TEXAS DETAILED CLAIM INFORMATION STATISTICAL PLAN

Compiled by the
TEXAS DEPARTMENT OF INSURANCE
333 Guadalupe
P.O. Box 149096

AUSTIN, TEXAS 78714-9096

PREFACE

The ***Texas Detailed Claim Information Statistical Plan*** 2010 Edition contains the rules, requirements, and examples for reporting accurate and timely Detailed Claim Information for claims with a Reported to Insurer Date of September 2010 and later.

For all claims with a Reported to Insurer Date prior to September 2010, data providers must use the ***Texas Detailed Claim Information Statistical Plan*** effective January 1, 1997.

Runoff of Claims in the Current DCI Program

The final Reported to Insurer Date for valuation of 1st reports under the current DCI program is August 2010—with those 4th reports due in April 2014.

All report levels that are due up to and including April 2014 are required. Reporting is not required for **any** reports that would have been due after April 2014.

Example:

Claims valued with a Reported to Insurer Date (RTI) of July 2008 require a 6th report due by March 2014. A 7th report would be due March 2015, which is later than the April 2014 cutoff date. Therefore, for this example, the 6th report would be the last report required.

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PART 1—DCI STATISTICAL PLAN

OVERVIEW

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

A. PURPOSE OF THE MANUAL

The ***Detailed Claim Information Statistical Plan*** is your source for the rules and requirements for reporting Detailed Claim Information (DCI), 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 manual:

- DCI uses
- Participation
- 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 for original reports, subsequent reports, and replacement reports
- Data element dentitions, 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 manual

B. STATISTICAL AGENT

The National Council on Compensation Insurance, Inc. (NCCI) is the statistical agent for Texas Department of Insurance to collect Detailed Claim Information data. Detailed Claim Information reports must be submitted to NCCI in accordance with this plan.

C. CUSTOMER SUPPORT AND CONTACT INFORMATION

1. Texas Department of Insurance (TDI)

For questions regarding the Texas Detailed Claim Information program, contact the Data Services Division, DCI Section of the Texas Department of Insurance at 512-475-1878.

2. NCCI Customer Service Center

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 manual at ncci.com (or ordering hard copies of this manual)
- Ordering any of the reports, data tools, or other products and services mentioned in this manual
- 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
Email:	customer_service@ncci.com

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PART 2—GENERAL RULES

OVERVIEW

Detailed Claim Information (DCI) is a Texas data collection program whereby insurance companies furnish specific information on workers' compensation claims. Part 2 of this manual 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, including:

- Pricing of changes to state law or state regulations;
- State insurance department reporting; and
- Research studies.

B. SCOPE AND ISSUED DATE

1. Scope

Detailed Claim Information (DCI) applies to:

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

DCI data may be submitted by insurance carriers, state funds, or third party administrators. This manual 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); or
- **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 a carrier, quality and timeliness of the data are the responsibility of the carrier.

2. Issued Date

This manual is being issued for the 2010 DCI participation program, which began with claims with a Reported to Insurer Date of September 2010 and later.

C. PARTICIPATION PROCESS

1. Participation Eligibility

Participation in the Texas Detailed Claim Information (DCI) program is mandatory per Insurance Code, Section 2053.151. All insurers or other entities authorized to write workers' compensation in the State of Texas are required to report DCI.

2. Individual Carrier Participation

Participation in the Texas Detailed Claim Information (DCI) program is on an individual carrier basis. Carrier group reporting is not permitted.

3. Mergers and Acquisitions

In the event a carrier 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 that was not previously required to report DCI merges with or becomes acquired by a reporting carrier, the acquired carrier would not be required to report as part of that carrier 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 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

D. DESIGNATED CARRIER COORDINATOR

Each carrier 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; and
- Serve as central control for Texas DCI within their organization.

E. ELECTRONIC SUBMISSION

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

PART 3—DCI STRUCTURE

OVERVIEW

Part 3 of this manual 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 employer's liability indemnity claims.

All Death and Lifetime Income Benefits claims, and all other open indemnity claims that meet the above criteria are required to be reported.

Closed claims are to be sampled based on a 66% sampling ratio. A state sample ratio evaluation will be conducted at least every two years to ensure that the number of new claims needed for Texas is maintained.

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, the following is excluded from DCI:

- Claims where the jurisdiction state is not Texas;
- Medical only claims (i.e., claims in which there are no incurred indemnity losses recorded and no anticipation of an indemnity payment in the future);
- Losses paid to another insurer because of reinsurance assumed by the reporting insurer; and
- 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 removing medical-only, Federal Act, or a jurisdiction state other than Texas that were reported in error, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this manual.

Note: For specific instructions on subsequent reporting of claims that become medical only or have been reclassified as a Federal Act or a jurisdiction state other than Texas due to the development from one report to the next, refer to Subsequent Reports in the **Reporting and Record Layouts** section (Part 5) of this manual.

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 to determine what the valuation level (6–138 months) should be when reporting claims that become Death or Lifetime Income Benefits claims. For details, refer to Death and Lifetime Income Benefits Claims in the **Claim Selection and Sampling** section (Part 4) of this manual.

Note: The DCI selection and sampling process is performed on a monthly basis under the DCI program. For details, refer to the **Claim Selection and Sampling** section (Part 4) of this manual.

D. VALUATION OF CLAIMS

Detailed Claim Information (DCI) losses are valued at specific time frames corresponding to the valuation levels (6–138 months). Losses are first valued during the 6th 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 manual.
Subsequent reporting of claims must be valued 12 months after the loss valuation date of the preceding report (18-138 months), or until the claim has become:

- Closed; or
- Reclassified as medical only (i.e., no indemnity payments made or anticipated), Federal Act, or a jurisdiction state other than Texas.

Note: For specific instructions on reporting of claims that close, reopen, become medical only, or must otherwise be reclassified from what was originally reported, refer to Replacement Reports if reported in error, and Subsequent Reports if due to development from one report to the next, in the **Reporting and Record Layouts** section (Part 5) of this manual.

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 payment amounts gross of the recovery and report the recovery amount in the Recovery Reimbursement Amount field.

Note: Total incurred amounts are to be reported net of recoveries as defined in the ***Texas Workers' Compensation Statistical Plan.***

For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

Refer to the ***Texas Workers' Compensation Statistical Plan*** for details, including exceptions for reporting recoveries and reimbursements.

PART 4—CLAIM SELECTION AND SAMPLING

OVERVIEW

In addition to collecting data for **all** Death and Lifetime Income Benefits claims, and **all** other open indemnity claims, a sampling process where data providers select closed claims according to the Texas sampling rules is used. Part 4 of this manual 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 6 months after the Reported to Insurer Date (first loss valuation level). As noted in Death and Lifetime Income Benefits Claims in the **Claim Selection and Sampling** section (Part 4) of this manual, Death and Lifetime Income Benefits 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.

B. DEATH AND LIFETIME INCOME BENEFITS CLAIMS

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

A claim identified as Death or Lifetime Income Benefits based on the established indemnity reserve, must be reported even if no Death or Lifetime Income Benefits benefit payments have been made as of the loss valuation. Any claim reported as Death or Lifetime Income Benefits 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 manual.

C. RANDOM SAMPLING

Data providers are required to randomly select 66% of closed eligible claims reported to the insurer each month.

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.

It is recommended 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 manual 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.

The claim selection and sampling process is performed 6 months after the Reported to Insurer Date. The following steps and examples will use:

- Texas as the state to be reported
- September 2010 as the Reported to Insurer Date
- March 2011 (6 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 where Texas is the jurisdiction state.

Example: Selecting the Appropriate Jurisdiction State

This example assumes there are 40 claims with a Reported to Insurer Date of September 2010. The jurisdiction state being sampled is Texas (Jurisdiction State Code 42).

Claim Number	Jurisdiction State	Include in Selection for This Jurisdiction? Y/N
WC3658692	42	Y
WC3862354	42	Y
WC3876935	42	Y
WC3900522	42	Y
WC3915366	42	Y
WC3928655	42	Y
WC3939652	42	Y
WC4123456	**01**	**N**
WC3939766	42	Y
WC3942322	42	Y
WC4298765	42	Y
WC3943005	42	Y
WC3944022	42	Y
WC3952115	42	Y
WC3930023	42	Y
WC3945626	42	Y
WC4412392	42	Y
WC3232317	42	Y
WC3273931	42	Y
WC3900129	42	Y
WC3911443	42	Y
WC3922333	42	Y
WC4321987	**39**	**N**

Claim Number	Jurisdiction State	Include in Selection for This Jurisdiction? Y/N
WC3939312	42	Y
WC3939744	42	Y
WC4563721	**39**	**N**
WC3972355	42	Y
WC3973001	**42**	**N**
WC4063255	42	Y
WC3125654	42	Y
WC3698520	42	Y
WC3652369	42	Y
WC3452653	42	Y
WC3860025	42	Y
WC4676859	**39**	**N**
WC3763260	42	Y
WC3880088	42	Y
WC3869201	42	Y
WC4765432	42	Y
WC4879675	**01**	**N**

Of our initial population of 40 claims, 35 claims have been identified with Jurisdiction State Code 42 (Texas) and are eligible for the next step in the claim selection process.

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)

Claim Number	Benefit Type	Claim Status	Eligible for Selection Process? Y/N
WC3658692	Temporary Income Benefits (05)	Closed	Y
WC3862354	Death & Burial Benefits (01)	Closed	Y
WC3876935	Temporary Income Benefits (05)	Open	Y
WC3900522	Impairment Income Benefits (04)	Closed	Y
WC3915366	Temporary Partial (07)	Closed	Y
WC3928655	Temporary Partial (07)	Open	Y
WC3939652	Temporary Partial (07)	Closed	Y
WC3939766	Temporary Partial (07)	Closed	Y
WC3942322	Impairment Income Benefits (04)	Closed	Y
WC4298765	**Medical Only**	**Open**	**N**
WC3943005	Temporary Partial (07)	Open	Y
WC3944022	Temporary Partial (07)	Open	Y
WC3952115	Death & Burial Benefits (01)	Open	Y
WC3930023	Temporary Income Benefits (05)	Closed	Y
WC3945626	Lifetime Income Benefits (02)	Open	Y
WC4412392	Temporary Partial (07)	Closed	Y
WC3232317	Temporary Partial (07)	Closed	Y
WC3273931	Temporary Partial (07)	Open	Y
WC3900129	Temporary Partial (07)	Closed	Y
WC3911443	Lifetime Income Benefits (02)	Open	Y
WC3922333	Temporary Partial (07)	Open	Y
WC3939312	Temporary Partial (07)	Closed	Y
WC3939744	Temporary Income Benefits (05)	Closed	Y
WC3972355	Temporary Partial (07)	Closed	Y
WC3973001	Lifetime Income Benefits (02)	Open	Y
WC4063255	Temporary Partial (07)	Closed	Y
WC3125654	Lifetime Income Benefits (02)	Open	Y

Claim Number	Benefit Type	Claim Status	Eligible for Selection Process? Y/N
WC3698520	Temporary Partial (07)	Closed	Y
WC3652369	Temporary Partial (07)	Closed	Y
WC3452653	Temporary Partial (07)	Open	Y
WC3860025	Temporary Income Benefits (05)	Closed	Y
WC3763260	Temporary Partial (07)	Closed	Y
WC3880088	Temporary Partial (07)	Closed	Y
WC3869201	Temporary Partial (07)	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 Lifetime Income Benefits Claims
Once the appropriate claims have been excluded from the population of claims, identify **all** Death and Lifetime Income Benefits claims.

Example: Selecting Death and Lifetime Income Benefits Claims
This example uses the 33 claims remaining after Step #2 and based on Benefit Type identifies all Death and Lifetime Income Benefits claims.

Claim Number	Benefit Type	Claim Status	Subject to Sampling? Y/N
WC3658692	Temporary Income Benefits (05)	Closed	Y
WC3862354	**Death & Burial Benefits (01)**	**Closed**	**N**
WC3876935	Temporary Income Benefits (05)	Open	Y
WC3900522	Impairment Income Benefits (04)	Closed	Y
WC3915366	Temporary Partial (07)	Closed	Y
WC3928655	Temporary Partial (07)	Open	Y
WC3939652	Temporary Partial (07)	Closed	Y
WC3939766	Temporary Partial (07)	Closed	Y
WC3942322	Impairment Income Benefits (04)	Closed	Y
WC3943005	Temporary Partial (07)	Open	Y
WC3944022	Temporary Partial (07)	Open	Y
WC3952115	**Death & Burial Benefits (01)**	**Open**	**N**
WC3930023	Temporary Income Benefits (05)	Closed	Y
WC3945626	**Lifetime Income Benefits (02)**	**Open**	**N**
WC4412392	Temporary Partial (07)	Closed	Y
WC3232317	Temporary Partial (07)	Closed	Y
WC3273931	Temporary Partial (07)	Open	Y
WC3900129	Temporary Partial (07)	Closed	Y
WC3911443	**Lifetime Income Benefits (02)**	**Open**	**N**
WC3922333	Temporary Partial (07)	Open	Y
WC3939312	Temporary Partial (07)	Closed	Y
WC3939744	Temporary Income Benefits (05)	Closed	Y
WC3972355	Temporary Partial (07)	Closed	Y
WC3973001	**Lifetime Income Benefits (02)**	**Open**	**N**
WC4063255	Temporary Partial (07)	Closed	Y
WC3125654	**Lifetime Income Benefits (02)**	**Open**	**N**
WC3698520	Temporary Partial (07)	Closed	Y
WC3652369	Temporary Partial (07)	Closed	Y
WC3452653	Temporary Partial (07)	Open	Y

Claim Number	Benefit Type	Claim Status	Subject to Sampling? Y/N
WC3860025	Temporary Income Benefits (05)	Closed	Y
WC3763260	Temporary Partial (07)	Closed	Y
WC3880088	Temporary Partial (07)	Closed	Y
WC3869201	Temporary Partial (07)	Closed	Y

From the population of 33 claims, 2 claims were identified as Death claims and 4 were identified as Lifetime Income Benefits claims. These 6 claims will be included on the original report but will not be subject to the sampling process in Step #4.

3. Step #3A—Select Open Claims
Once the Death and Lifetime Income Benefits claims have been identified, use the claim status to identify all open claims.

Example: Selecting Open Claims
This example uses the 27 claims remaining after Step #3 and based on Claim Status, identifies all open claims.

Claim Number	Benefit Type	Claim Status	Subject to Sampling? Y/N
WC3658692	Temporary Income Benefits (05)	Closed	Y
WC3876935	**Temporary Income Benefits (05)**	**Open**	**N**
WC3900522	Impairment Income Benefits (04)	Closed	Y
WC3915366	Temporary Partial (07)	Closed	Y
WC3928655	**Temporary Partial (07)**	**Open**	**N**
WC3939652	Temporary Partial (07)	Closed	Y
WC3939766	Temporary Partial (07)	Closed	Y
WC3942322	Impairment Income Benefits (04)	Closed	Y
WC3943005	**Temporary Partial (07)**	**Open**	**N**
WC3944022	**Temporary Partial (07)**	**Open**	**N**
WC3930023	Temporary Income Benefits (05)	Closed	Y
WC4412392	Temporary Partial (07)	Closed	Y
WC3232317	Temporary Partial (07)	Closed	Y
WC3273931	**Temporary Partial (07)**	**Open**	**N**
WC3900129	Temporary Partial (07)	Closed	Y
WC3922333	**Temporary Partial (07)**	**Open**	**N**
WC3939312	Temporary Partial (07)	Closed	Y
WC3939744	Temporary Income Benefits (05)	Closed	Y
WC3972355	Temporary Partial (07)	Closed	Y
WC4063255	Temporary Partial (07)	Closed	Y
WC3698520	Temporary Partial (07)	Closed	Y

Claim Number	Benefit Type	Claim Status	Subject to Sampling? Y/N
WC3652369	Temporary Partial (07)	Closed	Y
WC3452653	**Temporary Partial (07)**	**Open**	**N**
WC3860025	Temporary Income Benefits (05)	Closed	Y
WC3763260	Temporary Partial (07)	Closed	Y
WC3880088	Temporary Partial (07)	Closed	Y
WC3869201	Temporary Partial (07)	Closed	Y

From the population of 27 claims, 7 claims were identified as open claims. These 7 claims will be included on the original report but will not be subject to the sampling process in Steps #4 and #5.

4. Step #4—Assign a Random Number
The population of claims that remain after Steps #3-3A 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 20 claims remaining after Steps #3-3A.

Claim Number	Random Number (000-999)	Claim Status
WC3658692	355	Closed
WC3900522	475	Closed
WC3915366	586	Closed
WC3939652	389	Closed
WC3939766	943	Closed
WC3942322	028	Closed
WC3930023	681	Closed
WC4412392	134	Closed
WC3232317	001	Closed
WC3900129	721	Closed
WC3939312	833	Closed
WC3939744	322	Closed
WC3972355	012	Closed
WC4063255	123	Closed
WC3698520	037	Closed
WC3652369	152	Closed
WC3860025	288	Closed
WC3763260	972	Closed
WC3880088	849	Closed
WC3869201	184	Closed

5. Step #5—Apply Sampling Ratios to Closed Claims
Once the three-digit random number is assigned to the claims subject to sampling, the sampling ratio for closed indemnity claims specified by Texas will be used to determine which closed claims will be reported. For the following example the closed claim sampling ratio is multiplied by 1000 and the result is subtracted by 1 to provide a range for selecting the closed claims.

Example: Applying Sampling Ratios to Close Claims
This example uses the Texas sampling ratio of 66% for closed claims. The sampling ratio is multiplied by 1000 and the result is subtracted by 1. So, 66% times 1000 minus 1 is 659 (0.66 × 1000 = 660 − 1 = 659). Closed claims for which the random three-digit number is in the range 000 to 659 (including 000 and 659) to equal a range of 660 numbers are selected. Of the 20 closed claims remaining after Steps #3-3A, 14 claims fall within the 000–659 range.

Note: Any range that includes 660 numbers would be acceptable here—for example, a range of 001–660 inclusive of 001 and 660 could also be used.

Claim Number	Random Number (000-659)	Claim Status	Report to NCCI? Y/N
WC3658692	355	Closed	Y
WC3900522	475	Closed	Y
WC3915366	586	Closed	Y
WC3939652	389	Closed	Y
WC3939766	**943**	**Closed**	**N**
WC3942322	028	Closed	Y
WC3930023	**681**	**Closed**	**N**
WC4412392	134	Closed	Y
WC3232317	001	Closed	Y
WC3900129	**721**	**Closed**	**N**
WC3939312	**833**	**Closed**	**N**
WC3939744	322	Closed	Y
WC3972355	012	Closed	Y
WC4063255	123	Closed	Y
WC3698520	037	Closed	Y
WC3652369	152	Closed	Y
WC3860025	288	Closed	Y
WC3763260	**972**	**Closed**	**N**
WC3880088	**849**	**Closed**	**N**
WC3869201	184	Closed	Y

6. Summary—Claims Reported on Original Report for Jurisdiction

At loss valuation date (6 months after Reported to Insurer Date), claims selected for original reports are determined by:

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

In the examples above, loss valuation and selection began March 2011 (6 months after the September 2010 Reported to Insurer Date) for Texas. After completing all the steps, the following claims would be reported on the original report:

• 2 Death claims
• 4 Lifetime Income Benefits claims
• 7 open indemnity claims
• 14 closed indemnity claims

PART 5—REPORTING AND RECORD LAYOUTS

OVERVIEW

Part 5 of this manual provides the instructions and examples for Original 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. ORIGINAL REPORTS

NCCI must receive an Original Report valued as of 6 months for all Death claims, Lifetime Income Benefits claims, open indemnity claims and all eligible closed 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 manual.

Submit the Original Report (Valuation Level Code 006, Record Type Code 1) to NCCI within three months after the 6 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 manual.

B. SUBSEQUENT REPORTS

A Subsequent Report must be valued every 12 months after the original 6 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 jurisdiction state other than Texas
- 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 manual.

Submit Subsequent Reports (Valuation Level Code 018–138, 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 manual.

A Subsequent Report must match a claim on NCCI's database unless reporting a Death or Lifetime Income Benefits (Benefit Type Code 01 or 02 respectively) that has not been previously reported. A non-match condition will occur if:

- A prior report was not submitted
- A prior report rejected, was never corrected and was subsequently removed after 120 days.

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 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 valuation 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 Lifetime Income Benefits Claim Reclassified as Another Benefit Type

A claim may be identified and reported as Death or Lifetime Income Benefits based on the established indemnity reserve, even if no Death or Lifetime Income Benefits payments have been made as of the loss valuation. Any claim reported as Death or Lifetime Income Benefits 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) due to the development from one report to the next 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).

Note: For specific instructions on removing medical-only claims that were reported in error, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this manual.

5. Subsequent Reporting of a Claim Reclassified to a Jurisdiction State other than Texas

A claim reported as Jurisdiction State Code 42 (Texas) on a previous report that is reclassified to a state other than Texas due to the development from one report to the next must be reported at the next report due date with all data valued as of the subsequent loss valuation date and the appropriate Jurisdiction State Code. Refer to Jurisdiction State Code in the **Data Dictionary** section (Part 6) of this manual.

No further reporting is required unless the jurisdiction state is reclassified as Jurisdiction State Code 42 (Texas).

Note: For specific instructions on removing claims that were reported as Jurisdiction State Code 42 (Texas) in error, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this manual.

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) due to the development from one report to the next 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.

Note: For specific instructions on removing Federal Act claims that were reported in error, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this manual.

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 Original Report is valued 6 months after the Reported to Insurer Date and is due at NCCI by the 9th month. It can be received at NCCI between the beginning of the 6th month and the end of the 9th month, and still be considered on time.

Month	Data Provider Action	NCCI Action
6	Selects, samples, and values all reportable claims for the original report (Valuation Level Code 006)	N/A
6-9	Submits the original report by the last day of the 9th month	Edits and generates a Submission Results Report
16	N/A	Generates Expected Subsequent Report
18	Values and updates all reportable claims for Valuation Level Code 018	N/A
18–21	Submits the subsequent report by the last day of the 21st month	Edits and generates a Submission Results Report
28	N/A	Generates Expected Subsequent Report
30	Values and updates all reportable claims for Valuation Level Code 030	N/A
30–33	Submits the subsequent report by the last day of the 33rd month	Edits and generates a Submission Results Report
40	N/A	Generates Expected Subsequent Report
42	Values and updates all reportable claims for Valuation Level Code 042	N/A

Month	Data Provider Action	NCCI Action
42–45	Submits the subsequent report by the last day of the 45th month	Edits and generates a Submission Results Report
52	N/A	Generates Expected Subsequent Report
54	Values and updates all reportable claims for Valuation Level Code 054	N/A
54–57	Submits the subsequent report by the last day of the 57th month	Edits and generates a Submission Results Report
64	N/A	Generates Expected Subsequent Report
66	Values and updates all reportable claims for Valuation Level Code 066	N/A
66–69	Submits the subsequent report by the last day of the 69th month	Edits and generates a Submission Results Report
76	N/A	Generates Expected Subsequent Report
78	Values and updates all reportable claims for Valuation Level Code 078	N/A
78–81	Submits the subsequent report by the last day of the 81st month	Edits and generates a Submission Results Report
88	N/A	Generates Expected Subsequent Report
90	Values and updates all reportable claims for Valuation Level Code 090	N/A
90–93	Submits the subsequent report by the last day of the 93rd month	Edits and generates a Submission Results Report
100	N/A	Generates Expected Subsequent Report
102	Values and updates all reportable claims for Valuation Level Code 102	N/A
102–105	Submits the subsequent report by the last day of the 105th month	Edits and generates a Submission Results Report

Month	Data Provider Action	NCCI Action
112	N/A	Generates Expected Subsequent Report
114	Values and updates all reportable claims for Valuation Level Code 114	N/A
114–117	Submits the subsequent report by the last day of the 117th month	Edits and generates a Submission Results Report
124	N/A	Generates Expected Subsequent Report
126	Values and updates all reportable claims for Valuation Level Code 126	N/A
126–129	Submits the subsequent report by the last day of the 129th month	Edits and generates a Submission Results Report
136	N/A	Generates Expected Subsequent Report
138	Values and updates all reportable claims for Valuation Level Code 138	N/A
138–141	Submits the subsequent report by the last day of the 141st month	Edits and generates a Submission Results Report

D. DCI RECORD LAYOUTS

1. Detailed Claim Information Record

This record is for electronic reporting of all Detailed Claim Information (DCI) valuation levels (Valuation Level Code 006–138).

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 manual.

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	Reserved for Future Use		7–11	5
4	Policy Number Identifier	AN	12–29	18

Field No.	Field Title/Description	Class	Position	Bytes
5	Policy Effective Date	N	30–37	8
6	Valuation Level Code	N	38–40	3
7	Replacement Report Code	AN	41	1
8	Claim Number Identifier	AN	42–53	12
9	Reserved for Future Use		54–70	17
10	Jurisdiction State Code	N	71–72	2
11	Accident State Code	N	73–74	2
12	Accident Date	N	75–82	8
13	Reported to Insurer Date	N	83–90	8
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

Field No.	Field Title/Description	Class	Position	Bytes
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	Incurred Indemnity Amount Total	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

Field No.	Field Title/Description	Class	Position	Bytes
47	Vocational Rehabilitation Maintenance Benefit Amount Paid	N	255–263	9
48	Vocational Rehabilitation Education Expense Amount Paid	N	264–272	9
49	Vocational Rehabilitation Other Amount Paid	N	273–281	9
50	Incurred Medical Amount Total	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

Field No.	Field Title/Description	Class	Position	Bytes
62	Benefits Covered by Lump Sum Settlement Code	N	352–353	2
63	Lump Sum Settlement Amount Paid	N	354–362	9
64	Benefits Covered by Lump Sum Settlement Code	N	363–364	2
65	Lump Sum Settlement Amount Paid	N	365–373	9
66	Benefits Covered by Lump Sum Settlement Code	N	374–375	2
67	Lump Sum Settlement Amount Paid	N	376–384	9
68	Benefits Covered by Lump Sum Settlement Code	N	385–386	2
69	Lump Sum Settlement Amount Paid	N	387–395	9
70	Benefits Covered by Lump Sum Settlement Code	N	396–397	2
71	Lump Sum Settlement Amount Paid	N	398–406	9
72	Reserved for Future Use		407	1
73	Return to Work Date	N	408–415	8
74	Return to Work Rate of Pay 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	Reserved for Future Use		431–435	5

Field No.	Field Title/Description	Class	Position	Bytes
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	Recovery Reimbursement Amount	N	482-490	9
84	Reserved for Future Use		491-500	10
85	Employee Social Security Number	N	501-509	9
86	Employer Federal Tax Number	N	510-518	9
87	Reserved For Future Use		519-522	4
88	Reserved For Future Use		523-526	4
89	Zip Code of Injury Site	A/N	527-531	5
90	Date of First Payment	N	532-539	8
91	Hospital Costs Amount Paid	N	540-548	9
92	Total Payments to Physicians	N	549-557	9
93	Reserved for Future Use		558-600	43

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	**Carrier Group Code** Report the code assigned by NCCI that corresponds to the dominant insurer in a carrier group.	N	2-6	5
3	**Filler** Fill positions 7–41 of this record with nines.	N	7–41	35
4	**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
5	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 (Valuation Level Code 006–138) that resides on NCCI's database and:

- Contains nonrejected values that have been incorrectly reported (i.e., mistakenly excluded or misrepresented), or
- 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 manual.

Note: Rejected reports do not reside on the database. Original or Subsequent reports that have rejected require a re-submission of the report.

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, and claims that should not have been reported (i.e., medical only, non-eligible DCI State, or Federal Act) can mistakenly be reported. For example, a medical only claim may have mistakenly been reported as an indemnity claim. Since medical only claims must not be reported, the claim must be removed from the database as soon as the data provider becomes aware of the error.

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

To correct an incorrect value:

- Report the appropriate Valuation Level Code (Positions 38–40)
- Report "R" in Replacement Report Code (Position 41)
- Report **all** data elements—because this is a complete replacement, the corrected data and the data that is unchanged must be reported according to the reporting requirements for each data element.

  Note: For specific instructions on subsequent reporting of claims that become medical-only or have been reclassified as a Federal Act or a non-eligible DCI state due to development from one report to the next, refer to Subsequent Reports in the **Reporting and Record Layouts** section (Part5) of this manual.

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 valuation levels (Valuation Level Code 006–138) unless a Replacement Report has been submitted to change the value:

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Reported to Insurer Date
- Claim Number Identifier

To change one or more of these data elements between valuations:

- Report the last valuation level (Valuation Level Code, Positions 38–40).
- Report "R" in Replacement Report Code (Position 41)
- Report **all** data elements—because this is a complete replacement, the revised data and the data that is unchanged must be reported according to the reporting requirements for each data element.
- Report the appropriate revised and previously reported key data elements as follows

To change one or more of these data elements at valuation:

- Report the valuation level of the report that is due (Valuation Level Code, Positions 38–40).
- Leave the Replacement Report Code (Position 41) blank.
- Report the current cumulative values for all data elements.
- Report the appropriate revised and previously reported key data elements.

Report the revised and previously reported key 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
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 42–53	Previous Claim Number Identifier—Positions 470–481

Example: Replacement Report to Revise Claim Number Identifier

After submitting a Subsequent Report with Valuation Level Code 030, 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	01
6	Valuation Level Code	38–40	030
7	Replacement Report Code	41	R
8	Claim Number Identifier	42–53	WC3922333
82	Previous Claim Number Identifier	470–481	WC9322333

Because this is a complete replacement, the revised data and **all** of the data elements that are unchanged must be reported according to the reporting requirements for each data element.

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

RESERVED FOR FUTURE USE

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

Accident 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 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.

Accident State Code

Field(s)	11
Positions(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 the same as the jurisdiction state.

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
Florida	09
Foreign Territory (Not Otherwise Classified)	80
Georgia	10
Hawaii	52
Idaho	11
Illinois	12
Indiana	13
Iowa	14
Kansas	15
Kentucky	16
Louisiana	17
Maine	18

State or Province	Code
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 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

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

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 or 04—Liability Over, 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 gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount. For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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 Incurred Indemnity Amount Total (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 original report was Temporary Partial (Benefit Type Code 07), and at subsequent loss valuation (18 months), the benefits now correspond to Impairment Income (Benefit Type Code 04). For this example, the Benefit Type Code and Benefit Amount Paid that were reported on the original 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).

- Original report

Valuation Level Code	**Benefit Type**	**Report:**	
006	Temporary Partial	Benefit Type Code = 07 (Positions 144–145)	Benefit Amount Paid = 4000 (Positions 146–154)

- Subsequent report

Valuation Level Code	Benefit Type	Report:	
018	Temporary Partial	Benefit Type Code = 07 (Positions 144–145)	Benefit Amount Paid = 4200 (Positions 146–154)
	Impairment Income	Benefit Type Code = 04 (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 (6 month) and subsequent (18 month) valuations. Therefore, Positions 146–154—Benefit Amount Paid was increased from $4,000 to $4,200.

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.

Zero-fill if the claim has become medical only (Claim Status Code 5).

Code	Description
01	**Death & Burial Benefits**—Benefits paid or payable for the death of the claimant resulting from a work-related accident or occupational injury or disease.
02	**Lifetime Income Benefits (LIBs)—**Benefits paid or payable for the life of the claimant for certain loss of limbs and/or injuries as established in the *Texas Labor Code,* §408.161.
03	**Supplemental Income Benefits (SIBs)—**Benefits paid or payable for the period during which the claimant has an impairment rating of at least 15% following the expiration of Impairment Income Benefits (Benefit Type Code 04).
04	**Impairment Income Benefits (IIBs)—**Benefits paid or payable for the period during which the claimant has an impairment rating of at least 1% after reaching maximum medical improvement.
05	**Temporary Income Benefits (TIBs)/Temporary Total Benefits—** Benefits paid or payable for the period during which the claimant, as a result of a work-related injury or illness, is unable to obtain and retain employment and which period precedes the date of maximum medical improvement.
07	**Temporary Income Benefits (TIBs)/Temporary Partial Benefits—** Benefits paid or payable for the period during which the claimant, as a result of the work-related injury, is unable to obtain or retain employment for his/her regular pay, but is receiving a reduced rate of pay and which period precedes the date of maximum medical improvement.
08	**Employers Liability—**Amounts paid for employers liability.

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 original report was Temporary Partial (Benefit Type Code 07), and at subsequent loss valuation (18 months), the benefits now correspond to Impairment Income (Benefit Type Code 04). For this example, the Benefit Type Code and Benefit Amount Paid that were reported on the original 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).

- Original Report

Valuation Level Code	Benefit Type	Report:	
006	Temporary Partial	Benefit Type Code = 07 (Positions 144–145)	Benefit Amount Paid = 4000 (Positions 146–154)

- Subsequent Report

Valuation Level Code	Benefit Type	Report:	
018	Temporary Partial	Benefit Type Code = 07 (Positions 144–145)	Benefit Amount Paid = 4000 (Positions 146–154)
	Impairment Income	Benefit Type Code = 04 (Positions 161–162)	Benefit Amount Paid = 951 (Positions 163–171)

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. Please note that Section 408.005, Texas Labor Code, prohibits the use of lump sum settlements in the Texas workers' compensation system; however, Impairment Income Benefits may be commuted in accordance with Section 408.128, Texas Labor Code.

Reporting Requirement: Report code 04 when reporting 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 (i.e., if Impairment Income Benefits have not been commuted) as of loss valuation, or if the claim becomes medical only (Claim Status Code 5).

Code	Description
04	**Impairment Income Benefits (IIBs)—** Lump Sum Settlement paid (i.e., IIBs have been commuted) or payable for the period during which the claimant has an impairment rating of at least 1% after reaching maximum medical improvement.

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

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 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.

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 the carrier code assigned by NCCI to identify the individual carrier submitting the claim.

Carrier Code is a key data element and must remain the same throughout DCI reporting (Valuation Level Codes 018–138), 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 manual.

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

Code	Cause of Injury	Narrative Description
a.	**Burn or Scald—Heat or Cold Exposures—Contact With**	
01	Chemicals	
02	Hot Objects or Substances	
03	Temperature Extremes	
04	Fire or Flame	
05	Steam or Hot Fluids	
06	Dust, Gases, Fumes, or Vapors	
07	Welding Operation	
08	Radiation	
09	Contact With, NOC	
11	Cold Objects or Substances	
14	Abnormal Air Pressure	
84	Electrical Current	
b.	**Caught In, Under, or Between**	
10	Machine or Machinery	
12	Object Handled	
13	Caught In, Under, or, Between, NOC	
20	Collapsing Materials (Slides of Earth)	Either Man-made or Natural
c.	**Cut, Puncture, Scrape—Injured By**	
15	Broken Glass	

Code	Cause of Injury	Narrative Description
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	
31	Fall, Slip, or Trip, NOC	
32	On Ice or Snow	
33	On Stairs	
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	
60	Strain or Injury, NOC	
61	Wielding or Throwing	
97	Repetitive Motion	Carpal Tunnel Syndrome
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	
70	Striking Against or Stepping On, NOC	
h.	**Struck or Injured By**	Includes Kicked, Stabbed, Bit, etc.
74	Fellow Worker; Patient	Not in Act of a Crime
75	Falling or Flying Object	
76	Hand Tool or Machine in Use	

77	Motor Vehicle	
78	Moving Parts of Machine	
79	Object Being Lifted or Handled	
80	Object Handled by Others	
81	Struck or Injured, NOC	Includes Kicked, Stabbed, Bit, etc.
85	Animal or Insect	
86	Explosion or Flare Back	
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	

Claim Number Identifier

Field(s)	8
Position(s)	42–53
Class	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes	12
Format	A/N 12, exclude embedded 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 (Valuation Level Codes 006–138), 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 manual.

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 original 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.

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

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, or 04—Liability Over, 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 gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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

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

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 ***Texas Basic Manual of Rules, Classifications and Rates for Workers' Compensation and Employers Liability Insurance***.

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

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).

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, extent of injury, 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, extent of injury, and/or disability by the insurer.

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

Examples of contests/disputes include:

- Compensability/extent of injury—whether the claim is a valid workers' compensation claim or whether an injury is related to a compensable workers' compensation claim.
- Degree of disability or impairment
- Type of benefits that should apply
- Termination of benefits

The Controverted/Disputed Case Indicator should be reported as "Y" if any of the above apply.

Date of First Payment

Field(s)	90
Position(s)	532-539
Class	Numeric (N)—Field contains only numeric characters
Bytes	8
Format	YYYYMMDD

Definition: The date on which the first indemnity payment was issued.

Reporting Requirement: Report the date that the first indemnity payment was issued. The Date of First Payment must be reported if any amount greater than zero is reported in:

- Benefit Amount Paid (Positions 146-154, 163-171, 180-188, 197-205, 214-222)
- Claimant Legal Amount Paid (Positions 323-331),
- Lump Sum Settlement Amount Paid (Positions 343-351, 354-362, 365-373, 376-384, 387-395, 398-406),
- 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)

The Date of First Payment must be equal to or greater than the Reported to Insurer Date (Positions 83-90).

Employee Social Security Number

Field(s)	85
Position(s)	501-509
Class	Numeric (N)—Field contains only numeric characters
Bytes	482-490
Format	N 9

Definition: A number assigned to an employee by the Social Security Administration.

Reporting Requirement: Report the employee's (claimant's) Social Security Number. Zero-fill if the claimant will not divulge the Social Security Number.

Employer Federal Tax Number

Field(s)	86
Position(s)	510-518
Class	Numeric (N)—Field contains only numeric characters
Bytes	9
Format	N 9

Definition: A number assigned to each employer for federal tax purposes. Also referred to as the Federal Employer Identification Number.

Reporting Requirement: Report the employer's Federal Tax Number. Zero-fill if unavailable.

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 gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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

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. An Extraordinary Loss Event (ELE) catastrophe is a significant loss event from a workers' compensation perspective, which is determined by the Texas Department of Insurance for claims being paid under the Texas Workers' Compensation Act or by the respective state workers' compensation insurance rating bureau for claims being paid under that state's workers' compensation laws.

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.

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 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 Date.

Hospital Costs Amount Paid

Field(s)	91
Position(s)	540-548
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 directly to a hospital for in-patient and out-patient services received by the claimant for the work-related injury.

Reporting Requirement: Report the amount paid directly to a hospital for all in-patient and out-patient services. Examples of hospital costs are emergency room services, X-rays, and hospital lab tests.

The Hospital Costs Amount Paid must also be included in 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 Hospital Costs Amount Paid gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

Zero-fill if no hospital costs have been paid.

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: All impairment ratings in the Texas workers' compensation system are based on the whole body, therefore report Code 1 (Impairment percentage based on the whole body) in this field 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).

CODE	DESCRIPTION
1	Impairment percentage based on the whole body

Zero-fill if benefits are are based on a disability percentage or if the determination of benefits uses neither impairment nor disability percentages.

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 impairment or disability rating of a claim expressed as a percentage.

Reporting Requirement: Report the percentage of impairment or disability for those claims where an impairment rating or disability rating was used to determine benefits. This field must be completed if:

- Claimant has received Impairment benefits (Benefit Type Code 03, Supplemental Income or 04, Impairment Income,) and the corresponding Benefit Amount Paid (Positions 146-154, 163-171, 180-188, 197-205, 214-222) is greater than zero
- Claim Status Code (Position 126) is reported as "1" (Closed)

Zero-fill if other than listed above.

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. **Please note that impairment ratings in Texas are based on a whole body impairment percentage.

If a disability rating is reported in this field, zero-fill Impairment Percentage Basis Code (Position 312).

Incurred Indemnity Amount Total

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 or 04—Liability Over, then the entire amount of losses including allocated loss adjustment expenses (ALAE) must be reported as incurred indemnity.

The Incurred Indemnity Amount Total 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).
- 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 Incurred Indemnity Amount Total.

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).

Incurred Medical Amount Total

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 (Total Payments to Physicians, Positions 549-557), hospitals (Hospital Costs Amount Paid, Positions 540-548), drugs, physical rehabilitation, and other related services, excluding loss adjustment expenses (e.g., ALAE and ULAE).

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).

If Type of Claim—Loss Condition Code (Positions 99–100) is 02—Employers Liability Only, or 04—Liability Over, zero fill this field and include in Benefit Amount Paid (Positions 146–154, 163–171, 180–188, 197–205, 214–222).

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 Jurisdiction State Code 42 for payment of claimant's benefits being made under the *Texas Labor Code*.

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 due to development from one report to the next, use Jurisdiction State Code 59 on a subsequent report. Jurisdiction State Code 59 (Federal Act) is not a valid code if Valuation Level Code is 06. For information on subsequent reports, refer to the **Reporting and Record Layouts** section (Part 5) of this manual.

Note: For specific instructions on removing Federal Act or nonapplicable DCI state claims that were reported in error, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this manual.

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. Please note that Section 408.005, Texas Labor Code, prohibits the use of lump sum settlements in the Texas workers' compensation system; however, Impairment Income Benefits may be commuted in accordance with Section 408.128, Texas Labor Code.

Reporting Requirement: Report the amount paid to date as a lump sum settlement or annuity for Benefits Covered by Lump Sum Settlement Code 04-Impairment Income Benefits (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 gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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

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 Benefits Covered by Lump Sum Settlement Code (reported in the corresponding Benefits Covered by Lump Sum Settlement Code) positions.

If reporting Lump Sum Settlement Amount Paid in Positions ...	**Then the amount must correspond to Benefits 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

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 or the expiration of 104 weeks from the date that income benefits began to accrue, whichever is earlier.

Reporting Requirement: Report the Maximum Medical Improvement (MMI) Date for those claims where Benefit Type Code (Positions 144-145, 161-162, 178-179, 195-196, 211-213) is reported as 03, Supplemental Income or 04, Impairment Income and the corresponding Benefit Amount Paid (Positions 146-154, 163-171, 180-188, 197-205, 214-222) is greater than zero.

Maximum Medical Improvement (MMI) Date must also be reported if the Claim Status Code (Postition126) is Closed (01) and the claimant received only Temporary Income Benefits (Benefit Type Code 05 or 07).

Zero-fill if the Benefit Type Code is other than listed above or if the claimant has not been certified as to maximum medical improvement by the physician of the Commission at the time of loss valuation. Report the MMI date on a subsequent report.

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

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

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
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

Code	Nature of Injury	Narrative Description
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

Code	Nature of Injury	Narrative Description
52	Strain	Internal Derangement, the Trauma to the Muscle or the Musculotendinous Unit from Violent Contraction or Excessive Forcible Stretch
53	Syncope	Swooning, Fainting, Passing Out, no other Injury
55	Vascular	Cerebrovascular and Other Conditions of Circulatory Systems, NOC; excludes Heart and Hemorrhoids; includes Strokes, Varicose Veins—Nontoxic
58	Vision Loss	
59	All Other Specific Injuries, NOC	
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)	Manmade or Organic
67	Poisoning—Metal	Manmade

Code	Nature of Injury	Narrative Description
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	
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	

Code	Nature of Injury	Narrative Description
80	All Other Cumulative Injury, NOC	
c.	**Multiple Injuries**	
90	Multiple Physical Injuries Only	
91	Multiple Injuries Including Both Physical and Psychological	

Part of Body Code—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

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
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

Code	Part of Body	Narrative Description
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
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

Code	Part of Body	Narrative Description
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
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

Code	Part of Body	Narrative Description
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 and External Part such as a Back Injury that includes damage to the Nerves of the Spinal Cord
99	Whole Body	

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 Date (Positions 75–82).

Policy Effective Date is a key data element and must remain the same throughout Detailed Claim Information (DCI) reporting (Valuation Level Codes 006–138), 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 manual.

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.

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 (Valuation Level Codes 006–138), 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 manual.

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 weekly wage amount that the claimant earns and that is used to determine the benefits when the claimant returns to work. 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.

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 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 the ***Texas Basic Manual of Rules, Classifications and Experience Rating Plan for Workers' Compensation and Employers Liability Insurance***.

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 manual.

Zero-fill if Replacement Report Code (Position 41) is blank.

Previous Claim Number Identifier

Field(s)	82
Position(s)	470–481
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 42–53. For information on revising Claim Number Identifier, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this manual.

Zero-fill or leave blank if Replacement Report Code (Position 41) is blank.

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 manual.

Zero-fill or leave blank if Replacement Report Code (Position 41) is blank.

Previous Policy Number Identifier

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 Number Identifier, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this manual.

Zero-fill or leave blank if Replacement Report Code (Position 41) is blank.

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 manual.

Zero-fill or leave blank if Replacement Report Code (Position 41) is blank.

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

Recovery Reimbursement Amount

Field(s)	83
Positions(s)	482-490
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 of paid or anticipated recovery reimbursement.

Reporting Requirement: Report the recovery reimbursement amount as follows:

- Subrogation—Report the recovery reimbursement amount paid to date, less recovery expenses.
- Special funds (i.e., Second Injury Fund or Handicapped Workers' Reserve Fund)—Report the anticipated recovery amount. Anticipated reimbursement is defined as the amount expected to be reimbursed from such funds based on one of the following:
    - The rules governing these funds
    - A written agreement between these funds and the carrier on an amount
    - Percentage of the incurred cost, reimbursed to the carrier on a particular claim

Do not report deductible reimbursements in this field.

Zero-fill this field if any of the following applies:

- Recovery expenses are greater than the recovery amount,
- No subrogration recovery reimbursement has been received as of loss valuation, or
- No special fund recovery has been, or will be reimbursed as of loss valuation.

Replacement Report Code

Field(s)	7
Position(s)	41
Class	Alphanumeric (A) – Field contains alphabetic and numeric characters.
Bytes	1
Format	A/N

Definition: A code that indicates that a report should "replace" what is on the database due to incorrect value (not-rejected).

Reporting Requirement: Report Replacement Report Code "R" if the record being submitted corrects a nonrejected data element or data elements previously reported with an incorrect value.

The appropriate valuation level being replaced must also be identified. For example, to replace a report with Valuation Level Code 042, enter "R" in Replacement Report Code and "042" in Valuation Level Code (Positions 38—40).

Always submit replacement reports with the same key data elements: Carrier Code, 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 "R" in Replacement Report Code. For more information, refer to Replacement Reports in the **Reporting and Record Layouts** section (Part 5) of this manual.

Blank fill if the record being submitted is:

- An original report (Valuation Level Code 006)
- A resubmission of an original report due to rejected value (Valuation Level Code 006)
- A subsequent loss valuation update report (Valuation Level Code 018-138)
- A resubmission of a subsequent report due to rejected value (Valuation Level Code 018-138)

Code	Description
R	Replaces a previous report due to incorrect value (not rejected)

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 Date (Positions 75–82).

Use this date to determine original and subsequent valuations by comparing it with the DCI Due Date Table in this manual.

The Reported to Insurer Date must remain the same throughout DCI reporting (Valuation Level Codes 006–138), 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 manual.

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 Date (Positions 75–82).

Zero-fill if:

- Claimant has not returned to work as of loss valuation,
- Claimant returned to work but is not working as of loss valuation, or
- Claim Status Code 5—Became Medical Only is reported.

Return-to-Work Rate of Pay Indicator

Field(s)	74
Position(s)	416
Class	Alpha (A)—Field contains only alphabetic characters
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.

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).

Reporting Requirement: Report all paid amounts to date for physicians (Total Payments to Physicians, Positions 549-557), hospitals (Hospital Costs Amount Paid, Positions 540-548), drugs, physical rehabilitation, and other related services, excluding loss adjustment expenses (e.g., ALAE and ULAE).

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 gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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

Total Payments to Physicians

Field(s)	92
Position(s)	549-557
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 treating physicians, including all clinic and office visits.

Reporting Requirement: Report the amount paid to treating physicians, including all clinic and office visits.

This amount must also be included in Incurred Medical Amount Total (Positions 282-290) and 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 Total Payments to Physicians gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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.
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.
06	Excess Special Compensation—The loss is incurred under the provisions of excess coverage.

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.

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. Type of Recovery code 02, 03, or 04 must be reported if any amount greater than zero is reported in Recovery Reimbursement Amount (Positions 482-490).

Code	Description
01	**No Recovery**
02	**Second Injury Fund (Subsequent Injury Fund) Only**—Insurer has received, or anticipates receiving, reimbursement from the Second Injury Fund. The Second Injury Fund (also known as the Subsequent 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 and to reimburse insurers for overpayments resulting from a Division decision or order.
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 (Subsequent Injury Fund)**—Insurer has received reimbursement from both a Second Injury Fund and a third party.

Valuation Level Code

Field(s)	6
Position(s)	38–40
Class	Numeric (N)—Field contains only numeric characters
Bytes	3
Format	N 3

Definition: A code that corresponds to the loss valuation date.

Reporting Requirement: Report the code that corresponds to the loss valuation date per the Valuation Level Code table.

Code	Valuation Level
006	Valued 06 months from Reported to Insurer Date
018	Valued 18 months from Reported to Insurer Date
030	Valued 30 months from Reported to Insurer Date
042	Valued 42 months from Reported to Insurer Date
054	Valued 54 months from Reported to Insurer Date

Code	Valuation Level
066	Valued 66 months from Reported to Insurer Date
078	Valued 78 months from Reported to Insurer Date
090	Valued 90 months from Reported to Insurer Date
102	Valued 102 months from Reported to Insurer Date
114	Valued 114 months from Reported to Insurer Date
126	Valued 126 months from Reported to Insurer Date
138	Valued 138 months from Reported to Insurer Date

Vocational Rehabilitation Education Expense Amount Paid

Field(s)	48
Position(s)	264-272
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 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)

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 gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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

Vocational Rehabilitation Evaluation Expense Amount Paid

Field(s)	46
Position(s)	246-254
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 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)

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 gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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

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

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 Income 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)

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 gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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

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

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 gross of the recovery and report the recovery amount in Positions 482-490 (Recovery Reimbursement Amount). For claims subject to a deductible, report gross amounts (prior to the application of the deductible reimbursement amount). Deductible reimbursement amounts are not reported in DCI.

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

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

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 paid to the claimant for the corresponding Benefit Type.

Reporting Requirement: Report the most recent Weekly Benefit Amount paid to the claimant for the corresponding Benefit Type Code (Positions 144–145, 161–162, 178–179, 195–196, 212–213). In certain instances, a Weekly Benefit is not required, such as when specific indemnity losses have been paid. Refer to Lump Sum Settlement Amount Paid (Positions 343-351, 354-362, 365-373, 376-384, 387-395, 398-406) and Employers Liability Amount Paid (Positions 580-588).

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.

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 original report was Temporary Income Benefits/Temporary Partial (Benefit Type Code 07), and at subsequent loss valuation (18 months) the benefits now correspond to Impairment Income

(Benefit Type Code 04). For this example, the Benefit Type Code and Weekly Benefit Amount that were reported on the original 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).

- Original Report

Valuation Level Code	**Benefit Type**	**Report:**	
006	Temporary Partial	Benefit Type Code = 07 (Positions 144–145)	Weekly Benefit Amount = 150 (Positions 155–160)

- Subsequent Report

Valuation Level Code	**Benefit Type**	**Report:**	
018	Temporary Partial	Benefit Type Code = 07 (Positions 144–145)	Weekly Benefit Amount = 150 (Positions 155–160)
	Impairment Income	Benefit Type Code = 04 (Positions 161–162)	Weekly Benefit Amount = 275 (Positions 172–177)

Zip Code of Injury Site

Field(s)	89
Position(s)	527-531
Class	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes	5
Format	A/N 5

Definition: The first five digits of the nine digit US postal code that corresponds to the location where the injury occurred or the first five characters of the alphanumeric postal code if the injury occurred outside the US.

Reporting Requirement: Report the postal (US ZIP or Country) code that corresponds to the location where the injury occurred.

Zero-fill or leave blank if unavailable.

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