
c. Type of Injury
d. Carrier Code
e. Policy Number
f. Policy Effective Date
g. Claim Number
h. Status Code
i. Payroll State
j. Accident Date
k. Total Incurred Indemnity
l. Total Incurred Medical
m. Vocational Rehabilitation Total Incurred
n. Insured's Name
o. Date of Death
p. Date of Birth
q. Worker's Last Name
r. Average Weekly Wage
s. Date Closed
t. Reserve Type Code

u. Date Single Sum Paid
v. Beneficiary Code
w. Beneficiary Date of Birth
x. Temporary Indemnity Incurred
y. Scheduled Indemnity Incurred
z. Non-Scheduled Indemnity Incurred
aa. Employers Liability or Other Indemnity Incurred
bb. Single Sum Paid
cc. Data Provider Comment
dd. Pension Indemnity Paid to Valuation
ee. Pension Indemnity Previously Reserved but Not Paid
ff. Present Value Future Indemnity Payments
gg. Funeral Allowance
hh. Social Security Offset indicator
ii. Worker's Sex
jj. Social Security or Other Offset amount

All other data elements are not required or are not applicable to Massachusetts Individual Case Reports. If the other data element fields are reported, they will not be stored or edited.

C. Individual Case Reports - Data Elements

1. Class Code (Record/Sub Record 7A)

a. Characteristic: Numeric

b. Length: 4

c. Definition: The code where the payroll of the injured worker was reported.

d. Requirement: Report the loss class code as it appears on the last loss claim record.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

2. Report Number (Rpt. No.)

a. Characteristic: ***Alpha***/Numeric

b. Length: 1

c. Definition: A code appearing on a unit report that indicates the number of times data has been reported on a policy, excluding correction reports that correspond to the number of valuations.

d. Requirement: Report the report code that corresponds to the number of months since the policy effective date for the current valuation.

Code	Valuation
1	18 months
2	30 months
3	42 months
4	54 months
5	66 months
6	***78 months***
7	***90 months***
8	***102 months***
9	***114 months***
A	***126 months***

3. Transaction Type Code (Trans. Type Code) (Record/Sub Record 7A)

a. Characteristic: Numeric

b. Length: 1

c. Definition: The Transaction Type identifies an ICR as an original report, subsequent or correction report, requested by the Bureau or initiated by the carrier.

d. Requirement: Leave blank or zero fill. Not Applicable to Massachusetts.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~4. Injury Code (Type of Inj. Code) (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric~~

~~b. Length: 2~~

~~c. Definition: A code that identifies under which provision(s) of the law benefits are paid or expected to be paid.~~

~~d. Requirement: Report the injury code as it appears on the last loss claim record.~~

~~5. Carrier Code (Carrier Number) (Record 7 Link)~~

~~a. Characteristic: Numeric~~

~~b. Length: 5~~

~~c. Definition: A unique code assigned by the NCCI to each company which supplies data.~~

~~d. Requirement: Report the carrier code as it appears on the last loss report.~~

~~6. Carrier Name (Record/Sub Record 7F)~~

~~a. Characteristic: Alphanumeric~~

~~b. Length: 18~~

~~c. Definition: The name of the insuring company.~~

~~d. Requirement: Optional reporting for Massachusetts.~~

~~7. Exposure State (Payroll State Code) (Record 7 Link)~~

~~a. Characteristic: Numeric~~

~~b. Length: 2~~

~~c. Definition: A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.~~

~~d. Requirement: Report the exposure state as it appears on the last unit report.~~

~~8. Administrate File Number (Admin. File number)~~

~~a. Characteristic: Numeric~~

~~b. Length: 6~~

~~c. Definition: Space reserved for the Bureau.~~

~~d. Requirement: Leave blank or zero fill. Not Applicable to Massachusetts.~~

~~9. Policy Number (Record 7 Link)~~

~~a. Characteristic: Alphanumeric~~

~~b. Length: 18~~

~~c. Definition: A unique identifier assigned to a policy. This number must be identical to the policy number shown on the policy information page.~~

~~d. Requirement: Report the policy number as it appears on the policy information page (or as endorsed) and the last loss report.~~

~~10. Certificate Number (Cert. No.) (Record 7 Link)~~

~~a. Characteristic: Alphanumeric~~

~~b. Length: 7~~

~~c. Definition: Certificate of a Master Policy.~~

~~d. Requirement: Not applicable to Massachusetts.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

11. Policy Effective Date (Record 7 Link)

a. Characteristic: Numeric MM-DD-YY – hardcopy
YY-MM-DD – electronic

b. Length: 6

c. Definition: The inception date of the policy as shown both on the policy information page and the unit report.

d. Requirement: Report the policy effective date as it appears on the policy information page (or as endorsed) and the last loss report.

12. Claim Number (Claim No.) (Record/Sub Record 7A-J)

a. Characteristic: Alphanumeric

b. Length: 12

c. Definition: A unique number assigned by the insurance company to a claim for the life of that claim.

d. Requirement: Report the claim number as it appears on the last loss claim record.

13. Status Code (Stat. Code) (Record/Sub Record 7A)

a. Characteristic: Numeric

b. Length: 1

c. Definition: A code that identifies claims where final payment has been made.

d. Requirement: If, in the estimation of the carrier, the final payment has been made at the time of valuation report 1. If the carrier anticipates additional payments, report 0.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

14. Date of Attorney Disclosure (Date Attny. Disc.) (Record/Sub Record 7I)

a. Characteristic: Numeric

b. Length: 6

c. Definition: Date carrier receives the attorney disclosure form.

d. Requirement: Leave blank or zero fill, not applicable to MA.

15. Loss Conditions Act Code (Act.) (Record/Sub Record 7A)

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that identifies the basis of liability which describes the claim.

d. Requirement: Optional.

16. Loss Conditions Type of Loss (Typ.) (Record/Sub Record 7A)

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that describes the circumstances of the injury.

d. Requirement: Optional.

17. Loss Conditions Type of Recovery (Rec.) (Record/Sub Record 7A)

a. Characteristic: Numeric

b. Length 2

c. Definition: Code that identifies some types of reimbursements that the carrier has received.

d. Requirement: Optional.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~18. Loss Conditions Coverage (Cov.) (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric~~

~~b. Length: 2~~

~~c. Definition: A code that identifies under which part of the standard workers' compensation policy and employers' liability policy that the claim is incurred.~~

~~d. Requirement: Optional.~~

~~19. Loss Conditions Settlement Code (Set.) (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric~~

~~b. Length: 2~~

~~c. Definition: Code that identifies certain claim settlement situations.~~

~~d. Requirement: Optional.~~

~~20. Jurisdiction State Code (Juris. State) (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric~~

~~b. Length: 2~~

~~c. Definition: The governing body/territory, who will administer the claim and whose statutes will apply to the claim adjustment process.~~

~~d. Requirement: Optional.~~

~~21. Managed Care Organization Type Indicator (MCO Type) (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric~~

~~b. Length: 2~~

~~c. Definition: A code that indicates the claim was administered by a managed care organization.~~

~~d. Requirement: Optional.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

22. Insured's Name (Record/Sub Record 7E)

a. Characteristic: Alphanumeric

b. Length: 24

c. Definition: The person or business with whom an insurance contract is made and who is specifically designated by name in item 1 of the policy information page, (or as endorsed).

d. Requirement: Report the insured's name as it appears on the policy information page (or as endorsed) and on the last unit report. Insured's name is required on the original ICR and to report corrections to the Insured's name.

23. Accident Date (Acc. Date) (Record/Sub Record 7A)

a. Characteristic: Numeric MM-DD-YY – hardcopy
YY-MM-DD – electronic

b. Length: 6

c. Definition: The date on which the injury occurred. (Applies only to individually listed losses).

d. Requirement: Report the accident date as it appears on the last loss claim record.

24. Date of Death (Record/Sub Record 7A)

a. Characteristic: Numeric MM-DD-YY – hardcopy
YY-MM-DD – electronic

b. Length: 6

c. Definition: The date on which the injured worker died.

d. Requirement: Report the date of death for all death (kind of injury code 1) claims. Date of Death is required on the original ICR and to report corrections to the Date of Death.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~25. Date Reported (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric MM-DD-YY – hardcopy~~
~~YY-MM-DD – electronic~~

~~b. Length: 6~~

~~c. Definition: The date on which the claim was first established in the carriers' statistical/accounting system.~~

~~d. Requirement: Optional.~~

~~26. Date of Birth (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric MM-DD-YY – hardcopy~~
~~YY-MM-DD – electronic~~

~~b. Length: 6~~

~~c. Definition: The date on which the injured worker was born.~~

~~d. Requirement: Report the month, day and year of injured worker's birth. Date of Birth is required on the original ICR and to report corrections to the Date of Birth.~~

~~27. Surgery Code (Surg. Code) (Record/Sub Record 7I)~~

~~a. Characteristic: Numeric~~

~~b. Length: 1~~

~~c. Definition: Indicates that a surgical procedure was performed on the injured worker as a result of the work related injury.~~

~~d. Requirement: Optional.~~

MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN

28. Attorney Code (Attny. Code) (Record/Sub Record 7I)

    a. Characteristic: Numeric

    b. Length: 1

    c. Definition: Indicates an involvement of a claimant's attorney during the claim resolution process.

    d. Requirement: Optional.

29. Worker's Last Name (Record/Sub Record 7F)

    a. Characteristic: Alphanumeric

    b. Length: 18

    c. Definition: The last name of the injured worker.

    d. Requirement: Report the first 18 letters of the injured or deceased worker's last name. Worker's Last Name is required on the original ICR and to Report corrections to the Worker's Name.

30. Average Weekly Wage (Record/Sub Record 7B)

    a. Characteristic: Numeric

    b. Length: 5

    c. Definition: An average of the weekly compensation received by the injured worker prior to injury. The average weekly wage is computed in accordance with statutory provisions.

    d. Requirement: Report the full average weekly wage of the injured worker. The full wage should be reported, not the wage sufficient to qualify for minimum compensation. The average weekly wage is required on the original ICR and to report corrections to the average weekly wage.

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~31. Injury Description Code (Injury Desc. Code Part/Nature/Cause) (Record/Sub Record 7B)~~

~~a. Characteristic: Numeric~~

~~b. Length: 6~~

~~c. Definition: A code comprised of three individual data elements, part of body, nature of injury, and cause of injury that describes the injury.~~

~~d. Requirement: Optional.~~

~~32. Occupation (Record/Sub Record 7F)~~

~~a. Characteristic: Alphanumeric~~

~~b. Length: 18~~

~~c. Definition: The usual or regular employment capacity of the injured worker.~~

~~d. Requirement: Optional.~~

~~33. Date Closed (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric MM-YY – hardcopy~~
~~YY-MM – electronic~~

~~b. Length: 4~~

~~c. Definition: The month and year the claim was closed in the carrier's statistical/accounting systems.~~

~~d. Requirement: Report the month and year the final payment was recorded in the carrier's system. Leave blank or zero fill on all open claims. Date closed is required on the ICR where the claim is first reported as closed and to report corrections to the Date Closed.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

34. Reserve Type Code (Record/Sub Record 7A)

a. Characteristic: Numeric

b. Length: 2

c. Definition: The reserve type code identifies a situation which may impact the case reserve.

d. Requirement:

Code	Description
00	Standard Reserve - Reserved in accordance with the rules and pension tables contained in the Massachusetts Workers' Compensation Unit Statistical Plan.
03	Questionable Compensability - Standard reserve is adjusted due to the carrier's doubt concerning compensability of the claim.
04	Second Injury Fund Involvement - Standard reserve is adjusted due to the carrier's anticipation of Second Injury Fund recovery.
05	Partial Dependency - Standard reserve is adjusted due to the partial dependency of one or more beneficiaries.
10	***Other Pension Value identifies claims where in the judgment of the carrier the claim is more accurately reserved using other than the pension table value in the statistical plan.***
11	***Other Age Accrual identifies claims, where in the judgment of the carrier, the claim is more accurately reserved using age at accident.***
12	***Hunter Claim Offset identifies claims where the reserve is offset by the claimant's receipt of a settlement from a third party.***
13	***Expected Early Termination or Settlement of Benefits***
14	***Expected Extension of Benefits for Minor Beneficiary***
15	***Death claim without apparent beneficiaries.***
16	***Expected Recovery of Loss, by the employer from a third party.***
17	***Permanent Total claim weighted with surviving spouse pension value.***
99	All Other Situations Impacting Pension Reserve

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~35. Lump Sum Indicator (Lump Sum) (Record/Sub Record 7A)~~

~~a. Characteristic: Alphabetic~~

~~b. Length: 1~~

~~c. Definition: Code identifying claims that have been settled by an agreement between the carrier and the injured worker, with the employer's approval, to redeem the liability for compensation by payment of specified amount representing a discounted or commuted value of benefit.~~

~~d. Requirement: Optional.~~

~~36. Fraudulent Claim Indicator (Fraud.) (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric~~

~~b. Length: 1~~

~~c. Definition: A code identifying claims that are partially or fully fraudulent in the opinion of the carrier, employer, claim resolution or jurisdiction.~~

~~d. Requirement: Leave blank or zero fill, not applicable to Massachusetts.~~

~~***37. Social Security Number*** (Record/Sub Record 7F)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The code assigned by the Social Security Administration to the claimant.~~

~~***d. Requirement***: ***Zero fill. Social Security Number is not to be reported. When reported, the Bureau will not store or make Social Security Number available for view.***~~

~~38. Date Single Sum Paid (Record/Sub Record 7J)~~

~~a. Characteristic: Numeric MM-DD-YY – hardcopy~~
~~YY-MM-DD – electronic~~

~~b. Length: 6~~

~~c. Definition: The date a lump sum payment was paid to the injured worker or beneficiary.~~

~~d. Requirement: Report the date the injured worker or beneficiary received the lump sum settlement. The Date Single Sum Paid is required on the original ICR and to report corrections to the Date Single Sum Paid.~~

~~39. Employment Status (Record/Sub Record 7H)~~

~~a. Characteristic: Numeric~~

~~b. Length: 2~~

~~c. Definition: The injured worker's employment status as of the date the claim was first reported to the carrier.~~

~~d. Requirement: Leave blank or zero fill, not applicable to Massachusetts.~~

~~40. Year Last Exposed (Record/Sub Record 7A)~~

~~a. Characteristic: Numeric YYYY~~

~~b. Length: 4~~

~~c. Definition: In disease or cumulative injury claims, the last year the injured worker (claimant) was in contact with the hazard or was engaged in the repetitive activity that caused the injury.~~

~~d. Requirement: Optional.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~41. Date of Hire (Record/Sub Record J)~~

~~a. Characteristic: Numeric MM-DD-YY – hardcopy~~
~~YY-MM-DD – electronic~~

~~b. Length: 6~~

~~c. Definition: The date which the injured worker began the most recent employment with the employer.~~

~~d. Requirement: Leave blank or zero fill, not applicable to Massachusetts~~

~~42. Temporary Indemnity - Number of Weeks (No. Weeks) (Record/Sub Record 7B)~~

~~a. Characteristic: Numeric~~

~~b. Length: 4~~

~~c. Definition: The number of weeks the injured worker received indemnity benefits due to a temporary loss of earning caused by loss time from work~~

~~d. Requirement: ***Optional.***~~

~~43. Temporary Indemnity Incurred (Record/Sub Record 7B)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The incurred indemnity amount (paid plus case reserves) as of the valuation date for benefits due to a temporary loss of earnings caused by loss time from work.~~

~~d. Requirement: Report the total incurred indemnity (paid plus case outstanding) as of the valuation date of all benefits to the injured worker related to temporary loss of earnings due to loss time from work. Only whole dollars should be reported.~~

~~e. Benefits incurred under M.G.L., Chapter 152, Section 34.~~

~~44. Scheduled Indemnity Percent of Disability (% Disab.) (Record/Sub Record 7B)~~

~~a. Characteristic: Numeric~~

~~b. Length: 3~~

~~c. Definition: The percentage of loss or loss of use of the specific body member on which the scheduled indemnity benefit is based.~~

~~d. Requirement: ***Optional.***~~

~~e. Benefits incurred under M.G.L., Chapter 152, Section 36.~~

~~45. Scheduled Indemnity Body Member Code (Body Memb. Code) (Record/Sub Record 7B)~~

~~a. Characteristic: Numeric~~

~~b. Length: 2~~

~~c. Definition: The code corresponding to the part of the body on which the scheduled indemnity benefit is based.~~

~~d. Requirement: ***Optional.***~~

~~e. Benefits incurred under M.G.L., Chapter 152, Section 36.~~

~~46. Scheduled Indemnity-Number of Weeks (No. Weeks) (Record/Sub Record 7B)~~

~~a. Characteristic: Numeric~~

~~b. Length: 4~~

~~c. Definition: The number of weeks upon which the scheduled indemnity benefit is based.~~

~~d. Requirement: Leave blank or zero fill, not applicable to Massachusetts.~~

~~47. Scheduled Indemnity Incurred Loss (Record/Sub Record 7B)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The total loss amount (paid plus case outstanding) due to a scheduled benefit.~~

~~d. Requirement: Report the whole dollar incurred amount (paid plus case outstanding) as of the valuation date of the scheduled benefit. Each scheduled benefit is listed as separate scheduled benefit.~~

~~e. Benefits under M.G.L, Chapter 152, Section 36.~~

~~48. Non-scheduled Indemnity-Percent of Disability (% Disab.) (Record/Sub Record 7C)~~

~~a. Characteristic: Numeric~~

~~b. Length: 3~~

~~c. Definition: The percent by which the earning capacity has diminished due to a non-scheduled indemnity benefit (partial incapacity).~~

~~d. Requirement: ***Optional.***~~

~~e. Benefits incurred under M.G.L., Chapter 152, Section 35, which are based on percent of diminished earning capacity, i.e., if the average weekly wage prior to injury is $550, and the average weekly wage after injury is $325, then the percent of disability is 41%. [1-(325/550)]~~

~~49. Non-scheduled Indemnity Incurred Losses (Record/Sub Record 7C)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The total amount of incurred indemnity (paid plus case outstanding) as of the valuation date of all non-scheduled (partial incapacity) benefits.~~

~~d. Requirement: Report the total whole dollar incurred indemnity (paid plus case outstanding) as of the valuation date due to non-scheduled (partial incapacity) benefits.~~

~~e. Benefits Incurred under M.G.L, Chapter 152, Section 35.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~50. Employers' Liability or Other Indemnity (Record/Sub Record 7C)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The total amount of incurred losses (paid plus case outstanding) as of the valuation date due to employer liability benefits.~~

~~d. Requirement: Report the whole dollar total incurred indemnity amount (paid plus case outstanding) as of the valuation date of all employers liability wage loss or other non-pension benefits not including, temporary indemnity, scheduled indemnity, vocational rehabilitation incurred, or non-scheduled indemnity.~~

~~51. Vocational Rehabilitation Total Incurred (Record/Sub Record 7C)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The total amount (paid plus case outstanding) as of the valuation date of any expenses incurred to restore an injured employee to suitable employment.~~

~~d. Requirement: Report the whole dollar incurred (paid plus case outstanding) as of the valuation date of any vocational rehabilitation expenses.~~

~~52. Claimant Legal Expenses Incurred (Record/Sub Record 7G)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The total incurred (paid plus case outstanding) legal costs of the claimant which will be paid by the carrier. See definition and reporting instructions for Indemnity Losses and Allocated Loss Adjustment Expense for additional information.~~

~~d. Requirement: Optional.~~

~~53. Physicians Paid (Record/Sub Record 7I)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: Total dollar amount paid to treating physicians including cost of all clinic and office visits.~~

~~d. Requirement: Optional.~~

~~54. Hospital Paid (Record/Sub Record 7G)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The cost paid for the hospitalization of the injured worker, including payments to physicians for tests, equipment, etc., used during the hospital stay.~~

~~d. Requirement: Optional.~~

~~55. Applicants Medical Evaluation Paid (App. Med. Eval. Paid) (Record/Sub Record 7I)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The amount paid by the carrier for medical evaluations procured by the applicant or applicant's attorney, excluding evaluations performed by the treating physicians. See definition of Indemnity Losses and Allocated Loss Adjustment Expense for additional instructions.~~

~~d. Requirement: Optional.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~56. Defense Medical Evaluation Costs (Defense Med. Eval. Paid) (Record/Sub Record 7I)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The cost of medical evaluations procured by the insurance carrier excluding evaluations performed by the treating physician or by a qualified medical evaluator. Refer to definition of Allocated Loss Adjustment Expense for additional instructions.~~

~~d. Requirement: Optional.~~

~~57. Independent Medical Evaluation Paid (Indep. Med. Eval. Paid) (Record/Sub Record 7I)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: Total dollar amount paid for medical evaluations procured by agreement of the parties or by appointment by the governing agency, including the cost of an evaluation. See definitions of Allocated Loss Adjustment Expense and Incurred Losses for special MA instructions.~~

~~d. Requirement: Optional.~~

~~58. Legal Expense Defense (Legal Exp. Defense) (Record/Sub Record 7G)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The incurred amount (paid plus case outstanding), of the legal costs of the carrier on behalf of the employer or insurance carrier during the claim resolution process. See definition of Allocated Loss Adjustment Expense for additional information.~~

~~d. Requirement: Optional.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~59. Annuity Purchased Amount (Annuity Purchased Amt.) (Record/Sub Record 7J)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The cost to the carrier for the purchase of an investment or guarantee of annual income for the claimant.~~

~~d. Requirement: Leave blank or zero fill not applicable to Massachusetts.~~

~~60. Total Gross Incurred (Record/Sub Record 7G)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The total gross incurred including paid plus case outstanding expenses. This amount is not reduced by subrogation received.~~

~~d. Requirement: Leave blank or zero fill not applicable to Massachusetts.~~

~~61. Temporary Disability Paid (Temp. Disability Paid) (Record/Sub Record 7H)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The amount paid in temporary benefits for total incapacity.~~

~~d. Requirement: ***Optional.***~~

~~e. Benefits paid under M.G.L., Chapter 152, Section 34.~~

MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN

~~62. Permanent Partial Paid (Perm. Partial Paid) (Record/Sub Record 7H)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The amount paid in permanent partial (partial incapacity) disability benefits.~~

~~d. Requirement: ***Optional.***~~

~~e. Benefits under M.G.L., Chapter 152, Section 35.~~

~~63. Permanent Total Paid (Perm. Total Paid) (Record/Sub Record 7H)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The amount paid in benefits due to the permanent and total incapacity of the claimant.~~

~~d. Requirement: ***Optional.***~~

~~e. Benefits paid under M.G.L., Chapter 152, Section 34A.~~

~~64. Death Paid (Record/Sub Record 7H)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The dollar amount paid in benefits due to the death of a worker.~~

~~d. Requirement: ***Optional.***~~

~~e. Benefits paid under M.G.L. Chapter 152, Section 31.~~

MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN

~~65. Single Sum Paid (Record/Sub Record 7I)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The total dollar amount in indemnity benefits that have been paid as a single lump sum amount.~~

~~d. Requirement: Report the whole dollar amount as of the valuation paid as the lump sum settlement.~~

~~66. Vocational Rehabilitation Paid (V. R. Paid) (Record/Sub Record 7H)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The total dollar amount paid as benefits to restore an injured employee to suitable employment (including training, evaluation, and vocational rehabilitation indemnity).~~

~~d. Requirement: ***Optional.***~~

~~67. Vocational Rehabilitation Indemnity Incurred (V. R. Indemn. Incurred) (Record/Sub Record 7G)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The amount (paid plus case outstanding) incurred by the carrier for the return of an injured employee to suitable employment. The vocational rehabilitation indemnity incurred excludes training and evaluation expenses.~~

~~d. Requirement: ***Optional***.~~

~~68. Vocational Rehabilitation Training Incurred (V.R. Training Incurred) (Record/Sub Record 7G)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The amount incurred (paid plus case outstanding) by the carrier for training an injured worker to return to suitable employment.~~

~~d. Requirement: Optional.~~

~~69. Vocational Rehabilitation Evaluation Incurred (V. R. Eval. Incurred) (Record/Sub Record 7G)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The amount incurred (paid plus case outstanding) by the carrier for determining the eligibility, attitude and effectiveness of vocational rehabilitation of the injured worker.~~

~~d. Requirement: Optional.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

70. Beneficiary Code(s) (Record/Sub Record 7E)

a. Characteristic: Beneficiary Code – Numeric
Dependency – Alphanumeric

b. Length: 2

c. Definition: Codes identify the relationship of the beneficiary to the injured worker and the degree of dependency.

d. Requirement: On magnetic tape report the beneficiary code-dependency and beneficiary code relationship as separate data elements.

On hard copy, combine into the beneficiary code space.

Beneficiary Code is required on the original ICR and to report corrections to the Beneficiary Code.

Relationship Beneficiary Code Dependency Beneficiary Code

Code	Definition
1	Injured Worker
2	Widow/Wife
3	Widower/Husband
4	Children (sons or daughters)
5	Siblings (brothers or sisters)
6	Parents (mother or father)
7	Other

Code	Definition
T	The beneficiary is totally dependent
P	The beneficiary is partially dependent

Example: A partially dependent son and completely dependent wife of a deceased worker require beneficiary codes 2T & 4P on a hard copy report.

~~71. Beneficiary Date of Birth (Record/Sub Record 7E)~~

~~a. Characteristic: Numeric MM-DD-YY – hardcopy~~
~~YY-MM-DD – electronic~~

~~b. Length: 6~~

~~c. Definition: The date of birth for each person eligible for benefits.~~

~~d. Requirement: Report the month, day and year on which each beneficiary was born.~~

~~Beneficiary Date of Birth is required on the original ICR and to report corrections to the Beneficiary Date of Birth.~~

~~***72. Data Provider Comment (Benefit Calculations) (Record/Sub Record 7J)***~~

~~***a. Characteristic: Alphanumeric***~~

~~***b. Length: 60***~~

~~***c. Definition: The pertinent information that details the incurred indemnity reported on lines 1 through 9. This information allows the Bureau to calculate the incurred amount for each benefit.***~~

~~***d. Requirement: Report any information relevant to the reserve or pension calculation. This text field may be used for commentary on the claim that may eliminate the need for verification requests from the Bureau. For example, as an option to the data providers, they may express the pension value, weekly benefit, duration of dependent child's benefits, or any applicable cost of living increases.***~~

~~***Information reported in this text field will be held in the Bureau's database. However, the field will not be edited to ensure that items are reported. The Bureau will continue to solicit the information as the ICRs are reported.***~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~73. Pension Indemnity Paid to Valuation Date (Pension Indemn. Paid to Val. Date) (Record/Sub Record 7C)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The total amount of pension benefits paid as of the valuation date excluding any remarriage payment.~~

~~d. Requirement: Report the whole dollar amount of pension benefits as of the valuation date.~~

~~e. Benefits under M.G.L., Chapter 152, Sections 31 or 34A.~~

~~74. Pension Indemnity Previously Reserved-Not Paid (Pens. Indemn Prev. Reserved Not Paid) (Record/Sub Record 7D)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The amount of indemnity reserved at a previous valuation, but not yet paid which is not included in present value of future indemnity payment, or pension indemnity.~~

~~d. Requirement: Report the whole dollar amount reserved for a pension claim that has been delayed but normally would have been paid by the valuation date that cannot be included in pension indemnity paid to valuation date but is included in value of future indemnity. Note: The amount is expressed separately on line 8 and included in 9.~~

~~e. Benefits under M.G.L., Chapter 152, Sections 31 or 34A.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~75. Present Value Future Indemnity Payment (Pres. Value Future Indemn. Pmnt.) (Record/Sub Record 7C)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The present value of total indemnity payments, which are expected to be paid at a future time. This includes losses previously reserved but not yet paid.~~

~~d. Requirement: Report the whole dollar present value of total future indemnity payments.~~

~~e. Benefits under M.G.L., Chapter 152, Sections 31 or 34A.~~

~~76. Funeral Allowance (Record/Sub Record 7C)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The cost incurred (paid plus case outstanding) for the funeral and burial of a deceased worker.~~

~~d. Requirement: Report the whole dollar amount of funeral allowance.~~

~~e. Benefits under M.G.L., Chapter 152, Section 33.~~

~~77. Lump Sum Re-marriage (Record/Sub Record 7C)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The total amount paid to either the widow or widower upon re-marriage to resolve the claim.~~

~~d. Requirement: Leave blank or zero fill, not applicable to Massachusetts.~~

MASSACHUSETTS WORKERS' COMPENSATION
STATISTICAL PLAN

~~78. Total Incurred Indemnity (Total Incurred Indem.) (Record/Sub Record 7D)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The total incurred indemnity amount for the claim. This amount is net of subrogation or offsets. The amounts should include any temporary, scheduled, non-scheduled, vocation rehabilitation, claimant's attorney fees and pension indemnity. Refer to definition of Incurred Indemnity.~~

~~d. Requirement: Report the whole dollar indemnity incurred (paid plus case outstanding). This amount must be net of subrogation and net of any social security or other benefit offsets. This amount must be identical to the incurred indemnity loss shown on the accompanying unit report for this claim.~~

~~79. Total Incurred Medical (Record/Sub Record 7D)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The total medical amount incurred by the insurance carrier. This amount is net of subrogation or offsets.~~

~~d. Requirement: Report the whole dollar medical incurred (paid plus case outstanding). This amount must be net of subrogation or other offsets. This amount must be identical to the medical incurred loss shown on the accompanying unit report for this claim.~~

~~80. Total Indemnity Paid to Valuation Date (Total Indemn. Paid to Val. Date) (Record/Sub Record 7D)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The total indemnity amount paid. Refer to Incurred Indemnity for definition.~~

~~d. Requirement: Optional.~~

~~81. Total Medical Paid to Valuation Date (Total Med. Paid to Val. Date) (Record/Sub Record 7D)~~

~~a. Characteristic: Numeric~~

~~b. Length: 10~~

~~c. Definition: The total medical amount paid. Refer to Incurred Medical losses for definition.~~

~~d. Requirement: Optional.~~

~~82. Social Security or Other Offset (Soc. Sec. or Other Offset Amt.) (Record/Sub Record 7D)~~

~~a. Characteristic: Numeric~~

~~b. Length: 9~~

~~c. Definition: The amount of social security or any other offset used in determination of the total incurred indemnity amount.~~

~~d. Requirement: Report the whole dollar amount of social security or other offset used in the calculation of the total incurred indemnity.~~

~~***83. Social Security Indicator (Record/Sub Record 7A)***~~

~~***a. Characteristic: Social Security Indicator (Record/Sub Record 7A)***~~

~~***a. Characteristic: Alphanumeric***~~

~~***b. Length: 1***~~

~~***c. Definition: Code identifying claims where the cost of living factor used in establishing the claim reserve has been limited due to eligibility of the claimant for Social Security Benefits.***~~

~~***d. Requirement:***~~

~~*Indicator*~~	~~*Description*~~
~~*Y*~~	~~*Claim reserve or payments have been modified by Social Security Offset.*~~
~~*N*~~	~~*Claim reserve or payments have NOT been modified by Social Security Offset.*~~

~~***84. Worker's Sex (Record/Sub Record 7A)***~~

~~***a. Characteristic: Alphanumeric***~~

~~***b. Length: 1***~~

~~***c. Definition: Code identifying the gender of the injured worker. Information is required to select pension value.***~~

~~***d. Requirement:***~~

~~*Indicator*~~	~~*Description*~~
~~*M*~~	~~*Male*~~
~~*F*~~	~~*Female*~~

MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN

Section IX **Effective: *January 1, 2009***
PENSION TABLES **Distributed: *TBD***
Page 18 **Part I – Unit Statistical Reporting**

Example - Fatal Claim - Spouse & One Child
Usage of: Surviving Spouse's Pension Table (Table IE-398)

Calculation of incurred loss to be reported when benefits are payable to a surviving spouse until death or remarriage, due to a fatal injury occurring after December 23, 1991.

Accident Date	2/5/1999	Policy Effective Date:	1/1/1999
Date of Death:	2/5/1999	Spouse's Birthdate:	2/18/1959
Weekly Wages:	$300	Child's Birthdate:	10/15/1985

Calculation		**1st Report**	**2nd Report**	**3rd Report**
1.	Valuation Date	7/2000	7/2001	7/2002
2.	Spouse's attained age at death date	39	39	39
3.	Duration since death date (to nearest year), t.	1	2	3
4.	Weekly Benefit Payable = (66 2/3%) x Wkly Wages	$200.00	$200.00	$217.05
5.	Annual Benefit Payable =(4) x 52	$10,400	$10,400	$11,287
Benefits for Spouse beyond the Valuation Date				
6.	Factor from Table IE-398	30.894	31.594	29.695
7.	Present Value of Future Payment=(5) x (6)	$321,298	$328,578	$335,163
	……. ~~as of line (9) in ICR~~			
Others				
8.	Payment since 2/5/99	$15,200	$25,600	$36,699
	……. ~~as of line (7) in ICR~~			
9.	Funeral Allowance, Maximum of $4,000	$4,000	$4,000	$4,000
	……. ~~as of line (10) in ICR~~			
10.	Total Incurred Indemnity Loss = (7) + (8) + (9)	$340,498	$358,178	$375,862
	……. ~~as of line (12) in ICR~~			

An extra $6 is paid to each additional child on top of the regular benefit for spouse with children if the original weekly benefit is less than $110. The adjusted amount may not exceed $150 in total.

Weekly Benefit Payments are subjected to "Cost of Living Adjustments" (COLA):

1 Increase each October 1, the first escalated benefit starts at the next October 1st following 24 months after the accident date.

2 The supplemental benefit increase shall not exceed the minimum of:
- a. The increase in the State Average Weekly Wage (SAWW)
- b. The increase in the Northeastern region CPI for all urban consumers
- c. 5%.

3 The adjusted benefit is not greater than "three times the base benefit."

		Benefit Reevaluation Date			
	2/5/1999	10/1/1999	10/1/2000	10/1/2001	10/1/2002
SAWW	$699.91	$749.69	$830.89	$890.94	$882.57
a. Increase in SAWW		1.071	1.108	1.072	0.991
b. Increase in Northeastern CPI		1.021	1.034	1.028	1.021
c. 5%		1.05	1.05	1.05	1.05
Weekly Benefit =	$200.00	$200.00	$200.00	$217.05	$217.05
	Base Benefit			*1st escalated benefit*	

~~ICR = Individual Case Report~~

MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN

Effective: *January 1, 2009* **Section IX**
Distributed: *TBD* **PENSION TABLES**
Part I – Unit Statistical Reporting **Page 19**

Example - Fatal Claim - Other than Spouse
Usage of: Other than Surviving Spouse's Pension Table (Table IIE-398)

Calculation of incurred loss to be reported when benefits are payable to an other then surviving spouse due to a fatal injury occurring after December 23, 1991.

Accident Date	2/5/1999	Policy Effective Date:	1/1/1999
Date of Death:	2/5/1999	Dependent's Birthdate	2/18/1959
Weekly Wages:	$300		

Calculation		**1st Report**	**2nd Report**	**3rd Report**
1.	Valuation Date	7/2000	7/2001	7/2002
2.	Spouse's attained age at death date	39	39	39
3.	Duration since death date (to nearest year), t.	1	2	3
4.	Weekly Benefit Payable = (66 2/3%) x Wkly Wages	$80.00	$80.00	$86.82
5.	Annual Benefit Payable =(4) x 52	$4,160	$4,160	$4,515
Benefits for Spouse beyond the Valuation Date				
6.	Factor from Table IIE-398	35.086	35.370	32.674
7.	Present Value of Future Payment=(5) x (6)	$145,958	$147,139	$147,515
	…….. ~~as of line (9) in ICR~~			
Others				
8.	Payment since 2/5/99	$6,080	$10,240	$14,680
	…….. ~~as of line (7) in ICR~~			
9.	Funeral Allowance, Maximum of $4000	$1,500	$1,500	$1,500
	…….. ~~as of line (10) in ICR~~			
10.	Total Incurred Indemnity Loss = (7) + (8) + (9)	$153,538	$158,879	$163,694
	…….. ~~as of line (12) in ICR~~			

The maximum base benefit is limited by $80 per week, however, if there is more than one such dependent, the total amount should not exceed the weekly amount payable to the surviving spouse.

Weekly Benefit Payments are subjected to "Cost of Living Adjustments" (COLA):

1 Increase each October 1, the first escalated benefit starts at the next October 1st following 24 months after the accident date.

2 The supplemental benefit increase shall not exceed the minimum of:
- a. The increase in the State Average Weekly Wage (SAWW)
- b. The increase in the Northeastern region CPI for all urban consumers
- c. 5%.

3 The adjusted benefit is not greater than "three times the base benefit."

		Benefit Reevaluation Date			
	1/15/1999	10/1/1999	10/1/2000	10/1/2001	10/1/2002
SAWW	$699.91	$749.69	$830.89	$890.94	$882.57
a. Increase in SAWW		1.071	1.108	1.072	0.991
b. Increase in Northeastern CPI		1.021	1.034	1.028	1.021
c. 5%		1.05	1.05	1.05	1.05
Weekly Benefit =	$80.00	$80.00	$80.00	$86.82	$86.82
	Base Benefit			*1st escalated benefit*	

~~ICR = Individual Case Report~~

MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN

Example - Permanent Total Claim - Female Worker
Usage of: Permanent Total Claimant's Pension Table (Table IIIEF-398)

Calculation of incurred loss to be reported when benefits are payable to an injured female worker for life, due to a permanent total injury occurring after December 23, 1991.

Accident Date:	2/5/1999	Policy Effective Date:	1/1/1999
Weekly Wages:	$300	Injured worker's Birthdate:	2/18/1959
		Spouse's Birthdate:	10/15/1952

Calculation		**1st Report**	**2nd Report**	**3rd Report**
1.	Valuation Date	7/2000	7/2001	7/2002
2.	Injured worker's attained age at accident date	39	39	39
3.	Spouse's attained age at accident date	46	46	46
4.	Duration since death date (to nearest year), t.	1	2	3
5.	Weekly Benefit Payable = (66 2/3%) x Wkly Wages	$200.00	$200.00	$217.05
6.	Annual Benefit Payable =(5) x 52	$10,400	$10,400	$11,287
Benefits for Injured Worker beyond the Valuation Date				
7.	Factor from Table IIIEF-398	33.001	33.269	30.733
8.	Factor from Table IE-398	29.301	29.676	27.587
9.	Maximum of {(7),[2 x (7) + (8)]/3}, if (8) is n/a then (9) = (7)	33.001	33.269	30.733
10.	Present Value of Future Payment=(6) x (9) …….. ~~as of line (9) in ICR~~	$343,210	$345,998	$346,879
Others				
11.	Payment since 2/5/99 …….. ~~as of line (7) in ICR~~	$15,200	$25,600	$36,699
12.	Total Incurred Indemnity Loss = (10) + (11) …….. ~~as of line (12) in ICR~~	$358,410	$371,598	$383,578

Weekly Benefit Payments are subjected to "Cost of Living Adjustments" (COLA):

1 Increase each October 1, the first escalated benefit starts at the next October 1st following 24 months after the accident date.

2 The supplemental benefit increase shall not exceed the minimum of:
- a. The increase in the State Average Weekly Wage (SAWW)
- b. The increase in the Northeastern region CPI for all urban consumers
- c. 5%.

3 The adjusted benefit is not greater than "three times the base benefit."

		Benefit Reevaluation Date			
	1/15/1999	10/1/1999	10/1/2000	10/1/2001	10/1/2002
SAWW	$699.91	$749.69	$830.89	$890.94	$882.57
a. Increase in SAWW		1.071	1.108	1.072	0.991
b. Increase in Northeastern CPI		1.021	1.034	1.028	1.021
c. 5%		1.05	1.05	1.05	1.05
Weekly Benefit =	$200.00	$200.00	$200.00	$217.05	$217.05
	Base Benefit			*1st escalated benefit*	

~~ICR = Individual Case Report~~

United States Longshore and Harbor Workers' Act Pension Tables

These tables are used to estimate the present value of pension related indemnity benefits for death and permanent total injuries payable in accordance with the United States Longshore and Harbor Workers' Act ("USL&HW Act"). The values contained in the pension tables are to be used to calculate estimated case reserves for indemnity benefits for death and permanent total injuries for purposes of reporting unit statistical reports (USRs) ~~and individual claims reports (ICRs)~~ to the WCRIB. ~~For death and permanent total claims where these tables have not been used, a reserve type code must be reported on the individual case report that accompanies the unit statistical report of death and permanent total claims. The reserve type code identifies situations that may impact the case reserve, such as but not limited to Hunter claim offset, subrogation, expected early termination of benefits. For more information and a list of all reserve type codes, refer to Section VII, page 13.~~

These pension tables are based on USL&HW Act, life expectancies from 1999 United States Life Tables, and the remarriage probabilities from the 1980 United States of America Railroad Retirement Board Remarriage Table. All of the tables assume a 3.5% discount rate and a 4% rate of benefit escalation.

Table Descriptions

UI - USLH: Surviving Spouse
Apply this table for all death claims incurred under the USL&HW Act to estimate the present value of the surviving spouse's benefits, exclusive of any remarriage dowry. This table is derived using female life expectancies and reflects the probability that the surviving spouse remarries.

UII - USLH: Present Value of the Remarriage Dowry
Apply this table to all death claims incurred under the USL&HW Act to estimate the present value of the surviving spouse's remarriage dowry. This table is derived using female life expectancies.

UIIIM – USLH: Male Other than Surviving Spouse
Apply this table to all permanent total claims incurred under the USL&HW Act to estimate the present value of wage losses benefits payable for the balance of a male claimant's life. This table is derived using male life expectancies.

UIIIF – USLH: Female Other than Surviving Spouse
Apply this table to all permanent total claims incurred under the USL&HW Act to estimate the present value of wage losses benefits payable for the balance of a female claimant's life. This table is derived using female life expectancies.

UIV – USLH: Present Value of Survivorship Benefits