WCIO WORKERS COMPENSATION DATA SPECIFICATION

WORKERS COMPENSATION INDEMNITY REPORTING SPECIFICATION (WCIND)

October 8, 2024

Field No.	Field Title/Description	Class	Position	Bytes

FILE CONTROL RECORD

1 **RECORD TYPE CODE** N 1-2 2

Definition: A code used to identify the type of record being reported.

Reporting Requirement: Report "03" for the File Control Record.

2 **SUBMISSION FILE TYPE CODE** A 3-3 1

Definition: A code that identifies the type of file being submitted.

Reporting Requirement: Report the code that identifies the type of file being submitted.

Note: All Key Field Change files must be reported as "O" (Original). Replacement files are not allowed for Key Field Change files.

Code	Description
O	Original
R	Replacement

3 **CARRIER GROUP CODE** N 4-8 5

Definition: A code used and assigned by NCCI or other DCO to identify a carrier group

Reporting Requirement: Report the code assigned by NCCI or other DCO to identify a carrier group.

4 **REPORTING QUARTER CODE** N 9-9 1

Definition: A code that corresponds to the quarter when the claim activity being reported occurred.

Reporting Requirement: Report the code that corresponds to the quarter using the code values below.

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

5 **REPORTING YEAR** N 10-13 4

Definition: A code that identifies the year in which the payments or claim changes occurred.

Reporting Requirement: Report the year in which the payments or claim changes occurred.

Population Rule: Format CCYY

Field No.	Field Title/Description	Class	Position	Bytes
6	**SUBMISSION FILE IDENTIFIER**	AN	14-43	30
Definition:	A unique identifier created by the data provider that is used to distinguish the file being submitted from previously submitted files.			
Reporting Requirement:	Report the unique identifier created by the data provider to distinguish the file being submitted from previously submitted files.			
7	**SUBMISSION DATE**	N	44-51	8
Definition:	The date that the file was generated and/or submitted.			
Reporting Requirement:	Report the date that the file was generated and/or submitted.			
Population Rule:	Format CCYYMMDD			
8	**SUBMISSION TIME**	N	52-57	6
Definition:	The time that the file was generated noted in military time.			
Reporting Requirement:	Report the time that the file was generated in military time.			
Population Rule:	Format HHMMSS (24-Hour Clock)			
9	**RECORD TOTAL**	N	58-68	11
Definition:	The total number of records (Transactional or Quarterly) in the file.			
Reporting Requirement:	Report the total number of records on the submission.			
Notes:	This total should exclude this File Control Record.			
10	**RESERVED FOR FUTURE USE**	AN	69-300	232

Field No.	Field Title/Description	Class	Position	Bytes

TRANSACTIONAL RECORD

1 **RECORD TYPE CODE** N 1-2 2

Definition: A code used to identify the type of record being reported.

Reporting Requirement: Report "01" for the Transactional Record.

2 **TRANSACTION CODE** N 3-4 2

Definition: A code used to define the type of transaction being submitted.

Reporting Requirement: Report the code identifying the type of transaction being submitted.

Notes: This code is reported as 01 if the Transaction Identifier (Position 13-32) is blank.

Population Rule: Right-justified and left zero-filled.

Code	Description
01	Original
02	Cancellation/Void
03	Replacement

3 **TRANSACTION DATE** N 5-12 8

Definition: Transactional Record: The date that the payment (check) was made or the recovery received.

Quarterly Record: The date that the transaction was established by the source system of the claim administrator or the date that the Quarterly record was created.

Reporting Requirement: Report the date that the payment (check) was made or the recovery received.

Notes: In the case of a cancelation or replacement, the Transaction Date would reflect the date the changes were made to the source system.

Population Rule: Format CCYYMMDD

4 **TRANSACTION IDENTIFIER** AN 13-32 20

Definition: A unique identifier created by the data provider for each transaction within a claim.

Field No.	Field Title/Description	Class	Position	Bytes
Reporting Requirement:	Report a unique identifier for each transaction for a claim. Refer to specific DCO for reporting requirements.			
Notes:	The identifier should be unique, no two transactions for a claim will ever have the same identifier. For each claimant, every transaction identifier is different; but the identifiers are reusable, for example, for every claim the identifier for a first transaction may be the same.			
5	**CARRIER CODE**	N	33-37	5
Definition:	A code used and assigned by NCCI or other DCO to identify a reporting company.			
Reporting Requirement:	Report the code assigned to the reporting company by NCCI or other DCO.			
Notes:	The reported code must match the Unit Statistical Carrier Code reported for this claim.			
6	**POLICY NUMBER IDENTIFIER**	AN	38-55	18
Definition:	An identifier used to uniquely identify the policy number.			
Reporting Requirement:	Report the unique identifier used for identifying the policy.			
Notes:	The Policy Number Identifier must match the Unit Statistical data Policy Number Identifier reported for this claim, including any prefixes or suffixes.			
Population Rule:	Do not report embedded blanks or marks of punctuation. The policy number identifier cannot be all zeros, all blanks nor a combination of zeros and blanks.			
7	**POLICY EFFECTIVE DATE**	N	56-63	8
Definition:	The date of inception of the policy; for policies greater than one year and 16 days, this is the start date of the period.			
Reporting Requirement:	Report the date that the policy became effective.			
Notes:	The Policy Effective Date must match the Unit Statistical data Policy Effective Date reported for this claim.			
Population Rule:	Format CCYYMMDD			
8	**CLAIM NUMBER IDENTIFIER**	AN	64-75	12
Definition:	The alphanumeric characters that uniquely identify the claim (excluding blanks).			

Field No.	Field Title/Description	Class	Position	Bytes
	Reporting Requirement: Report the number that uniquely identifies the claim.			
	Notes: The Claim Number Identifier must match the Unit Statistical data claim number reported for this claim. This number must be used consistently for all future reporting of the claim transactions.			
	Population Rule: The claim number identifier cannot be all zeros, all blanks nor a combination of zeros and blanks. Do not report any embedded blanks, marks of punctuation or special characters.			
9	**ACCIDENT DATE** Definition: The date of the injury.	N	76-83	8
	Reporting Requirement: Report the date on which the injury occurred.			
	Notes: The Accident Date must match the Unit Statistical data Accident Date reported for this claim. This date must be within the policy period.			
	Population Rule: Format CCYYMMDD			
10	**JURISDICTION STATE CODE** Definition: A code used to identify the governing body/territory, who will administer the claim, and whose statutes will apply to the claim adjustment process.	N	84-85	2
	Reporting Requirement: Report the code that corresponds to the state workers compensation law, employers liability law, or the federal law under which the claimant's benefits are being paid. For the Transactional record, report the Jurisdiction State Code that underlies the transaction amount (i.e., benefit payable). The code could be a state jurisdiction in some instances and federal jurisdiction in others. For the Quarterly record, if the incurred losses include both state and federal benefits payable, report the Federal Jurisdiction State Code. Refer to individual DCO for reporting requirements.			
11	**TRANSACTION FROM DATE** Definition: The first date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code.	N	86-93	8
	Reporting Requirement: Report the first date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code.			

Field No.	Field Title/Description	Class	Position	Bytes
Notes:	This represents the first date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code (Positions 114-115). The Transaction From Date represents the first day of the specific period of the transaction.			
Population Rule:	Format CCYYMMDD If payment represents a single day, Transaction To Date and Transaction From Date will be the same. Zero-fill if unknown.			
12	**TRANSACTION TO DATE**	N	94-101	8
Definition:	The last date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code.			
Reporting Requirement:	Report the last date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code.			
Notes:	This represents the last date of the uninterrupted period corresponding to the paid indemnity amount for a particular Benefit Type Code (Positions 114-115). The Transaction To Date represents the last day of the specific period of the transaction.			
Population Rule:	Format CCYYMMDD If payment represents a single day, Transaction To Date and Transaction From Date will be the same. Zero-fill if unknown.			
13	**TRANSACTION AMOUNT**	N	102-113	12
Definition:	The amount of the financial transaction being submitted; may be negative (e.g., to correct overpayments).			
Reporting Requirement:	Report the amount of the financial transaction being submitted. The amount reported includes dollars and cents and may represent a positive or negative transaction amount.			
Population Rule:	Format $10.2			

Field No.	Field Title/Description	Class	Position	Bytes
	If a negative transaction amount is reported, the negative (–) sign must be reported in position 102 prior to the transaction amount. This field must be right-justified and left zero-filled. There is an assumed decimal between positions 111 and 112. If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount.			
14	**BENEFIT TYPE CODE**	N	114-115	2
Definition:	A code that corresponds to the type of benefits paid to the claimant, including recovery reimbursement amounts paid.			
Reporting Requirement:	A code used to identify the type of benefits.			

Code	Description
01	Death Benefits
02	Permanent Total Disability Benefits
03	Scheduled Permanent Partial Disability Benefits
04	Unscheduled Permanent Partial Disability Benefits
05	Temporary Total Disability Benefits
09	Disfigurement Benefits
11	Temporary Partial Disability Benefits
12	Employers Liability
15	Supplemental Benefits N/A: DE, PA, WI
20	Claimant Legal Amount Paid
30	Indemnity Recovery Reimbursement Amount—Third Party Actions
31	Indemnity Recovery Reimbursement Amount—State Administered Funds
32	Section 32 Waiver Agreements – Indemnity Only N/A: CA, DE, MA, MI, MN, NC, NCCI, NJ, PA, WI
33	Section 32 Waiver Agreements – Indemnity and Medical Combined N/A: CA, DE, MA, MI, MN, NC, NCCI, NJ, PA, WI
48	Penalties, Assessments, Interest
49	Indemnity and Medical Combined
50	Other Specified Indemnity Benefits
60	Vocational Rehabilitation—Evaluation Benefit Costs
61	Vocational Rehabilitation—Education Benefit Costs
62	Vocational Rehabilitation—Maintenance Benefit Costs
63	Vocational Rehabilitation—Payment NOC

Field No.	Field Title/Description	Class	Position	Bytes

75	New York Aggregate Trust Fund Deposit Amount N/A: CA, DE, MA, MI, MN, NC, NCCI, NJ, PA, WI
79	Lump Sum Including Multiple Indemnity
99	Other Indemnity Benefits Not Otherwise Specified

15 LUMP SUM INDICATOR — A — 116-116 — 1

Definition: Indicates if the amount is a lump sum.

Reporting Requirement: Report the applicable indicator code.

Notes: This indicator identifies whether the claim is settled by a lump sum amount.

Code	Description
Y	Claim has been settled by an agreement to a lump sum amount
N	Claim has not been settled by an agreement to a lump sum amount

16 BENEFIT OFFSET CODE — N — 117-117 — 1

Definition: A code that indicates that the claim has an offset for payments/contributions from another source. That is, a code that indicates whether the statutory payment amount has been explicitly reduced to reflect payments/contributions from other sources such as social security disability insurance (SSDI),employer-paid disability plans, retirement plans, and unemployment insurance.

Reporting Requirement: Report the applicable Benefit Offset Code.

Code	Description
1	None
2	Social Security Disability Insurance (SSDI)
3	Other

17 BENEFIT OFFSET AMOUNT — N — 118-128 — 11

Definition: The amount of the benefit offset applied because of payments from another source (i.e., the statutory payment amount had there not been any offsets for payments/contributions from other source, such as social security disability insurance, employer-paid disability plans, retirement plans, and unemployment insurance, less the Transactional Amount).

Field No.	Field Title/Description	Class	Position	Bytes
Reporting Requirement:	Report the amount of the benefit offset applied because of payments from another source.			
Notes:	The amount reported includes dollars and cents. Offsetting amounts do not include penalties and liens or subrogation recoveries.			
Population Rule:	Format $9.2 There is an assumed decimal between positions 126 and 127. If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount.			
18	**WEEKLY BENEFIT AMOUNT**	N	129-137	9
Definition:	The weekly benefit amount, per the applicable state's approved minimums and maximums, underlying the periodic payment to the claimant for the corresponding Benefit Type Code.			
Reporting Requirement:	Report the most recent Weekly Benefit Amount, per applicable state's approved minimums/maximums, paid to the claimant for the corresponding Benefit Type Code.			
Population Rule:	Format $7.2 There is an assumed decimal between positions 135 and 136. Right justified and zero-filled If the reported amount does not include digits after the decimal, add 00 to the right of the reported amount.			
19	Case Number Assigned by State	AN	138-162	25
Definition:	N/A: CA, DE, MA, MI, MN, NC, NCCI, NJ, PA, WI A number used by a Workers Compensation Board to uniquely identify the claim			
Reporting Requirement:	Report the unique Case Number assigned by the Workers' Compensation Board.			
20	**RESERVED FOR FUTURE USE**	AN	163-300	137

Field No.	Field Title/Description	Class	Position	Bytes
QUARTERLY RECORD				
1	**RECORD TYPE CODE**	N	1-2	2
Definition:	A code used to identify the type of record being reported.			
Reporting Requirement:	Report “02” for the Quarterly Record.			
2	**TRANSACTION DATE**	N	3-10	8
Definition:	Transactional Record: The date that the payment (check) was made or the recovery received. Quarterly Record: The date that the Quarterly record was created.			
Reporting Requirement:	Report the date the Quarterly Record was created. The Transaction Date cannot be prior to the valuation date for the quarter.			
Population Rule:	Format CCYYMMDD			
3	**CARRIER CODE**	N	11-15	5
Definition:	A code used and assigned by NCCI or other DCO to identify a reporting company.			
Reporting Requirement:	Report the code assigned to the reporting company by NCCI or other DCO.			
Notes:	The reported code must match the Unit Statistical Carrier Code reported for this claim.			
4	**POLICY NUMBER IDENTIFIER**	AN	16-33	18
Definition:	An identifier used to uniquely identify the policy number.			
Reporting Requirement:	Report the unique identifier used for identifying the policy.			
Notes:	The Policy Number Identifier must match the Unit Statistical data Policy Number Identifier reported for this claim, including any prefixes or suffixes.			
Population Rule:	Do not report embedded blanks or marks of punctuation.			

Field No.	Field Title/Description	Class	Position	Bytes
	The policy number identifier cannot be all zeros, all blanks nor a combination of zeros and blanks.			
5	**POLICY EFFECTIVE DATE**	N	34-41	8
Definition:	The date of inception of the policy; for policies greater than one year and 16 days, this is the start date of the period.			
Reporting Requirement:	Report the date that the policy became effective.			
Notes:	The Policy Effective Date must match the Unit Statistical data Policy Effective Date reported for this claim.			
Population Rule:	Format CCYYMMDD			
6	**CLAIM NUMBER IDENTIFIER**	AN	42-53	12
Definition:	The alphanumeric characters that uniquely identify the claim (excluding blanks).			
Reporting Requirement:	Report the number that uniquely identifies the claim.			
Notes:	The Claim Number Identifier must match the Unit Statistical data claim number reported for this claim. This number must be used consistently for all future reporting of the claim transactions.			
Population Rule:	The claim number identifier cannot be all zeros, all blanks nor a combination of zeros and blanks. Do not report any embedded blanks, marks of punctuation or special characters.			
7	**ACCIDENT DATE**	N	54-61	8
Definition:	The date of the injury.			
Reporting Requirement:	Report the date on which the injury occurred.			
Notes:	The Accident Date must match the Unit Statistical data Accident Date reported for this claim. This date must be within the policy period.			
Population Rule:	Format CCYYMMDD			

Field No.	Field Title/Description	Class	Position	Bytes
8	**JURISDICTION STATE CODE**	N	62-63	2
Definition:	A code used to identify the governing body/territory, who will administer the claim, and whose statutes will apply to the claim adjustment process.			
Reporting Requirement:	Report the code that corresponds to the state workers compensation law, employers liability law, or the federal law under which the claimant's benefits are being paid. For the Transactional record, report the Jurisdiction State Code that underlies the transaction amount (i.e., benefit payable). The code could be a state jurisdiction in some instances and federal jurisdiction in others. For the Quarterly record, if the incurred losses include both state and federal benefits payable, report the Federal Jurisdiction State Code.			
9	**CLAIMANT GENDER CODE**	N	64-64	1
Definition:	A code used to identify the claimant's gender.			
Reporting Requirement:	Report the code that corresponds to the claimant's gender.			
Notes:	If the claimant's gender is unknown, do NOT report 3 (Other).			
Population Rule:	Zero-fill if unknown.			

Code	Description
1	Male
2	Female
3	Other

10	**BIRTH YEAR**	N	65-68	4
Definition:	The actual or estimated (accident year minus claimant age) year the claimant was born.			
Reporting Requirement:	Report the year the claimant was born.			
Notes:	If the claimant's birth year is unknown but the claimant's age is known, then report the estimated birth year (accident year minus claimant age). The Birth Year must be before the Accident Date year. Zero-fill if neither the birth year nor age is known.			

Field No.	Field Title/Description	Class	Position	Bytes
	Population Rule: Format CCYY			
11	**HIRE DATE** Definition: The date of hire or the date the injured worker began his/her most recent employment with the employer. Reporting Requirement: Report the date on which the injured worker began his/her most recent employment with the employer. Notes: The Hire Date must be on or before the accident date. Population Rule: Format CCYYMMDD If the Hire Date is unknown but the hire year is available, report the hire year followed by four zeros.	N	69-76	8
12	**EMPLOYMENT STATUS CODE** Definition: A code used to identify the injured worker's employment status as of the date the claim was first reported to the insurer. Reporting Requirement: Report the code that indicates the employee's primary work status at the time of the injury with the covered employer as used in the statutory calculation of pre-injury wages. When multiple codes apply, report the lowest in the hierarchy. Refer to individual DCO for reporting requirements. Population Rule: Leave blank if unknown. **Code** **Description** 9 Volunteer 8 Seasonal 1 Regular Full-Time 2 Part-Time X Other	AN	77-77	1
13	**CLOSING DATE** Definition: The date that the claim was closed (i.e., further indemnity or medical payments are not expected), the judgment date, or the date	N	78-85	8

Field No.	Field Title/Description	Class	Position	Bytes
	an agreement was made regarding the final amount paid.			
Reporting Requirement:	Report the date that the claim was closed (i.e., further indemnity or medical payments are not expected), the judgment date, or the date an agreement was made regarding the final amount paid. Refer to individual DCO for reporting requirements.			
Notes:	A claim's status (Open/Closed) is derived based on the population of the Closing Date and Reopen Date fields.			
Population Rule:	Format CCYYMMDD Do not zero fill this data element when a claim reopens. Do not zero fill the Reopen Date (Positions 86-93) when the claim closes again.			
14	**REOPEN DATE**	N	86-93	8
Definition:	The date a claim is reopened as defined by the carrier.			
Reporting Requirement:	Report the date that a closed claim was last reopened for additional benefits.			
Notes:	A claim's status (Open/Closed) is derived based on the population of the Closing Date and Reopen Date fields.			
Population Rule:	Format CCYYMMDD Do not zero fill this data element when a claim closes. Do not zero fill the Closing Date (Positions 78-85) when the claim reopens.			
15	**MAXIMUM MEDICAL IMPROVEMENT DATE** N/A: DE	N	94-101	8
Definition:	The date of those claims where a permanent total benefit or a permanent partial benefit has been paid or is expected to be paid after final determination of MMI.			
Reporting Requirement:	Report the Maximum Medical Improvement (MMI) Date for those claims where permanent benefits (including lump-sum			

Field No.	Field Title/Description	Class	Position	Bytes
	amounts) have been paid or are expected to be paid after final determination of MMI.			
Population Rule:	Zero-fill if not applicable or if MMI has not been determined as of the quarter-end valuation date. Format CCYYMMDD			
16	**REPORTED TO INSURER DATE**	N	102-109	8
Definition:	The date that a claim was originally reported by the insured.			
Reporting Requirement:	Report the date the claim was originally reported to the insurer.			
Notes:	The Reported To Insurer Date must be on or after the Accident Date (position 54-61).			
Population Rule:	Format CCYYMMDD Zero Fill if unknown			
17	**ACCIDENT STATE CODE**	N	110-111	2
Definition:	The code that corresponds to the state or foreign location where the claimant was injured or contracted an occupational disease.			
Reporting Requirement:	Report the code that corresponds to the state or foreign location where the claimant was injured or contracted an occupational disease.			
Population Rule:	Zero-fill if unknown.			
18	**ATTORNEY OR AUTHORIZED REPRESENTATIVE INDICATOR**	A	112-112	1
Definition:	A code used to report if the injured worker has an attorney or authorized representative.			
Reporting Requirement:	Report “Y” or “N” to indicate whether the claimant has an attorney or authorized representative. Report “Y” if the claimant has obtained attorney representation regardless of whether the claim is litigated			
Population Rule:	Leave blank if unknown.			

Code	Description
Y	Claimant has an attorney or authorized representative

Field No.	Field Title/Description	Class	Position	Bytes
	N — Claimant does not have an attorney or authorized representative			
19	**METHOD OF DETERMINING PRE-INJURY/AVERAGE WEEKLY WAGE CODE**	N	113-113	1
Definition:	A code used to define the method used to determine the preinjury/average weekly wage amount.			
Reporting Requirement:	Report the code that corresponds to the method used to determine the Pre-Injury/Average Weekly Wage Amount.			
Population Rule:	Zero-fill if unknown.			

Code	Description
1	Claimant's actual average weekly wage is known Note: For NCCI, this code refers to Actual/Estimated Wage
2	Claimant's average weekly wage is not known but is below the wage required by statute for receiving minimum benefits
3	Claimant's actual average weekly wage is not known but qualifies for the maximum weekly benefit as defined by statute

20	**IMPAIRMENT PERCENTAGE BASIS CODE**	N	114-114	1
Definition:	The code that corresponds to whether the reported Impairment Percentage was based on the whole body or part of body.			
Reporting Requirement:	Report the code that corresponds to whether the impairment percentage was reported based on the whole body or part of body.			
Notes:	This field must be completed when an impairment percentage is reported in the Impairment Percentage (positions 115-117). With a single impairment, the carrier data provider can choose either whole body or part of body for the basis code. Multiple impairments must be reported based on a whole-body basis.			

Field No.	Field Title/Description	Class	Position	Bytes

Population Rule: Zero-fill if not applicable.

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

21 **IMPAIRMENT PERCENTAGE** N 115-117 3

Definition: The actual, final impairment rating of a claim (i.e., medical assessment of claimant's post-MMI functionality) expressed as a percentage.

Reporting Requirement: Report the percentage of impairment of a claim. This field is conditional and is only required to be reported when applicable to the Quarterly record.

Refer to individual DCO for reporting requirements.

Population Rule: Zero-fill if not applicable.
Field is to be right-justified and left zero-filled; enter the percentage as a whole number with a leading zero or zeros

22 **DISABILITY/LOSS EARNINGS CAPACITY (LOEC) PERCENTAGE** N 118-120 3

Definition: In jurisdictions where permanent partial disability (PPD) benefits are based on a formal assessment of the claimant's loss of earnings capacity (LOEC)post-maximum medical improvement, this is the actual, final LOEC of a claim, expressed as a percentage, which underlies the benefits paid.

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

Reporting Requirement: Report the final LOEC or disability of a claim as a percentage, which underlies the permanent benefits paid.

Field No.	Field Title/Description	Class	Position	Bytes
Population Rule:	Field is to be right-justified and left zero-filled. Enter the percentage as a whole number with a leading zero or zeros			
23	**PRE-EXISTING DISABILITY PERCENTAGE**	N	121-123	3
Definition:	The pre-existing disability percentage that directly affects the amount of benefits payable and is contemplated in the determination of a claimant's permanent disability benefits (i.e., compensation is reduced to reflect a pre-existing impairment or disability).			
Reporting Requirement:	Report the percentage of the pre-existing disability when it directly impacts the disability rating for the claim.			
Notes:	The Pre-Existing Disability Percentage field is to be reported on a whole-body basis.			
Population Rule:	Field is to be right-justified and left zero-filled; enter the percentage as a whole number with a leading zero or zeros. Zero-fill if not applicable.			
24	**PART OF BODY CODE**	N	124-125	2
Definition:	A code used to identify the injured body part.			
Reporting Requirement:	Report the Part of Body Code that identifies the specific body part affected by the injury that is the most significant contributor to the expected overall cost of the claim.			
Notes:	When the specific body part affected by the injury cannot be determined, Part of Body Code 65 (Insufficient Information to Properly Identify—Unclassified) must be reported. When the specific Part of Body Code is determined subsequently, report the appropriate Part of Body Code in the next Quarterly reporting. Refer to DCO Statistical Plan for applicable codes.			
Population Rule:	Zero-fill if unknown.			
25	**NATURE OF INJURY CODE**	N	126-127	2
Definition:	The code used to identify the nature of the injury.			

Field No.	Field Title/Description	Class	Position	Bytes
Reporting Requirement:	Report the code that corresponds to the nature of the injury sustained by the claimant.			
Notes:	Refer to DCO Statistical Plan for applicable codes.			
Population Rule:	Zero-fill if unknown.			
26	**CAUSE OF INJURY CODE**	N	128-129	2
Definition:	A code used to identify the cause of the injury/accident.			
Reporting Requirement:	Report the applicable code that corresponds to the cause of injury sustained by the claimant using the Injury Description.			
Notes:	Refer to DCO Statistical Plan for applicable codes.			
Population Rule:	Zero-fill if unknown.			
27	**ACT—LOSS CONDITION CODE**	N	130-131	2
Definition:	The code that identifies the act or law governing the basis of liability for the claim.			
Reporting Requirement:	Report the code that corresponds to the act or law governing the basis of the liability for the claim.			
Population Rule:	Zero-fill if unknown.			

Code	Descriptions
00	Reserved for Future Use
01	State Act or Federal Act excluding USL&HW and Federal Mine Safety and Health Act
02	USL&HW F-Classes and USL&HW coverage on Non-F-Classes
03	Federal Mine Safety and Health Act Only N/A: NY
04	Federal Mine Safety and Health Act and the State Act N/A: NY
05	Oil, Gas, and Other Mineral Operations On or Over Water N/A: NY
08	USL&HW Act for Oil, Gas, or Other Mineral Operations On or Over Water N/A: NY

28	**TYPE OF SETTLEMENT CODE**	N	132-133	2

Field No.	Field Title/Description	Class	Position	Bytes

Definition: A code used to identify the type of settlement for the claim.

Reporting Requirement: Report the code that identifies the certain claim settlement situations for the claim.

Population Rule: Zero-fill if unknown.

Code	Descriptions
00	Claim Not Subject to Settlement
01	Reserved for Future Use
02	Reserved for Future Use
03	Stipulated Award (Insurer/Claimant Settlement)
04	Findings and Award (Judicial Award) N/A: NY
05	Dismissal or Take Nothing (Noncompensable)
06	Compromise Settlement N/A: NY
07	No Safety Devices N/A: DE, NY, PA
08	Exemplary Damages N/A: DE, NY, PA
09	All Other Settlements
10	Aggravation of Prior Work Related Injuries N/A: DE, NY, PA

29 **MEDICAL EXTINGUISHMENT INDICATOR** A 134-134 1

Definition: The code that indicates if future medical liabilities are extinguished based on a lump sum settlement agreement.

Reporting Requirement: Report “Y” or “N” to indicate whether medical liabilities are extinguished based on a lump-sum settlement agreement.

Refer to individual DCO for reporting requirements.

Notes: 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.

Do not report “N” when medical benefits have not been extinguished; in this case, leave the field blank. Only report “N” when

Field No.	Field Title/Description	Class	Position	Bytes
	there has been a lump-sum settlement made and medical payments are still ongoing.			
Population Rule:	Leave blank if unknown or not applicable.			

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

30	**TEMPORARY DISABILITY BENEFIT EXTINGUISHMENT CODE**	N	135-135	1
Definition:	The code that corresponds to the reason why temporary disability benefits were terminated.			
Reporting Requirement:	Report the code that corresponds to the reason why temporary disability benefits were terminated. If temporary benefits are still being paid or this is not applicable (e.g. the claimant died from injuries and only death benefits have been paid), report zero. When multiple codes apply, use lowest in hierarchy. Refer to individual DCO for reporting requirements.			
Notes:	Switching from Temporary Total Disability to Temporary Partial Disability (or vice versa) would not result in the reporting of this data element. Only when both temporary disability benefit types are extinguished would this field be required to be reported.			
~~Population Rule:~~	~~Zero-fill if unknown.~~			

Code	Description
0	Temporary benefits not extinguished or not applicable
1	Return to Work (RTW)
2	Release RTW
3	Maximum Medical Improvement (MMI) N/A: DE
4	Maximum Statutory Duration

Field No.	Field Title/Description	Class	Position	Bytes
	5 Medical Noncompliance (e.g. missed medical appointments or refusal to be examined) 6 Other			
31	**INDEMNITY PAID-TO-DATE** Definition: The paid-to-date amount of all indemnity payments for the claim as of the quarter-end valuation date. This definition is equivalent to the rules for unit statistical reporting. Reporting Requirement: Report the paid-to-date amount of all indemnity payments for the claim as of the quarter-end valuation date. Notes: Refer to DCO's Statistical Plan Manual for information on allocating subrogation recoveries and special fund reimbursements between indemnity and medical. Population Rule: Format $W9	N	136-144	9
32	**MEDICAL PAID-TO-DATE** Definition: The paid-to-date amount of all medical payments for the claim as of the quarter-end valuation date. This definition is equivalent to the rules for unit statistical reporting. Reporting Requirement: Report the paid-to-date amount of all medical payments for the claim as of the quarter-end valuation date. Notes: Refer to individual DCO's Statistical Plan Manual for information on reporting Loss and Expense Information. Population Rule: Format $W9	N	145-153	9
33	**INCURRED INDEMNITY AMOUNT** Definition: The amount of incurred indemnity due to an employee's lost wages or inability to work, including all paid and outstanding reserve benefits. Reporting Requirement: Report the total of indemnity paid-to-date and outstanding reserves as of the quarter-end valuation date. Notes: Refer to individual DCO's Statistical Plan Manual for information on reporting Loss and Expense Information. Population Rule: Format $W9	N	154-162	9

Field No.	Field Title/Description	Class	Position	Bytes
34	**INCURRED MEDICAL AMOUNT**	N	163-171	9
Definition:	The amount of incurred medical, including all paid and outstanding reserve benefits as of the loss valuation date.			
Reporting Requirement:	Report the total of the medical paid-to-date and outstanding reserves as of the quarter-end valuation date.			
Notes:	Refer to individual DCO's Statistical Plan Manual for information on reporting Loss and Expense Information.			
Population Rule:	Format $W9			
35	**EMPLOYER LEGAL AMOUNT PAID**	N	172-180	9
Definition:	The cumulative amount paid by the employer or insurer for the services of an attorney or authorized representative to defend against a proceeding brought under the workers compensation or employer's liability laws, net of recoveries received.			
Reporting Requirement:	Report the whole-dollar amount paid by the employer or insurer for the services of an attorney or authorized representative.			
Notes:	If a special fund (e.g., Second Injury Fund) has or will reimburse the insurer for a claim, or where the recovery was received due to subrogation; report the Employer Legal Amount Paid gross of the recovery Refer to individual DCO statistical plan manual for information on reporting Loss and Expense information.			
Population Rule:	Format $W9			
36	**ALLOCATED LOSS ADJUSTMENT EXPENSE (ALAE) PAID**	N	181-189	9
Definition:	The cumulative amount of all ALAE paid for the specific claim, net of recoveries.			
Reporting Requirement:	Report the whole-dollar amount of ALAE that has been paid for the claim as of the loss valuation date.			
Notes:	Reporting must be consistent with the reporting of ALAE for this same claim for Unit Statistical data.			

Field No.	Field Title/Description	Class	Position	Bytes
	Refer to individual DCO's Statistical Plan Manual for information on reporting Loss and Expense Information.			
Population Rule:	Format $W9			
37	**PRE-INJURY/AVERAGE WEEKLY WAGE AMOUNT**	N	190-194	5
Definition:	The average weekly wage of the claimant or deceased worker prior to injury, as defined by state or federal law.			
Reporting Requirement:	Report the pre-injury average weekly wage of the claimant or deceased worker computed in accordance with statutes and rules of the applicable jurisdiction.			
Notes:	Report this field in conjunction with the Method of Determining Pre-Injury/Average Week Wage Code (position 113).			
Population Rule:	Format $W5 Zero-fill if unknown			
38	**CLASSIFICATION CODE**	N	195-198	4
Definition:	A code used to identify the classification assigned to the insured according to the rules of the manual for workers compensation, or the statistical code defined by the jurisdiction.			
Reporting Requirement:	Report the classification code corresponding to the classification assigned to the insured according to the rules of the manual for Workers Compensation or the statistical code defined by the DCOs. Refer to individual DCO for reporting requirements.			
Population Rule:	Format 4N			
39	**RETURN TO WORK DATE**	N	199-206	8
Definition:	The date of the claimant's most recent return to work.			
Reporting Requirement:	Report the most recent date on which the claimant returned to work Refer to individual DCO for reporting requirements.			
Population Rule:	Format CCYYMMDD			

Field No.	Field Title/Description	Class	Position	Bytes
40	**ZIP CODE OF INJURY SITE**	AN	207-215	9
Definition:	The postal or United States Postal Service ZIP+4 Code of the location where the injury occurred.			
Reporting Requirement:	If the 9-digit ZIP+4 code is known, report the 9-digit ZIP+4 code. If only the standard 5-digit ZIP code is known, report the 5-digit ZIP code. Refer to individual DCO for reporting requirements.			
Population Rule:	Left-justified and left zero filled.			
41	**NUMBER OF DEPENDENTS**	N	216-217	2
Definition:	The number of dependents the injured worker has at the time of injury.			
Reporting Requirement:	Report the number of dependents eligible to receive compensation at time of injury. Refer to individual DCO for reporting requirements.			
Population Rule:	Report a value of 00 through 20. If more than 20 dependents, report 20.			
42	**EXPOSURE STATE CODE**	N	218-219	2
Definition:	A code used to identify the state in which coverage has been provided for the classifications and corresponding exposures, if any, and to which the payrolls of claimants have been assigned.			
Reporting Requirement:	Report the state code in which coverage has been provided for the classification and corresponding exposure, and to which the payroll of claimant has been assigned. Refer to individual DCO for reporting requirements.			
43	**INDEMNITY CLAIM CODE**	N	220-220	1
Definition:	A code that can aid in identifying and deleting claims.			

Field No.	Field Title/Description	Class	Position	Bytes
	Reporting Requirement: Report the applicable code. Refer to individual DCO for reporting requirements. **Code** — **Description** 1 — Compensable indemnity claim 2 — Noncompensable indemnity claim 3 — Medical-only claim 4 — Jurisdiction State no longer applicable			
44	**RESERVED FOR FUTURE USE**	AN	221-300	80

Field No.	Field Title/Description	Class	Position	Bytes
KEY FIELD CHANGE RECORD				
1	**RECORD TYPE CODE**	N	1-2	2
Definition:	A code used to identify the type of record being reported.			
Reporting Requirement:	Report “04” for the Key Field Change Record.			
2	**PREVIOUS CARRIER CODE**	N	3-7	5
Definition:	The previously reported Carrier Code (assigned to the carrier by NCCI) of the record being changed by the Key Field Change record.			
Reporting Requirement:	Report the previously reported Carrier Code, whether it is being changed by the Key Field Change record or not.			
3	**PREVIOUS POLICY NUMBER IDENTIFIER**	AN	8-25	18
Definition:	The previously reported Policy Number Identifier of the record being changed by the Key Field Change record. The Policy Number Identifier is the unique set of numbers and/or letters that identify the policy under which the claim occurred.			
Reporting Requirement:	Report the previously reported Policy Number Identifier, whether it is being changed by the Key Field Change record or not.			
4	**PREVIOUS POLICY EFFECTIVE DATE**	N	26-33	8
Definition:	The previously reported Policy Effective Date of the record being changed by the Key Field Change record. The Policy Effective Date is the date that the policy under which the claim occurred became effective.			
Reporting Requirement:	Report the previously reported Policy Effective Date whether it is being changed by the Key Field Change record or not.			
Population Rule:	Format CCYYMMDD			
5	**PREVIOUS CLAIM NUMBER IDENTIFIER**	AN	34-45	12
Definition:	The previously reported Claim Number Identifier of the record being changed by the Key Field Change record. The Claim Number Identifier is the unique set of numbers and/or letters that identify the specific claim that the report/transaction applies to.			

Field No.	Field Title/Description	Class	Position	Bytes
Reporting Requirement:	Report the previously reported Claim Number Identifier, whether it is being changed by the Key Field Change record or not.			
6	**PREVIOUS ACCIDENT DATE**	N	46-53	8
Definition:	The previously reported Accident Date of the record being changed by the Key Field Change record. The Accident Date is the month, day, and year on which the injury occurred.			
Reporting Requirement:	Report the previously reported Accident Date, whether it is being changed by the Key Field Change record or not.			
Population Rule:	Format CCYYMMDD			
7	**CARRIER CODE**	N	54-58	5
Definition:	A code used and assigned by NCCI or other DCO to identify a reporting company.			
Reporting Requirement:	Report the code assigned to the reporting company by NCCI or other DCO.			
Notes:	The reported code must match the unit statistical Carrier Code reported for this claim.			
8	**POLICY NUMBER IDENTIFIER**	AN	59-76	18
Definition:	An identifier used to uniquely identify the policy number.			
Reporting Requirement:	Report the unique identifier used for identifying the policy.			
Notes:	The Policy Number Identifier must match the unit statistical data Policy Number Identifier reported for this claim, including any prefixes or suffixes.			
Population Rule:	Do not report embedded blanks or marks of punctuation. The Policy Number Identifier cannot be all zeros, all blanks nor a combination of zeros and blanks.			
9	**POLICY EFFECTIVE DATE**	N	77-84	8
Definition:	The date of inception of the policy; for policies greater than one year and 16 days, this is the start date of the period.			
Reporting Requirement:	Report the date that the policy became effective.			

Field No.	Field Title/Description	Class	Position	Bytes
Notes:	The Policy Effective Date must match the unit statistical data Policy Effective Date reported for this claim.			
Population Rule:	Format CCYYMMDD			
10	**CLAIM NUMBER IDENTIFIER**	AN	85-96	12
Definition:	The alphanumeric characters that uniquely identify the claim (excluding blanks).			
Reporting Requirement:	Report the number that uniquely identifies the claim.			
Notes:	The Claim Number Identifier must match the unit statistical data claim number reported for this claim. This number must be used consistently for all future reporting of the claim transactions.			
Population Rule:	The Claim Number Identifier cannot be all zeros, all blanks nor a combination of zeros and blanks. Do not report any embedded blanks, marks of punctuation or special characters.			
11	**ACCIDENT DATE**	N	97-104	8
Definition:	The date of the injury.			
Reporting Requirement:	Report the date on which the injury occurred.			
Notes:	The Accident Date must match the unit statistical data Accident Date reported for this claim. This date must be within the policy period.			
Population Rule:	Format CCYYMMDD			
12	**RESERVED FOR FUTURE USE**	AN	105-300	196