

Nebraska Workers' Compensation Court

SROI R1 Implementation Guide

Electronic Data Interchange (EDI)



Revised

June 1, 2015

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Section One:

Introduction

Overview

Since 1997, the Nebraska Workers' Compensation Court's Electronic Data Interchange (EDI) Initiative has allowed employers, insurers, and others to file certain forms with the court in an electronic format as opposed to sending these forms through the mail. The benefits of EDI include:

1. Reduced typographical errors, computational errors, misinterpretations, and omissions.
2. Reduced paper-based costs: paper and forms, postage and express mail, faxing.
3. Faster document exchange/turnaround time.
4. Operational improvements: reduced inventory and outstanding receivables.
5. Reduced processing costs.
6. Increased employee efficiency.
7. Benchmarking among jurisdictions and provinces using a central data repository for statistical analysis.

Since July 1, 2001, the court has required claims administrators to use Release 1 electronic transaction standards, using the A49 transaction. This includes the following SROI Maintenance Type Codes (MTC); additional MTCs may be added in the future:

IP—Initial Payment
AP—Acquired Payment
PY—First Non-Indemnity Payment
02—Change
CO—Correction
04—Denial
SA—Periodic Semi-Annual Report
FN—Final Report
RB—Reinstatement of Benefits
UR—Upon Request
S8—Suspension: Jurisdiction has Changed

On May 12, 2004, the Nebraska Workers' Compensation Court adopted an amendment to its Rule 30, Subsequent Report that provides for mandatory electronic filing of subsequent reports. As of this publication date, the court is at full EDI production for First Reports of Injury (FROI), Subsequent Reports of Injury (SROI) and Proof of Coverage (POC).

Staff contact information (for purposes of EDI) may be found on the next page.

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Contact List

Nebraska Workers' Compensation Court

P.O. Box 98908
Lincoln, NE 68509-8908
402-471-6468 or 800-599-5155
402-471-2700 (FAX)
<http://www.wcc.ne.gov/> (Website)

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Michelle Pester

2nd NWCC EDI Technical Contact
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International Association of Industrial Accidents Boards and Commissions (IAIABC)

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Madison, Wisconsin 53711
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608-663-1546 (FAX)
edi@iaabc.org (Email)
<http://www.iaabc.org> (Website)

Section Two:

Filing Requirements

Nebraska Workers' Compensation Court Rule 30, Subsequent Report, provides for mandatory electronic filing of subsequent reports. Following is the current text of Rule 30:

RULE 30

SUBSEQUENT REPORT

- A.** In every case in which benefit payments have been made a subsequent report shall be filed with the court by the employer or its insurer or risk management pool. All such reports shall include cumulative weekly, medical, hospital, vocational rehabilitation and other benefit payments, and shall be filed within the timeframe* prescribed by the administrator of the compensation court. A subsequent report must be filed even for cases in which only medical or other non-income benefit payments have been made. For cases in which the employer has continued to pay full salary, any portion of the full salary payment that was intended to apply to workers' compensation benefits shall be reported.
- B.** Except as otherwise approved by the administrator of the compensation court, all subsequent reports shall be filed electronically in the form and manner, and to include the content prescribed by the administrator. With approval of the administrator, such reports may be filed by means of the paper Subsequent Report (Form 4), an exact copy of which appears on the two pages following this rule.** The mandatory fields identified on the back of the Form 4 must be completed before the report will be deemed filed with the court. Blank forms for paper reports are furnished by the administrator upon request.
- C.** No subsequent report shall be deemed filed with the court until the report has been received and accepted by the court.

Sections 48-144, 48-163, 48-165, R.S. Supp., 2006.

Effective date April 24, 2008.

* Please refer to the Event Table (Page 13) and the Addendum to the Event Table (Page 14) of this implementation guide for detailed information regarding the timeframe for submission of Subsequent Reports.

** The paper version of the Subsequent Report is not included in this implementation guide. To view the paper Subsequent Report, please select the following link:

https://www.wcc.ne.gov/publications/rule30_form4.pdf.

Exceptions to the electronic filing of subsequent reports

The following types of subsequent reports are still under development. These exceptions should continue to be filed on paper:

- Third party subrogation.
- Structured Settlement Agreements with Annuities.
- Complex Lump Sum Settlements, Awards, or Orders. See *Scenario 5* for an example of a non-complex lump sum settlement that will be accepted electronically.
- Payments made by organizations for insolvent entities.

This Implementation Guide will be updated and advisory notices will be sent to trading partners when there have been further developments made at the work group meetings of the IAIABC.

Section Three:

Subsequent Report Detailed Claim Information Codes

This is the first edition of the Nebraska Workers' Compensation Court's Subsequent Report Detailed Claim Information Codes publication. This issue contains the most up-to-date codes approved by the International Association of Industrial Accident Boards and Commissions. Please use this as a reference tool in coding injuries on the Subsequent Report paper form and for electronic reporting.

If you have any questions or need additional information, please do not hesitate to contact the court at 402-471-6468 or 800-599-5155.

Payment Codes (codes that identify the payment being made):

Note: Please refer to the FAQ section for questions related to which payment type codes are to be used in certain situations. For example, when mileage is involved or reporting lump sum settlements.

| Specific Payment Codes | | |
|-------------------------------|---------------------------------------|---|
| Code | Description | Definition |
| 010 | Fatal | Benefits paid or payable for the death of the claimant resulting from a work-related accident or occupational injury or disease |
| 020 | Permanent Total | Benefits paid or payable for the loss of or the permanent loss of use of any body part or function which renders the claimant unable to engage in any employment or occupation |
| 030 | Permanent Partial Scheduled | Benefits paid or payable as established by a statutory list (schedule) of payments for certain injuries. The benefit amount is determined by the part of body that was injured subject to limitations set forth in the statute. |
| 040 | Permanent Partial Unscheduled | Benefits paid or payable for injuries to parts of the body not covered by a schedule. These benefits are payable for the claimant's actual wage loss or reduction in wage earning ability, subject to limitations set forth in the statute. |
| 050 | Temporary Total | Benefits paid or payable for the period during which the claimant is unable to perform any work for pay as a result of disability from which that individual can be expected to fully recover and which period precedes the date of maximum medical improvement. |
| 070 | Temporary Partial | Benefits paid or payable for the period during which the claimant, as a result of a disability from which he/she is expected to fully recover, is unable to perform work for his/her regular pay, but is receiving a reduced rate of pay and which period precedes the date of maximum medical improvement. |
| 240 | Employer Paid | Wages paid by the employer to the claimant during their absence from work. Note: this payment code is only allowed on IP, and sweeps for CO, 02, 04, RB, S8, UR, SA and FN. |
| 410 | Vocational Rehabilitation Maintenance | Weekly maintenance benefits pay during which the claimant is participating in a vocation rehabilitation program. |

| Compromised Payment Codes (Note: Use these codes for court-approved settlements ONLY) | | |
|--|-----------------------------|---|
| Code | Description | Definition |
| 500 | Unspecified | Amounts that cannot be assigned to a specific Benefit Type |
| 501 | Medical | Compromised settlement amount paid to the employer to conclude past, present, and/or future medical exposure. |
| 510 | Fatal | Benefits paid or payable for the death of the claimant resulting from a work-related accident or occupational injury or disease |
| 520 | Permanent Total | Benefits paid or payable for the loss of or the permanent loss of use of any body part or function which renders the claimant unable to engage in any employment or occupation |
| 530 | Permanent Partial Scheduled | Benefits paid or payable as established by a statutory list (schedule) of payments for certain injuries. The benefit amount is determined by the part of body that was injured subject to limitations set forth in the statute. |

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| Compromised Payment Codes (Note: Use these codes for court-approved settlements ONLY) | | |
|--|---------------------------------------|---|
| Code | Description | Definition |
| 540 | Permanent Partial Unscheduled | Benefits paid or payable for injuries to parts of the body not covered by a schedule. These benefits are payable for the claimant's actual wage loss or reduction in wage earning ability, subject to limitations set forth in the statute. |
| 541 | Vocational Rehabilitation Maintenance | Weekly maintenance benefits paid during which the claimant is participating in a vocation rehabilitation program. |
| 550 | Temporary Total | Benefits paid or payable for the period during which the claimant is unable to perform any work for pay as a result of disability from which that individual can be expected to fully recover and which period precedes the date of maximum medical improvement. |
| 570 | Temporary Partial | Benefits paid or payable for the period during which the claimant, as a result of a disability from which he/she is expected to fully recover, is unable to perform work for his/her regular pay, but is receiving a reduced rate of pay and which period precedes the date of maximum medical improvement. |

Paid-To-Date Codes

| Code | Term | Definition |
|-------------|--------------------------------------|---|
| 300 | Funeral Expenses | Sum of the funeral expenses |
| 310 | Penalties | Sum of the penalties |
| 320 | Interest | Sum of the interest |
| 330 | Employer's Legal Expenses | Sum of the employer's legal expenses |
| 340 | Claimant's Legal Expenses | Sum of the claimant's legal expenses |
| 350 | Total Payments to Physicians to Date | Sum of services paid to physicians |
| 360 | Hospital Cost | Sum of services paid to hospitals |
| 370 | Other Medical | Sum of medical services not otherwise reported |
| 380 | Vocational Rehabilitation Evaluation | Sum of vocational rehabilitation evaluation services |
| 390 | Vocational Rehabilitation Education | Sum of vocational rehabilitation education payments |
| 400 | Other Vocational Rehabilitation | Sum of vocational rehabilitation services not otherwise reported |
| 420 | Expert Witness Fees | Sum of fees paid to expert witnesses |
| 430 | Unallocated Prior Indemnity Benefits | Sum of prior Indemnity Benefits paid to date that can not be classified by a specific Payment Adjustment Code |
| 440 | Unallocated Prior Medical | Sum of prior Medical paid to date that can not be classified by a specific Paid To Date Code |
| 450 | Pharmaceutical | Sum of medication payments for this claim |
| 460 | Physical Therapy | Sum of physical therapy payments for this claim |
| 800 | Special Fund Recovery | Sum of monies recovered from special funds |
| 810 | Deductibles Recovery | Sum of monies recovered through Insured reimbursement of deductible amounts |
| 820 | Subrogation Recovery | Sum of monies recovered through subrogation |
| 830 | Overpayment Recovery | Sum of monies recovered due to overpayment of indemnity medical or expenses |
| 840 | Unspecified Recovery | Sum of monies recovered through salvage, apportionment/contribution, and all others not otherwise defined |

Permanent Impairment Part of Body Codes

I. Head

10. Multiple Head Injury: Any combination of brain, scalp, skull with or without ears, eyes, nose, mouth, teeth, face, or neck. This includes "Head - Not Otherwise Classified."
11. Skull: Cranial bones
12. Brain: Includes brain concussion; brain damage.
13. Ear(s): Includes inner and outer ear, eardrum, hearing and loss of hearing.
 - 13A: Total deafness of both ears
 - 13B: Total deafness of one ear
 - 13C: Where worker prior to injury has suffered a total loss of hearing in one ear, and as a result of the accident loses total hearing in remaining ear
14. Eye(s): Includes optic nerves, vision and loss of vision.
 - 14A: The loss of eye by enucleation (including disfigurement resulting there from)
 - 14B: Total blindness of one eye
 - 14C: Blindness in both eyes
15. Nose: Includes nasal passages, sinus and sense of smell.
16. Teeth: Does not include gums or false teeth
17. Mouth: Includes tongue, gums, lips, throat, and sense of taste. This includes jaw and chin. This does not include teeth.
18. Soft Tissue: Pertaining to cuts and bruises; includes cheek, eyebrow, forehead, and scalp.
19. Facial Bones: Pertaining to fractures of facial bones, not the skull.

II. Neck

20. Multiple Injury: Any combination of vertebrae, disc, spinal cord or soft tissue in neck. Also includes "Neck - Not Otherwise Classified."
21. Vertebrae: Spinal column bone in the neck, includes the first seven bones of the spinal column (cervical vertebrae).
22. Disc: Spinal column cartilage in the neck.
23. Spinal Cord: Nerve tissue in the neck.
24. Larynx: "Voice box", includes loss of voice, vocal chords.
25. Soft Tissue: Soft tissue in the neck area (internal) other than the larynx or trachea.
26. Trachea: Cartilage tube leading from the larynx to the bronchial tubes.

III. Upper Extremities

30. Multiple Upper Extremities: Any combination of arm, elbow, or fingers. Also, Arm - Not Otherwise Classified. Does not include a specific wrist & hand combination.
31. Upper Arm(s): Arm between elbow and shoulder. This does not include shoulder, clavicle (collarbone), scapula (shoulder blade) or rotator cuff.
32. Elbow(s): Joint of the upper arm and the forearm.
33. Lower Arm(s): Between the elbow and the wrist.
34. Wrist(s): Joint of the hand and the forearm.
35. Hand(s): Does not include the wrist or fingers. This includes metacarpal bones, top of hand and the palm. Use for any injury described as "between the fingers".
36. Finger(s): Includes fingernail(s)
 - 36A: The loss of an index finger and metacarpal bone there of
 - 36B: The loss of an index finger at the proximal joint
 - 36C: The loss of an index finger at the second joint
 - 36D: The loss of an index finger at the distal joint

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36E: The loss of a second finger and the metacarpal bone there of

36F: The loss of a middle finger at the proximal at the proximal joint

36G: The loss of a middle finger at the second joint

36H: The loss of a middle finger at the distal joint

36I: The loss of a third or ring finger and the metacarpal thereof

36J: The loss of a ring finger at the proximal joint

36K: The loss of a ring finger at the second joint

36L: The loss of a ring finger at the distal joint

36M: The loss of a little finger and the metacarpal bone thereof

36N: The loss of a little finger at the proximal joint

36O: The loss of a little finger at the second joint

36P: The loss of a little finger at the distal joint

37. Thumb(s): Includes thumbnail(s)

37A: The loss of a thumb and metacarpal bone thereof

37B: The loss of a thumb at the proximal joint

37C: The loss of a thumb at the second or distal joint

38. Shoulder(s): Junction of clavicle & scapula where arm meets trunk; includes rotator cuff, collarbone and shoulder blade.

39. Wrist(s) & Hand(s): Specific injury or Occupational Disease where both the Wrist(s) and Hand(s) are involved.

IV. Trunk

40. Multiple Trunk: Any combination of hip, abdomen, chest, back, and shoulder. Also, Trunk - Not Otherwise Classified. This includes "side."

41. Upper Back Area: Thoracic area, includes vertebrae and muscle pull or ligament strain.

42. Low Back Area: Lumbar and lumbo-sacral areas, includes muscle pull or ligament strain; use when description does not differentiate between upper and lower back, i.e., "back". This does not include lumbar or sacral vertebrae.

43. Disc: Spinal column cartilage in the back.

44. Chest: Includes ribs, sternum (breastbone), soft tissue and "chest pain"; does not include heart or lungs.

45. Sacrum and Coccyx: Posterior boundary of pelvis and base of vertebral column (tailbone).

46. Pelvis: Bone structure formed by innominate (nameless) bones and the ligament uniting them.

47. Spinal Cord: Nerve tissue in the back.

48. Internal Organs: Applies when the functioning of an entire body system has been affected without specific injury to any other part, as in the case of poisoning, corrosive action affecting internal organs, insect bites resulting in an allergic reaction, damage to nerve centers, stress, etc.

49. Heart: Use in cases of heart attack, congestive heart failure.

60. Lungs: Specific injury or condition affecting the lungs only.

61. Abdomen Including Groin: Specific injury to specific parts only; includes stomach, lower esophagus, groin, small or large intestines, liver, gall bladder, spleen, pancreas, kidneys, and appendix. Do not use if functioning of entire body system is affected (INTERNAL ORGANS).

62. Buttocks: External posterior of pelvis & hip area.

63. Lumbar and/or Sacral Vertebrae: Vertebrae of the Lumbar and/or Sacral areas; also includes vertebrae in trunk area that are Not Otherwise Classified.

V. Lower Extremities

50. Multiple Lower Extremities: Any combination of leg, hip, thigh, knee, ankle, foot and toe. Also includes "Leg - Not Otherwise Classified."

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51. Hip(s): Upper part of thigh formed by femur and innominate (nameless) bones. The region on each side of pelvis; does not include buttocks or "side".
52. Upper Leg(s): Between knee and hip; part of thigh below hip.
53. Knee(s): Includes the patella (kneecap) and supporting ligaments.
54. Lower Leg(s): Above the ankle, below the knee.
55. Ankle(s): Joint between the leg and the foot.
56. Foot/Feet: Does not include the ankle or the toes. Includes the heel. Use for any injury described as "between the toes".
57. Toe(s): Includes toenail(s)
 - 57A: Little toe metatarsal bone
 - 57B: Little toe at distal joint
 - 57C: The loss of any other toe with the metatarsal bone thereof
 - 57D: The loss of any other toe at the proximal joint
 - 57E: Other toe at middle joint
 - 57F: The loss of any other toe at the second or distal joint
 - 57G: Other toe at distal joint
58. Great Toe(s): Large toe (s)
 - 58A: The loss of a great toe with the metatarsal bone thereof
 - 58B: The loss of a great toe at the proximal joint
 - 58C: The loss of great toe at the second or distal joint

VI. Multiple Body Parts

64. Artificial Appliance: Damage to a device that is used to augment performance of a natural function, i.e. hearing aid, eyeglasses, dentures, artificial limbs, etc.
65. Insufficient Info to Properly Identify - Unclassified: Applies when Specific Part of Body is not identified or known.
66. No Physical Injury: Applies when Specific Part of Body is stated as "No Injury".
90. Multiple Body Parts: Applies when more than one major body part has been affected, such as an arm and a leg.
91. Body Systems & Multiple Body Systems: Applies when one or more body systems have been affected, i.e. circulatory and/or respiratory systems. Includes AIDS, paralysis, electrocution, electrical shock, forms of infectious or parasitic illnesses (such as scabies, ticks, chicken pox, shingles, etc.). Also includes Fatality, NOC.
99. Body As A Whole.

Name Standards

Following are the name standards for employees, employers, insurers and third party administrators:

- **Employee** names must be the full legal name. Do not use abbreviations, initials, nicknames, punctuation, or extraneous characters.
- **Employer, insurer, self-insured employer and third party administrator** names must be the entity's full legal business name. Do not use abbreviations, initials, punctuation, or extraneous characters.

Section Four:

EDI Trading Partner Requirements

Trading Partner Agreements

A Trading Partner Agreement already exists between the court and our trading partners. There will be no need to issue Trading Partner Agreements or to modify existing agreements unless a need is discovered.

NWCC EDI Subsequent Report of Injury Event Table

| Interpreting the jurisdiction's requirements: For a (Report Type) (Maintenance Type-Code) with (Trigger Criteria-Trigger Value), the Report is due (Report Due Value) from the (Report Due-From). | | | | | | |
|---|------------------|---------------------------------|--|--|-------------------------|---|
| Report Type | Maintenance Type | | Report Trigger | | When is the Report Due? | |
| | Code | Description | Criteria | Trigger Value(s) | Value | From |
| A49 | IP | Initial Payment | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | 14 days | Within 14 days following initial payment of workers' compensation benefits. NOTE: Do not submit IP for med-only claims. |
| A49 | AP | Acquired Payment | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | 14 days | Within 14 days following initial payment of workers' compensation benefits. NOTE: Do not submit AP for med-only claims. |
| A49 | PY | Payment Report | B = Cumulative Medical \$ Paid O = Maintenance Type Event | B > 0 (B greater than zero \$) | 14 days | A PY is required on medical only claims within 14 days following initial payment of non-indemnity workers' compensation benefits (medical, hospital, funeral, etc.). NOTE: This requirement does not apply to injuries where indemnity has already been paid and reported with an IP or AP. Instead cumulative payments should be reported on an SA. |
| A49 | 02 | Change | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR B > 0 (B greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | 14 days | Within 14 days a claim administrator has knowledge of a change in primary match information that includes but is not limited to insurer FEIN, TPA FEIN, social security number, date of injury, claims administrator number, or employee date of death. |
| A49 | CO | Correction | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR B > 0 (B greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | 14 days | Within 14 days from the time at which the claims administrator receives a warning error from the NWCC (TE received in a electronic transaction acknowledgement). |
| A49 | 04 | Denial | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR B > 0 (B greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | 14 days | Within 14 days that a claims administrator has knowledge that a determination has been made to deny a claim. |
| A49 | SA | Semi-Annual | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR B > 0 (B greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | 180 days | Within 14 days of the semi-annual anniversary of the date of injury, and every 180 days thereafter until the case is closed. |
| A49 | FN | Final | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR B > 0 (B greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | 14 days | Within 14 days following payment pursuant to a final order, award, or judgment of the court, including an order approving a lump sum settlement or settlement agreement or within 14 working days following the closing of any case for which benefits have been paid. |
| A49 | UR | Upon Request | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR B > 0 (B greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | # days | Determined by mutual agreement between the Nebraska Workers' Compensation Court and it's trading partners |
| A49 | S8 | Suspension, Jurisdiction Change | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR B > 0 (B greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | 14 days | Within 14 days a claim administrator has knowledge that a claim's jurisdiction has been changed and initiates a transfer of a claim to a new jurisdiction. |
| A49 | RB | Reinstatement of Benefits | N = Cumulative Indemnity \$ Paid B = Cumulative Medical \$ Paid O = Maintenance Type Event | N > 0 (N greater than zero \$) OR B > 0 (B greater than zero \$) OR N and B > 0 (N and B greater than zero \$) | 14 days | Within 14 days following payment of compensation benefits (ONLY after a Final (FN) or Lump Sum Settlement report has been previously filed to close the claim). |

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Addendum to Event Table

Release1

| MTC | Event | Time Report Is Due |
|------|---|--|
| 'IP' | Initial Payment: The first payment of indemnity benefits has been made. A previous Subsequent report (other than IP) may or may not have been filed, but NO previous IP reports have been filed for this claim by the same claim administrator/TPA. | Within 14 days following the initial payment of indemnity benefits. |
| 'AP' | Acquired/Payment: The acquiring claim administrator has made the first payment of indemnity benefits. | Within 14 days following the first payments made on a claim by the acquiring claims administrator. |
| 'PY' | Payment: Identifies payment information for which reporting is required by the jurisdiction. Used for reporting payments on medical only claims within 14 days following initial payment of non-indemnity workers' compensation benefits (medical, hospital, funeral, etc.). NOTE: This requirement does not apply to injuries where indemnity has already been paid and reported with an IP or AP. Instead cumulative payments should be reported on an SA. | Within 14 days following the initial payment of non-indemnity benefits (medical, hospital, funeral, etc.) on medical only claims. |
| '02' | Change: a change transaction is made when the claim administrator identifies that a change is necessary on a previously filed report. All mandatory fields must be completed for transmission of the record. NOTE: A <i>change</i> is not made as a result of a warning error (TE) received from the NWCC in an electronic transaction acknowledgement. This scenario would require a <i>correction</i> , shown below. | Within 14 days — defined to be the time at which the claims administrator has knowledge of a change in primary match information that includes, but is not limited to, insurer FEIN, TPA FEIN, social security number, date of injury, claims administrator number, employee date of death. |
| 'CO' | Correction: a correction transaction (MTC CO) is made when NWCC identifies a warning-error or non-critical error (TE). Since an original report has previously been filed with NWCC, the trading partner files a correction including all mandatory fields with the transmission. NOTE: This report should include all payment totals paid to date for indemnity and non-indemnity compensation benefits. | Within 14 days — defined to be the time at which the claims administrator receives a warning error from the NWCC (received in a electronic transaction acknowledgement), makes the necessary changes to their internal system, and instructs their system to send the correction in the next transmission. |
| '04' | Denial: Used by the trading partner to indicate that the claims administrator denies the claim. A previous original report must have been filed. All mandatory fields and optional fields must be completed for transmission of the record. This report should include all payment totals paid to date for indemnity and non-indemnity compensation benefits. | Within 14 days — defined to be the time at which the claims administrator determines the claim is to be denied and instructs their system to send the denial request in the next transmission. |
| 'SA' | Semi-Annual: Periodic Report submitted every 180 days. This report should include all payment totals paid to date for indemnity and non-indemnity compensation benefits. | Within 14 days of the semi-annual anniversary date of the date of injury, and every 180 days thereafter until the case is closed. |
| 'FN' | Final: Closed claim, no further payments of any kind anticipated. A Final (FN) will not be accepted without a prior IP, AP or PY being received and accepted. This report should include all payment totals paid to date for indemnity and non-indemnity compensation benefits. | Within 14 days following the closing of any claim for which benefits have been paid. |
| 'UR' | Upon Request: Submitted in response to a specific request from the trading partner. This report should include all payment totals paid to date for indemnity and non-indemnity compensation benefits. | To be determined upon mutual agreement between trading partners. |
| 'S8' | Suspension: Jurisdiction has Changed: To report that all payments of compensation benefits have stopped because the jurisdiction has been changed. This report should include all payment totals paid to date for indemnity and non-indemnity compensation benefits. | Within 14 days — defined to be the time at which the claims administrator determines the claim's jurisdiction has been changed and instructs their system to send the S8 request in the next transmission. |
| 'RB' | Reinstatement of Benefits: To report that compensation benefits have been paid after a claim has been reported closed or final was submitted. This report should include all payment totals paid to date for indemnity and non-indemnity compensation benefits. | Within 14 days following payment of compensation benefits (ONLY after a Final (FN) or Lump Sum Settlement report has been previously filed to close the claim). |

**NWCC Summary Element Requirements Table
for IAIABC Release 1 Subsequent Report of Injury**

(Rev. 05/01/2014)

| NEWCC REQUIREMENTS BY MAINTENANCE TYPE CODE (MTC) FOR THE SUBSEQUENT REPORT OF INJURY (A49) | | | | | | | | | | | | | | | | | |
|---|-----------|-------------------------------------|---------------|-----------|-----|------------------------|----|----|----|----|----|----|----|----|----|----|-------|
| IAIABC GROUPING | IAIABC DN | IAIABC DATA ELEMENT NAME | IAIABC FORMAT | POSITIONS | | NEWCC MTC REQUIREMENTS | | | | | | | | | | | NOTES |
| | | | | BEG | END | IP | AP | PY | 02 | CO | 04 | SA | S8 | FN | UR | RB | |
| TRANSACTION | | | | | | | | | | | | | | | | | |
| | 0001 | Transaction Set ID | 3 A/N | 1 | 3 | M | M | M | M | M | M | M | M | M | M | M | |
| | 0002 | Maintenance Type Code | 2 A/N | 4 | 5 | M | M | M | M | M | M | M | M | M | M | M | |
| | 0003 | Maintenance Type Code Date | DATE | 6 | 13 | M | M | M | M | M | M | M | M | M | M | M | |
| JURISDICTION | | | | | | | | | | | | | | | | | |
| | 0004 | Jurisdiction | 2 A/N | 14 | 15 | M | M | M | M | M | M | M | M | M | M | M | |
| CLAIM ADMINISTRATOR | | | | | | | | | | | | | | | | | |
| | 0006 | Insurer FEIN | 9 A/N | 16 | 24 | M | M | M | M | M | M | M | M | M | M | M | |
| | 0008 | Third Party Administrator FEIN | 9 A/N | 25 | 33 | C | C | C | C | C | C | C | C | C | C | C | |
| | 0014 | Claim Administrator Postal Code | 9 A/N | 34 | 42 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0042 | Social Security Number | 9 A/N | 43 | 51 | M | M | M | M | M | M | M | M | M | M | M | |
| | 0055 | Number of Dependents | 2 N | 52 | 53 | C | C | C | C | C | C | C | C | C | C | C | |
| | 0069 | Pre-Existing Disability | 1 A/N | 54 | 54 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0056 | Date Disability Began | DATE | 55 | 62 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0070 | Date of Maximum Medical Improvement | DATE | 63 | 70 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0071 | Return to Work Qualifier | 1 A/N | 71 | 71 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0072 | Date of Return/Release to Work | DATE | 72 | 79 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0057 | Employee Date of Death | DATE | 80 | 87 | C | C | C | C | C | C | C | C | C | C | C | |
| WAGE | | | | | | | | | | | | | | | | | |
| | 0062 | Wage | \$9.2 | 88 | 98 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0063 | Wage Period | 2 A/N | 99 | 100 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0064 | Number of Days Worked | 1 N | 101 | 101 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0067 | Salary Continued Indicator | 1 A/N | 102 | 102 | O | O | O | O | O | O | O | O | O | O | O | |
| ACCIDENT | | | | | | | | | | | | | | | | | |
| | 0031 | Date of Injury | DATE | 103 | 110 | M | M | M | M | M | M | M | M | M | M | M | |
| | 0026 | Insured Report Number | 25 A/N | 111 | 135 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0015 | Claim Administrator Claim Number | 25 A/N | 136 | 160 | M | M | M | M | M | M | M | M | M | M | M | |
| | 0005 | Agency Claim Number | 25 A/N | 161 | 185 | M | M | M | M | M | M | M | M | M | M | M | |
| CLAIM STATUS | | | | | | | | | | | | | | | | | |
| | 0073 | Claim Status | 1 A/N | 186 | 186 | M | M | M | M | M | M | M | M | M | M | M | |
| | 0074 | Claim Type | 1 A/N | 187 | 187 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0075 | Agreement to Compensate Code | 1 A/N | 188 | 188 | O | O | O | O | O | O | O | O | O | O | O | |
| | 0076 | Date of Representation | DATE | 189 | 196 | O | O | O | O | O | O | O | O | O | O | O | |

**NWCC Summary Element Requirements Table
for IAIABC Release 1 Subsequent Report of Injury**

(Rev. 05/01/2014)

| NEWCC REQUIREMENTS BY MAINTENANCE TYPE CODE (MTC) FOR THE SUBSEQUENT REPORT OF INJURY (A49) | | | | | | | | | | | | | | | | |
|--|-----------|--|---------------|-----------|-----|------------------------|----|----|----|----|----|----|----|----|----|-------|
| IAIABC GROUPING | IAIABC DN | IAIABC DATA ELEMENT NAME | IAIABC FORMAT | POSITIONS | | NEWCC MTC REQUIREMENTS | | | | | | | | | | NOTES |
| | | | | BEG | END | IP | AP | PY | 02 | CO | 04 | SA | S8 | FN | UR | |
| PAYMENTS | | | | | | | | | | | | | | | | |
| | 0077 | Late Reason Code | 2 A/N | 197 | 198 | O | O | O | O | O | O | O | O | O | O | O |
| VARIABLE SEGMENT COUNTERS | | | | | | | | | | | | | | | | |
| | 0078 | Number of Permanent Impairments | 2 N | 199 | 200 | M | M | M | M | M | M | M | M | M | M | M |
| | 0079 | Number of Payments/Adjustments | 2 N | 201 | 202 | M | M | M | M | M | M | M | M | M | M | M |
| | 0080 | Number of Benefit Adjustments | 2 N | 203 | 204 | M | M | M | M | M | M | M | M | M | M | M |
| | 0081 | Number of Paid to Date/Reduced Earnings/Recoveries | 2 N | 205 | 206 | M | M | M | M | M | M | M | M | M | M | M |
| | 0082 | Number of Death Dependent/Payee Relationships | 2 N | 207 | 208 | M | M | M | M | M | M | M | M | M | M | M |
| VARIABLE SEGMENTS | | | | | | | | | | | | | | | | |
| Permanent Impairments Occurs Number of Permanent Impairments times (MAX 6). | | | | | | | | | | | | | | | | |
| | 0083 | Permanent Impairment Body Part Code | 3 A/N | 1 | 3 | O | O | O | O | O | O | O | O | O | O | O |
| | 0084 | Permanent Impairment Percentage | 3.2 N | 4 | 8 | O | O | O | O | O | O | O | O | O | O | O |
| Payment/Adjustments Occurs Number of Payment/Adjustments times (MAX 10). | | | | | | | | | | | | | | | | |
| | 0085 | Payment/Adjustment Code | 3 A/N | 1 | 3 | C | C | R | C | C | C | C | C | C | C | C |
| | 0086 | Payment/Adjustment Paid to Date | \$9.2 | 4 | 14 | C | C | R | C | C | C | C | C | C | C | C |
| | 0087 | Payment/Adjustment Weekly Amount | \$9.2 | 15 | 25 | C | C | R | C | C | C | C | C | C | C | C |
| | 0088 | Payment/Adjustment Start Date | DATE | 26 | 33 | C | C | R | C | C | C | C | C | C | C | C |
| | 0089 | Payment/Adjustment End Date | DATE | 34 | 41 | C | C | R | C | C | C | C | C | C | C | C |
| | 0090 | Payment/Adjustment Weeks Paid | 4 N | 42 | 45 | C | C | R | C | C | C | C | C | C | C | C |
| | 0091 | Payment/Adjustment Days Paid | 1 N | 46 | 46 | C | C | R | C | C | C | C | C | C | C | C |
| Benefit Adjustments Occurs Number of Benefit Adjustments times (MAX 10). | | | | | | | | | | | | | | | | |
| | 0092 | Benefit Adjustment Code | 4 A/N | 1 | 4 | O | O | O | O | O | O | O | O | O | O | O |
| | 0093 | Benefit Adjustment Weekly Amount | \$9.2 | 5 | 15 | O | O | O | O | O | O | O | O | O | O | O |
| | 0094 | Benefit Adjustment Start Date | DATE | 16 | 23 | O | O | O | O | O | O | O | O | O | O | O |
| Paid to Date/Reduced Earnings/Recoveries Occurs Number of Paid to Date/Reduced Earning/Recoveries times (MAX 25). | | | | | | | | | | | | | | | | |
| | 0095 | Paid To Date/Reduced Earnings/Recoveries Code | 3 A/N | 1 | 3 | C | C | C | C | C | C | C | C | C | C | C |
| | 0096 | Paid To Date/Reduced Earnings/Recoveries Amount | \$9.2 | 4 | 14 | C | C | C | C | C | C | C | C | C | C | C |
| Death Dependent/Payee Relationship Occurs Number of Death Dependent/Payee Relationship times (MAX 12). | | | | | | | | | | | | | | | | |
| | 0097 | Dependent/Payee Relationship | 2 A/N | 1 | 2 | O | O | O | O | O | O | O | O | O | O | O |
| Note 1: Required on fatalities. | | | | | | | | | | | | | | | | |
| Note 2: Mandatory where there is a TPA | | | | | | | | | | | | | | | | |
| Note 3: Mandatory for First Med/Hosp Payment | | | | | | | | | | | | | | | | |
| Note 4: Avoid specifying claim type equals "N" for notification only. | | | | | | | | | | | | | | | | |
| Note 5: Payment amount fields require amounts greater than zero. See Payment/Adjustment Element Requirements table for details. | | | | | | | | | | | | | | | | |

**NWCC Payment / Adjustment
Element Requirements Table
for IAIABC Release 1**

Subsequent Report of Injury

Revised 09/01/2005

Element Criteria Codes:

M = Mandatory

C = Conditional — Trading Partner must specify applicable P/A Codes and required segment conditions

O = Optional — if data is sent it will be edited

*** = If Value Changed, Send It**

| P/A Description | P/A Code | P/A Start Date | P/A End Date | P/A Weeks Paid | P/A Days Paid | Rate Amount | Total Paid-To-Date |
|---|-----------|-----------------------|--------------|----------------|---------------|-------------|--------------------|
| Fatal | 010 | M | M | M | M | M | M |
| Permanent Total | 020 | M | M | M | M | M | M |
| Permanent Total Supplemental | 021 | Not Statutorily Valid | | | | | |
| Permanent Partial/Scheduled | 030 | M | M | M | M | M | M |
| Permanent Partial/Unscheduled | 040 | M | M | M | M | M | M |
| Temporary Total | 050 | M | M | M | M | M | M |
| Temporary Total Catastrophic | 051 | Not Statutorily Valid | | | | | |
| Temporary Partial | 070 | M | M | M | M | O | M |
| Employer's Liability | 080 | Not Statutorily Valid | | | | | |
| Permanent Partial Disfigurement | 090 | Not Statutorily Valid | | | | | |
| Employer Paid | 240 | Not Allowed on MTC FS | | | | | |
| Vocational Rehabilitation | 410 | M | M | M | M | M | M |
| Reduced Earnings | 600 - 674 | Not Statutorily Valid | | | | | |
| Compromised Unspecified (Lump Sum) | 500 | O | O | O | O | O | M |
| Compromised Medical | 501 | O | O | O | O | O | M |
| Compromised Fatal | 510 | O | O | O | O | O | M |
| Compromised Permanent Total | 520 | O | O | O | O | O | M |
| Compromised Permanent Total Supplemental | 521 | Not Statutorily Valid | | | | | |
| Compromised Employer Paid | 524 | Not Statutorily Valid | | | | | |
| Compromised Permanent Partial Scheduled | 530 | O | O | O | O | O | M |
| Compromised Permanent Partial Unscheduled | 540 | O | O | O | O | O | M |
| Compromised Vocational Rehabilitation | 541 | O | O | O | O | O | M |
| Compromised Temporary Total | 550 | O | O | O | O | O | M |
| Compromised Temporary Total Catastrophic | 551 | Not Statutorily Valid | | | | | |
| Compromised Temporary Partial | 570 | O | O | O | O | O | M |
| Compromised Employer's Liability | 580 | Not Statutorily Valid | | | | | |
| Compromised Permanent Partial Disfigurement | 590 | Not Statutorily Valid | | | | | |

NWCC EDIT MATRIX TABLE FOR SUBSEQUENT REPORTS (Rev. 08/14/2006)

| | | ERROR MESSAGE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------------------------|--------------------------------|-----------------------------|-----------------------------------|----------------------------|-----------------------|---------------------------------|-----------------------------|-------------------------------|---------------------------|---------------------------|----------------------------------|--------------------------|---------------------------------------|-----------------------------------|----------------------|-------------------------------|-------------------------|-----------------------|--|--|--------------------------------------|-------------------------|------------------------------------|-----------------|---|------------------------|------------------------------|-------------------------------------|------------------------------------|-------------------------------------|----------------------|----------------------------------|----------------------------------|------------------------------|--|--|--|--|
| | | Mandatory field not present | Number of Days worked must be 0-7 | Number of Days must be 0-6 | Must be numeric (0-9) | Must be a valid date (CCYYMMDD) | Must be A-Z, 0-9, or spaces | Must be a valid time (HHMMSS) | 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 >= Payment Adj 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 | Must be valid occurrence for segment | Must be <= Date of Hire | Duplicate transmission/transaction | Code/ID invalid | Value not consistent with value previously reported | Event Criteria not met | Required Segment Not Present | Invalid event sequence/relationship | Invalid data sequence/relationship | Corresponding report/data not found | Invalid record count | Must be >= Policy Effective Date | Must be <= Policy Effective Date | No Leading / Imbedded Spaces | | | | |
| Elem # | Element Description | 001 | 018 | 019 | 028 | 029 | 030 | 031 | 033 | 034 | 035 | 036 | 037 | 038 | 039 | 040 | 041 | 042 | 044 | 045 | 054 | 055 | 057 | 058 | 059 | 061 | 062 | 063 | 064 | 065 | 066 | 067 | 068 | 100 | | | | |
| SUBSEQUENT REPORT TRANSACTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 001 | Transaction Set ID | R | | | | | | | | | | | | | | | | | | | | | R | R | | | | | | | | | | | | | | |
| 002 | Maintenance Type Code | R | | | | | | | | | | | | | | | R | | | | | | | | | | | R | | | | | | | | | | |
| 003 | Maintenance Type Code Date | R | | | | R | | | | | | | | | | | | | R | | | | | | | | | | | | | | | | | | | |
| 004 | Jurisdiction | R | | | | | | | | | | | | | | | | | | | | | | R | | | | | | | | | | | | | | |
| 005 | Agency Claim Num | R | | | | | | | | | | | | | R | | | | | | | | | | | | | | | | | | | | | | | |
| 006 | Insurer FEIN | R | | | R | | | | | | | | | | R | R | | | | | | | | | | | | | | | | | | | | | | |
| 008 | Third Party Administrator FEIN | | | | R | | | | | | | | | | R | R | | | | | | | | | | | | | | | | | | | | | | |
| 014 | Claim Admin Post Code | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 015 | Claim Admin Claim Nurr | R | | | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 026 | Insured Report Nurr | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 031 | Date of Injury | R | | | | R | | | | | | | R | | R | | | | | | | | | | | | | | | | | | | | | | | |
| 042 | Social Security Nurr | R | | | R | | | | | | | | | | R | R | | | | | | | | | | | | | | | | | | | | | | |
| 055 | Num of Dependents | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 056 | Date Disability Began | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 057 | Employee Date of Death | | | | | E | | | E | | | | E | | | | | | | | | | | | | | | | | | | | | | | | | |
| 062 | Wage | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 063 | Wage Period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 064 | Num of Days Worked | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 067 | Salary Cont Indicator | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 069 | Pre-Existing Disability | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 070 | Date of MMI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 071 | RTW Qualifier | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 072 | Date Return/Release RTW | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 073 | Claim Status | R | | | | | | | | | | | | | | | | | | | | | | R | | | | | | | | | | | | | | |
| 074 | Claim Type | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 075 | Agreement to Comp Code | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 076 | Date of Representation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 077 | Late Reason Code | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 078 | Num Perm Impairments | R | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 079 | Num Payment Adjustments | R | | | R | | | | | | | | | | | | | | | | R | | | | | | R | | | | | | | | | | | |
| 080 | Num Benefit Adjustments | R | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 081 | Num PTD Reduced Earns | R | | | R | | | | | | | | | | | | | | | | R | | | | | | R | | | | | | | | | | | |
| 082 | Num Death Dep/Pay Rel | R | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 083 | Perm Impair Body Part | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

NWCC EDIT MATRIX TABLE FOR SUBSEQUENT REPORTS (Rev. 08/14/2006)

| | | ERROR MESSAGE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------------------------|-----------------------------|-----------------------------|-----------------------------------|----------------------------|-----------------------|---------------------------------|-----------------------------|-------------------------------|---------------------------|---------------------------|----------------------------------|--------------------------|---------------------------------------|-----------------------------------|----------------------|-------------------------------|-------------------------|-----------------------|--|--|--------------------------------------|-------------------------|------------------------------------|-----------------|---|------------------------|------------------------------|-------------------------------------|------------------------------------|-------------------------------------|----------------------|----------------------------------|----------------------------------|------------------------------|--|--|--|--|--|--|
| | | Mandatory field not present | Number of Days worked must be 0-7 | Number of Days must be 0-6 | Must be numeric (0-9) | Must be a valid date (CCYYMMDD) | Must be A-Z, 0-9, or spaces | Must be a valid time (HHMMSS) | 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 >= Payment Adj 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 | Must be valid occurrence for segment | Must be <= Date of Hire | Duplicate transmission/transaction | Code/ID invalid | Value not consistent with value previously reported | Event Criteria not met | Required Segment Not Present | Invalid event sequence/relationship | Invalid data sequence/relationship | Corresponding report/data not found | Invalid record count | Must be >= Policy Effective Date | Must be <= Policy Effective Date | No Leading / Imbedded Spaces | | | | | | |
| Elem # | Element Description | 001 | 018 | 019 | 028 | 029 | 030 | 031 | 033 | 034 | 035 | 036 | 037 | 038 | 039 | 040 | 041 | 042 | 044 | 045 | 054 | 055 | 057 | 058 | 059 | 061 | 062 | 063 | 064 | 065 | 066 | 067 | 068 | 100 | | | | | | |
| SUBSEQUENT REPORT TRANSACTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 084 | Perm Impair Percentage | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 085 | Pay / Adj Code | R | | | | | | | | | | | | | | | | R | | | | | | R | | | | | | | | | | | | | | | | |
| 086 | Pay / Adj Paid to Date | R | | | R | | | | | | | | | | | | | | | R | | | | | | | | | | | | | | | | | | | | |
| 087 | Pay / Adj Weekly Amount | R | | | R | | | | | | | | | | | | | E | | R | | | | | | | | | | | | | | | | | | | | |
| 088 | Pay / Adj Start Date | R | | | | R | | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 089 | Pay / Adj End Date | R | | | | R | | | | | | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 090 | Pay / Adj Weeks Paid | R | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 091 | Pay / Adj Days Paid | R | | R | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 092 | Benefit Adj Code | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 093 | Benefit Adj Amount | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 094 | Benefit Adj Start Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 095 | PTD/Reduced Earn Code | | | | | | | | | | | | | | | | | | | | | | | | R | | | | | | | | | | | | | | | |
| 096 | PTD/Reduced Earn Amount | | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 097 | Death Depend Payee Relatior | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 098 | Sender ID | R | | | R | | | | | | | | | | R | | | | | | | | | | | | | | | | | | | | | | | | | |
| 099 | Receiver ID | R | | | R | | | | | | | | | | | | | | | | | | | R | | | | | | | | | | | | | | | | |
| 100 | Date Transm. Sent | R | | | R | R | | | | | | | | | | | | R | | | | | | | | | | | | | | | | | | | | | | |
| 101 | Time Transm. Sent | R | | | R | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 102 | Original Transm. Date | | | | R | R | | | | | | | | | | | | R | | | | | | | | | | | | | | | | | | | | | | |
| 103 | Original Transm. Time | | | | R | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 104 | Test/Prod. Indicator | R | | | | | | | | | | | | | | | | | | | | | | R | | | | | | | | | | | | | | | | |
| 105 | Interchange Vers. ID | R | | | | | | | | | | | | | R | | | | | | | | | | R | | | | | | | | | | | | | | | |
| 106 | Detail Rec. Count | R | | | R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 107 | Record Sequence Num. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 108 | Date Processed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 109 | Time Processed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 110 | ACK Transaction Set ID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 111 | Application ACK Code | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 112 | Request Code | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 113 | Free-Form Text | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 114 | Number of Errors | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 115 | Element Number | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 116 | Elem. Error Number | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 117 | Variable Seg. Number | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

NWCC Electronic Data Interchange SROI R1 Implementation Guide

Match Data Table

The Match Data Table is designed to convey which data elements NWCC uses as primary or secondary 'match' data elements. It is used to match to an existing claim for updating and processing. This match process is primarily employed on an Initial Acquired Payment (MTC 'IP/AP') and First Non Indemnity Payment (MTC 'PY') but can also be used on Denial (MTC '04'), Semi-Annual (MTC 'SA') or Final (MTC 'FN'). Match data may also be used to reconcile duplicate claims. NWCC has identified the primary match data element and secondary match data elements for Subsequent Reporting.

Note: A transaction may include only one changed match value at a time to allow the remaining match values to accomplish a match to a claim in the court's database.

The data element names are listed down the center column. An 'X' placed in the appropriate column indicates a 'P' (primary) or 'S' (secondary) match data.

| Grouping | Data Element Name | P | S |
|----------------------------|---|---|---|
| Claim Administrator | Jurisdiction Claim Number Format is nine numeric digits with leading zeroes (E.g., 010041234). (Not to be sent when original new claim is created using MTC '00') | X | |
| | Claim Administrator Claim Number | | X |
| | Insurer FEIN | | X |
| | TPA FEIN | | X |
| Claimant | Employee ID <ul style="list-style-type: none"> Employee SS Employee ID Assigned by Jurisdiction | | X |
| | Date of Injury | | X |

Transaction Sequencing

The current NWCC system design does not allow for a single batch to contain both 148 and A49 transactions as the batch header indicates the transaction types expected in the Interchange Version ID (DN105). The NWCC system does allow for mixing batches in a single transmission as long as the Interchange Version ID in each batch header indicates the transaction type expected in the batch.

| MTC | Transaction Name | Requirements |
|-----|--------------------------------------|--|
| IP | Initial Payment | <ul style="list-style-type: none"> • Must match an existing First Report. • Must follow 00 or 04. • Can follow PY. |
| AP | Acquired Payment | <ul style="list-style-type: none"> • Must match an existing First Report. • Must follow AU. |
| PY | First Non-Indemnity Payment | <ul style="list-style-type: none"> • Must match an existing First Report. • Must follow 00, 04 or AU. |
| 02 | Change | <ul style="list-style-type: none"> • Must match existing Subsequent Report. • Must follow 00, 04, AU. • Can follow any Subsequent Report. |
| CO | Correction | <ul style="list-style-type: none"> • Must match existing Subsequent Report. • Must follow 00, 04, AU. • Can follow any Subsequent Report. |
| 04 | Denial | <ul style="list-style-type: none"> • Must match an existing First Report. • Can follow any Subsequent Report. |
| SA* | Semi-Annual Periodic | <ul style="list-style-type: none"> • Must match an existing First Report. • Must follow at least one IP, AP, PY, SA, UR. |
| FN* | Final Report | <ul style="list-style-type: none"> • Must match an existing First Report. • Must follow at least one IP, AP, PY. |
| RB | Reinstatement of Benefits | <ul style="list-style-type: none"> • Must match an existing First Report. • Must follow FN. |
| UR | Upon Request | <ul style="list-style-type: none"> • Must follow 00, 04, AU. • Can follow any Subsequent Report. |
| S8 | Suspension: Jurisdiction has Changed | <ul style="list-style-type: none"> • Must follow 00, 04, AU. |

* Is allowed without an electronic IP, AP, or PY for **valid** legacy reports previously received via paper.

Note: Effective November 1, 2005, edits that have been specified in the Edit Matrix will no longer allow the following sequencing scenarios to occur:

1. An Initial Payment (IP) or Semi-Annual (SA) will no longer be accepted following an Acquired/Unallocated (AU).
2. An Acquired Payment (AP) will no longer be accepted after an Original (00).
3. Indemnity Benefits will no longer be accepted on a First Non-Indemnity Payment (PY), as this interferes with transaction sequencing and it is not an R1 standard.
4. A Final (FN) will not be accepted without a prior IP, AP or PY being received and accepted.
5. A Semi-Annual (SA) will not be accepted without a prior IP, AP or PY being received and accepted.

Process Rules

Sweeping the System in Release 1

In the absence of a definition, one needs to refer to the examples of periodic transactions AN (Annual) and FN (Final) that exist in the Release 1 Implementation Guide scenarios section. A sentence in each scenario indicates the following:

“For this scenario, the Sample of Payment Input Fields does not list each check but only the summary for each Payment Code”.

The “Sample of Payment Input Fields” lists multiple benefit type codes. It is implicitly understood but not explicitly documented that what is being reported are all benefit type codes paid to date. This is the way NE interprets the documentation and is what is understood to be standard practice in the industry. Certain excerpts of the R2 definition apply to Release 1 and an attempt is made here to clarify when to sweep in Release 1.

Sweep Definition: A Sweep is the process of providing current aggregate Payment/Adjustment Type and Paid to Date/Reduced Earnings/Recoveries data in addition to data required for a particular MTC Transaction. Sweep data is provided as a means of reporting financial amounts not specifically reported otherwise.

- Only one occurrence of any one Payment/Adjustment Type Code (DN 85) or Paid to Date/Reduced Earnings/Recoveries Type Code (DN 95) is allowed per transaction.
- Any Payment/Adjustment Type or Paid to Date/Reduced Earnings/Recoveries with *financial amounts* will be included in the sweep.
- A sweep will only include the following financial data:
 - Payment/Adjustment Type Information:
 - Payment/Adjustment Type Code (DN 85)
 - Payment/Adjustment Type Amount Paid (DN 86)
 - Payment/Adjustment Weekly Amount Paid (DN 87)
 - Payment/Adjustment Type Claim Weeks (DN 90)
 - Payment/Adjustment Type Claim Days (DN 91)
 - Payment/Adjustment Period Start Date (DN 88)
 - Payment/Adjustment Period Through Date (DN 89)
 - Paid to Date/Reduced Earnings/Recoveries
 - Paid to Date/Reduced Earnings/Recoveries Code (DN 95)
 - Paid to Date/Reduced Earnings/Recoveries Amount (DN 96)

Reporting Intermittent Periods of Disability and Continuing Payments

In the past, the Nebraska Workers' Compensation Court may have asked claim administrators to list each payment of the same benefit type as a separate line item. On paper it was the industry standard in almost all jurisdictions and it is still done this way in many jurisdictions today.

With the move to EDI, many claim administrators are now combining benefit payments of the same type on paper so there is just one line item per benefit type. The EDI national standard does not allow multiple lines for the same benefit type to be sent electronically and that is why claim administrators have coordinated paper and electronic reporting. Vendor software will allow claim administrators to enter multiple periods of disability for the same benefit type or send more than one line item for a given benefit type. The Nebraska Workers' Compensation Court, which enforces the national standard, edits for this scenario and will reject the payment report when it is submitted.

Best Practices for Acquired Claims

In order to more efficiently process claim acquisition transactions, the Nebraska Workers' Compensation Court now requires **acquiring** and **prior** claim administrators to each provide **written notice** to the court on company letterhead not less than **30 days prior to** the effective date of the claims acquisition, effective immediately.

The written notice should be as specific as possible about the acquisition and must provide:

1. Claim administrator **Names** and **FEINs** (for both the **acquiring** and the **prior** claims administrators).
2. Transmission **start date**. If a phased transition is planned (e.g., FROIs acquired first, then SROIs), include the transmission **start dates** for each.
3. An explanation of how open claims will be administered:
 - Will the prior claims administrator continue to administer open claims and report ongoing payments until the open claims are closed (runoff)?
 - Or will the acquiring claims administrator begin to administer open claims and report ongoing payments?
4. Contact information for the acquiring claim administrator's Business and Technical contacts.
5. An explanation of whether the acquiring claims administrator is able to report Paid-To-Date Codes **430** (Unallocated Prior Indemnity Benefits) and **440** (Unallocated Prior Medical). **If not, explain why.**

Claim administrators that fail to provide notice of acquisition in the form and manner described above may have their Acquired Unallocated (AU) and Acquired Payment (AP) transactions rejected. These transactions also may be rejected if they are not reported in accordance with the notice of acquisition provided to the court.

Nebraska State Specific Scenarios

Scenario 1: PY – SUBS (Non-Indemnity Payment Report With No Lost Work Days)

Narrative:

Employee was injured on 01/04/2000. The employee left work the afternoon of the day of the injury to seek medical treatment and returned to work on 01/05/2000 resulting in no lost workdays due to the injury. The jurisdiction requires a first report of injury within seven days after the date of injury. The claim administrator transmitted the first report of injury on 01/10/2000. The jurisdiction requires a subsequent report for payment of any non-indemnity dollars amount within 14 days upon issuance of the first non-indemnity payment. The claim administrator determines the claim is compensable and initiates payment on 02/12/2000. The claim administrator transmits a payment report to the jurisdiction on 02/13/2000. Future medical is not anticipated.

Implementation Note: Optionally, if no future reporting activity is not anticipated for this case, the claim status may be set to a value of 'C' and no final report (FN) is required to be sent.

This will allow trading partners to satisfy the requirements of Rule 30, A3 and A4, without having to send the same information in two reports (PY and FN).

Sequence of Reports for this Scenario: **00, PY**

Sample of Payment Input Fields:

| AWW: 600.00 | | Days per week: 5 | | Weekly Rate: | Daily Rate: |
|--------------|-----------|------------------|------------------|--------------|-------------|
| Payment Code | From Date | Thru Date | Weeks (1/7) Paid | Weekly Rate | Total Paid |
| 360 | | | | | 121.54 |
| 370 | | | | | 135.88 |

Sample of "PY" Subsequent Data

MTC: PY
MTC Date: 02/12/2000
Date Disability Began:
Wage: 600.00
Wage Period: 1
Claim Status: O
Salary Continued: N
Date Return/Release to Work: 01/05/2000

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Scenario 2: FN – SUBS (Close Non-Indemnity Payment Report With No Lost Work Days)

Narrative:

Employee was injured on 01/04/2000. All reporting to the jurisdiction has occurred. No indemnity benefits are currently being paid and no additional or future medical treatment is anticipated. On 02/12/2000 the claims administrator decides to close the claim due to the fact that all payments owed have been made and no future payments are anticipated. The jurisdiction requires notification within 14 days of when the claim administrator closes the claim; therefore the claim administrator transmits a final report to the jurisdiction on 02/13/2000.

Sequence of Reports for this Scenario: **00, PY, FN**

Sample of Payment Input Fields:

AWW: 600.00

Days per week: 5

Weekly Rate:

Daily Rate:

| Payment Code | From Date | Thru Date | Weeks (1/7) Paid | Weekly Rate | Total Paid |
|--------------|-----------|-----------|------------------|-------------|------------|
| 360 | | | | | 121.54 |
| 370 | | | | | 135.88 |

Sample of "FN" Subsequent Data

MTC: FN
MTC Date: 02/12/2000
Date Disability Began:
Wage: 600.00
Wage Period: 1
Claim Status: C
Salary Continued: N
Date Return/Release to Work: 01/05/2000

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Scenario 3: PY – SUBS (Non-Indemnity Payment Report With Lost Work Days)

Narrative:

Employee was injured on 01/04/2000. The employee was taken by ambulance that afternoon to seek emergency medical treatment. The employee had immediate surgery and had an overnight hospital stay and was allowed to check out of the hospital the next day. The physician indicated the employee could return to work with light duty on 01/08/2000 after two days off resulting in three lost workdays due to the injury. The jurisdiction requires a first report of injury within seven days after the date of injury. The claim administrator transmitted the first report of injury on 01/10/2000. The jurisdiction requires a subsequent report for payment of any non-indemnity payments within 14 days upon issuance of the first non-indemnity payment. Since no compensation is allowed for the first seven calendar days of disability (48-119) the employee is not owed disability compensation. The claim administrator determines the claim is compensable and initiates payment on 02/20/2000. The claim administrator transmits a payment report to the jurisdiction on 02/20/2000. Future medical is anticipated.

Sequence of Reports for this Scenario: **00, PY**

Sample of Payment Input Fields:

| AWW: 600.00 | | Days per week: 5 | | Weekly Rate: | Daily Rate: |
|--------------|-----------|------------------|------------------|--------------|-------------|
| Payment Code | From Date | Thru Date | Weeks (1/7) Paid | Weekly Rate | Total Paid |
| 360 | | | | | 2937.23 |
| 370 | | | | | 1682.55 |

Sample of "PY" Subsequent Data

MTC: PY
MTC Date: 02/20/2000
Date Disability Began: 01/04/2000
Wage: 600.00
Wage Period: 1
Claim Status: O
Claim Type: M
Salary Continued: N
Date Return/Release to Work: 01/10/2000

Data from FROI

Date Return to Work: 01/10/2000
Date Last Day Worked: 01/04/2000

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Scenario 4: FN – SUBS (Close Non-Indemnity Payment Report With Lost Work Days)

Narrative:

Employee was injured on 01/04/2000. After having surgery and returning to work for light duty on 01/10/2000 with no loss in wages, the doctor requested the employee schedule a follow up visit after six weeks. On 02/24/2000 the employee was examined and the results indicated the employee could now work with no restrictions. All reporting to the jurisdiction (other than this follow-up doctor visit) has occurred. No indemnity benefits are currently being paid and no additional or future medical treatment is anticipated. On 03/06/2000 the claims administrator decides to pay the doctor bill and to close the case due to the fact that all payments owed have been made and no future payments are anticipated. The jurisdiction requires notification within 14 days of when the claim administrator closes the claim therefore the claim administrator transmits a final report to the jurisdiction on 03/09/2000.

Sequence of Reports for this Scenario: **00, PY, FN**

Sample of previously reported non-indemnity benefit payments on the PY:

| Payment Code | From Date | Thru Date | Weeks (1/7) Paid | Weekly Rate | Total Paid |
|--------------|-----------|-----------|------------------|-------------|------------|
| 360 | | | | | 2937.23 |
| 370 | | | | | 1682.55 |

Sample of new non-indemnity benefit payments that need to be reported:

| Payment Code | From Date | Thru Date | Weeks (1/7) Paid | Weekly Rate | Total Paid |
|--------------|-----------|-----------|------------------|-------------|------------|
| 360 | | | | | 121.54 |
| 370 | | | | | 180.88 |

Sample of cumulative non-indemnity benefit payments that need to be reported on the FN:

| Payment Code | From Date | Thru Date | Weeks (1/7) Paid | Weekly Rate | Total Paid |
|--------------|-----------|-----------|------------------|-------------|------------|
| 360 | | | | | 3058.77 |
| 370 | | | | | 1863.43 |

Sample of "FN" Subsequent Data

MTC: FN
MTC Date: 03/06/2000
Date Disability Began: 01/04/2000
Wage: 600.00
Wage Period: 1
Claim Status: C
Claim Type: M
Salary Continued: N
Date Return/Release to Work: 01/10/2000

Data from FROI

Date Return to Work: 01/10/2000
Date Last Day Worked: 01/04/2000

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Scenario 5: FN – Lump Sum Settlement

Narrative:

Employee sustained a lower back injury on 06/26/1998. Employee petitioned the court and a hearing was set to resolve a dispute for payment of compensation benefits before a judge. On 11/20/2000 a hearing was held and a judge decided in favor of the employee and ordered the employer/insurer to pay temporary total benefits at \$444.00 a week (statutory max) for 11 2/7 weeks from 09/28/1998 through 12/15/1998. In addition \$51.67 is to be paid for 288 5/7 weeks for a 10 percent permanent loss of earning power. The claims administrator made the first indemnity and medical payments on 01/17/2001. Subsequently, the court received an Application for an Order Approving Lump Sum Settlement. In the application the employee agreed to receive a single payment of \$12,000.00 to close this case so that no further liability would be incurred by the employer/insurer for this date of accident. A total of \$5,010.86 has been paid for temporary total benefits, \$6,310.25 for permanent partial benefits at 10 percent, and \$17,590.15 for medical/hospital benefits to date. The employer/insurer indicated that the balance due on permanent disability is 166 4/7 weeks at \$51.67 and is allowing for additional consideration. The judge approved the application and ordered payment of the lump sum. The claim administrator also determined that under Nebraska law the employee is owed wages from the date of injury and made payment for that prior to the application for lump sum settlement was approved. The claim administrator makes final payment on 03/06/2001.

Sample of Payment Input Fields:

AWW: 775.00 Days per week: 5 Weekly Rate: 444.00 Daily Rate:51.67

| Payment Code | From Date | Thru Date | Weeks (1/7) Paid | Weekly Rate | Total Paid |
|--------------|------------|------------|------------------|-------------|------------|
| 040 | 06/27/1998 | 01/15/2001 | 122 1/7 | 51.67 | 6,310.25 |
| 050 | 09/28/1998 | 12/15/1998 | 11 2/7 | 444.00 | 5010.86 |
| 500 | | | | | 12000.00 |
| 360 | | | | | 9383.57 |
| 370 | | | | | 8206.58 |

Sample of "FN" Subsequent Data

MTC: FN
MTC Date: 03/06/2001
Date Disability Began: 09/28/1998
Wage: 775.00
Wage Period: 1
Claim Status: C
Salary Continued: N
Date Return/Release to Work: 12/16/1998

**Nebraska Workers' Compensation Court
 Acknowledgment Record (AK1) For First Report (148) and Subsequent Report (A49)**

| IAIABC Release 1 Acknowledgment Record (AK1) For First Report (148) & Subsequent Report (A49) | | | | | |
|--|----------------------|-------------------------------------|--------------------------|------------------|------------|
| <i>IAIABC GROUPING</i> | <i>IAIABC DN</i> | <i>IAIABC DATA ELEMENT NAME</i> | <i>IAIABC FORMAT</i> | <i>POSITIONS</i> | |
| | | | | <i>BEG</i> | <i>END</i> |
| TRANSACTION | | | | | |
| | 0001 | Transaction Set ID | 3 A/N | 1 | 3 |
| | 0107 | Record Sequence Number | 9 N | 4 | 12 |
| | 0108 | Date Processed | Date | 13 | 20 |
| | 0109 | Time Processed | Time | 21 | 26 |
| | 0006 | Insurer FEIN | 9 A/N | 27 | 35 |
| | 0014 | Claim Administrator Postal Code | 9 A/N | 36 | 44 |
| | 0008 | Third Party Administrator Fein | 9 A/N | 45 | 53 |
| | 0110 | Acknowledgement Transaction Set ID | 3 A/N | 54 | 56 |
| | 0111 | Application Acknowledgment Code | 2 A/N | 57 | 58 |
| | 0026 | Insured Report Number | 25 A/N | 59 | 83 |
| | 0015 | Claim Administrator Claim Number | 25 A/N | 84 | 108 |
| | 0005 | Agency Claim Number | 25 A/N | 109 | 133 |
| | 0002 | Maintenance Type Code | 2 A/N | 134 | 135 |
| | 0003 | Maintenance Type Date | Date | 136 | 143 |
| | 0112 | Request Code (Purpose) | 3 A/N | 144 | 146 |
| | 0113 | Free Form Text | 60 A/N | 147 | 206 |
| | 0114 | Number of Errors | 2 N | 207 | 208 |
| VARIABLE SEGMENT ERROR CODE: Error Code Occurs Number of Error Times (maximum number of occurrences = 99) | | | | | |
| | 0115 | Element Number | 4 N | 209 | 212 |
| | 0116 | Element Error Number | 3 N | 213 | 215 |
| | 0117 | Variable Segment Number | 2 N | 216 | 217 |

Section Five:

EDI Certification Test Procedure

Definitions

Trading Partner ('TP') — a regulated party defined to be an insurance carrier, self-insured employer or risk management pool that is legally responsible for filing reports and payment of compensation benefits. The regulated party may do their own claims administration or they may contract with a third party administrator which is licensed in the State of Nebraska to perform claims administration functions, file reports and pay compensation benefits on behalf of a regulated party. Therefore, the court refers to a third party administrator as a trading partner where a contract exists between a regulated party and a third party administrator for claims administration services. The trading partner may format claim data into EDI transaction sets and transmit it electronically to the court or contract with a reporter to perform such services on their behalf.

Reporter — a third party vendor that receives claim information via telephone, fax, mail, or otherwise and formats claim data into EDI transaction sets and transmits it electronically to the court. This excludes Value Added Network Service providers or Internet Service providers that are intermediary channels used only to route electronic messages from one point to another. A reporter (also known as a “reporting service” or “data collection agent”) does not perform claims administration services and is not responsible for making payment of compensation benefits.

NWCC Reportable Injuries and Related Maintenance Type Codes

Any first report of injury a claims administrator gains knowledge of must be sent electronically to the NWCC to include medical only first reports (see additional information below), any lost time, or any indemnity.

Certification Test Procedure Instructions

1. Trading Partner needs to submit Six (6) FROI claims in the first test transmission as follows:
 - a. Four (4) Original transactions MTC '00'.
 - b. One (1) Original acquired transaction MTC 'AU' without agency claim number.
 - c. One (1) Acquired transaction MTC 'AU' with agency claim number.
2. Nebraska Worker's Compensation Court will process the transactions, apply all edits, validate data accuracy and return acknowledgments with agency claim numbers to the Trading Partner.
3. Trading Partner needs to submit transmissions as soon as can be scheduled with the following A49 transactions. Agency Claims Numbers are mandatory for SROI certification testing:
 - a. Initial Payment with the agency claim number.
 - b. Acquired Payment with the agency claim number.
 - c. Medical/Hospital Payment with the agency claim number.
 - d. Change with the agency claim number.
 - e. Denial with the agency claim number.
 - f. Semi-Annual Periodic Report with the agency claim number.
 - g. Final Payment with the agency claim number.
 - h. Correction

Note: MTC sequences of **IP-SA** or **PY-SA** or **IP-FN** or **PY-FN** or **SA-FN** must demonstrate that prior payments made early in the life of the claim cycle are reported with continued payments during the middle and end of the claim life cycle. (Example: an FN with Agency Claim Number of 123456789 which follows an SA with Agency Claim Number of 123456789 should include a total of all payments paid to date for indemnity and non-indemnity with one payment type code reporting the grand total per benefit type). Additional testing may be required if the court cannot validate this from the received data during the pilot testing.

4. Nebraska Worker's Compensation Court will process the transactions, apply all edits, validate data accuracy and return acknowledgments to the Trading Partner. Processing is usually done the same day. In this test, the ability of the Trading Partner to store and properly use the agency claim number assigned by the court will be validated. The agency claim number is a nine digit numeric number that is used as primary match data to locate the claim in the NWCC database.
5. This test process will be repeated until the Trading Partner demonstrates the ability to submit the transactions in steps 1 and 3 above with no errors. **Note:** Trading partners must demonstrate that they can report all prior payments paid on periodic transactions.
6. NWCC will notify Trading Partner with an email notifying Trading Partner has passed the pilot tests and is approved for production.
7. NWCC and the Trading Partner determine a day in which to schedule and begin production. This is usually mutually agreed upon between the Nebraska Worker's Compensation Court and Trading Partner. Once all the parties have agreed on the production start date each party makes sure to switch the test indicator to production.
8. Production data sent to NWCC will continue to be monitored for completeness and validity. Reports transmitted by trading partners should be at least 95 percent free of mandatory and conditional data element errors.

Section Six:

SROI Frequently Asked Questions (FAQs)

Q: *What date should be listed in the Report Effective Date field?*

A: The report effective date should have the date of the event that requires the report to be filed with the court. For initial payments, the Report Effective Date is the same as the date of initial draft. For all other MTCs, it is the date of the event that necessitated the filing of the Form 4.

Q: *What is the Maintenance Type Code (MTC) Date to be used for Initial Payment (IP), Acquired Payment (AP), First Non-Indemnity Payment (PY), and other transactions?*

A: For IP and AP, the MTC Date is the issue date of the initial indemnity benefit check. For PY, the MTC Date is the issue date of the payment. For all other transactions, the MTC Date is the date the transaction is marked for sending to the Nebraska Workers' Compensation Court.

Q: *What should be reported in the Report Purpose field?*

A: The Report Purpose field is used to report the reason for the filing of the form in conjunction with the requirements under Rule 30. For example, an initial payment would be an IP and a semi-annual report would be an SA. Indicate PY for the Report Purpose code if this is the first non-indemnity payment. If medical/hospital is to be reported with indemnity payments, the Report Purpose code should be IP, AP, SA, or FN. The SROI Implementation Guide on the court website (https://www.wcc.ne.gov/edi/electronic_data_interchange.aspx) has a listing of the valid codes for the Report Purpose field.

Q: *What is the format of the agency claim number (DN 5)? Must it have leading zeroes?*

A: The agency claim number format is a nine-digit number and leading zeroes are required. Example: 010041234.

Q: *How can we send the agency claim number if the claim was originally filed on paper?*

A: There are three methods for obtaining match data for your claims:

1. Review acknowledgements from the court,
2. Submit a records request on the court's website (<https://www.wcc.ne.gov/apps/IPUBA0003Afrm.aspx>),
3. Contact the court's EDI staff (<https://www.wcc.ne.gov/apps/IPUBA0001Afrm.aspx>).

Q: *In an acquired claim situation, does Nebraska require the current claim administrator to submit a PY for its First Non-Indemnity Payment if the previous claim administrator had already filed a PY for its First Non-Indemnity Payment?*

A: Yes, Nebraska will assume these are new dollars from the acquiring claims administrator. It is nearly impossible to determine if the prior claim administrator reported a First Non-Indemnity Payment.

Q: *If the date of injury changes on a claim, how does the claim administrator report the SA? What if the 180 days from the date of injury causes an SA to be reported 30 days from the last SA or 210 days from the last SA?*

A: If the date of injury changes, the next SA report is due 180 days from the new date of injury, regardless of previously filed SROIs.

Please Note: A Change (02) transaction is required prior to submitting the SA.

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Q: *Is Nebraska a "Body As a Whole" state?*

A: Yes.

Q: *When do I use specific payment codes and when do I use compromised payment codes?*

A: There are two different tables for payment codes: specific and compromised. The specific payment codes should be used whenever you are reporting indemnity benefits that are for a definite time period with start and end dates and the corresponding amount is known. The compromised codes are to be used to report the amount of a court-approved settlement. For example: A subsequent report for a court-approved lump sum settlement could have payments that were not part of the actual settlement figure, most often the temporary benefits (on occasion this may also include a portion of the permanent benefits that were paid prior to the agreement to settle). These payments should be reported using the specific codes because the amount of each payment is specifically known and from and through dates for each payment are specifically known. The other payments on the subsequent report will need to be reported using the compromised payment codes because it is for the actual lump sum settlement amount. The lump sum settlement amount represents a dollar figure that often includes payment of future permanent benefits, future medical, and additional consideration.

Please Note: Compromised payment codes should never be used when reporting payments on a claim that is not for a court-approved settlement.

Q: *Where do I report court-approved settlements?*

A: Each subsequent report that is reported to the court should include all previously reported payment information. Therefore, the report will often consist of a variety of information, e.g. previous TTD, TPD, PPD Payments and previous Paid-To-Date information. Often a subsequent report for a court-approved settlement will only add the amount of the settlement. The settlement should be reported using the appropriate 500-series compromised payment code and is reported in the payment section of the subsequent report.

Example: An individual suffers a work-related injury on January 1, 2003 and misses two weeks of work from 01/01/2003 to 01/14/2003. The employee returns to work on light duty and receives TPD benefits from 01/15/2003 through 01/28/2003. Due to surgery the person is off two more weeks from work and is paid TTD benefits from 01/29/2003 through 02/11/2003. Released to return to work on light duty the employee receives TPD benefits for an additional two weeks from 02/12/2003 through 02/25/2003 before reaching maximum medical improvement. The employee reaches MMI on 03/01/2003 and is given an impairment rating entitling the employee to PPD benefits. However, no PPD benefits are paid. Instead the parties enter into a court-approved settlement for \$20,000. Payments should be reported as follows. (**Please Note:** This example ignores the seven-day waiting period for indemnity benefits.)

| Payment Code | Start Date | End Date | Days and Weeks | Weekly Amount | Total Amount |
|---------------------|-------------------|-----------------|-----------------------|----------------------|---------------------|
| 050 | 01/01/2003 | 02/11/2003 | 4 Weeks | \$400 | \$1600 |
| 070 | 01/15/2003 | 02/25/2003 | 4 Weeks | | \$400 |
| 500 | | | | | \$20,000 |

In the example above the TTD and TPD benefit types are identified using their appropriate detailed information codes, 050 and 070, respectively. Even though the benefits were not paid consecutively they are reported as though they were. The number of weeks reported will not match what is reflected by the start and end dates. There is no requirement that the Start Date, End Date, Days and Weeks, and Weekly Amount be completed when using code 500.

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While this scenario does not include PPD benefits that were paid, it can easily be changed. You would simply insert a line for the appropriate PPD code, either 030 or 040, and report the amount that was paid for the benefit that is not part of the settlement.

A list of the valid codes can be found on our website's EDI page (<http://www.nol.org/workcomp/>). If a compromised payment code is reported in either the Benefit Adjustment section or the Paid-to-Date section, the filing will be rejected.

Q: How do I report Permanent Partial Disability (PPD) payments when I have more than one type of PPD benefit?

A: Each indemnity benefit payment should be reported using the appropriate payment code. In this case the PPD benefit will be paid using either the 030 code for Permanent Partial Scheduled benefit or the 040 code will be used to report Permanent Partial Unscheduled or Body As a Whole (BAW) payments. If there is more than one period of PPD benefits to be paid, then they should be collapsed into one period using the correct payment code. For example, there is a rating to the left and right upper extremity. In this case there are two periods of PPD scheduled benefits to pay. Both payments should be reported using one 030 code with the payment periods running consecutively. What if there is a rating to the left upper extremity and a separate BAW rating for a back injury? In this case the 030 code would be used to report the scheduled payments, and then the 040 code would be used to report the BAW payments. Please see examples below:

Example One: PPD Benefits are five percent to the left upper extremity and five percent to the right upper extremity, with payments beginning on 01/01/2002.

| Payment Code | Start Date | End Date | Days and Weeks | Weekly Amount | Total Amount |
|---------------------|-------------------|-----------------|-----------------------|----------------------|---------------------|
| 030 | 01/01/2002 | 06/07/2002 | 22 Weeks & 4 Days | Correct Amount | Correct Amount |

Example Two: PPD Benefits are five percent to the left upper extremity and five percent BAW rating for a back injury. Payments for the upper extremity begin on 01/01/2002. BAW payments begin when the upper extremity payments are finished.

| Payment Code | Start Date | End Date | Days and Weeks | Weekly Amount | Total Amount |
|---------------------|-------------------|----------------------|-----------------------|----------------------|---------------------|
| 030 | 01/01/2002 | 03/20/2002 | 11 Weeks & 2 Days | Correct Amount | Correct Amount |
| 040 | 03/21/2002 | Appropriate End Date | Correct Weeks & Days | Correct Amount | Correct Amount |

Please note: There should probably not be a situation where there is more than one BAW rating. Therefore, there should not be a need to collapse multiple BAW ratings into one 040 payment. Also, adjust accordingly if there are more than two scheduled member ratings. If there are two or more scheduled ratings and one separate BAW rating, then report as above with the scheduled ratings collapsed into one payment code. Finally, please contact the court if you have a complex situation and would like help completing the subsequent report.

Q: How do I report indemnity benefits paid while an injured worker is participating in an approved vocational rehabilitation plan?

A: Report payment of these benefits using Temporary Total (Payment Code 050) or Temporary Partial (Payment Code 070), whichever is appropriate. Please **do not** report payment of these benefits using Vocational Rehabilitation Maintenance (Payment Code 410).

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Q: How do I report indemnity benefits paid based on a loss of earning power?

A: As permanent partial for the number of weeks paid, unless the LOEP is 100 percent and then it would be PTD.

Q: How do I report payments and other benefits that were paid on a claim?

A: All benefits paid on a claim are to be reported to the court on a subsequent report. Each type of benefit is reported by using the appropriate detailed information code found in the SROI Implementation Guide on our website's EDI page (https://www.wcc.ne.gov/edi/electronic_data_interchange.aspx). Payment reporting is cumulative in nature. *No code should be used more than once on each subsequent report.* If there is multiple start and stop dates of a particular benefit code, all payments with that code should be "collapsed" into one line.

Example: An individual suffers a work related injury on January 1, 2003 and misses two weeks of work from 01/01/2003 to 01/14/2003. The employee returns to work on light duty and receives TPD benefits from 01/15/2003 through 01/28/2003. Due to surgery the person is off two more weeks from work and is paid TTD benefits from 01/29/2003 through 02/11/2003. Released to return to work on light duty the employee receives TPD benefits for an additional two weeks from 02/12/2003 through 02/25/2003 before reaching maximum medical improvement. Payments should be reported as follows. (*Note: This example ignores the seven-day waiting period for indemnity benefits.*)

| Payment Code | Start Date | End Date | Days and Weeks | Weekly Amount | Total Amount |
|---------------------|-------------------|-----------------|-----------------------|----------------------|---------------------|
| 050 | 01/01/2003 | 02/11/2003 | 4 Weeks | \$400 | \$1600 |
| 070 | 01/15/2003 | 02/25/2003 | 4 Weeks | | \$400 |

In the above example the TTD and TPD benefit types are identified by using their appropriate detailed information codes, 050 and 070 respectively. Even though the benefits were not paid consecutively they are reported as though they were. The number of weeks reported will not match what is reflected by the start and end dates. While this scenario specifically involves payment codes, the same applies to paid-to-date codes. *No code should be used more than once on each subsequent report.*

Q: Where can a list of the Payment Codes be found?

A: A list of Payment Codes, Paid-to-Date Codes and Body Part Codes can be found in the SROI Implementation Guide on the court website: <http://www.nol.org/workcomp/edi/edi.htm>.

Q: Is it possible to report payments with a future end date?

A: Yes, but there are two different scenarios that will be applied:

1. If you are filing an FN MTC, then you may report payments with a future end date; however, the end date will be given an edit check of seven years. If the end date is greater than seven years from the current date, then a TR will be returned.
2. For all other MTCs, a future end date will be allowed, but the end date will carry a 180-day edit check. If the end date is greater than 180 days from the current date, then a TR will be returned. Please contact the court if you have further questions.

Please note: The court will use a UR MTC transaction at the time a trading partner begins sending EDI subsequent reports. Future end dates will be allowed on UR transactions, the same as the FN transaction above. If there are any questions about the UR transaction they should be resolved prior to being certified for EDI subsequent report transactions.

Q: Does the court accept compromised payment codes (5XX)?

A: Yes, but only to report court-approved settlements and **not including** codes 521, 524, 551, 580, and 590.

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Q: *Are there situations where certain codes could be rejected?*

A: Yes, those codes that are not statutorily valid will be rejected.

Q: *Does the court allow multiple concurrent benefits?*

A: Yes, as long as the benefit types are different. The court does not accept multiple occurrences of the same benefit type.

Q: *There was a place to put Subrogation amounts on the old Form 4, how do you report Subrogation on the new Form 4?*

A: Place the 820 code and the amount in Paid-to-Date section.

Q: *What sort of medical/hospital/other expenses should I report?*

A: Only those expenses that have a corresponding code should be reported in the Paid-To-Date section. For example: a claimant's legal expenses should be reported using code 340.

Please Note: Please do not report your own internal claims adjusting expenses. This includes employer legal expenses.

Q: *Where do I report Medical/Hospital (expense) payments?*

A: In the Paid-To-Date field, located on the lower half of the Subsequent Report (Form 4), a list of Paid-to-Date codes can be found in the SROI Implementation Guide on our website's EDI page (<http://www.nol.org/workcomp/edi/edi.htm>).

Q: *When reporting Non-Indemnity Payments, are codes 350 (physicians), 360 (hospitals), or 370 (other) sufficient to meet the jurisdictions need?*

A: Nebraska will accept any of the valid Paid-to-Date codes in the R1 Implementation Guide and the Nebraska SROI Implementation Guide on our website's EDI page (https://www.wcc.ne.gov/edi/electronic_data_interchange.aspx). A few other examples are: funeral expenses (code 300), claimant legal expenses (code 340), and expert witness fees (code 420). Remember to indicate PY for the Report Purpose code.

Q: *How do I report mileage?*

A: Mileage should be reported using the Paid-to-Date code 370 (Other Medical). However, if the mileage payment is part of a Vocational Rehabilitation expense, then it should be reported using Paid-to-Date code 400 (Other Vocation Rehabilitation).

Q: *The old Form 4 (Compensation & Expense Report) had an "Other" category for reporting mileage, interest, penalties, and other payments. Is there a corresponding code on the new Form 4 (Subsequent Report)?*

A: Report Total Medical Mileage as code 370 - Other Medical Paid to Date. You can report Funeral Expenses Paid to Date with code 300, Penalties Paid to Date with code 310 and Interest Paid to Date with code 320. There are three codes available to report Vocational Rehabilitation, codes 380, 390 and 400. See the codes section of the SROI Implementation Guide on our website's EDI page (<http://www.nol.org/workcomp/edi/edi.htm>) for details.

Q: *If there is no more space available on the paper Subsequent Report (Form 4), then how do I report additional payments?*

A: Attach a second copy of the form to the first and report the additional payments on the second form.

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Q: *How do I report claims in existence prior to the new Rule 30?*

A: Rule 30 governs the filing of a paper Subsequent Report (Form 4). This means that all claims, both old and new, have to be filed in accordance with Rule 30. Effective July 1, 2001, Rule 30 requires a subsequent report to be submitted as soon as the first payment occurs on a claim after July 1, 2001.

Q: *How does the Nebraska Workers' Compensation Court define "complex settlements?"*

A: Complex settlements are those which cover more than one date of injury. Additionally, cases involving a death, an annuity, or a subrogation may be considered complex.

Q: *What should a claim administrator do in the following scenarios?*

- **Claim sent in error:** *An original first report is filed in error as a result of an "oops" (with no subsequent reports filed).*
- **Jurisdiction change with payments:** *An original first report and subsequent reports are filed, but the claim is then transferred to another jurisdiction.*
- **Jurisdiction change with no payments:** *An original first report (no subsequent reports) is filed, but the claim is then transferred to another jurisdiction.*

A: The claim administrator should respond for each scenario as follows:

- **Claim sent in error:** Send a FROI 01 (Cancel) transaction.
- **Jurisdiction change with payments:** Send a SROI S8 (Suspension: Jurisdiction has changed) transaction.
- **Jurisdiction change with no payments:** No further action is required.

Q: *If we are paying indemnity benefits and trigger the IP, does a PY also need to be triggered also so that medical payments can be documented? Or will that be caught on the semi-annual report? For example, if we pay indemnity benefits right away and do not pay medical bills until two weeks later, the IP should have been triggered for the indemnity benefits. Does a PY then need to be triggered for medical payments?*

A: An IP is made to report the first payment of benefits which may include indemnity and non-indemnity (medical). The SA is a periodic report which includes all payment totals for both indemnity and non-indemnity compensation benefits. In your example, you do not need to submit a PY for the medical bill, but would have to report that medical bill along with the initial payment on an SA (accumulated total of payments made).

Q: *Do we have to send an FN on a closed claim if no dollars were reported?*

A: No.

Q: *Do we have to send an IP, PY, or SA if no benefit payments were made?*

A: No. An exception is a SROI Denial (04), which can be reported with or without benefit payments made.

Q: *How do you report death benefits for multiple payees?*

A: Add the amounts together to create one row of benefit type 010 and report the number of dependents.

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Q: *Can I make changes to a FROI match data elements (Name, DOI, SSN, etc.) while reporting a Cancellation (01), Denial (04) or Acquired Unallocated (AU) transaction?*

A: Changes to match data elements should be accomplished first with a Change (02) transaction. That can be followed with another transaction to perform a Cancel, Denial or Acquired Unallocated. This follows the standard that each Maintenance Type Code (MTC) defines one and only one event for which a transaction has a specific purpose. This also applies to SROI transactions as well. A Change (02) should be sent and accepted before submitting a Semi-Annual (SA) report.

Q: *Does an RB require that all previously reported dollars paid to date be reported?*

A: Yes, see addendum to event table.