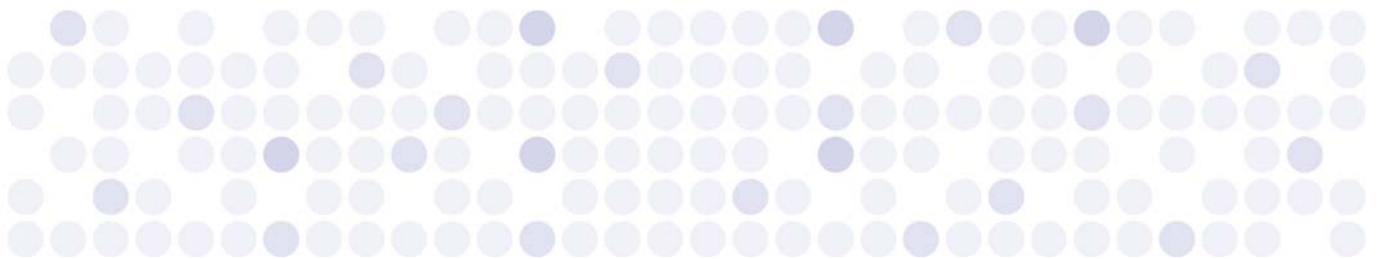




# Workers' Compensation Insurers' Interface Data Specifications

Version 6.1 – July 2011



## Table of Contents

<b>1</b>	<b>Introduction.....</b>	<b>7</b>
1.1	Purpose.....	7
1.2	Content.....	7
1.3	Audience.....	7
1.4	Q-COMP assistance.....	7
<b>2</b>	<b>Definitions.....</b>	<b>8</b>
2.1	Terminology.....	8
2.2	Common formats.....	11
<b>3</b>	<b>Data submission process.....</b>	<b>12</b>
3.1	How to supply data.....	12
3.2	Data frequency.....	12
3.3	Data format.....	13
3.3.1	Data file.....	13
3.3.2	Control file.....	13
3.4	Mandatory / conditional.....	13
3.5	Unique keys and delete flags.....	14
3.6	Modifications.....	14
3.7	Physical file identification.....	15
3.8	Data processing.....	15
3.9	Validation.....	16
3.9.1	Control file validation.....	16
3.9.2	Record validation.....	16
3.9.3	Field validation.....	16
3.9.4	Data warning.....	17
3.9.5	Error recording.....	17
3.9.6	Validation report.....	17
3.9.7	Management of insurer data errors.....	18
<b>4</b>	<b>User data description.....</b>	<b>19</b>
4.1	Control file.....	20
4.1.1	Insurer number.....	20
4.1.2	Reporting period from.....	20
4.1.3	Reporting period to.....	21
4.1.4	Filename.....	21
4.1.5	Number of bytes.....	21
4.1.6	Number of records.....	22
4.1.7	Control total.....	22
4.2	Claim base file.....	23
4.2.1	Insurer number.....	23
4.2.2	Reporting period from.....	23
4.2.3	Reporting period to.....	24
4.2.4	Claim number.....	24
4.2.5	Liability commencement date.....	24
4.2.6	Injury narrative.....	25
4.2.7	Injury date.....	25
4.2.8	Injury time.....	25
4.2.9	Injury occurrence code.....	26
4.2.10	Injury period occurred.....	26
4.2.11	Injured worker identifier.....	27
4.2.12	Injured worker occupation description.....	27
4.2.13	Injured worker date deceased.....	28
4.2.14	Injury occurred address.....	28
4.2.15	Injury identifier.....	29

4.2.16	Injury location.....	30
4.2.17	Injury nature.....	30
4.2.18	Injury mechanism.....	31
4.2.19	Injury agency .....	31
4.2.20	Business workplace registration number .....	31
4.2.21	Workplace accreditation number .....	31
4.2.22	WorkCover industry code/industry business code .....	31
4.2.23	Workplace industry description.....	31
4.2.24	Employer number .....	32
4.2.25	Previous insurer code .....	32
4.2.26	Previous insurer's claim number.....	33
4.2.27	Psychological work related impairment (WRI) percent .....	34
4.2.28	Physical work related impairment (WRI) percent.....	34
4.2.29	Return to work status.....	35
4.2.30	Date injury first reported to employer.....	36
4.2.31	Fatality Flag .....	36
<b>4.3</b>	<b>Injured worker file .....</b>	<b>37</b>
4.3.1	Insurer number .....	37
4.3.2	Reporting period from .....	37
4.3.3	Reporting period to .....	38
4.3.4	Injured worker identifier .....	38
4.3.5	Delete flag.....	39
4.3.6	Injured worker date of birth .....	39
4.3.7	Injured worker name .....	40
4.3.8	Injured worker name change reason .....	40
4.3.9	Injured worker residential address.....	41
4.3.10	Injured worker gender.....	41
<b>4.4</b>	<b>Lodgement file.....</b>	<b>42</b>
4.4.1	Insurer number .....	42
4.4.2	Reporting period from .....	42
4.4.3	Reporting period to .....	43
4.4.4	Claim number .....	43
4.4.5	Lodgement record identifier .....	43
4.4.6	Delete flag.....	44
4.4.7	Lodgement date.....	44
<b>4.5</b>	<b>Claim status file.....</b>	<b>45</b>
4.5.1	Insurer number .....	45
4.5.2	Reporting period from .....	45
4.5.3	Reporting period to .....	46
4.5.4	Claim number .....	46
4.5.5	Status record identifier .....	46
4.5.6	Delete flag.....	47
4.5.7	Claim status .....	48
4.5.8	Claim status date .....	51
4.5.9	Liability reversed indicator .....	52
4.5.10	Claim staff name.....	52
4.5.11	Reason for status.....	53
<b>4.6</b>	<b>Compensation period file .....</b>	<b>55</b>
4.6.1	Insurer number .....	55
4.6.2	Reporting period from .....	56
4.6.3	Reporting period to .....	56
4.6.4	Claim number .....	56
4.6.5	Compensation record identifier.....	57
4.6.6	Delete flag.....	57
4.6.7	Compensation from date .....	58

4.6.8	Compensation to date.....	58
4.6.9	Normal work hours.....	59
4.6.10	Workdays lost .....	59
4.6.11	First compensation payment date.....	60
4.6.12	Hours lost.....	60
4.6.13	Partial/total incapacity flag .....	61
4.6.14	Excess flag .....	61
<b>4.7</b>	<b>Fatal application file.....</b>	<b>62</b>
4.7.1	Insurer number .....	62
4.7.2	Reporting period from .....	62
4.7.3	Reporting period to .....	63
4.7.4	Claim number .....	63
4.7.5	Fatal application record identifier .....	63
4.7.6	Delete flag.....	64
4.7.7	Fatal application date.....	64
4.7.8	Fatal application decision .....	65
<b>4.8</b>	<b>Former names file .....</b>	<b>66</b>
4.8.1	Insurer number .....	66
4.8.2	Reporting period from .....	66
4.8.3	Reporting period to .....	67
4.8.4	Injured worker identifier .....	67
4.8.5	Former name record identifier .....	67
4.8.6	Delete flag.....	68
4.8.7	Former name .....	68
<b>4.9</b>	<b>Damages base file .....</b>	<b>69</b>
4.9.1	Insurer number .....	69
4.9.2	Reporting period from .....	69
4.9.3	Reporting period to .....	70
4.9.4	Claim number .....	70
4.9.5	Damages claim number.....	70
4.9.6	Delete flag.....	71
4.9.7	Date notification received of damages claim .....	71
4.9.8	Intimation date .....	72
4.9.9	Amount on NOC indicator.....	72
4.9.10	Amount of first offer .....	73
4.9.11	Other defendants indicator .....	73
4.9.12	Notice of claim compliant date .....	74
4.9.13	Liability decision date.....	74
4.9.14	Estimated damages .....	75
4.9.15	Estimated costs .....	75
4.9.16	Urgent Proceedings Application Indicator.....	76
4.9.17	Legal Representation.....	76
4.9.18	Plaintiff Lawyer Firm .....	77
4.9.19	Plaintiff Lawyer Location Postcode.....	77
4.9.20	Liability Response.....	78
4.9.21	Date of Compulsory Conference .....	78
4.9.22	CTP Contributors .....	79
4.9.23	Public Liability Contributors .....	79
4.9.24	Other Contributors .....	79
<b>4.10</b>	<b>Damages resolution file.....</b>	<b>80</b>
4.10.1	Insurer number .....	80
4.10.2	Reporting period from .....	80
4.10.3	Reporting period to .....	81
4.10.4	Claim number .....	81
4.10.5	Damages claim number.....	81

4.10.6	Delete flag.....	82
4.10.7	Resolution date.....	82
4.10.8	Resolution outcome.....	83
4.10.9	Resolution stage.....	84
4.10.10	Finalisation date.....	85
4.10.11	Dominant Injury Item Number.....	85
4.10.12	Injury Scale Value.....	86
4.10.13	Multiple Injury Indicator.....	86
4.10.14	Gross settlement amount.....	87
4.10.15	Heads of damage – general damages.....	87
4.10.16	Heads of damage – past economic loss.....	88
4.10.17	Heads of damage – future economic loss.....	88
4.10.18	Heads of damage – treatment and rehabilitation.....	88
4.10.19	Heads of damage – care.....	89
4.10.20	Heads of damage – other.....	89
<b>4.11</b>	<b>Damages contributory negligence file.....</b>	<b>90</b>
4.11.1	Insurer number.....	90
4.11.2	Reporting period from.....	90
4.11.3	Reporting period to.....	91
4.11.4	Claim number.....	91
4.11.5	Damages claim number.....	91
4.11.6	Delete flag.....	92
4.11.7	Contributory negligence section.....	93
4.11.8	Contributory negligence percentage.....	94
<b>4.12</b>	<b>Payments file.....</b>	<b>95</b>
4.12.1	Insurer number.....	97
4.12.2	Reporting period from.....	97
4.12.3	Reporting period to.....	97
4.12.4	Claim number.....	98
4.12.5	Payment month.....	98
4.12.6	Payment category.....	98
4.12.7	Payment type.....	100
4.12.8	Delete flag.....	103
4.12.9	Net claims cost.....	103
4.12.10	Total GST amount.....	104
4.12.11	Gross claims cost.....	104
4.12.12	Item number.....	105
<b>4.13</b>	<b>Payment total file.....</b>	<b>106</b>
4.13.1	Insurer number.....	106
4.13.2	Reporting period from.....	106
4.13.3	Reporting period to.....	107
4.13.4	Claim number.....	107
4.13.5	Delete flag.....	107
4.13.6	Total statutory claim cost.....	108
4.13.7	Total damages claim cost.....	108
4.13.8	Replace all payments flag.....	108
<b>4.14</b>	<b>Permanent impairment injury file.....</b>	<b>109</b>
4.14.1	Insurer number.....	110
4.14.2	Reporting period from.....	110
4.14.3	Reporting period to.....	111
4.14.4	Claim number.....	111
4.14.5	Delete flag.....	111
4.14.6	Permanent impairment injury identifier.....	112
4.14.7	Injury code.....	112
4.14.8	Permanent impairment percent.....	112

4.14.9	Permanent impairment lump sum amount .....	113
4.14.10	Outcome – permanent impairment percent .....	113
4.14.11	Date permanent impairment assessed .....	114
4.14.12	Outcome of offer of lump sum compensation .....	114
<b>4.15</b>	<b>Ordinary earnings file .....</b>	<b>115</b>
4.15.1	Insurer number .....	115
4.15.2	Reporting period from .....	115
4.15.3	Reporting period to .....	116
4.15.4	Claim number .....	116
4.15.5	Ordinary earnings record identifier .....	116
4.15.6	Delete flag.....	117
4.15.7	Ordinary earnings from date .....	117
4.15.8	Ordinary earnings to date .....	117
4.15.9	Normal weekly earnings .....	118
4.15.10	Award rate .....	118
<b>4.16</b>	<b>Multiple injury file.....</b>	<b>119</b>
4.16.1	Insurer number .....	119
4.16.2	Reporting period from .....	119
4.16.3	Reporting period to .....	120
4.16.4	Claim number .....	120
4.16.5	Delete flag.....	120
4.16.6	Multiple injury record identifier .....	121
4.16.7	Injury location for all injuries .....	121
4.16.8	Injury nature for all injuries.....	122
4.16.9	Injury identifier for all injuries .....	122
<b>Appendix A</b>	<b>– National data set .....</b>	<b>123</b>
<b>Appendix B</b>	<b>– Control file and record validation errors .....</b>	<b>126</b>
<b>Appendix C</b>	<b>– Address formats.....</b>	<b>127</b>
<b>Appendix D</b>	<b>– Name formats .....</b>	<b>130</b>
<b>Appendix E</b>	<b>– Injury Location and Injury Identifier Validation .....</b>	<b>131</b>
<b>Appendix F</b>	<b>– Claim type derivation .....</b>	<b>133</b>
<b>Appendix G</b>	<b>– Version control.....</b>	<b>135</b>

## 1 Introduction

### 1.1 Purpose

This document describes the data and processing for the interface between Workers' Compensation Insurers and Q-COMP. It provides Workers' Compensation Insurers with a complete understanding of the required data fields for the interface.

### 1.2 Content

This document specifies the data required from Workers' Compensation Insurers for regulatory and monitoring purposes. For a full explanation of the workers' compensation scheme (including benefits, WorkCover and self-insurance), refer to the *Workers' Compensation and Rehabilitation Act 2003*, *Workers' Compensation and Rehabilitation Regulation 2003* and repealed Acts and Industrial Gazette Notice that is in force at any given time.

The design of the interface between Workers' Compensation Insurers and Q-COMP is explained in detail in this document. It further describes the data required and the validation rules for the acceptance of that data from Workers' Compensation Insurers into the Q-COMP system. The validation rules defined in this document are processed by Q-COMP to validate the summary information supplied.

### 1.3 Audience

This specification is primarily designed for Workers' Compensation Self-Insurers, WorkCover Queensland and workers' compensation system providers, to enable them to provide the data required by Q-COMP. Users of the data will also find it useful for its description of the definitions used and validations performed.

### 1.4 Q-COMP assistance

Additional information regarding this Workers' Compensation Insurer's Interface Data Specification can be obtained by contacting the Data Management team. Alternatively, Q-COMP has a number of Data Management Bulletins which may assist insurers with the coding and validation of claims. For further information on Data Management Bulletins, please refer to <http://qcomp.com.au/services/data-hub/data-management-bulletins.aspx>.

**Telephone:** (07) 3020 6418  
**Email:** [datasubmissions@qcomp.com.au](mailto:datasubmissions@qcomp.com.au)  
**Webpage:** <http://qcomp.com.au/services/data-hub.aspx>

## 2 Definitions

This section defines the terms used within this document. It also describes the common data field formats.

### 2.1 Terminology

<b>Act</b>	<i>Workers' Compensation and Rehabilitation Act 2003, WorkCover Queensland Regulation 1997, WorkCover Queensland Act 1996, Workers' Compensation Act 1990, Workers' Compensation Regulation 1992 and repealed Acts.</i>
<b>Admitted (ADM)</b>	The insurer allows the application for compensation and liability continues to be accepted by the insurer (this is considered to be an initial decision on the claim - refer to initial decision).
<b>Admitted Claims</b>	For validation purposes, admitted claims are claims that have had liability admitted including admitted, ceased, suspended and finalised claim statuses.
<b>Business Rule</b>	A Business Rule cannot be validated by Q-COMP (due to only summary information being supplied from the insurer), but Q-COMP has documented the rule so the insurer can utilise it in their claims management system.
<b>Cancelled (CAN)</b>	The cancellation of the claim. This status is used on intimated claims that are found not to need any further processing because the claim should never have been intimated (For example, the application has already been intimated once on the system).
<b>Ceased (CSD)</b>	The insurer has terminated entitlements to compensation.
<b>Claim Status</b>	The predetermined processing stages in the life of a worker's compensation claim (as defined by Q-COMP within this document).  All status changes are recorded as at the time they are entered/processed on the insurer's claims management system.
<b>Common Law Only (CLO)</b>	Where a damages claim is lodged without a corresponding statutory claim.
<b>Continuation</b>	When the current incapacity relates solely to a previously allowed compensable injury and there is no further event. It is treated as a continuation of the claim. An application to continue must be lodged by the injured worker.  The continuation is identified in the data when a claim has been finalised or ceased, then at a later date the injured worker applies for further compensation for the same event, but for a new period of incapacity. The injured worker is required to lodge an application for compensation, where the application is intimated and a decision made, thus causing a continuation of an existing claim.  The continuation causes the claim to be processed in the same manner as a new claim, but with the existing claim number.  A continuation cannot be performed on a claim that had been originally rejected. However it is possible to continue a claim that was originally admitted, but has had a subsequent continuation rejected.  That is, a claim that is rejected in the first decision on liability cannot be continued at a later stage. Only a claim that has had liability accepted initially can have rejections later in the claim or further continuations.
<b>Control File Validation</b>	A Control File Validation error causes all data supplied to be rejected and not loaded on the Q-COMP system. Refer to Section 3.9.5 Error recording on page 17.

<b>Data Warning</b>	A data warning on suspect data allows the data to be loaded on the Q-COMP system. The warning is issued to the insurer, but no follow up action is required unless the insurer believes the data to be incorrect. Refer to Section 3.9.5, Error recording on page 17.
<b>Event</b>	Refer to Section 31 of the Act in reference to claims subject to the <i>Workers' Compensation and Rehabilitation Act 2003</i> only. The definition of event does not necessarily apply to previous Acts.
<b>Field Validation</b>	A Field Validation error allows the invalid data to be loaded (with an appropriate error) on the Q-COMP system. No data is rejected, just flagged as being in error. Refer to Section 3.9.5, Error recording on page 17.
<b>Finalisation Status</b>	The status of the statutory claim where liability has finished, such as finalised, ceased or rejected.
<b>Finalised (FIN)</b>	It is considered that the liability has ended through the normal course of the claim (even if it is possible that a continuation may occur in the future).
<b>Initial Decision</b>	The initial decision made on the claim. The initial decision is the decision made after the claim has been entered or intimated onto the insurer's computer system. It refers to whether the insurer has accepted liability (admitted), or rejected liability (rejected), for the claim. If claim has been transferred as with "tail claims" a history of the liability should be supplied using original information supplied such as injury dates, injury description, etc.
<b>Insurer</b>	Insurer relates to either self-insurers or WorkCover Queensland.
<b>Insurer Number</b>	This refers to the self-insurance licence number supplied to each self-insurer by Q-COMP or, in the case of WorkCover, WCQ.
<b>Intimated (INT)</b>	The registration of the worker's application for compensation onto the insurer's claims management system after the application is lodged with the insurer. The intimation of a claim creates a record.
<b>Lodgement</b>	Lodgement refers to each application for compensation made under a claim. It will include the <b>initial application</b> and any <b>subsequent applications</b> for continuation.
<b>National Data Set</b>	The National Data Set (NDS) is a collection of data about workers' compensation claims supplied by all jurisdictions in Australia. Some of the data collected by Q-COMP is supplied to Safe Work Australia from this data set – these fields are identified throughout the document. Some of the codes and validation used (such as injury nature, location, agency and mechanism) are developed and maintained by Safe Work Australia for this data set. Appendix A contains information on the National Data Set and injury codes.
<b>No Action Required (NAR)</b>	The claim is intimated and no further processing is required at the time, either because the injured worker does not pursue the claim, or the injured worker has only lodged the claim for report purposes.
<b>OESR</b>	Office of Economic and Statistical Research.
<b>Q-COMP</b>	The Workers' Compensation Regulatory Authority.
<b>Record Validation</b>	A Record Validation error causes all data supplied to be rejected and not loaded on the Q-COMP system. Refer to Section 3.9.5, Error recording on page 17.
<b>Rejected (REJ)</b>	The application for compensation is rejected (this is considered to be an initial decision on the claim - refer to initial decision).
<b>Reporting Period</b>	A reporting period must be from the first day of a calendar month to the last day of the same calendar month (inclusive).

<b>Safe Work Australia</b>	Formerly the Australian Safety and Compensation Council.
<b>Self-Insurer</b>	The employer or group of employers, who hold the self-insurance licence. If a group employer holds the self-insurance licence, this term refers to the group as a whole, for example; only one data set is to be supplied by the whole group.
<b>Subsequent Decision</b>	The change in claim status, such from admitted to finalised, admitted to ceased, admitted to suspended, and all other status changes that are not initial decisions.
<b>Suspended (SPD)</b>	The suspension of entitlements to compensation.
<b>Tail/Transferred Claims</b>	These are defined as “outstanding liability” in Section 87 (1)(b) of the <i>Workers' Compensation and Rehabilitation Act 2003</i> .
<b>Unique Key</b>	Unique keys identify records in the files supplied by insurers (refer to each file for a description of the unique key fields). This in turn identifies the data on the Q-COMP system to be stored or modified. Refer to Section Unique keys and delete flags on page 14.
<b>Validation/ Business Rules</b>	The validation or Business Rules which are applied by Q-COMP to the data supplied by the insurer:
<b>Withdrawn (WDN) - WCQ only</b>	No actual claim lodged by the injured worker other than a medical certificate and account provided by medical practitioner for the purpose of medical fax fee only. For the fee to be paid a claim number is required to be issued. This applies to WorkCover Queensland only.
<b>WorkCover</b>	WorkCover Queensland

## 2.2 Common formats

This document uses the following list of common data field formats:

Format	Format content	Description
<b>Char(nn)</b>	Characters	Alpha/numeric characters, left justified, spaced filled, (where 'nn' is the length of the field).
<b>Num(nn)</b>	Numbers	Numeric integer, right justified, zero filled, (where 'nn' is the length of the field), for example, '073419' defined as a Num(6) represents the integer value of 73,419.
<b>Date</b>	CCYYMMDD	8 character field containing a date, where DD is day in month, MM is month in year, YY is year in the century, and CC is the Century, for example, '19970523' is 23 May 1997.
<b>Date/Time</b>	CCYYMMDD HH:MM:SS	17 character field containing date and time, where CC is the century, YY is the year in the century, MM is the month in the year and DD is day in month, HH is the hour of the day (in 24 hour format), MM is the minute of the hour, and SS is the second in the minute. For example, 23rd August 1997 at 3:24pm is defined as '19970823 15:24:00'. One space exists between the day and hour.
<b>Time</b>	HH:MM:SS	8 character field containing time, HH is the hour of the day (in 24 hour format), MM is the minute of the hour, and SS is the second in the minute, for example, 3:24pm is defined as '15:24:00'. Midnight is 00:00:00.
<b>Decimal(nn)</b>	Numbers	A numeric field with 2 decimal places implied (no decimal point physically supplied in the field), where nn is the total length of the field including the two implied decimal places, for example, 3419 defined as a decimal(4) represents the decimal number of 34.19.
<b>Amt(nn)</b>	Numbers	Numeric field with two (2) decimal places implied (no decimal point physically supplied in the field) and a leading floating negative sign (only present if amount is negative). nn is the total length of the field including the two implied decimal places and the floating negative sign, for example, -073419 defined as a Amt(7) represents the decimal number of 734.19.
<b>Pct(nn)</b>	Numbers	Numeric field with two (2) decimal places implied (no decimal point physically supplied in the fields), where nn is the total length of the field including the two implied decimal places. There are no negative values. A blank field implies null. For example, 00000 defined as Pct(5) represents 0.00%; 10000 defined as Pct(5) represents 100.00%; 08285 defined as Pct(5) represents 82.85% and ' ' defined as Pct(5) represents null.

The following are null values of the common data field formats (this is the value supplied when the field has no value to be reported):

FORMAT	DESCRIPTION OF NULL VALUE	EXAMPLE OF NULL VALUES
<b>Char(nn)</b>	Spaces	Char(5) is ' '
<b>Num(nn)</b>	Zero	Num(5) is '00000'
<b>Date</b>	Spaces	Date is ' '
<b>Date/Time</b>	Spaces	Date/Time is ' '
<b>Time</b>	Spaces	Time is ' '
<b>Decimal(nn)</b>	Zero	Decimal(5) is '00000'
<b>Amt(nn)</b>	Zero	Amt(5) is '00000'
<b>Pct(nn)</b>	Spaces	Pct(5) is ' '

The following term is used in this document in relation to null values:

**Nullled** Replacing the value stored in the field with the appropriate null value.

### 3 Data submission process

This section details the data submission process between insurers and Q-COMP, including:

- How the data is supplied to Q-COMP
- The frequency in which it should be sent
- The required data format
- Q-COMP data validation
- Error management
- Error reporting

#### 3.1 How to supply data

Insurers can supply data by e-mail to [datasubmissions@qcomp.com.au](mailto:datasubmissions@qcomp.com.au).

- It is preferred that Insurers supply data within a zip file.
- It is recommended that Insurers keep a backup copy of the supplied data

Once supplied, the data remains the property of Q-COMP; any subsequent data requires a new submission.

The data submission **must not** contain any other data and must not be stored using a directory structure.

#### 3.2 Data frequency

Data is required each month and insurers are encouraged to supply data as early in the month as practically possible. Insurers must supply valid data to Q-COMP no later than the 8<sup>th</sup> day of the month following the reporting month. For example, January data must be supplied by 8 February.

- If the 8<sup>th</sup> day is a public holiday or weekend, the data must be supplied by the previous working day.

In the event that no changes occurred during the reporting month, data is to be supplied containing only the Control file with the appropriate Control information.

There are a number of dependencies that rely on the efficient supply of data. The advantages for supplying data as soon as possible include:

- Longer lead time to correct load/record errors before due date
- Efficient delivery of monthly insurer and annual reporting

### 3.3 Data format

Data supplied to Q-COMP is contained in at least two files, one or more data files and the Control file.

In the event that no changes occurred during the reporting month, data is to be supplied containing only the Control file with the appropriate Control information.

#### 3.3.1 Data file

Data files contain information for each data field. All data fields must be supplied as records in an appropriate file. Below is a sample of a claim status data file. Each file contains records. Each record contains fields.

Insurers are required to supply data to Q-COMP that was created, modified or deleted during the reporting period. If a claim has not been processed during the reporting period, claim details need not be supplied.

Record	Field
SEI00000999200108012001083112345 1	NINT20010802 09:16:59 BLOGGS/JOE,JOHN
SEI00000999200108012001083112345 2	NADM20010802 09:40:23 BLOGGS/JOE,JOHN
SEI00000999200108012001083112345 3	NFIN20010802 13:58:29 BLOGGS/JOE,JOHN

Each record in a file must contain control information to associate the file with the insurer and reporting period.

In some files, information relating to a claim may be found in more than one record. For example, more than one compensation period associated with a claim is represented by more than one record in the compensation period file.

#### 3.3.2 Control file

The control file is used to confirm insurer’s data is received by Q-COMP. The control file contains the following information:

- insurer number
- reporting period
- control information for each file (name, character count, record count and control totals)

This control data is compared with the actual data supplied.

### 3.4 Mandatory / conditional

Data fields within file records are either mandatory or conditional. Mandatory data fields must contain data; conditional fields may contain data if appropriate.

Mandatory data fields must contain valid data and not null values. Refer to Section Common formats, on page 11. Null values in mandatory fields cause validation errors. Refer to Section 3.9, Validation on page 16.

- Null values in conditional data files are interpreted as actual data.

### 3.5 Unique keys and delete flags

Each record in the file must be uniquely identified and must always be referenced with the same unique identifier. For example, the claim number and the compensation record identifier identify compensation periods in a claims' compensation period file.

The records in the files supplied by insurers are identified by a unique key (refer to each file for a description of the unique key fields. This in turn identifies the data on the Q-COMP system to be stored or modified).

Q-COMP uses unique keys to link data between files supplied by the insurer. If errors occur within these unique keys, the integrity of the data and Q-COMP's capacity to link data is compromised.

Some unique keys contain identifiers (for example, injured worker identifier, ordinary earning record identifier, etc.) that are generated by insurer's claims management systems. These may be visible to the user or created by the system automatically.

In some cases, insurers may need to delete data supplied to Q-COMP (due to input errors or to report a null value, for example, in the case of payments). The delete flag associated with each record indicates to the Q-COMP system that the data should be deleted.

### 3.6 Modifications

Insurers can update data that exists on the Q-COMP system when additional information becomes available about a claim. This section explains how existing data is modified on the Q-COMP system:

If one record changes, not all data for the claim needs to be re-supplied. Only the record containing the changed details needs to be supplied.

- Damages claim details reported to Q-COMP have changed on the insurer's system. Only the appropriate damages claim record needs to be supplied and not any of the unchanged claim base details.

If one field changes, all data fields must be supplied in the record of the appropriate file.

- The compensation period file record contains from and to dates, workdays lost, return to work date, etc. If the return to work date is changed, all data in the compensation period record needs to be re-supplied.

Each record supplied must only be supplied once for the reporting period. Q-COMP does not require a record to be supplied for each modification made to details throughout the reporting period. The data supplied in each record should reflect the values in the record as at the end of the reporting period.

- If the details on a particular compensation period record changes several times during the month, the compensation period details for this record as they are defined at the end of the reporting period should be supplied.
- However, if the claim status progresses from INT to ADM and then ADM to FIN, a record must be supplied for each status, as each status progression must be supplied as a separate record.
- If a status is amended during the reporting period, for example, the status was entered as ADM and should have been CAN, this is an amendment to an existing record and only the value of the status at the end of the reporting period should be supplied.

### 3.7 Physical file identification

It must be possible, using the claim number and damages claim number supplied from insurers, to easily cross-reference the physical file stored by insurers.

### 3.8 Data processing

The Q-COMP system uses the unique key and delete flag (see Unique keys and delete flags on page 14 for more detail) to process the insurer's data files as follows:

- records containing a unique key not previously recorded on the Q-COMP database are interpreted as new data
- records containing a delete flag are identified by the unique key and deleted from the system
- records containing a unique key and no delete flag are modified

Data processing is dependent on database referential integrity rules, that is, each field has a unique key that links it to other fields. For example, the claim has to exist before a compensation period can be created for the claim.

**If database integrity is compromised, the system rejects all other data supplied in the data submission and the insurer must correct the error and resupply the data submission.** A complete list of all fields with the unique keys highlighted is identified in Insurers' Interface Technical Specification.

When deleting records, the Q-COMP system processes the records to preserve database referential integrity. Based on the information supplied, the Q-COMP system deletes the appropriate records (including cascade deletes) only if database integrity is not compromised (refer to each file for delete rules).

Q-COMP will never delete a claim. Only the appropriate data associated with the claim can be deleted (for example, compensation periods, claim status, etc.). If a claim has been created in error, the claim must be cancelled. Refer to Section 4.5, Claim status file on page 45.

## 3.9 Validation

Q-COMP processes the data files supplied by insurers. Four levels of validation (control, record, field and warning validation) are performed on the data at a control file, record and field level.

If the data fails the control file or record validation, a failed validation report is sent to the insurer. Once the data is loaded successfully, a validation report is sent to the insurer that contains details of the record validation and data warning errors. The following sections explain each level of validation.

### 3.9.1 Control file validation

Before the data is loaded onto the Q-COMP system, the following criteria are used to validate the data files against the control file:

- the number of files provided is the same as that identified in the Control File,
- no extra files exist in the data files provided that are not identified in the Control File,
- valid insurer number,
- correct reporting period,
- each record in all files supplied in the load data are associated with the same insurer number and reporting period,
- each file has the correct number of characters and number of records, and control totals reconcile,
- data has been supplied in the correct format. For example, no Mandatory data fields contain null values, and
- alphabetic characters are not in numeric fields (for example, a Num(5) field containing the value 23A56 or invalid dates, for example, 35/07/97)

If there are any Control File Validation errors, all data is rejected by the Q-COMP system. A file validation report is sent to the insurer identifying the errors to be corrected.

### 3.9.2 Record validation

Data integrity must not be compromised when data is loaded into the Q-COMP system. If a record fails the data integrity check (for example, if a compensation period is to be inserted but no claim exists), all data supplied in the load data is rejected.

These errors must be corrected to enable reporting by the end of the current reporting period (the reporting period in which the insurer was notified of the errors), and the corrected data, together with the normal data for this current reporting period, is supplied to Q-COMP.

### 3.9.3 Field validation

After all the data has been loaded onto the Q-COMP system, a process validates the loaded data, (For example, injury date is greater than the injured workers date of birth - validation rules for each field are described under Validation/Business Rules later in this document). A validation report is sent to the insurer identifying the errors to be corrected.

At the time of processing record validation, the record validation rules are re-processed. This performs a double check on data which may have been modified and relate to record validation on other fields. These validation errors are treated as record validation errors.

The errors must be corrected by the end of the current reporting period (the reporting period in which the insurer was notified of the errors), so the corrected data, together with the normal data for this current reporting period, is supplied to Q-COMP on the next scheduled data load.

### 3.9.4 Data warning

Q-COMP issues a warning to insurers in the validation report when unusual data is found during record validation. For example, the date of birth makes the injured worker less than 14 years old. Though this may not be an error, the data may need to be checked by the insurer and corrected as necessary.

### 3.9.5 Error recording

Error rates are recorded by Q-COMP. This information is used for statistical reporting on individual insurers to indicate how well the insurer is performing in supplying accurate data to Q-COMP.

- If errors in the data from the insurer are not fixed in line with the Queensland Workers' Compensation Insurer's Performance Standards and Benchmarks, the matter may be escalated via an Insurer Advisor of the Q-COMP Insurer Services Group.

The appropriate number and timeframe for errors are considered on a case by case basis. An appropriate warning is issued from Q-COMP to the offending insurer before any action is taken. A summary of the procedure used to govern error management is included in Appendix B.

### 3.9.6 Validation report

The validation report sent to insurers contains information to assist error correction, such as the:

- claim number
- error type
- error number
- data file affected by the error
- error message
- number of months the error has been uncorrected.

The report is ordered by claim number and error type, which allows for easy error identification relating to a single claim. The insurer can use the sort feature to change the way in which the report is sorted.

- The error message column in the validation report contains references to the relevant section of the data specifications to help fix the error.

Q-COMP provides insurers with year to date error statistics. These statistics assist insurers and Q-COMP to identify patterns of errors occurring in the data interface. These error statistics are provided in two ways:

- 1) Each outstanding error is aged from the point at which this error first occurred. This information is found under the "months in error" column
- 2) An "Error Statistics" tab is also provided in the validation report that summarises outstanding errors according to how long they have been in error.

Claim Number	Error Type	Error Number	Data File	Error Message	Months in Error	Priority
1234	Data Warning	405066	Claim Status	The Claim <Q00759> has a Notice of Claim Received Date and has not been Finalised (4.5.6)	0	
1111	Field Validation	406100	Compensation Period	The number of Work Days Lost has not been supplied (4.6.10)	10	High
1233	Field Validation	414061	Payment Total	The Claim <Q01495> has a Total Statutory Claim Cost of <9355.39> in the Payments file and this does not equal <10356.21> in the Payment Total file (4.13.6)	4	Medium
9876	Field Validation	406100	Compensation Period	The number of Work Days Lost has not been supplied (4.6.10)	0	
9999	Field Validation	406100	Compensation Period	The number of Work Days Lost has not been supplied (4.6.10)	10	High
8765	Field Validation	414061	Payment Total	The Claim <Q01571> has a Total Statutory Claim Cost of <910.76> in the Payments file and this does not equal <455.38> in the Payment Total file (4.13.6)	0	
1222	Field Validation	406100	Compensation Period	The number of Work Days Lost has not been supplied (4.6.10)	11	High
1235	Field Validation	406100	Compensation Period	The number of Work Days Lost has not been supplied (4.6.10)	11	High

Upon the successful supply of data, the insurer is provided with a validation report.

A “test” validation report (this is where the insurer’s data is validated, but not committed to the Q-COMP database) may be run when submitting data. A test validation report enables the insurer the opportunity to correct errors before the data is committed to the database or counted in monthly statistics. This option may only be taken if the insurer can supply the final data before it is due on the 8<sup>th</sup> of the month.

Test validation may be undertaken at any time during the data supply month.

- Q-COMP strongly recommends pre-validation to ensure minimal errors are loaded onto the database.

### 3.9.7 Management of insurer data errors

The *Insurer Performance Management Program* states ‘data supplied to Q-COMP is to be accurate and in accordance with the *Workers’ Compensation Insurer’s Data Specifications*’. The benchmarks for these errors as documented in the *Insurer Performance Management Program* are as follows:

- Insurers should action all data errors within one month and rectify within two to three months.
- No data errors are to be outstanding beyond six months.
- Insurers should notify Q-COMP of any changes to their workers’ compensation data systems at least 20 business days before implementation.

If, at any point, an insurer believes the validation and error reporting process is incorrect, the insurer is to provide a formal written submission to Q-COMP detailing the error and situations in which it may not apply. In consultation with the Data Reference Group, Q-COMP will evaluate the submission and make a determination as to whether the appropriate course of action.

Where errors have occurred due to the implementation of new data specifications, a grace period of three months is allowed. During this time any errors generated by the insurer or Q-COMP as a result of the changes, may be excluded from the statistics. However, it is expected testing be performed prior to the release of any changes to reduce the likelihood of errors occurring.

## 4 User data description

The following sections in this chapter define the format and description of each data field in the file(s) to be supplied by the insurer.

The table below provides a short description and purpose of each file to be supplied by the insurer in the data interface. These files are fully described later in this chapter.

Self-insurer File Name	WorkCover File Name	Short description	Purpose
CONTROL.DTA	WCONTROL.DTA	Control File	Contains control information to verify the contents of the load.
CLAIMBSE.DTA	WCLAIMBS.DTA	Claim Base File	Contains the base details for the claim. Must only be one record per claim.
WORKER.DTA	WWORKER.DTA	Injured Worker File	Contains injured worker detail. One or more claims can be associated with an injured worker.
LODGE.DTA	WLODGE.DTA	Lodgement File	Contains the lodgement date of the application for workers' compensation by the injured worker. Multiple records per claim.
CLAIMSTA.DTA	WCLAIMST.DTA	Claim Status File	Contains details on the status of the claim. Multiple records per claim.
COMPPER.DTA	WCOMPPER.DTA	Compensation Period File	Contains details on a weekly compensation period for the claim. Multiple records per claim.
FATALAPP.DTA	WFATALAPP.DTA	Fatal Application File	Contains details on a fatal application lodged against the claim. Multiple records per claim.
FORMNAME.DTA	WFORMNAM.DTA	Former Names File	Contains details on a former name of the injured worker. Multiple records per injured worker.
DAMAGESB.DTA	WDAMGESB.DTA	Damages Base File	Contains the base details of a damages claim. This damages claim is associated with the statutory claim. Must only be one record per claim.
DAMAGESR.DTA	WDAMGESR.DTA	Damages Resolution File	Contains details that describe the resolution of the damages claim. Must only be one record per claim.
CONTNEG.DTA	WCONTNEG.DTA	Damages Contributory Negligence File	Contains details that describe the circumstances under which a reduction of damages occurred because of contributory negligence. Multiple records per claim.
PAYMENTS.DTA	WPAYMENT.DTA	Payments File	Contains a total of payments made against the claim per month, based on a predetermined list of payment types and categories. Multiple records per claim.
PAYTOTAL.DTA	WPAYTOTL.DTA	Payment Total File	Contains two 'as at' totals of payments made against the claim, as a statutory claim initially and later as a damages claim. Must only be one record per claim.
PI.DTA	WPI.DTA	Permanent Impairment File	Contains details of injuries for which offers of permanent impairment have been made to the injured worker. Multiple records per claim.
EARN.DTA	WEARN.DTA	Ordinary Earnings File	Contains details of the ordinary earnings for the worker including normal weekly earnings and award rate. Multiple records per claim.
MULTINJ.DTA	WMULTINJ.DTA	Multiple Injury File	Contains details of all injuries on the claim including the most serious injury. Multiple records per claim.

## 4.1 Control file

The Control File must exist, and only exist once, in the data submission. For the appropriate file name, refer to User Data Description on page 19.

The control file contains control information used to validate the data the insurer is expected to send against what is actually contained in the data files. If any of the control data is incorrect, the data is rejected and a file validation report is sent to the insurer.

The control information held in this file is:

- insurer number
- the reporting period
- name of each file supplied
- number of characters in each file
- number of records in each file
- control totals of appropriate numeric fields in each file

The control file must contain one record for each file contained in the data supplied (including the control file itself).

### 4.1.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be a valid insurer number.

### 4.1.2 Reporting period from

The start date of the reporting period for the data supplied by the insurer.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be the first day of the reporting period (for example, for the month of March 1997, it would be 19970301).

#### 4.1.3 Reporting period to

The ending date of the reporting period for the data supplied by the insurer.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- Must be the last day of the reporting period (for example, for the month of March 1997, it would be 19970331).

#### 4.1.4 Filename

The name of each file supplied in the data.

**Format/Length** Char(12)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- The filename must include the '.' and the extension (for example, CLAIMBSE.DTA).
- A file with this filename must exist in the data.
- If a file exists in the data, the filename must exist in this control file.

#### 4.1.5 Number of bytes

This field contains the number of characters (bytes) in the file.

**Format/Length** Num(9)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- This field contains the number of characters (bytes) in the file identified in the file name. This count must be equal to the actual number of characters (bytes) that relate to the data found in the file (Refer to Insurers' Interface Technical Specification); the count excludes any control characters (for example, record delimiters, end-of-file markers, etc.).

#### 4.1.6 Number of records

This field contains the number of records in the file.

**Format/Length** Num(6)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- This field contains the number of records in the file identified in the file name. This must be equal to the actual number of records in the file (read by Q-COMP).
- Extra rows in the file (e.g. blank rows) will be counted by Q-COMP as data, which will result in a Control File Validation error.

#### 4.1.7 Control total

This field contains the sum of a numeric field identified in the file (the field used for this sum differs depending on the file being described – see each individual file for more information).

The insurer, while processing the information to create the file, sums a predetermined numeric field and stores the result in this control total field. Q-COMP, when processing the data, calculates the total for the same numeric field. A file validation error is generated if a difference is found between these two totals.

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Control File Validation

- This field is Mandatory for any file with a control total field defined:
  - Claim Base File (**Injury Location** field on page 30)
  - Compensation Period File (**Workdays Lost** field on page 59)
  - Damages Base File (**Amount of First Offer** field on page 73)
  - Damages Resolution File (**Resolution Outcome** field on page 83)
  - Damages Contributory Negligence File (**Contributory Negligence Section** field on page 93)
  - Multiple Injury File (**Injury Location** field on page 121)
  - Ordinary Earnings File (**Normal Weekly Earnings** field on page 118)
  - Payments File (**Net Claims Cost** field on page 103)
  - Payment Total File (**Total Statutory Claim Cost** field on page 108)
- This field containing the total must be equal to the actual total as calculated by Q-COMP.

## 4.2 Claim base file

This file forms the base of a claim's details. A claim cannot physically be deleted. If an insurer wishes to advise Q-COMP that a claim was created in error, the claim has to be cancelled (claim status associated with the claim must become CAN (Refer to Section 4.5, Claim status file on page 45)).

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- **insurer number**
- **claim number**

The **injury location** field has been defined in this file as the control total. Refer to Section 4.1.7, Control total on page 22.

### 4.2.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

Must be the valid insurer licence number supplied by Q-COMP that uniquely identifies the insurer.

### 4.2.2 Reporting period from

The starting date of the reporting period for the data supplied by the insurer. This date is used to identify that the record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation & Business Rules

##### Control File Validation

- The reporting period from date must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.2.3 Reporting period to

The end date of the reporting period for the data supplied by the insurer. This date is used to identify that the record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation & Business Rules

##### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.2.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer.

This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system and must be used in any subsequent dealings with Q-COMP.

**Format/Length** Char(15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

### 4.2.5 Liability commencement date

The date that entitlement for compensation arose. This date should only be supplied once for a claim, even if there are continuations.

**Format/Length** Date

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Field Validation

- The liability commencement date must be greater than or equal to the injury date.
- The liability commencement date must be supplied at the time the initial admitted claim status is supplied for the claim (refer to Section 4.5, Claim status file on page 45).
- The liability commencement date must be less than or equal to the initial admitted claim status of the claim (refer to Section 4.5, Claim status file on page 45).

#### 4.2.6 Injury narrative

This field contains a brief description of what the worker was doing at the time of the injury and how the injury occurred, (for example, I was climbing a ladder to the top of the tank. I lost my footing and slipped off the ladder and fell to the ground). Narratives with insufficient information will be sent back to insurers for more information. This narrative is used by the Office of Economic and Statistical Research to code mechanism and agency for the National Data Set.

**Format/Length** Char(250)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- Must describe the action and the cause of the injury.

##### Field Validation

- Must be a least 15 characters of description.
- Where the description is less than five words, no word can be duplicated. For example, FELL OVER FELL OVER.

#### 4.2.7 Injury date

The date the injury occurred. In the case of a latent onset injury, or an injury over a period of time, this is the date the worker was assessed by a doctor or dentist, for the injury.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Injury date must be less than or equal to lodgement date (Refer to Section 4.4, Lodgement file on Page 42).
- Injury date must be greater than the worker's date of birth.

#### 4.2.8 Injury time

The time during the day the injury occurred.

**Format/Length** Time

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rules

- The injury time must be supplied except where the injury occurred over a period of time.

#### 4.2.9 Injury occurrence code

The type of occurrence of the injury.

**Format/Length** Num(1)

**Mandatory/Conditional** Conditional

**Validation/Business Rules**

**Field Validation**

- Must be a valid code:

Injury Occurrence	Code
Traffic Accident - Nature of Work (for example, motor vehicle accident by delivery driver or courier during normal duties)	1
Not Traffic Accident - Nature of Work (normal work related injury during course of employment - for example, butcher cuts finger slicing meat at work)	2
Not Nature of Work (for example, worker twists ankle playing touch football during working hours but the touch football game was not sanctioned by employer)	3
During Recess at Place of Work (for example, worker slips injuring back in lunch room during designated lunch break)	4
During Recess Not at Place of Work (for example, worker who goes away from workplace for lunch and sustains injury)	5
Journey to Work (for example, injury sustained by employee on way to work)	6
Journey from Work (for example, injury sustained by employee on way home from work)	7
Nature of Work – away from normal workplace (for example, an employee who does not normally perform site visits is required to perform an urgent site visit because all other officers who normally perform site visits are busy. If employee is injured whilst performing this site visit then Injury Occurrence Code 8 should be used.)	8

#### 4.2.10 Injury period occurred

No longer used.

#### 4.2.11 Injured worker identifier

This number uniquely identifies each injured worker within the insurer's system (Refer to Section 4.3, Injured worker file on page 37).

The Injured Worker Identifier field in this record is only used to associate the claim with the appropriate injured worker.

**Format/Length** Char(20)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- The Injured Worker Identifier must be equal to a previously supplied Injured Worker Identifier or the Injured Worker Identifier must currently be supplied (in the Injured Worker File)

#### 4.2.12 Injured worker occupation description

This field contains a brief description of the occupation of the injured worker at the time of the injury (that is, builder, painter, waitress, etc.).

**Format/Length** Char(40)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- Codes (such as the ABS Australian Standard Classification of Occupation) should not be used for reporting this field unless coders have been trained in the use of codes or the codes have been specifically developed to represent the occupations of the insurer.

#### 4.2.13 Injured worker date deceased

The date the injured worker died as a result of the injury that is the subject of this claim.

**Format/Length**                      Date

**Mandatory/Conditional**    Conditional

#### Validation/Business Rules

##### Business Rule

- This field is only to be supplied if the injured worker died as a result of the injuries sustained as a part of this claim.

##### Field Validation

- The Injured Worker Date Deceased must be greater than or equal to the Injury Date.
- Must be supplied where the Liability for Workplace Fatality (4.2.31) is provided.
- Must be supplied when a Fatal Payment has been supplied, Payment Category 04 (4.12.6)

#### 4.2.14 Injury occurred address

The address of where the injury occurred.

**Format/Length**                      Char(30)  
                                                 Char(30)  
                                                 Char(25)  
                                                 Num(4)

**Mandatory/Conditional**    Mandatory

#### Validation/Business Rules

##### Business Rule

- Must comply with Address Format 1 standard. Refer to Appendix C, Address Formats.

#### 4.2.15 Injury identifier

This field contains a value to identify whether the most serious injury was on the left or right side of the body, or is not applicable for the type of injury.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

<b>Injury Identifier</b>	<b>Code</b>
Left	L
Right	R
Bilateral	B
Not applicable	N

##### Warning

- Must comply with the Injury Location and Injury Identifier validation rules. Refer to Appendix E, Injury Location and Injury Identifier Validation.

#### 4.2.16 Injury location

A code to identify the location of the most serious injury.

**Format/Length** Num(3)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- The staff member has an adequate level of competency in coding the injury.

##### Field Validation

- The Injury Location value must be valid (based on the coding standards of the *Type of Occurrence Classification System – Safe Work Australia*).
  - claims intimated from 01/07/2006 use TOOCS v3.1
  - claim intimated from 01/07/2005 to 30/06/2006 use TOOCS v3
  - claims intimated to 30/06/2005 use TOOCS v2.

##### Warning

- The Injury Location must be valid for the Injury Nature (must comply with the Injury Location and Injury Nature Validation Rules as developed by Safe Work Australia - information about Safe Work Australia and the National Data Set is contained in Appendix A).

#### 4.2.17 Injury nature

A code to identify the nature of the most serious injury.

**Format/Length** Num(3)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- The staff member has an adequate level of competency in coding the injury.

##### Field Validation

- The Injury Nature value must be valid (based on the coding standards of the *Type of Occurrence Classification System – Safe Work Australia*).

##### Warning

- The Injury Nature must be valid for the Injury Location (must comply with the Injury Location and Injury Nature Validation Rules as developed by Safe Work Australia (information about Safe Work Australia and the National Data Set is contained in Appendix A.).

#### 4.2.18 Injury mechanism

No longer used (but field will remain in the data specifications for insurers who continue to use the field). Format remains Num(2).

#### 4.2.19 Injury agency

No longer used (but field will remain in the data specifications for insurers who use). Format remains Num(3).

#### 4.2.20 Business workplace registration number

No longer used.

#### 4.2.21 Workplace accreditation number

No longer used.

#### 4.2.22 WorkCover industry code/industry business code

This field contains the industry code that identifies the industry in which the injured worker was employed at the time of the injury. Claims where the date of injury is prior to 1 July 1997 use an Industry Business Code; injuries on or after 1 July 1997 will use a WorkCover Industry Code (WIC).

- These Industry codes (and description) are supplied to the insurer. The insurer is then responsible for allocating the appropriate code to each claim.

**Format/Length** Num(6)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid WorkCover Industry/Industry Business Code for the insurer.

#### Warning

- The WorkCover Industry/Industry Business Code must be current for the member or policy at the injury date.

#### 4.2.23 Workplace industry description

The description of the main industry or business activity of the establishment (workplace) where the injured worker was based at the time of the injury.

**Format/Length** Char(40)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

- None

#### 4.2.24 Employer number

The employer number (also known as member number for self-insurers) to identify the employer of the injured worker. At the time of issuing the licence, a number is allocated by Q-COMP to each employer identified on the insurer licence. In the case of WorkCover this relates to the policy number of the employer.

**Format/Length** Char(12)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid Employer Number for the insurer.

#### 4.2.25 Previous insurer code

The unique identifier for the insurer who had liability for the claim prior to the current insurer.

**Format/Length** Char(3)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

#### Field Validation

- If another insurer managed this claim, both previous insurer code and previous insurer claim number must be reported.
- If previous insurer claim number is null, previous insurer licence number must be null. If previous insurer claim number is not null, previous insurer licence number must not be null.
- Previous insurer cannot be equal to the current insurer number.
- Must be a valid code:

Previous Insurer	Code
WorkCover Queensland	WCQ
Local Government Workcare	017
CSR Limited	023
Brisbane City Council	030
QR Limited	046
Australia and New Zealand Banking Group Limited	052
Council of the City of Gold Coast	069
Westpac Banking Corporation	075
Commonwealth Bank of Australia (no longer self-insured)	081
Arnott's Biscuits Limited	098
Woolworths Limited	103
Golden Circle (no longer self-insured)	110
Redland City Council	126
Townsville City Council	132
Xstrata Queensland Limited	149
BHP Billiton Limited	155
Brambles (no longer self-insured)	161
Qantas Airways Limited	178
Consolidated Meat Group Pty Limited	184
Franklins (no longer self-insured)	190

Previous Insurer	Code
Coles Group Limited	206
Symbion Health Limited (no longer self insured)	212
JBS Australia Pty Limited	229
The University of Queensland	235
OneSteel Limited	241
Tabcorp Holdings Limited	258
National Australia Bank (no longer self-insured)	264
Aged Care Employers Self Insurance Group (ACES)	270
Toll Holdings Limited	287
Myer Holdings Limited	293
Sucrogen Australia Pty Ltd	367
Queensland Rail Limited	373

#### 4.2.26 Previous insurer's claim number

The unique identifier for the claim when it was managed by the insurer who had liability for the claim prior to the current insurer. The insurer and claim number combination can only be supplied once by any insurer, that is, it must be a unique number on the insurer's system.

**Format/Length** Char(15)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rule

- If a claim was managed by another insurer, both previous insurer code and previous insurer claim number must be reported.

##### Field Validation

- If previous insurer code is null, previous insurer claim number must be null. If previous insurer code is not null, previous insurer claim number must not be null.

##### Warning

- The date of injury on the current claim must be the same as reported by the previous insurer or confirmed.
- The injured worker date of birth on the current claim must be the same as reported by the previous insurer or confirmed.
- The number of workdays lost on the current claim must be the same as or greater than those reported by the previous insurer or confirmed.
- The total payments by category and type on the current claim must be the same as or greater than those reported by the previous insurer.

#### 4.2.27 Psychological work related impairment (WRI) percent

The WRI percent for a psychiatric or psychological injury resulting from an event as described in the regulation.

**Format/Length** Pct(5)

**Mandatory/Conditional** Conditional

##### Validation/Business Rules

##### Field Validation

- If there is a permanent impairment injury offer for injury codes 6000, 6001, 6002 or 6003 then Psychological Work Related Impairment (WRI) Percent must not be null. 0% is an acceptable value.

#### 4.2.28 Physical work related impairment (WRI) percent

The WRI percent for physical injury or injuries resulting from an event as described in the regulation.

**Format/Length** Pct(5)

**Mandatory/Conditional** Conditional

##### Validation/Business Rules

##### Field Validation

- If there is a permanent impairment injury offer for injury codes other than (6000, 6001, 6002, or 6003) then Physical Work Related Impairment (WRI) Percent must not be null. 0% is an acceptable value.

#### 4.2.29 Return to work status

A code for the return to work outcome at finalisation of the claim.

The return to work outcome must not be limited to the medical certification at finalisation of the statutory claim and consideration should be given to the workers actual capacity for work with their employer. Claims with a Return to Work outcome of 05, 06 or 07 must be referred to Q-COMP's RTW Assist program.

**Format/Length** Num(2)

**Mandatory/Conditional** Conditional

**Validation/Business Rule**

**Field Validation**

- Must be supplied if claim have at least one Category 03 payment greater than \$0.00 as defined in Section 4.12.6, Payment category on page 98 and has reached finalisation status (that is, status is 'FIN', 'CSD' or 'REJ') as defined in Section 2.1, Terminology on page 8.
- Must be a valid code:

<b>Return to Work Outcome</b>	<b>Code</b>
<b>Fit for work: same job/tasks with same employer</b>	01
The injured worker has returned to the same or job tasks with the same employer	
<b>Fit for work: same job/tasks with different employer</b>	02
The injured worker has returned to the same or job tasks with a different employer	
<b>Fit for work: different job/tasks with same employer</b>	03
The injured worker has returned to a different job or the tasks involved have been modified with a same employer	
<b>Fit for work: different job/tasks with different employer</b>	04
The injured worker has returned to a different job or the tasks involved have been modified with a different employer	
<b>Fit for work – no job</b>	05
The injured worker is fit for work but is unable to return to work because there is no job available. Examples of this situation include:	
a) termination	
b) redundancy	
c) seasonal employment	
<b>Fit for work – worker does not return</b>	06
The injured worker is fit for work but has voluntarily decided not to return to work. Examples of this situation include:	
a) resignation	
b) abandonment of employment	
c) extended leave	
d) moved interstate/overseas	
e) retirement	
<b>Not fit for work</b>	07
The injured worker is not fit for work when entitlement to weekly payments of compensation stops.	
<b>Alternative outcome</b>	08
a) The injured worker has died	

#### 4.2.30 Date injury first reported to employer

The employer has a duty to report an injury. The date the employer was first aware (s133) that any of the following happened:

- The employer knows the injury has been sustained.
- The worker reports the injury to the employer.
- The employer receives an insurer's written request for a report.
- For self-insurers, this could include an employer, work site, work unit, a supervisor, etc.

**Format/Length** Date

**Mandatory/Conditional** Conditional

#### Validation/Business Rule

##### Business Rule

- Must be supplied for all injuries other than over period of time claims.

##### Field Validation

- Must be greater than or equal to the date of injury.

#### 4.2.31 Fatality Flag

The value in this field indicates whether the claim is a fatality under the Act.

**Format/Length** Char(1)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

Accepted Workplace Fatality	Code
No – The fatality is not a fatality under the Act on this application	N
Yes – The fatality is a fatality under the Act on this application	Y

- Must be supplied where the Injured Worker Date Deceased (4.2.13) is provided.
- Must be supplied when a fatal payment is supplied, Payment Category 04 (4.12.6).

### 4.3 Injured worker file

This file contains injured worker details that are only supplied when a new injured worker is identified or a change has occurred to the injured worker's details. If the same injured worker lodges subsequent claims, and the injured worker's details have not changed, this information does not have to be supplied. One Injured Worker record can be linked to a number of claims.

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- insurer number
- injured worker identifier

No field is defined in this file for the purpose of a control total. Refer to Section 4.1.7, Control total on page 22.

#### 4.3.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- Must be a valid insurer number.

#### 4.3.2 Reporting period from

The starting date of the reporting period for the data supplied by the insurer. This date is used to identify that the record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- The reporting period from date must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.3.3 Reporting period to

The end date of the reporting period for the data supplied by the insurer. This date is used to identify that the record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.3.4 Injured worker identifier

The injured worker identifier uniquely identifies each injured worker and associates claims to the injured worker.

- The injured worker identifier helps supports Q-COMP maintain a history of claims for an injured worker.

Once an identifier has been allocated to an injured worker it must not change, as it is used as the key to reference this injured worker's data in any subsequent data transfers.

- In relation to claims transferred from another insurer, the unique identifier used by that insurer may be altered to fit the insurer's system to ensure a worker is only recorded once in the insurer's system and in the Q-COMP database.

**Format/Length** Char(20)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- If the injury worker identifier is supplied, at least one claim has been supplied associated with this injured worker identifier.

### 4.3.5 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be deleted, added, or modified on the Q-COMP validation system.

**Format/Length** Char (1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

Delete Flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes - the data identified by the key of this record is deleted.	Y

- If the injured worker identified by the injured worker identifier is associated with at least one claim and the delete flag is set to Y, the injured worker record must not be deleted.

### 4.3.6 Injured worker date of birth

The injured worker's date of birth.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- The date of birth must be less than the injury date.

#### Warning

- The date of birth must not be less than fourteen (14) years before the injury date. The worker must be over 14 year of age.
- The date of birth must not be greater than seventy-nine (79) years before the injury date. The worker must not be over 79 years of age.

#### 4.3.7 Injured worker name

The injured worker's name.

**Format/Length** Char(70)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Warning**

- The injured worker's name must comply with the Q-COMP Personal Name format standard. Refer to Appendix D, Name Formats.

#### 4.3.8 Injured worker name change reason

The injured worker name change reason field contains a code that identifies the reason the name changed, which assists validation of any changes to the injured worker name.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Field Validation**

- Must be a valid code:

<b>Name Change Reason</b>	<b>Code</b>
No Change - the name has not changed	N
Error - the name changed due to correction of input error	E
Legitimate - the name changed due to a legitimate reason other than error. For example, the name changed due to marriage, deed poll, etc	L

- If the change is due to a legitimate reason, a former name associated with this injured worker must be supplied. The previous name must be recorded as a former name. The former name is the same as the injured worker name before the change. Refer to Section 4.8, Former names file page 66.

### 4.3.9 Injured worker residential address

The injured worker's residential address.

<b>Format/Length</b>	First address line	Char(30)
	Second address line	Char(30)
	Third address line	Char(25)
	Post Code	Num(4)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Business Rule

- The injured worker residential address must comply with the Q-COMP Address Formats. Refer to Appendix C, Address Formats.

### 4.3.10 Injured worker gender

The injured worker's gender.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

<b>Gender</b>	<b>Code</b>
Female	F
Male	M

## 4.4 Lodgement file

This file contains the lodgement dates of applications for workers' compensation. These details must be supplied when an initial claim is lodged with the insurer, or whenever a continuation is lodged.

For the appropriate file name, refer to User Data Description on page 19.

- Refer to Section 2.1, Terminology, for the definition of lodgement and continuation.

The unique key of the data represented in each record of this file is:

- insurer number
- claim number
- lodgement record identifier

No field has been defined in this file for the purpose of a control total. Refer to Section 4.1.7, Control total on page 22.

### 4.4.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be a valid insurer number.

### 4.4.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

#### 4.4.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

#### 4.4.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length** Char(15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

#### 4.4.5 Lodgement record identifier

The lodgement record identifier uniquely identifies each lodgement associated with a claim. This identifier assists Q-COMP to identify whether the data already exists on the Q-COMP system and if the appropriate action can be taken to add, modify, or delete the data on the Q-COMP system.

- Once an identifier has been allocated to a lodgement record it must not change, as it is used in the key to reference this data in any subsequent data transfers.

**Format/Length** Char(10)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- Must be unique for each lodgement made against a claim.

#### 4.4.6 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

Delete Flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

- If a lodgement record is deleted, a corresponding claim status for intimation must be deleted. This is based on validation rule number of lodgements must equal the number of intimations. Refer to Section 4.5.7, Claim Status on page 48.
- If the lodgement record to be deleted is the only lodgement for the claim, the delete must not be allowed.

#### 4.4.7 Lodgement date

The date the injured worker or claimant lodged the application for workers' compensation, that is, the initial application or further compensation, that is, a continuation of a claim with the insurer.

- This date represents when the injured worker (or a person on behalf of the injured worker) delivers the application form for workers' compensation to the insurer.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- The lodgement date must be greater than or equal to the injury date.
- The lodgement date must be less than or equal to the corresponding claim status date of intimation.
- The lodgement date must be greater than any previous lodgement date (if one exists).

## 4.5 Claim status file

This file contains details of all changes in claim status.

For the appropriate file name, refer to User Data Description on page 19.

The unique keys for the data represented in each record of this file are:

- insurer number
- claim number
- status record identifier

No field has been defined in this file for the purpose of a control total. Refer to Section 4.1.7, Control total on page 22.

All changes to the status of a claim must be recorded and supplied to Q-COMP. After the creation of a new claim at least one record must be supplied to Q-COMP.

### 4.5.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- Must be a valid insurer number.

### 4.5.2 Reporting period from

The starting date of the reporting period for the data supplied by the insurer. This date is used to identify that the record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- The reporting period from date must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.5.3 Reporting period to

The end date of the reporting period for the data supplied by the insurer. This date is used to identify that the record belongs to a particular reporting period.

**Format/Length**                      Date

**Mandatory/Conditional**    Mandatory

#### **Validation/Business Rules**

#### **Control File Validation**

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.5.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length**                      Char(15)

**Mandatory/Conditional**    Mandatory

#### **Validation/Business Rules**

#### **Record Validation**

- Each claim created by the insurer must be unique and is identified by this field.

### 4.5.5 Status record identifier

The status record identifier uniquely identifies each status change associated with a claim.

- The status record identifier helps support Q-COMP to maintain a history of status changes for the claim.
- Once an identifier has been allocated to a record (status details) it must not change, as it is used as the key to reference this data in any subsequent data transfers.

**Format/Length**                      Char(10)

**Mandatory/Conditional**    Mandatory

#### **Validation/Business Rules**

#### **Record Validation**

- The status record identifier must be unique for each status change made against a claim.

#### 4.5.6 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be deleted, added, or modified on the Q-COMP system.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- If a claim status record associated with an intimation is deleted, a corresponding lodgement record must be deleted (based on the validation rule, number of lodgements must equal the number of intimations).

##### Field Validation

- Must be a valid code:

Delete Flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

- If the claim status to be deleted is the only status for the claim, the delete is not allowed.
- If a claim status is to be deleted, the claim status following the deletion must comply with all appropriate validation rules. Refer to Field Validation in Section 4.5.7, Claim Status on page 48).
- If the claim status to be deleted is a finalisation, a notice of claim received date must not be supplied (that is, a claim for damages cannot proceed). For more information on notice of claim received date. Refer to Section 4.9, Damages base file on page 69.
- If the claim status to be deleted is the only admitted claim status for the claim and the claim has had payments in payment categories 03, 04, 05, 06 or 07, the delete will not be allowed. Refer to Section 4.12, Payments file on page 95.

#### 4.5.7 Claim status

The claim may have many changes in claim status as it progresses through the life of the claim. Refer to section 2.1, Terminology on page 8.

If the Review Unit, Industrial Magistrate or Industrial Court overturns a decision, the claim status may be revised on the outcome of the decision.

The correct sequence of claim status can be seen in Figure 1: Claim Status Process Map on page 50. This figure clearly outlines the changes of claim status allowable by the Q-COMP system.

**Format/Length** Char(3)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

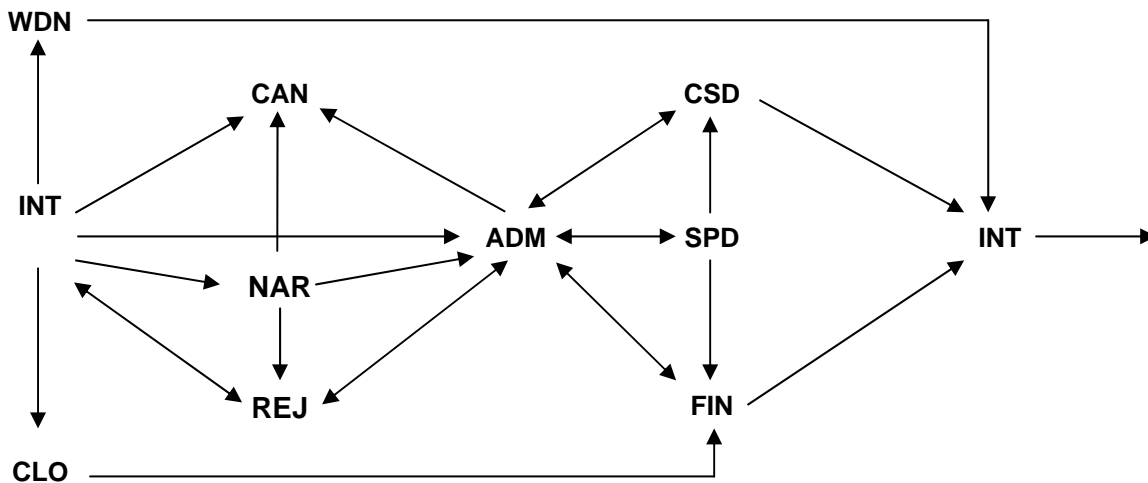
Status	Code
Admitted (liability accepted, liability accepted after review/appeal, liability continued)	ADM
Cancelled	CAN
Ceased	CSD
Finalised	FIN
Intimated	INT
Rejected	REJ
Suspended	SPD
No Action Required	NAR
Withdrawn (WCQ only)	WDN
Common Law Only	CLO

- The first status on creation of a claim **must be intimated**.
- The claim status date associated with the **intimated** claim status must be greater than or equal to the corresponding lodgement date.
- The first status on continuation of a claim **must be intimated**. A lodgement record must be supplied in this case only. Refer to section 2.1, Terminology on page 8.
- If the claim is processed to the **intimated** status for a continuation, a new lodgement date must be supplied (that is, the number of times the claim is intimated must be equal to the number of lodgements).
- Any **subsequent intimated** status must be due to a continuation and the previous claim states must be finalised, ceased, or rejected.
- If the claim is processed from **intimated** status to cancelled status, only payments of categories 01 or 02 can be associated with the claim. Refer to Section 4.12, Payments file on page 95.
- If a **new intimation on an existing claim is cancelled**, this status with the intimation and lodgement must be deleted from the existing claim and the lodgement and intimation submitted on another claim or a new claim.

- If the claim is processed to the **intimated** status due to a reopening/continuation of the claim, the notice of claim received date must not be supplied. The injured worker cannot be claiming for damages as well at this stage. Refer to Section 4.9, Damages base file on page 69.
- If a claim is in the **intimated** status, the claim can be processed to any of the following status:
  - Rejected
  - Cancelled
  - No action required
  - Admitted (liability accepted)
  - Withdrawn (WCQ only)
  - Common law only
- If a claim is in the **cancelled** status, the claim cannot progress to any other status. Furthermore, it can have no payments of any payment category supplied if it is in the cancelled status.
- If a claim is in the **no action required** status, the claim can be processed to any of the following status:
  - Rejected
  - Admitted (liability accepted)
  - Cancelled
- If a claim is in the **rejected** status, the claim can only be processed to the following status:
  - Admitted (liability accepted after review/appeal)
- If a claim is in the **rejected** status, and this is the decision made against a continuation of the claim, the claim can be processed to (1) intimated on the registration of a further continuation application. Each intimation status must include a corresponding lodgement record.
- Conditions exist on rejected claims. Refer to continuation in section 2.1, Terminology on page 8.
- If a claim is in the **admitted** status (liability accepted), the claim can only be processed to any of the following status:
  - Finalised
  - Ceased
  - Suspended
- If the claim is processed to the **admitted** status, the liability commencement date must be supplied.
- If the claim is processed to the **admitted, rejected** or **no action required** status, the injury occurrence code must be supplied.
- If a claim is in the **admitted** status (liability accepted), the claim can be processed to rejected only in the case of a reversal of a review decision by Q-COMP's Review Unit or on an appeal to the Industrial Magistrate or Industrial Court.
- If a claim is in the **finalised** status, the claim can be processed to any of the following status:
  - Admitted (to allow for processing of further payments)
  - Intimated (due to a continuation)
- If a claim is in the **ceased** status, the claim can be processed to any of the following status:

- ❑ Admitted (liability continued)
  - ❑ Intimated (due to a continuation)
- If a claim is in the **suspended** status, the claim can be processed to any of the following status:
  - ❑ Finalised
  - ❑ Ceased
  - ❑ Admitted (liability continued)
- If a claim is in the **withdrawn** status, the claim can only be processed to the following status:
  - ❑ Intimated
- If a claim is in the **common law only** status, the claim can only be processed to the following status:
  - ❑ Finalised
- If the claim is processed to **finalised** or **rejected** status, all fatal applications must have a decision supplied. Refer to Section 4.7.8, Fatal application decision of the Fatal application file on page 65.
- If the claim is processed to the **finalised** or **ceased** status, no open compensation periods can exist. All compensation from dates should have a corresponding compensation to date (if any compensation periods exist).

**Figure 1: Claim Status Process Map**



\* **WDN – for use by WorkCover Queensland Only (refer to section 2.1, Terminology on page 8 for definition of Withdrawn)**

The following table represents a quick reference map of claim status changes.

**Figure 2: Claim Status Reference Map**

		Status To								
		INT	CLO	CAN	NAR	REJ	ADM	CSD	SPD	FIN
Status From	INT		X	X	X	X	X			
	CLO									X
	CAN									
	NAR			X		X	X			
	*REJ	X					X			
	ADM			X		X		X	X	X
	*CSD	X					X			
	SPD						X	X		X
*FIN	X					X				

	INT	CLO	CAN	NAR	REJ	ADM	CSD	SPD	FIN
WDN ^	X								

^ WCQ only

#### 4.5.8 Claim status date

This is the date and time the status change was made on the insurer's system. It is not the date the liability changed if the claim is a transferred claim.

There are cases where the time is not supplied for claims that have been transferred from another insurer. The date must be input and the time the status change was made must be generated by the current insurer. This data is supplied, ensuring the sequence of status changes is correct for the claim. The Q-COMP system uses the dates AND times to order the status.

**Format/Length**                      Date/Time

**Mandatory/Conditional**    Mandatory

**Validation/Business Rules**

**Warning**

- The initial intimation date must be the same as the initial intimation date supplied by another insurer.

#### 4.5.9 Liability reversed indicator

This field records whether the decision to cease entitlements is due to:

- The reversal of an earlier decision to admit liability in the application for compensation. For example, an administrative error or a decision of the Review Unit under Section 545(5) of the *Workers' Compensation and Rehabilitation Act 2003*, or
- A decision to terminate or suspend an entitlement following a review of the claim and where the earlier decision to admit liability has not changed. For example, a decision under Sections 168(2) and 177(1) of the *Workers' Compensation and Rehabilitation Act 2003*.

**Format/Length** Char(1)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

Liability Reversed Indicator	Code
No - on ceasing the benefits of this claim, the liability for the claim was not reversed.	N
Yes - on ceasing the benefits of this claim, the liability for the claim was reversed.	Y

- The liability reversed indicator must be supplied, if the claim status is ceased.

#### 4.5.10 Claim staff name

The claim staff name is the name of the insurer's staff member who made the decision to change the status of the claim.

For claims transferred from another insurer where the claim staff name has not been supplied, the name of staff member of the insurer who is currently responsible for the claim must be supplied for each claim status except intimated.

**Format/Length** Char(70)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

#### Field Validation

- The claim staff name must comply with the personal name standard. Refer to Appendix D, Name Formats.
- The claim staff name must be supplied with all claim status except intimation.

#### 4.5.11 Reason for status

The reason for status is the reason for a claim being rejected, ceased or suspended.

**Format/Length** Num(2)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

#### Field Validation

- Must be supplied if the claim status is rejected, ceased or suspended.
- Must not be supplied if status is other than rejected, ceased or suspended.
- Must be a valid code:

Rejection Reason (REJ)	Code
Not a worker – S11	01
Not an injury – S32(1-4)	02
Not an injury – psychiatric – excluded by S.32(5)	03
Subjecting to abnormal risk during absence – S.34(1)(c)	04
Not a journey – S35	05
Journey – traffic offence or breach of Criminal Code – S36(2)(a)	06
Journey – substantial delay, interruption or deviation –S36(2)(b)	07
Insurer not liable – S87	08
Outside Queensland – S113	09
Industrial deafness – excluded under S125 – initial application	10
Industrial deafness – excluded under S126 – further application	11
Out of time – excluded under S131	12
Invalid application – S132	13
Fraud – excluded under S537	14
Persons other than workers – not covered under Div 3 Part 4 Ch 1	15
Compensated under corresponding law – S116	16
Self-inflicted injury – excluded under S129	17
Wilful misconduct – excluded under S130	18
Seafarer – excluded under S121	19
Miner – excluded under S123	20

#### Cessation Reason (CSD)

Entitlement to compensation stops if compensation under corresponding laws – s.116	41
Entitlement to compensation ends if damages claim is finalised (settlement or judgement) – s.119	42
Maximum statutory entitlement reach – s.140	43
5 year limit reached – s.144A	44
Injury not likely to improve with further treatment – s.144B	45
Insurer review of entitlement to compensation – s.168	46
Worker receives notice of assessment – s.190	47
Redemptions – s.171, s.172, s.173, s.176	48

**Suspension Reason (SPD)**

Worker refuses to be examined by registered person – s.135	61
Worker serving a term of imprisonment – s.137	62
Compensation not payable during suspension under Chapters 3,4,11 or 13 – s.138	63
Insurer review of entitlement to compensation – s.168	64
Worker refuses to participate in rehabilitation – s.232	65

## 4.6 Compensation period file

This file contains details of any compensation period associated with claims. This period is associated with weekly payments.

For the appropriate file name, refer to User Data Description on page 19.

The unique keys for the data represented in each record of this file are:

- insurer number
- claim number
- status record identifier

The **workdays lost** field has been defined in this file as the control total. Refer to Section 4.1.7, Control total on page 22.

If the compensation period is for **excess days lost**, this must be supplied separately to compensation periods paid by the insurer. An excess days lost flag (4.6.14) indicates the days as being for excess.

**All days lost (where the worker is paid under the *Workers' Compensation and Rehabilitation Act 2003*) excluding day of injury must be supplied on the claim, regardless of if they are excess days paid by the employer or paid by the insurer.**

A **new compensation period** must be supplied separately for each period of partial and total incapacity.

### 4.6.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be a valid insurer number.

#### 4.6.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length**                      Date

**Mandatory/Conditional**    Mandatory

#### **Validation/Business Rules**

#### **Control File Validation**

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

#### 4.6.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length**                      Date

**Mandatory/Conditional**    Mandatory

#### **Validation/Business Rules**

#### **Control File Validation**

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

#### 4.6.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length**                      Char(15)

**Mandatory/Conditional**    Mandatory

#### **Validation/Business Rules**

#### **Record Validation**

- Each claim created by the insurer must be unique and is identified by this field.

#### 4.6.5 Compensation record identifier

This field uniquely identifies each compensation period associated with a claim. This identifier assists Q-COMP to identify whether the data already exists on the Q-COMP system and if the appropriate action can be taken to add, modify, or delete the data on the Q-COMP system.

**Format/Length** Char(10)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Record Validation

- Must be unique for each compensation period on the claim.

#### 4.6.6 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

Delete Flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

- If the compensation period to be deleted is the only compensation period for the claim and the claim has had weekly compensation payments, the delete must not be allowed. Refer to payment category 03 in Section 4.12.6, Payment category on page 98.

#### 4.6.7 Compensation from date

The date of the first day of entitlement to weekly payments.

**Format/Length**            Date

**Mandatory/Conditional**    Conditional

#### Validation/Business Rules

##### Field Validation

- The compensation from date must not be within any other compensation period (compensation from date to compensation to date, inclusive) supplied.
- The compensation from date must be greater than or equal to the liability commencement date.

#### 4.6.8 Compensation to date

The date of the last day of entitlement to weekly payments. More than one compensation period can be supplied for a claim, not only one continuous compensation period. The compensation period to date can be no greater than one month ahead of the reporting period. For example, if the reporting period is from 1 May to 31 May, the greatest compensation period to date will be 30 June.

**Format/Length**            Date

**Mandatory/Conditional**    Conditional

#### Validation/Business Rules

##### Field Validation

- The compensation to date must not be within any other compensation period (compensation from date to compensation to date, inclusive) supplied.
- The compensation to date must be greater than or equal to the compensation from date of this compensation period.

##### Warning

- The compensation to date should be less than or equal to the injured worker date deceased for this claim.

#### 4.6.9 Normal work hours

The number of hours normally worked per week by the injured worker under the Industrial Instrument/Award.

**Format/Length** Decimal(4)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- Part of an hour must be represented as a decimal. For example, 36 hours and 15 minutes is supplied as 36.25.

#### 4.6.10 Workdays lost

The total number of working days lost in this compensation period, for which weekly compensation payments are being made.

- Where the injured worker was entitled to weekly payments due to partial incapacity, these days are counted as whole days.

**Format/Length** Num(6)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rule

- The workdays lost must have been supplied once a compensation period has been started (compensation from date supplied), but if a compensation period started at the end of the reporting period the value zero (0) is valid.

##### Field Validation

- The number of workdays lost must not be greater than the number of calendar days in the compensation period.
- The number of workdays lost cannot be less than or equal to zero, unless the compensation period was started at the end of the reporting period.

#### 4.6.11 First compensation payment date

The date the first compensation payment was drawn for this compensation period. This is not the first date of entitlement, but the date the payment is made to the injured worker.

- Only the date for the first payment made for this compensation period is to be supplied, not all payments made.

**Format/Length**                      Date

**Mandatory/Conditional**    Conditional

#### Validation/Business Rules

##### Business Rule

- The first compensation payment date must have been supplied at the time of the weekly compensation period commenced for this compensation period.

##### Warning

- The first compensation payment date must be greater than or equal to the liability commencement date of this claim. (This allows for advance payments to injured workers.)

#### 4.6.12 Hours lost

The total number of hours lost from work in this compensation period. If the person is back at work full time but on diminished capacity this is counted as zero hours lost.

**Format/Length**                      Decimal(6)

**Mandatory/Conditional**    Conditional

#### Validation/Business Rules

##### Business Rule

- Hours lost are reported in decimal format to the nearest two decimal places – if a person lost an hour and a quarter this would be reported as 000125 which would equal 1.25 hours.

##### Field Validation

- If hours lost is greater than 0, workdays lost must be greater than 0 (given that partial time lost has a minimum of 1 day – refer to section 4.6.10 Workdays lost on page 59 for workday lost validation rules).
- If partial/total incapacity is equal to total incapacity and workdays lost is greater than 0 then hours lost must be greater than 0.

#### 4.6.13 Partial/total incapacity flag

A flag to indicate whether the compensation period was partial or total incapacity.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- If the compensation period is for partial time lost from work, that is, where the employer is also paying the injured worker the partial days lost flag must be P (Partial).
- If the compensation period is for total time lost from work, that is, where the employer is not paying the injured worker the total days lost flag must be T (Total).

#### Field Validation

- Must be a valid code:

Total / Partial Incapacity Flag	Code
Total - the compensation period does not contain any partial days lost.	T
Partial - the compensation period is for partial days lost.	P

#### 4.6.14 Excess flag

A flag to identify excess days lost, that is where the employer has paid for the excess period (not the insurer).

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

Excess Flag	Code
No - the compensation period is not for excess.	N
Yes - the compensation period is for excess.	Y

## 4.7 Fatal application file

This file contains details of any fatal application submitted on the statutory claim. More than one fatal application can be lodged against a claim.

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- insurer licence number
- claim number
- fatal application record identifier

No field has been defined in this file for the purpose of a control total. Refer to Section 4.1.7, Control total on page 22.

### 4.7.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- Must be a valid insurer number.

### 4.7.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.7.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.7.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length** Char(15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

### 4.7.5 Fatal application record identifier

This field uniquely identifies each fatal application lodgement associated with a claim. This identifier assists Q-COMP to identify whether the data already exists on the Q-COMP system and if the appropriate action can be taken to add, modify, or delete the data on the Q-COMP system.

- Once an identifier has been allocated to a fatal application record it must not change, as it is used in the key to reference this data in any subsequent data transfers.

**Format/Length** Char(10)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Record Validation

- Must be unique for each fatal application made against a claim of the insurer.

#### 4.7.6 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

Delete Flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

- If the fatal application to be deleted is the only fatal application accepted (fatal application decision equal to A (accepted) for the claim, and the claim has had a payment of category 04 (fatal), the delete **must not** be allowed.

#### 4.7.7 Fatal application date

The date the application for dependency compensation on an injured worker's death resulting from the injury was lodged.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- If this is the initial application for workers' compensation, this date is also the initial lodgement date of the statutory claim.

##### Field Validation

- The fatal application date must be greater than or equal to the injury date for the claim.

#### 4.7.8 Fatal application decision

The decision made on each fatal application for the claim.

**Format/Length** Char(1)

**Mandatory/Conditional** Conditional

**Validation/Business Rules**

**Field Validation**

- Must be a valid code:

<b>Fatal Application Decision</b>	<b>Code</b>
Accepted	A
Rejected	R
No Action Required	N

- If the fatal application decision is equal to A, the injured worker date deceased must be supplied.

## 4.8 Former names file

This file contains details of any former names of the injured worker.

For the appropriate file name, refer to User Data Description on page 19.

The unique keys for the data represented in each record of this file are:

- insurer number
- injured worker identifier
- former name record identifier

No field has been defined in this file for the purpose of a control total. Refer to Section 4.1.7, Control total on page 22.

If the worker has no former names, the file must not be supplied.

### 4.8.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be a valid insurer number.

### 4.8.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.8.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.8.4 Injured worker identifier

The injured worker identifier uniquely identifies each injured worker within the insurer's system. The injured worker identifier is used to associate the former name with the appropriate injured worker. Refer to Section 4.3, Injured worker file on page 37.

- Once an identifier has been allocated to a former name record it must not change, as it is used in the key to reference this data in any subsequent data transfers.

**Format/Length** Char(20)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- The injured worker identifier must be the same as a previously supplied injured worker identifier or the injured worker identifier must currently be supplied in the injured worker file.

### 4.8.5 Former name record identifier

The former name record identifier uniquely identifies each former name associated with an injured worker. This identifier assists Q-COMP to identify whether the data already exists on the Q-COMP system and if the appropriate action can be taken to add, modify, or delete the data on the Q-COMP system.

- Once a former name record identifier is allocated to a former name record, it must not change, as it is used as a unique key to reference this data in any subsequent data transfers.

**Format/Length** Char(10)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- Must be unique for each former name of the injured worker of the insurer.

#### 4.8.6 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

Delete Flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

#### 4.8.7 Former name

The injured worker's former name.

**Format/Length** Char(70)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- The former name must comply with the personal name format standard. Refer to Appendix D, Name Formats.

## 4.9 Damages base file

This file contains damages claim base details. This data must be supplied if an injured worker or a dependant of a deceased worker seeks damages.

If a damages claim has been lodged without a statutory claim, a statutory claim status and lodgement must be provided with a claim status of common law only, and all other data as per this document.

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- insurer number
- claim number
- damages claim number

The **amount of first offer** field has been defined in this file as the control total. Refer to Section 4.1.7, Control total on page 22.

### 4.9.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- Must be a valid insurer number.

### 4.9.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.9.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.9.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length** Char(15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

### 4.9.5 Damages claim number

The unique identifier for the damages claim as generated by the insurer.

**Format/Length** Char(15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- Must be unique for each damages claim for the insurer.

#### Warning

- If a Damages Claim Number has already been supplied, the Damages Claim Number should not change.

#### 4.9.6 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char (1)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Field Validation**

- Must be a valid code:

Delete flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

- If the Damages record is to be deleted and the claim has had a payment of Payment Category 07 (Damages), the delete must not be allowed.

#### 4.9.7 Date notification received of damages claim

The date a notice of claim, a claim, writ or plaint or a letter of demand was served/received by the insurer. The term claim in this context refers to new actions commenced under the Uniform Civil Procedure Rules that took effect on 1 July 1999.

**Format/Length** Date

**Mandatory/Conditional** Conditional

**Validation/Business Rules**

**Warning**

- The notice of claim received date should not be supplied until the associated statutory claim has reached a finalisation status (except for a finalisation status of rejected on the initial application of workers' compensation (that is, the original application was refused, thus damages cannot be sought). This only applies to claims where the date of injury is on or after 01 February 1997.

#### 4.9.8 Intimation date

The date the damages claim was entered onto the insurer's system.

**Format/Length**            Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- The intimation date must be greater than or equal to the claim status date associated with the initial intimated claim status of the statutory claim.

#### 4.9.9 Amount on NOC indicator

This field contains a value to indicate whether the amount of first offer is contained on the Notice of Claim supplied by the injured worker/claimant. This field does not apply to claims where the date of injury is prior to 01 February 1997.

**Format/Length**            Char(1)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

<b>Notice of Claim Offer Supplied</b>	<b>Code</b>
No - if amount of first offer is not contained in the Notice of Claim.	N
Yes - if amount of first offer is contained in the Notice of Claim	Y

- If the date of injury is on or after 01 February 1997, the amount on NOC Indicator must be supplied if the Notice of Claim Received Date has been supplied.

#### 4.9.10 Amount of first offer

The amount of the first offer received from the injured worker/plaintiff by means of a Notice of Claim or submitted at a later date. This field will not apply to claims where the date of injury is prior to 01 February 1997.

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rule

- This amount is calculated as the: gross settlement amount **less** statutory claim payments **less** contribution from third party **less** contributory negligence.

##### Field Validation

- The amount of first offer must be supplied if the amount on NOC indicator is Y (that is, amount of first offer was supplied on the Notice of Claim).

#### 4.9.11 Other defendants indicator

This field contains a value that indicates whether any other defendant is involved in the damages claim.

**Format/Length** Char(1)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

Other defendants	Code
No - there are no other defendants.	N
Yes - there are one or more other defendants.	Y

- The other defendants indicator must be supplied, if the notice of claim received date has been supplied.

#### 4.9.12 Notice of claim compliant date

The date the insurer considers the Notice of Claim to be compliant or the date the Notice of Claim is declared compliant by a court. This field does not apply to claims where the date of injury is prior to 01 February 1997.

**Format/Length**                      Date

**Mandatory/Conditional**    Conditional

#### Validation/Business Rules

##### Field Validation

- If notice of claim compliant date is supplied, the notice of claim received date must have been supplied.
- The notice of claim compliant date must be greater than or equal to the notice of claim received date.
- If the date of injury is prior to 01 February 1997, the notice of claim compliant date must not be supplied.

##### Warning

- The notice of claim compliant date must not be supplied until the associated statutory claim has reached a finalisation status (except for a finalisation status of rejected on the initial application of workers' compensation (that is, the original application was refused, thus damages cannot be sought). This only applies to claims where the date of injury is on or after 01 February 1997.

#### 4.9.13 Liability decision date

The date the insurer decides to admit or deny common law liability for the injury. This field does not apply to claims where the date of injury is prior to 01 February 1997.

**Format/Length**                      Date

**Mandatory/Conditional**    Conditional

#### Validation/Business Rules

##### Field Validation

- If liability decision date is supplied, the notice of claim compliant date must have been supplied.
- The liability decision date must be greater than or equal to the notice of claim compliant date.
- If the date of injury is prior to 01 February 1997, the liability decision date must not be supplied.

#### 4.9.14 Estimated damages

An estimate of the most recent available assessment from solicitors or insurer on the cost of outstanding damages payable on the damages claim. This estimate must be re-adjusted as damages payments are being made.

**Format/Length** Amt (12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rule

- Estimated damages must be supplied upon receipt of advice from plaintiff's solicitor, claim or notice of claim.

##### Warning

- Estimated damages to be supplied when there is no resolution date.

#### 4.9.15 Estimated costs

An estimate of the most recent available assessment from solicitors or insurer on all damages of all outstanding legal (professional fees and outlays), investigation or any other costs the insurer pays in managing the damages claim.

Example: Original estimate of \$50 000 supplied, \$20 000 paid in legal costs.  
Re-adjusted costs \$30 000.

**Format/Length** Amt (12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rule

- Estimated costs must be supplied upon receipt of advice from plaintiff's solicitor, claim or notice of claim.

##### Warning

- Estimated costs must be supplied when there is no finalisation date.

#### 4.9.16 Urgent Proceedings Application Indicator

The value in this field indicates whether there is an urgent need for the claimant to start a proceeding for damages. Where a damages application is received with a need to start urgent proceedings for damages, this field must be indicated as 'Y'. If this field is indicated as 'Y' for urgent proceedings, the value must not change.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

Urgent Proceedings Indicator	Code
Yes – Need for urgent proceedings	Y
No – No need for urgent proceedings	N

- Must be supplied when a Damages Claim Number (4.9.5) is supplied.
- Must be supplied if Injury Date (4.2.7) is equal to or greater than 01 July 2010.

#### 4.9.17 Legal Representation

The value in this field indicates whether the injured worker has legal representation.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

Legal Representation	Code
Yes – Legal Representation	Y
No – Not represented	N

- Must be supplied when a Damages Claim Number (4.9.5) is supplied.
- Must be supplied if Injury Date (4.2.7) is equal to or greater than 01 July 2010.

#### 4.9.18 Plaintiff Lawyer Firm

The legal entity name of the plaintiff lawyer firm representing the injured worker.

**Format/Length** Char(70)

**Mandatory/Conditional** Conditional

##### Validation/Business Rules

##### Field Validation

- Must be supplied if Legal Representation (4.9.17) is *Y – Legal Representation*.
- Text must be in uppercase.

#### 4.9.19 Plaintiff Lawyer Location Postcode

The postcode of the plaintiff lawyer representing the injured worker.

**Format/Length** Num(4)

**Mandatory/Conditional** Conditional

##### Validation/Business Rules

##### Business Rule

- If present, must be a valid Australia Post postcode.

##### Field Validation

- Must be supplied if Legal Representation (4.9.17) is *Y – Legal Representation*.

#### 4.9.20 Liability Response

The value in this field indicates the liability response and is to be supplied with the Liability Decision Date.

**Format/Length** Char(1)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

Liability Response	Code
Yes – Liability Accepted	Y
No – Liability Declined	N

- Must be supplied when Liability Decision Date (4.9.13) is supplied and the Injury Date (4.2.7) is equal to or greater than 01 July 2010.

#### 4.9.21 Date of Compulsory Conference

The date the compulsory conference is held.

**Format/Length** Date(8)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Field Validation

- Must be supplied if Resolution Stage (4.10.9) is 05, 06, 07, 08, 09, 10, 11, 12, 13 or 14 and the Injury Date (4.2.7) is equal to or greater than 01 July 2010.
- Must be greater than or equal to the Date Notification Received of Damages Claim (4.9.7).
- Must be equal to or less than the Resolution Date (4.10.7).

#### 4.9.22 CTP Contributors

The value in this field indicates the number of third party CTP Contributors with an interest in the damages application.

**Format/Length** Num(2)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be supplied if Damages Claim Number (4.9.5) is not null and Injury Date (4.2.7) is equal to or greater than 01 July 2010.

#### 4.9.23 Public Liability Contributors

The value in this field indicates the number of third party Public Liability Contributors with an interest in the damages application.

**Format/Length** Num(2)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be supplied if Damages Claim Number (4.9.5) is not null and Injury Date (4.2.7) is equal to or greater than 01 July 2010.

#### 4.9.24 Other Contributors

The value in this field indicates the number of third party Other Contributors with an interest in the damages application.

**Format/Length** Num(2)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be supplied if Damages Claim Number (4.9.5) is not null and Injury Date (4.2.7) is equal to or greater than 01 July 2010.

## 4.10 Damages resolution file

This file contains damages resolution details. This data must be supplied at the resolution of the damages claim.

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- insurer number
- claim number
- damages claim number

The **resolution outcome** field has been defined in this file as the control total. Refer to Section 4.1.7, Control Total on page 19.

### 4.10.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be a valid insurer number.

### 4.10.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.10.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length**                      Date

**Mandatory/Conditional**    Mandatory

#### Validation/Business Rules

#### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.10.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length**                      Char(15)

**Mandatory/Conditional**    Mandatory

#### Validation/Business Rules

#### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

### 4.10.5 Damages claim number

The unique identifier for the damages claim as generated by the insurer.

**Format/Length**                      Char(15)

**Mandatory/Conditional**    Mandatory

#### Validation/Business Rules

#### Record Validation

- Must be unique for each damages claim for the insurer.

#### Warning

- If a Damages Claim Number has already been supplied, the Damages Claim Number should not change.

#### 4.10.6 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

Delete flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

- If the damages resolution record is to be deleted and the claim has a payment of Payment Category 07 and Payment Type 003 (net damages), the delete must not be allowed.

#### 4.10.7 Resolution date

The date the damages claim was settled or resolved in some way. (Refer to Section 4.10.8, Resolution outcome on page 83 and Section 4.10.9, Resolution stage on page 84 for a full list of the ways in which a Damages Claim could be resolved).

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- The resolution date must be greater than the notice of claim compliant date (Refer to Section 4.9.12, Notice of claim complaint date on page 74), except where the resolution outcome is cancelled (01) (that is, notice of claim received date may not be supplied).

#### 4.10.8 Resolution outcome

This field contains a code that identifies the outcome at the resolution of the damages claim.

**Format/Length** Num(2)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

<b>Resolution code</b>	<b>Code</b>
Cancelled (claim made up incorrectly, may be unable to reallocate)	01
Proceedings discontinued	02
Statute barred	03
Withdrawn	04
Struck out (for want of prosecution)	05
Appraisal accepted	06
Offer accepted by insurer (to include Negotiated Settlement, Settlement Conference and mediation)	07
Offer accepted by Claimant/Plaintiff (to include Negotiated Settlement, Settlement Conference and mediation)	08
Dismissed	09
Discontinued with costs	10
Discontinued without costs	11
Judgement; in favour of Claimant/Plaintiff	12
Judgement; in favour of self	13
Appeal; reversal	14
Appeal; reduced damages	15
Appeal; increased damages	16
Taken over by Third Party	17
Recovery from Third Party	18
Claimant/Plaintiff withdrawn; Suspected fraud	19
Rights extinguished due to fraud prosecution	20

#### 4.10.9 Resolution stage

This field contains a code that identifies the stage at which the damages claim was resolved.

**Format/Length** Num(2)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Field Validation**

- Must be a valid code:

<b>Resolution stage</b>	<b>Code</b>
Prior to Notice of Claim for Damages offer (Section 275(6))	01
Notice of Claim offer (Section 275(6)) accepted by insurer	02
Insurer (counter) offer (Section 281(4)(c)) accepted by Claimant/Plaintiff	03
Any other resolution prior to the compulsory conference (Section 289)	04
At compulsory conference (Section 289)	05
Final written offer accepted at or after compulsory conference (Section 289) conference	06
Any other resolution between compulsory conference (Section 289) and legal proceedings commencing	07
Prior to legal proceedings commencing	08
After legal proceedings have commenced	09
Mediation	10
Case appraisal	11
Court judgement	12
After Appeal lodged	13
Appeal Court decision	14

- If the injury date is prior to 01 February 1997, the following values are not applicable:

<b>Resolution Stage</b>	<b>Code</b>
Prior to Notice of Claim for Damages offer (Section 275(6))	01
Notice of Claim offer (Section 275(6)) accepted by insurer	02
Insurer (counter) offer (Section 281(4)(c)) accepted by Claimant/Plaintiff	03
Any other resolution prior to the compulsory conference (Section 289)	04
At compulsory conference (Section 289)	05
Final written offer accepted at or after compulsory conference (Section 289) conference	06
Any other resolution between compulsory conference (Section 289) and legal proceedings commencing	07

- If the injury date is 01 February 1997 or later, the following value is not applicable:

<b>Resolution Stage</b>	<b>Code</b>
Prior to legal proceedings commencing	08

#### 4.10.10 Finalisation date

The date at which the common law matter is finalised and all payments required have been made.

**Format/Length**                      Date

**Mandatory/Conditional**    Conditional

#### Validation/Business Rules

#### Field Validation

- The Finalisation Date must be greater than or equal to Resolution Date.

#### 4.10.11 Dominant Injury Item Number

This is the item number relating to the dominant injury as specified in Schedule 9 of the Workers' Compensation and Rehabilitation Regulation.

**Format/Length**                      Num(5)

**Mandatory/Conditional**    Conditional

#### Validation/Business Rules

#### Field Validation

- Must be a valid code referencing Schedule 9 – Ranges of Injury Scale Values of the Workers' Compensation and Rehabilitation Regulation.
- Must be supplied if Heads of Damage – General Damages is not null and the Injury Date (4.2.7) is equal to or greater than 01 July 2010.
- Must be supplied if an Injury Scale Value (4.10.12) is not null.

#### 4.10.12 Injury Scale Value

The general damages point score (Injury Scale Value) is assigned to a claim for the purpose of assessing general damages. The point score range is between 0 and 100, and this field represents the dominant injury ISV only. Any additional points given as a result of multiple injuries are to be recorded in 4.10.13 – multiple injury indicator. All damages applications with the injury occurring from 1 July 2010 require an Injury Scale Value where General Damages have been agreed. The ISV score must be reported as a whole number.

**Format/Length** Num(3)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Field Validation

- Must be supplied if a dominant injury item number (4.10.11) is not null.
- Must be a valid ISV for the Dominant Injury Item Number.
- Must be supplied if Heads of Damage – General Damages is not null and the Injury Date (4.2.7) is equal to or greater than 01 July 2010.
- The total of Injury Scale Value and Multiple Injury Identifier cannot equal more than 100.

#### 4.10.13 Multiple Injury Indicator

This is the injury scale value relating to any multiple injuries. The multiple injury indicator is to identify any allocated points additional to the dominant injury ISV. If there is a Dominant Injury Item Number but no multiple injury allocation, this field must be zero.

**Format/Length** Num(2)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Field Validation

- Must be supplied if the dominant injury item number (4.10.11) is not null.
- The total of Injury Scale Value and Multiple Injury Identifier cannot equal more than 100.

#### 4.10.14 Gross settlement amount

The gross settlement amount at the agreed offer stage of settlement prior to statutory deductions. Amount must equal the sum of heads of damage amounts. It is the responsibility of the Insurer to appropriately apportion each the six heads of damage based on the gross settlement amount at the agreed offer stage.

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rules

- Must represent the gross settlement amount at the agreed offer stage of the settlement.

##### Field Validation

- Must be supplied if the Finalisation Date (4.10.10) is from 01 July 2010 and a payment has been submitted against Payment Category 07, Type 003.
- Must equal the sum of the individual heads of damage amounts indicated.
  - 4.10.15 – Heads of Damages - General damages
  - 4.10.16 – Heads of Damages - Future economic loss
  - 4.10.17 – Heads of Damages - Past economic loss
  - 4.10.18 – Heads of Damages - Treatment and rehab
  - 4.10.19 – Heads of Damages - Care
  - 4.10.20 – Heads of Damages - Other

#### 4.10.15 Heads of damage – general damages

The amount of general damages at the agreed offer stage of the settlement. Amount must be reflective of the gross amount agreed (prior to statutory deductions).

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rules

- Section 112E of the Workers' Compensation and Rehabilitation Act states that Schedule 12 – Injury Scale Value is prescribed as the general damages calculation provision for an injury sustained on or after 1 July 2010.
- Must represent the gross amount of general damages at the agreed offer stage of the settlement.

##### Field Validation

- Must be supplied if the Finalisation Date (4.10.10) is from 01 July 2010.
- Must not be less than the amount specified for the Total ISV (the combination of the Injury Scale Value and the Multiple Injury Indicator)

#### 4.10.16 Heads of damage – past economic loss

The amount of past economic loss at the agreed offer stage of the settlement. Amount must be reflective of the gross amount agreed (prior to statutory deductions)

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

##### Validation/Business Rules

###### Business Rules

- Must represent the monetary apportionment of the gross settlement amount of Past Economic Loss at the agreed offer stage.

###### Field Validation

- Must be supplied if the Finalisation Date (4.10.10) is from 01 July 2010.

#### 4.10.17 Heads of damage – future economic loss

The amount of future economic loss at the agreed offer stage of the settlement. Amount must be reflective of the gross amount agreed (prior to statutory deductions)

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

##### Validation/Business Rules

###### Business Rules

- Must represent the monetary apportionment of the gross settlement amount of economic loss future at the agreed offer stage.

###### Field Validation

- Must be supplied if the Finalisation Date (4.10.10) is from 01 July 2010.

#### 4.10.18 Heads of damage – treatment and rehabilitation

The amount of treatment and rehabilitation at the agreed offer stage of the settlement. Amount must be reflective of the gross amount agreed (prior to statutory deductions)

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

##### Validation/Business Rules

###### Business Rules

- Must represent the monetary apportionment of the gross settlement amount of treatment and rehabilitation at the agreed offer stage.

###### Field Validation

- Must be supplied if the Finalisation Date (4.10.10) is from 01 July 2010.

#### 4.10.19 Heads of damage – care

The amount of care at the agreed offer stage of the settlement. Amount must be reflective of the gross amount agreed (prior to statutory deductions).

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rules

- Must represent the monetary apportionment of the gross settlement amount of care at the agreed offer stage.

##### Field Validation

- Must be supplied if the Finalisation Date (4.10.10) is from 01 July 2010.

#### 4.10.20 Heads of damage – other

The amount of other at the agreed offer stage of the settlement. Amount must be reflective of the gross amount agreed (prior to statutory deductions).

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Business Rules

- Must represent the monetary apportionment of the gross settlement amount of other at the agreed offer stage.

##### Field Validation

- Must be supplied if the Finalisation Date (4.10.10) is from 01 July 2010.

## 4.11 Damages contributory negligence file

This file contains details defining the circumstances under which a reduction of damages occurred because of contributory negligence. This data must be supplied at the resolution of the damages claim (if any contributory negligence applies).

One record will exist in the file for each circumstance under which reduced damages were applied to a claim.

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- insurer number
- claim number
- damages claim number
- contributory negligence section

The **contributory negligence section** field has been defined in this file as the control total. Refer to Section 4.1.7, Control total on page 22.

### 4.11.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- Must be a valid insurer number.

### 4.11.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.11.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length**                      Date

**Mandatory/Conditional**    Mandatory

#### Validation/Business Rules

##### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.11.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length**                      Char(15)

**Mandatory/Conditional**    Mandatory

#### Validation/Business Rules

##### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

### 4.11.5 Damages claim number

The unique identifier for the damages claim as generated by the insurer.

**Format/Length**                      Char(15)

**Mandatory/Conditional**    Mandatory

#### Validation/Business Rules

##### Record Validation

- Must be unique for each damages claim for the insurer.

#### Warning

- If a Damages Claim Number has already been supplied, the Damages Claim Number should not change.

#### 4.11.6 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char (1)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

#### Field Validation

- Must be a valid code:

#### Delete Flag

#### Code

No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).

N

Yes – the data identified by the key of this record is deleted.

Y

#### 4.11.7 Contributory negligence section

This field contains a code that defines the circumstances under which a reduction of damages occurred because of contributory negligence.

**Format/Length** Num(2)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Record Validation**

- Must be a valid code:

Contributory Negligence Section	Code
Failed to comply, so far as was practicable, with instructions given by the worker's employer for the health and safety of the worker or other persons (Section 307(1)(a) of the Act)	01
Failed at the material time to use, so far as was practicable, protective clothing and equipment provided, or provided for, by the worker's employer, in a way in which the worker had been properly instructed to use them (Section 307(1)(b) of the Act)	02
Failed at the material time to use, so far as was practicable, anything provided that was designed to reduce the worker's exposure to risk of injury (Section 307(1)(c) of the Act)	03
Inappropriately interfered with or misused something provided that was designed to reduce the worker's exposure to risk of injury (Section 307(1)(d) of the Act)	04
Was adversely affected by the intentional consumption of a substance that induces impairment (Section 307(1)(e) of the Act)	05
Failed, without reasonable excuse, to attend safety training organised by the worker's employer that was conducted during normal working hours at which the information given would probably have enabled the worker to avoid, or minimise the effects of, the event resulting in the worker's injury. (Section 307(1)(f) of the Act)	06
For any other circumstances where the date of injury is on or after 01 Feb 97	07
For claims where the date of injury is prior to 01 Feb 97	08

- The Contributory Negligence (Contributory Negligence Section) must not be supplied, if the Resolution Date (Resolution File) has not been supplied.

#### 4.11.8 Contributory negligence percentage

This field contains a value, which identifies the reduction of the award of damages (represented as a percentage) for each circumstance (defined in Section 4.11.7, Contributory negligence section on page 93).

**Format/Length** Num(2)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

##### Field Validation

- If the Contributory Negligence Section is 01, 02, 03, 04, 05 or 06, the Contributory Negligence Percentage must be greater than or equal to 25% and less than 100%.

## 4.12 Payments file

This file contains totals per month of all payments and recoveries made against the claim, based on the payment categories and payment types defined below.

For the appropriate file name, refer to page 19.

The unique key of the data represented in each record of this file is:

- insurer number
- claim number
- payment month
- payment category
- payment type
- item number

For certain types of payments made on or after 1st July 2000, a GST figure is applicable.

The **net claims cost** field has been defined in this file as the control total. Refer to Section 4.1.7, Control total on page 22.

The totals **must** include any adjustment due to overpayments recovered and must be reflected in the totals supplied by the insurer at the time.

The following is an example of the payment data that could be supplied over time:

- To correct an amount due to input error, the original Monthly Amount must be corrected (that is, a new amount for the Payment Month, Payment Category and Payment Type must be supplied to overwrite the original amount supplied).
- To adjust an amount due to an overpayment, the adjustment amount must be supplied in the month it was performed (that is, the adjustment amount for the overpayment is supplied in a different payment month than the original payment (thus creating two entries for the payment category and payment type on the claim).
- When correcting a payment that should have never been allocated to the claim, the payment should be deleted using the delete flag.
- When recovering payments from a third party, only the positive amount must be submitted against Category 08.
- The original payments are not to be adjusted as a result of receiving a recovery from a third party.
- Monies received from an overpayment are not considered as a recovery for the purposes of workers' compensation.

	Payment			Total			Reason for data change *
	Month	Category	Type	Amount (month)	Statutory cost	Damages cost	
1/1/97 to 31/1/97	31/1/97	06	001	\$200	\$200	\$0	Doctor Paid
	31/1/97	06	002	\$100	\$300	\$0	Dentist Paid
1/2/97 to 28/2/97	28/2/97	06	001	\$50	\$350	\$0	Doctor Paid
1/3/97 to 31/3/97	31/3/97	06	001	\$100	\$450	\$0	Doctor Paid
	31/3/97	06	002	-\$50	\$400	\$0	Adjustment of \$50 overpayment to Dentist in January
1/4/97 to 30/4/97	31/3/97	06	001	\$50	\$350	\$0	To correct input error for Doctor's payment report in March '97 (should have been \$50 not \$100)
	30/4/97	06	002	\$150	\$500	\$0	Dentist
1/5/97 to 31/5/97	31/5/97	06	002	\$100	\$600	\$0	Dentist paid \$150 and adjustment of \$50 overpayment to Dentist in April
1/6/97 to 30/6/97	30/6/97	08	001	\$600	\$0	\$0	Recovery of full Statutory payments from a third party
	30/6/97	08	002	\$700	\$0	\$0	Recovery of part Damages payments from a third party

The following is an example of the treatment of GST:

- **Gross claims cost** – the GST inclusive amount (4.12.11)
- **Total GST Amount** – GST amount included in the about total amount (4.12.10)
- **Net claims cost** – payable to the supplier less any input tax credit entitlement (4.12.9)

Example: Invoice for \$110.00 being for:

	Gross claims cost (4.12.11)	Total GST amount (4.12.10)	Net claims cost (4.12.9)
Insurer making taxable supplies	\$110.00	\$10.00	\$100.00
Insurer making totally input taxed supplies	\$110.00	\$10.00	\$110.00
Insurer making partially input taxed supplies with ITC entitlement of 60%	\$110.00	\$10.00	\$104.00

Q-COMP may be unable to determine the exact item for which the insurer cannot claim an input tax credit, but will know which times within a payment type are taxable versus GST free.

If an insurer is claiming input tax credits for an item would not reasonably attract credits, this will be apparent from the net GST and net cost data specifications.

The following is an example of the way in which payments should be submitted to Q-COMP:

Payments collected by Q-COMP are at a monthly summary level for insurers' transactions. The Q-COMP system does not accept individual transaction payments.

If payments change in a month, the insurer's system must re-supply the payments by month, category and type. If this amount sums to \$0.00, then the payment is deleted, using the delete flag.

#### 4.12.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be a valid insurer number.

#### 4.12.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

#### 4.12.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

#### 4.12.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer.

This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length** Char(15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

#### 4.12.5 Payment month

The month for the total of the payment made against the claim. Only months where payments or recoveries have been made against the claim need to be supplied.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Record Validation

- The value must be represented by the last day of the month (for example, for the month of March 1997 the value will be associated with the 31st of March 1997 (19970331)).

#### 4.12.6 Payment category

This field contains a value that identifies the categories of payments that must be reported to Q-COMP.

These payment categories are further subdivided into types for reporting purposes.

**Format/Length** Num(2)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

Due to Q-COMP only being supplied summary payment information, it is not possible to perform exact validation, thus some of the following validation rules can be quite general. Q-COMP relies on the insurer to perform comprehensive validation on their system.

## Record Validation

- Must be a valid code:

Costs associated with services requested by the insurer for the determination or administration of the claim. Including:	01
<ul style="list-style-type: none"> <li>• medical examinations and reports for claims administration,</li> <li>• consultations,</li> <li>• case management services,</li> <li>• audiology tests,</li> <li>• diagnostic procedures,</li> <li>• expenses associated with Medical Assessment Tribunal hearings and</li> <li>• travel associated with any of these items</li> </ul>	
Legal and investigation payments (not Damages), for example, surveillance, legal opinion, etc. (but excluding appeal costs)	02
Weekly compensation payments	03
Fatal payments	04
Lump sum payments (as defined in the appropriate section of the Act, refer to Section 4.12.7 Payment type on page 100.)	05
Treatment and rehabilitation payments (only to be used for the treatment and rehabilitation of injured workers)	06
Damages payments	07
Recovery amount, actually recovered on the claim, due to some or all of the liability belonging to a Third Party (excludes recoveries due to overpayments)	08
Pre-damages legal payments	17

## Field Validation

- No payments of any payment category can be supplied, if the claim status is cancelled (refer Section 4.5, Claim status file on page 45).
- If payment being supplied is for payment category of 07, the damages base file must be supplied for claims with an injury date on or after 1 February 1997.
- If payment being supplied is for payment category of 08, the cumulative total of payment categories 01, 02, 03, 04, 05, 06, 07 and 17 must be greater than or equal to 0 (that is, payments recovered cannot be greater than payments made).
- No payments of any payment category other than 01 or 02 can be supplied, if the claim status is no action required (Refer to Section 4.5 Claim status file on page 45).
- If payment being supplied is for payment category 03, at least one compensation period (Refer to Section 4.6, Compensation period file on page 55) must be supplied.
- If payment being supplied is for payment category 03 and payment type 001, 002, 999 the cumulative total of workdays lost (for all compensation periods) must be greater than 0.
- If payment being supplied is for payment category 03, and payment type 998, the compensation period flagged with excess days lost must be supplied.
- Injured worker date deceased (4.2.13) must be provided if a fatal payment (payment category 04) is supplied.

## Warning

- If payment being supplied is for payment category 03, 04, 05, 06, or 07, the claim status must have been "Admitted" or "Common Law Only (CLO)" for 07 payments at some stage in the life of the claim. Refer to Section 4.5, Claim status file on page 45.

- If payment being supplied is for payment category 04, then there must be at least one accepted fatal application.

#### 4.12.7 Payment type

This field contains a value that identifies each payment category type that must be reported to Q-COMP.

**Format/Length** Num(3)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- If lump sum payments are made as a result of multiple references to a Medical Assessment Tribunal (for example, aggravation of an injury due to a second incident), each payment must be reported against the respective claim.
- If a payment is for loss of wages due to attendance at treatment this should be coded to Payment Category 06, Payment Type 017 Travel and Accommodation.
- If a payment is for loss of wages due to attendance at a Medical Assessment Tribunal or to attend an appointment for Medical Report this should be coded to Payment Category 01, Payment Type 999 General code for Payment Category 01.

##### Record Validation

- Must be a valid code:

For **Payment Category 01** (Cost associated with services requested by the insurer for the determination or administration of the claim)

- **Medical reports** (any reports or diagnostic tests requested for the administration of the claim rather than the treatment or rehabilitation of the injured worker) 001
- General code for all **other payments** 999

For **Payment Category 02** (Legal and investigation payments (excluding damages))

- **Statutory legal costs** 001
- **Statutory legal outlays** (for example, loss adjusting fees, interpreter, surveillance, investigation) 002
- General code for all **other payments** 999

For **Payment Category 03** (Weekly compensation payments)

- **Total incapacity** – weekly compensation payments for total incapacity (including Sections 150, 151, 152, 153, 154, 155, 157 and 159 of the Act) 001
- **Partial incapacity** – weekly compensation payments for partial incapacity (Section 163 of the Act) 002
- Payment for **excess days** lost (must be reported where excess days lost are reported) 998
- General code for all **other compensation payments** not specified 999

For **Payment Category 04** (Fatal)

- Dependant Additional Lump Sum (Section 200(2)(b) of the Act) 001
- Dependant Lump Sum (Section 200(2)(a) & (aa) and Section 201(2)(a) of the Act) 002
- Dependant Weekly Payments (Section 200(2) (ab) & (c) and Section 201(2) (b) of the Act) 003

- the Act)
- Funeral (Section 199 of the Act) 004
- Payment to parent (Section 202 of the Act) 005
- Non-Dependant Lump Sum (Section 201A of the Act) 006

For **Payment Category 05** (Lump Sum)

- Permanent Impairment (Section 180(3) of the Act) 001
- Additional Lump Sum compensation for certain workers (Section 192 of the Act) 002
- Additional Lump Sum compensation for gratuitous care (Section 193 of the Act) 003
- Redemption Payment – worker receiving weekly payment for at least two years (Section 171 of the Act) 004
- Redemption Payment – worker moves interstate (Section 172 of the Act) 005
- Redemption Payment - injured worker moving abroad (Section 173 of the Act (applicable to all Acts) 006
- Prescribed Disfigurement 007
- Settlement under the Table of Injuries (refers to claims where the date of injury is prior to 01 Jan 96) 008
- Latent onset condition / terminal condition (Section 128B of the Act) – also includes payments made to dependants under Section 128D of the Act for injuries under Section 128B. 009

For **Payment Category 06** (Treatment and rehabilitation)

- Doctor (including doctor's fees for operations) 001
- Dentist 002
- Psychologist 003
- Occupational Therapist 004
- Chiropractor 005
- Physiotherapist 006
- Podiatrist 007
- Speech Pathologist 008
- No longer used 009
- Diagnostic procedures (excluding those specified in Payment Category 01) 010
  - including:
    - MRI,
    - x-ray
    - radiology
- Other rehabilitation including 011
  - alternative therapies (such as acupuncture)
  - home modifications and services
  - independent living aids
  - information technology aids
  - motor vehicle modifications
  - workplace modifications
  - workplace assessments by Occupational Therapists, Physiotherapists, Psychologists
- Caring allowance 012
- Multi-disciplinary 013
- Chemist supplies (including hospital chemist), nursing, medical or surgical supplies, crutches or other supportive devices given to the worker other than as an in-patient at a private hospital 014
- Prosthetics including: 015
  - dentures
  - spectacles
- Hospitalisation costs 016

- Travel and accommodation (excluding ambulance and travel specified in Payment Category 01) including loss of wages due to an appointment 017
- Ambulance (including Royal Flying Doctor Service and other ambulance providers) 018
- Air ambulance transport 019
- Pathology 020

#### For **Payment Category 07** (Damages)

- **Defendant's Costs**
  - Legal costs (professional cost of solicitors or lawyers) 001
  - Outlays (other costs including barristers fees, assessors, loss adjusters, case appraiser, mediator and private investigators) 002
  - Net damages (excluding legal costs and outlays) 003

#### **Net damages is calculated as the: Gross Settlement Amount**

- **less statutory claim payments**
- **less contribution from third party**
- **less contributory negligence**
- **Plaintiff's Costs**
  - Legal costs (professional cost of solicitors) 004
  - Outlays (other costs including barristers, assessors and private investigators) 005
- **Rehabilitation Provisions**
  - Additional rehabilitation expenses for treatment 006
  - Additional rehabilitation expenses for occupational and vocational rehabilitation 007

#### For **Payment Category = 08** (Recoveries)

- Statutory recovery 001
- Common law recovery 002
- For recoveries received prior to 1 July 2003 999

#### For **Payment Category = 17** (Total Pre-damages legal payments)

- Pre-damages legal costs 001
- Pre-damages legal outlays (for example, loss adjusting fees, interpreter, surveillance, investigation) 002
- **Rehabilitation Provisions**
  - Additional rehabilitation expenses for treatment 006
  - Additional rehabilitation expenses for occupational and vocational rehabilitation 007

#### **Field Validation**

- If payment being supplied is for Payment Category 07 / Payment Type 003, the Resolution Date (refer to Section 4.10, must have been supplied).
- The total of all payments made to Payment Category 03 must not be greater than the maximum statutory compensation amount provided under the Act for claims with an injury date **greater than or equal to 1 January 2005**.
- The total of all payments made to Payment Category 05 Type 001, 004, 005, 006, 007 and 008 must not be greater than the maximum statutory compensation amount provided under the Act for claims with an injury date **greater than or equal to 1 January 2005**.

#### 4.12.8 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char (1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

Delete Flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

#### 4.12.9 Net claims cost

This field must contain the net claims cost for the month, associated with each payment category and type made against the claim. This amount is calculated as the claims cost before GST, plus any GST paid, less any input tax credits claimable.

- This is not a progressive total. Any total the insurer supplies for the month will be stored on the Q-COMP system, replacing any existing data for the month.

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

#### Business Rule

- When the amount is representing a payment to any Payment Category, including 08 (Recovery), the amount should be positive.
- When the amount is representing an adjustment to a previously supplied monthly total, the amount can be either positive or negative.

#### Field Validation

- All amounts for Net Claims Cost, Gross Claims Cost and GST cannot be zero.

#### Warning

- The Net Claims Cost should be equal to or greater than the Gross Claims Cost less Total GST Amount.

#### 4.12.10 Total GST amount

The GST payable on the total price of the goods or services, where applicable, associated with each payment category and type made against the claim.

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

##### Field Validation

- Value supplied must be for services performed on or after 1 July 2000 only.

#### 4.12.11 Gross claims cost

The total amount payable in the month inclusive of GST associated with each payment category and type made against the claim.

**Format/Length** Amt(12)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- When the amount is representing a payment to any Payment Category, including 08 (Recovery), the amount should be positive.
- When the amount is representing an adjustment to a previously supplied monthly total, the amount can be either positive or negative.

##### Field Validation

- The gross claims cost is a Mandatory field.

##### Warning

- The gross claims cost cannot be less than the net claims cost.

#### 4.12.12 Item number

The relevant item number from the following fee schedules for medical and allied health professionals:

- Q-COMP Medicare Benefits Schedule.
- Q-COMP Supplementary Table of Costs.
- Q-COMP Allied Health Tables of Costs.

Q-COMP maintains these schedules and updates fees annually. Q-COMP makes files containing updated fee schedules available one month before new fees and fee changes are implemented. Files are supplied in the format specified in the Item Number File Specification and available from the Q-COMP website [www.qcomp.com.au](http://www.qcomp.com.au).

**Format/Length** Num(8)

**Mandatory/Conditional** Conditional

**Validation/Business Rule**

#### Record Validation

- May be supplied for payment category 01 or 06
- Must not be supplied for payment category 02, 03, 04, 05, 07, 08 or 17.
- The value must be a valid code from one of the following item number schedules:
  - Q-COMP Medicare Benefits Schedule.
  - Q-COMP Supplementary Table of Costs.
  - Q-COMP Allied Health Tables of Costs.

Item numbers (allied health, supplementary and medical item numbers) are updated regularly and the capacity to add / delete and change valid codes is essential.

### 4.13 Payment total file

This file contains details on the total of all payments made to the claim, either as a statutory claim or a damages claim. When any payments are made to a claim, the new totals must be supplied.

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- insurer number
- claim number

The **total statutory claim cost** field has been defined in this file as the control total. Refer to Section 4.1.7, Control total on page 22.

#### 4.13.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be a valid insurer number.

#### 4.13.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Control File Validation**

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.13.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.13.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length** Char (15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

### 4.13.5 Delete flag

The value in this field indicates whether the data identified by the key of this record will be deleted/annulled, added, or modified on the Q-COMP database.

**Format/Length** Char (1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- Must be a valid code:

Delete flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

- If a payment is associated with any Payment Category, the payment total record cannot be deleted.

#### 4.13.6 Total statutory claim cost

The total net claims cost including adjustments made on the statutory part of the claim to date.

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

##### Validation/Business Rules

##### Field Validation

- Must be equal to the total of all net claims costs (and adjustments) made to the payment categories 01, 02, 03, 04, 05, and 06 to date.

#### 4.13.7 Total damages claim cost

The total of all net claims cost including adjustments made on the damages part of the claim to date including any pre-damages legal costs or outlays.

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

##### Validation/Business Rules

##### Field Validation

- Must be equal to the total of all net claims cost (and adjustments) made to the payment categories 07 and 17 to date.

#### 4.13.8 Replace all payments flag

The value of this field indicates whether all past reported payments are to be deleted from the Q-COMP system and replaced by the payments supplied in the current submission.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

##### Validation/Business Rule

##### Field Validation

- Must be a valid code:

Delete flag	Code
No - the existing payment records in <b>the Payments File on the Q-COMP system are to remain</b> . The Payment File in this data submission adds to or modifies the existing payments in the Q-COMP system.	N
Yes - the existing payment records in <b>the Payments File on the Q-COMP system are to be deleted and replaced</b> with the payments supplied in the Payments File in the current data submission.	Y

#### 4.14 Permanent impairment injury file

This file provides details of any injuries for which offers of permanent impairment have been made to the injured worker. If permanent impairment lump sums have been paid, this file must also be supplied.

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- insurer number
- claim number
- permanent impairment injury identifier

No field has been defined in this file as the control total. Refer to Section 4.1.7, Control total on page 22.

The key requirement for Q-COMP is that at the finalisation of a claim, all permanent impairment injury assessments are reported. If an injury is assessed after the finalisation of the claim this must be reported once the impairment assessments are finalised.

There are two options for providing permanent impairment data these are outlined below:

##### Supply of PI data during the claim

Each time the permanent impairment offer changes on the claim, the supply of the current injury assessment information should be submitted.

Permanent impairment records should be reported only once for any assessed injury.

However, if a subsequent assessment and offer is made this should **replace** previous assessments.

For example, if an injured worker is offered three permanent impairment assessments:

- Sequence 1 - 1999 - Fracture of head of right radius
- Sequence 2 - 1401 - Soft tissue injury to right shoulder
- Sequence 3 - 1103 - Soft tissue injury right thumb

These would be reported to Q-COMP, however if the injured worker disagrees with this assessment and is sent to the Medical Assessment Tribunal for re-assessment and is offered:

- Sequence 1 modified to 1998 - Fracture to radius and soft tissue injury to right shoulder
- Sequence 2 - deleted
- Sequence 3 - modified if PI value changed 1103 - soft tissue injury right thumb

## Supply of Data on the Finalisation of the Claim

Once a claim has been finalised, all current injury assessments should be submitted. If a further injury is assessed on the claim (for example, a psychological injury is assessed prior to common law) this injury must also be reported once impairment assessments are finalised.

For example:

- Sequence 1 - 1999 - Fracture of head of right radius
- Sequence 2 - 1401 - Soft tissue injury to right shoulder
- Sequence 3 - 1103 - Soft tissue injury right thumb

These are reported on finalisation of the claim, however a year later the claim is assessed for psychological impairment - the following PI is added:

- Sequence 4 - 6000 - Psychological Injury

### 4.14.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Control File Validation

- Must be a valid insurer number.

### 4.14.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Control File Validation

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

#### 4.14.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

#### 4.14.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length** Char(15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

#### 4.14.5 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char (1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

##### Delete flag

##### Code

No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).

N

Yes – the data identified by the key of this record is deleted.

Y

#### 4.14.6 Permanent impairment injury identifier

The permanent impairment identifier for each injury reported to Q-COMP. This field is to enable the identification of specific injuries for deletion and modification of permanent impairment injury assessments.

**Format/Length** Char(10)

**Mandatory/Conditional** Mandatory

##### Validation/Business Rules

##### Record Validation

- Must be unique for each injury supplied.

#### 4.14.7 Injury code

Based on the Table of Injury as per the *Workers' Compensation and Rehabilitation Regulation 2003*.

**Format/Length** Num(4)

**Mandatory/Conditional** Mandatory

##### Validation/Business Rules

##### Field Validation

- A valid table of injury code must be supplied. The Table of Injury codes are available from the Q-COMP website [www.qcomp.com.au](http://www.qcomp.com.au).

#### 4.14.8 Permanent impairment percent

The percentage of permanent impairment assessed by either a medical practitioner or the medical assessment tribunal for the injury code.

**Format/Length** Pct(5)

**Mandatory/Conditional** Mandatory

##### Validation/Business Rules

##### Field Validation

- Percent must be less than or equal to the valid percent on the injury code.
- If the permanent impairment injury code (4.17.7) is a psychological injury (codes 6000, 6001, 6002 or 6003) and the permanent impairment is equal to or greater than 0.01%, then a corresponding psychological injury nature (4.16.8) must be recorded in the multiple injury file.
- If the permanent impairment injury code (4.17.7) is a physical injury (any code other than 6000, 6001, 6002 or 6003) and the permanent impairment is equal to or greater than 0.01%, then a corresponding physical injury nature (4.16.8) must be recorded in the multiple injury file.

#### 4.14.9 Permanent impairment lump sum amount

The amount of permanent impairment lump sum available for each injury code, according to the Table of Injuries.

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

**Validation/Business Rules**

**Field Validation**

- The amount offered for each injury code. Null is only acceptable if the permanent impairment percent is equal to zero percent.

#### 4.14.10 Outcome – permanent impairment percent

Outcome of the assessment of permanent impairment.

**Format/Length** Num(1)

**Mandatory/Conditional** Conditional

**Validation/Business Rules**

**Business Rules**

- Once a decision regarding a permanent impairment assessment has been made, the code must be supplied.

**Field Validation**

- Must be a valid code:

<b>Outcome – permanent impairment percent</b>	<b>Code</b>
No Response, Deemed Accepted or Agreed	0
Agree	1
Disagree	2

- If no decision on the permanent impairment percentage has been made, zero is an acceptable value.

#### 4.14.11 Date permanent impairment assessed

The date the worker was assessed for permanent impairment.

**Format/Length**                 Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Field Validation

- The date permanent impairment assessed must be greater than the date of injury (Refer to Section 4.9.12, Notice of claim compliant date on page 74).

#### 4.14.12 Outcome of offer of lump sum compensation

Outcome of the offer of permanent impairment lump sum compensation amount.

**Format/Length**                 Num(1)

**Mandatory/Conditional** Conditional

#### Validation/Business Rules

#### Business Rules

- Once a decision regarding the offer of permanent impairment lump sum has been made, the code must be supplied.

#### Field Validation

- If the permanent impairment assessment equals zero percent, the outcome must be null
- If the lump sum amount is null, the Outcome of Offer of Lump Sum Compensation must also be null.
- The worker has 20 business days to respond to the offer, no outcome of offer of lump sum compensation needs to be supplied within this period. If the worker has not responded to the offer within this time frame, a 'no response received' code 3 must be supplied.
- Must be a valid code:

<b>Outcome of offer of lump sum compensation</b>	<b>Code</b>
Accept	1
Reject	2
Defer/no response from worker	3

## 4.15 Ordinary earnings file

This file provides details of the ordinary earnings for the injured worker. If weekly compensation has been paid, this file must also be supplied. Although there is only one NWE and award rate for most claims, the capacity for incremental or indexation increases are also allowed.

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- insurer number
- claim number
- ordinary earnings record identifier

The **normal weekly earnings** field has been defined in this file for the purpose of a control total. Refer to Section 4.1.7, Control total on page 22.

### 4.15.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Control File Validation

- Must be a valid insurer number.

### 4.15.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Control File Validation

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.15.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.15.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length** Char(15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

### 4.15.5 Ordinary earnings record identifier

The ordinary earnings record identifier uniquely identifies each record of ordinary earning supplied. This identifier assists Q-COMP to identify whether the data already exists on the Q-COMP system and if the appropriate action can be taken to add, modify, or delete the data on the Q-COMP system.

- Once an identifier has been allocated to an ordinary earnings record it must not change, as it is used in the key to reference this data in any subsequent data transfers.

**Format/Length** Char(10)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Record Validation

- Must be unique for each ordinary earning record supplied against a claim.

#### 4.15.6 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char (1)

**Mandatory/Conditional** Mandatory

**Validation/Business Rules**

**Field Validation**

- Must be a valid code:

Delete Flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

#### 4.15.7 Ordinary earnings from date

The date the ordinary earnings rate commenced is from the start of claim or from compensation being paid, and only needs to be re-supplied if it changes.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

**Validation/Business Rule**

**Field Validation**

- Must be supplied for any claim receiving weekly benefits or if workdays lost is not null.

#### 4.15.8 Ordinary earnings to date

If the earnings rate changes at any point during the claim, this is the date this level of payment is valid to. Only the last record for a claim can have null ordinary earnings to date.

**Format/Length** Date

**Mandatory/Conditional** Conditional

**Validation/Business Rule**

- The ordinary earnings to date must be greater than or equal to the ordinary earnings from date of this ordinary earnings period.

#### 4.15.9 Normal weekly earnings

The amount of normal weekly earnings used in calculating benefits as per the *Workers' Compensation and Rehabilitation Act 2003*.

**Format/Length** Amt(12)

**Mandatory/Conditional** Mandatory

**Validation/Business Rule**

**Field Validation**

- Must be supplied if a record is supplied.

#### 4.15.10 Award rate

The amount of earnings as per the injured worker's industrial agreement.

**Format/Length** Amt(12)

**Mandatory/Conditional** Conditional

**Validation/Business Rule**

**Business Rule**

- Must be supplied if the injured worker is employed under an industrial agreement.

## 4.16 Multiple injury file

This file provides details of all injuries on the claim including the most serious injury (that is, if there is only one injury the injury will be reported both in both Section 4.2, Claim base file on page 23 and the Multiple injury file).

For the appropriate file name, refer to User Data Description on page 19.

The unique key of the data represented in each record of this file is:

- insurer number
- claim number
- multiple injury record identifier

The **injury location** field has been defined in this file for the purpose of a control total. Refer to Section 4.1.7, Control total on page 22.

### 4.16.1 Insurer number

The insurer number is the unique identifier for the insurer supplied at the time of licence approval.

The identifier is used to identify the insurer data. For example, the joining of the insurer number and the claim number (described later) forms the unique identifier for the insurer's claims on the Q-COMP system.

**Format/Length** Char(11)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Control File Validation

- Must be a valid insurer number.

### 4.16.2 Reporting period from

The reporting period from date is the first date of the reporting period for the data being supplied. This date is used to identify this record belongs to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

#### Control File Validation

- Must be the first day of the reporting period, that is, the first day of the month. For example, for the month of March 1997, it is 19970301.

### 4.16.3 Reporting period to

The reporting period to date is the last date of the reporting period for the data being supplied. This date is used to identify this record belonging to a particular reporting period.

**Format/Length** Date

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Control File Validation

- The reporting period to date must be the last day of the reporting period, that is, the last day of the month. For example, for the month of March 1997, it is 19970331.

### 4.16.4 Claim number

The unique identifier for the statutory workers' compensation claim lodged with the insurer. This is the unique identifier generated by the insurer. This identifier must not change, as it is used by Q-COMP to uniquely identify the claim details within the Q-COMP system.

**Format/Length** Char(15)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- Each claim created by the insurer must be unique and is identified by this field.

### 4.16.5 Delete flag

The value in this field indicates whether the data identified by the key of this record is to be added, modified or deleted on the Q-COMP system.

**Format/Length** Char (1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

Delete Flag	Code
No - the data identified by the key of this record is added (if it does not exist) or modified (if it does exist).	N
Yes – the data identified by the key of this record is deleted.	Y

#### 4.16.6 Multiple injury record identifier

The multiple injury record identifier uniquely identifies each multiple injury record associated with a claim. This identifier assists Q-COMP to identify whether the data already exists on the Q-COMP system and if the appropriate action can be taken to add, modify, or delete the data on the Q-COMP system.

- Once an identifier has been allocated to a multiple injury record it must not change, as it is used in the key to reference this data in any subsequent data transfers.

**Format/Length** Char(10)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Record Validation

- Must be unique for each multiple injury record supplied against a claim.

#### 4.16.7 Injury location for all injuries

A code to identify the location of the injury for all injuries on the claim.

- It is to be expected that the staff member has an adequate level of competency in coding the injury. For further information regarding Types of Occurrence coding, refer to Coding and Validation.

**Format/Length** Num(3)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- The Injury Location value must be valid (based on the coding standards of the *Type of Occurrence Classification System - Safe Work Australia*).

##### Warning

- The Injury Location must be valid for the Injury Nature (must comply with the Injury Location and Injury Nature Validation Rules as managed by the Safe Work Australia (information about Safe Work Australia and the National Data Set is contained in Appendix A).

#### 4.16.8 Injury nature for all injuries

A code to identify the nature of the injury for all injuries on the claim.

**Format/Length** Num(3)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Business Rule

- The staff member has an adequate level of competency in coding the injury.

##### Field Validation

- The Injury Nature value must be valid (based on the coding standards of the *Type of Occurrence Classification System - Safe Work Australia*) current version.

##### Warning

- The Injury Nature must be valid for the Injury Location (must comply with the Injury Location and Injury Nature Validation Rules as managed by the Safe Work Australia - information about Safe Work Australia and the National Data Set is contained in Appendix A.

#### 4.16.9 Injury identifier for all injuries

This field contains a value to identify whether the injury was on the left or right side of the body, or is not applicable for the type of injury.

**Format/Length** Char(1)

**Mandatory/Conditional** Mandatory

#### Validation/Business Rules

##### Field Validation

- Must be a valid code:

Injury Identifier	Code
Left	L
Right	R
Bilateral	B
Not applicable	N

##### Warning

- Must comply with the Injury Location and Injury Identifier validation rules. Refer to Appendix E, Injury Location and Injury Identifier Validation.

## Appendix A – National data set

One of the reasons for the collection of data from insurers' is to enable Queensland to supply data to Safe Work Australia for the National Data Set. This enables the production of national and nationally comparable workers' compensation-based data.

Q-COMP provides data to Safe Work Australia based on the National Data Set for Compensation-based Statistics, Third Edition July 2004.

The National Data Set for Compensation based Statistics specification is available from Safe Work Australia at

<http://www.safeworkaustralia.gov.au/swa/aboutus/publications/nationaldatasetforcompensation-basedstatisticsnclsclassificationssystem.htm>

### Injury Narrative (Insurers' Interface Data Specification Section 4.2.6 page 25)

This field is used in the national data set for the following data item(s) *(these items are coded by the Office of Economic and Statistical Research for the National Data Set based on injury narrative information – therefore validation exists to ensure the narrative exceeds 15 characters)*;

**Item D5 Mechanism of injury or disease**

Description: The mechanism of injury/disease is intended to identify the action, exposure or event that was the direct cause of the most serious injury or disease.

**Item D6 Agency of injury or disease**

Description: The agency of injury/disease refers to the object, substance or circumstance directly involved in inflicting the most serious injury or disease.

**Item D7 Breakdown agency**

Description: The breakdown agency is intended to identify the object, substance or circumstance that was principally involved in, or most closely associated with, the point at which things started to go wrong and which ultimately led to the most serious injury or disease.

### Injury Date (Insurers' Interface Data Specification Section 4.2.7 page 25)

This Field is used in the national data set for the following data item(s);

**Item D1 Date of occurrence/report**

Description: The date on which the injury occurred or the occupational disease was first reported to the employer.

### Injury Occurrence (Insurers' Interface Data Specification Section 4.2.9 page 26)

This Field is used in the national data set for the following data item(s);

**Item C2 Duty status**

Description: The worker's duty status at the time of the injury or disease.

### Injured Worker Occupation (Insurers' Interface Data Specification Section 4.2.12 page 27)

This field is used in the national data set for the following data item(s) (coded by Qstats for the National Data Set);

**Item C1 Occupation**

Description: The worker's occupation at the time of the injury or reporting of the occupational disease.

### **Injury Location (Insurers' Interface Data Specification Section 4.2.16 page 30)**

This field is used in the national data set for the following data item(s);

**Item D4                    Bodily Location of Injury or Disease**

Description:            The bodily location of injury/disease is intended to identify the part of the body affected by the most serious injury or disease.

### **Injury Nature (Insurers' Interface Data Specification Section 4.2.17 page 30)**

This field is used in the national data set for the following data item(s);

**Item D3                    Nature of Injury or Disease**

Description:            The nature of injury/disease is intended to identify the most serious injury or disease sustained or suffered by the worker. The injury or disease suffered is generally physical although the classification includes categories for mental illness.

### **WorkCover Industry Code/Industry Business Code (Insurers' Interface Data Specification Section 4.2.22 page 31)**

This field is used in the national data set for the following data item(s);

**Item A1                    Industry of Employer**

Description:            Industry of employer relates to the main activity of the establishment at which the worker was employed at the time of reporting the occupational injury or disease. For incidents occurring away from the establishment it relates to the main activity of the establishment at which the worker was based.

### **Injured Worker Date of Birth (Insurers' Interface Data Specification Section 4.3.6 page 39)**

This field is used in the national data set for the following data item(s);

**Item B1                    Date of Birth**

Description:            The date of birth of the worker making the claim for an injury or disease.

### **Injured Worker Gender (Insurers' Interface Data Specification Section 4.3.10 page 41)**

This field is used in the national data set for the following data item(s);

**Item B2                    Sex**

Description:            The sex of the worker.

### **Lodgement Date (Insurers' Interface Data Specification Section 4.4.7 page 44)**

This field is used in the national data set for the following data item(s);

**Item D2                    Date of lodgement of Claim**

Description:            The date on which a claim for compensation was made with the insurer.

### **Normal Work Hours (Insurers' Interface Data Specification Section 4.6.9 page 59)**

This field is used in the national data set for the following data item(s);

**Item C3                    Number of Hours Usually Worked Each Week**

Description:            The number of hours and minutes usually worked each week by the injured worker.

### **Hours Lost (Insurers' Interface Data Specification Section 4.6.12 page 60)**

This field is used in the national data set for the following data item(s);

**Item E1                    Time lost**

Description:            The number of hours and minutes lost for which compensation was paid by **any party** (for example, employer, insurer, Workcover Authority). This data item should be collected for all cases included in the scope outlined at paragraphs 2.1 and 2.2 in Part 2 Concepts and Methods for Collecting Data on page 3.

**Payments (Insurers' Interface Data Specification Section 4.12 page 95)**

This field is used in the national data set for the following data items;

**Data Item E3a, E3b, E3c - Payments Made**

**Definition:** All payments made in respect of the injury or disease. This includes payments below any non-compensable payments thresholds operated by workers' compensation authorities.

**Purpose:** To provide an indicator of the economic cost of employment injuries and provide a basis for evaluation of planned preventive strategies.

**Item E3a Compensation or sustenance payments to worker or worker's family**

This category includes payments for:

- Death
- Lump Sums for permanent injury
- Lump sums for pain and suffering
- Lump sums for redemption
- Partially incapacitated compensated as fully incapacitated
- Weekly payments for total incapacity
- Weekly payments for partial incapacity

**Item E3b Payments for goods and services**

This category includes payments for:

- Ambulance services
- Accommodation expenses
- Attendance by a nurse
- Funeral expenses
- Medical treatment
- Hospital treatment
- Rehabilitation services
- Physiotherapy services
- Chiropractic services
- Damaged artificial limbs etc
- Damaged clothing

**Item E3c Non-compensation payments**

This category includes payments for:

- Transport and maintenance
- Damages and common law
- Investigation expenses
- Interpreter services
- Legal costs

## Appendix B – Control file and record validation errors

Control File and Record Validation errors prevent insurer data from being loaded. The following table detail the fields, except the Control File (where all fields are Control File Validation), which may cause data not to be loaded, the type of error (C = Control File and R = Record Validation) and reference page for the validation are identified.

FILE NAME	Insurer Number	Claim Number	Reporting Period From	Reporting Period To	Injured Worker Identifier	Lodgement Record Identifier	Status Record Identifier	Compensation Record Identifier	Fatal Application Record Identifier	Former Name Record Identifier	Damages Claim Number	Payment Month	Permanent Impairment Injury Identifier	Ordinary Earning Record Identifier	Multiple Injury Record Identifier	Contributory Negligence Section	Payment Category	Payment Type	Item Number
Claim Base File	C - 23	R - 24	C -	C - 24	C - 26														
Injured Worker File	C - 37		C - 37	C - 38	R - 38														
Lodgement File	C - 42	R - 43	C -	C -		R - 43													
Claim Status File	C - 45	R - 46	C -	C -			R - 46												
Compensation Period File	C - 55	R - 56	C -	C -				R - 57											
Fatal Application File	C - 62	R - 63	C -	C -					R - 63										
Former Names File	C - 66		C -	C -	R - 67					R - 67									
Damages Base File	C - 69	R - 70	C -	C -							R - 70								
Damages Resolution File	C - 80	R - 81	C -	C -							R - 81								
Damages Contributory Negligence File	C - 90	R - 91	C -	C -							R - 91					R - 93			
Payments File	C - 97	R - 98	C -	C -								R - 98					R - 98	R - 100	R - 105
Payment Total File	C - 106	R - 107	C -	C -															
Permanent Impairment File	C - 110	R - 111	C -	C -									R - 112						
Ordinary Earnings File	C - 115	R - 116	C -	C -										R - 116					
Multiple Injury File	C - 119	R - 120	C -	C -											R - 121				

## Appendix C – Address formats

There are two address formats within the Q-COMP validation system, the injured worker address and the address where the injury occurred.

### Format 1: Injured Worker Address

Field	Description
Address line 1	30 characters fixed length string
Address line 2	30 characters fixed length string (optional)
Address line 3	25 characters fixed length string - contains the valid locality as defined by the australia post locality list
Postcode	4 digits - contains a valid postcode as defined by the australia post postcodes

### Format 2: Injury Occurred Address

Field	Description
Address line 1	30 characters fixed length string
Address line 2	30 characters fixed length string (optional)
Address line 3	30 characters fixed length string (optional)
Address line 4	25 characters fixed length string - contains the valid locality as defined by the australia post locality list
Postcode	4 digits - contains a valid postcode as defined by the australia post postcodes

Business Rules apply to addresses. Standard address formats include:

All characters must be either:

- alphanumeric and in upper case
  - hyphen
  - apostrophe
  - quote
  - bracket
  - slash
  - space.
- Addresses consist of at least two lines and a postcode. Address line 2 and address line 3 are optional.
  - Address lines must not contain punctuation (except " " and "()") where appropriate).
  - Punctuation must be as according to Australia Post recommendations.
  - Within an address line, adjacent words must be separated by one space.
  - The character / must not have spaces on either side.
  - The prefixes mac and mc must not be separated from the following word.
  - The locality (address line 3 for format 1 or address line 4 for format 2) must be a valid Australia post locality.
  - The postcode must be a valid Australia Post postcode.
  - The postcode must be valid for the locality (and vice versa).

## Formatting Validation

The following formatting rules must be followed:

- the symbol for care of must be C/-
- replace character string C/O by C/-
- where the line starts with C/ ensure it starts with C/-
- replace character string G P O by GPO
- replace character string M S O by PO
- replace character string MC BOX by PO BOX
- replace character string ROAD EAST/ROAD WEST by RD EAST/RD WEST
- POST OFFICE BOX must be abbreviated to PO BOX, but where PO is by itself in the address line replace PO by POST OFFICE
- MAIL SERVICE must be abbreviated to MS.

The following abbreviations must be applied to all address lines (except postcode); replace ending character strings.

ABBREVIATION	Q-COMP STANDARD ABBREVIATION
AV	AVE
AVENUE	
BLVD	BOULEVARD
BLVDE	BOULEVARDE
CL	CLOSE
CIRCUIT	CIRCUIT
CORNER	CNR
CT	CRT
COURT	
CR	CRES
CRESCENT	
CVAN PARK	CARAVAN PARK
DR NTH	DR NORTH
DR STH	DR SOUTH
DRIVE EAST	DR EAST
DRIVE NORTH	DR NORTH
DRIVE NTH	
DRIVE SOUTH	
DRIVE STH	DR SOUTH
DRIVE WEST	DR WEST
DRIVE	DR
DRV	
DVE	
ESP	
ESPL	ESPLANADE
H/WAY	HWY
HIGHWAY	
HWAY	
HWAY	
HWY	
LA	LANE
PARADE	PDE
PD	
PL	PLACE
PLC	

ABBREVIATION	Q-COMP STANDARD ABBREVIATION
ROAD	RD
ROADS	RDS
ST NTH	ST NORTH
ST STH	ST SOUTH
STR	ST
STREET EAST	ST EAST
STREET NORTH	ST NORTH
STREET NTH	
STREET SOUTH	ST SOUTH
STREET STH	
STREET WEST	ST WEST
STREET	ST
STREETS	STS
STRS	
TER	TCE
TERRACE	
WAY	WAY

Exceptions exist if the address line contains THE as in the following address labels (for example, THE AVENUE, THE CRESCENT, THE DRIVE, etc.), no abbreviation will be applied to the label, but where the address label has been abbreviated, the following expansion must be applied.

ABBREVIATION	Q-COMP STANDARD ABBREVIATION
THE TCE	THE TERRACE
THE AVE	THE AVENUE
THE CRES	THE CRESCENT
THE DR	THE DRIVE
THE HWY	THE HIGHWAY
THE PDE	THE PARADE

- If any street type (for example, STREET, ROAD, HIGHWAY, etc.) is found at the start of the line, abbreviate to the end of the previous line (if possible).
- If any two word address labels (for example, CARAVAN PARK) is spread over two lines, abbreviate into the first line; otherwise make it part of the second line.
- The character string following PO BOX must be numeric.

### Q-COMP processing

Occasionally, there are addresses that do not fit any particular format (for example, international, etc.). In such cases, these addresses are allowed to be valid in the Q-COMP system.

The warning message is not being permanently recorded against the address (as with errors). This warning message will be issued to the insurer and Q-COMP will rely on the insurer to check and correct this address if required. If the insurer finds they cannot re-format the address to the standards in this Appendix, the addresses remain as reported. If the insurer finds the address is not to standard and can be corrected, Q-COMP expects the address to be corrected.

## Appendix D – Name formats

Characters in a name field must be supplied in UPPER CASE. A name field includes, injured worker name, former names and claim staff name.

The name field must be 70 characters in length.

There are two basic types of names, these being personal names and business names:

### Personal Names

Personal names must be in the following format:

- SURNAME/FIRSTNAME,SECONDNAME,THIRDNAME, . . .
- the separator '/' denotes the end of the surname (or equivalent)
- the separator '/' must not be separated from the adjacent words
- the comma ',' denotes the end of each christian name (or equivalent)
- the comma ',' must not be separated from the adjacent words
- the prefixes 'MAC' and 'MC' must not be separated from the following word
- no other characters other than those listed above are acceptable
- Only one Surname is to be included
- No other special characters are to be recorded in the name field

Acceptable Characters:

- - hyphen
- ' apostrophe
- Spaces can only be included in the name eg. Jo Ann or Mary Lou.

### Business Names

Business names must be supplied and entered into the insurer's system.

Acceptable characters:

- - hyphen
- ' apostrophe
- Spaces can only be included in the name eg. Jo Ann or Mary Lou.

### Name Formats Not Acceptable

The Personal Names format is not to include former names as part of the Injured Workers Name. Valid spaces are not to be replaced with commas or separator.

Examples of invalid Personal Name formats:

- Smith (White)/Sue,Jane
- Smith,(Nee,White)/Sue,Jane
- Smith,(,White,)/Sue,Jane
- Smith/Sue,(,Jane,)

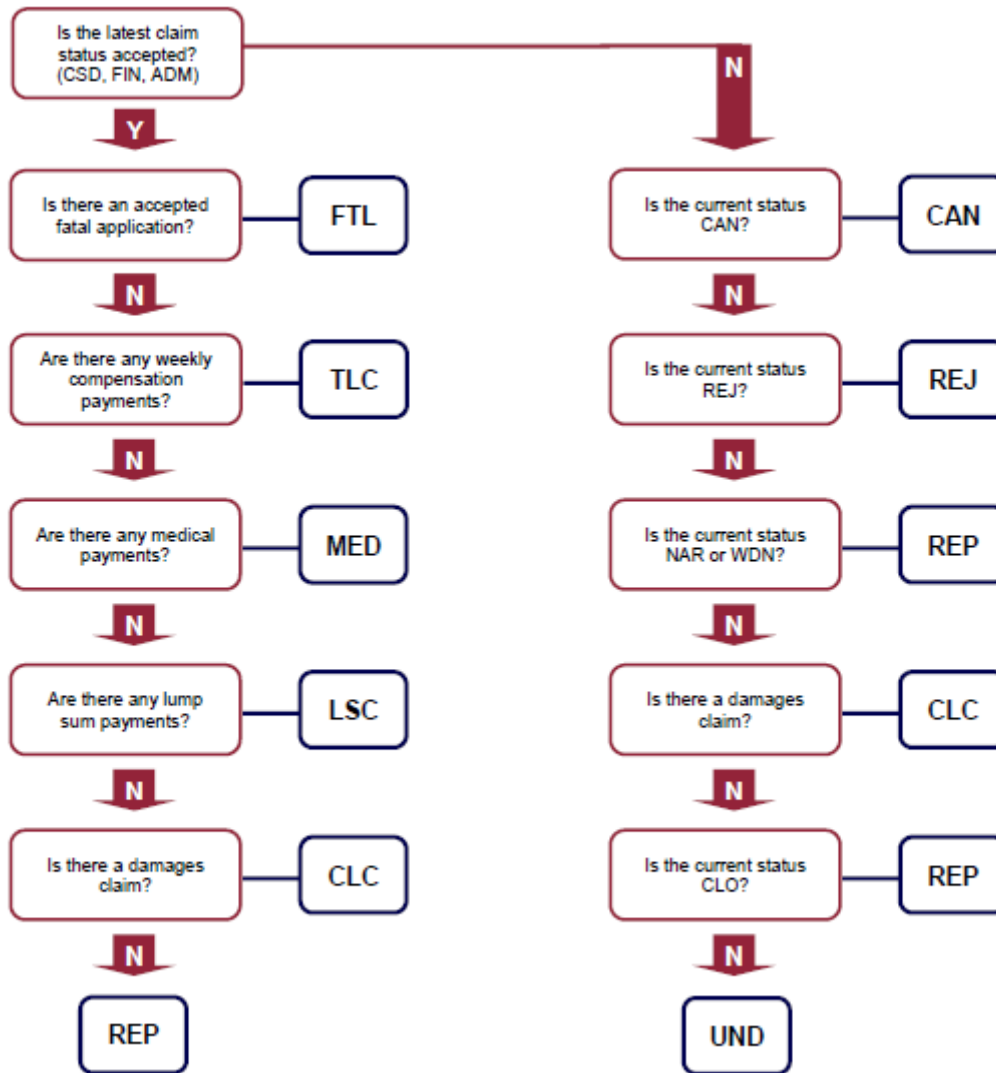
## Appendix E – Injury Location and Injury Identifier Validation

In the following table, represents the allowable combination of injury location and injury identifier.

INJURY LOCATION Location code	INJURY IDENTIFIER			
	Not applicable	Right	Left	Bilateral
110	X			
111	X			
120		X	X	X
121		X	X	X
128		X	X	X
129		X	X	X
130		X	X	X
140	X			
141	X			
150	X			
160	X			
180	X			
190	X			
210	X			
211	X			
218	X			
219	X			
310	X			
311	X			
318	X			
319	X			
330		X	X	X
331		X	X	X
332		X	X	X
333	X			
334	X			
335	X			
338	X			
339	X			
340	X			
341	X			
342	X			
343	X			
344	X			
345	X			
346	X			
347	X			
350	X			
351		X	X	X
352	X			
353	X			
354	X			
358	X			
359	X			
380	X			
390	X			

INJURY LOCATION Location code	INJURY IDENTIFIER			
	Not applicable	Right	Left	Bilateral
410		X	X	X
420		X	X	X
430		X	X	X
440		X	X	X
450		X	X	X
460		X	X	X
461		X	X	X
462		X	X	X
468		X	X	X
469		X	X	X
480		X	X	X
490		X	X	X
510		X	X	X
520		X	X	X
530		X	X	X
540		X	X	X
550		X	X	X
560		X	X	X
561		X	X	X
568		X	X	X
569		X	X	X
580		X	X	X
590		X	X	X
610	X			
620	X			
630	X			
640	X			
650		X	X	X
660	X			
680	X			
688	X			
690	X			
710	X			
720	X			
730	X			
740	X			
750	X			
780	X			
790	X			
800	X			
900	X			

### Appendix F – Claim type derivation



### Legend of Claim Types

Claim type	Description
FTL	Fatal
TLC	Time Lost Claim
MEC	Medical Expense Claim
LSC	Lump Sum Claim
CLC	Common Law Claim
REP	Report Only
REJ	Rejected
CAN	Cancelled
UND	Undetermined

## Claim Type Derivation Rules

### Rule 1

If the claim is accepted and has an accepted fatal application, the claim type will be derived as FTL.

### Rule 2

If the claim is accepted and has weekly compensation payments made, the claim type will be derived as TLC.

### Rule 3

If the claim is accepted and has treatment and rehabilitation payments made, the claim type will be derived as MED.

### Rule 4

If the claim is accepted and has lump sum payments made, the claim type will be derived as LSC.

### Rule 5

If the claim is accepted and has an associated common law claim, the claim type will be derived as CLC.

### Rule 6

If the claim is accepted, the claim type will be derived as REP.

### Rule 7

If the current claim status is CAN, the claim type will be derived as CAN.

### Rule 8

If the current claim status is REJ, the claim type will be derived as REJ.

### Rule 9

If the current claim status is NAR, the claim type will be derived as REP.

### Rule 10

If the current claim status is WDN, the claim type will be derived as REP.

### Rule 11

If the claim has an associated common law claim, the claim type will be derived as CLC.

### Rule 12

If the current claim status is CLC, the claim type will be derived as REP.

### Rule 13

The claim type will be derived as UND if none of the above are matched.

## Appendix G – Version control

Version	Date Issued	Date Effective	Reason/Affected Pages
1	14 November 1997		Original Version
1.1	4 December 1997		Chapter 5 - File character positions adjusted
1.2	29 April 1998		<p>Replace all pages for text changes: Section 2.1, Terminology and Section 3.3, Modifications.</p> <p>Replace all pages for chapter 4 changes. Formatting changes (for easier reference): Validation/Business Rules were underlined and reordered into business/control file/record/field/warning order.</p> <p>Validation/Business Rule changes to sections: 4.1.5, 4.2.7, 4.4.7, 4.5.6, 4.5.7, 4.6.12, 4.7.8, 4.10.5, 4.11.5, and 4.12.5</p>
1.3	9 November 1998		Chapter 4 – warning title added to sections 4.2.15, 4.2.16, 4.2.17, 4.2.18, 4.2.19, and 4.2.22.
2	30 June 1999		Replace all pages. See change bars on right-hand side of pages throughout document.
2.1	5 October 1999		<p>All pages - new logo for Regulatory Functions Division.</p> <p>Figure 1 changed, page 36.</p> <p>Tail claims definition added on page 4.</p> <p>Section. 3.2 &amp; 3.5 - CD-R must be supplied to WorkCover with all data corrected by the 15th day of the month.</p> <p>Section. 4.2.4 - tail claim rules identified in Validation/Business Rules.</p> <p>Section. 4.5.8 – paragraph added to description</p> <p>Section. 4.5.10 – paragraph added to description.</p> <p>Section. 4.7.7 - definition of medical certificate type “D” changed.</p> <p>Section. 4.10.5 – tail claim rules identified in Validation/Business Rules.</p> <p>Section. 4.10.12 - Record Validation added.</p> <p>Section. 4.11.7 - resolution date now Mandatory.</p> <p>Section. 4.13.6 - warning duplication removed from Record Validations.</p>
2.2	April 2000		<p>Section. 4.13.6 - for payment category 07, NOC received date must be supplied for injury dates on or after 1/2/97.</p> <p>Last Record Validation removed from page 65.</p> <p>Addition of two new fields in damages base file:</p> <ul style="list-style-type: none"> <li>Section. 4.10.14 – estimated damages</li> <li>Section. 4.10.15 – estimated costs</li> </ul> <p>Section. 4.13 - paragraph added to payments file re GST</p> <p>Addition of two new fields in payments file:</p> <ul style="list-style-type: none"> <li>Section. 4.13.10 – GST.</li> <li>Section. 4.13.11 - invoice amount.</li> </ul> <p>Section. 5.10 - updated damages base file.</p> <p>Section. 5.13 - updated payments file.</p> <p>Section. 5.14 - updated payments total file.</p>
2.3	May 2000		<p>All pages - new logo for Q-COMP.</p> <p>Changes to 2 new fields in damages base file:</p> <ul style="list-style-type: none"> <li>Section 4.10.14 - estimated damages.</li> </ul>

Version	Date Issued	Date Effective	Reason/Affected Pages
			<p>Section 4.10.15 – estimated costs.</p> <p>Changes to new fields in payments file:</p> <p>Section 4.13.9 – net claims cost.</p> <p>Section 4.13.10 – total GST amount.</p> <p>Section 4.13.11 – gross claims cost.</p> <p>Changes to Record Validations:</p> <p>Section 4.2.4 – claim number</p> <p>Section 4.10.4 – claim number</p> <p>Section 4.10.5 – damages claim number</p> <p>Payment category 07 subdivided to include plaintiffs costs and creation of two new payment types:</p> <p>Section 4.13.7 – payment type 004 legal costs and 005 outlays</p> <p>Section 4.14.6 - total statutory claim cost</p> <p>Section 4.14.7 - total damages claim cost</p>
<b>2.4</b>	<b>December 2000</b>		<p>Changes to injury location and nature combinations and to mechanism and agency combinations:</p> <p>Appendix D - injury location and nature combinations.</p> <p>Appendix E - mechanism and agency combinations.</p>
<b>2.5</b>	<b>March 2001</b>		<p>All pages - References to WorkCover changed to Q-COMP.</p> <p>Changes to data warnings:</p> <p>Section 4.10.14 - estimated damages.</p> <p>Section 4.13.6 - payment category.</p> <p>Section 4.13.7 -payment type.</p> <p>Section 4.13.9 - net claims cost.</p> <p>Section 4.13.11 - gross claims cost.</p> <p>Changes to Field Validation:</p> <p>Section 4.13.6 - payment category.</p> <p>Section 4.13.10 - total GST.</p> <p>Change to Control File Validation: Section 4.13.9 - net claims cost.</p> <p>Change to Record Validation: Section 4.13.6 payment category - definition amended.</p> <p>Change to definition: Section 4.13 payments file - total amount changed to net claims cost.</p> <p>Section 4.13.6 payment category - heading added Field Validation.</p> <p>Chapter 4a – page 36 correct diagram.</p>
<b>2.6</b>	<b>October 2001</b>	<b>1 March 2002</b>	<p>Changes to new common format: Section 2.2 - ability to cater for null percent values.</p> <p>Change to claim base file:</p> <p>Section 4.2.25 - previous insurer code.</p> <p>Section 4.2.26 - previous insurer's claim number.</p> <p>Section 4.2.27 - psychological work related impairment percent.</p> <p>Section 4.2.28 - physical work related impairment percent.</p> <p>Addition of Section 4.15 - permanent impairment injury file.</p> <p>Addition of claim base file table.</p> <p>Addition of permanent impairment injury file table</p>

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3	28 March 2002	1 July 2003	<p>The entire document has been reworded with symbols and examples added and some changes in terminology.</p> <p>The following is a list of the changes made to structure, data and validation other than cosmetic changes. Where deletions have been made these have been referenced back to the last version of the data specifications (v2.6)</p> <p><b>Files deleted</b></p> <p>Medical Certification File (Section 4.7 in v2.6)</p> <p><b>Files modified</b></p> <p>Compensation Period File (Section 4.6 in v3.0) should now report periods of partial and total incapacity as separate compensation periods.</p> <p>Payments File (Section 4.12 in v3.0) includes a number of examples regarding the supply of payments and GST that were previously circulated as separate documents.</p> <p><b>Files added</b></p> <p>Ordinary Earnings File (Section 4.15 in v3.0)</p> <p>Multiple Injury File (Section 4.16 in v3.0)</p> <p><b>Fields removed</b></p> <p>Injury Period Occurred (Section 4.2.10 in v2.6)</p> <p>Business Workplace Registration Number (Section 4.2.20 in v2.6)</p> <p>Workplace Accreditation Number (Section 4.2.21 in v2.6)</p> <p>Return to Work Date (Section 4.6.11 in v2.6)</p> <p><b>Fields modified</b></p> <p>Injury Mechanism and Injury Agency (Section 4.2.17 and Section 4.2.18 in v3.0) are no longer Mandatory or validated although may still be supplied.</p> <p>Injury Narrative (Section 4.2.6 in v3.0) increased from 150 characters to 250 characters.</p> <p>Employer Number (Section 4.2.21 in v3.0) changed format from Num(4) to Char(12).</p> <p>Changes to the payment category and type codes (Section 4.13.6 and Section 4.13.7 in v3.0) including the following new codes:</p> <p><b>Payment category:</b></p> <p>17 - Pre-damages legal payments</p> <p><b>Payment type:</b></p> <p>001 - Medical reports (in Payment Category 01)</p> <p>001 - Statutory legal costs (in Payment Category 02)</p> <p>002 - Statutory legal outlay (in Payment Category 02)</p> <p>001 - Total incapacity (in Payment Category 03)</p> <p>002 - Partial incapacity (in Payment Category 03)</p> <p>998 - Excess period (in Payment Category 03)</p> <p>006 - Additional rehabilitation expenses for treatment (in Payment Category 07)</p> <p>007 - Additional rehabilitation expenses for occupational and vocational rehabilitation (in Payment Category 07)</p>

Version	Date Issued	Date Effective	Reason/Affected Pages
			<p>001 - Statutory recovery (in Payment Category 08)                      002 - Common law recovery (in Payment Category 08)                      001 - Pre-damages legal costs (in Payment Category 17)                      002 - Pre-damages outlays (in Payment Category 17)</p> <p>The following code was deleted (are no longer valid): 999 in Payment Category 08</p> <p><b>Fields added</b></p> <p>Return to Work Status (Section 4.2.26 in v3.0)                      Reason for Rejection (Section 4.5.11 in v3.0)                      Hours Lost (Section 4.6.12 in v3.0)                      Partial / Total Incapacity Flag (Section 4.6.13 in v3.0).                      Excess Days Lost Flag (Section 4.6.14 in v3.0)</p> <p><b>Validation</b></p> <p>Injury narrative (Section 4.2.6 in v3.0) must not repeat words to reach Mandatory length.</p> <p>The Claim Status “CLO” (Common Law Only) (Section 4.5.7 in v3.0) permitted for any common law claim.</p> <p>Change to claim status validation (Section 4.5.7 in v3.0).</p> <p>Settled prior to legal proceedings is only applicable to for claims with an injury date prior to 1/2/97 (Section 4.10.9 in v3.0).</p> <p>Injury Nature and Injury Location (Section 4.2.15 and Section 4.2.16 in v3.0). Q-COMP will no longer maintain valid combinations for the Type of Occurrence Classification System codes but will refer all validation queries to the Australian Safety and Compensation Council website:                      (<a href="http://www.ascc.gov.au/ascc/AboutUs/Publications/StatReports/TheTypeofOccurrenceClassificationSystemTOOCS.htm">http://www.ascc.gov.au/ascc/AboutUs/Publications/StatReports/TheTypeofOccurrenceClassificationSystemTOOCS.htm</a>) for the most up to date information.</p> <p>Calculation of Total Damages Claim Cost to include of Payment Category 17 (Section 4.13.7 in v3.0).</p> <p><b>Terminology</b></p> <p>“Re-opening” now called “continuation” throughout specifications                      “Self-insurer” now called “Insurer” throughout specifications                      “Self-insurer number” now called “Insurer number” (in all files in v3.0).                      “Liability Recinded Indicator” now called “Liability Reversed Indicator” (Section 4.5.9 in v3.0).</p> <p>“First Weekly Payment Date” now called “First Compensation Payment Date” (Section 4.6.11 in v3.0)</p> <p>“Notice of Claim Received Date” now called “Date of Notification of Damages Claim” (Section 4.9.7 in v3.0)</p> <p>Codes in damages resolution stage reworded to cover possible gaps that may have existed (Section 4.10.9 in v3.0).</p> <p>“Offer Outcome” now called “Outcome” (Section 4.14.10 in v3.0)</p>

Version	Date Issued	Date Effective	Reason/Affected Pages
			Codes for outcome of PI assessment changed to reflect agreement / disagreement with PI rather than offer acceptance. (Section 4.14.10 in v3.0)
3.1	30 June 2003		<p><b>Field modified:</b> Workdays Lost (Section 4.6.10 in v3.1) format changed from Num(3) to Num(6)</p> <p><b>Change to Record Validation:</b> Section 4.2.26 Return to Work Status - definition amended</p>
4.0	9 July 2004	1 July 2005	<p><b>Fields added</b></p> <p>Date injury first reported to employer (Section 4.2.30 in v4.0)</p> <p>Item Number (Section 4.12.12 in v4.0). File specifications for Item Number information to be supplied annually by Q-COMP documented (Appendix G in v4.0)</p> <p>Replace All Payments Flag (Section 4.13.7 in v4.0)</p> <p><b>Payment type:</b></p> <p>006 - Additional rehabilitation expenses for treatment (in Payment Category 17)</p> <p>007 - Additional rehabilitation expenses for occupational and vocational rehabilitation (in Payment Category 17)</p> <p><b>Validation</b></p> <p>Record Validation rules have been modified to cause the rejection of any data submission with Record Validation error (3.10.2 in v4.0).</p> <p>Previous insurer number can not equal current insurer number (4.2.25 in v4.0)</p> <p>Previous insurer messages (relating to data comparison) changed from Field Validation to warning (4.2.26 in v4.0)</p> <p>A listing of fields which may cause rejection of data submission has been documented (Appendix B in v4.0)</p> <p>The process used by Q-COMP to monitor and manage data errors has been documented (Appendix C in v4.0)</p> <p><b>Additional information</b></p> <p>Information for insurers regarding the National Data Set and coding for injury nature, location, agency and mechanism (including coding support) (Appendix A in v4.0)</p>
4.1	16 December 2005	16 December 2005	<p><b>Payment type:</b></p> <p>05 009 – Latent onset condition / terminal condition (in Payment Category 05)</p> <p><b>Injury code:</b></p> <p>Replaces codes previously in legislation – <i>Workers' Compensation and Rehabilitation Act Regulation 2003.</i></p>
4.1.1	13 September 2006	13 September 2006	<p><b>Additional fields:</b></p> <p><b>4.12.7 - Payment type</b></p> <p>New Payment Type added - "006 - Non-Dependant Lum Sum"</p> <p>Payment Type "002 – Dependant Lump Sum" updated to reflect Section 200(2) (aa) of the Act.</p> <p>Payment Type "003 – Dependant Weekly Payments" updated to reflect Section 200(2) (ab) of the Act.</p>
4.2	1 July 2006	1 July 2007	<p><b>Injury Occurrence code:</b></p> <p>Additional Occurrence Code 8 (Nature of work – away from normal workplace) to made available to self insurers. (4.2.9)</p> <p><b>Reasons for Rejection:</b></p> <p>Change of name to incorporate reasons for cessations and</p>

Version	Date Issued	Date Effective	Reason/Affected Pages
			<p>suspensions and coding New name – Reason for Status. (4.5.11)</p> <p><b>Additional fields –</b> <b>Permanent impairment injury file</b> Date Permanent Impairment Assessed (4.14.11) Outcome of Offer of Lump Sum Compensation (4.14.12)</p> <p><b>Definitions/terminology:</b> Status – Withdrawn – new addition – for WorkCover Only</p> <p><b>Claim status –</b> Additional claim status – Withdrawn – for WorkCover Only (4.5.7)</p>
4.2.1	1 February 2009	1 February 2009	<p>The current document has been updated to ensure the information contained is up to date and reflective of current legislation. Changes of note include:</p> <ul style="list-style-type: none"> <li>References to the National Occupational Health and Safety Commission have been changed to the Australian Safety and Compensation Council.</li> <li>A detailed description of claim type derivation has been included.</li> <li>The procedure for entering a transferred claim has been described in detail.</li> </ul> <p>Changes to validation include:</p> <p><b>3.2 Data Frequency</b> Updated reference for supply of data submission to Q-COMP from the 10<sup>th</sup> day to 8<sup>th</sup> day</p> <p><b>4.12.7 – Payment Type</b> Payment Type 05 009 – <i>Latent onset condition/terminal condition</i> updated to include reference to Section 128D of the Act for payment to dependants for injuries under Section 128B</p> <p><b>The following Warning from v4.2 has been removed.</b></p> <ul style="list-style-type: none"> <li>The total of all payments made to Payment Category 03 or Payment Category 05 / Payment Type 001 and Payment Category 05 / Payment Type 004, 005, 006, 007, and 008 must not be greater than the maximum statutory compensation amount provided under the Act. For injuries <b>prior to 1 January 2005</b>.</li> </ul> <p><b>The following Warnings from v4.2 have been changed to Field Validations.</b></p> <ul style="list-style-type: none"> <li>The total of all payments made to Payment Category 03 must not be greater than the maximum statutory compensation amount provided under the Act for claims with an injury date <b>greater than or equal to 1 January 2005</b>.</li> <li>The total of all payments made to Payment Category 05 Type 001, 004, 005, 006, 007 and 008 must not be greater than the maximum statutory compensation amount provided under the Act for claims with an injury date <b>greater than or equal to 1 January 2005</b>.</li> </ul> <p><b>4.2.27 – Psychological WRI</b> Include reference to Psychological WRI codes of 6002 and 6003</p> <p><b>4.2.28 – Physical WRI</b> Include reference to Psychological WRI codes of 6002 and 6003</p>
5.0	1 April 2010	1 April 2010	<p>The technical specification that was previously attached as an appendix in this publication has been removed and is now a stand-alone document.</p>

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			<p>This document is available at the Data Hub on the Q-COMP website.</p> <p><b>New Validation:</b></p> <p><b>4.5.7 – Claim Status</b> The validation has been made more flexible by allowing claims with a status of ADM or NAR to be able to progress to a CAN status.</p> <p><b>4.12.6 – Payment Category</b> A new data warning triggers when a fatal payment (payment category 04) has been made but no accepted fatal application exists.</p> <p><b>4.14.8 – Permanent Impairment Percent</b></p> <ul style="list-style-type: none"> <li>When a psychological PI is greater than 0.01% then there must be at least one psychological injury nature recorded in the multiple injury file.</li> <li>When a physical PI is greater than 0.01% then there must be at least one physical injury nature recorded in the multiple injury file.</li> </ul>
6.0	1 July 2010	1 July 2010	<p><b>Additional Fields</b> 20 new fields have been added to the data specification to comply with legislation changes and improve reporting purposes. The new fields are as follows:</p> <p><i>Claim Base File:</i> 4.2.31 Liability for workplace fatality</p> <p><i>Damages Base File:</i> 4.9.16 Urgent proceedings indicator 4.9.17 Legal Representation 4.9.18 Plaintiff lawyer firm 4.9.19 Plaintiff lawyer location 4.9.20 Liability Response 4.9.21 Date of Compulsory Conference 4.9.22 CTP Contributors 4.9.23 Public Liability Contributors 4.9.24 Other contributors</p> <p><i>Damages Resolution File:</i> 4.10.11 Dominant injury item number 4.10.12 Injury Scale Value 4.10.13 Multiple injury indicator 4.10.14 Gross Settlement Amount 4.10.15 HOD – General Damages 4.10.16 HOD – Past Economic Loss 4.10.17 HOD – Future Economic Loss 4.10.18 HOD – Treatment &amp; Rehab (Special Damages Past and Future) 4.10.19 HOD – Care 4.10.20 HOD – Other</p> <p><b>New Validation</b></p> <p><b>4.2.13 - Injured Worker Date Deceased:</b></p> <ul style="list-style-type: none"> <li>Must be supplied where the Liability for Workplace Fatality (4.2.31) is provided.</li> <li>Must be supplied when a Fatal Payment has been supplied, Payment Category 04 (4.12.6)</li> </ul>
6.1	1 July 2011	1 July 2011	<p><b>4.2.29 – Return to Work Status</b> Change to the definitions of RTW Status codes 05, 06, 07 and 08.</p>

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			<p><b>4.2.31 – Liability for Workplace Fatality</b> Change of name to Fatality Flag and change to descriptions for codes Y and N.</p>