	IOWA EDIT MATRIX	Iowa Division of Workers' Compensation - IWD																																
	ERROR MESSAGE	Mandatory field not present	All digits must be 0-9	Must be a valid date (CCYYMMDD)	Must be A-Z, 0-9, or spaces	Must be a valid time	Must be <= Date of Injury	Must be >= Date of Injury	Must be >= Date Disability Began	Must be <= Date of Death	Must be <= Maintenance Type Code date	Must be >= Start date	No match on database	All digits cannot be the same	Must be <= Current date	Not statutorily valid	Value is > than required by jurisdiction	Value is < than required by jurisdiction	No matching Subsequent report	No matching First Report of Injury	Must be <= Date of Hire	Duplicate transmission/transaction	Code/ID invalid	Value not consistent with value previously reported	Previous supporting documentation not received	Event Criteria not met	Invalid event sequence/relationship	Invalid data sequence/relationship	Corresponding report/data not found	Invalid record count	Must be >= Coverage Effective Date	Must be <= Coverage Expiration Date	Must be >= Date of Submission	Code value relationship invalid
DN	DATA ELEMENT NAME	001	028	029	030	031	033	034	035	036	037	038	039	040	041	042	044	045	050	053	055	057	058	059	060	061	063	064	065	066	067	068	069	076
0249	Accident Premises Code	x											x										x											
0121	Accident Site City	x											x																					
0118	Accident Site County/Parish	x																																
0119	Accident Site Location Narrative	x																																
0120	Accident Site Organization Name	x																																x
0033	Accident Site Postal Code	x											x										x											
0123	Accident Site State Code	x											x										x											
0122	Accident Site Street	x											x																					
0038	Accident/Injury Description Narrative	x																																
0110	Acknowledgment Transaction Set ID	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a
0124	Actual Reduced Earnings	x	x																							x								
0269	Address Type Qualifier	x																					x											x
0075	Agreement to Compensate Code	*																																
0111	Application Acknowledgment Code	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a
0062	Average Wage	x	x																					x										
0268	Benefit ACR Qualifier	x																					x											
0092	Benefit Adjustment Code	x																					x											
0125	Benefit Adjustment End Date	x		x				x				x			x																			
0094	Benefit Adjustment Start Date	x		x				x							x																			
0093	Benefit Adjustment Weekly Amount	x	x																															
0126	Benefit Credit Code	x																					x											
0128	Benefit Credit End Date	x		x				x				x			x																			
0127	Benefit Credit Start Date	x		x				x	x		x				x																			
0129	Benefit Credit Weekly Amount	x	x														x	x																
0088	Benefit Period Start Date	x		x				x	x		x				x																			
0089	Benefit Period Through Date	x		x								x			x																			
0130	Benefit Redistribution Code	x																					x											
0132	Benefit Redistribution End Date	x		x								x			x																			
0131	Benefit Redistribution Start Date	x		x				x	x		x				x																			
0133	Benefit Redistribution Weekly Amount	x	x														x	x																

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0086	Benefit Type Amount Paid	x	x															x																
0091	Benefit Type Claim Days	x	x														x	x																
0090	Benefit Type Claim Weeks	x	x														x	x																
0085	Benefit Type Code	x																					x											
0134	Calculated Weekly Compensation Amount	x	x														x	x																
0037	Cause of Injury Code	x																					x											x
0015	Claim Administrator Claim Number	x			x																													
0137	Claim Administrator Claim Representative Business Phone Number	x	x																															
0138	Claim Administrator Claim Representative E-Mail Address	x																																
0139	Claim Administrator Claim Representative FAX Number	x	x																															
0140	Claim Administrator Claim Representative Name	x																																
0187	Claim Administrator FEIN	x			x								x	x																				
0012	Claim AdminIstrator Mailing City	x											x																					
0136	Claim Administrator Mailing Country Code	*																																
0135	Claim Administrator Mailing Information/Attention Line	x																																
0014	Claim Administrator Mailing Postal Code	x											x										x											
0010	Claim Administrator Mailing Primary Address	x											x																					
0011	Claim Administrator Mailing Secondary Address	x											x																					
0013	Claim Administrator Mailing State Code	x											x										x											
0188	Claim Administrator Name	x																																
0073	Claim Status Code	x																					x											
0074	Claim Type Code	x																					x											
0142	Concurrent Employer Contact Business Phone Number	*																																
0141	Concurrent Employer Name	*																																
0143	Concurrent Employer Wage	x	x																															
0029	Coverage Effective Date	x		x			x								x																	x		
0030	Coverage Expiration Date	x		x				x																							x			
0144	Current Date Disability Began	x		x				x			x				x																			
0145	Current Date Last Day Worked	x		x				x			x				x																			
0072	Current Return to Work Date	x		x				x	x						x																			

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0041	Date Claim Administrator Had Knowledge of the Injury	x		x				x			x				x																			
0076	Date Claim Administrator Notified of Employee Representation	*																																	
0040	Date Employer Had Knowledge of the Injury	x		x							x																								
0031	Date of Injury	x		x						x	x				x																				
0070	Date of Maximum Medical Improvement	x		x				x	x		x				x																				
0108	Date Processed	x		x											x																				
0100	Date Transmission Sent	x		x							x				x																				
0146	Death Result of Injury Code	x																					x												x
0147	Deemed Reduced Earnings	*														x																			
0240	Denial Effective Date	x		x				x							x																				
0173	Denial Reason Code	x																					x												
0148	Denial Reason Narrative	x																																	
0190	Denial Rescission Date	x		x				x							x																				
0097	Dependent/Payee Relationship Code	x																					x												
0106	Detail Record Count	x	x																											x					
0149	Discontinued Fringe Benefits	x	x														x	x																	
0116	Element Error Number	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a
0115	Element Number	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a
0150	Employee Authorization to Release Medical Records Indicator	*																																	
0052	Employee Date of Birth	x		x			x				x				x						x						X								
0057	Employee Date of Death	x		x				x			x				x																				x
0061	Employee Date of Hire	x		x			x				x				x																				
0151	Employee Education Level	x																					x												
0152	Employee Employment Visa	x																																	
0044	Employee First Name	x																																	
0053	Employee Gender Code	x																					x												
0153	Employee Green Card	x																																	
0154	Employee ID Assigned by Jurisdiction	x											x	x																					
0270	Employee ID Type Code	x																					x												
0043	Employee Last Name	x																																	

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0255	Employee Last Name Suffix	x																																
0048	Employee Mailing City	x											x																					
0155	Employee Mailing Country Code	*																																
0050	Employee Mailing Postal Code	x											x										x											
0046	Employee Mailing Primary Address	x											x																					
0047	Employee Mailing Secondary Address	x											x																					
0049	Employee Mailing State Code	x											x										x											
0054	Employee Marital Status Code	x																					x											
0045	Employee Middle Name/Initial	x																																
0055	Employee Number of Dependants	*																																
0213	Employee Number of Entitled Exemptions	x	x																				x											
0214	Employee Number of Withholding Exemptions	*														x																		
0156	Employee Passport Number	x																																
0051	Employee Phone Number	x	x																															
0157	Employee Social Security Number Release Indicator	*																																
0042	Employee SSN	x	x										x	x									x											
0158	Employee Tax Filing Status Code	*														x																		
0159	Employer Contact Business Phone Number	x	x																															
0161	Employer Contact E-Mail Address	x																																
0162	Employer Contact FAX Number	x	x																															
0160	Employer Contact Name	x																																
0016	Employer FEIN	x			x								x	x																				
0165	Employer Mailing City	x											x																					
0166	Employer Mailing Country Code	*																																
0163	Employer Mailing Information/Attention Line	x																																
0167	Employer Mailing Postal Code	x											x										x											
0168	Employer Mailing Primary Address	x											x																					
0169	Employer Mailing Secondary Address	x											x																					
0170	Employer Mailing State Code	x											x										x											
0018	Employer Name	x																																

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0210	Employer Nature of Business	x																																
0021	Employer Physical City	x											x																					
0164	Employer Physical Country Code	*																																
0023	Employer Physical Postal Code	x											x										x											
0019	Employer Physical Primary Address	x											x																					
0020	Employer Physical Secondary Address	x											x																					
0022	Employer Physical State Code	x											x										x											
0025	Employer SIC Code	x											x										x											
0171	Employer Type Code	*																																
0329	Employer UI Number	x			x								x	x																				
0058	Employment Status Code	x																					x											
0000	Entire Batch	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a
0172	Estimated Gross Weekly Amount Indicator	*														x																		
0113	Free-Form Text	x																																
0066	Full Wages Paid for Date of Injury Indicator	x																					x											
0174	Gross Weekly Amount	x	x														x	x						x										
0175	Gross Weekly Amount Effective Date	x		x					x		x				x																			
0056	Initial Date Disability Began	x		x				x		x	x				x																			
0065	Initial Date Last Day Worked	x		x						x	x				x																			
0176	Initial Medical Provider Name	x																																
0177	Initial Medical Provider Physical City	x											x																					
0178	Initial Medical Provider Physical Country Code	*																																
0179	Initial Medical Provider Physical Postal Code	x											x										x											
0180	Initial Medical Provider Physical Primary Address	x											x																					
0181	Initial Medical Provider Physical Secondary Address	x											x																					
0182	Initial Medical Provider Physical State Code	x											x										x											
0068	Initial Return to Work Date	x		x				x	x		x																							x
0039	Initial Treatment Code	x																					x											
0314	Insured FEIN	x			x								x	x																				
0027	Insured Location Number	x			x																													

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0017	Insured Name	x																					x											
0183	Insured Postal Code	x											x										x											
0026	Insured Report Number	x			x																													
0184	Insured Type Code	x																					x											
0006	Insurer FEIN	x			x								x	x																				
0007	Insurer Name	x											x																					
0185	Insurer Type Code	x																					x											
0105	Interchange Version ID	x																					x											
0186	Jurisdiction Branch Office Code	*																																
0005	Jurisdiction Claim Number	x			x								x																					
0004	Jurisdiction Code	x																					x											
0077	Late Reason Code	x																					x											
0002	Maintenance Type Code	x														x			x	x		x	x			x	x		x					
0003	Maintenance Type Code Date	x		x											x																			
0207	Managed Care Organization Code	*																																
0208	Managed Care Organization Identification Number	*																																
0209	Managed Care Organization Name	*																																
0059	Manual Classification Code	x																					x											
0035	Nature of Injury Code	x																					x											x
0087	Net Weekly Amount	x	x														x	x																
0211	Net Weekly Amount Effective Date	x		x					x		x				x																			
0212	Non-Consecutive Period Code	x																					x											
0064	Number of Days Worked Per Week	*																																
0114	Number of Errors	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a
0060	Occupation Description	x																																
0102	Original Transmission Date	x		x											x																			
0103	Original Transmission Time	x				x																												
0215	Other Benefit Type Amount	x	x														x	x																
0216	Other Benefit Type Code	x																					x											
0036	Part of Body Injured Code	x																					x											x

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0217	Payee	x																																
0218	Payment Amount	x	x														x	x																
0219	Payment Covers Period Start Date	x		x					x		x				x																			
0220	Payment Covers Period Through Date	x		x					x		x				x																			
0195	Payment Issue Date	x		x				x	x		x				x																			
0222	Payment Reason Code	x																					x											
0083	Permanent Impairment Body Part Code	x																					x											
0223	Permanent Impairment Minimum Payment Indicator	x																					x											
0084	Permanent Impairment Percentage	x	x																				x											
0224	Physical Restrictions Indicator	*																																
0028	Policy/Contract Number	x																																
0069	Pre-Existing Disability Code	x																					x											
0099	Receiver ID	x																					x											
0107	Record Sequence Number	x	x																									x						
0267	Record Type Qualifier	x																					x				x							
0225	Recovery Amount	*																																
0226	Recovery Code	*																																
0242	Reduced Earnings Week Number	x	x																															
0227	Reporting Period Code	x																					x											
0112	Request Code (Purpose)	x																					x											
0189	Return to Work Type Code	x																					x											x
0228	Return to Work With Same Employer Indicator	*																																
0067	Salary Continued in Lieu of Compensation Indicator	x																					x											
0239	Self Insurance License/Certificate Number	*																																
0250	Self-Insurer Authorization Type Code	x																					x											
0232	Self-Insurer Organization Type Code	x																					x											
0098	Sender ID	x																					x											
0241	Settlement Type Code	x																					x											
0193	Suspension Effective Date	x		x				x							x																			
0233	Suspension Narrative	x																																

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0104	Test/Production Indicator	x																					x											
0272	Text Type Qualifier	x																					x											
0032	Time of Injury	x				x																												
0109	Time Processed	x				x																												
0101	Time Transmission Sent	x				x																												
0191	Transaction Count	x	x																											x				
0266	Transaction Tracking Number	x			x																													
0117	Variable Segment Number	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a	a
0256	Wage Effective Date	x		x			x								x																			
0063	Wage Period Code	x																					x											
0237	Witness Business Phone Number	x	x																															
0238	Witness Name	x																																

*** = Data element not being used by Iowa**

a = Acknowledgement Record Only

Colored boxes represent changes made since the last revision.