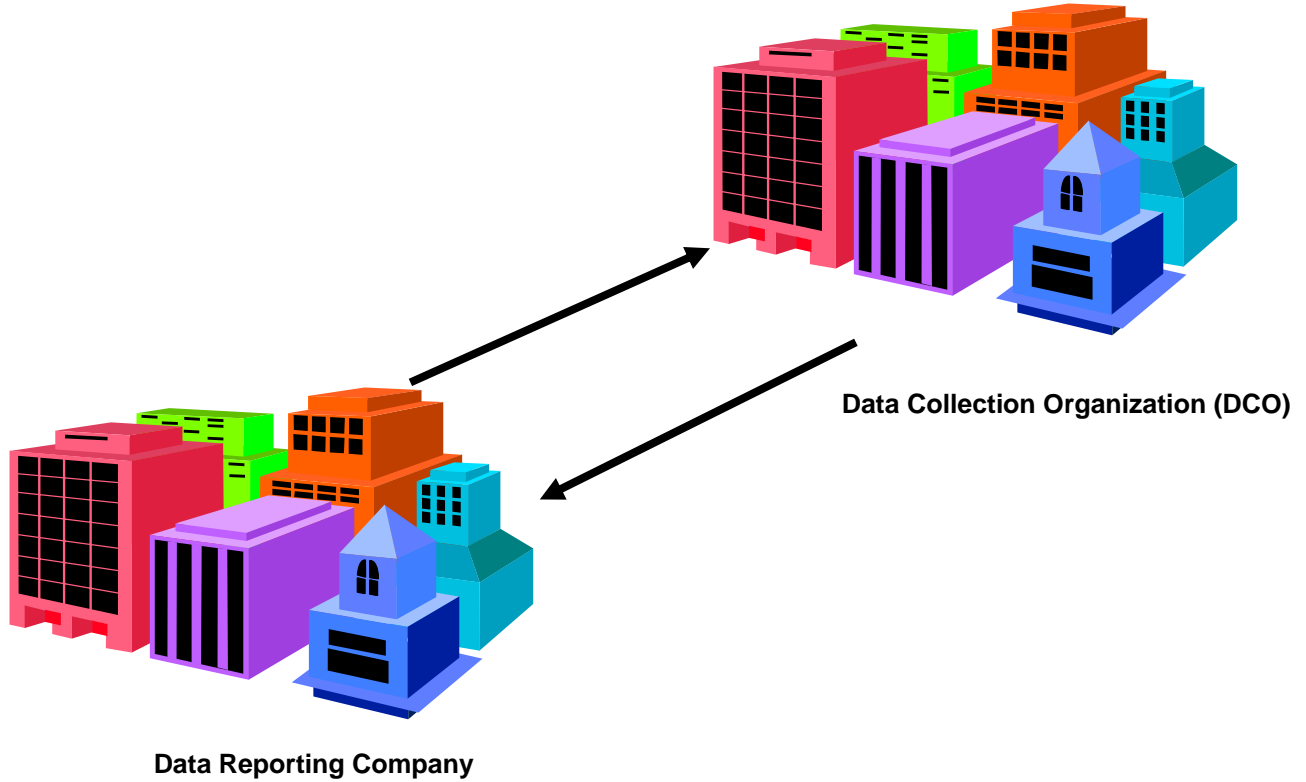


**DETAILED CLAIM DATA REPORTING**

DETAILED CLAIM DATA (INCL. TEXAS) FLOW BETWEEN  
DATA REPORTING COMPANY AND DATA COLLECTION ORGANIZATION



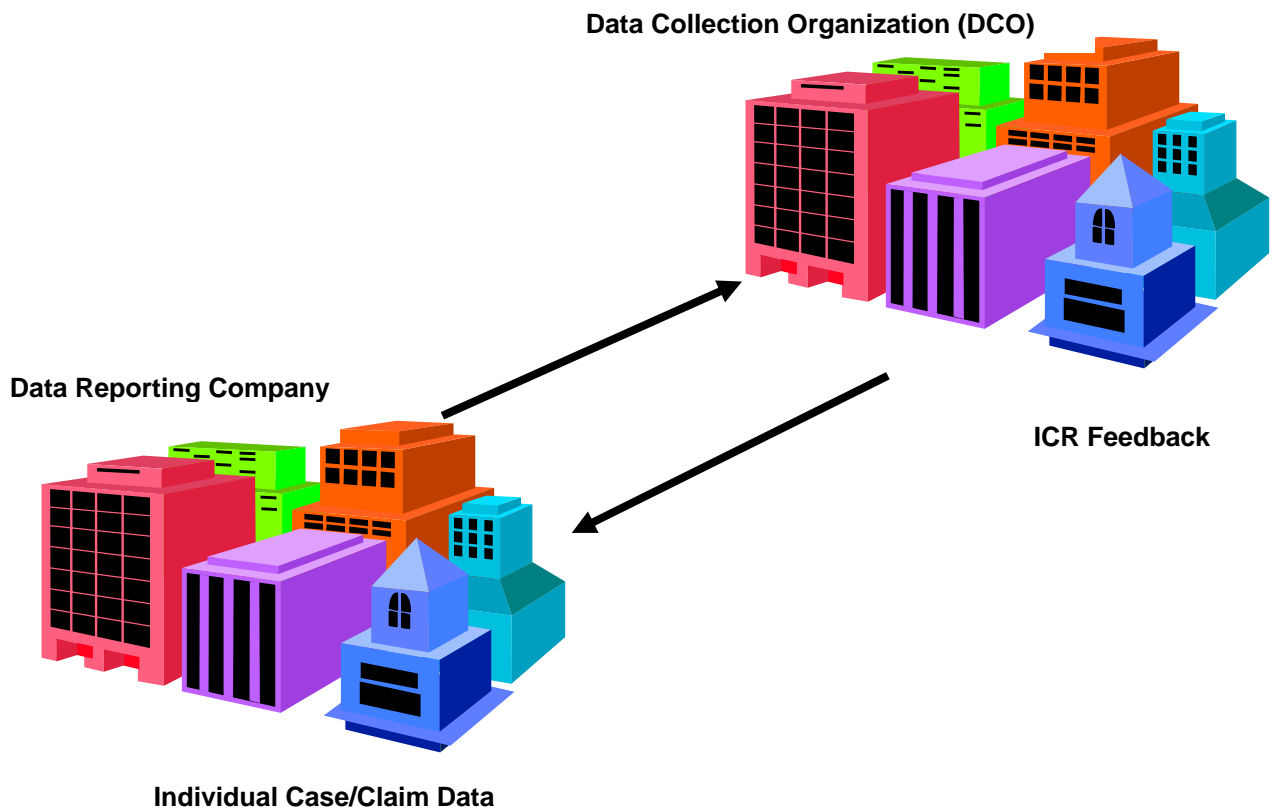
**DATA REPORTING COMPANY**

- = INSURANCE COMPANIES
- = STATE FUNDS
- = SELF-INSURED GROUPS
- = THIRD PARTY ADMINISTRATORS (TPAs)

**DATA COLLECTION ORGANIZATION**

- = NCCI

### USE OF DETAILED CLAIM DATA



Detailed claim data is used to:

- Provide valuable information for law evaluations
- Provide valuable information for cost containment
- Provide “drill down” or research capabilities on major claims

### **DETAILED CLAIM DATA (OTHER THAN TEXAS) REPORTING GUIDELINES**

The collection of detailed claim information began in 1979. Detailed claim information provides valuable information in the cost evaluation of benefit changes, fees for medical care, and various types of legislation.

The primary uses of detailed claim data are:

- to provide valuable information for law evaluation
- to provide valuable information for cost containment
- to provide “drill down” capabilities on major claims

In 1991, detailed claim was expanded from 54-elements to 85-elements, and in 1996 to 86-elements. All detailed claim information is collected by the NCCI.

#### **The following are helpful hints:**

- Participation in the detailed claim reporting program is determined on a company group basis, using standard earned premium. Participation is required for companies whose total statewide standard earned premium for the current year is equal to or greater than 0.1% and whose total expected indemnity claim count is 60 or more per year.
- Participation ratio is usually reviewed every three years. When an insurer is required to report data, the insurer will remain in the participation period for three years. If an insurer no longer qualifies for detailed claim reporting, the insurer is required to report on all open claims, based on the criteria defined by the DCO.
- Detailed claim reporting is a random sampling of direct workers' compensation indemnity claims. The sampling should not include medical only claims.
- Claims selected in the sample must be evaluated six months and reported within eight months after the date the claim was first reported to the company. For example if a claim occurred on January 3, 2001 and was reported to the insurer on January 6, 2001, the claim must be evaluated July 2001 and reported by September 2001.
- Subsequent reports on this claim are due annually, i.e., September 2002, etc., as long as the claim remains open, includes indemnity or has not reached the ninth report level.
- The detailed claim reporting program is not applicable to:
  - Medical only claims
  - Reinsurance (assumed or ceded)
  - Admiralty, USL&HW, FELA, Coal Mine

- Detailed claim data is to be reported as long as the claim remains open up to a ninth report. If a claim closes and reopens during the nine-year timeframe, then the claim is reported at the next valuation after the claim reopens. For example:

<b>CLAIM STATUS</b>	<b>REPORT</b>
1 <sup>st</sup> report open	Report as open
2 <sup>nd</sup> report closed	Report as closed
3 <sup>rd</sup> report closed	No report due
4 <sup>th</sup> report reopens	Report as reopened
5 <sup>th</sup> report closed	Report as closed
6 <sup>th</sup> report reopen	Report as reopened
7 <sup>th</sup> report closed	Report as closed
8 <sup>th</sup> report closed	No report due
9 <sup>th</sup> report closed	No report due

- Correction reports are required when the data was incorrectly reported. Corrections can be reported on hard copy or by using the WCCDCI format with the appropriate transaction type code indicated.
- When reporting the correction of key data fields electronically, use the WCCDCI Common Information Change Record format (Record Type 3) found in the *WCIO Workers' Compensation Data Specifications Manual*.
- With the implementation of the ASWG format, detailed claim data underwent several changes, i.e., codes were added or discontinued and field names were revised. The overall change was that the detailed claim format went from an 85-data element format to an 86-data element format.

<b><u>Type of Change</u></b>	<b><u>85-Element Claim Form</u></b>	<b><u>86-Element Claim Form</u></b>
Field Name	Date of Injury	Accident Date
Field Name	Loss Coverage	Loss Conditions
Different Codes	Loss Coverage Claim Status, e.g., Code 1 = Open	Loss Conditions Claim Status, e.g., Code 1 = Closed
Different Requirement	Deductible – Yes or No	Deductible – net or gross reporting by state
Different Requirement	Managed Care Indicator Not Applicable	Managed Care Indicator Required

Discontinued Fields  
Effective 2/26/96

Benefit Offsets Fields

- Social Security
- Unemployment
- Pension Plan
- Special Fund
- Other

Penalties Paid to Date Field

Subrogation Fields

- Product Liability
- Automobile Liability
- Other

Number of Dependents Field

- In the WCIO WCCDCI format, the claim number field is an 18-digit field. The claim number field for WCSTAT (unit reports) is a 12-digit field. This difference can cause unmatched claims; e.g., claim reported on WCCDCI does not match to claim reported on WCSTAT.

**TEXAS DETAILED CLAIM INFORMATION**  
**REPORTING GUIDELINES**

The Texas Detailed Claim Information is a data collection program whereby insurance companies furnish specific information on all workers' compensation claims with total incurred losses of \$5,000 or more when valued six months after the date the claim has been reported to the insurer.

The purpose of the Texas Detailed Claim Information (DCI) is to develop and maintain a database for research and cost containment efforts. Carrier participation in the Texas call is mandatory.

**The following are helpful hints:**

- Texas DCI is **not** a sampling. If a claim has a total incurred loss (paid plus reserves) equal to or greater than \$5,000 when valued 6 months after the date the claim was reported to the insurer, detailed claim information is required.
- For insurance companies or other entities authorized to write workers' compensation in Texas participation is mandatory in Texas DCI; excluding all self-insureds. Reporting is on an individual company basis; company group reporting is disallowed.
- Insurance companies evaluate claims 6 months after filing by injured worker and report on claims with total incurred losses of \$5,000 or more.
- Texas DCI applies to medical only claims. In other states such as Florida, DCI reporting is not applicable for medical only claims.
- Texas DCI does not apply to claims payable under the following:
  - U.S. Longshore and Harbor Workers' Compensation Act
  - Admiralty Law
  - FELA Benefits
  - Employers' Liability only
  - Exemplary Damages and Benefits based on laws of other states
- Must be certified by Texas Department of Insurance (TDI) or statistical agent (NCCI) to file data using the WCIO WCCDCI format.
- Carriers writing ½ of 1% of total Texas workers' compensation premiums must submit DCI in electronic format.
- A request for subsequent reports will be generated approximately 60 days prior to claim valuation date. Request is for all open claims. The request for subsequent reports will include all previously reported data fields with the prior information and the new Report Level Code.
- A claim cannot be updated when it remains in error.

- Carrier Code, Policy Number, Claim Number, State of Jurisdiction and Date Reported to Insurer are common information or claim linking fields. Changes to these fields must be submitted on a Common Information Change Form. The Common Information Change Form is used to accomplish the following:
  - Change data residing in valid DCI database
  - Delete data from valid DCI database

**HARD COPY DETAILED CLAIM DATA REPORTING GUIDELINES**

NCCI accepts detailed claim data reported on paper.

NCCI has developed forms for the reporting of detailed claim data.

### ELECTRONIC DETAILED CLAIM DATA REPORTING GUIDELINES

The guidelines for reporting detailed claim data electronically are found in the *WCIO Workers' Compensation Data Specifications Manual*.

The format for electronic reporting is called the WCCDCI format and is a 500-byte record.

The term 'electronic reporting' can mean different methods of reporting such as by cartridge, PC to PC zip files, mainframe to mainframe, etc. The NCCI should be consulted as to their accepted methods of electronic submissions.

Before reporting electronically to the NCCI, a test submission may be required. The test usually requires the following:

- A letter or record of transmittal
- 'X' amount of records
- Hard copies of the test material

It is important while testing for electronic submission, that the reporting of data on paper be continued. You should continue reporting on paper until approval is received for electronic reporting.

The WCCDCI Section of the *WCIO Workers' Compensation Data Specifications Manual* is very specific and contains guidelines pertinent to the filing of detailed claim data. Some of the more important guidelines are:

- Electronic submissions shall consist of up to four record types.

Record Type 1—Detailed Claim Information Record  
Record Type 2—Sample Control Record  
Record Type 3—Common Information Change Record  
Record Type 9—Submission Control Record

- A transmittal form shall be prepared and shall accompany each electronic submission.
- Insurers within a group should submit their data on the same file, except for Texas. For Texas Detailed Claim Data, individual insurer codes are needed. Texas can not be reported using a group carrier code.
- Data from more than one state can be reported in the same submission.

### **STATE AND REPORTING JURISDICTIONS**

Detailed claim data, including Texas, is reported to the NCCI. Refer to the NCCI's Call for Detailed Claim Information Instruction Manual and the Texas Detailed Claim Information Statistical Plan for reporting instructions.

### **DETAILED CLAIM FORMS**

The forms for reporting detailed claim data can be ordered from the NCCI. In addition, the NCCI will accept equivalent company-generated forms that follow the standard format for detailed claim data.

### DETAILED CLAIM TRANSMITTAL INFORMATION

A Letter (hard copy) or Record (electronic) of Transmittal must accompany all data reported on hard copy or electronically. The transmittal can be submitted electronically (transmittal record) or on paper (transmittal letter).

The Letter/Record of Transmittal is used for record control, balancing, and communication purposes.

The Letter/Record of Transmittal provides the following:

1. Critical information pertaining to the company filings, such as:
  - Data type (policy, unit statistical reports, detail claims)
  - Submission type (test, resubmission, standard)
2. Information to facilitate the two-way communication between the DCO and the insurer. Therefore, it is necessary to include all available insurer information, such as:
  - Contact name
  - Phone number
  - Fax number
  - E-mail address
3. Date of receipt by DCO, number of records processed, and status of submission.

For hard copy submissions, most DCOs will accept a company-generated transmittal form. The form should contain:

- Company information
- Contact person; telephone; fax number and E-mail address.
- Type of submission and quantity
- Certification statement, signed and dated
- Receipt type information

**EXAMPLE OF A DETAILED CLAIM TRANSMITTAL LETTER**  
**ELECTRONIC TRANSMITTAL LETTER**  
**DETAILED CLAIM DATA**

Please complete one transmittal for each electronic file submitted.

CHECK HERE IF INSURER INFORMATION HAS CHANGED

Carrier Name \_\_\_\_\_

Carrier Code \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Contact Name \_\_\_\_\_

Tape Serial Number \_\_\_\_\_ Date \_\_\_\_\_

E-Mail Address \_\_\_\_\_

**Detailed Claim Information Reports** (Rec Type 1) # records \_\_\_\_\_

**Sample Control/Forms** (Rec Type 2) # records \_\_\_\_\_

**Common Information Changes** (Rec Type 3) # records \_\_\_\_\_

Total # Records on Tape \_\_\_\_\_