

COMMON EDITS

POLICY DATA EDIT OVERVIEW

DCOs edit policies in different ways. Some DCOs produce error listings only for policies reported electronically. DCOs may use a different editing philosophy on data used in the Proof of Coverage service. In summary, there is not a common editing method for all DCOs.

The following pages include representations of the type of policy edits performed by the DCOs. DCOs may edit more or less than the edits described.

FIELD NAME	WCPOLS RECORD LOCATION	EDIT
Carrier Code	Link	Must be numeric and other than 00000; must be valid per DCO Table.
Policy Effective Date	Link	Must be numeric; month must = 01-12; day must be 01-31; if leading "0" not present then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
Policy Effective Date	Link	Must be before Policy Expiration Date.
Policy Number	Link	Must be alphanumeric with no imbedded blanks, punctuation or more than 18 positions.
Classification Code	Exposure Record	Must be present and valid.
Federal Employers ID (FEIN)	Name Record	Must be numeric for policy transactions.
Insured Name	Name Record	Must be Alphanumeric; else invalid.
Mod Effective Date	Endorsement Record	Must be blank or numeric; month must be 01-12; day must be 01-31; if leading "0" not present move "0"; first 2 digits of year must be blank or numeric; last 2 digits must be numeric; else invalid.
Rate Effective Date	Endorsement Record	Must be blank or numeric; month must be 01-12; day must be 01-31; if leading "0" not present move "0"; first 2 digits of year must be blank or numeric; last 2 digits must be numeric; else invalid.
Policy Expiration Date	Header	Must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
Exposure State	Exposure Record	Must be alpha or numeric per state code table.
Policy Term Indicator	Header	If Policy Term Indicator submitted as blank, "0", "3", or "9" then default to "1".
Policy Term Indicator	Header	Policy period dates must = Policy Term Indicator (i.e., Policy Term "1" standard, one year (364-381 days).
Policy Type ID Code	Header	Must be numeric; must be "1"–"6".
Policy Total Estimated Standard Premium	Header	If Policy Term Indicator reflects 3 Year Fixed Rate then Policy Total Estimated Standard Premium must be <\$2100.
Prior Policy Number	Header	If Transaction Code = renewal must be present and be alphanumeric with no imbedded blanks or punctuation; If Transaction Code = new business must be blank.
Policy Total Estimated Standard Premium	Header	Must be numeric and > than "0".
Experience Rating Indicator	Header	Must be numeric; must = "1"–"5".
Producer Name	Header	If data is submitted in the Name of Producer field, it must begin in the first position.
Original Carrier Code	Header	If Transaction Code = rewrite or reissue must be present and valid per Carrier Code Table.
Original Policy Number	Header	If Transaction Code = Rewrite or Reissue must be present.
Original Policy Effective Date	Header	If Transaction Code = rewrite or reissue must be present; must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.

FIELD NAME	WCPOLS RECORD LOCATION	EDIT
Effective Date of Policy Changes	Header	If Transaction Code = "08" – "15" must be present; must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
Expiration Date of Policy Changes	Header	If Transaction Code = "08" – "15" must be present; must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
Cancel / Reinstate Effective Date	Cancellation Reinstate. Record	Must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric; must not be prior to Policy Effective Date.
Insured City & State	Address Record	Must contain City and valid State abbreviation.
Street Address	Address Record	Must be alphanumeric with no leading blanks.
Legal Nature of Insured	Header	Must be a valid code alpha or numeric per state code table.
Type of Address	Address Record	Must be numeric; must be "1" – "5".
Legal Nature of Entity	Name Record	Must be a valid code.
Effective Date of Policy Changes	Name Record	If Transaction Code = "08" – "15" must be present; must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
Expiration Date of Policy Changes	Name Record	If Transaction Code = "08" – "15" must be present; must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
Effective Date of Policy Changes	Address Record	If Transaction Code = "08" – "15" must be present; must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
Expiration Date of Policy Changes	Address Record	If Transaction Code = "08" – "15" must be present; must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
State Code	State Premium Record	Must be present; must be alpha or numeric per state code table.
State Add/Delete Indicator	State Premium Record	If Transaction Code = "15" State Add/Delete Indicator must not be blank on all State Premium Records or must be blank on at least one State Premium Record.
Experience Modification Status	State Premium Record	Must be numeric; must be valid per Experience Modification Status Table.
State Add/Delete Indicator	State Premium Record	Must be blank if Transaction Code not = "15".
Transaction Code	Link	If Transaction Code = "15" must not delete all states on the policy; policy must have at least one state of coverage to be valid.
Effective Date of Policy Changes	State Premium Record	If Transaction Code = '15' and State Add/Delete Indicator is = 'A' or 'D' then Effective Date of Policy Changes must be within the Policy Period.
Expiration Date of Policy Changes	State Premium Record	If Transaction Code = '15' and State Add/Delete Indicator is = 'A' or 'D' then Effective Date of Policy Changes must be within the Policy Period.

FIELD NAME	WCPOLS RECORD LOCATION	EDIT
Effective Date of Policy Changes	State Premium Record	If Transaction Code = "08" – "15" must be present; must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
Expiration Date of Policy Changes	State Premium Record	If Transaction Code = "08" – "15" must be present; must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
Estimated Premium	Exposure Record	Must be numeric.
Endorsement Number	Endorsement Record	Must be alphanumeric.
State Code	Endorsement Record	Must be present; must be alpha or numeric per state code table.
Insured Address (Address type 1)	Address Record	If Transaction Code = "01", "02", "04", "06", "07", "08" – "15" then the Insured Address Record must be present.
Carrier Address (Address type 3)	Address Record	If Transaction Code = "01", "02", "04", "06", "07", "08" – "15" then the Carrier Issuing/Service Office Address must be present.
Transaction Code	Link	If Transaction Code = "01", "02", "04", "06", "07", "08" – "15" then at least one State Premium Record must be present; a State Premium Record must be submitted for each state in which an Exposure Record is submitted.
Transaction Code	Link	If Transaction Code = "03" or "05" then must not have a Header Record.
Effective Date of Cancellation/Reinstatement Date	Cancellation/Reinstatement Record	The Cancellation/Reinstatement Date can not be a date before the Policy Effective Date or after the Policy Expiration Date.
Transaction Code	Header Record	If Transaction Code = "01", "02", "04", "06", "07", "08", "09", "10", "11", "12", "13", "14" & "15" then a header record must be present.
Transaction Code	Header Record	Two or more Header Records were submitted for the same Policy/Transaction.
Transaction Type	Cancellation/Reinstatement	Transaction Code was submitted as "05" but the Record Type was not "08".
Estimated State Standard Premium	State Premium Record	Estimated State Standard Premium Records for this policy/transaction must be zero. Must have at least one Estimated State Standard Premium greater than zero.
Transaction Type	Cancellation/Reinstatement	Transaction did not = "05" for submitted Record Type "08".
Exposure	Exposure Record	If Transaction Code = "01", "02", "04", "06", "07", "08", "09", "10", "11", "12", "13", "14" & "15" then exposure record must be present.
Effective Date of Policy Changes	Exposure Record	Transaction Code = "15" the Effective Date of Policy Changes on the Exposure Record for the state(s) being added or deleted not = to the Effective Date of the Policy Changes reported on the state's State Record Premium Record.
Expiration Date of Policy Changes	Exposure Record	Transaction Code = "15" the Expiration Date of Policy Changes on the Exposure Record for the state(s) being added or deleted not = to the Expiration Date of the Policy Changes reported on the state's State Record Premium Record.
Effective Date of Policy Changes	Exposure Record	If Transaction Code = "08" – "15" must be present, must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.

FIELD NAME	WCPOLS RECORD LOCATION	EDIT
Expiration Date of Policy Changes	Exposure Record	If Transaction Code = "08" – "15" must be present, must be numeric; month must be 01-12; day must be 01-31; if leading "0" not present, then move "0"; first 2 digits of year must be blank or numeric; last 2 digits of year must be numeric.
State Code	State Premium Record	Two or more duplicate State Premium Records were submitted for the same Policy/Transaction.
Cancellation Code	Cancellation/Reinstatement	Cancellation/Reinstatement submitted and Cancel code is not "1", "2", or "3" for Transaction Code "1" or not "0" for Transaction Code "2", "3", or "9". Defaulted to "1" for Transaction Code "1" and "0" for Transaction codes "2", "3", and "9".
Cancellation Code	Cancellation/Reinstatement	Cancellation/Reinstatement submitted, Cancellation does not = "0" for Transaction Code "2", "3", or "9" or is not "01" through "08" for Transaction Code "1" Defaulted to "06" for Transaction code "1" and to "00" for Transaction Codes "2", "3", and "9".
Effective Date	Cancellation/Reinstatement	Cancellation/Reinstatement Effective Date was not submitted in the Valid YYMMDD format or contained alphas and/or spaces.
Effective Date	Endorsement Record	Effective Date of Endorsement Record was not submitted in valid YYMMDD format, or contained alphas and/or spaces.
Experience Modification Factor	State Premium Record	The Experience Mod Factor was submitted with "0000", spaces or alphas (and the state code was not 04), or as "9999".
Expense Constant	State Premium Record	Expense Constant submitted with spaces or alphas.
Experience Modification Status	State Premium Record	The Experience Mod Status was submitted as "3" (Mod not Applicable), but the Experience Modification Factor was not submitted as 1.000 (or 0000 for CA).
Total Estimated State Standard Premium	State Premium Record	Total Estimated State Standard Premium contains spaces and/or alphas.
Transaction Type	Cancellation/Reinstatement	Transaction Code was not "1", "2", "3", or "9".
Loss Constant	State Premium Record	Loss Constant submitted with alphas or spaces.
Premium Discount	State Premium Record	Premium Discount was submitted with alphas or spaces or the Premium Discount was = to or greater then the State Standard Premium.
Reinstatement Code	Cancellation/Reinstatement Record	Reinstatement Code is not = to "1", "2", "3" for Transaction Code "2" or is not "0" for Transaction Code "1", "3", or "9". Default to "1" for Transaction Code "2" and "0" for Transaction Code "1", "3", and "9".
Date Cancellation Mailed Employer	Cancellation/Reinstatement Record	Date Cancellation Mailed Employer was not submitted with YYMMDD or contained alphas and/or spaces or submitted as zeros when Transaction Code is "1", or "3". Default to cancellation Effective Date.

UNIT STAT DATA EDIT OVERVIEW

DCOs use different editing philosophies concerning unit reports. As unit report editing becomes more sophisticated, i.e., editing back to policies, or prior reports; the elimination of redundant coding will become a reality.

In view of the different needs and data collection requirements of the DCOs, the editing methods can differ from jurisdiction to jurisdiction. However, with the introduction of software packages for editing, standardization of some basic edits has materialized. The software packages cannot edit back to a DCO's database (at this time). In summary, data is validated using the following types of edits:

- **Fatal Editing (Reject Errors)** – Edits that the data reported contains those elements critical to the linking and identification process; e.g., policy number. The data is flagged as a reject error, and is usually not captured on the DCO's database.
- **Link Editing (Unmatched)** – Through the use of key fields; i.e., company code, policy number, policy effective date, state, report number and claim number, data is tied together both within the same data type and amongst data types.
- **Basic Editing** – Edits for numeric, alpha or alphanumeric fields; blanks vs. zeroes; whether values within a field are valid.
- **Relational Editing** – Edits that the data reported in one field is valid in relationship to another field(s) reported for the same data type and/or among other data types.
- **Net Editing** – Edits that the data remains valid and reasonable throughout the life of a particular policy, unit report, financial report, etc. For example, correction report properly corrects prior data, while revised data meets all applicable editing criteria; e.g., loss without payroll on correction reports. Please note that not all DCOs edit in this manner.
- **Range or Tolerance Editing** – Edits that the data reported in a particular field falls within a specified range or tolerance; e.g., Incurred Medical Amount does not fall within range. Please note that all DCOs do not edit in this manner.
- **Reasonability/Suspect Editing** – Edits that the data reported, although valid, is reasonable overall; e.g., if the total indemnity and medical losses for a claim is greater than or equal to \$500,000 at any point and a significant fluctuation occurs, an explanation should be provided. Please note that not all DCOs edit in this manner.

The following pages include representations of the type of unit report edits performed by the DCOs. DCOs may edit more or less than the edits described.

FIELD NAME	EDIT LOGIC
Previously Reported Indicator	Must be 0 or 1, or P or R.
Previously Reported Indicator	Must be 0 for Report Number 1 with Correction Sequence Indicator = 0.
Correction Type	Must be blank, H, E, L, A, T or M.
Policy Expiration Date	Policy Expiration Date must be the Policy Expiration Date reported on the policy.
Insured Name	If name is blank or contains unreadable characters and unit is not matched.
Previous Carrier Code	If Previous Carrier Code is not = blank or zeroes and Correction Type = H or M, then Previous Carrier Code must be numeric and valid.
Previous Carrier Code	Previous Carrier Code must be zeroes if Correction Type does not = H or M.
Previous Carrier Code	Previous Carrier Code cannot be the Carrier Code.
Carrier Code	Must be numeric and valid.
Correction Type	If Correction Type = E, then Report Number must be 01.
Policy Effective Date	Must be < than the policy expiration date.
Report Number	Must = 1-9, and A-Z.
Exposure State Code	Must = 01-58.
Correction Sequence Number	If Correction Type = H, E, L, A, T, or M, then Correction Sequence Number must be present and sequential to last correction report on database.
Date of Receipt	Unit Report must not be received prior to loss valuation date; e.g., if policy effective date for unit is January 1999 and it is received in June of 2000, then reject it.
Update Type	If the Report Number is = 1 and the Correction Sequence Number = 0, then the Correction Type and Update Type must be blank. If the Report Number is > 1 and the Correction Sequence Number = 00, then the Correction Type must be blank and the Update Type must be A, C, D, P, or R. Report Number is > or = 1 and the Correction Sequence Number is >0, then the Correction Type must = H, E, L, A, T or M and the Update Type must be A, C, D, P or R.
Correction Sequence Number	Must be 0-9, or A-Z.
Policy Effective Date	Must be numeric and valid; i.e., month must be 01-12, day must be 01-31, and year must be numeric. Must = the Policy Effective date reported on the Policy.
Policy Number Identifier	Must be reported; cannot be blank filled.
Record Type	Must = 1, 2, 3, 4, 5, 6, 7 or 9.
Classification Code	Must be present and valid as indicated on the classification code table.
Exposure Amount	Must be numeric.
Exposure Amount	Must be present for classification in class code table.
Exposure Amount	Must be 0 if code listed is a statistical code.
Manual Rate	Must be numeric.
Premium Amount	Must be numeric.
Premium Amount	Exposure divided by 100 x manual rate reported on the unit must be the Premium Amount. (Note: Not applicable in California for policies effective 1-1-95 and later) (excluding per capita classes)
Experience mod	Must be blank or numeric.
Classification Code	Confirm that Exposure Class Code 0900, expense constant, is not duplicated on unit. (Pertains to 1st reports and revised sides of exposure correction reports.)

FIELD NAME	EDIT LOGIC
Classification Code	Confirm that no losses are reported on unit with Exposure Class Code = 1111, "If Any" Exposures. (Pertains to 1st reports.)
Classification Code	If Class Code = 9663 or 9664, then the deductible type codes must be valid.
Accident Date	If the Number of Claims = 1, then the Accident Date must be valid.
Accident Date	Accident Date must be = or > the Policy Effective Date and = or < Policy Expiration Date.
Incurred Indemnity	If Injury Type = 01, 02, 03, 04 or 09, then Incurred Indemnity must be present.
Incurred Medical	If Injury Type = 06 or 07, then Incurred Medical amount must be present.
Class Code	If loss class code present, must have corresponding exposure class code. (Excludes code 7777).
Injury Type (Code)	Must be numeric and be 01, 02, 03, 04, 05, 06, 07, 08, 09.
Injury Type (Code)	Must be valid Injury Type for state and accident date.
Loss Condition Act	Must be numeric and be 01, 02, 03 and 04.
Loss Condition – Type of Loss	Must be numeric and be 01, 02 or 03.
Loss Condition – Type of Recovery	Must be numeric and be 01, 02, 03 and 04.
Loss Condition – Type of Coverage	Must be numeric and be 01, 02 or 03.
Loss Condition – Type of Settlement	Must be numeric and be 00, 03, 04, 05, 06 or 09.
Jurisdiction State	If present, must be valid per state table.
Catastrophe No.	Must be numeric or blank.
Social Security No.	Must be numeric.
Injury – Part of Body	Must be numeric and valid according to table.
Injury – Nature of Injury	Must be numeric and valid according to table.
Injury – Cause of Accident	Must be numeric and valid according to table.
Fraudulent Claim Code	If present, must be 00, 01, or 02.
Paid Indemnity	If Claim Status = 1 and Incurred Indemnity is present, then Paid Indemnity must be Incurred Indemnity; unless anticipated recovery.
Paid Medical	If Claim Status = 1 and Incurred Medical is present, then Paid Medical must = Incurred Medical; unless anticipated recovery.
Deductible Reimbursement	Deductible Reimbursement Amount cannot be > the total of the incurred indemnity and medical.
Allocated Loss Adjustment Expense Paid (ALAE)	If ALAE Incurred > 0, ALAE Paid < or = ALAE Incurred.
Claim Number	Must be reported if Accident Date is not = zeroes or blank.
Claim Number	If Number of Claims is >1, then Claim Number should be blank or all zeroes.
Class Code	For coal mine class codes, confirm that the Loss Coverage Code does not indicate disease coverage.
Class Code	For coal mine disease class codes, confirm that the Loss Coverage Code indicates disease coverage.
Class Code	Must be present and valid as indicated on the classification code table.
Loss Coverage Code	Must be numeric and valid according to pertinent state's code table and accident date.
Number of Claims	Must be numeric.
Number of Claims	Must be > or = 1 except for claims for Injury Type 7.
Number of Claims	If the Number of Claims > 1, then the average amount of Incurred Indemnity and Medical must be < or = to \$2,000.
Number of Claims	If the Number of Claims is > 1, then the Accident Date must be zero or blank.

FIELD NAME	EDIT LOGIC
Paid Indemnity	If present, must be < or = Incurred Indemnity.
Paid Medical	If present, must be < or = to Incurred Medical.
Injury Type (Code)	Confirm that originally reported Injury Type = 1 is not revised to another Injury Type on subsequent report.
Policy Expiration Date	Must be numeric and valid: month must be 01-12, day must be 01-31, and year must be numeric.
Interstate Rated Policy	If indicator = Y, then Experience Modification Factor must be present.
Deductible Percent	Must be numeric and rounded to the nearest whole percent.
Deductible Amount Per Claim/Accident	Must be numeric.
Deductible Amount Aggregate	Must be numeric.
Canceled Policy Indicator	Must be 0 or 1; Y or N
Plan Indicator	Must be 01 or 02 for all reports.
Mod Effective Date	Modification Effective Date must be < Policy Expiration Date if the class code is subject to modification.
Rate Effective Date	If the Exposure Class Code has a manual rate, the Rate Effective Date must be < than the Policy Expiration Date.
Previous Correction Sequence Number	If the Previous Correction Sequence Number is not = 0 and Correction Type = H or M, then Previous Correction Sequence Number must be 1-9 or A-Z.
Previous Correction Sequence Number	Previous Correction Sequence Number must be blank or 0 for correction types not = H or M.
Previous Correction Sequence Number	Previous Correction Sequence Number cannot be the Correction Sequence Number.
Previous Policy Number	Previous Policy Number cannot be the Policy Number.
Previous Policy Effective Date	If the Previous Policy Effective Date does not = blank or zeros and Correction Type = H or M, then it must be a valid date.
Previous Policy Effective Date	Previous Policy Effective Date must be blank or zeros if the Correction Type does not = H or M.
Previous Policy Effective Date	Previous Policy Effective Date cannot be the Policy Effective Date.
Previous Exposure State	If the Previous Exposure State does not = zeros and the correction type = H or M, then it must be a valid state code.
Previous Exposure State	Previous Exposure State must be blank or zeros if the Correction Type does not = H or M.
Previous Exposure State	Previous Exposure State cannot be the Exposure State.
Claim Number	If Update Type = blank, C, D or P and Correction Type = L, A, or M, the claim number on the unit report must be the Claim Number reported on the prior unit report for subsequent and correction reports.

INDIVIDUAL CASE/CLAIM DATA EDIT OVERVIEW

DCOs use different editing philosophies related to Individual Case/Claim Reports (ICRs). The driving force in each state is the unique requirements and criteria for that state.

Helpful Hints

The following are some helpful hints for reporting ICRs:

- Should be filed concurrently with submission of associated unit stat report.
- Must meet criteria for each state; e.g., death claim.
- Information on the ICR should agree with information reported on the unit stat report.
- The same edits apply to information that is reported on both the unit stat report and the ICR; e.g., carrier code must be 5-digit numeric.

There is no universal set of edits that is used by all DCOs collecting ICR data.

DETAILED CLAIM DATA EDIT OVERVIEW

Detailed Claim Information (DCI) is collected and edited by the NCCI. There are two types of DCI collected-Texas and all other. The editing for Texas and traditional DCI are similar. The following pages summarize these edits.

It should be noted that the edits shown on the following pages may not be the actual edits used by the DCO.

DETAILED CLAIM DATA EDITS

REJECT EDITS

A "reject error" is a critical error that causes a form or record to be rejected from the database. The following are reject edits:

DESCRIPTION

CARRIER CODE, POLICY NUMBER OR CLAIM NUMBER INVALID

One or more of the following fields are invalid: Carrier Code, Policy Number, or Claim Number

Submission of the following conditions will cause this error:

Carrier Code

- not a valid NCCI Carrier Code
- all blank

Policy Number and/or Claim Number

- embedded blanks
- special characters or marks of punctuation
- not left-justified (Policy number)
- not right-justified (Claim number)

REPORT OR TRANSACTION CODES INVALID

One or both of the following fields are invalid: Report Type or Transaction Code

Submission of the following conditions will cause this error:

Report Type

- not equal to 1 through 9

Transaction Code

- not equal to 1 through 3

CLAIM STATUS INVALID

The Claim Status indicator must be equal to 1 (open), 2 (open-Med only), or 4 (closed) when (Report Type) is equal to 1 (6 month evaluation)

NO CLAIM ON FILE FOR SUBSEQUENT, CORRECTION OR REVISION

Report Type = 2-9, using Carrier Code, Policy Number and Claim Number, no claim is found (matched on database)

NO REPORT TYPE FOR CLAIM ON FILE FOR CORRECTION

Transaction Code 3 (Correction Report) is submitted. There is a match against the database using the three fields, Carrier Code, Policy Number and Claim Number, but no match for the Report Type being submitted.

This reject error occurs when a correction is submitted for a Report Type not in the database.

VALID REPORT ALREADY ON FILE; NO CORRECTION NEEDED

Transaction Code 3 (Correction Report) is submitted. There is a match against the database using the four fields Carrier Code, Policy Number, Claim Number and Report Type, but the claim on the database is valid. A valid report can only be revised (Transaction Code 2) when carriers need to change a valid claim existing in the database.

DATE REPORTED TO INSURER INVALID

The date reported in "Date Reported to Insurer" does not pass the standard date edit, is prior to the Date of Injury, or is after the date the report is submitted to the DCO.

REVISION NOT ALLOWED; REPORT TYPE NOT RECEIVED

Transaction Code 2 (Revised Report) is submitted. There is a match against the database using the three fields Carrier Code, Policy Number and Claim Number, but no match for the Report Type being submitted.

CLAIM PENDING DELETION; REPORT INVALID

A report has been submitted for a claim for which the carrier has sent in a Common Information Change Form indicating that the claim should be deleted as per the Deletion Reason Code on the CIC. No further activity can be performed on a claim that the carrier has indicated should be deleted from the database.

CLAIM CLOSED; REOPEN REQUIRED FOR THIS REPORT

A subsequent report (Report Type 2 through 9) is submitted for a claim that was reported as closed on the prior report.

This edit is not performed if the Claim Status was reported as '3' (Reopened) or '6' (Reopened, Closed).

REPORT TYPE ALREADY ON FILE FOR CLAIM (Duplicate Report Type)

A subsequent report (Report Type 2 through 9) is submitted; however, a claim already exists in database with the same Carrier Code, Policy Number, Claim Number and Report Type. Duplicate Report Types are not accepted.

REPORT SUBMITTED FOR OPEN CLAIM BEFORE VALUATION DATE

This reject error is generated when a claim is submitted to DCO before its valuation date. The six-month report should be valued six months after the claim is reported and filed with the DCO within the next 60 days. Subsequent valuations should be submitted every 12 months but not before the valuation date. Example – claim occurs on 1/3/00 and is reported to stat agent on 5/15/00.

REVISION TO CLOSE NOT ALLOWED; SUBSEQUENT CLAIM OPEN ON DATABASE

Transaction Code 2 (Revised Report) has been submitted closing a claim for a given Report Type. A subsequent Report Type is currently in the database containing a Claim Status of other than '4' (Closed) or '6' (Reopened, Closed). A claim cannot be closed as of a given report if subsequent reports indicate that the claim is open.

DUPLICATE CLAIM WITH DIFFERENT REPORT TYPE

This reject error is generated when duplicated claims with different report types are included in the same submission. Duplicate claims have identical Carrier Codes, Policy Numbers and Claim Numbers. The earliest report type can be processed; all subsequent report types are rejected as reject errors.

REVISION CAUSED CURRENTLY VALID REPORT TO FAIL

Transaction Code 2 (Revised Report) is submitted. There is an error contained on the Revised Report that caused the currently valid claim in the database to fail edits. The revision is not accepted as a valid claim in the database and should not be updated with revised information that fails any edits.

CLAIM ALREADY ON FILE FOR NEW CLAIM

An original report (Report Type 1 and Transaction Code 1) is submitted. A claim for this six-month report already exists in database with the same Carrier Code, Policy Number and Claim Number. Duplicate Report Types are not accepted.

INVALID REPORT TYPE FOR CORRECTION REPORTS

Transaction Code 3 (Correction Type) is submitted for a Report Type not currently residing in database. Corrections can only be accepted for claims identified as being in error and for which the DCO had generated a correction report. Carrier initiated corrections are not allowed. Any revisions the carrier needs to make to a valid claim should be done using Transaction Code 2 (Revised Report).

INVALID REPORT TYPE FOR SUBSEQUENT REPORTS

Report Type 2 through 9 and Transaction Code 1 (Original Report) are submitted, but there is no prior report type in the database, although there are reports previous to the prior report. For example, a carrier submits a Report Type 3 when there is no Report Type 2 in the database for this claim. There is, however, a Report Type 1. In this case, the carrier has caused gaps in the reporting flow of the claim which is unacceptable. Exception: Reports submitted with a Claim Status of '3' (Reopened) or '6' (Reopened, Closed) are acceptable.

COMMON INFORMATION CHANGE (CIC) FORM EDITS

Common Information Change (CIC) forms can also contain reject errors. Because of the importance of CICs any discrepancies found on the forms will cause a reject error.

The reject edits for CICs are mainly in relation to field validations, i.e., alpha or numeric field specifications, or specifically linked to the database in that the previous information reported on the CIC must match exactly to information already residing in the database.

The following are CIC reject edits:

Previous Carrier Code contains other than numeric characters.

Previous Policy Number contains other than numeric or alphanumeric characters.

Previous Claim Number contains other than numeric or alphanumeric characters.

Previous Date Reported to Insurer contains other than numeric characters.

Previous State of Jurisdiction contains other than numeric characters.

Previous Date Reported to Insurer is not a valid date or is a date other than the date currently residing in the database for the claim.

Claim Record as previously reported cannot be found in the database using the key fields (Carrier Code, Policy Number and Claim Number).

Deletion Reason Code provided does not equal 01, 02 or 03.

Multiple CICs submitted for the same claim number, carrier code and policy number.

Revised Carrier Code contains other than numeric characters.

Revised Policy Number contains other than numeric or alphanumeric characters.

Revised Claim Number contains other than numeric or alphanumeric characters.

Revised Date Reported to Insurer contains other than numeric characters.

Revised Date Reported to Insurer is not a valid date.

Common Information as revised already exists in the DCI database.

Revised Carrier Code is not a valid NCCI Carrier Code.

Previous and Revised Information contained on the CIC are exactly the same.

Claim Information as revised already exists in the DCI database.

Claim has already been deleted via a previous CIC.

Revised Date Reported to Insurer conflicts with claim reports.

Revised Data submitted with Deletion Reason Code.

No Change Allowed; Claim Has Been Deleted.

PRIORITY EDITS

Priority edits are different from reject edits in several respects. Logical edits pertain mainly to individual fields or the relationship between fields on a given form. Priority edit failures do not occur due to an invalid interaction with information already contained in the database as is usually the case with reject errors.

DESCRIPTION

COMMON INFORMATION:

- * **CARRIER CODE**
Carrier code must be a valid NCCI Carrier Code.
- * **POLICY NUMBER**
Policy Number may contain only characters A through Z or 0 through 9.
- * **POLICY EFFECTIVE DATE**
Policy Effective Date must pass the Standard Date Edit.

Policy Effective Date must be earlier than or equal to the Date of Injury.
- * **CLAIM NUMBER**
Claim Number may contain only characters A through Z or 0 through 9.
- * **REPORT TYPE**
Report Type must be equal to a number from 1 to 9.
- * **TRANSACTION CODE**
Transaction Code must be equal to 1, 2 or 3.
- * **STATE OF JURISDICTION**
State of Jurisdiction must be numeric and valid.
- * **STATE OF ACCIDENT**
State of Accident must be valid.
- * **DATE REPORTED TO INSURER**
Date Reported to Insurer must pass the Standard Date Edit.

Date Reported to Insurer must be later than or equal to the Date of Injury.

Date Reported to Insurer must be earlier than the date that the DCI report was received by the DCO.
- * Failing this priority edit will also cause a reject error
- * **EMPLOYEE SOCIAL SECURITY NUMBER**
Employee Social Security Number must be a 9-digit number.

CLAIMANT AND EMPLOYER INFORMATION:

EMPLOYER FEDERAL TAX NUMBER (FEIN)

Employer Federal Tax Number must be a 9-digit number.

EMPLOYER SIC CODE

Employer SIC Code must be a 4-digit number.

EMPLOYER PAYROLL

Employer Payroll indicator must = 1, 2, 3, 4, or 5.

ZIP CODE OF INJURY SITE

ZIP Code of Injury Site must be a 5-digit number. This field may contain alpha characters if the State of Accident is outside the United States of America.

ZIP Code of Injury Site must be valid for the State of Accident indicated.

EMPLOYEE NAME

Employee Name must be left-justified and only contain up to 6 characters, A through Z, followed by blanks, if necessary. First initial must be an alpha character.

SEX

Sex indicator must = 1, 2 or 3.

MARITAL STATUS

Marital Status indicator must = 1, 2, 3, or 4.

DATE OF BIRTH

Date of Birth must pass the Standard Date Edit.

Date of Birth must be earlier than or = to Date of Injury.

DATE OF HIRE

Date of Hire must pass the Standard Date Edit.

Date of Hire must be earlier than or = to the Date of Injury.

EMPLOYMENT STATUS

Employment Status indicator must be = to 1, 2, 3, 4, 5, 6 or 7.

DATE OF INJURY

Date of Injury must pass the Standard Date Edit.

Date of Injury must be prior or = to the Date Reported to Employer.

CLASS CODE

Class Code must be a valid Standard Classification Code.

PART OF BODY

Part of Body code must be valid.

Part of Body code indicated must be consistent with the Nature of Injury.

NATURE OF INJURY

Nature of Injury code must be valid.

Nature of Injury code indicated must be consistent with the Cause of Injury.

CAUSE OF INJURY

Cause of Injury code must be valid.

Cause of Injury code indicated must be consistent with the Part of Body.

LOSS COVERAGE CODE

Loss Coverage Code must = 10, 11, 12, 14, 15, 17, 18, 41, 44 or 47.

Loss Coverage Code must be consistent with the combination of Part of Body Nature of Injury and Cause of Injury indicated.

NUMBER OF DEPENDENTS

Number of Dependents must be a 2-digit number.

PRE-INJURY WEEKLY WAGE

Pre-Injury Weekly Wage must be numeric.

METHOD OF DETERMINING PRE-INJURY WAGE

Method of Determining Pre-Injury Wage indicator must = 1, 2, 3 or 4.

OTHER WEEKLY PAYMENTS

Other Weekly Payments must be numeric.

DATE REPORTED TO EMPLOYER

Date Reported to Employer must pass the Standard Date Edit.

Date Reported to Employer must be earlier than or equal to the Date Reported to Insurer.

SURGERY

Surgery indicator must = 1 or 2.

CLAIM STATUS

* Claim Status indicator must = 1, 2, 3, 4 or 6.

* Claim Status indicator must = 1, 2 or 4, when Report Type is equal to 1.

DATE OF CLOSING

Date of Closing must pass the Standard Date Edit if the claim is closed, claim status = 4 or 6.

If present, Date of Closing must be later than or equal to the Date Reported to Insurer.

DATE OF FIRST PAYMENT

Date of First Payment must pass the standard date edit if indemnity payments have been made, and Benefits Paid to Date Fields, Vocational Rehabilitation Evaluation Expense Paid to Date Field, Vocational Rehabilitation Maintenance Benefits Paid to Date, Vocational Rehabilitation Education Expense Paid to Date Field, Other Vocational Rehabilitation Paid to Date Field or Lump Sum Settlement Amount is greater than zero.

If present, Date of First Payment must be later than or equal to the Date Reported to Insurer.

DATE OF RETURN TO WORK

If present, Date of Return to Work must pass the Standard Date Edit.

If present, Date of Return to Work must be later than or equal to the Date of Injury.

Date of Return to Work must be left blank if any Benefit Type Field = 01.

BENEFITS AND PAYMENTS:

TOTAL INCURRED INDEMNITY

Total Incurred Indemnity must be numeric.

Total Incurred Indemnity must be zero if Benefit Type is = to 06.

BENEFIT TYPE

Benefit Type must be valid according to the Benefit Type Code.

Specific Benefit Types may be entered only one time per claim, e.g., cannot have 2 Benefit Type 04 for example.

Benefit Type must be 06 when Total Incurred Indemnity is equal to zero and the loss coverage code does not denote subrogation Loss Coverage Code = 11, 14, 17, 41, 44 or 47).

If Benefit Type is equal to 01 and there are no other Benefit Types fields with codes, then Date of Return to Work, Post-Injury Weekly Wage, Percentage of Impairment, and Date of Maximum Medical Improvement must be blank or zero filled.

BENEFITS PAID TO DATE

Benefit Paid to Date must be numeric if Benefit Type has been completed.

Benefit Paid to Date that corresponds to Benefit Type 01 must be greater than or equal to Funeral Expenses Paid to Date.

Benefit Paid to Date that corresponds to Benefit Type 08 must be greater than or equal to Employers Liability Paid to Date.

Benefit Paid to Date Fields must be zero when Benefit Type is equal to 06.

WEEKLY BENEFIT

Weekly Benefit must be numeric if Benefit Type has been completed.

Weekly Benefit must fall within the minimum or maximum benefits of the state if the corresponding Benefit Paid to Date is greater than zero and the corresponding Benefit Type is equal to 03, 04, or 05.

Weekly Benefit must be zero for Benefit Type 06, 08 or 50.

Weekly Benefit must be zero for Benefit Type 01, if corresponding Benefit Paid to Date minus Funeral Expenses is equal to zero.

TOTAL INCURRED VOCATIONAL REHABILITATION

Total Incurred Vocational Rehabilitation must be numeric.

TOTAL INCURRED MEDICAL

Total Incurred Medical must be numeric.

Total Incurred Medical must be greater than zero when Surgery (Code) equals 1 (Yes).

HOSPITAL COSTS PAID TO DATE

Hospital Costs Paid to Date must be numeric.

TOTAL PAYMENTS TO PHYSICIANS

Total Payments to Physicians must be numeric.

OTHER MEDICAL PAID TO DATE

Other Medical Paid to Date must be numeric.

POST-INJURY WEEKLY WAGE

If present, Post-Injury Weekly Wage must be numeric.

Post Injury must be left blank if any Benefit Type Fields = 01.

PERCENTAGE IMPAIRMENT

Percentage Impairment must be numeric.

DATE OF MAXIMUM MEDICAL IMPROVEMENT

Date of Maximum Medical Improvement must pass the Standard Date Edit.

If present, Date of Maximum Medical Improvement must be later than or equal to the Date of Injury.

FUNERAL EXPENSES

If Funeral Expenses are greater than zero, Benefit Type must be equal to 01.

LUMP SUM SETTLEMENT AMOUNT

Lump Sum Settlement Amount must be numeric.

EMPLOYERS' LIABILITY PAID TO DATE

Employers' Liability Paid to Date must be numeric.

ATTORNEY OR AUTHORIZED REPRESENTATIVE

Attorney or Authorized Representative indicator must be equal to 1 or 2.

CONTROVERTED/DISRUPTED CASE

Controverted/Disrupted Case indicator must be equal to 1 or 2.

DEDUCTIBLE

Deductible indicator must be equal to 1 or 2.

PRODUCT LIABILITY SUBROGATION

Product Liability Subrogation must be numeric.

If Product Liability Subrogation is greater than zero, then Loss Coverage Code must be equal to 10, 12, 15 or 18.

AUTOMOBILE LIABILITY SUBROGATION

Automobile Liability Subrogation must be numeric.

If Automobile Liability Subrogation is greater than zero, then Loss Coverage Code must be equal to 10, 12, 15 or 18.

OTHER SUBROGATION

Other Subrogation must be numeric.

If Other Subrogation is greater than zero, then Loss Coverage Code must be equal to 10, 12, 15 or 18.

EMPLOYER LEGAL EXPENSE PAID TO DATE

Employer Legal Expense Paid to Date must be numeric.

CLAIMANT LEGAL EXPENSE PAID TO DATE

Claimant Legal Expense Paid to Date must be numeric.

EXPERT WITNESS FEES PAID TO DATE

Expert Witness Fees Paid to Date must be numeric.

PENALTIES PAID TO DATE

Penalties Paid to Date must be numeric.

ALLOCATED LOSS ADJUSTMENT EXPENSE PAID TO DATE

Allocated Loss Adjustment Expense Paid to Date must be numeric.

Allocated Loss Adjustment Expense Paid to Date must be greater than or equal to Employer Legal Expense Paid to Date, when the claim does not include Employers' Liability (Loss Coverage Code = 10, 11, 12, 14, 15, 17 or 18).

SOCIAL SECURITY BENEFIT OFFSET

Social Security Benefit Offset indicator must be equal to 1 or 2.

UNEMPLOYMENT BENEFIT OFFSET

Pension Plan Benefit Offset indicator must be equal to 1 or 2.

SPECIAL FUND BENEFIT OFFSET

Special Fund Benefit Offset indicator must be equal to 1 or 2.

OTHER BENEFIT OFFSET

Other Benefit Offset indicator must be equal to 1 or 2.

AGGREGATE/FINANCIAL DATA EDIT OVERVIEW

For most DCOs, Aggregate/Financial data is edited as follows:

1. Basic edits – These edits determine if the fields are populated with numerics, zeros, blanks, etc. They also determine whether a total is equal to the sum of its components. Some DCOs also determine whether a particular element which is required on several different reports is consistently reported.
2. Actuarial or Reasonability edits – These edits, also called distribution edits, compare several fields to determine whether the answer is within a reasonable range.

These types of edits will compare the numbers shown on one report to the numbers shown on a separate report.

Helpful Hints

The following are helpful hints for reporting financial data:

1. The transmittal letter must agree with the financial data submission.
2. The submission must be complete for all states.
3. The annual statement may be required for some states. Other states may require the Insurance Expense Exhibit data, but not the entire annual statement.
4. The transmittal letter must be signed and dated.
5. If the data has been processed through a company's internal edits, or other edit packages, and errors were found, they should be corrected before submitting to the DCO.
6. For financial data that is reported on paper (hard copy), one of the more common errors is that the sums do not equal the numbers entered in the total fields.
7. For the Calendar Year Reconciliation (CYR) Report, the fields on this report should be compared to the figures shown on page 15, line 16, column (3), of the annual statement. Most DCOs require that differences of \pm \$1,000 be explained.

Reasonability edits are categorized as follows:

- Premium
- Loss
- Claim Count
- Defense and Cost Containment
- Policy Year/Accident Year Comparison
- Statewide/Assigned Risk Comparison
- Annual Statement/Financial Report Reconciliation
- Column Total

The edits refer to “Reasonableness Range.” For most states, a reasonableness range is generally determined based on the premium volume of the company and the standard deviation of the value tested in the validation edit. For example, the reasonableness ranges for a mid-sized state may be determined as follows:

Premium Volume	Reasonableness Range
>1% of total data for all carriers	1 standard deviation
Between .02% and 1% of total data for all carriers	2 standard deviations
<0.2% of total data for all carriers	3 standard deviations

The reasonableness ranges may be calculated separately for each year that the validation edit is performed.

In reviewing the edits on the following pages, some DCO’s may reject the data or require your company to provide an explanation. For example, premium writings of \$100,000 and no losses, are possible, but not common. A company would be asked to verify that there are no losses.

DCOs may edit more or fewer than the edits described, or the edits may vary from those edits listed in this handbook.

It should be noted that the edits shown on the following pages may not be the actual edits used by the various DCOs.

REASONABILITY EDITS – PREMIUM		
REPORTS	EDIT SPECIFICATION	RESULT
All policy years and latest 5 calendar-accident years.	The ratio of Net Premium to Uniform Reporting Level Premium separately by type of discount the company is using (“stock”/“non-stock”).	To verify that all premium discounts outside the reasonableness range are correct as reported. The reasonableness range will be calculated separately for “stock” and “non-stock” companies.
Latest 5 calendar/accident years.	The comparison of premium amounts between successive valuation dates of the calendar/accident year financial report.	To verify that the calendar year premium amounts do not change between successive valuation dates of the calendar/accident year financial report.
All policy years.	The ratio of Policy Year Uniform Reporting Level Premium between successive valuation dates.	To verify that all premium development values outside the reasonableness range are correct as reported.
Latest 3 policy years.	The ratio of uniform reporting level premium to company standard premium is the deviation. A deviation for a reporting company must be approved by the State Insurance Department.	To verify that the Policy Year Uniform Reporting Level Premium equals the Standard at Company Level Premium adjusted by approved deviation.
All policy years, latest 5 calendar/accident years.	If there are losses, there must be premium.	To verify that if any of the fields listed below are non-zero, then there must be premium reported >0. <ul style="list-style-type: none"> • indemnity paid • indemnity case reserves • indemnity bulk reserve • indemnity IBNR • medical paid • medical case reserves • medical bulk reserve • medical IBNR

REASONABILITY EDITS – LOSSES		
REPORTS	EDIT SPECIFICATION	RESULT
All policy years and accident years.	There must be a reserve on all open claims.	To verify that open indemnity claims exist in a year, then indemnity case reserves for that year must be >0.
All policy years and accident years (except “prior years”).	The ratio of indemnity paid losses between successive valuation dates.	To verify that all indemnity paid development values outside the reasonableness range are correct as reported.
All policy years and accident years (except “prior years”).	The ratio of indemnity paid plus case losses between successive valuation dates.	To verify that all indemnity paid plus case development values outside the reasonableness range are correct as reported.
All policy years and accident years (except “prior years”).	The ratio of medical paid losses between successive valuation dates.	To verify that all medical paid development values outside the reasonableness range are correct as reported.
All policy years and accident years (except “prior years”).	The ratio of medical paid plus case losses between successive valuation dates.	To verify that all medical paid plus case development values outside the reasonableness range are correct as reported.
Prior years only (both policy year and calendar/accident year financial reports).	The difference between prior years indemnity paid loss at successive valuation dates divided by indemnity paid loss in the oldest available year (policy year 1978, accident year 1979).	To verify that all values outside the reasonableness range are correct as reported.
Prior years only (both policy year and calendar/accident year financial reports).	The difference between prior years indemnity paid plus case losses at successive valuation dates divided by indemnity paid + case loss in the oldest available year (policy year 1978, accident year 1979).	To verify that all values outside the reasonableness range are correct as reported.
Prior years only (both policy year and calendar/accident year financial reports).	The difference between prior years indemnity paid plus case + IBNR losses at successive valuation dates divided by indemnity paid + case + adverse development + IBNR loss in the oldest available year (policy year 1978, accident year 1979).	To verify that all values outside the reasonableness range are correct as reported.
Prior years only (both policy year and calendar/accident year financial reports).	The difference between prior years medical paid loss at successive valuation dates divided by medical paid loss in the oldest available year (policy year 1978, accident year 1979).	To verify that all values outside the reasonableness range are correct as reported.
Prior years only (both policy year and calendar/accident year financial reports).	The difference between “prior years” medical paid plus case losses at successive valuation dates divided by medical paid + case loss in the oldest available year (policy year 1978, accident year 1979).	To verify that all values outside the reasonableness range are correct as reported.

REASONABILITY EDITS – LOSSES		
REPORTS	EDIT SPECIFICATION	RESULT
Prior years only (both policy year and calendar/accident year financial reports).	The difference between “prior years” medical incurred loss at successive valuation dates divided by medical incurred loss in the oldest available year (policy year 1978, accident year 1979).	To verify that all values outside the reasonableness range are correct as reported.
All policy years. All calendar/accident years.	The ratio of indemnity paid plus case losses to medical paid plus case losses.	To verify that all indemnity/medical ratios outside the reasonableness range are correct as reported.
All policy years. All calendar/accident years.	It is unusual for there to be significant premium for a reporting company without losses existing for that company as well.	To verify that if premium amounts in excess of \$100,000 are reported for a year, then the sum of the fields listed below must be greater than zero. <ul style="list-style-type: none"> • indemnity paid • indemnity case reserves • indemnity IBNR • medical paid • medical case reserves • medical IBNR

REASONABILITY EDITS – CLAIM COUNT		
REPORTS	EDIT SPECIFICATION	RESULT
All policy years. All calendar/accident years (except prior years).	The ratio of open + closed claims between successive valuation dates.	To verify that all claims counts development values outside the reasonableness range are correct as reported.
All policy years, latest 5 calendar/accident years.	The ratio of open + closed claims to uniform standard premium.	To verify that all claim frequencies outside the reasonableness range are correct as reported.
All policy years. All calendar/accident years.	The ratio of indemnity paid losses to closed claims (indemnity severity).	To verify that all indemnity paid severities outside the reasonableness range are correct as reported.
All policy years. All calendar/accident years.	The ratio of indemnity case reserve to open claims.	To verify that all indemnity case reserve ratios outside the reasonableness range are correct as reported.

REASONABILITY EDITS – DCC		
REPORTS	EDIT SPECIFICATION	RESULT
All policy years. All calendar/accident years.	The ratio of DCC paid + case reserves to open + closed claims.	To verify that all total DCC ratios outside the reasonableness range are correct as reported.
All policy years. All calendar/accident years.	The ratio of DCC case reserves to open claims.	To verify that all DCC reserve ratios outside the reasonableness range are correct as reported.
All policy years, latest 5 calendar/accident years.	The ratio of DCC to Uniform Reporting Level Premium.	To verify that all DCC ratios outside the reasonableness range are correct as reported.
All policy years. All calendar/accident years.	If there are closed indemnity claims then DCC paid must be >0.	To verify that if there are closed indemnity claims then DCC paid must be >0.
All policy years. All calendar/accident years.	The ratio of paid + case DCC between successive valuation dates.	To verify that all ALAE development values outside the reasonableness range are correct as reported.

REASONABILITY EDITS – POLICY YEAR/ACCIDENT YEAR COMPARE		
REPORTS	EDIT SPECIFICATION	RESULT
All data fields.	<p>Calendar Year data can be derived from successive valuation years of a financial report as follows:</p> <ol style="list-style-type: none"> 1. Sum data from all years (including “prior years”) for a particular field. This should be done separately for the policy year and calendar/accident year financial reports. 2. The Calendar Year value for that field is the sum calculated from the newer financial report minus the sum calculated from the older financial report. <p>Example: On the 1996 policy year report, Indemnity Paid Losses sum to \$1,000,000. On the 1997 policy year, report Indemnity Paid Losses sum to \$1,200,000. The derived calendar year indemnity paid losses are \$200,000.</p>	To verify that calendar year data derived from the policy year report equals calendar year data derived from the calendar/accident year report.
All data fields. All policy years excluding the most recent and the prior years row.	<p>Each policy year contains data from two accident years. Accidents can occur in the year that the policy was written or in the subsequent year. The sum of the values in those two accident years must be greater than the value in the policy year for a particular field.</p> <p>Example: Indemnity paid losses for accident year 1996 + indemnity paid losses for accident year 1997 must be greater than indemnity paid losses for policy year 1996.</p>	To verify that all data fields on the policy year report are consistent with data fields on the calendar/accident year report as described in this edit.

REASONABILITY EDITS – POLICY YEAR/ACCIDENT YEAR COMPARE		
REPORTS	EDIT SPECIFICATION	RESULT
All data fields. All calendar/accident years excluding the prior years row.	<p>Each accident year contains data from two policy years. The policy that covered an accident could have been written in the same year as the accident or the prior year. The sum of the values in those two policy years must be greater than the value in the accident year for a particular field.</p> <p>Example: Indemnity paid losses for policy year 1995 + indemnity paid losses for policy year 1996 must be greater than indemnity paid losses for accident year 1996.</p>	To verify that all data fields on the policy year report are consistent with data fields on the calendar/accident year report as described in this edit.

REASONABILITY EDITS – STATEWIDE/ASSIGNED RISK COMPARE		
REPORTS	EDIT SPECIFICATION	RESULT
All policy years, all accident years (except prior years), all fields.	An insurance carrier must be approved by the state to write assigned risk business in any year.	To verify for each policy year in which assigned risk business was reported that the reporting company is an approved servicing carrier. To verify for each accident year in which assigned risk business was reported, that the reporting company is an approved servicing carrier in either the same year or the year prior to the accident year business. (Example: If carrier “X” reported assigned risk business for accident year 1997, then it must be an approved servicing carrier for either 1996 or 1997.)
All years, all fields except indemnity bulk reserve, indemnity IBNR, medical IBNR, medical bulk reserve, DCC IBNR.	Voluntary data is derived by subtracting assigned risk data from statewide data.	To verify that the derived voluntary data should be greater than or equal to 0.

REASONABILITY EDITS – ANNUAL STATEMENT/FINANCIAL REPORT RECONCILIATION		
REPORTS	EDIT SPECIFICATION	RESULT
Calendar year direct net premium, total incurred losses (Policy Year data and Large Deductible data).	The calendar year reconciliation report contains data fields for calendar year net premium and incurred losses for statewide business and large deductible business separately. The values on the report should match the values reported on the financial reports.	To verify that calendar year values on the financial reports match calendar year values on the reconciliation report.
Calendar year direct net premium, total incurred losses (Policy Year data and Large Deductible data).	Insurance companies report calendar year premium, paid losses, and unpaid losses for workers' compensation on their annual statements. They also report this data on the financial reports. The Calendar Year Reconciliation Report requires the reporting company to show the calendar year data reported on the financial reports as well as the pieces of Workers' Compensation business that are excluded on the financial reports. The annual statement data should equal the sum of all the pieces of Workers' Compensation business.	To verify that the difference between the data on the Annual Statement and the sum of the workers' compensation values reported on the financial reports is less than \$1000.
Calendar year direct net premium, total incurred losses (Policy Year data and Large Deductible data).	This item is requested on the calendar year reconciliation report.	To verify that all values outside the reasonableness range are correct as reported.
All data fields.	The sum of all lines in the financial report.	To verify that the sum of all rows on the financial report add to the total within a \$50,000 tolerance.
All data fields.	The sum of all lines on the previous year's financial report.	To verify that the sum of all rows on the financial report add to the total within a \$50,000 tolerance.

REASONABILITY EDITS – COLUMN TOTAL		
REPORTS	EDIT SPECIFICATION	RESULT
All data fields.	Calendar year is the sum calculated from the new financial report minus the sum calculated from the older financial report.	To verify that the total equals the derived calendar year value within a \$50,000 tolerance.
Direct Net Premium, Direct Incurred Losses (indemnity paid + indemnity case + indemnity bulk reserve + indemnity IBNR + medical paid + medical case + medical bulk reserve + medical IBNR).	Line 1 on the calendar year reconciliation report should match the totals on the policy year reports.	To verify that line 1 of calendar year reconciliation report equals the totals of financial report.