

Compensation Board

eClaims

NYS SPECIFIC BUSINESS SCENARIOS EDI RELEASE 3

REVISED 6/30/2016

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TABLE OF CONTENTS

SCENARIO 1-1 – Medical Only (FROI 00)
SCENARIO 1-2 – Late Report By Employer (FROI 00) +++
SCENARIO 1-3 – Medical Only, Now Lost Time (SROI IP) ###
SCENARIO 1-4 – Notification Only (FROI 00)
SCENARIO 1-5 – Cancellation of Claim (FROI 01)
SCENARIO 1-6 – Notification Only, Now Medical Only (FROI 02)
SCENARIO 1-7 – Notification Only, Now Lost Time (SROI IP)
SCENARIO 1-8 – Medical Only, Report of Payment of Medical Bills (SROI PY)
SCENARIO 2-1 – Initial Payment - Disability Immediate & Continuous (FROI 00, SROI IP)47
SCENARIO 2-2 – Initial Payment - Non-Consecutive Periods of Disability (SROI IP)**** +++###58
SCENARIO 2-3 – Initial Payment - Late Report By Claim Administrator (FROI 00, SROI IP)69
SCENARIO 2-4 – Benefit Rate Change Due to Subsequent Payroll Data (SROI CA)
SCENARIO 2-5 – Change in Benefit Type Due to Medical (SROI CB)
SCENARIO 2-6 – Reduced Earnings (SROI RE)92
SCENARIO 2-7 – Suspension, Claimant Returned to Work Full Duty (SROI S1)
SCENARIO 2-8 – Suspension, Medical Release to Full Duty (SROI S1)104
SCENARIO 2-9 – Suspension, Medical Non-Compliance (SROI S2)
SCENARIO 3-1 – Employer Paid Wages (FROI 00, SROI EP) +++116
SCENARIO 3-2 – Employer Paid Wages, then Initial Payment by
Claim Administrator (SROI IP) +++127
SCENARIO 3-3 – Employer Reimbursement Directed by Jurisdiction (SROI PY) +++133
SCENARIO 3-4 – Employer Reimbursement Directed by Jurisdiction, after SROI-EP and SROI-IP
filings in Scenario 3-2 (SROI PY) +++144
SCENARIO 4-1- Initial Payment of Death Benefits (FROI 00, SROI IP)
SCENARIO 4-2 – Compensable Death with Beneficiary Investigation (SROI CD, SROI IP)166
SCENARIO 4-3 – Compensable Death - No Dependents (FROI 00, SROI CD, SROI PY)182
SCENARIO 4-4 – Compensable Death – Dependent Benefits Exhausted (SROI 02)188
SCENARIO 4-5 – Subsequent Death - Different Date of Accident & Date of Death
(SROI S4, FROI 00, SROI IP)194
SCENARIO 4-6 – Subsequent Death - Different Date of Accident & Date of Death
Date of Accident Prior to 1/1/2008 (SROI S4, FROI 00, SROI IP)

(Click on Scenario Number or Page Number to be taken to a Specific Scenario) Table of Contents - Page 1 of 2 -

TABLE OF CONTENTS (CONT.)

SCEN	ARIO 5-1 – Full Denial (FROI 04)	
SCEN	ARIO 5-2 – Subsequent Full Denial (FROI 00, SROI 04) ****	
SCEN	ARIO 5-3 – Partial Denial - Carrier Denying Indemnity Only,	
	No Medical Evidence of Disability (SROI PD)	
SCEN	ARIO 6-1 – Volunteer Firefighter - Medical Only (FROI 00) ^^^	
SCEN	ARIO 6-2 – Volunteer Firefighter – Lost Time/Initial Payment (FROI 00, SROI IP) ^^^	
SCEN	ARIO 6-3 – Volunteer Ambulance Worker - Medical Only (FROI 00) ^^^	
SCEN	ARIO 7-1 – Section 32 - Full Settlement (SROI SD, SROI PY)	
SCEN	ARIO 7-2 – Section 32 - Partial Settlement, Medicals Open (SROI SD, SROI PY)	
SCEN	ARIO 7-3 – Section 32 - Closing Additional Files (SROI PY)	
SCEN	ARIO 8-1 – Suspension, Board Ordered Suspension (SROI PY, SROI SD)	
SCEN	ARIO 8-2 – Suspension, Claim Administrator Appeals Decision (SROI SJ)	
SCEN	ARIO 8-3 – Suspension, Benefits Exhausted due to PPD Cap (SROI CB, SROI S7)	
SCEN	ARIO 8-4 – Reinstatement of Benefits (SROI RB)	
SCEN	ARIO 9-1 – Sub-Annual Report for Open Claims (SROI SA)	
SCEN	ARIO 9-2 – Sub-Annual Report for No Further Action Claims (SROI PY, SROI SA)	
SCEN	ARIO 9-3 – Schedule Loss of Use (SLU) Award, Late Payment of Award (SROI PY)	
SCEN	ARIO 9-4 – Legacy Claim (FROI UR, SROI UR, SROI S4)	
SCEN	ARIO 9-5 – Claim Administrator Acquires Claim (FROI AQ, SROI AP)	
SCEN	ARIO 9-6– Additional Lost Time,	
	Credit for Prior Schedule Loss of Use (SLU) Award (SROI-RB)	
SCEN	ARIO 10-1 – Varied Work Week (FROI 00)	
SCEN	ARIO 10-2 Fixed Work Week, other than Monday through Friday (FROI 00)	
SCEN	ARIO 10-3 – Notification Only Claim, Now Lost Time Payment without Admitting Liab	ility and
	Without Prejudice per §21(a) (FROI 00/SROI IP)	
SCEN	ARIO 10-4– Reclassification of Benefit, Benefit Type Misreported on SROI-IP (SROI-C	CB) 408
+++	Scenario Includes Example of DN270 Employee ID Type Qualifier of "Assigned by Jurisdiction" per t Matrix Algorithm.	he Edit
^ ^ ^	Scenario Includes Example of Managed Care Organization (MCO) Submission on FROI 00.	
###	Scenario Includes Example of Concurrent Employment.	
****	Scenario Includes Example of Multiple Injury Sites.	

(Click on Scenario Number or Page Number to be taken to a Specific Scenario) Table of Contents - Page 2 of 2 -

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 1-1

Medical Only – MTC 00

(Claimant has NOT lost any time from work and continues treatment for injury)

NARRATIVE:

Employee John Doe missed the last step getting off a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and sprained his right ankle on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident. The employee **continued to work that day**. Mr. Doe began experiencing worsening pain after leaving work at the end of his shift and sought treatment **beyond ordinary first aid**. Mr. Doe was initially treated and released from the Emergency Room of Albany Memorial Hospital. The employee was **paid for the date of the injury and returned to work full duty the next day**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury on August 3, 2012** to the Insurer / Claim Administrator.

On August 8, 2012, the Claim Administrator determined that the claim is compensable. The Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **August 8, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report

See NYS Workers' Compensation Law §110(2), §25(1)(c)

eClaims Business Scenarios

00 -	- First Report Event	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury	1300	1:00 PM	471	474
0033	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	49	Sprain	485	486
0036	Part of Body Injured Code	55	Ankle	487	488
0037	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
0041	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
0049	Employee Mailing State Code	NY		789	790

2

eClaims Business Scenarios

00 -	- First Report Event	Transaction L	.ayout		
	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
0063	Wage Period Code	01	Weekly	893	894
	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked			896	903
0066	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
		8 Elements			
		a Elements			1
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
				220	
	Employee ID Type Qualifier	s	Social Security Number	231	231
0042	Employee ID Type Qualifier Employee SSN	S 324556745			
0042	Employee ID Type Qualifier			231	246
0042 0255	Employee ID Type Qualifier Employee SSN			231 232	231 246 250 251
0042 0255 0150	Employee ID Type Qualifier Employee SSN Employee Last Name Suffix Employee Authorization to Release Medical	324556745		231 232 247	246 250

3

00 -	- First Report Event	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
OO - First Report EventDNData Element Name0045Employee Middle Name/Initial0046Employee Mailing Primary Address0047Employee Mailing Secondary Address0155Employee Mailing Country Code0051Employee Phone Number0146Death Result of Injury Code0290Type of Loss Code0228Return To Work With Same Employer Indice0149Deature To Work With Same Employer Indice		Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
0314	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
	Employer Contact Name	JANE SMITH		921	960
	Employer ID Assigned by Jurisdiction			961	975

	- First Report Event	Transaction La			_
	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
	Employer Mailing Information/Attention Line			-	1100
	Employer Mailing City	ALBANY		1101	
	Employer Mailing Country Code			1116	
	Employer Mailing Postal Code	12241		1119	
	Employer Mailing Primary Address	PO BOX 1587		1128	
	Employer Mailing Secondary Address			1168	
0170	Employer Mailing State Code	NY		1208	
	Filler			1210	
	Occupation Description	CARPENTER		1260	
0199	Full Denial Effective Date			1310	
	Filler			1318	
0073	Claim Status Code		N/A	1481	
	Claim Type Code	М	Medical Only	1482	1482
	Late Reason Code			1483	
0273	Employer Paid Salary in Lieu of Compensation Indicator			1485	148
	Filler			1486	159
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1590
0278	Number of Managed Care Organizations	00		1597	1598
	Number of Witnesses	01	1 Occurrence	1599	160
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS DESCENDING A LADDER AND MISSED THE LAS		1601	165
0038	Accident/Injury Description Narrative	T STEP & INJURED RT ANKLE		1651	170
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				
	Managed Care Organizations				
0207	Managed Care Organization Code				
0209	Managed Care Organization Name				
)208	Managed Care Organization Identification Number				
	Witnesses		1 Occurrence	1	
0238	Witness Name	JANE SMITH		1701	174
	Witness Business Phone Number	5184029394	(518) 402-9394	1741	
0201			. ,		

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 1-2

Late Report by Employer/Claim Administrator - Medical Only - MTC 00

(Claimant has NOT lost any time from work and continues treatment for injury)

NARRATIVE:

Employee John Doe missed the last step getting off a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and sprained his right ankle on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident. The employee **continued to work that day**. Mr. Doe began experiencing worsening pain after leaving work at the end of his shift and sought treatment **beyond ordinary first aid**. Mr. Doe was initially treated and released from the Emergency Room of Albany Memorial Hospital. The employee was **paid for the date of the injury and returned to work full duty the next day**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. The employer **did NOT report the injury** to the Insurer / Claim Administrator.

On **September 10, 2012**, the Claim Administrator received a call from the claimant's doctor requesting authorization for an MRI for the claimant. Upon reviewing their system, the Claim Administrator discovered they had no information on John Doe's injury. The Claim Administrator contacted the employer and discovered that the employer had not notified them regarding the injury.

On **September 12, 2012**, the Claim Administrator determined that the claim is compensable. The Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **September 12, 2012**. On the FROI 00 the Claim Administrator indicated L2 - "Late Notification, Employer" for DN0077 (Late Reason Code).

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report

eClaims Business Scenarios

<u>00 –</u>	148 Data Elements148001Transaction Set ID148002Maintenance Type Code00003Maintenance Type Code Date20120912004Jurisdiction CodeNY005Jurisdiction Claim Number1006Insurer FEIN141456789011Claim Administrator CityLATHAM012Claim Administrator State CodeNY013Claim Administrator Postal Code12110014Claim Administrator Claim Number120892356015Claim Administrator Claim Number202016Employer FEIN089898765021Employer Physical CityALBANY022Employer Physical State CodeNY023Employer Physical Postal Code12241023Employer Physical Postal Code12241024Employer Physical Postal Code12241025Industry Code12241025Industry Code12241				
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120912	September 12, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury	1300	1:00 PM	471	474
0033	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	49	Sprain	485	486
0036	Part of Body Injured Code	55	Ankle	487	488
0037	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
0041	Date Claim Administrator Had Knowledge of the Injury	20120910	September 10, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
	Employee Mailing State Code	NY		789	790

7

eClaims Business Scenarios

00 -	- First Report Event	Transaction L	Layout		
	Data Element Name	Data	Description	Beg	Ena
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	M	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
		00000105000	\$1050.00	882	892
		01	Weekly	893	894
		5		895	895
0065	Initial Date Last Day Worked			896	903
	· · · · · · · · · · · · · · · · · · ·	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
	End 14	8 Elements			
		ta Elements	- 1	1	
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356			
0187	Claim Administrator EEIN			24	48
0400		141456789		24 49	48 57
	Claim Administrator Name	141456789 ALL AMERICAN INSURANCE COMPANY			
0135	Claim Administrator Name Claim Administrator Information/Attention Line	ALL AMERICAN INSURANCE		49	57
0135	Claim Administrator Name Claim Administrator Information/Attention Line	ALL AMERICAN INSURANCE		49 58	57 97
0135 0010	Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address	ALL AMERICAN INSURANCE COMPANY		49 58 98	57 97 147 187
0135 0010 0011	Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address	ALL AMERICAN INSURANCE COMPANY		49 58 98 148	57 97 147
0061 Employee Date of Hire 0062 Wage 0063 Wage Period Code 0064 Number of Days Worked Per Week 0065 Initial Date Last Day Worked 0066 Full Wages Paid for Date of Injury Indicator Filler Filler 0068 Initial Return to Work Date 0061 Transaction Set ID 00295 Maintenance Type Correction Code 0296 Maintenance Type Correction Code Date 0196 Denial Rescission Date 0186 Jurisdiction Branch Office Code 0015 Claim Administrator Claim Number 0187 Claim Administrator FEIN 0188 Claim Administrator Primary Address 0011 Claim Administrator Country Code 0270 Employee ID Type Qualifier 0154 Employee ID Assigned by Jurisdiction 0255 Employee Last Name Suffix 0150 Employee Authorization to Release Medical Records Indicator	Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code	ALL AMERICAN INSURANCE COMPANY	ID Assigned by Jurisdiction	49 58 98 148 188	57 97 147 187 227
0135 0010 0011 0136 0270	Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier	ALL AMERICAN INSURANCE COMPANY PO BOX 12345		49 58 98 148 188 228	57 97 147 187 227 230
0135 0010 0011 0136 0270 0154	Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee ID Assigned by Jurisdiction	ALL AMERICAN INSURANCE COMPANY PO BOX 12345		49 58 98 148 188 228 231	57 97 147 187 227 230 231
0135 0010 0011 0136 0270 0154 0255	Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee ID Assigned by Jurisdiction Employee Last Name Suffix Employee Authorization to Release Medical	ALL AMERICAN INSURANCE COMPANY PO BOX 12345		 49 58 98 148 188 228 231 232 	57 97 147 187 227 230 231 246 250
0135 0010 0011 0136 0270 0154 0255 0150	Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee ID Assigned by Jurisdiction Employee Last Name Suffix Employee Authorization to Release Medical	ALL AMERICAN INSURANCE COMPANY PO BOX 12345 A 771101JDOE		 49 58 98 148 188 228 231 232 247 	57 97 147 187 227 230 231 246

8

00 -	- First Report Event	Transaction La	yout		
	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
0314	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
	Insurer Type Code	l	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	Е	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
	Employer Contact Name	JANE SMITH		921	960
	Employer ID Assigned by Jurisdiction			961	975

00 -	- First Report Event	Transaction La	ayout		
	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	Μ	Medical Only	1482	1482
0077	Late Reason Code	L2	Late Notification, Employer	1483	1484
0273	Employer Paid Salary in Lieu of Compensation Indicator			1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS DESCENDING A LADDER AND MISSED THE LAS		1601	1650
0038	Accident/Injury Description Narrative	T STEP & INJURED RT ANKLE		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
	Managed Care Organizations				
0207	Managed Care Organization Code				
0209	Managed Care Organization Name				
0208	Managed Care Organization Identification Number				
	Witnesses		1 Occurrence		
0238	Witness Name	JANE SMITH		1701	1740
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755
	Filler			1756	1775
	End R21 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 1-3

Medical Only (MTC 00) Now Lost Time - MTC IP

(Claimant lost time; however, lost time was not immediate)

NARRATIVE:

Employee John Doe, from Scenario 1-1, followed up with Albany Orthopedics on August 28, 2012 due to his work-related injury. The doctor determined that the claimant had fractured his ankle and needed an emergent surgery the next day. His doctor took him **out of work beginning August 29, 2012**. The Claim Administrator mailed a check to the claimant on **September 10, 2012**, paying him **Temporary Total Benefits** for the period **August 29, 2012 through September 10, 2012**. Doe also reported to the Claim Administrator that he had **Concurrent Employment** with Apple Supermarkets and provided proof of his wages of **\$150.00 per week** with the employer. Total wages for both employers was \$1,200.00 per week and was subject to the statutory maximum benefit of \$792.07 per week.

The Claim Administrator reported the initial payment information to the NYS Workers' Compensation Board by sending Initial Payment (**SROI IP**) transaction reports to the NYSWCB on **September 10, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 1-1</u> Event 1: FROI MTC 00 – Original First Report

<u>Scenario 1-3</u> Event 2: SROI MTC IP – Initial Payment

See NYS Workers' Compensation Law §110(2), §25(1)(c)

eClaims Business Scenarios

	Initial Payment, Event 2	Transactio		Pag	End
DN		Data	Description	Beg	Ena
0004	A49 Data Elements		Outras museus Dan ant		
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	IP	Initial Payment	4	5
	Maintenance Type Code Date	20120910	September 10, 2012	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
	Employee Number of Dependents			52	53
	Pre-Existing Disability Code	Ν	No	54	54
	Initial Date Disability Began	20120829	August 29, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Became Lost Time	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements				

13

IP –	Initial Payment, Event 2	Transaction Layout			
	Data Element Name	Data	Description	Beg	End
	R22 Data Elements			-	
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
	Employee Middle Name/Initial			314	328
	Employee Last Name Suffix			329	332
-	Employee Date of Birth	19771101	November 1, 1977	333	340
	Employee Marital Status Code		N/A	341	341
-	Employee Education Level			342	343
-	Employee Number of Entitled Exemptions			344	345
-	Anticipated Wage Loss Indicator			346	346
	Reduced Benefit Amount Code			347	347
-	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator	00400000		386	386
-	1,	20120828	August 28, 2012	387	394
	Non-Consecutive Period Code			395	395
	Estimated Gross Weekly Amount Indicator			396	396
-	Current Date Last Day Worked			397	404
	Current Date Disability Began	00400000	August 00, 0040	405	412
	Initial Date Last Day Worked	20120828	August 28, 2012	413	420
-	Return To Work Type Code			421	421
-	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430

IP –	Initial Payment, Event 2	Transaction	Layout		
	Data Element Name	Data	Description	Beg	End
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000079207	\$792.07	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation	N	No	494	494
0286	Average Wage	00000120000	\$1200.00	495	505
	Initial Date of Lost Time	20120829	August 29, 2012	506	505
	Award/Order Date	20120029	August 29, 2012	500	513
	Claim Administrator Alternate Postal Code			522	530
	Employer Paid Salary Prior to Acquisition Code			522	530
JZU3					
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	01	1 Occurrence	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	01	1 Occurrence	643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code	IP	Initial Payment	654	655
	Gross Weekly Amount	00000079207	\$792.07	656	666
	Gross Weekly Amount Effective Date	20120829	August 29, 2012	667	674
	Net Weekly Amount	00000079207	\$792.07	675	685
	Net Weekly Amount Effective Date	20120829	August 29, 2012	686	693
			August 29, 2012		701
8800	Benefit Period Start Date	20120829	August 29, 2012	694	101

	Initial Payment, Event 2	Transaction	-	_	
DN	Data Element Name	Data	Description	Beg	End
	Benefit Type Claim Weeks	0001		710	713
	Benefit Type Claim Days	4		714	714
	Benefit Type Amount Paid	00000145273	\$1452.73	715	725
0192	Benefit Payment Issue Date	20120910	September 10, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	050	Temporary Total	754	756
0217	Payee	JOHN DOE		757	796
0218	Payment Amount	00000145273	\$1452.73	797	807
0219	Payment Covers Period Start Date	20120829	August 29, 2012	808	815
0220	Payment Covers Period Through Date	20120910	September 10, 2012	816	823
0195	Payment Issue Date	20120910	September 10, 2012	824	831
	Filler			832	851
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
	Benefit Adjustment End Date				
	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
	Benefit Redistribution End Date				
	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
	Deemed Reduced Earnings				
	Concurrent Employers		1 Occurrence		
0141	Concurrent Employer Name	APPLE SUPERMARKETS		852	891
0142	Concurrent Employer Contact Business Phone	5185555555	(518) 555-5555	892	906
	Concurrent Employer Wage	00000015000	\$150.00	907	917
0140	oonounent Employer wage	0000013000	φ130.00	301	937

<i>IP</i> –	Initial Payment, Event 2	Transacti	ion Layout		
DN	Data Element Name	Data	Description	Beg	End
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 1-4

Notification Only – MTC 00

(Claimant has NOT lost any time from work and has NOT sought medical treatment for the injury)

NARRATIVE:

Employee John Doe missed the last step getting off a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and sprained his right ankle on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident. The employee **continued to work that day**. Mr. Doe **sought no treatment** for his injury. The employee was **paid for the date of the injury and returned to work full duty the next day**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury on August 3, 2012** to the Insurer / Claim Administrator.

On August 8, 2012, the Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **August 8, 2012**. The Claim Administrator **utilized "N" Notification Only with DN0074** (Claim Type Code).

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 - Original First Report - Notification Only

00 -	First Report Event Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
	Employer Physical State Code	NY		374	375
	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury	1300	1:00 PM	471	474
0033	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	49	Sprain	485	486
0036	Part of Body Injured Code	55	Ankle	487	488
0037	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	0	No Medical Treatment	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
0041	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
0049	Employee Mailing State Code	NY		789	790

00 -	- First Report Event	Transaction I	Layout		
DN	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
	Wage Period Code	01	Weekly	893	894
	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked			896	903
	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
0001	R21 Dat Transaction Set ID	a Elements R21	First Report	1	3
			Companion Record	-	•
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Information/Attention Line			98	147
	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
	Employee ID Type Qualifier	s	Social Security Number	231	231
	Employee SSN	324556745		232	246
	Employee Last Name Suffix			247	250
	Employee Authorization to Release Medical Records Indicator			251	251
0157	Employee Social Security Number Release Indicator	r		252	252
	Employee Last Name	DOE		253	292

00 -	- First Report Event	Transaction La			
	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
0314	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
	Insured Type Code		Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	Е	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
	Employer Contact Name	JANE SMITH		921	960
	Employer ID Assigned by Jurisdiction			961	975

00 -	- First Report Event	Transaction La	iyout		
DN	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	N	Notification Only	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation Indicator			1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS DESCENDING A LADDER AND MISSED THE LAS		1601	1650
0038	Accident/Injury Description Narrative	T STEP & INJURED RT ANKLE		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1701	1740	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755	
	Filler			1756	1775	
	End R21 Elements					

NYS Workers' Compensation Board eClaims Business Scenarios Scenario 1-5

Cancellation of Claim – MTC 01

(Claim Administrator submits Cancellation of Claim submitted in error)

NARRATIVE:

Employee John Doe slipped on a wet floor while working for ABC Supermarkets in **Pittsfield**, **MA** on August 1, 2012. ABC Supermarkets Corporate Office is located in Albany, NY. The claimant did NOT seek any treatment for the injury and continued to work without interruption. The employer notified the Claim Administrator of the injury on **August 3**, **2012**. When reporting the injury, the employer mistakenly used their corporate address as the injury location.

On August 8, 2012, the Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **August 8, 2012**. The Claim Administrator **utilized "N" Notification Only with DN0074 (Claim Type Code)**.

On August 10, 2012, the employer noticed their error and immediately informed the Claim Administrator that the claimant was injured while working at a supermarket location in Massachusetts and that the claim is NOT a New York claim but in fact a Massachusetts claim. The Claim Administrator reported the error and cancellation to the NYS Workers' Compensation Board by sending the cancellation (FROI 01) to the NYSWCB on August 10, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report – Notification Only Event 2: FROI MTC 01 – Cancel *** FROI 00 Data Table is NOT supplied for this Scenario ***

NOTE: If any **SROI MTC** has been accepted **OR** <u>other documents for this claim exist in the</u> <u>Electronic Case Folder</u>, the **FROI 01** will **NOT** be accepted.

<u>01 -</u>	- First Report Event, Cancel	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	01	Cancel	4	5
0003	Maintenance Type Code Date	20120810	August 10, 2012	6	13
	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number	G0055555		16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City		N/A	359	373
	Employer Physical State Code		N/A	374	375
	Employer Physical Postal Code		N/A	376	384
	Filler			385	385
0025	Industry Code			386	391
	Filler			392	401
0027	Insured Location Identifier		N/A	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury		N/A	471	474
0033	Accident Site Postal Code		N/A	475	483
	Filler			484	484
0035	Nature of Injury Code		N/A	485	486
0036	Part of Body Injured Code		N/A	487	488
0037	Cause of Injury Code		N/A	489	490
	Filler		N/A	491	640
0039	Initial Treatment Code		N/A	641	642
	Date Employer Had Knowledge of the Injury		N/A	643	650
	Date Claim Administrator Had Knowledge of the Injury		N/A	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
50 - - T	Filler			713	773
0048	Employee Mailing City		N/A	774	788
	Employee Mailing State Code		N/A	789	790

	- First Report Event, Cancel	Transaction			
DN	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code		N/A	791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code		N/A	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents		N/A	820	821
0056	Initial Date Disability Began		N/A	822	829
0057	Employee Date of Death		N/A	830	837
0058	Employment Status Code		N/A	838	839
0059	Manual Classification Code		N/A	840	843
	Filler		N/A	844	873
0061	Employee Date of Hire		N/A	874	881
0062	Wage		N/A	882	892
0063	Wage Period Code		N/A	893	894
	Number of Days Worked Per Week		N/A	895	895
	Initial Date Last Day Worked		N/A	896	903
	Full Wages Paid for Date of Injury Indicator		N/A	904	904
	Filler			905	905
0068	Initial Return to Work Date		N/A	906	913
0004		a Elements	First Des ert	4	0
	Transaction Set ID	a Elements R21	First Report Companion Record	1	3
0295	Transaction Set ID Maintenance Type Correction Code			1	3
0295 0296	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date				5 13
0295 0296 0196	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date		Companion Record	4	5
0295 0296 0196	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date			4	5 13
0295 0296 0196 0186 0015	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number		Companion Record	4 6 14	5 13 21
0295 0296 0196 0186 0015 0187	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN	R21	Companion Record	4 6 14 22	5 13 21 23
0295 0296 0196 0186 0015 0187	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number	R21	Companion Record	4 6 14 22 24	5 13 21 23 48
0295 0296 0196 0186 0015 0187 0188	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN	R21 TW0892356 141456789	Companion Record	4 6 14 22 24 49	5 13 21 23 48 57
0295 0296 0196 0186 0015 0187 0188 0135	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name	R21 TW0892356 141456789	Companion Record	4 6 14 22 24 49 58	5 13 21 23 48 57 97
0295 0296 0196 0186 0015 0187 0188 0135 0010	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line	R21 TW0892356 141456789	Companion Record Companion Record N/A N/A N/A N/A	4 6 14 22 24 49 58 98	5 13 21 23 48 57 97 147
0295 0296 0196 0186 0015 0187 0188 0188 0135 0010 0011	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address	R21 TW0892356 141456789	Companion Record Companion Record N/A N/A N/A N/A N/A N/A	4 6 14 22 24 49 58 98 148	5 13 21 23 48 57 97 147 187
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0011	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address	R21 TW0892356 141456789	Companion Record Companion Record N/A N/A N/A N/A N/A N/A N/A N/A N/A	4 6 14 22 24 49 58 98 148 188	5 13 21 23 48 57 97 147 187 227
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0136 0270	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code	R21 TW0892356 141456789 N/A	Companion Record Companion Record N/A	4 6 14 22 24 49 58 98 148 188 228	5 13 21 23 48 57 97 147 187 227 230
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0136 0270 0042	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier	R21 TW0892356 141456789 N/A S	Companion Record Companion Record N/A	4 6 14 22 24 49 58 98 148 188 228 231	5 13 21 23 48 57 97 147 187 227 230 231
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0136 0270 0042 0255	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN	R21 TW0892356 141456789 N/A S	Companion Record Companion Record N/A N/A N/A N/A N/A N/A N/A N/A N/A Social Security Number	4 6 14 22 24 49 58 98 148 188 228 231 232	5 13 21 23 48 57 97 147 187 227 230 231 246
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0136 0270 0042 0255 0150	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator FEIN Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN Employee Last Name Suffix Employee Authorization to Release Medical	R21 TW0892356 141456789 N/A S 324556745	Companion Record	4 6 14 22 24 49 58 98 148 188 228 231 232 247	5 13 21 23 48 57 97 147 187 227 230 231 246 250

	- First Report Event, Cancel	Transactior			r
DN	Data Element Name	Data	Description	Beg	End
	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address		N/A	308	347
0047	Employee Mailing Secondary Address		N/A	348	387
0155	Employee Mailing Country Code		N/A	388	390
0051	Employee Phone Number		N/A	391	405
0146	Death Result of Injury Code		N/A	406	406
0290	Type of Loss Code		N/A	407	408
0228	Return To Work With Same Employer Indicator		N/A	409	409
0189	Return To Work Type Code		N/A	410	410
	Physical Restrictions Indicator		N/A	411	411
	Insured FEIN		N/A	412	420
0017	Insured Name		N/A	421	460
	Insured Type Code		N/A	461	461
0026	Insured Report Number		N/A	462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name		N/A	496	535
0185	Insurer Type Code		N/A	536	536
0292	Insolvent Insurer FEIN		N/A	537	545
0200	Claim Administrator Alternate Postal Code		N/A	546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code		N/A	578	578
0118	Accident Site County/Parish		N/A	579	598
0119	Accident Site Location Narrative		N/A	599	648
0120	Accident Site Organization Name		N/A	649	698
0121	Accident Site City		N/A	699	713
0122	Accident Site Street		N/A	714	753
0123	Accident Site State Code		N/A	754	755
	Accident Site Country Code		N/A	756	758
0281	Date Employer Had Knowledge of Date of Disability		N/A	759	766
	Filler			767	767
0018	Employer Name		N/A	768	807
0329	Employer UI Number		N/A	808	822
0019	Employer Physical Primary Address		N/A	823	862
0020	Employer Physical Secondary Address		N/A	863	902
0164	Employer Physical Country Code		N/A	903	905
	Employer Contact Business Phone Number		N/A	906	920
	Employer Contact Name		N/A	921	960
	Employer ID Assigned by Jurisdiction			961	975

DN	Data Element Name	Data	Description	Beg	Enc
24.00			N1/A	4054	440
	Employer Mailing Information/Attention Line		N/A	1051	
	Employer Mailing City		N/A	1101	
	Employer Mailing Country Code		N/A	1116	
	Employer Mailing Postal Code		N/A	1119	
	Employer Mailing Primary Address		N/A	1128	
	Employer Mailing Secondary Address		N/A	1168	
0170	Employer Mailing State Code		N/A	1208	
	Filler		N1/A	1210	
	Occupation Description		N/A	1260	
0199	Full Denial Effective Date		N/A	1310	
	Filler			1318	
	Claim Status Code		N/A	1481	-
0074	Claim Type Code		N/A	1482	148
0077	Late Reason Code		N/A	1483	148
0273	Employer Paid Salary in Lieu of Compensation Indicator		N/A	1485	148
	Filler			1486	159
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	00		1591	159
0277	Number of Full Denial Reason Codes	00		1593	159
0276	Number of Denial Reason Narratives	00		1595	159
0278	Number of Managed Care Organizations	00		1597	159
0279	Number of Witnesses	00		1599	160
	Variable Segments				
	Accident/Injury Description Narratives				
	Accident/Injury Description Narrative				
0038	Accident/Injury Description Narrative				
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
)197	Denial Reason Narrative				
	Managed Care Organizations				
	Managed Care Organization Code				
	Managed Care Organization Name				
)208	Managed Care Organization Identification Number				
	Witnesses				
0238	Witness Name				
	Witness Business Phone Number				I

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 1-6

Notification Only, Now Medical Only – MTC 00/02

(Claimant has NOT lost any time from work but has now sought medical treatment for the injury)

NARRATIVE:

Employee John Doe, from Scenario 1-4, sought medical treatment on August 15, 2012, from his primary care physician due to ongoing pain from his injury. After receiving the medical report on August 25, 2012, the Claim Administrator determined that the claim is compensable. The Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Change Report (FROI MTC 02) to the NYSWCB on August 25, 2012. The FROI 02 notes a change from "N" (Notification Only) to "M" (Medical Only) for DN0074 (Claim Type Code).

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 1-4</u> Event 1: FROI MTC 00 – Original First Report – Notification Only

<u>Scenario 1-6</u> Event 2: FROI MTC 02 – Change Report – Change to "M" (Medical Only)

02 -	2 – First Report Event Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	02	Change	4	5
0003	Maintenance Type Code Date	20120825	August 25, 2012	6	13
	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
	Claim Administrator State Code	NY		194	195
	Claim Administrator Postal Code	12110		196	204
	Claim Administrator Claim Number	TW0892356		205	229
	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
	Employer Physical State Code	NY		374	375
	Employer Physical Postal Code	12241		376	384
0020	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
	Policy Expiration Date	20130101	January 1, 2013	455	462
	Date of Injury	20120801	August 1, 2012	463	470
	Time of Injury	1300	1:00 PM	471	474
	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	49	Sprain	485	486
	Part of Body Injured Code	55	Ankle	487	488
	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	2	Minor Clinic/ Hospital	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
	Employee Mailing State Code	NY		789	790

02 -	02 – First Report Event Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
	Wage Period Code	01	Weekly	893	894
	Number of Days Worked Per Week	5	-	895	895
	Initial Date Last Day Worked			896	903
	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
		8 Elements			
	R21 Dat	ta Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136		1	1		230
	Claim Administrator Country Code			228	200
	Claim Administrator Country Code Employee ID Type Qualifier	s	Social Security Number	228 231	231
0270		S 324556745			
0270 0042	Employee ID Type Qualifier			231	231
0270 0042 0255	Employee ID Type Qualifier Employee SSN			231 232	231 246
0270 0042 0255 0150	Employee ID Type Qualifier Employee SSN Employee Last Name Suffix Employee Authorization to Release Medical	324556745		231 232 247	231 246 250

02 -	First Report Event	Transaction Layout			
	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
0184	Insured Type Code		Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	Е	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
0160	Employer Contact Name	JANE SMITH		921	960
0230	Employer ID Assigned by Jurisdiction			961	975

eCLAIMS BUSINESS SCENARIOS

02 -	- First Report Event	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	Μ	Medical Only	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation Indicator			1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS DESCENDING A LADDER AND MISSED THE LAS		1601	1650
0038	Accident/Injury Description Narrative	T STEP & INJURED RT ANKLE		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

eClaims Business Scenarios

02 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1701	1740	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755	
	Filler			1756	1775	
	End R21 Elements					

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 1-7

Notification Only, Now Lost Time - MTC 00/IP

(Claimant has lost time from work and has now sought medical treatment for the injury)

NARRATIVE:

Employee John Doe, from Scenario 1-4, sought medical treatment on August 15, 2012, from his primary care physician due to ongoing pain from his injury and difficulty working. The medical provider noted a **Temporary Total Disability** and a follow up in four weeks for the claimant. After receiving the medical report on August 24, 2012, the Claim Administrator determined that the claim is compensable. The Claim Administrator mailed a check to the claimant on August 27, 2012 paying him **Temporary Total Benefits** for the period August 15, 2012 through August 27, 2012.

The Claim Administrator reported the initial payment information to the NYS Workers' Compensation Board by sending an Initial Payment (**SROI IP**) transaction report to the NYSWCB on **August 27, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 1-4</u> Event 1: FROI MTC 00 – Original First Report – Notification Only

<u>Scenario 1-7</u> Event 2: SROI MTC IP – Initial Payment – Claim Type Code of "I" (Indemnity)

	Initial Payment, Event 2	Transaction Layout			_
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	IP	Initial Payment	4	5
0003	Maintenance Type Code Date	20120827	August 27, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120815	August 15, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments			-	
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements				I

<u> IP –</u>	- Initial Payment, Event 2 Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
0139	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
	1, , , , , , , , , , , , , , , , , , ,	20120824	August 24, 2012	387	394
	Non-Consecutive Period Code			395	395
	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	Initial Date Last Day Worked	20120812	August 12, 2012	413	420
	Return To Work Type Code			421	421
	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430

Beg 431 439 447 448 459 467 478 480 482 483 491 492 494 506 514 522 531 532 533	End 438 446 447 458 466 477 479 481 482 490 491 493 494 505 513 521 530 531 532
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447 448 459 467 478 480 482 483 491 492 494 506 514 522 531 532	447 458 466 477 479 481 482 490 491 493 494 505 513 521 530 531
448 459 467 478 480 482 483 491 492 494 506 514 522 531	458 466 477 479 481 482 490 491 493 494 505 513 521 530 531
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483 491 492 494 495 506 514 522 531 532	490 491 493 494 505 513 521 530 531
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492 494 506 514 522 531 532	493 494 505 513 521 530 531
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686 694	693 701
	632 634 636 639 641 643 645 647 649 651 654 656 667 675

	Initial Payment, Event 2	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	Benefit Type Claim Weeks	0001		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000126000	\$1260.00	715	725
0192	Benefit Payment Issue Date	20120827	August 27, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	050	Temporary Total	754	756
0217	Payee	JOHN DOE		757	796
0218	Payment Amount	00000126000	\$1260.00	797	807
0219	Payment Covers Period Start Date	20120815	August 15, 2012	808	815
0220	Payment Covers Period Through Date	20120827	August 27, 2012	816	823
0195	Payment Issue Date	20120827	August 27, 2012	824	831
	Filler			832	851
	Other Benefits				
0216	Other Benefit Type Code				
	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
	Benefit Adjustment End Date				
	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone				
	Concurrent Employer Wage				

IP – I	Initial Payment, Event 2	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives					
0233	Suspension Narrative					
	End R22 Elements					

NYS Workers' Compensation Board eClaims Business Scenarios Scenario 1-8

Medical Only, Report of Payment of Medical Bills (Optional) – MTC PY

(Claimant has NOT lost any time from work and continues treatment for the injury)

NARRATIVE:

Employee John Doe, from Scenario 1-1, stopped medical treatment after a couple months of treatment.

On November 16, 2012, the Claim Administrator reported the medical payment information to the NYS Workers' Compensation Board by sending the Payment Report (**SROI PY**) to the NYSWCB on **November 16, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

Scenario 1-1: Event 1: FROI MTC 00 – Original First Report

Scenario 1-8: Event 2: SROI MTC PY – Payment Report

<u>NOTE: Reporting the individual payment of a medical bill on a SROI is an optional event in NY and</u> <u>not required. If the SROI-PY in this scenario was filed, it would be accepted by NYSWCB.</u>

<u>Cumulative reporting of Medical Expenses within the Other Benefit Types (OBT) continues to be a</u> <u>mandatory filing requirement when a SROI is filed due to an event occurring per the NYS Event</u> <u>Table filing requirements.</u>

eClaims Business Scenarios

	– Payment Report, Event 2	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	PY	Payment Report	4	5
	Maintenance Type Code Date	20121116	November 16, 2012	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	N	No	54	54
	Initial Date Disability Began			55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	Μ	Medical Only	187	187
	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code	-			
0031	End A49 Elements				1

42

<u> PY -</u>	– Payment Report, Event 2 Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
	Employee Date of Birth	19771101	November 1, 1977	333	340
	Employee Marital Status Code		N/A	341	341
	Employee Education Level			342	343
	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability			387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked			413	420
	Return To Work Type Code			421	421
0224	Physical Restrictions Indicator			422	422

eCLAIMS BUSINESS SCENARIOS

DN Data Element Name	Data	Description	Beg	End
0193 Suspension Effective Date			423	430
0199 Full Denial Effective Date			431	438
0196 Denial Rescission Date			439	446
0294 Partial Denial Code			447	447
0134 Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256 Wage Effective Date		N/A	459	466
0149 Discontinued Fringe Benefits			467	477
D290 Type of Loss Code	01	Trauma	478	479
0058 Employment Status Code	1	Full Time	480	481
0223 Permanent Impairment Minimum Payment Indica	tor		482	482
0068 Initial Return to Work Date			483	490
0066 Full Wages Paid For Date Of Injury Indicator			491	491
0293 Lump Sum Payment/Settlement Code			492	493
0273 Employer Paid Salary in Lieu of Compensation			494	494
Indicator	N	No		
0286 Average Wage	00000105000	\$1050.00	495	505
0297 Initial Date of Lost Time			506	513
0299 Award/Order Date			514	521
0200 Claim Administrator Alternate Postal Code			522	530
203 Employer Paid Salary Prior to Acquisition Code			531	531
0204 Work Week Type Code	s	Standard Work Week	532	532
0205 Work Days Scheduled	NSSSSSN		533	539
206 Employee Security ID			540	554
0229 Injury Severity Code			555	555
Filler			556	629
Variable Segment Counters				
0288 Number of Benefits	00		630	631
0283 Number of Payments	01	1 Occurrence	632	633
0282 Number of Other Benefits	01	1 Occurrence	634	635
0289 Number of Benefit ACR	000		636	638
0284 Number of Recoveries	00		639	640
0285 Number of Reduced Earnings	00		641	642
0275 Number of Concurrent Employers	00		643	644
0277 Number of Full Denial Reason Code	00		645	646
0276 Number of Denial Reason Narratives	00		647	648
0287 Number of Suspension Narratives	00		649	650
Variable Segments				
Benefits				
0085 Benefit Type Code				
0002 Maintenance Type Code				
0174 Gross Weekly Amount				
0175 Gross Weekly Amount Effective Date				
0087 Net Weekly Amount			1	

PY	– Payment Report, Event 2	Transaction	Transaction Layout				
	Data Element Name	Data	Description	Beg	End		
0211	Net Weekly Amount Effective Date						
0088	Benefit Period Start Date						
0089	Benefit Period Through Date						
0090	Benefit Type Claim Weeks						
0091	Benefit Type Claim Days						
0086	Benefit Type Amount Paid						
0192	Benefit Payment Issue Date						
	Filler						
	Payments						
0222	Payment Reason Code	350	Total Payments to Physicians	651	653		
0217	Payee	Dr. Timothy Jones		654	693		
0218	Payment Amount	0000012000	\$120.00	694	704		
0219	Payment Covers Period Start Date	20121101	November 01, 2012	705	712		
0220	Payment Covers Period Through Date	20121101	November 01, 2012	713	720		
0195	Payment Issue Date	20121115	November 15, 2012	721	728		
	Filler			729	748		
	Other Benefits		1 Occurrence				
0216	Other Benefit Type Code	350	Total Payments to Physicians	749	751		
0215	Other Benefit Type Amount	0000057000	\$570.00	752	762		
	Filler			763	782		
	Benefit Adjustments						
0092	Benefit Adjustment Code						
	Benefit Adjustment Start Date						
	Benefit Adjustment End Date						
-	Benefit Adjustment Weekly Amount						
	Benefit Credits						
0126	Benefit Credit Code						
	Benefit Credit Start Date						
	Benefit Credit End Date						
	Benefit Credit Weekly Amount						
	Benefit Redistribution						
0130	Benefit Redistribution Code						
	Benefit Redistribution Start Date						
	Benefit Redistribution End Date						
	Benefit Redistribution Weekly Amount						
0.00	Recoveries						
0226	Recovery Code						
	Recovery Amount						
0220	Reduced Earnings						
0242	Reduced Earnings Week Number						
	Actual Reduced Earnings						
	Deemed Reduced Earnings						
0147	Deemeu Reuuceu Eamings				<u>i</u>		

eCLAIMS BUSINESS SCENARIOS

<u> PY-</u>	– Payment Report, Event 2	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Concurrent Employers					
0141	Concurrent Employer Name					
0142	Concurrent Employer Contact Business Phone					
0143	Concurrent Employer Wage					
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives					
0233	Suspension Narrative					
	End R22 Elements					

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 2-1

Initial Payment by Claim Administrator – MTC 00/IP

(Disability is immediate and continuous)

NARRATIVE:

Employee John Doe fell from a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and broke his right leg on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident. The employee left work immediately after the injury and **did not return to work**. Mr. Doe was initially treated and released from the Emergency Room of Albany Memorial Hospital and **advised to remain out of work** with follow-up care through an orthopedic doctor. The employee was **paid for the date of the injury**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury on August 3, 2012** to the Insurer/Claim Administrator.

The Claim Administrator issued a check on August 15, 2012 to the injured employee, for Temporary Total Disability Benefits, for the period August 2, 2012 through August 15, 2012 and continuing.

The Claim Administrator reported the loss and initial payment information to the NYS Workers' Compensation Board by sending both the Original First Report of Injury (**FROI 00**) and Initial Payment (**SROI IP**) transaction reports to the NYSWCB on **August 8**, **2012** (**FROI**) and **August 15**, **2012** (**SROI**).

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

See NYS Workers' Compensation Law §110(2), §25(1)(c)

00 -	- First Report Event	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury	1300	1:00 PM	471	474
0033	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	28	Fracture	485	486
	Part of Body Injured Code	54	Lower Leg	487	488
	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
0041	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
	Employee Mailing State Code	NY		789	790

00 -	- First Report Event	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began	20120802	August 02, 2012	822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
0063	Wage Period Code	01	Weekly	893	894
0064	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked	20120801	August 01, 2012	896	903
0066	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
	End 148	B Elements			
		a Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
0270	Employee ID Type Qualifier	s	Social Security Number	231	231
0042	Employee SSN	324556745		232	246
0255	Employee Last Name Suffix			247	250
	Employee Last Name Suffix Employee Authorization to Release Medical Records Indicator			247 251	250 251
0150	Employee Authorization to Release Medical	·			

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	yout		
	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
0314	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	l	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
	Employer Contact Name	JANE SMITH		921	960
	Employer ID Assigned by Jurisdiction			961	975

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	I	Indemnity	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation	N	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS STEPPING OFF A ROOF AND LOST HIS FOOTI		1601	1650
0038	Accident/Injury Description Narrative	NG AND FELL FROM A LADDER INJURING RT LEG		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1701	1740	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755	
	Filler			1756	1775	
	End R21 Elements					

eClaims Business Scenarios

IP –	Initial Payment, Event 2	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	IP	Initial Payment	4	5
0003	Maintenance Type Code Date	20120815	August 15, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code				<u> </u>
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships			<u> </u>	
	Dependent/Payee Relationship Code				<u> </u>
	End A49 Elements				

53

<u> IP –</u>	Initial Payment, Event 2	Transaction L	ayout		
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
	Employee Date of Birth	19771101	November 1, 1977	333	340
	Employee Marital Status Code		N/A	341	341
	Employee Education Level			342	343
	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
-	Reduced Benefit Amount Code			347	347
	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator	00400004		386	386
	1,	20120801	August 01, 2012	387	394
	Non-Consecutive Period Code			395	395
	Estimated Gross Weekly Amount Indicator			396	396
-	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	Initial Date Last Day Worked	20120801	August 01, 2012	413	420
	Return To Work Type Code			421	421
-	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430

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467 a 478 ne 480 482 483 491 492 494 494 00 495 2012 506 514 522 531 Kork	477 479 481 482 490 491 493 494 505 513 521 530
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483 491 492 494 2012 506 514 522 531 Work 532	490 491 493 494 505 513 521 530
491 492 494 2012 506 514 522 531 Work 532	491 493 494 505 513 521 530
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2012 094 2012 702	701
	556

	Initial Payment, Event 2	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0090	Benefit Type Claim Weeks	0002		710	713
0091	Benefit Type Claim Days	0		714	714
0086	Benefit Type Amount Paid	00000140000	\$1400.00	715	725
0192	Benefit Payment Issue Date	20120815	August 15, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	050	Temporary Total	754	756
0217	Payee	JOHN DOE		757	796
0218	Payment Amount	00000140000	\$1400.00	797	807
0219	Payment Covers Period Start Date	20120802	August 02, 2012	808	815
0220	Payment Covers Period Through Date	20120815	August 15, 2012	816	823
0195	Payment Issue Date	20120815	August 15, 2012	824	831
	Filler			832	851
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings			1	
	Deemed Reduced Earnings			1	
	Concurrent Employers			1	
0141	Concurrent Employer Name			1	
	Concurrent Employer Contact Business Phone				
	Concurrent Employer Wage				

IP – I	Initial Payment, Event 2	Transactio	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 2-2

Initial Payment by Claim Administrator – MTC 00/IP

(Non-consecutive periods of disability occurring)

NARRATIVE:

Employee John Doe fell off a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and hurt his low back, left foot, and left hip on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident. The employee left work immediately after the injury and **returned to work without restrictions on August 6, 2012** (the disability did not exceed the waiting period). Mr. Doe was initially treated and released from the Emergency Room of Albany Memorial Hospital and advised to stay out of work for a few days. The employee was **NOT paid for the date of the injury**. At the time of injury, Mr. Doe earned \$22.50 an hour and worked 40 hours per week. Doe's foreman **reported the injury on August 6, 2012** to the Insurer/Claim Administrator.

On August 6, 2012, the Claim Administrator determined that the claim is compensable. The Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **August 6, 2012**. This was reported as a Medical Only claim as the disability did not exceed the waiting period.

On August 7, 2012, John Doe followed up with his family doctor due to his work related injury. The doctor placed him **out of work beginning August 8, 2012 with work restrictions (partial disability)**. The Claim Administrator mailed a check to the claimant on **August 17, 2012** paying him **Temporary Total Benefits** for the period **August 1, 2012 through August 3, 2012 and Temporary Partial Benefits** for the period **August 8, 2012 through August 16, 2012**. Doe also reported to the Claim Administrator that he had **Concurrent Employment** with Apple Supermarkets and provided proof of his wages of **\$150.00 per week** with the employer.

The Claim Administrator reported the initial payment information to the NYS Workers' Compensation Board by sending Initial Payment (**SROI IP**) transaction reports to the NYSWCB on **August 17, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

00 -	- First Report Event	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120806	August 06, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury	1300	1:00 PM	471	474
0033	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	28	Fracture	485	486
	Part of Body Injured Code	42	Lower Back Area	487	488
	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
	Date Claim Administrator Had Knowledge of the Injury	20120806	August 6, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
	Employee Mailing State Code	NY		789	790

<u>00 -</u>	- First Report Event	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	Ena
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	M	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began	20120801	August 01, 2012	822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
0062	Wage	0000002250	\$22.50	882	892
	Wage Period Code	01	Weekly	893	894
0064	Number of Days Worked Per Week	5		895	895
	Initial Date Last Day Worked	20120801	August 01, 2012	896	903
0066	Full Wages Paid for Date of Injury Indicator	N	No	904	904
	Filler			905	905
0068	Initial Return to Work Date	20120806	August 06, 2012	906	913
		ta Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	40
0196	Denial Rescission Date				13
0186				14	21
0.00	Jurisdiction Branch Office Code			14 22	
0015	Jurisdiction Branch Office Code Claim Administrator Claim Number	TW0892356			21
0015	Jurisdiction Branch Office Code Claim Administrator Claim Number	TW0892356 141456789		22	21 23
0015 0187	Jurisdiction Branch Office Code			22 24	21 23 48
0015 0187 0188 0135	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line	141456789 ALL AMERICAN INSURANCE		22 24 49	21 23 48 57 97
0015 0187 0188 0135	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name	141456789 ALL AMERICAN INSURANCE		22 24 49 58	21 23 48 57
0015 0187 0188 0135 0010 0011	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address	141456789 ALL AMERICAN INSURANCE COMPANY		22 24 49 58 98	21 23 48 57 97 147
0015 0187 0188 0135 0010 0011	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address	141456789 ALL AMERICAN INSURANCE COMPANY		22 24 49 58 98 148	21 23 48 57 97 147 187 227
0015 0187 0188 0135 0010 0011 0136	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address	141456789 ALL AMERICAN INSURANCE COMPANY	ID Assigned by Jurisdiction	22 24 49 58 98 148 188	21 23 48 57 97 147 187
0015 0187 0188 0135 0010 0011 0136 0270	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code	141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345		22 24 49 58 98 148 188 228	21 23 48 57 97 147 187 227 230
0015 0187 0188 0135 0010 0011 0136 0270 0154	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier	141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345		22 24 49 58 98 148 188 228 231	21 23 48 57 97 147 187 227 230 231
0015 0187 0188 0135 0010 0011 0136 0270 0154 0255	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee ID Assigned by Jurisdiction	141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345		22 24 49 58 98 148 188 228 231 232	21 23 48 57 97 147 187 227 230 231 246
0015 0187 0188 0135 0010 0011 0136 0270 0154 0255 0150	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee ID Assigned by Jurisdiction Employee Last Name Suffix Employee Authorization to Release Medical	141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345 A 771101JDOE		22 24 49 58 98 148 188 228 231 232 247	21 23 48 57 97 147 187 227 230 231 246 250
0015 0187 0188 0135 0010 0011 0136 0270 0154 0255 0150 0157	Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee ID Type Qualifier Employee Last Name Suffix Employee Authorization to Release Medical Records Indicator	141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345 A 771101JDOE		22 24 49 58 98 148 188 228 231 232 247 251	21 23 48 57 97 147 187 227 230 231 246 250 251

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator	Y	Yes	409	409
0189	Return To Work Type Code	A	Actual	410	410
0224	Physical Restrictions Indicator	Ν	Without Physical Restrictions	411	411
0314	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
	Accident Site Location Narrative			599	648
	Accident Site Organization Name			649	698
	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
	Employer UI Number	16-10000		808	822
	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
0160	Employer Contact Name	JANE SMITH		921	960
0230	Employer ID Assigned by Jurisdiction			961	975

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Lay	yout		
	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	Μ	Medical Only	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation	Ν	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	CLT WAS STEPPING OFF A ROOF AND FELL FROM A LADDER		1601	1650
0038	Accident/Injury Description Narrative	INJURING LOW BACK, LT FOOT, LT HIP		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1701	1740	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755	
	Filler			1756	1775	
	End R21 Elements					

IP –	– Initial Payment, Event 2 Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	IP	Initial Payment	4	5
0003	Maintenance Type Code Date	20120817	August 17, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120801	August 01, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	L	Became Lost Time	187	187
	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters		·		
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage			<u> </u>	
	Death/Dependent/Payee Relationships				
	Dependent/Payee Relationship Code				
5051	End A49 Elements				

IP –	Initial Payment, Event 2	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	R22 Data Elements					
0001	Transaction Set ID	R22	Subsequent Report	1	3	
0295	Maintenance Type Correction Code			4	5	
-	Maintenance Type Correction Code Date			6	13	
0298	Date Claim Administrator Had Knowledge of Lost			14	21	
0186	Jurisdiction Branch Office Code			22	23	
0015	Claim Administrator Claim Number	TW0892356		24	48	
0187	Claim Administrator FEIN	141456789		49	57	
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97	
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137	
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152	
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232	
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242	
0270	Employee ID Type Qualifier	S	Social Security Number	243	243	
0042	Employee SSN	324556745		244	258	
0043	Employee Last Name	DOE		259	298	
0044	Employee First Name	JOHN		299	313	
0045	Employee Middle Name/Initial			314	328	
0255	Employee Last Name Suffix			329	332	
0052	Employee Date of Birth	19771101	November 1, 1977	333	340	
0054	Employee Marital Status Code		N/A	341	341	
0151	Employee Education Level			342	343	
0213	Employee Number of Entitled Exemptions			344	345	
0201	Anticipated Wage Loss Indicator			346	346	
0202	Reduced Benefit Amount Code			347	347	
0158	Employee Tax Filing Status Code			348	348	
0146	Death Result of Injury Code			349	349	
0314	Insured FEIN	089898765		350	358	
0292	Insolvent Insurer FEIN			359	367	
	Employer FEIN	089898765		368	376	
0023	Employer Physical Postal Code			377	385	
0228	Return To Work With Same Employer Indicator	Y	Yes	386	386	
	, , , , , , , , , , , , , , , , , , , ,	20120801	August 01, 2012	387	394	
0212	Non-Consecutive Period Code	В	Benefit Period	395	395	
0172	Estimated Gross Weekly Amount Indicator			396	396	
0145	Current Date Last Day Worked	20120807	August 07, 2012	397	404	
0144	Current Date Disability Began	20120808	August 08, 2012	405	412	
0065	Initial Date Last Day Worked	20120801	August 01, 2012	413	420	
0189	Return To Work Type Code	A	Actual	421	421	

0224 0193	Data Element Name	Data	Description	Beg	End
0193				- 5	LIIU
	Physical Restrictions Indicator	Ν	Without Physical Restrictions	422	422
0199	Suspension Effective Date			423	430
	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
	Wage Effective Date		N/A	459	466
	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator	-		482	482
	Initial Return to Work Date	20120806	August 06, 2012	483	490
	Full Wages Paid For Date Of Injury Indicator	N	No	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	N	No		
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120801	August 01, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	s	Standard Work Week	532	532
)205	Work Days Scheduled	NSSSSSN		533	539
)206	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	02	2 Occurrences	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	01	1 Occurrence	643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments			010	000
	Benefits		2 Occurrences		
	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	IP	Initial Payment	654	655
	Gross Weekly Amount	00000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120801	August 01, 2012	667	674
				001	014

<u>P –</u>	Initial Payment, Event 2	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date	20120801	August 01, 2012	686	693
8800	Benefit Period Start Date	20120801	August 01, 2012	694	701
0089	Benefit Period Through Date	20120803	August 3, 2012	702	709
0090	Benefit Type Claim Weeks	0000		710	713
0091	Benefit Type Claim Days	3		714	714
0086	Benefit Type Amount Paid	00000042000	\$420.00	715	725
0192	Benefit Payment Issue Date	20120817	August 17, 2012	726	733
	Filler			734	753
0085	Benefit Type Code	070	Temporary Partial	754	756
0002	Maintenance Type Code	IP	Initial Payment	757	758
0174	Gross Weekly Amount	0000035000	\$350.00	759	769
0175	Gross Weekly Amount Effective Date	20120808	August 08, 2012	770	777
	Net Weekly Amount	0000035000	\$350.00	778	788
0211	Net Weekly Amount Effective Date	20120808	August 08, 2012	789	796
0088	Benefit Period Start Date	20120808	August 08, 2012	797	804
0089	Benefit Period Through Date	20120816	August 16, 2012	805	812
	Benefit Type Claim Weeks	0001		813	816
	Benefit Type Claim Days	2		817	817
	Benefit Type Amount Paid	00000049000	\$490.00	818	828
	Benefit Payment Issue Date	20120817	August 17, 2012	829	836
	Filler			837	856
	Payments		2 Occurrences		
0222	Payment Reason Code	050	Temporary Total	857	859
0217	Payee	JOHN DOE		860	899
0218	Payment Amount	00000042000	\$420.00	900	910
0219	Payment Covers Period Start Date	20120801	August 01, 2012	911	918
0220	Payment Covers Period Through Date	20120803	August 03, 2012	919	926
0195	Payment Issue Date	20120817	August 17, 2012	927	934
	Filler			935	954
0222	Payment Reason Code	070	Temporary Partial	955	957
	Payee	JOHN DOE		958	997
0218	Payment Amount	00000049000	\$490.00	998	1008
	Payment Covers Period Start Date	20120808	August 08, 2012	1009	1016
	Payment Covers Period Through Date	20120808	August 16, 2012	1017	1024
	Payment Issue Date	20120817	August 17, 2012	1025	1032
	Filler			1033	1052
	Other Benefits				
0216	Other Benefit Type Code				
	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
0094					1
	Benefit Adjustment End Date				

IP –	Initial Payment, Event 2	Transaction Layout					
	Data Element Name	Data	Description	Beg	End		
	Benefit Credits						
0126	Benefit Credit Code						
0127	Benefit Credit Start Date						
0128	Benefit Credit End Date						
0129	Benefit Credit Weekly Amount						
	Benefit Redistribution						
0130	Benefit Redistribution Code						
0131	Benefit Redistribution Start Date						
0132	Benefit Redistribution End Date						
0133	Benefit Redistribution Weekly Amount						
	Recoveries						
0226	Recovery Code						
0225	Recovery Amount						
	Reduced Earnings						
0242	Reduced Earnings Week Number						
0124	Actual Reduced Earnings						
0147	Deemed Reduced Earnings						
	Concurrent Employers		1 Occurrence				
0141	Concurrent Employer Name	APPLE SUPERMARKETS		1053	1092		
0142	Concurrent Employer Contact Business Phone	5185555555	(518) 555-5555	1093	1107		
0143	Concurrent Employer Wage	0000015000	\$150.00	1108	1118		
	Filler			1119	1138		
	Denial Reason Codes						
0198	Full Denial Reason Code						
	Denial Reasons						
0197	Denial Reason Narrative						
	Suspension Narratives						
0233	Suspension Narrative						
	End R22 Elements						

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 2-3

Late Report by Claim Administrator Initial Payment by Claim Administrator – MTC 00/IP

(Disability is immediate and continuous)

NARRATIVE:

Employee John Doe fell from a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and broke his right leg on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident. The employee left work immediately after the injury and **did not return to work**. Mr. Doe was initially treated and released from the Emergency Room of Albany Memorial Hospital and **advised to remain out of work** with follow-up care through an orthopedic doctor. The employee was **paid for the date of the injury**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury on August 3, 2012** to the Insurer/Claim Administrator.

On **September 10, 2012**, the Claim Administrator received a call from the claimant for the status of his compensation payments. Upon reviewing their system, the Claim Administrator realized that they should have begun payments several weeks prior but for an unknown reason they did not notify the NYSWCB of the injury and had not begun payments on the claim.

The Claim Administrator issued a check on September 10, 2012 to the injured employee, for Temporary Total Disability Benefits, for the period August 2, 2012 through September 10, 2012 and continuing.

The Claim Administrator reported the loss and initial payment information to the NYS Workers' Compensation Board by sending both the Original First Report of Injury (**FROI 00**) and Initial Payment (**SROI IP**) transaction reports to the NYSWCB on **September 10, 2012**. On the FROI 00 the Claim Administrator indicated **L1-"No Excuse" for DN0077** (Late Reason Code).

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction l	Layout		
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
	Maintenance Type Code Date	20120910	September 10, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
	Employer Physical State Code	NY		374	375
	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury	1300	1:00 PM	471	474
	Accident Site Postal Code	12204		475	483
	Filler			484	484
	Nature of Injury Code	28	Fracture	485	486
	Part of Body Injured Code	54	Lower Leg	487	488
	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
0041	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
	Employee Mailing State Code	NY		789	790

eClaims Business Scenarios

00 -	- First Report Event	Transaction L	.ayout		
	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
	Wage Period Code	01	Weekly	893	894
	Number of Days Worked Per Week	5		895	895
	Initial Date Last Day Worked	20120801	August 01, 2012	896	903
	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
		8 Elements			
	R21 Dat	a Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
	Claim Administrator Country Code			220	
	Employee ID Type Qualifier	S	Social Security Number	231	231
0270 0042	Employee ID Type Qualifier Employee SSN	S 324556745			231
0270 0042	Employee ID Type Qualifier			231	231 246
0270 0042 0255	Employee ID Type Qualifier Employee SSN			231 232	
0270 0042 0255 0150	Employee ID Type Qualifier Employee SSN Employee Last Name Suffix Employee Authorization to Release Medical	324556745		231 232 247	231 246 250

71

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	yout		
	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	s	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
0160	Employer Contact Name	JANE SMITH		921	960
0230	Employer ID Assigned by Jurisdiction			961	975

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	yout		
	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	I	Indemnity	1482	1482
0077	Late Reason Code	L1	No Excuse	1483	1484
0273	Employer Paid Salary in Lieu of Compensation	N	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS STEPPING OFF A ROOF AND LOST HIS FOOTI		1601	1650
0038	Accident/Injury Description Narrative	NG AND FELL FROM A LADDER INJURING RT LEG		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 – First Report Event		Transaction			
DN	Data Element Name	Data	Description	Beg	End
	Managed Care Organizations				
0207	Managed Care Organization Code				
0209	Managed Care Organization Name				
0208	Managed Care Organization Identification Number				
	Witnesses		1 Occurrence		
0238	Witness Name	JANE SMITH		1701	1740
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755
	Filler			1756	1775
	End R21 Elements				

eClaims Business Scenarios

	Initial Payment, Event 2	Transactio		Pag	End
DN		Data	Description	Beg	Ena
0004	A49 Data Elements		Outres and Descent		
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	IP	Initial Payment	4	5
	Maintenance Type Code Date	20120910	September 10, 2012	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
	Employee Number of Dependents			52	53
	Pre-Existing Disability Code	Ν	No	54	54
	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code	L1	No Excuse	197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements				

75

IP –	Initial Payment, Event 2	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
-	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
	Initial Date Last Day Worked	20120801	August 01, 2012	413	420
	Return To Work Type Code			421	421

IP –	Initial Payment, Event 2	Transaction	n Layout		
	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	N	No		
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	01	1 Occurrence	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code	IP	Initial Payment	654	655
0174	Gross Weekly Amount	0000070000	\$700.00	656	666
0175	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
0087	Net Weekly Amount	00000070000	\$700.00	675	685
	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693

eClaims Business Scenarios

<u> </u>	nitial Payment, Event 2	Transactior	n Layout		
DN	Data Element Name	Data	Description	Beg	End
8800	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120910	September 10, 2012	702	709
0090	Benefit Type Claim Weeks	0005		710	713
0091	Benefit Type Claim Days	3		714	714
0086	Benefit Type Amount Paid	00000392000	\$3920.00	715	725
0192	Benefit Payment Issue Date	20120910	September 10, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	050	Temporary Total	754	756
0217	Payee	JOHN DOE		757	796
0218	Payment Amount	00000392000	\$3920.00	797	807
0219	Payment Covers Period Start Date	20120802	August 02, 2012	808	815
0220	Payment Covers Period Through Date	20120910	September 10, 2012	816	823
0195	Payment Issue Date	20120910	September 10, 2012	824	831
	Filler			832	851
	Other Benefits				
0216	Other Benefit Type Code				
	Other Benefit Type Amount				
	Filler				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
	Deemed Reduced Earnings				

78

eCLAIMS BUSINESS SCENARIOS

IP – Initial Payment, Event 2 **Transaction Layout** DN Data Element Name Data Description Beg End Concurrent Employers 0141 Concurrent Employer Name 0142 Concurrent Employer Contact Business Phone 0143 Concurrent Employer Wage Denial Reason Codes 0198 Full Denial Reason Code Denial Reasons 0197 Denial Reason Narrative Suspension Narratives 0233 Suspension Narrative End R22 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 2-4

Benefit Rate Change by Claim Administrator - MTC 00/IP/CA

(Benefit rate change due to subsequent payroll data)

NARRATIVE:

Employee John Doe, from Scenario 2-1, remained out of work.

On August 31, 2012, the Claim Administrator received the C-240 payroll data from the employer. Upon inspection, they determined that for the 52 weeks prior the claimant actually had an **average weekly wage of \$1,500**. The Claim Administrator **issued a check on August 31, 2012** for **an adjustment to the benefit rate for period August 2, 2012 through August 31, 2012**.

The Claim Administrator reported the adjustment in rate due to payroll date by sending the Change in Benefit Amount (SROI CA) transaction report to the NYSWCB on August 31, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 2-4</u> Event 3: SROI MTC CA – Change in Benefit Amount

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	СА	Change in Benefit Amount	4	5
0003	Maintenance Type Code Date	20120831	August 31, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code			54	54
0056	Initial Date Disability Began			55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week			101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
5057	End A49 Elements				

eClaims Business Scenarios

DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked			413	420
0189	Return To Work Type Code			421	421

eClaims Business Scenarios

Element Name cal Restrictions Indicator nsion Effective Date enial Effective Date Rescission Date Denial Code ated Weekly Compensation Amount Effective Date ntinued Fringe Benefits of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code yer Paid Salary Prior to Acquisition Code	Data	Description	Beg 422 423 431 439 447 448 459 467 478 480 482 483 491 492 494 495	End 422 430 438 446 447 458 466 477 479 481 482 490 491 493 494 505
nsion Effective Date enial Effective Date Rescission Date Denial Code ated Weekly Compensation Amount Effective Date ntinued Fringe Benefits of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	01 1 Y N	N/A Trauma Full Time Yes No	423 431 439 447 448 459 467 478 480 482 483 491 492 494	430 438 446 447 458 466 477 479 481 482 490 491 493 494
enial Effective Date Rescission Date Denial Code ated Weekly Compensation Amount Effective Date ntinued Fringe Benefits of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	01 1 Y N	N/A Trauma Full Time Yes No	431 439 447 448 459 467 478 480 482 483 491 492 494 495	438 446 447 458 466 477 479 481 482 490 491 493 494
Rescission Date Denial Code ated Weekly Compensation Amount Effective Date ntinued Fringe Benefits of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	01 1 Y N	N/A Trauma Full Time Yes No	439 447 448 459 467 478 480 482 483 491 492 494 495	446 447 458 466 477 479 481 482 490 491 493 494
Denial Code ated Weekly Compensation Amount Effective Date ntinued Fringe Benefits of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	01 1 Y N	N/A Trauma Full Time Yes No	447 448 459 467 478 480 482 483 491 492 494 495	447 458 466 477 479 481 482 490 491 493 494
ated Weekly Compensation Amount Effective Date Antinued Fringe Benefits of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	01 1 Y N	N/A Trauma Full Time Yes No	448 459 467 478 480 482 483 491 492 494 495	458 466 477 479 481 482 490 491 493 494
Effective Date Intinued Fringe Benefits of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	01 1 Y N	N/A Trauma Full Time Yes No	459 467 478 480 482 483 491 492 494 495	466 477 479 481 482 490 491 493 494
Effective Date Intinued Fringe Benefits of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	01 1 Y N	Trauma Full Time Yes No	467 478 480 482 483 491 492 494 495	477 479 481 482 490 491 493 494
of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	1 Y N	Full Time Yes No	478 480 482 483 491 492 494 495	479 481 482 490 491 493 494
of Loss Code yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	1 Y N	Full Time Yes No	480 482 483 491 492 494 495	481 482 490 491 493 494
yment Status Code anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	Y N	Yes	482 483 491 492 494 495	482 490 491 493 494
Anent Impairment Minimum Payment Indicator Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	Y N	No	483 491 492 494 495	490 491 493 494
Return to Work Date ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	Y N	No	491 492 494 495	491 493 494
ages Paid For Date Of Injury Indicator Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	N	No	492 494 495	493 494
Sum Payment/Settlement Code yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code	N	No	494 495	494
yer Paid Salary in Lieu of Compensation tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code			494 495	494
tor ge Wage Date of Lost Time /Order Date Administrator Alternate Postal Code			495	
Date of Lost Time /Order Date Administrator Alternate Postal Code	00000150000	\$1500.00		505
Date of Lost Time /Order Date Administrator Alternate Postal Code			500	l
Administrator Alternate Postal Code			506	513
			514	521
ver Deid Selery Drier to Acquisition Code			522	530
			531	531
Week Type Code	s	Standard Work Week	532	532
Days Scheduled	NSSSSSN		533	539
yee Security ID			540	554
Severity Code			555	555
			556	629
ble Segment Counters				
er of Benefits	01	1 Occurrence	630	631
er of Payments	00	N/A	632	633
	00		634	635
er of Benefit ACR				638
				640
				642
5				644
· ·				646
				648
				650
			010	000
its		1 Occurrence		
	050		651	653
	CA	Change in Benefit	654	655
enance Type Code			656	666
	00000079207		000	674
weekly Amount Weekly Amount Effective Date	00000079207 20120802	August 02, 2012	667	D/4
	er of Payments er of Other Benefits er of Benefit ACR er of Recoveries er of Reduced Earnings er of Concurrent Employers er of Concurrent Employers er of Full Denial Reason Code er of Denial Reason Narratives er of Suspension Narratives <i>Ie Segments</i> <i>its</i> Type Code nance Type Code	ProvideOUer of Payments00er of Other Benefits00er of Benefit ACR000er of Recoveries00er of Reduced Earnings00er of Concurrent Employers00er of Full Denial Reason Code00er of Denial Reason Narratives00er of Suspension Narratives00It SIt SType Code050nance Type CodeCA	PriorN/Aer of Payments00N/Aer of Other Benefits00er of Benefit ACR000er of Recoveries00er of Reduced Earnings00er of Reduced Earnings00er of Concurrent Employers00er of Full Denial Reason Code00er of Denial Reason Narratives00er of Suspension Narratives00er of Suspension Narratives00er of Suspension Narratives00Its1 OccurrenceType Code050Temporary Totalnance Type CodeCAChange in Benefit AmountWeekly Amount00000079207\$792.07	PriorN/A632er of Payments00N/A632er of Other Benefits00634er of Benefit ACR000636er of Recoveries00639er of Reduced Earnings00641er of Concurrent Employers00643er of Concurrent Employers00645er of Denial Reason Code00645er of Denial Reason Narratives00647er of Suspension Narratives00649 <i>le Segments</i> 100ts10ccurrenceType Code050Temporary Totalnance Type CodeCAChange in Benefit AmountWeekly Amount00000079207\$792.07656

eCLAIMS BUSINESS SCENARIOS

<u>CA -</u>	- Change in Benefit Amt., Event 3	Iransaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120831	August 31, 2012	702	709
	Benefit Type Claim Weeks	0004		710	713
0091	Benefit Type Claim Days	2		714	714
	Benefit Type Amount Paid	00000348511	\$3485.11	715	725
0192	Benefit Payment Issue Date	20120831	August 31, 2012	726	733
	Filler			734	753
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
	Concurrent Employer Wage				

eClaims Business Scenarios

CA – Change in Benefit Amt., Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				

End R22 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios SCENARIO 2-5

Change in Benefit Type Due to Medical – MTC 00/IP/CB

(Claimant medical indicates change in degree of disability)

NARRATIVE:

Employee John Doe, from Scenario 2-1, remained out of work.

On September 12, 2012, the Claim Administrator was notified by John Doe's doctor that Mr. Doe was no longer at a Total Disability. Mr. Doe was now at a Moderate Temporary Partial Disability as of September 5, 2012. John Doe's employer cannot accommodate the work restrictions. The Claim Administrator issued a check on September 19, 2012 to the injured employee, for Temporary Partial Disability Benefits, for the period September 5, 2012 through September 19, 2012 and continuing.

The Claim Administrator reported the adjustment in rate based upon the medical report by sending the Change in Benefit Type (**SROI CB**) transaction report to the NYSWCB on **September 19, 2012**. As the carrier had previously issued a payment of Temporary Total Benefits for the period of Temporary Partial Disability, the carrier noted an **overpayment credit of \$350.00** on the SROI CB transaction report due to the change in degree of disability.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 2-5</u> Event 3: SROI MTC CB – Change in Benefit Type

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	СВ	Change in Benefit Type	4	5
0003	Maintenance Type Code Date	20120919	September 19, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code			54	54
0056	Initial Date Disability Began			55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week			101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters		· · ·		
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097					
0031	Dependent/Payee Relationship Code End A49 Elements				

eCLAIMS BUSINESS SCENARIOS

DN Data Element Name	Data	Description	Beg	End
R22 Data Elements				
0001 Transaction Set ID	R22	Subsequent Report	1	3
0295 Maintenance Type Correction Code			4	5
0296 Maintenance Type Correction Code Date			6	13
0298 Date Claim Administrator Had Knowledge of Lost			14	21
0186 Jurisdiction Branch Office Code			22	23
0015 Claim Administrator Claim Number	TW0892356		24	48
0187 Claim Administrator FEIN	141456789		49	57
0188 Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140 Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137 Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138 Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
0139 Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270 Employee ID Type Qualifier	s	Social Security Number	243	243
0042 Employee SSN	324556745		244	258
0043 Employee Last Name	DOE		259	298
0044 Employee First Name	JOHN		299	313
0045 Employee Middle Name/Initial			314	328
0255 Employee Last Name Suffix			329	332
0052 Employee Date of Birth	19771101	November 1, 1977	333	340
0054 Employee Marital Status Code		N/A	341	341
0151 Employee Education Level			342	343
0213 Employee Number of Entitled Exemptions			344	345
0201 Anticipated Wage Loss Indicator			346	346
0202 Reduced Benefit Amount Code			347	347
0158 Employee Tax Filing Status Code			348	348
0146 Death Result of Injury Code			349	349
0314 Insured FEIN	089898765		350	358
0292 Insolvent Insurer FEIN			359	367
0016 Employer FEIN	089898765		368	376
0023 Employer Physical Postal Code			377	385
0228 Return To Work With Same Employer Indicator			386	386
0281 Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212 Non-Consecutive Period Code			395	395
0172 Estimated Gross Weekly Amount Indicator			396	396
0145 Current Date Last Day Worked			397	404
0144 Current Date Disability Began			405	412
0065 Initial Date Last Day Worked			413	420
0189 Return To Work Type Code			421	421

eClaims Business Scenarios

DN	Data Element Name	Data	Description	Beg	End
0224 F	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199 F	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294 F	Partial Denial Code			447	447
0134 (Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058 E	Employment Status Code	1	Full Time	480	481
0223 p	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066 F	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	N	No		
	Average Wage	00000105000	\$1050.00	495	505
0297 I	nitial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203 E	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205 \	Work Days Scheduled	NSSSSSN		533	539
0206 E	Employee Security ID			540	554
F	Filler			555	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	001	1 Occurrence	636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
1	Variable Segments	-			
	Benefits		2 Occurrences		
0085 E	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code	СВ	Change in Benefit Type	654	655
0174 (Gross Weekly Amount	00000070000	\$700.00	656	666
0175 (Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
0087	Net Weekly Amount	00000070000	\$700.00	675	685
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120904	September 04, 2012	702	709
0090	Benefit Type Claim Weeks	0004		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000336000	\$3360.00	715	725
0192	Benefit Payment Issue Date	20120919	September 19, 2012	726	733
	Filler			734	753
0085	Benefit Type Code	070	Temporary Partial	754	756
0002	Maintenance Type Code	СВ	Change in Benefit Type	757	758
0174	Gross Weekly Amount	0000035000	\$350.00	759	769
0175	Gross Weekly Amount Effective Date	20120905	September 05, 2012	770	777
0087	Net Weekly Amount	0000035000	\$350.00	778	788
0211	Net Weekly Amount Effective Date	20120905	September 05, 2012	789	796
0088	Benefit Period Start Date	20120905	September 05, 2012	797	804
0089	Benefit Period Through Date	20120919	September 19, 2012	805	812
0090	Benefit Type Claim Weeks	0002		813	816
0091	Benefit Type Claim Days	1		817	817
0086	Benefit Type Amount Paid	00000077000	\$770.00	818	828
0192	Benefit Payment Issue Date	20120919	September 19, 2012	829	836
	Injury Severity Code			555	555
	Filler			556	629
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Payment Reason Code				
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0002	Benefit Adjustment Weekly Amount				1

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End	
	Benefit Credits		1 Occurrence			
0126	Benefit Credit Code	C070	Overpayment Credit	857	860	
0127	Benefit Credit Start Date	20120905	September 05, 2012	861	868	
0128	Benefit Credit End Date	20120919	September 19, 2012	869	876	
0129	Benefit Credit Weekly Amount	0000035000	\$350.00	877	887	
	Filler			888	907	
	Benefit Redistribution					
0130	Benefit Redistribution Code					
0131	Benefit Redistribution Start Date					
0132	Benefit Redistribution End Date					
0133	Benefit Redistribution Weekly Amount					
	Recoveries					
	Recovery Code					
0225	Recovery Amount					
	Reduced Earnings					
0242	Reduced Earnings Week Number					
0124	Actual Reduced Earnings					
0147	Deemed Reduced Earnings					
	Concurrent Employers					
0141	Concurrent Employer Name					
0142	Concurrent Employer Contact Business Phone					
0143	Concurrent Employer Wage					
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives					
0233	Suspension Narrative					
	End R22 Elements					

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 2-6

Reduced Earnings Paid by Claim Administrator – MTC 00/IP/RE

(Claimant has returned to work at reduced pay)

NARRATIVE:

Employee John Doe, from **Scenario 2-5**, received notification from his employer on October 4, 2012 that they **can accommodate his work restrictions effective October 8, 2012**. The claimant returned to work and his employer notified the Claim Administrator accordingly. The claimant worked for two weeks at Reduced Earnings.

The Claim Administrator received the Reduced Earnings Payroll information on October 22, 2012 from the employer. The claimant **earned \$500.00 per week** per the payroll. The Claim Administrator **issued a check on October 22, 2012** to the injured employee, for **Reduced Earnings Benefits**, for the period **October 8, 2012 through October 19, 2012**.

The Claim Administrator reported the Reduced Earnings Benefits by sending the Reduced Earnings (SROI RE) transaction report to the NYSWCB on October 22, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 2-5</u> Event 3: SROI MTC CB – Change in Benefit Type

Scenario 2-6 Event 4: SROI MTC RE – Reduced Earnings

RE -	– Reduced Earnings, Event 4	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	RE	Reduced Earnings	4	5	
0003	Maintenance Type Code Date	20121022	October 22, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents			52	53	
0069	Pre-Existing Disability Code			54	54	
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date			72	79	
0057	Employee Date of Death			80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
0064	Number of Days Worked Per Week	5		101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number			111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code	I	Indemnity	187	187	
0075	Agreement to Compensate Code	L	With Liability	188	188	
	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
0083	Permanent Impairment Body Part Code					
	Permanent Impairment Percentage					
	Death/Dependent/Payee Relationships					
	Dependent/Payee Relationship Code					
-	End A49 Elements					

eCLAIMS BUSINESS SCENARIOS

<u>RE</u> -	- Reduced Earnings, Event 4	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	R22 Data Elements					
0001	Transaction Set ID	R22	Subsequent Report	1	3	
0295	Maintenance Type Correction Code			4	5	
0296	Maintenance Type Correction Code Date			6	13	
0298	Date Claim Administrator Had Knowledge of Lost			14	21	
0186	Jurisdiction Branch Office Code			22	23	
0015	Claim Administrator Claim Number	TW0892356		24	48	
0187	Claim Administrator FEIN	141456789		49	57	
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97	
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137	
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152	
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232	
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242	
0270	Employee ID Type Qualifier	S	Social Security Number	243	243	
0042	Employee SSN	324556745		244	258	
0043	Employee Last Name	DOE		259	298	
0044	Employee First Name	JOHN		299	313	
0045	Employee Middle Name/Initial			314	328	
0255	Employee Last Name Suffix			329	332	
0052	Employee Date of Birth	19771101	November 1, 1977	333	340	
	Employee Marital Status Code		N/A	341	341	
	Employee Education Level			342	343	
0213	Employee Number of Entitled Exemptions			344	345	
	Anticipated Wage Loss Indicator			346	346	
0202	Reduced Benefit Amount Code			347	347	
	Employee Tax Filing Status Code			348	348	
0146	Death Result of Injury Code			349	349	
0314	Insured FEIN	089898765		350	358	
0292	Insolvent Insurer FEIN			359	367	
	Employer FEIN	089898765		368	376	
	Employer Physical Postal Code			377	385	
0228	Return To Work With Same Employer Indicator	Y	Yes	386	386	
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394	
0212	Non-Consecutive Period Code			395	395	
0172	Estimated Gross Weekly Amount Indicator			396	396	
0145	Current Date Last Day Worked			397	404	
0144	Current Date Disability Began			405	412	
0065	Initial Date Last Day Worked			413	420	
0189	Return To Work Type Code	A	Actual	421	421	

eCLAIMS BUSINESS SCENARIOS

<u>RE</u>	– Reduced Earnings, Event 4	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator	Y	With Restrictions	422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date	20121008	October 08, 2012	483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
0293	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
	Award/Order Date			514	521
	Claim Administrator Alternate Postal Code			522	530
	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	s	Standard Work Week	532	532
)205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Filler			555	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	00	N/A	632	633
	Number of Other Benefits	00		634	635
	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	02	2 Occurrences	641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				1
	Benefits		2 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code		N/A	654	655
0174	Gross Weekly Amount		N/A	656	666
	Gross Weekly Amount Effective Date		N/A	667	674
	Net Weekly Amount		N/A	675	685
	Net Weekly Amount Effective Date		N/A	686	693

RE ·	– Reduced Earnings, Event 4	Transactior	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120904	September 04, 2012	702	709
0090	Benefit Type Claim Weeks	0004		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000336000	\$3360.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	070	Temporary Partial	754	756
	Maintenance Type Code	RE	Reduced Earnings	757	758
	Gross Weekly Amount	0000036667	\$366.67	759	769
0175	Gross Weekly Amount Effective Date	20121008	October 08, 2012	770	777
	Net Weekly Amount	0000036667	\$366.67	778	788
0211	Net Weekly Amount Effective Date	20121008	October 08, 2012	789	796
0088	Benefit Period Start Date	20120905	September 05, 2012	797	804
0089	Benefit Period Through Date	20121019	October 19, 2012	805	812
	Benefit Type Claim Weeks	0006		813	816
	Benefit Type Claim Days	3		817	817
	Benefit Type Amount Paid	00000234334	\$2,343.34	818	828
	Benefit Payment Issue Date	20121022	October 22, 2012	829	836
	Injury Severity Code		,	555	555
	Filler			556	629
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
0222	Payment Reason Code				
0217	Payee				
	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
	Benefit Adjustment End Date				
	Benefit Adjustment Weekly Amount				

eCLAIMS BUSINESS SCENARIOS

<u>RE</u> ·	– Reduced Earnings, Event 4	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings		2 Occurrences		
0242	Reduced Earnings Week Number	1		857	858
0124	Actual Reduced Earnings	0000050000	\$500.00	859	869
0147	Deemed Reduced Earnings			870	880
	Filler			881	900
0242	Reduced Earnings Week Number	2		901	902
0124	Actual Reduced Earnings	0000050000	\$500.00	903	913
0147	Deemed Reduced Earnings			914	924
	Filler			925	944
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0000	Suspension Narrative				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 2-7

Suspension of Benefits by Claim Administrator – MTC 00/IP/S1

(Indemnity suspended – claimant has returned to work full duty)

NARRATIVE:

Employee John Doe, from Scenario 2-1, remained out of work.

On September 27, 2012, the Claim Administrator received notification that John Doe returned to work on September 26, 2012 with no restrictions. The Claim Administrator mailed John Doe his final indemnity check on September 27, 2012.

The Claim Administrator reported the suspension of benefits by sending the Suspension (SROI S1) transaction report to the NYSWCB on September 27, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 2-7</u> Event 3: SROI MTC S1 – Suspension, Returned to Work, or Medically Determined/Qualified to Return to Work

<u>S1 -</u>	– Suspension, RTW, Event 3 Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	S1	Suspension, RTW	4	5
0003	Maintenance Type Code Date	20120927	September 27, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents		N/A	52	53
0069	Pre-Existing Disability Code		N/A	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death		N/A	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week		N/A	101	101
	Filler			102	102
	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number		N/A	111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code		N/A		
	Permanent Impairment Percentage		N/A		
	Death/Dependent/Payee Relationships				
	Dependent/Payee Relationship Code				
5001	End A49 Elements				<u> </u>

<u>S1 -</u>	– Suspension, RTW, Event 3 Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code		N/A	4	5
0296	Maintenance Type Correction Code Date		N/A	6	13
0298	Date Claim Administrator Had Knowledge of Lost		N/A	14	21
0186	Jurisdiction Branch Office Code		N/A	22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level		N/A	342	343
0213	Employee Number of Entitled Exemptions		N/A	344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code		N/A	348	348
0146	Death Result of Injury Code		N/A	349	349
	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN		N/A	359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code		N/A	377	385
	Return To Work With Same Employer Indicator	Y	Yes	386	386
	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
	Non-Consecutive Period Code		N/A	395	395
	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked		N/A	397	404
	Current Date Disability Began		N/A	405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code	A	Actual	421	421

<u> S1 -</u>	– Suspension, RTW, Event 3	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator	N	Without Physical Restrictions	422	422
0193	Suspension Effective Date	20120925	September 25, 2012	423	430
0199	Full Denial Effective Date		N/A	431	438
0196	Denial Rescission Date		N/A	439	446
0294	Partial Denial Code		N/A	447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits		N/A	467	477
0290	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator		N/A	482	482
	Initial Return to Work Date	20120926	September 26, 2012	483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code		N/A	492	493
	Employer Paid Salary in Lieu of Compensation Indicator			494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time		N/A	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code		N/A	522	530
)203	Employer Paid Salary Prior to Acquisition Code			531	531
)204	Work Week Type Code	s	Standard Work Week	532	532
)205	Work Days Scheduled	NSSSSSN		533	539
)206	Employee Security ID			540	554
)229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	01	1 Occurrence	649	650
	Variable Segments		•		
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	S1	Suspension, RTW	654	655
	Gross Weekly Amount	0000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
	Net Weekly Amount	00000070000	\$700.00	675	685

<u>S1 -</u>	- Suspension, RTW, Event 3	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120925	September 25, 2012	702	709
0090	Benefit Type Claim Weeks	0007		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000546000	\$5460.00	715	725
0192	Benefit Payment Issue Date	20120927	September 27, 2012	726	733
	Filler			734	753
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone				
	Concurrent Employer Wage				

eClaims Business Scenarios

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- Suspension, RTW, Event 3	Transaction l	Transaction Layout				
Data Element Name	Data	Description	Beg	End		
Denial Reason Codes						
Full Denial Reason Code						
Denial Reasons						
Denial Reason Narrative						
Suspension Narratives		1 Occurrence				
Suspension Narrative	EMPLOYEE RETURNED TO WORK ON 09/26/2012		754	803		
	Data Element Name Denial Reason Codes Full Denial Reason Code Denial Reasons Denial Reason Narrative Suspension Narratives	Data Element Name Data Denial Reason Codes	Data Element Name Data Description Denial Reason Codes	Data Element NameDataDescriptionBegDenial Reason CodesFull Denial Reason CodeDenial ReasonsDenial Reason NarrativeSuspension Narratives1 OccurrenceSuspension NarrativeEMPLOYEE RETURNED TO WORK ON754		

End R22 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 2-8

Suspension of Benefits by Claim Administrator – MTC 00/IP/S1

(Indemnity suspended – medical release to full duty)

NARRATIVE:

Employee John Doe, from Scenario 2-1, remained out of work.

On **September 27, 2012**, the Claim Administrator received notification that John Doe's doctor gave him a full duty release to **return to work on October 1, 2012 with no restrictions**. The Claim Administrator mailed John Doe his final indemnity check on October 2, 2012.

The Claim Administrator reported the suspension of benefits by sending the Suspension (SROI S1) transaction report to the NYSWCB on October 2, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 2-8</u> Event 3: SROI MTC S1 – Suspension, Returned to Work, or Medically Determined/Qualified to Return to Work

eCLAIMS BUSINESS SCENARIOS

S1 – Suspension, MDQ/RTW, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	S1	Suspension, MDQ	4	5
0003	Maintenance Type Code Date	20121002	October 02, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents		N/A	52	53
0069	Pre-Existing Disability Code		N/A	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date	20121001	October 01, 2012	72	79
0057	Employee Date of Death		N/A	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week		N/A	101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number		N/A	111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code		N/A	<u> </u>	
	Permanent Impairment Percentage		N/A		
	Death/Dependent/Payee Relationships				
	Dependent/Payee Relationship Code				
	End A49 Elements				

MDQ = *Medically Determined/Qualified to Return to Work*

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code		N/A	4	5
	Maintenance Type Correction Code Date		N/A	6	13
0298	Date Claim Administrator Had Knowledge of Lost		N/A	14	21
0186	Jurisdiction Branch Office Code		N/A	22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level		N/A	342	343
0213	Employee Number of Entitled Exemptions		N/A	344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code		N/A	348	348
0146	Death Result of Injury Code		N/A	349	349
0314	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN		N/A	359	367
	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code		N/A	377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code		N/A	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked		N/A	397	404
0144	Current Date Disability Began		N/A	405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code	R	Released	421	421

eCLAIMS BUSINESS SCENARIOS

	- Suspension, MDQ/RTW, Event 3	Iransaction			
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator	Ν	Without Physical Restrictions	422	422
	Suspension Effective Date	20120930	September 30, 2012	423	430
0199	Full Denial Effective Date		N/A	431	438
0196	Denial Rescission Date		N/A	439	446
0294	Partial Denial Code		N/A	447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits		N/A	467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator		N/A	482	482
0068	Initial Return to Work Date	20121001	October 01, 2012	483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code		N/A	492	493
0273	Employer Paid Salary in Lieu of Compensation			494	494
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time		N/A	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code		N/A	522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	01	1 Occurrence	649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	S1	Suspension, MDQ	654	655
	Gross Weekly Amount	00000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674

S1 – Suspension, MDQ/RTW, Event 3	Transaction Layout
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DN Data Element Name	Data	Description	Beg	End
0211 Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693
0088 Benefit Period Start Date	20120802	August 02, 2012	694	701
0089 Benefit Period Through Date	20120930	September 30, 2012	702	709
0090 Benefit Type Claim Weeks	0008		710	713
0091 Benefit Type Claim Days	0		714	714
0086 Benefit Type Amount Paid	00000560000	\$5600.00	715	725
0192 Benefit Payment Issue Date	20121001	October 01, 2012	726	733
Filler			734	753
Payments				
0222 Payment Reason Code		N/A		
0217 Payee				
0218 Payment Amount				
0219 Payment Covers Period Start Date				
0220 Payment Covers Period Through Date				
0195 Payment Issue Date				
Other Benefits				
0216 Other Benefit Type Code				
0215 Other Benefit Type Amount				
Benefit Adjustments				
0092 Benefit Adjustment Code				
0094 Benefit Adjustment Start Date				
0125 Benefit Adjustment End Date				
0093 Benefit Adjustment Weekly Amount				
Benefit Credits				
0126 Benefit Credit Code				
0127 Benefit Credit Start Date				
0128 Benefit Credit End Date				
0129 Benefit Credit Weekly Amount				
Benefit Redistribution				
0130 Benefit Redistribution Code				
0131 Benefit Redistribution Start Date				
0132 Benefit Redistribution End Date				
0133 Benefit Redistribution Weekly Amount				
Recoveries				
0226 Recovery Code				
0225 Recovery Amount				
Reduced Earnings				
0242 Reduced Earnings Week Number				
0124 Actual Reduced Earnings				
0147 Deemed Reduced Earnings				
Concurrent Employers				
0141 Concurrent Employer Name				
0142 Concurrent Employer Contact Business Phone				
0143 Concurrent Employer Wage				L

eCLAIMS BUSINESS SCENARIOS

S1 – Suspension, MDQ/RTW, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives		1 Occurrence		
0233	Suspension Narrative	CLT MD CLEARED CLT TO RETURN TO WORK ON 10/01/2012		754	803

End R22 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 2-9

Suspension of Benefits by Claim Administrator – MTC 00/IP/S2

(Indemnity suspended – medical non-compliance)

NARRATIVE:

Employee John Doe, from Scenario 2-1, remained out of work.

On **September 19, 2012**, the Claim Administrator received notification that John Doe **failed to attend two** Independent Medical Exams (IMEs) scheduled on August 29, 2012 and September 17, 2012 and did not contact the parties regarding not attending the exams. The Claim Administrator decided to suspend payments for the claimant's failure to attend the exams.

The Claim Administrator reported the suspension of benefits by sending the Suspension (SROI S2) transaction report to the NYSWCB on September 19, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 2-9</u> Event 3: SROI MTC S2 – Suspension, Medical Non-Compliance

eClaims Business Scenarios

<u>S2 -</u>	- Suspension, MNC, Event 3	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	S2	Suspension, MNC	4	5	
0003	Maintenance Type Code Date	20120919	September 19, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents		N/A	52	53	
0069	Pre-Existing Disability Code		N/A	54	54	
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date		N/A	72	79	
0057	Employee Date of Death		N/A	80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
0064	Number of Days Worked Per Week		N/A	101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number		N/A	111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code	I	Indemnity	187	187	
0075	Agreement to Compensate Code	L	With Liability	188	188	
	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
0083	Permanent Impairment Body Part Code		N/A			
	Permanent Impairment Percentage		N/A			
	Death/Dependent/Payee Relationships		1 1/7 1			
0097	Dependent/Payee Relationship Code					
0031	End A49 Elements					

MNC = Medical Non-Compliance

eCLAIMS BUSINESS SCENARIOS

	- Suspension, MNC, Event 3	Transaction L			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code		N/A	4	5
0296	Maintenance Type Correction Code Date		N/A	6	13
0298	Date Claim Administrator Had Knowledge of Lost		N/A	14	21
0186	Jurisdiction Branch Office Code		N/A	22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level		N/A	342	343
0213	Employee Number of Entitled Exemptions		N/A	344	345
0201	Anticipated Wage Loss Indicator		N/A	346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code		N/A	348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN		N/A	359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code		N/A	377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code		N/A	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked		N/A	397	404
	Current Date Disability Began		N/A	405	412
	Initial Date Last Day Worked		N/A	413	420
	Return To Work Type Code			421	421

eClaims Business Scenarios

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S2 -	- Suspension, MNC, Event 3	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator	Ν	Without Physical Restrictions	422	422
0193	Suspension Effective Date	20120919	September 19, 2012	423	430
0199	Full Denial Effective Date		N/A	431	438
0196	Denial Rescission Date		N/A	439	446
0294	Partial Denial Code		N/A	447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits		N/A	467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator		N/A	482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code		N/A	492	493
0273	Employer Paid Salary in Lieu of Compensation			494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time		N/A	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code		N/A	522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
)229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	02	2 Occurrences	649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code	S2	Suspension, MNC	654	655
0174	Gross Weekly Amount	0000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
	Net Weekly Amount	0000070000	\$700.00	675	685

S2 -	- Suspension, MNC, Event 3	Transactior	n Layout		
	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693
8800	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120919	September 19, 2012	702	709
0090	Benefit Type Claim Weeks	0007		710	713
0091	Benefit Type Claim Days	0		714	714
0086	Benefit Type Amount Paid	00000490000	\$4900.00	715	725
0192	Benefit Payment Issue Date	20120919	September 19, 2012	726	733
	Filler			734	753
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
	Deemed Reduced Earnings				
	Concurrent Employers				<u> </u>
0141	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone				

eClaims Business Scenarios

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- Suspension, MNC, Event 3	Transaction La	ayout		
Data Element Name	Data	Description	Beg	End
Denial Reason Codes				
Full Denial Reason Code				
Denial Reasons				
Denial Reason Narrative				
Suspension Narratives		2 Occurrences		
Suspension Narrative	CLT FAILED TO APPEAR FOR IME EXAM ON 09/17/2012. N		754	803
Suspension Narrative	O EXCUSE GIVEN BY CLT FOR NO SHOW.		804	853
	Denial Reason Codes Full Denial Reason Code Denial Reasons Denial Reason Narrative Suspension Narratives Suspension Narrative	Data Element Name Data Denial Reason Codes	Data Element Name Data Description Denial Reason Codes	Data Element NameDataDescriptionBegDenial Reason CodesFull Denial Reason CodeDenial ReasonsDenial Reason NarrativeSuspension Narratives2 OccurrencesSuspension NarrativeCLT FAILED TO APPEAR FOR IME EXAM ON 09/17/2012. N754Suspension Narrative0 EXCUSE GIVEN BY CLT FOR NO804

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 3-1

Employer Paid – MTC 00/EP

(Employer paid wages in lieu of compensation)

NARRATIVE:

Employee John Doe fell from a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and broke his right leg on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident. The employee left work immediately after the injury and **has not returned to work**. Mr. Doe was initially treated and released from the Emergency Room of Albany Memorial Hospital and referred for follow up with a local orthopedic doctor. The employer has **continued to pay Mr. Doe's wages since his injury.** At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury on August 3, 2012** to the Insurer / Claim Administrator.

On August 8, 2012, the Claim Administrator determined that the claim is compensable. The **employer continued to pay Mr. Doe full wages in lieu of compensation**. The employer indicated that they will submit a reimbursement request at a later date to be reimbursed at the statutory rate.

After the Claim Administrator confirmed that the employee will remain disabled beyond the waiting period, the Claim Administrator reported the loss and payment information to the NYS Workers' Compensation Board by sending both the Original First Report of Injury (**FROI 00**) and Employer (**SROI EP**) transaction reports to the NYSWCB on **August 8**, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC EP – Employer Paid

<u>Note</u>: The Benefit Type Code (BTC) used in this scenario is BTC 240 (Employer Paid Unspecified) to indicate the employee is receiving wages in lieu of compensation for an undetermined type of compensation benefits. However, BTC 250 (Employer Paid Temporary Total) could have been used to indicate the receipt of wages specifically in lieu of Temporary Total compensation benefits. Also, BTC 270 (Employer Paid Temporary Partial) is available for reporting wages paid in lieu of Temporary Partial compensation benefits, if applicable.

See NYS Workers' Compensation Law §110(2), §25(1)(c)

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	148 Data Elements					
0001	Transaction Set ID	148	First Report	1	3	
0002	Maintenance Type Code	00	Original	4	5	
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0005	Jurisdiction Claim Number			16	40	
0006	Insurer FEIN	141456789		41	49	
	Filler			50	178	
0012	Claim Administrator City	LATHAM		179	193	
	Claim Administrator State Code	NY		194	195	
0014	Claim Administrator Postal Code	12110		196	204	
0015	Claim Administrator Claim Number	TW0892356		205	229	
0016	Employer FEIN	089898765		230	238	
	Filler			239	358	
0021	Employer Physical City	ALBANY		359	373	
	Employer Physical State Code	NY		374	375	
	Employer Physical Postal Code	12241		376	384	
	Filler			385	385	
0025	Industry Code	236116	Multifamily housing Construction	386	391	
	Filler			392	401	
0027	Insured Location Identifier	JS51	Job Site 51	402	416	
0028	Policy Number Identifier	COA65432		417	434	
	Filler			435	446	
0029	Policy Effective Date	20120101	January 1, 2012	447	454	
0030	Policy Expiration Date	20130101	January 1, 2013	455	462	
0031	Date of Injury	20120801	August 1, 2012	463	470	
	Time of Injury	1300	1:00 PM	471	474	
	Accident Site Postal Code	12204		475	483	
	Filler			484	484	
	Nature of Injury Code	28	Fracture	485	486	
0036	Part of Body Injured Code	54	Lower Leg	487	488	
	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490	
	Filler			491	640	
0039	Initial Treatment Code	3	Emergency room	641	642	
	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650	
	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658	
	Filler			659	697	
0044	Employee First Name	JOHN		698	712	
	Filler			713	773	
0048	Employee Mailing City	SCHENECTADY		774	788	
	Employee Mailing State Code	NY		789	790	

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	Μ	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
0063	Wage Period Code	01	Weekly	893	894
0064	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked			896	903
0066	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
	End 148	8 Elements			
0001		a Elements		[-
	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
	Employee ID Type Qualifier	A	ID Assigned by Jurisdiction	231	231
	Employee ID Assigned by Jurisdiction	771101JDOE		232	246
0154					
	Employee Last Name Suffix			247	250
0255				247 251	250 251
0255 0150	Employee Last Name Suffix Employee Authorization to Release Medical				

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
0314	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
	Employer Contact Name	JANE SMITH		921	960
	Employer ID Assigned by Jurisdiction			961	975

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	I	Indemnity	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation	Y	Yes	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				-
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS STEPPING OFF A ROOF AND LOST HIS FOOTI		1601	1650
0038	Accident/Injury Description Narrative	NG AND FELL FROM A LADDER INJURING RT LEG		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction			
DN	Data Element Name	Data	Description	Beg	End
	Managed Care Organizations				
0207	Managed Care Organization Code				
0209	Managed Care Organization Name				
0208	Managed Care Organization Identification Number				
	Witnesses		1 Occurrence		
0238	Witness Name	JANE SMITH		1701	1740
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755
	Filler			1756	1775
	End R21 Elements				

EP -	– Employer Paid, Event 2	Transactic	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	EP	Employer Paid	4	5
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code		N/A	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0091	Dependent/Payee Relationship Code End A49 Elements				

eCLAIMS BUSINESS SCENARIOS

EP -	- Employer Paid, Event 2	Transaction l	Layout		
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	A	ID Assigned by Jurisdiction	243	243
0154	Employee ID Assigned by Jurisdiction	771101JDOE		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code		N/A	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code			421	421

eClaims Business Scenarios

EP –	Employer Paid, Event 2	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation	Y	Yes	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
-	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	240	Employer Paid (Unspecified)	651	653
0002	Maintenance Type Code	EP	Employer Paid	654	655
0174	Gross Weekly Amount			656	666
0175	Gross Weekly Amount Effective Date			667	674
	Net Weekly Amount			675	685

	- Employer Paid, Event 2	Transactio		Dear	F
	Data Element Name	Data	Description	Beg	End
	Net Weekly Amount Effective Date		A (00, 0040	686	693
	Benefit Period Start Date	20120802	August 02, 2012	694	701
	Benefit Period Through Date	20120808	August 08, 2012	702	709
	Benefit Type Claim Weeks			710	713
	Benefit Type Claim Days			714	714
	Benefit Type Amount Paid			715	725
0192	Benefit Payment Issue Date			726	733
	Filler			734	753
	Payments		N/A		
0222	Payment Reason Code				
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
	Benefit Adjustment End Date				
	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
	Benefit Credit End Date				
	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
	Benefit Redistribution Start Date				
	Benefit Redistribution End Date				
	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
	Recovery Amount				
0220	Reduced Earnings				
02/2	Reduced Earnings Week Number				
	Actual Reduced Earnings				
	Deemed Reduced Earnings				
0147					
01.4.4	Concurrent Employers				
	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				l

eCLAIMS BUSINESS SCENARIOS

EP ·	– Employer Paid, Event 2	Transacti	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End		
	Denial Reason Codes						
0198	Full Denial Reason Code						
	Denial Reasons						
0197	Denial Reason Narrative						
	Suspension Narratives						
0233	Suspension Narrative						
	End R22 Elements						

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 3-2

Employer Paid / Claim Administrator Makes Initial Payment - MTC 00/EP/IP

(Claim Administrator makes initial payment after employer paid)

NARRATIVE:

Employee John Doe, from Scenario 3-1, remained out of work.

On August 27, 2012, the employer reported to the Claim Administrator that Mr. Doe had exhausted his accruals as of August 22, 2012 and was removed from the payroll effective August 23, 2012. The Claim Administrator issued a check on August 29, 2012 to the injured employee, for Temporary Total Disability Benefits, for the period August 23, 2012 through August 29, 2012 and continuing.

The Claim Administrator reported the initial payment information to the NYS Workers' Compensation Board by sending Initial Payment (**SROI IP**) transaction reports to the NYSWCB on **August 29, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 3-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC EP – Employer Paid

<u>Scenario 3-2</u> Event 3: SROI MTC IP – Initial Payment

<u>Note</u>: The Benefit Type Code (BTC) used in this scenario is BTC 240 (Employer Paid Unspecified) to indicate the employee is receiving wages in lieu of compensation for an undetermined type of compensation benefits. However, BTC 250 (Employer Paid Temporary Total) could have been used to indicate the receipt of wages specifically in lieu of Temporary Total compensation benefits. Also, BTC 270 (Employer Paid Temporary Partial) is available for reporting wages paid in lieu of Temporary Partial compensation benefits, if applicable.

See NYS Workers' Compensation Law §110(2), §25(1)(c)

IP –	- Initial Payment, Event 3 Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	IP	Initial Payment	4	5	
0003	Maintenance Type Code Date	20120829	August 29, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents			52	53	
0069	Pre-Existing Disability Code	N	No	54	54	
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date			72	79	
0057	Employee Date of Death			80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
0064	Number of Days Worked Per Week	5		101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number			111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code	I	Indemnity	187	187	
	Agreement to Compensate Code	L	With Liability	188	188	
	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
0083	Permanent Impairment Body Part Code					
	Permanent Impairment Percentage					
	Death/Dependent/Payee Relationships					
0097	Dependent/Payee Relationship Code					
	End A49 Elements					

eClaims Business Scenarios

IP –	Initial Payment, Event 3	Transaction L			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	A	ID Assigned by Jurisdiction	243	243
0154	Employee ID Assigned by Jurisdiction	771101JDOE		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
		20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked			413	420
0189	Return To Work Type Code			421	421

IP –	Initial Payment, Event 3	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	01	1 Occurrence	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments				I
	Benefits		2 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	IP	Initial Payment	654	655
	Gross Weekly Amount	0000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
	Net Weekly Amount	0000070000	\$700.00	675	685
	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693

<u> </u>	Initial Payment, Event 3	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
8800	Benefit Period Start Date	20120823	August 23, 2012	694	701
0089	Benefit Period Through Date	20120829	August 29, 2012	702	709
0090	Benefit Type Claim Weeks	1		710	713
0091	Benefit Type Claim Days	0		714	714
0086	Benefit Type Amount Paid	0000070000	\$700.00	715	725
0192	Benefit Payment Issue Date	20120829	August 29, 2012	726	733
	Filler			734	753
0085	Benefit Type Code	240	Employer Paid (Unspecified)	754	756
0002	Maintenance Type Code			757	758
0174	Gross Weekly Amount			759	769
0175	Gross Weekly Amount Effective Date			770	777
0087	Net Weekly Amount			778	788
0211	Net Weekly Amount Effective Date			789	796
0088	Benefit Period Start Date	20120802	August 02, 2012	797	804
0089	Benefit Period Through Date	20120822	August 22, 2012	805	812
0090	Benefit Type Claim Weeks			813	816
0091	Benefit Type Claim Days			817	817
0086	Benefit Type Amount Paid			818	828
0192	Benefit Payment Issue Date			829	836
	Filler			837	856
	Payments				
0222	Payment Reason Code	050	Temporary Total	857	859
0217	Payee	JOHN DOE		860	899
0218	Payment Amount	00000700000	\$700.00	900	910
0219	Payment Covers Period Start Date	20120823	August 23, 2012	911	918
0220	Payment Covers Period Through Date	20120829	August 29, 2012	919	926
0195	Payment Issue Date	20120829	August 29, 2012	927	934
	Filler			935	954
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				<u> </u>
	Benefit Credit Code				<u> </u>
	Benefit Credit Start Date				
	Benefit Credit End Date				<u> </u>
0129	Benefit Credit Weekly Amount				

P – I	nitial Payment, Event 3	Transacti	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 3-3

Employer Reimbursement Directed by Jurisdiction – MTC PY

(Reclassification of Benefit Type and reporting of Employer Reimbursement Paid)

NARRATIVE:

Employee John Doe, from Scenario 3-1, remained out of work.

On September 27, 2012, the Claim Administrator received notification that John Doe's doctor gave him a full duty release to return to work on October 1, 2012 with no restrictions. The claimant returned to work on that date with the same employer.

The Claim Administrator reported the suspension of benefits by sending the Suspension (**SROI S1**) transaction report to the NYSWCB on **October 4, 2012**. The Employer filed a Reimbursement Request (C-107 Paper Form) with the Board requesting reimbursement for wages paid while the claimant was out of work.

On November 9, 2012, the Workers' Compensation Board issued an Administrative Decision establishing the case and directing the reimbursement to the employer at a Temporary Total Rate for the claimant's period of lost time. The Claim Administrator issued payment per the Notice of Decision and reported the payment information to the NYS Workers' Compensation Board by sending the Payment Report (SROI PY) transaction reports to the NYSWCB on November 14, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 3-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC EP – Employer Paid

<u>Scenario 3-3</u> Event 3: SROI MTC S1 – Suspension, Return to Work or Medically Determined/Qualified Event 4: SROI MTC PY – Payment Report (Includes Reclassification of Benefit)

<u>Note</u>: The optional reporting of Lump Sum Payment/Settlement Code (DN0293) = "AW" Award is shown in this scenario. The use of Lump Sum Payment/Settlement Code (DN0293) is only required for BTC 5xx reporting, however, will be accepted on other SROI-PY transactions if submitted.

133

The Board will also accept the BTC 250 and 270 in lieu of 050 and 070 for the period in which the employer paid.

See NYS Workers' Compensation Law §110(2), §25(1)(c)

eCLAIMS BUSINESS SCENARIOS

S1 – Suspension, MDQ/RTW, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	S1	Suspension, MDQ	4	5
0003	Maintenance Type Code Date	20121004	October 04, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents		N/A	52	53
0069	Pre-Existing Disability Code		N/A	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death		N/A	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week		N/A	101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number		N/A	111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code			188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code		N/A		
	Permanent Impairment Percentage		N/A		
	Death/Dependent/Payee Relationships				
	Dependent/Payee Relationship Code				
	End A49 Elements			I	I

MDQ = *Medically Determined/Qualified to Return to Work*

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code		N/A	4	5
0296	Maintenance Type Correction Code Date		N/A	6	13
0298	Date Claim Administrator Had Knowledge of Lost		N/A	14	21
0186	Jurisdiction Branch Office Code		N/A	22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	771101JDOE		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level		N/A	342	343
0213	Employee Number of Entitled Exemptions		N/A	344	345
	Anticipated Wage Loss Indicator			346	346
	Reduced Benefit Amount Code			347	347
	Employee Tax Filing Status Code		N/A	348	348
	Death Result of Injury Code		N/A	349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN		N/A	359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code		N/A	377	385
	Return To Work With Same Employer Indicator			386	386
	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
	Non-Consecutive Period Code		N/A	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked		N/A	397	404
0144	Current Date Disability Began		N/A	405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code	A	Actual	421	421

eCLAIMS BUSINESS SCENARIOS

	- SUSPENSION, MDQ/RIW, EVENT 3 Data Element Name	I ransaction	Description	Beg	End
	Physical Restrictions Indicator		Without Physical	422	422
0224		Ν	Restrictions	722	722
0193	Suspension Effective Date	20120930	September 30, 2012	423	430
	Full Denial Effective Date		N/A	431	438
0196	Denial Rescission Date		N/A	439	446
0294	Partial Denial Code		N/A	447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
	Wage Effective Date		N/A	459	466
	Discontinued Fringe Benefits		N/A	467	477
	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator		N/A	482	482
	Initial Return to Work Date	20121001	October 01, 2012	483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code		N/A	492	493
	Employer Paid Salary in Lieu of Compensation	Y	Yes	494	494
0286	Indicator Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	00000103000	N/A	506	513
	Award/Order Date			500	513
	Claim Administrator Alternate Postal Code			522	530
	Employer Paid Salary Prior to Acquisition Code			531	530
0203			Standard Wark	532	532
0204	Work Week Type Code	S	Standard Work Week	552	552
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	01	1 Occurrence	649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	240	Employer Paid (Unspecified)	651	653
0002	Maintenance Type Code	S1	Suspension, RTW	654	655
	Gross Weekly Amount	<u>-</u> .		656	666
	Gross Weekly Amount Effective Date			667	674

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
0087	Net Weekly Amount			675	685
	Net Weekly Amount Effective Date			686	693
	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089 E	Benefit Period Through Date	20120930	September 30, 2012	702	709
0090 E	Benefit Type Claim Weeks			710	713
0091 E	Benefit Type Claim Days			714	714
0086 E	Benefit Type Amount Paid			715	725
0192 E	Benefit Payment Issue Date			726	733
F	Filler			734	753
l	Payments				
0222 F	Payment Reason Code		N/A		
0217 F	Payee				
0218 F	Payment Amount				
0219 F	Payment Covers Period Start Date				
0220 F	Payment Covers Period Through Date				
0195 F	Payment Issue Date				
C	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
L	Benefit Adjustments				
0092 E	Benefit Adjustment Code				
0094 E	Benefit Adjustment Start Date				
0125 E	Benefit Adjustment End Date				
0093 E	Benefit Adjustment Weekly Amount				
L	Benefit Credits				
0126 E	Benefit Credit Code				
0127 E	Benefit Credit Start Date				
0128 E	Benefit Credit End Date				
0129 E	Benefit Credit Weekly Amount				
L	Benefit Redistribution				
0130 E	Benefit Redistribution Code				
0131 E	Benefit Redistribution Start Date				
0132 E	Benefit Redistribution End Date				
0133 E	Benefit Redistribution Weekly Amount				
1	Recoveries				
0226 F	Recovery Code				
0225 F	Recovery Amount				
I	Reduced Earnings				
0242 F	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147 [Deemed Reduced Earnings				
(Concurrent Employers				
0141 (Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				

eCLAIMS BUSINESS SCENARIOS

S1 – Suspension, MDQ/RTW, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives		1 Occurrence		
0233	Suspension Narrative	CLT RETURNED TO WORK ON 10/01/2012		754	803

End R22 Elements

<u> </u>	– Payment Report, Event 4	Transactio	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	PY	Payment Report	4	5
0003	Maintenance Type Code Date	20131024	October 24, 2013	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage			1	1
	Death/Dependent/Payee Relationships				
	Dependent/Payee Relationship Code				
5001	End A49 Elements				

eClaims Business Scenarios

<u> PY -</u>	– Payment Report, Event 4	Transaction L	ayout		
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
0139	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code	R	Reclassification of Benefit	347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
	Non-Consecutive Period Code		_	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	Initial Date Last Day Worked			413	420
	Return To Work Type Code	A	Actual	421	421

PY-	– Payment Report, Event 4	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator	N	Without Physical Restrictions	422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date	20121001	October 01, 2012	483	490
	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code	AW	Award	492	493
0273	Employer Paid Salary in Lieu of Compensation	Y	Yes	494	494
	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
	Award/Order Date	20120302	November 09, 2012	500	513
	Claim Administrator Alternate Postal Code	20121109			
				522 531	530 531
	Employer Paid Salary Prior to Acquisition Code Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	2 Occurrences	630	631
	Number of Payments	01	1 Occurrence	632	633
	Number of Other Benefits	00		634	635
	Number of Benefit ACR	000		636	638
	Number of Recoveries	00		639	640
	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
5201	Variable Segments			0-0	500
	Benefits		1 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	PY	Payment Report	654	655
	Gross Weekly Amount	00000070000	\$700.00	656	666
0174					
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674

PY-	– Payment Report, Event 4	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120930	September 30, 2012	702	709
0090	Benefit Type Claim Weeks	0008		710	713
0091	Benefit Type Claim Days	2		714	714
0086	Benefit Type Amount Paid	00000588000	\$5880.00	715	725
0192	Benefit Payment Issue Date	20121114	November 14, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	050	Temporary Total	857	859
0217	Payee	GREAT ROOFING INC.		860	899
0218	Payment Amount	00000588000	\$5880.00	900	910
0219	Payment Covers Period Start Date	20120802	August 02, 2012	911	918
0220	Payment Covers Period Through Date	20120930	September 30, 2012	919	926
0195	Payment Issue Date	20121114	November 14, 2012	927	934
	Filler			935	954
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				<u> </u>
	Benefit Adjustments				<u> </u>
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				

PY-	PY – Payment Report, Event 4 Transaction Layout						
DN	Data Element Name	Data	Description	Beg	End		
	Benefit Credits						
0126	Benefit Credit Code						
0127	Benefit Credit Start Date						
0128	Benefit Credit End Date						
0129	Benefit Credit Weekly Amount						
	Benefit Redistribution						
0130	Benefit Redistribution Code						
0131	Benefit Redistribution Start Date						
0132	Benefit Redistribution End Date						
0133	Benefit Redistribution Weekly Amount						
	Recoveries						
0226	Recovery Code						
0225	Recovery Amount						
	Reduced Earnings						
0242	Reduced Earnings Week Number						
0124	Actual Reduced Earnings						
0147	Deemed Reduced Earnings						
	Concurrent Employers						
0141	Concurrent Employer Name						
	Concurrent Employer Contact Business Phone						
0143	Concurrent Employer Wage						
	Denial Reason Codes						
0198	Full Denial Reason Code						
	Denial Reasons						
0197	Denial Reason Narrative						
	Suspension Narratives						
0233	Suspension Narrative						
	End R22 Elements						

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 3-4

Employer Reimbursement Directed by Jurisdiction – MTC PY

(Payments to Claimant for Indemnity Benefits after Employer ceased Paying Wages, Reclassification of Benefit Type and reporting of Employer Reimbursement Paid)

NARRATIVE:

Employee John Doe, from Scenario 3-2, remained out of work.

On September 27, 2012, the Claim Administrator received notification that John Doe's doctor gave him a full duty release to return to work on October 1, 2012 with no restrictions. The claimant returned to work on that date with the same employer. The Claim Administrator mailed John Doe his final indemnity check on October 2, 2012.

The Claim Administrator reported the suspension of benefits by sending the Suspension (**SROI S1**) transaction report to the NYSWCB on **October 4, 2012**. The Employer filed a Reimbursement Request (C-107 Paper Form) with the Board requesting reimbursement for wages paid while the claimant was out of work.

On **November 9, 2012**, the Workers' Compensation Board issued an Administrative Decision establishing the case and directing the reimbursement to the employer at a Temporary Total Rate for the claimant's lost time of August 2nd through 23rd during which the Employer paid wages. The Claim Administrator issued payment per the Notice of Decision and reported the payment information to the NYS Workers' Compensation Board by sending the Payment Report (**SROI PY**) transaction reports to the NYSWCB on **November 14, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 3-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC EP – Employer Paid

<u>Scenario 3-2</u> Event 3: SROI MTC IP – Initial Payment

<u>Scenario 3-4</u> Event 3: SROI MTC S1 – Suspension, Return to Work or Medically Determined/Qualified Event 4: SROI MTC PY – Payment Report (Includes Reclassification of Benefit)

<u>Note</u>: The optional reporting of Lump Sum Payment/Settlement Code (DN0293) = "AW" Award is shown in this scenario. The use of Lump Sum Payment/Settlement Code (DN0293) is only required for BTC 5xx reporting, however, will be accepted on other SROI-PY transactions if submitted.

The Board will also accept the BTC 250 and 270 in lieu of 050 and 070 for the period in which the employer paid.

See NYS Workers' Compensation Law §110(2), §25(1)(c)

eCLAIMS BUSINESS SCENARIOS

S1 – Suspension, MDQ/RTW, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	S1	Suspension, MDQ	4	5
0003	Maintenance Type Code Date	20121004	October 04, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents		N/A	52	53
0069	Pre-Existing Disability Code		N/A	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death		N/A	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week		N/A	101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number		N/A	111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code			188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters			•	
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code		N/A		
	Permanent Impairment Percentage		N/A		
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements			1	1

MDQ = *Medically Determined/Qualified to Return to Work*

eCLAIMS BUSINESS SCENARIOS

S1 – Suspension, MDQ/RTW, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements			-	
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code		N/A	4	5
	Maintenance Type Correction Code Date		N/A	6	13
0298	Date Claim Administrator Had Knowledge of Lost		N/A	14	21
0186	Jurisdiction Branch Office Code		N/A	22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	771101JDOE		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level		N/A	342	343
0213	Employee Number of Entitled Exemptions		N/A	344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code		N/A	348	348
	Death Result of Injury Code		N/A	349	349
0314	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN		N/A	359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code		N/A	377	385
	Return To Work With Same Employer Indicator			386	386
	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
	Non-Consecutive Period Code		N/A	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked		N/A	397	404
0144	Current Date Disability Began		N/A	405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code	A	Actual	421	421

eCLAIMS BUSINESS SCENARIOS

S1 – Suspension, MDQ/RTW, Event 3 Transaction Layout

	- Suspension, MDQ/RTW, Event 3	Iransaction			
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator	Ν	Without Physical Restrictions	422	422
0193	Suspension Effective Date	20120930	September 30, 2012	423	430
0199	Full Denial Effective Date		N/A	431	438
0196	Denial Rescission Date		N/A	439	446
0294	Partial Denial Code		N/A	447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits		N/A	467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator		N/A	482	482
	Initial Return to Work Date	20121001	October 01, 2012	483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code		N/A	492	493
0273	Employer Paid Salary in Lieu of Compensation	Y	Yes	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time		N/A	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code		N/A	522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	1 Occurrence	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	01	1 Occurrence	649	650
	Variable Segments	• •			
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	S1	Suspension, RTW	654	655
	Gross Weekly Amount	00000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674

eCLAIMS BUSINESS SCENARIOS

S1 -	- Suspension, MDQ/RTW, Event 3	3 Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0087	Net Weekly Amount	0000070000	\$700.00	675	685
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693
0088	Benefit Period Start Date	20120823	August 23, 2012	694	701
0089	Benefit Period Through Date	20120930	September 30, 2012	702	709
0090	Benefit Type Claim Weeks	5		710	713
0091	Benefit Type Claim Days	2		714	714
0086	Benefit Type Amount Paid	00000378000	\$3780.00	715	725
0192	Benefit Payment Issue Date	20121002	October 2, 2012	726	733
	Filler			734	753
0085	Benefit Type Code	240	Employer Paid (Unspecified)	754	756
0002	Maintenance Type Code	EP	Employer Paid	757	758
0174	Gross Weekly Amount			759	769
0175	Gross Weekly Amount Effective Date			770	777
0087	Net Weekly Amount			778	788
0211	Net Weekly Amount Effective Date			792	801
0088	Benefit Period Start Date	20120802	August 02, 2012	802	809
0089	Benefit Period Through Date	20120822	August 22, 2012	810	817
0090	Benefit Type Claim Weeks			818	821
0091	Benefit Type Claim Days			822	825
0086	Benefit Type Amount Paid			826	836
0192	Benefit Payment Issue Date			837	844
	Filler				
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				

eCLAIMS BUSINESS SCENARIOS

S1 – Suspension, MDQ/RTW, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives		1 Occurrence		
0233	Suspension Narrative	CLT RETURNED TO WORK ON 10/01/2012		845	894

End R22 Elements

	- Payment Report, Event 4	Transactio		Dem	
DN	Data Element Name	Data	Description	Beg	Ena
	A49 Data Elements				
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	PY	Payment Report	4	5
	Maintenance Type Code Date	20131024	October 24, 2013	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
	Pre-Existing Disability Code	N	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements				

PY-	– Payment Report, Event 4	Transaction L	Layout		
	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
0139	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code	R	Reclassification of Benefit	347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
		20120801	August 01, 2012	387	394
	Non-Consecutive Period Code			395	395
	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	Initial Date Last Day Worked			413	420
	Return To Work Type Code	A	Actual	421	421

PY-	– Payment Report, Event 4	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator	N	Without Physical Restrictions	422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date	20121001	October 01, 2012	483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code	AW	Award	492	493
0273	Employer Paid Salary in Lieu of Compensation	Y	Yes	494	494
	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
	Award/Order Date	20121109	November 09, 2012	514	521
	Claim Administrator Alternate Postal Code			522	530
	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrences	630	631
0283	Number of Payments	01	1 Occurrence	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments			<u> </u>	
	Benefits		1 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	PY	Payment Report	654	655
	Gross Weekly Amount	0000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
	Net Weekly Amount	0000070000	\$700.00	675	685

PY-	– Payment Report, Event 4	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120930	September 30, 2012	702	709
0090	Benefit Type Claim Weeks	0008		710	713
0091	Benefit Type Claim Days	2		714	714
0086	Benefit Type Amount Paid	00000588000	\$5880.00	715	725
0192	Benefit Payment Issue Date	20121114	November 14, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	050	Temporary Total	857	859
0217	Payee	GREAT ROOFING INC.		860	899
0218	Payment Amount	00000210000	\$2100.00	900	910
0219	Payment Covers Period Start Date	20120802	August 02, 2012	911	918
0220	Payment Covers Period Through Date	20120822	August 22, 2012	919	926
0195	Payment Issue Date	20121114	November 14, 2012	927	934
	Filler			935	954
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				

PY-	– Payment Report, Event 4	Transact	ion Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 4-1

Initial Payment of Death Benefits – MTC 00/IP

(Same date of death and accident – with dependents)

NARRATIVE:

Employee John Doe fell from a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and suffered a serious head injury on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Mr. Doe's foreman, Jane Smith, witnessed the accident as well as a bystander Michael Jones. The employee was immediately transported to the Emergency Room of Albany Memorial Hospital and was **pronounced dead on August 1, 2012**. The employee was **paid for the date of the injury**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury and death on August 3, 2012** to the Insurer/Claim Administrator.

The Claim Administrator contacted Mr. Doe's widow, Mary Doe, to verify her relationship and found the decedent had two children. All children are living with Doe's widow. His son Noah is 17 years old and his daughter Savannah is 5 years old. Based on Mr. Doe's wage (\$1,050.00 per week), Doe's widow is entitled to death benefits of \$700.00 per week: 36 2/3% for herself unless she remarries and 30% for the children (if the child is under age 18; or age 23 if attending school full-time in an accredited institution).

On August 17, 2012, the Claim Administrator issued a check for the first installment of death benefits to Mrs. Mary Doe as well as reimbursement of \$3,100 in funeral expenses she incurred. The Claim Administrator reported the loss and initial payment information to the NYS Workers' Compensation Board by sending both the Original First Report of Injury (FROI 00) on August 10, 2012 and Initial Payment (SROI IP) transaction reports to the NYSWCB on August 17, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

NOTES: If death does NOT occur on the SAME day as accident, a FROI-00 needs to be filed for BOTH the accident claim and the death claim (See Scenarios 4-5 & 4-6).

The AFF-1, C-62, C-64, and C-65 are still required for all Death Cases

See NYS Workers' Compensation Law §16, §110(2), §25(1)(c)

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120810	August 10, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury	1300	1:00 PM	471	474
0033	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	28	Fracture	485	486
0036	Part of Body Injured Code	10	Multiple Head Injury	487	488
0037	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
0041	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
0049	Employee Mailing State Code	NY		789	790

00 -	- First Report Event	Transaction L	.ayout		
	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	Μ	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began	20120802	August 02, 2012	822	829
0057	Employee Date of Death	20120801	August 01, 2012	830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
	Wage Period Code	01	Weekly	893	894
	Number of Days Worked Per Week	5		895	895
	Initial Date Last Day Worked	20120801	August 01, 2012	896	903
	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler	-		905	905
0068	Initial Return to Work Date			906	913
		8 Elements			
	R21 Dat	a Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name			43	57
		ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line	INSURANCE			
		INSURANCE		58	97
0010	Claim Administrator Information/Attention Line	INSURANCE COMPANY		58 98	97 147
0010 0011	Claim Administrator Information/Attention Line Claim Administrator Primary Address	INSURANCE COMPANY		58 98 148	97 147 187
0010 0011 0136	Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address	INSURANCE COMPANY	Social Security Number	58 98 148 188	97 147 187 227
0010 0011 0136 0270	Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code	INSURANCE COMPANY PO BOX 12345		58 98 148 188 228	97 147 187 227 230
0010 0011 0136 0270 0042	Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier	INSURANCE COMPANY PO BOX 12345 S		58 98 148 188 228 231	97 147 187 227 230 231
0010 0011 0136 0270 0042 0255	Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN	INSURANCE COMPANY PO BOX 12345 S		58 98 148 188 228 231 232	97 147 187 227 230 231 246
0010 0011 0136 0270 0042 0255 0150	Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN Employee Last Name Suffix Employee Authorization to Release Medical	INSURANCE COMPANY PO BOX 12345 S 324556745		58 98 148 188 228 231 232 247	97 147 187 227 230 231 246 250

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La			
	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code	Y	Yes	406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	s	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
	Employer Contact Name	JANE SMITH		921	960
	Employer ID Assigned by Jurisdiction			961	975

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	ayout		
	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	I	Indemnity	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation	N	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS STEPPING OFF A ROOF AND LOST HIS FOOTI		1601	1650
0038	Accident/Injury Description Narrative	NG AND FELL FROM A LADDER INJURING HEAD		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1701	1740	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755	
	Filler			1756	1775	
	End R21 Elements					

	Initial Payment, Event 2	Transactio		_	
DN	Data Element Name	Data	Description	Beg	Ena
	A49 Data Elements				
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	IP	Initial Payment	4	5
	Maintenance Type Code Date	20120817	August 17, 2012	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
	Employee Number of Dependents	03		52	53
	Pre-Existing Disability Code	N	No	54	54
	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
	Latest Return to Work Status Date			72	79
0057	Employee Date of Death	20120801	August 01, 2012	80	87
	Filler			88	98
	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
	Date of Injury	20120801	August 01, 2012	103	110
	Insured Report Number			111	135
	Claim Administrator Claim Number	TW0892356		136	160
	Jurisdiction Claim Number	G0055555		161	185
	Claim Status Code		N/A	186	186
	Claim Type Code		Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	03		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships		2 000000000		
	Dependent/Payee Relationship Code		3 Occurrences Widow / 1 st Birth	209	210
0097		21	Order		
0097	Dependent/Payee Relationship Code	41	Son / 1 st Birth Order	211	212
0097	Dependent/Payee Relationship Code	42	Daughter / 2 nd Birth Order	213	214

IP –	Initial Payment, Event 2	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
-	Death Result of Injury Code	Y	Yes	349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked	20120801	August 01, 2012	413	420
0189	Return To Work Type Code			421	421

IP –	Initial Payment, Event 2	Transaction	Layout		
	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	N	No		
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	02	2 Occurrences	632	633
0282	Number of Other Benefits	02	2 Occurrences	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	010	Fatal	651	653
0002	Maintenance Type Code	IP	Initial Payment	654	655
0174	Gross Weekly Amount	0000070000	\$700.00	656	666
0175	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
0087	Net Weekly Amount	00000070000	\$700.00	675	685
	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693

<u> IP –</u>	Initial Payment, Event 2	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120817	August 17, 2012	702	709
0090	Benefit Type Claim Weeks	0002		710	713
0091	Benefit Type Claim Days	2		714	714
0086	Benefit Type Amount Paid	00000168000	\$1,680.00	715	725
0192	Benefit Payment Issue Date	20120817	August 17, 2012	726	733
	Filler			734	753
	Payments		2 Occurrences		
0222	Payment Reason Code	010	Fatal	754	756
0217	Payee	MARY DOE		757	796
0218	Payment Amount	00000168000	\$1,680.00	797	807
0219	Payment Covers Period Start Date	20120802	August 02, 2012	808	815
0220	Payment Covers Period Through Date	20120817	August 17, 2012	816	823
0195	Payment Issue Date	20120817	August 17, 2012	824	831
	Filler			832	851
0222	Payment Reason Code	300	Funeral Expenses	852	854
0217	Payee	MARY DOE		855	894
0218	Payment Amount	00000310000	\$3,100.00	895	905
0219	Payment Covers Period Start Date	20120817	August 17, 2012	906	913
0220	Payment Covers Period Through Date	20120817	August 17, 2012	914	921
0195	Payment Issue Date	20120817	August 17, 2012	922	929
	Filler			930	949
	Other Benefits		2 Occurrences		
0216	Other Benefit Type Code	300	Total Funeral Expenses	950	952
0215	Other Benefit Type Amount	00000310000	\$3,100.00	953	963
	Filler			964	983
0216	Other Benefit Type Code	360	Total Hospital Costs	984	986
0215	Other Benefit Type Amount	00002322500	\$23,225.00	987	997
	Filler			998	1017
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
	Benefit Adjustment End Date				
	Benefit Adjustment Weekly Amount				

	Initial Payment, Event 2		tion Layout		1
DN	Data Element Name	Data	Description	Beg	End
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 4-2

Compensable Death with Beneficiary Investigation – MTC 00/CD/IP

(Same date of death and accident – with dependents)

NARRATIVE:

Employee John Doe fell from a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and suffered a serious head injury on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident as well as a bystander Michael Jones. The employee was immediately transported to the Emergency Room of Albany Memorial Hospital and was **pronounced dead on August 1, 2012**. The employee was **paid for the date of the injury**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury and death on August 3, 2012** to the Insurer/Claim Administrator.

The Claim Administrator attempted to contact Mr. Doe's widow, Mary Doe, to verify her relationship but was unable to get in touch with her immediately. The Claim Administrator reported the loss to the NYS Workers' Compensation Board by sending both the Original First Report of Injury (**FROI 00**) and Compensable Death (**SROI CD**) transaction reports to the NYSWCB on **August 8, 2012.**

On **August 14, 2012** the Claim Administrator heard from Mr. Doe's widow and found the decedent had two children. All children are living with Doe's widow. His son, Noah, is 17 years old and his daughter, Savannah, is 5 years old. Based on Mr. Doe's wage (\$1,050.00 per week), Doe's widow is entitled to death benefits of \$700.00 per week: 36 2/3% for herself unless she remarries and 30% for the children (if the child is under age 18; or age 23 if attending school full-time in an accredited institution). Additionally, the Claim Administrator verified and forwarded information to the Board that the widow incurred \$3,100 in funeral expenses related to John Doe's death.

On **August 17, 2012**, the Claim Administrator issued a check for the first installment of death benefits to Mrs. Mary Doe as well as payment for the funeral expenses that the widow had already incurred. The Claim Administrator reported the loss and initial payment information to the NYS Workers' Compensation Board by sending the Initial Payment (**SROI IP**) transaction report to the NYSWCB on **August 17, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 4-1</u> Event 1: FROI MTC 00 – Original First Report

Scenario 4-2 Event 2: SROI MTC CD – Compensable Death Event 3: SROI MTC IP – Initial Payment

NOTES: If death does NOT occur on the SAME day as accident, a FROI-00 must be filed for BOTH the accident claim and the death claim (See Scenarios 4-5 & 4-6).

The AFF-1, C-62, C-64, and C-65 are still required for all Death Cases

eCLAIMS BUSINESS SCENARIOS

	First Report Event	Transaction La		_	_
DN	Data Element Name	Data	Description	Beg	Enc
	148 Data Elements				
	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120810	August 10, 2012	6	13
	Jurisdiction Code	NY		14	15
	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
	Policy Expiration Date	20130101	January 1, 2013	455	462
	Date of Injury	20120801	August 1, 2012	463	470
	Time of Injury	1300	1:00 PM	471	474
	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	28	Fracture	485	486
	Part of Body Injured Code	10	Multiple Head Injury		488
	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
	Employee Mailing State Code	NY		789	790

00 -	- First Report Event	.ayout			
DN	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	Μ	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began	20120802	August 02, 2012	822	829
0057	Employee Date of Death	20120801	August 01, 2012	830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
	Wage Period Code	01	Weekly	893	894
0064	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked			896	903
0066	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
	End 148	8 Elements		1	
	•				
	R21 Dat	a Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date				-
				6	13
0196	Denial Rescission Date				
				6	13
0186	Denial Rescission Date Jurisdiction Branch Office Code	TW0892356		6 14	13 21
0186 0015	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number	TW0892356 141456789		6 14 22	13 21 23
0186 0015 0187	Denial Rescission Date Jurisdiction Branch Office Code			6 14 22 24	13 21 23 48
0186 0015 0187 0188	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN	141456789 ALL AMERICAN INSURANCE		6 14 22 24 49	13 21 23 48 57
0186 0015 0187 0188 0135	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name	141456789 ALL AMERICAN INSURANCE		6 14 22 24 49 58	13 21 23 48 57 97
0186 0015 0187 0188 0135 0010	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line	141456789 ALL AMERICAN INSURANCE COMPANY		6 14 22 24 49 58 98	13 21 23 48 57 97 147
0186 0015 0187 0188 0135 0010 0011	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address	141456789 ALL AMERICAN INSURANCE COMPANY		6 14 22 24 49 58 98 148	13 21 23 48 57 97 147 187
0186 0015 0187 0188 0135 0010 0011 0136	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address	141456789 ALL AMERICAN INSURANCE COMPANY	Social Security Number	6 14 22 24 49 58 98 148 188	13 21 23 48 57 97 147 187 227
0186 0015 0187 0188 0135 0010 0011 0136 0270	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code	141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345		6 14 22 24 49 58 98 148 188 228	13 21 23 48 57 97 147 187 227 230
0186 0015 0187 0188 0135 0010 0011 0136 0270 0042	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier	141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345 S		6 14 22 24 49 58 98 148 188 228 231	13 21 23 48 57 97 147 187 227 230 231
0186 0015 0187 0188 0135 0010 0011 0136 0270 0042 0255	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN	141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345 S		6 14 22 49 58 98 148 188 228 231 232	13 21 23 48 57 97 147 187 227 230 231 246
0186 0015 0187 0188 0135 0010 0011 0136 0270 0042 0255 0150	Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN Employee Last Name Suffix Employee Authorization to Release Medical	141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345 S 324556745		6 14 22 24 49 58 98 148 188 228 231 232 247	13 21 23 48 57 97 147 187 227 230 231 246 250

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
0045	Employee Middle Name/Initial	Т		293	307	
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347	
0047	Employee Mailing Secondary Address			348	387	
0155	Employee Mailing Country Code			388	390	
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405	
0146	Death Result of Injury Code	Y	Yes	406	406	
0290	Type of Loss Code	01	Trauma	407	408	
0228	Return To Work With Same Employer Indicator			409	409	
0189	Return To Work Type Code			410	410	
0224	Physical Restrictions Indicator			411	411	
0314	Insured FEIN	089898765		412	420	
0017	Insured Name	GREAT ROOFING INC.		421	460	
	Insured Type Code	l	Insured	461	461	
0026	Insured Report Number			462	486	
0204	Work Week Type Code	S	Standard Work Week	487	487	
0205	Work Days Scheduled	NSSSSSN		488	494	
0229	Injury Severity Type Code			495	495	
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535	
0185	Insurer Type Code	I	Insurer	536	536	
0292	Insolvent Insurer FEIN			537	545	
0200	Claim Administrator Alternate Postal Code			546	554	
0206	Employee Security ID			555	569	
	Filler			570	577	
0249	Accident Premises Code	E	Employer	578	578	
0118	Accident Site County/Parish	ALBANY		579	598	
0119	Accident Site Location Narrative			599	648	
0120	Accident Site Organization Name			649	698	
0121	Accident Site City	ALBANY		699	713	
0122	Accident Site Street	1234 BROADWAY		714	753	
0123	Accident Site State Code	NY		754	755	
0280	Accident Site Country Code			756	758	
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766	
	Filler			767	767	
0018	Employer Name	GREAT ROOFING INC.		768	807	
0329	Employer UI Number	16-10000		808	822	
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862	
0020	Employer Physical Secondary Address			863	902	
0164	Employer Physical Country Code			903	905	
-	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920	
	Employer Contact Name	JANE SMITH		921	960	
	Employer ID Assigned by Jurisdiction			961	975	

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	ayout		
DN	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	I	Indemnity	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation	N	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				-
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS STEPPING OFF A ROOF AND LOST HIS FOOTI		1601	1650
0038	Accident/Injury Description Narrative	NG AND FELL FROM A LADDER INJURING HEAD		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1701	1740	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755	
	Filler			1756	1775	
	End R21 Elements					

	– Compensable Death, Event 2	Transactio		-	_
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	CD	Compensable Death	4	5
	Maintenance Type Code Date	20120808	August 08, 2012	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death	20120801	August 01, 2012	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
	Insured Report Number			111	135
	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
	Claim Status Code		N/A	186	186
	Claim Type Code	1	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				1
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships			207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
0084	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements	•	· ·		•

	– Compensable Death, Event 2	Transaction			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code	Y	Yes	349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
	Non-Consecutive Period Code		-	395	395
	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	Initial Date Last Day Worked			413	420
	Return To Work Type Code			421	421

eClaims Business Scenarios

<u>CD</u>	– Compensable Death, Event 2	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount			448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation			494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time			506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
	Number of Benefits	00		630	631
0283	Number of Payments	00		632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits				
	Benefit Type Code			651	653
	Maintenance Type Code			654	655
	Gross Weekly Amount			656	666
	Gross Weekly Amount Effective Date			667	674
	Net Weekly Amount			675	685
0211	Net Weekly Amount Effective Date			686	693

eCLAIMS BUSINESS SCENARIOS

DN Data Description Beg 0088 Benefit Period Start Date 694 0089 Benefit Period Through Date 702 0090 Benefit Type Claim Weeks 710 0091 Benefit Type Claim Weeks 711 0091 Benefit Type Claim Weeks 711 0092 Benefit Paynent Sue Date 726 Filler 728 726 PaymentS 726 726 0221 Payment Reason Code 726 0221 Payment Covers Period Start Date 726 0222 Payment Covers Period Through Date 726 0225 Payment Reason Code 727 0226 Payment Covers Period Start Date 722 0218 Payment Covers Period Start Date 721 0219 Payment Covers Period Start Date 722 0219 Payment Covers Period Start Date 722 0219 Payment Covers Period Through Date 721 0195 Payment Covers Period Through Date 7210 0210	CD -	- Compensable Death, Event 2	Transact	ion Layout		
0089 Benefit Period Through Date 702 0090 Benefit Type Claim Weeks 710 0091 Benefit Type Claim Days 714 0086 Benefit Type Amount Paid 715 0192 Benefit Type Amount Paid 715 0192 Benefit Payment Issue Date 726 Filler 734 734 Payments 2022 Payment Reason Code 202 0217 Payee 202 Payment Covers Period Start Date 202 0218 Payment Reason Code 202 2019 Payment Reason Code 202 0219 Payment Reason Code 202 202 Payment Reason Code 202 0218 Payment Reason Code 202 202 Payment Covers Period Start Date 202 0218 Payment Suse Date 202 202 Payment Suse Date 203 0216 Other Benefit Type Code 204 204 204 0215 Other Benefit Type Amount 205 205 205 0216					Beg	End
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0192 Benefit Payment Issue Date 726 Filler 734 Payments 734 0222 Payment Reason Code 734 0217 Payee 734 0217 Payee 734 0217 Payee 734 0218 Payment Amount 734 0220 Payment Covers Period Start Date 734 0217 Payee 734 0218 Payment Amount 734 0219 Payment Covers Period Start Date 734 0210 Payment Covers Period Through Date 734 0135 Payment Tsue Date 734 0216 Other Benefit Type Code 734 0215 Other Benefit Type Amount 734 0215 Other Benefit Adjustments 734 0323 Benefit Adjustment Start Date 734 033 Benefit Adjustment Mate 734 <t< td=""><td>0091</td><td>Benefit Type Claim Days</td><td></td><td></td><td>714</td><td>714</td></t<>	0091	Benefit Type Claim Days			714	714
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0215 Other Benefit Type Amount Image: Constraint of the system of t						
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0092Benefit Adjustment CodeImage: Code Code Code Code Code Code Code Code	0215	Other Benefit Type Amount				
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Benefit Credits Image: Second Sec	0125	Benefit Adjustment End Date				
0126 Benefit Credit Code 0127 Benefit Credit Start Date 0128 Benefit Credit End Date 0129 Benefit Credit Weekly Amount Benefit Redistribution 0130 Benefit Redistribution Code 0131 Benefit Redistribution Start Date 0132 Benefit Redistribution End Date 0133 Benefit Redistribution Weekly Amount 0134 Benefit Redistribution End Date 0135 Benefit Redistribution End Date 0136 Benefit Redistribution Weekly Amount 0137 Benefit Redistribution Weekly Amount 0138 Benefit Redistribution Weekly Amount 0139 Benefit Redistribution Weekly Amount 0130 Benefit Redistribution Weekly Amount 0131 Benefit Redistribution Weekly Amount 0226 Recoveries	0093	Benefit Adjustment Weekly Amount				
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0129 Benefit Credit Weekly Amount Benefit Redistribution 0130 Benefit Redistribution Code 0131 Benefit Redistribution Start Date 0132 Benefit Redistribution End Date 0133 Benefit Redistribution Weekly Amount 0226 Recoveries	0127	Benefit Credit Start Date				
Benefit Redistribution Image: Constraint of the system 0130 Benefit Redistribution Code Image: Constraint of the system 0131 Benefit Redistribution Start Date Image: Constraint of the system 0132 Benefit Redistribution End Date Image: Constraint of the system 0133 Benefit Redistribution Weekly Amount Image: Constraint of the system 0226 Recoveries Image: Constraint of the system	0128	Benefit Credit End Date				
0130 Benefit Redistribution Code 0131 Benefit Redistribution Start Date 0132 Benefit Redistribution End Date 0133 Benefit Redistribution Weekly Amount <i>Recoveries</i> 0226 Recovery Code	0129	Benefit Credit Weekly Amount				
0131 Benefit Redistribution Start Date 0132 Benefit Redistribution End Date 0133 Benefit Redistribution Weekly Amount <i>Recoveries</i> 0226 Recovery Code		Benefit Redistribution				
0132 Benefit Redistribution End Date	0130	Benefit Redistribution Code				
0133 Benefit Redistribution Weekly Amount	0131	Benefit Redistribution Start Date				
Recoveries 0226 Recovery Code	0132	Benefit Redistribution End Date				
0226 Recovery Code	0133	Benefit Redistribution Weekly Amount				
		Recoveries				
0225 Recovery Amount	0226	Recovery Code				
	0225	Recovery Amount				

eCLAIMS BUSINESS SCENARIOS

CD -	- Compensable Death, Event 2	Transacti	ion Layout		
DN	Data Element Name	Data	Description	Beg	End
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
		•			

End R22 Elements

	Initial Payment, Event 3	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	Ena
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	IP	Initial Payment	4	5
0003	Maintenance Type Code Date	20120817	August 17, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents	03		52	53
0069	Pre-Existing Disability Code	N	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death	20120801	August 01, 2012	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	03		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code	21	Widow / 1 st Birth	209	210
0007	Dependent/Payee Relationship Code	44	Order Son / 1 st Birth Order	211	212
0097 0097	Dependent/Payee Relationship Code	41	Daughter / 2 nd Birth	211	212

IP –	Initial Payment, Event 3	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
-	Death Result of Injury Code	Y	Yes	349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked	20120801	August 01, 2012	413	420
0189	Return To Work Type Code			421	421

IP –	Initial Payment, Event 3	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
0293	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation Indicator	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	02	2 Occurrences	632	633
0282	Number of Other Benefits	02	2 Occurrences	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	010	Fatal	651	653
0002	Maintenance Type Code	IP	Initial Payment	654	655
0174	Gross Weekly Amount	0000070000	\$700.00	656	666
0175	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
	Net Weekly Amount	0000070000	\$700.00	675	685
	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693

<u> IP –</u>	Initial Payment, Event 3	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120817	August 17, 2012	702	709
0090	Benefit Type Claim Weeks	0002		710	713
0091	Benefit Type Claim Days	2		714	714
0086	Benefit Type Amount Paid	00000168000	\$1,680.00	715	725
0192	Benefit Payment Issue Date	20120817	August 17, 2012	726	733
	Filler			734	753
	Payments		2 Occurrences		
0222	Payment Reason Code	010	Fatal	754	756
0217	Payee	MARY DOE		757	796
0218	Payment Amount	00000168000	\$1,680.00	797	807
0219	Payment Covers Period Start Date	20120802	August 02, 2012	808	815
0220	Payment Covers Period Through Date	20120817	August 17, 2012	816	823
0195	Payment Issue Date	20120817	August 17, 2012	824	831
	Filler			832	851
0222	Payment Reason Code	300	Funeral Expenses	852	854
0217	Payee	MARY DOE		855	894
0218	Payment Amount	00000310000	\$3,100.00	895	905
0219	Payment Covers Period Start Date	20120817	August 17, 2012	906	913
0220	Payment Covers Period Through Date	20120817	August 17, 2012	914	921
0195	Payment Issue Date	20120817	August 17, 2012	922	929
	Filler			930	949
	Other Benefits		2 Occurrences		
0216	Other Benefit Type Code	300	Total Funeral Expenses	950	952
0215	Other Benefit Type Amount	00000310000	\$3,100.00	953	963
	Filler			964	983
0216	Other Benefit Type Code	360	Total Hospital Costs	984	986
0215	Other Benefit Type Amount	00002322500	\$23,225.00	987	997
	Filler			998	1017
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 4-3

Compensable Death with Beneficiary Investigation / No Dependents - MTC 00/CD/PY

(Same date of death and accident – with NO dependents)

NARRATIVE:

Employee John Doe fell from a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and suffered a serious head injury on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident as well as a bystander Michael Jones. The employee was immediately transported to the Emergency Room of Albany Memorial Hospital and was **pronounced dead on August 1, 2012**. The employee was **paid for the date of the injury**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury and death on August 3, 2012** to the Insurer/Claim Administrator.

The Claim Administrator was advised by Doe's foreman that Doe was single and had NO dependents. The Claim Administrator immediately began attempting to verify this information. The Claim Administrator reported the loss to the NYS Workers' Compensation Board by sending both the Original First Report of Injury (FROI 00) and Compensable Death (SROI CD) transaction reports to the NYSWCB on August 8, 2012.

On **August 14, 2012** the Claim Administrator confirmed with John Doe's surviving mother, Mary Doe, that there are in fact no dependents and she is the only surviving parent. The Claim Administrator immediately notified the NYSWCB of this information. On **August 21, 2012**, the Board issued a Desk Decision regarding John Doe's death. The Notice of Decision awarded \$50,000 to his surviving parent (WCL §16.4b), \$3,000 to the Uninsured Employers Fund (WCL §26-a(2)(e)), and \$2,000 payable to the Vocational Rehabilitation Fund (WCL §15.9). Additionally, the funeral home was still owed \$4,000 for funeral expenses.

On August 23, 2012, the Claim Administrator issued checks per the Notice of Decision, including a check to ABC Funeral Home for \$4,000. The Claim Administrator reported the payment information to the NYS Workers' Compensation Board by sending the Payment Report (SROI PY) transaction report to the NYSWCB on August 23, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 4-3</u> Event 1: FROI MTC 00 – Original First Report See Scenarios 4-1 & 4-2 for examples of FROI-00 submissions on death claims. Event 2: SROI MTC CD – Compensable Death See Scenario 4-2 for example of SROI-CD submission on death claim. Event 3: SROI MTC PY – Payment Report

NOTES: If death does NOT occur on the SAME day as accident, a FROI-00 must be filed for BOTH the accident claim and the death claim (See Scenarios 4-5 & 4-6).

The AFF-1, C-62, C-64, and C-65 are still required for all Death Cases

<u> </u>	– Payment Report, Event 3	Transactio	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	PY	Payment Report	4	5
0003	Maintenance Type Code Date	20121024	October 24, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death	20120801	August 01, 2012	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	02	2 Occurrences	207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
	Dependent/Payee Relationship Code	60	Mother / 0 Order	209	210
	Dependent/Payee Relationship Code		Jurisdiction /	211	212
		80	0 Order		
0097	Dependent/Payee Relationship Code End A49 Elements			213	214

eClaims Business Scenarios

<u> PY -</u>	- Payment Report, Event 3	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
-	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code	Y	Yes	349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
		20120801	August 01, 2012	387	394
	Non-Consecutive Period Code			395	395
	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	Initial Date Last Day Worked			413	420
	Return To Work Type Code			421	421
	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430

PY-	– Payment Report, Event 3	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code	AW	Award	492	493
0273	Employer Paid Salary in Lieu of Compensation	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date	20120821	August 21, 2012	514	521
	Claim Administrator Alternate Postal Code			522	530
	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	04	4 Occurrences	632	633
	Number of Other Benefits	01	1 Occurrences	634	635
0289	Number of Benefit ACR	000		636	638
	Number of Recoveries	00		639	640
	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
5201	Variable Segments			0-+0	000
	Benefits		1 Occurrence		
0085	Zenente	500	Unspecified Lump	651	653
0000	Benefit Type Code	500	Sum Payment		
			Sum Payment		655
0002	Maintenance Type Code	PY		654	655 666
0002 0174	Maintenance Type Code Gross Weekly Amount		Sum Payment	654 656	666
0002 0174 0175	Maintenance Type Code Gross Weekly Amount Gross Weekly Amount Effective Date		Sum Payment	654 656 667	666 674
0002 0174 0175 0087	Maintenance Type Code Gross Weekly Amount		Sum Payment	654 656	666

PY ·	– Payment Report, Event 3	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0089	Benefit Period Through Date	20120823	August 23, 2012	702	709
0090	Benefit Type Claim Weeks		N/A	710	713
0091	Benefit Type Claim Days		N/A	714	714
0086	Benefit Type Amount Paid	0005500000	\$55,000.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
	Payments		4 Occurrences		
0222	Payment Reason Code	500	Unspecified Lump Sum Payment	754	756
0217	Payee	MARY DOE		757	796
0218	Payment Amount	00005000000	\$50,000.00	797	807
0219	Payment Covers Period Start Date	20120823	August 23, 2012	808	815
0220	Payment Covers Period Through Date	20120823	August 23, 2012	816	823
0195	Payment Issue Date	20120823	August 23, 2012	824	831
	Filler			831	851
0222	Payment Reason Code	300	Total Funeral Expenses	852	854
0217	Payee	ABC FUNERAL HOME		855	894
0218	Payment Amount	00000400000	\$4,000.00	895	905
0219	Payment Covers Period Start Date	20120823	August 23, 2012	906	913
0220	Payment Covers Period Through Date	20120823	August 23, 2012	914	921
0195	Payment Issue Date	20120823	August 23, 2012	922	929
	Filler			930	950
0222	Payment Reason Code	500	Unspecified Lump Sum Payment		
0217	Payee	VOCATIONAL REHABILITATION FUND			
	Payment Amount	00000200000	\$2,000.00		
0219	Payment Covers Period Start Date	20120823	August 23, 2012		
0220	Payment Covers Period Through Date	20120823	August 23, 2012		
0195	Payment Issue Date	20120823	August 23, 2012		
	Filler				
0222	Payment Reason Code	500	Unspecified Lump Sum Payment		
0217	Payee	UNINSURED EMPLOYERS FUND			
0218	Payment Amount	0000030000	\$3,000.00		
0219	Payment Covers Period Start Date	20120823	August 23, 2012		
0220	Payment Covers Period Through Date	20120823	August 23, 2012		
0195	Payment Issue Date	20120823	August 23, 2012		
	Filler				_

DN	– Payment Report, Event 3 Data Element Name	Data	Description	Beg	End
211	Other Benefits		1 Occurrences	209	
0216	Other Benefit Type Code	300	Total Funeral Expenses	951	953
0215	Other Benefit Type Amount	0000400000	\$4,000.00	954	964
	Filler			965	984
	Benefit Adjustments				
0092	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
	Benefit Adjustment End Date				
	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 4-4

Change – Dependent Matures – MTC 02

(Same date of death and accident – dependent matures)

NARRATIVE:

The widow and children of John Doe, from Scenario 4-2, continue to receive benefits.

On **December 26, 2012**, the Claim Administrator confirmed that dependent Noah turned 18 years old on **December 24, 2012** and was no longer attending school. The Claim Administrator reported the suspension of Noah's payment to the NYS Workers' Compensation Board by sending the Change of Previous Report (**SROI 02**) transaction report to the NYSWCB on **December 26, 2012**. The transaction report removed Noah as one of the Dependent/Payees.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 4-2</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC CD – Compensable Death Event 3: SROI MTC IP – Initial Payment

Scenario 4-4 Event 4: SROI MTC 02 – Change – Dependent Matures

NOTES: If death does NOT occur on the SAME day as the accident, a FROI-00 needs to be filed for BOTH the accident claim and the death claim (See Scenarios 4-5 & 4-6).

The AFF-1, C-62, C-64, and C-65 are still required for all Death Cases

To Report a change in Dependents where the overall payment will not be changing to the Widow, a SROI 02 should be sent changing the Dependent/Payees and removing the Dependent who has exhausted their benefits.

	Change, Event 4	Transactio	-	-	
	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	02	Change	4	5
0003	Maintenance Type Code Date	20121226	December 26, 2012	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents	03		52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death	20120801	August 01, 2012	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters		·		
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	02		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code	21	Widow / 1 st Birth Order	209	210
0097	Dependent/Payee Relationship Code	41	Daughter / 1 st Birth Order	211	212

eCLAIMS BUSINESS SCENARIOS

02 –	Change, Event 4	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code	Y	Yes	349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked	20120801	August 01, 2012	413	420
0189	Return To Work Type Code			421	421

eClaims Business Scenarios

02 –	Change, Event 4	Transaction	n Layout		
	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation Indicator	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	02	2 Occurrences	632	633
0282	Number of Other Benefits	02	2 Occurrences	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrence		
	Benefit Type Code	010	Fatal	651	653
-	Maintenance Type Code	02	Change	654	655
-	Gross Weekly Amount	00000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
	Net Weekly Amount	00000070000	\$700.00	675	685
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693

eCLAIMS BUSINESS SCENARIOS

02 – Change, Event 4	Transactio	on Layout		
DN Data Element Name	Data	Description	Beg	End
0088 Benefit Period Start Date	20120802	August 02, 2012	694	701
0089 Benefit Period Through Date	20121226	December 26, 2012	702	709
0090 Benefit Type Claim Weeks	0021		710	713
0091 Benefit Type Claim Days	0		714	714
0086 Benefit Type Amount Paid	00001470000	\$14,700.00	715	725
0192 Benefit Payment Issue Date	20121226	December 26, 2012	726	733
Filler			734	753
Payments		0 Occurrences		
0222 Payment Reason Code			754	756
0217 Payee			757	796
0218 Payment Amount			797	807
0219 Payment Covers Period Start Date			808	815
0220 Payment Covers Period Through Date			816	823
0195 Payment Issue Date			824	831
Filler			831	850
0222 Payment Reason Code			851	853
0217 Payee			854	893
0218 Payment Amount			894	904
0219 Payment Covers Period Start Date			905	912
0220 Payment Covers Period Through Date			913	920
0195 Payment Issue Date			921	928
Filler			929	948
Other Benefits		2 Occurrences		
0216 Other Benefit Type Code	300	Total Funeral Expenses	949	951
0215 Other Benefit Type Amount	00000310000	\$3,100.00	952	962
Filler			963	982
0216 Other Benefit Type Code	360	Total Hospital Costs	983	985
0215 Other Benefit Type Amount	00002322500	\$23,225.00	986	996
Filler			997	1016
Benefit Adjustments				
0092 Benefit Adjustment Code				
0094 Benefit Adjustment Start Date				
0125 Benefit Adjustment End Date				
0093 Benefit Adjustment Weekly Amount				

eCLAIMS BUSINESS SCENARIOS

<i>0</i> 2 -	- Change, Event 4	Transact	ion Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 4-5

Initial Payment of Death Benefits - Subsequent Death - MTC 00/IP

(Different date of death and accident – with dependents)

NARRATIVE:

Employee John Doe, from **Scenario 2-1**, had surgery on August 15, 2012 and developed a serious infection in his leg the next day. He was admitted to the Intensive Care Unit for treatment of the infection.

John Doe continued to be treated at the Intensive Care Unit **until August 29, 2012** when he **passed away due to the infection he developed from the surgery**. The Claim Administrator was notified on **August 30, 2012** by Doe's widow of his death. The Claim Administrator verified her relationship and found the decedent had two children. All children are living with Doe's widow. His son, Noah, is 16 years old and his daughter, Savannah, is 5 years old. Based on Mr. Doe's wage (\$1,050.00 per week), Doe's widow is entitled to death benefits of \$700.00 per week: 36 2/3% for herself unless she remarries and 30% for the children (if the child is under age 18; or age 23 if attending school full-time in an accredited institution). Additionally, the Claim Administrator verified and forwarded information to the Board that the widow incurred \$3,100 in funeral expenses related to John Doe's death.

The Claim Administrator, **for the date of accident August 1, 2012**, reported the suspension of benefits and death information to the NYS Workers' Compensation Board by sending Claimant Death (**SROI S4**) transaction reports to the NYSWCB on **August 30, 2012**. Per the DN Reporting Requirements Specific to NYS, Death Result of Injury (DN0146) was reported as "N" on the original claim.

On **September 6, 2012**, the Claim Administrator issued a check for the first installment of death benefits to Mrs. Mary Doe as well as reimbursement of \$3,100 for funeral expenses she incurred. The Claim Administrator reported the loss and initial payment information to the NYS Workers' Compensation Board by sending both the Original First Report of Injury (**FROI 00**) and Initial Payment (**SROI IP**) transaction reports to the NYSWCB on **September 6, 2012**. The Claim Administrator **utilizes August 29, 2012 as the date of accident/death** on the new submissions.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 4-5</u> Event 3: SROI MTC S4 – Suspension, Claimant Death --- New Date of Accident / Death Starts Here ---Event 4: FROI MTC 00 – Original First Report (for subsequent death) Event 5: SROI MTC IP – Initial Payment

As the Original Date of Accident is on or after January 1, 2008:

On the new FROI 00, the Claim Administrator would enter the dates for DN0040 (Date Employer Had Knowledge of Injury), DN0041 (Date Claim Administrator Had Knowledge of Injury), and DN0281 (Date Employer Had Knowledge of Date of Disability) as the date of knowledge of the new death claim.

NOTE: The AFF-1, C-62, C-64, and C-65 are still required for all Death Cases

eCLAIMS BUSINESS SCENARIOS

- 40	- Suspension, Clt Death, Event 3	Transactio	псауби		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	S4	Suspension, Claimant Death	4	5
0003	Maintenance Type Code Date	20120830	August 30, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents		N/A	52	53
0069	Pre-Existing Disability Code		N/A	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death	20120829	August 29, 2012	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week		N/A	101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number		N/A	111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code		N/A		
	Permanent Impairment Percentage		N/A		
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements				

eCLAIMS BUSINESS SCENARIOS

S4 – Suspension, Clt Death, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code		N/A	4	5
	Maintenance Type Correction Code Date		N/A	6	13
	Date Claim Administrator Had Knowledge of Lost		N/A	14	21
0186	Jurisdiction Branch Office Code		N/A	22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level		N/A	342	343
0213	Employee Number of Entitled Exemptions		N/A	344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code		N/A	348	348
0146	Death Result of Injury Code	Ν	No	349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN		N/A	359	367
	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code		N/A	377	385
	Return To Work With Same Employer Indicator			386	386
	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code		N/A	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked		N/A	397	404
0144	Current Date Disability Began		N/A	405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code			421	421

eCLAIMS BUSINESS SCENARIOS

S4 – Suspension, Clt Death, Event 3 Transaction Layout

	- Suspension, Clt Death, Event 3	I ransaction		Dam	F to al
	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date	20120829	August 29, 2012	423	430
0199	Full Denial Effective Date		N/A	431	438
0196	Denial Rescission Date		N/A	439	446
0294	Partial Denial Code		N/A	447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits		N/A	467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator		N/A	482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
0293	Lump Sum Payment/Settlement Code		N/A	492	493
	Employer Paid Salary in Lieu of Compensation Indicator			494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time		N/A	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code		N/A	522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	02	2 Occurrences	649	650
	Variable Segments	-			I
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	S4	Suspension, Claimant Death	654	655
0174	Gross Weekly Amount	00000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674

<u>S4</u> -	- Suspension, Clt Death, Event 3	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
0087	Net Weekly Amount	0000070000	\$700.00	675	685	
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693	
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701	
0089	Benefit Period Through Date	20120829	August 29, 2012	702	709	
0090	Benefit Type Claim Weeks	0004		710	713	
0091	Benefit Type Claim Days	0		714	714	
0086	Benefit Type Amount Paid	00000280000	\$2800.00	715	725	
0192	Benefit Payment Issue Date	20120829	August 29, 2012	726	733	
	Filler			734	753	
	Payments					
0222	Payment Reason Code		N/A			
0217	Payee					
0218	Payment Amount					
0219	Payment Covers Period Start Date					
0220	Payment Covers Period Through Date					
0195	Payment Issue Date					
	Other Benefits					
0216	Other Benefit Type Code					
0215	Other Benefit Type Amount					
	Benefit Adjustments					
	Benefit Adjustment Code					
	Benefit Adjustment Start Date					
	Benefit Adjustment End Date					
0093	Benefit Adjustment Weekly Amount					
	Benefit Credits					
	Benefit Credit Code					
	Benefit Credit Start Date					
	Benefit Credit End Date					
0129	Benefit Credit Weekly Amount					
	Benefit Redistribution					
	Benefit Redistribution Code					
	Benefit Redistribution Start Date					
	Benefit Redistribution End Date					
0133	Benefit Redistribution Weekly Amount			-		
	Recoveries					
	Recovery Code					
0225	Recovery Amount					
	Reduced Earnings			-		
	Reduced Earnings Week Number	_				
	Actual Reduced Earnings					
0147	Deemed Reduced Earnings				ļ	
	Concurrent Employers				ļ	
	Concurrent Employer Name				ļ	
	Concurrent Employer Contact Business Phone				ļ	
0143	Concurrent Employer Wage				ĺ	

eClaims Business Scenarios

S4 – Suspension, Clt Death, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End	
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives		2 Occurrences			
0233	Suspension Narrative	CLT SUBSEQUENTLY PASSED AWAY 8/29/12 AS A RESULT O		754	803	
0233	Suspension Narrative	F INJURY. WILL BE FILING NEW CLAIM.		804	853	

End R22 Elements

00 -	- First Report, Event 4	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120906	September 6, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120829	August 29, 2012	463	470
0032	Time of Injury	1300	1:00 PM	471	474
0033	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	28	Fracture	485	486
	Part of Body Injured Code	10	Multiple Head Injury	487	488
0037	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120830	August 30, 2012	643	650
0041	Date Claim Administrator Had Knowledge of the Injury	20120830	August 30, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
	Employee Mailing State Code	NY		789	790

00 -	- First Report, Event 4	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began	20120829	August 29, 2012	822	829
0057	Employee Date of Death	20120829	August 29, 2012	830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
	Wage Period Code	01	Weekly	893	894
	Number of Days Worked Per Week	5		895	895
	Initial Date Last Day Worked	20120830	August 30, 2012	896	903
	Full Wages Paid for Date of Injury Indicator	N	No	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
		B Elements			
	R21 Data	a Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
0270	Employee ID Type Qualifier	S	Social Security Number	231	231
0042	Employee SSN	324556745		232	246
0255	Employee Last Name Suffix			247	250
0450	Employee Authorization to Release Medical			251	251
0150	Records Indicator				
				252	252

00 -	- First Report, Event 4	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code	Y	Yes	406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	s	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120830	August 30, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
-	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
	Employer Contact Name	JANE SMITH		921	960
-	Employer ID Assigned by Jurisdiction			961	975

	- First Report, Event 4	Transaction Lay	/out	-	
DN	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code		Indemnity	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation	N	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	01	1 Occurrence	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
	Number of Witnesses	00		1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		1 Occurrence		
0038	Accident/Injury Description Narrative	MR. DOE DIED AS A RESULT OF 8/1/12 INJURY.		1601	1650
0038	Accident/Injury Description Narrative				
	Full Denial Reason Codes				1
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

eCLAIMS BUSINESS SCENARIOS

00 – First Report, Event 4		Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses					
0238	Witness Name					
0237	Witness Business Phone Number					

End R21 Elements

eClaims Business Scenarios

	- Initial Payment, Event 5 Transaction Layout					
DN	Data Element Name	Data	Description	Beg	Enc	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	IP	Initial Payment	4	5	
0003	Maintenance Type Code Date	20120906	September 06, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents	03		52	53	
0069	Pre-Existing Disability Code	N	No	54	54	
	Initial Date Disability Began	20120830	August 30, 2012	55	62	
	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date			72	79	
	Employee Date of Death	20120829	August 29, 2012	80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
	Number of Days Worked Per Week	5		101	101	
	Filler	•		102	102	
0031	Date of Injury	20120829	August 29, 2012	103	110	
	Insured Report Number	20120020	/ loguet _e, _e ! _	111	135	
	Claim Administrator Claim Number	TW0892356		136	160	
	Jurisdiction Claim Number	G0055555		161	185	
	Claim Status Code	0000000	N/A	186	186	
	Claim Type Code	1	Indemnity	187	187	
	Agreement to Compensate Code	I	With Liability	188	188	
0076	Date Claim Administrator Notified of Employee Representation	-		189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	03		207	208	
	Variable Segments					
	Permanent Impairments					
0083	Permanent Impairment Body Part Code					
	Permanent Impairment Percentage					
0004		-	2.0000			
	Death/Dependent/Payee Relationships		3 Occurrences	000	040	
0097	Dependent/Payee Relationship Code	21	Widow / 1 st Birth Order	209	210	
0097	Dependent/Payee Relationship Code	41	Son / 1 st Birth Order	211	212	
0097	Dependent/Payee Relationship Code	42	Daughter / 2 nd Birth Order	213	214	

IP –	Initial Payment, Event 5	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
-	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code	Y	Yes	349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120830	August 30, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked	20120829	August 29, 2012	413	420
0189	Return To Work Type Code			421	421

IP –	Initial Payment, Event 5	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	N	No	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation Indicator	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120830	August 30, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	02	2 Occurrences	632	633
0282	Number of Other Benefits	01	1 Occurrences	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	010	Fatal	651	653
	Maintenance Type Code	IP	Initial Payment	654	655
	Gross Weekly Amount	00000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120830	August 30, 2012	667	674
	Net Weekly Amount	0000070000	\$700.00	675	685
	Net Weekly Amount Effective Date	20120830	August 30, 2012	686	693

IP –	Initial Payment, Event 5	Transactio	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End		
0088	Benefit Period Start Date	20120830	August 30, 2012	694	701		
0089	Benefit Period Through Date	20120906	September 06, 2012	702	709		
0090	Benefit Type Claim Weeks	0001		710	713		
	Benefit Type Claim Days	1		714	714		
0086	Benefit Type Amount Paid	00000084000	\$840.00	715	725		
0192	Benefit Payment Issue Date	20120906	September 06, 2012	726	733		
	Filler			734	753		
	Payments		2 Occurrences				
0222	Payment Reason Code	010	Fatal	754	756		
0217	Payee	MARY DOE		757	796		
0218	Payment Amount	0000084000	\$840.00	797	807		
0219	Payment Covers Period Start Date	20120830	August 30, 2012	808	815		
0220	Payment Covers Period Through Date	20120906	September 06, 2012	816	823		
0195	Payment Issue Date	20120906	September 06, 2012	824	831		
	Filler			832	851		
0222	Payment Reason Code	300	Funeral Expenses	852	854		
0217	Payee	MARY DOE		855	894		
0218	Payment Amount	00000310000	\$3,100.00	895	905		
0219	Payment Covers Period Start Date	20120906	September 06, 2012	906	913		
0220	Payment Covers Period Through Date	20120906	September 06, 2012	914	921		
0195	Payment Issue Date	20120906	September 06, 2012	922	929		
	Filler			930	949		
	Other Benefits		1 Occurrence				
0216	Other Benefit Type Code	300	Total Funeral Expenses	950	952		
0215	Other Benefit Type Amount	00000310000	\$3,100.00	953	963		
	Filler			964	983		
	Benefit Adjustments						
0092	Benefit Adjustment Code						
	Benefit Adjustment Start Date						
0125	Benefit Adjustment End Date						
0093	Benefit Adjustment Weekly Amount						

eCLAIMS BUSINESS SCENARIOS

	Initial Payment, Event 5	Transact	tion Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS Workers' Compensation Board eClaims Business Scenarios Scenario 4-6

Established Case with Date of Accident Prior to 1/1/2008, Subsequent Death

(Different date of death and accident – with dependents)

NARRATIVE:

Employee John Doe, from Scenario 9-4, remained out of work on a Permanent Partial Disability. *** It is assumed for the purposes of this Scenario that the claimant has NOT passed away. ***

On November 27, 2012, John Doe entered the local hospital for an authorized back surgery. While the surgery was taking place John Doe died due to the surgery. The Claim Administrator was notified on November 30, 2012 by Doe's widow of his death. The Claim Administrator verified her relationship and found that all children were grown and not eligible dependents. Based on Mr. Doe's wage (\$600.00 per week), Doe's widow is entitled to death benefits of \$400.00 per week. Additionally, the Claim Administrator verified and forwarded information to the Board that the widow incurred \$3,100 in funeral expenses related to John Doe's death.

The Claim Administrator, **for the date of accident February 2, 2004,** reported the suspension of benefits and death information to the NYS Workers' Compensation Board by sending Claimant Death (**SROI S4**) transaction reports to the NYSWCB on **November 30, 2012**.

On **December 7, 2012**, the Claim Administrator issued a check for the first installment of death benefits to Mrs. Mary Doe as well as reimbursement of \$3,100 for funeral expenses she incurred. The Claim Administrator reported the loss and initial payment information to the NYS Workers' Compensation Board by sending both the Original First Report of Injury (**FROI 00**) and Initial Payment (**SROI IP**) transaction reports to the NYSWCB on **December 7, 2012**. The Claim Administrator **utilized November 27, 2012 as the date of accident/death** on the new submissions.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 9-4</u> Event 1: FROI MTC UR – Original First Report Event 2: SROI MTC UR – Legacy Claim

<u>Scenario 4-6</u> Event 3: SROI MTC S4 – Suspension, Claimant Death See Scenario 4-5 for example of SROI-S4 submission on death claim. --- New Date of Accident / Death Starts Here ---Event 4: FROI MTC 00 – Original First Report (for subsequent death) Event 5: SROI MTC IP – Initial Payment

As the Original Date of Accident is Prior to January 1, 2008:

On the new FROI 00, the Claim Administrator would enter the dates for DN0040 (Date Employer Had Knowledge of Injury), DN0041 (Date Claim Administrator Had Knowledge of Injury), and DN0281 (Date Employer Had Knowledge of Date of Disability) as the original date rather than the date of knowledge of the new death claim.

NOTE: <u>The AFF-1, C-62, C-64, and C-65 are still required for all Death Cases</u>

00 -	First Report, Event 4	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	148 Data Elements					
0001	Transaction Set ID	148	First Report	1	3	
0002	Maintenance Type Code	00	Original	4	5	
0003	Maintenance Type Code Date	20121207	December 7, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0005	Jurisdiction Claim Number			16	40	
0006	Insurer FEIN	141456789		41	49	
	Filler			50	178	
0012	Claim Administrator City	LATHAM		179	193	
0013	Claim Administrator State Code	NY		194	195	
0014	Claim Administrator Postal Code	12110		196	204	
0015	Claim Administrator Claim Number	TW0892356		205	229	
0016	Employer FEIN	089898765		230	238	
	Filler			239	358	
0021	Employer Physical City	ALBANY		359	373	
0022	Employer Physical State Code	NY		374	375	
0023	Employer Physical Postal Code	12241		376	384	
	Filler			385	385	
0025	Industry Code	236116	Multifamily housing Construction	386	391	
	Filler			392	401	
0027	Insured Location Identifier	JS51	Job Site 51	402	416	
0028	Policy Number Identifier	COA65432		417	434	
	Filler			435	446	
0029	Policy Effective Date	20040101	January 1, 2004	447	454	
0030	Policy Expiration Date	20050101	January 1, 2005	455	462	
0031	Date of Injury	20121127	November 27, 2012	463	470	
	Time of Injury	1300	1:00 PM	471	474	
0033	Accident Site Postal Code	12204		475	483	
	Filler			484	484	
0035	Nature of Injury Code	28	Fracture	485	486	
	Part of Body Injured Code	42	Lower Back Area	487	488	
0037	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490	
	Filler			491	640	
0039	Initial Treatment Code	3	Emergency room	641	642	
0040	Date Employer Had Knowledge of the Injury	20040202	February 2, 2004	643	650	
0041	Date Claim Administrator Had Knowledge of the Injury	20040202	February 2, 2004	651	658	
	Filler			659	697	
0044	Employee First Name	JOHN		698	712	
	Filler			713	773	
0048	Employee Mailing City	SCHENECTADY		774	788	
	Employee Mailing State Code	NY		789	790	

<u>00 –</u>	First Report, Event 4	Transaction L	_ayout		
DN	Data Element Name	Data	Description	Beg	Ena
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents	1		820	821
0056	Initial Date Disability Began	20121127	November 27, 2012	822	829
0057	Employee Date of Death	20121127	November 27, 2012	830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
0062	Wage	00000105000	\$1050.00	882	892
0063	Wage Period Code	01	Weekly	893	894
	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked	20121127	November 27, 2012	896	903
0066	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
	End 148	8 Elements			1
	R21 Dat	a Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
0270	Employee ID Type Qualifier	s	Social Security Number	231	231
0042	Employee SSN	324556745		232	246
0255	Employee Last Name Suffix			247	250
0150	Employee Authorization to Release Medical Records Indicator			251	251
0157	Employee Social Security Number Release Indicator			252	252
	Employee Last Name	DOE		253	292

00 -	- First Report, Event 4	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code	Y	Yes	406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
0314	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
	Insurer Type Code	I	Insurer	536	536
	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20040202	February 02, 2004	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
0160	Employer Contact Name	JANE SMITH		921	960
	Employer ID Assigned by Jurisdiction			961	975

00 -	- First Report, Event 4	Transaction Lay	out		
DN	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	l	Indemnity	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation Indicator	Ν	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02		1591	1592
	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	00		1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 occurrences		
0038	Accident/Injury Description Narrative	MR. DOE DIED AS A RESULT OF BACK SURGERY RELATED T		1601	1650
0038	Accident/Injury Description Narrative	O HIS 2/1/04 INJURY.		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

eClaims Business Scenarios

00 -	- First Report, Event 4	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses					
0238	Witness Name					
0237	Witness Business Phone Number					

End R21 Elements

	Initial Payment, Event 5	Transactio			
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	IP	Initial Payment	4	5
0003	Maintenance Type Code Date	20121207	December 07, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents	01		52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20121127	November 27, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death	20121127	November 27, 2012	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20121127	November 27, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	01	1 Occurrence	207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships	-	1 Occurrence		
0097	Dependent/Payee Relationship Code	21	Widow / 1 st Birth Order	209	210
	End A49 Elements		Oldel		

eClaims Business Scenarios

IP –	Initial Payment, Event 5	Transaction L			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code	Y	Yes	349	349
	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
		20040202	February 02, 2004	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked	20121127	November 27, 2012	413	420
0189	Return To Work Type Code			421	421

IP –	Initial Payment, Event 5	Transactior	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000040000	\$400.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	N	No	491	491
0293	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation Indicator	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20121127	November 27, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	02	2 Occurrences	632	633
0282	Number of Other Benefits	01	1 Occurrences	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrence		
0085	Benefit Type Code	010	Fatal	651	653
	Maintenance Type Code	IP	Initial Payment	654	655
	Gross Weekly Amount	00000040000	\$400.00	656	666
	Gross Weekly Amount Effective Date	20121127	November 27, 2012	667	674
	Net Weekly Amount	00000040000	\$400.00	675	685
	Net Weekly Amount Effective Date	20121127	November 27, 2012	686	693

IP –	Initial Payment, Event 5	Transactio	Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End			
0088	Benefit Period Start Date	20121127	November 27, 2012	694	701			
0089	Benefit Period Through Date	20121207	December 07, 2012	702	709			
0090	Benefit Type Claim Weeks	0001		710	713			
0091	Benefit Type Claim Days	4		714	714			
0086	Benefit Type Amount Paid	00000072000	\$720.00	715	725			
0192	Benefit Payment Issue Date	20121207	December 07, 2012	726	733			
	Filler			734	753			
	Payments		2 Occurrences					
0222	Payment Reason Code	010	Fatal	754	756			
0217	Payee	MARY DOE		757	796			
0218	Payment Amount	00000072000	\$720.00	797	807			
0219	Payment Covers Period Start Date	20121127	November 27, 2012	808	815			
0220	Payment Covers Period Through Date	20121207	December 07, 2012	816	823			
0195	Payment Issue Date	20121207	December 07, 2012	824	831			
	Filler			832	851			
0222	Payment Reason Code	300	Funeral Expenses	852	854			
0217	Payee	MARY DOE		855	894			
0218	Payment Amount	00000310000	\$3,100.00	895	905			
0219	Payment Covers Period Start Date	20121207	December 07, 2012	906	913			
0220	Payment Covers Period Through Date	20121207	December 07, 2012	914	921			
0195	Payment Issue Date	20121207	December 07, 2012	922	929			
	Filler			930	949			
	Other Benefits		1 Occurrence					
0216	Other Benefit Type Code	300	Total Funeral Expenses	950	952			
0215	Other Benefit Type Amount	00000310000	\$3,100.00	953	963			
	Filler			964	983			
	Benefit Adjustments							
0092	Benefit Adjustment Code							
0094	Benefit Adjustment Start Date							
0125	Benefit Adjustment End Date							
0093	Benefit Adjustment Weekly Amount							

eCLAIMS BUSINESS SCENARIOS

	Initial Payment, Event 5		tion Layout	_	
DN I	Data Element Name	Data	Description	Beg	End
1	Benefit Credits				
126	Benefit Credit Code				
127	Benefit Credit Start Date				
128	Benefit Credit End Date				
129	Benefit Credit Weekly Amount				
1	Benefit Redistribution				
130 E	Benefit Redistribution Code				
131 [Benefit Redistribution Start Date				
132	Benefit Redistribution End Date				
133 E	Benefit Redistribution Weekly Amount				
1	Recoveries				
226 I	Recovery Code				
225 I	Recovery Amount				
1	Reduced Earnings				
242	Reduced Earnings Week Number				
124 /	Actual Reduced Earnings				
147 [Deemed Reduced Earnings				
(Concurrent Employers				
141 (Concurrent Employer Name				
142 (Concurrent Employer Contact Business Phone				
143 (Concurrent Employer Wage				
1	Denial Reason Codes				
198 I	Full Denial Reason Code				
1	Denial Reasons				
197 [Denial Reason Narrative				
	Suspension Narratives				
233	Suspension Narrative				
233	•				

NYS Workers' Compensation Board eClaims Business Scenarios Scenario 5-1

Full Denial – MTC 04

(Claim Administrator denies claim in its entirety)

NARRATIVE:

Employee John Doe fell off a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and hurt his low back on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident. Doe's foreman noticed that Doe appeared to be intoxicated at the time of the accident and smelled of alcohol. The employee was sent to the hospital and initially treated and released from the Emergency Room of Albany Memorial Hospital. The employee was **NOT paid for the date of the injury**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury on August 3, 2012** to the Insurer/Claim Administrator.

On August 8, 2012, the Claim Administrator determined that the claim is **NOT** compensable. The Claim Administrator reported the denial information to the NYS Workers' Compensation Board by sending the Denial First Report of Injury (**FROI 04**) to the NYSWCB on **August 8, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 04 – Denial First Report

<u>NOTE</u>: To deny additional injury sites and/or medical issues the Claim Administrator **should continue** to use the **C-8.1 Process** and/or **Medical Treatment Guidelines Process**.

04 -	- First Report, Denial	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	04	Denial	4	5
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	ALBANY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12241		376	384
	Filler			385	385
0025	Industry Code	236116	Multifamily housing Construction	386	391
	Filler			392	401
0027	Insured Location Identifier	JS51	Job Site 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury	1300	1:00 PM	471	474
	Accident Site Postal Code	12204		475	483
	Filler			484	484
0035	Nature of Injury Code	49	Sprain or Tear	485	486
	Part of Body Injured Code	42	Lower Back Area	487	488
	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
	Employee Mailing State Code	NY		789	790

04 -	- First Report, Denial	Transaction L	ayout		
	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	Μ	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began	20120802	August 2, 2012	822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
0062	Wage	00000105000	\$1050.00	882	892
0063	Wage Period Code	01	Weekly	893	894
0064	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked	20120801	August 01, 2012	896	903
0066	Full Wages Paid for Date of Injury Indicator	N	No	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
0001	Transaction Set ID	a Elements R21	First Report	1	3
0205	Maintanana Tura Correction Code		Companion Record	4	_
	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
	Denial Rescission Date			14	21
	Jurisdiction Branch Office Code	T 14/0000050		22	23
	Claim Administrator Claim Number	TW0892356		24	48
	Claim Administrator FEIN Claim Administrator Name	141456789 ALL AMERICAN		49 58	57 97
0100		INSURANCE COMPANY		50	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
	Employee ID Type Qualifier	s	Social Security Number	231	231
	Employee SSN	324556745		232	246
	Employee Last Name Suffix			247	250
	Employee Authorization to Release Medical Records Indicator			251	251
0157	Employee Social Security Number Release Indicator	•		252	252
0101				253	292

04 -	- First Report, Denial	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
0314	Insured FEIN	089898765		412	420
0017	Insured Name	GREAT ROOFING INC.		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	S	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	ALBANY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	GREAT ROOFING INC.		768	807
0329	Employer UI Number	16-10000		808	822
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
0160	Employer Contact Name	JANE SMITH		921	960
	Employer ID Assigned by Jurisdiction			961	975

04 -	- First Report, Denial	Transaction La	iyout		
DN	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date	20120808	August 08, 2012	1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	I	Indemnity	1482	1482
	Late Reason Code		-	1483	1484
0273	Employer Paid Salary in Lieu of Compensation	N	No	1485	1485
	Indicator	IN	No		
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	02	2 Occurrences	1593	1594
0276	Number of Denial Reason Narratives	01	1 Occurrence	1595	1596
0278	Number of Managed Care Organizations	00			1598
	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				1
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE ALLEGES HIS LOW BACK INJURED FROM FALL FRO		1601	1650
0038	Accident/Injury Description Narrative	M LADDER AT JOBSITE		1651	1700
	Full Denial Reason Codes		2 Occurrences		
0198	Full Denial Reason Code	1C	No Compensable Accident/Not in Course and Scope of Employment – Willful Intent to Injure Oneself	1701	1702
0198	Full Denial Reason Code	1E	No Compensable Accident/Not in Course and Scope of Employment – Deviation from Employment	1703	1704

04 -	- First Report, Denial	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Full Denial Reason Narratives		1 Occurrence			
0197	Denial Reason Narrative	MR. DOE WAS INTOXICATED AT THE TIME OF ACCIDENT		1705	1754	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1755	1794	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1795	1809	
	Filler			1810	1829	
	End R21 Elements			•	•	

NYS Workers' Compensation Board eClaims Business Scenarios Scenario 5-2

Subsequent Full Denial – MTC 04

(Claim Administrator denies claim in its entirety after submitting FROI 00)

NARRATIVE:

Employee John Doe fell off a ladder at the employer's jobsite located at 1234 Broadway, Albany, NY and hurt his low back, left foot, and left hip on **August 1, 2012** at 1:00 p.m. He started work at 7:00 a.m. Doe's foreman, Jane Smith, witnessed the accident. The employee was sent to the hospital and initially treated and released from the Emergency Room of Albany Memorial Hospital. The employee was **paid for the date of the injury and returned to work the next day**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week. Doe's foreman **reported the injury on August 3, 2012** to the Insurer/Claim Administrator.

On August 8, 2012, the Claim Administrator determined that the claim is compensable. The Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **August 8, 2012**.

On August 10, 2012, the employer received the results of the employer's mandatory toxicology screening performed at the hospital and learned that John Doe was in fact very intoxicated at the time of his accident. They immediately inform the Claim Administrator of this information.

On August 10, 2012, the Claim Administrator determined that the claim is NOT compensable due to this intoxication. The Claim Administrator reported the denial information to the NYS Workers' Compensation Board by sending the Denial Subsequent Report of Injury (SROI 04) to the NYSWCB on August 10, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report **Event 2:** SROI MTC 04 – Denial Subsequent Report

<u>NOTE</u>: To deny additional injury sites and/or medical issues the Claim Administrator **should continue** to use the **C-8.1 Process** and/or **Medical Treatment Guidelines Process**.

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	148 Data Elements					
0001	Transaction Set ID	148	First Report	1	3	
0002	Maintenance Type Code	00	Original	4	5	
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0005	Jurisdiction Claim Number			16	40	
0006	Insurer FEIN	141456789		41	49	
	Filler			50	178	
0012	Claim Administrator City	LATHAM		179	193	
0013	Claim Administrator State Code	NY		194	195	
0014	Claim Administrator Postal Code	12110		196	204	
0015	Claim Administrator Claim Number	TW0892356		205	229	
0016	Employer FEIN	089898765		230	238	
	Filler			239	358	
0021	Employer Physical City	ALBANY		359	373	
0022	Employer Physical State Code	NY		374	375	
	Employer Physical Postal Code	12241		376	384	
	Filler			385	385	
0025	Industry Code	236116	Multifamily housing Construction	386	391	
	Filler			392	401	
0027	Insured Location Identifier	JS51	Job Site 51	402	416	
0028	Policy Number Identifier	COA65432		417	434	
	Filler			435	446	
0029	Policy Effective Date	20120101	January 1, 2012	447	454	
0030	Policy Expiration Date	20130101	January 1, 2013	455	462	
0031	Date of Injury	20120801	August 1, 2012	463	470	
	Time of Injury	1300	1:00 PM	471	474	
	Accident Site Postal Code	12204		475	483	
	Filler			484	484	
0035	Nature of Injury Code	49	Sprain or Tear	485	486	
	Part of Body Injured Code	42	Lower Back Area	487	488	
	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490	
	Filler			491	640	
0039	Initial Treatment Code	3	Emergency room	641	642	
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650	
	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658	
	Filler			659	697	
0044	Employee First Name	JOHN		698	712	
	Filler			713	773	
0048	Employee Mailing City	SCHENECTADY		774	788	
	Employee Mailing State Code	NY		789	790	

00 -	- First Report Event	Transaction L	.ayout		
DN	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	Μ	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
DN Data Element Name Data 0050 Employee Mailing Postal Code 12308 Filler	1	Full Time	838	839	
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
		00000105000	\$1050.00	882	892
		01	Weekly	893	894
		5	-	895	895
	·		August 01, 2012	896	903
	*		Yes	904	904
				905	905
0068	Initial Return to Work Date			906	913
	End 148	8 Elements			1
	R21 Dat	a Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN			
				58	97
0135	Claim Administrator Information/Attention Line			58 98	97 147
					147
0010	Claim Administrator Primary Address	COMPANY		98	147 187
0010 0011	Claim Administrator Primary Address Claim Administrator Secondary Address	COMPANY		98 148	147 187 227
0010 0011 0136	Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code	COMPANY PO BOX 12345	Social Security Number	98 148 188	
0010 0011 0136 0270	Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier	COMPANY PO BOX 12345 S		98 148 188 228	147 187 227 230 231
0010 0011 0136 0270 0042	Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN	COMPANY PO BOX 12345 S		98 148 188 228 231	147 187 227 230 231 246
0010 0011 0136 0270 0042 0255	Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN Employee Last Name Suffix Employee Authorization to Release Medical	COMPANY PO BOX 12345 S		98 148 188 228 231 232	147 187 227 230
0010 0011 0136 0270 0042 0255 0150	Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN Employee Last Name Suffix Employee Authorization to Release Medical	COMPANY PO BOX 12345 S 324556745		98 148 188 228 231 232 247	147 187 227 230 231 246 250

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout				
	Data Element Name	Data	Description	Beg	End	
0045	Employee Middle Name/Initial	Т		293	307	
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347	
0047	Employee Mailing Secondary Address			348	387	
0155	Employee Mailing Country Code			388	390	
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405	
0146	Death Result of Injury Code			406	406	
0290	Type of Loss Code	01	Trauma	407	408	
0228	Return To Work With Same Employer Indicator			409	409	
	Return To Work Type Code			410	410	
	Physical Restrictions Indicator			411	411	
	Insured FEIN	089898765		412	420	
0017	Insured Name	GREAT ROOFING INC.		421	460	
	Insured Type Code	I	Insured	461	461	
0026	Insured Report Number			462	486	
0204	Work Week Type Code	S	Standard Work Week	487	487	
0205	Work Days Scheduled	NSSSSSN		488	494	
0229	Injury Severity Type Code			495	495	
	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535	
	Insurer Type Code	l	Insurer	536	536	
	Insolvent Insurer FEIN			537	545	
	Claim Administrator Alternate Postal Code			546	554	
0206	Employee Security ID			555	569	
	Filler			570	577	
	Accident Premises Code	E	Employer	578	578	
	Accident Site County/Parish	ALBANY		579	598	
	Accident Site Location Narrative			599	648	
	Accident Site Organization Name			649	698	
	Accident Site City	ALBANY		699	713	
	Accident Site Street	1234 BROADWAY		714	753	
	Accident Site State Code	NY		754	755	
	Accident Site Country Code			756	758	
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766	
	Filler			767	767	
0018	Employer Name	GREAT ROOFING INC.		768	807	
	Employer UI Number	16-10000		808	822	
	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862	
0020	Employer Physical Secondary Address			863	902	
	Employer Physical Country Code			903	905	
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920	
	Employer Contact Name	JANE SMITH		921	960	
0230	Employer ID Assigned by Jurisdiction			961	975	

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Lay	yout		
	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	Μ	Medical Only	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation		N/A	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01		1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	CLT WAS STEPPING OFF A ROOF AND FELL FROM A LADDER		1601	1650
0038	Accident/Injury Description Narrative	INJURING LOW BACK, LT FOOT, LT HIP		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 – First Report Event		Transaction l			
DN	Data Element Name	Data	Description	Beg	End
	Managed Care Organizations				
0207	Managed Care Organization Code				
0209	Managed Care Organization Name				
0208	Managed Care Organization Identification Number				
	Witnesses		1 Occurrence		
0238	Witness Name	JANE SMITH		1701	1740
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755
	Filler			1756	1775
	End R21 Elements				

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	04	Denial	4	5
0003	Maintenance Type Code Date	20120810	August 10, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began			55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	М	Medical Only	187	187
0075	Agreement to Compensate Code		N/A	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships			1	
0097	Dependent/Payee Relationship Code				
	End A49 Elements				

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
0139	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
		20120801	August 01, 2012	387	394
	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code			421	421

eClaims Business Scenarios

04 -	- Subseq. Report, Denial, Event 2	Iransaction	Layout	_	
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date	20120810	August 10, 2012	431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation		N/A	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time			506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	00		630	631
0283	Number of Payments	00		632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	02	2 Occurrences	645	646
0276	Number of Denial Reason Narratives	03	3 Occurrences	647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments				I
	Benefits				
0085	Benefit Type Code				
	Maintenance Type Code				
	Gross Weekly Amount			1	
	GIUSS WEEKIY AITIUUTI				
0174					
0174 0175	Gross Weekly Amount Effective Date Net Weekly Amount				

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date				
0089	Benefit Period Through Date				
0090	Benefit Type Claim Weeks				
0091	Benefit Type Claim Days				
0086	Benefit Type Amount Paid				
0192	Benefit Payment Issue Date				
	Filler				
	Payments				
0222	Payment Reason Code				
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				1
	Deemed Reduced Earnings	1			
	Concurrent Employers				1
	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone				
	Concurrent Employer Wage				1

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	Denial Reason Codes		2 Occurrences		
	Full Denial Reason Code	Denial Reason Code 1C No Compensable Accident/Not in Course and Scope of Employment – Willful Intent to Injure Oneself		651	652
0198	Full Denial Reason Code	1E	No Compensable Accident/Not in Course and Scope of Employment – Deviation from Employment	653	654
	Denial Reasons		3 Occurrences		
0197	Denial Reason Narrative	SUBSEQUENT REPORT RECEIVED BY EMPLOYER FROM HOSPIT		655	704
0197	Denial Reason Narrative	AL AND FURTHER INVESTIGATION OF CLAIM REVEALED CLA		705	754
0197	Denial Reason Narrative	IMANT WAS INTOXICATED AT TIME OF ACCIDENT		755	804
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

04 – Subseq. Report, Denial, Event 2 Transaction Layout

End R22 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios SCENARIO 5-3

Partial Denial – MTC 00/PD

(Claim Administrator accepts medical and denies partial indemnity)

NARRATIVE:

Employee John Doe, from Scenario 1-1, continued to work until August 15, 2012, when Doe sought further treatment from his primary care doctor. On August 27, 2012, the provider forwarded a medical report indicating that the claimant was disabled as of August 16, 2012 and had a Temporary Total Disability. In addition, the medical provider indicated that there was apportionment to a prior motor vehicle accident (MVA) the claimant suffered. The prior accident was not work related. The medical provider issued an apportionment opinion of 70% related to the work accident and 30% related to the MVA.

On August 29, 2012, the Claim Administrator determined that they would accept the apportionment opinion of the claimant's doctor and partially deny the indemnity portion of the claim for the unrelated 30% per the medical provider's opinion. The Claim Administrator reported the Initial Payment and Partial Denial to the NYS Workers' Compensation Board by sending the Initial Payment (SROI IP) and Partial Denial (SROI PD) transaction reports to the NYSWCB on August 29, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 1-1</u> Event 1: FROI MTC 00 – Original First Report

<u>Scenario 5-4</u> Event 2: SROI MTC PD – Partial Denial Event 3: SROI MTC IP – Initial Payment

<u>NOTE</u>: To deny additional injury sites and/or medical issues the Claim Administrator **should continue** to use the **C-8.1 Process** and/or **Medical Treatment Guidelines Process**.

PD -	– Partial Denial, Event 2	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	PD	Partial Denial	4	5
0003	Maintenance Type Code Date	20120829	August 29, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Y	Yes	54	54
0056	Initial Date Disability Began			55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	L	Became Lost Time	187	187
0075	Agreement to Compensate Code			188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0031	Dependent/Payee Relationship Code End A49 Elements				

eClaims Business Scenarios

<u> PD -</u>	– Partial Denial, Event 2	Transaction L	ayout		
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked		N/A	413	420
	Return To Work Type Code			421	421

PD -	– Partial Denial, Event 2	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code	В	Denying Indemnity in Part, Not Medical	447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
	Wage Effective Date		N/A	459	466
	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator	-		482	482
	Initial Return to Work Date			483	490
	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation		N/A	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time			506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	00		632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	001	1 Occurrence	636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	03	3 Occurrences	647	648
	Number of Suspension Narratives	00		649	650
-	Variable Segments	I			
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	PD	Partial Denial	654	655
	Gross Weekly Amount	00000070000	\$700.00	656	666
	Gross Weekly Amount Effective Date	20120801	August 01, 2012	667	674

PD ·	– Partial Denial, Event 2	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0087	Net Weekly Amount	00000049000	\$490.00	675	685
0211	Net Weekly Amount Effective Date	20120801	August 01, 2012	686	693
8800	Benefit Period Start Date	20120816	August 16, 2012	694	701
0089	Benefit Period Through Date	20120829	August 29, 2012	702	709
0090	Benefit Type Claim Weeks	02		710	713
0091	Benefit Type Claim Days	0		714	714
0086	Benefit Type Amount Paid	00000049000	\$490.00	715	725
0192	Benefit Payment Issue Date	20120829	August 29, 2012	726	733
	Filler			734	753
	Payments				
0222	Payment Reason Code				
	Payee				
	Payment Amount				
	Payment Covers Period Start Date				
	Payment Covers Period Through Date				
	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
	Other Benefit Type Amount				
	Benefit Adjustments		1 Occurrence		
0092	Benefit Adjustment Code	A	Apportionment	754	757
	Benefit Adjustment Start Date	20120816	August 16, 2012	758	765
	Benefit Adjustment End Date	20120829	August 29, 2012	766	773
	Benefit Adjustment Weekly Amount	0000021000	\$210.00	774	784
	Filler			785	804
	Benefit Credits				
0126	Benefit Credit Code				
	Benefit Credit Start Date				
0128	Benefit Credit End Date				
	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
	Benefit Redistribution Start Date				
	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number			1	
	Actual Reduced Earnings			1	
	r teteet i toadood Earningo			1	

eClaims Business Scenarios

PD ·	– Partial Denial, Event 2	Transaction La	ayout		
DN	Data Element Name	Data	Description	Beg	End
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
0198	Full Denial Reason Code				
	Denial Reasons		3 Occurrences		
0197	Denial Reason Narrative	CLT DR RENDERED APPORTIONMENT OPINION IN 8/15 MEDI		805	854
0197	Denial Reason Narrative	CAL REPORT, 70% RELATED to WC INJURY, 30% UNRELATE		855	904
0197	Denial Reason Narrative	D TO WC INJURY		905	954
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

End R22 Elements

<u> IP –</u>	- Initial Payment, Event 3 Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	IP	Initial Payment	4	5
0003	Maintenance Type Code Date	20120829	August 29, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Y	Yes	54	54
0056	Initial Date Disability Began	20120816	August 16, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
	Jurisdiction Claim Number	G0055555		161	185
	Claim Status Code		N/A	186	186
	Claim Type Code	1	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
0084	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements				I

		Fransaction La			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
	Transaction Set ID	R22	Subsequent Report	1	3
	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
		20120827	August 27, 2012	387	394
	Non-Consecutive Period Code			395	395
	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	Initial Date Last Day Worked	20120815	August 15, 2012	413	420
	Return To Work Type Code			421	421

IP –	Initial Payment, Event 3	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation Indicator	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120816	August 16, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	01	1 Occurrence	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	001	1 Occurrence	636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments	• 			•
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code	IP	Initial Payment	654	655
0174	Gross Weekly Amount	0000070000	\$700.00	656	666
0175	Gross Weekly Amount Effective Date	20120801	August 01, 2012	667	674
0087	Net Weekly Amount	00000049000	\$490.00	675	685
0211	Net Weekly Amount Effective Date	20120801	August 01, 2012	686	693

IP – I	Initial Payment, Event 3	Transaction	Layout		
	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20120816	August 16, 2012	694	701
0089	Benefit Period Through Date	20120829	August 29, 2012	702	709
0090	Benefit Type Claim Weeks	02		710	713
0091	Benefit Type Claim Days	0		714	714
0086	Benefit Type Amount Paid	00000049000	\$490.00	715	725
0192	Benefit Payment Issue Date	20120829	August 29, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	050	Temporary Total	754	756
0217	Payee	JOHN DOE		757	796
0218	Payment Amount	0000098000	\$980.00	797	807
	Payment Covers Period Start Date	20120816	August 16, 2012	808	815
	Payment Covers Period Through Date	20120829	August 29, 2012	816	823
0195	Payment Issue Date	20120829	August 29, 2012	824	831
	Filler			832	851
	Other Benefits				
0216	Other Benefit Type Code				
-	Other Benefit Type Amount				
	Benefit Adjustments		1 Occurrence		
0092	Benefit Adjustment Code	A	Apportionment	852	855
	Benefit Adjustment Start Date	20120816	August 16, 2012	856	863
	Benefit Adjustment End Date	20120829	August 29, 2012	864	871
	Benefit Adjustment Weekly Amount	00000021000	\$210.00	872	882
	Filler			883	902
	Benefit Credits				
0126	Benefit Credit Code				
	Benefit Credit Start Date				
	Benefit Credit End Date				
	Benefit Credit Weekly Amount				
0120	Benefit Redistribution				
0130	Benefit Redistribution Code				
	Benefit Redistribution Start Date				
	Benefit Redistribution End Date				
	Benefit Redistribution Weekly Amount				
0100	Recoveries				
0226	Recovery Code				
	Recovery Amount				
0220	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
	Deemed Reduced Earnings				
0147	Concurrent Employers				
01/1	Concurrent Employers				
	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone Concurrent Employer Wage				
0143	Concurrent Employer wage				

IP – I	Initial Payment, Event 3	Transaction L	ayout		
DN	Data Element Name	Data	Description	Beg	End
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS Workers' Compensation Board eClaims Business Scenarios Scenario 6-1

Volunteer Firefighter (VFF) Medical Only – MTC 00

(Claimant is not disabled from employment and continues treatment for the injury)

NARRATIVE:

Volunteer Firefighter (VFF) Michael Smith responded to a residential fire at 1801 Lancaster Street, Providence, NY on **August 1, 2012** at 7:00 p.m. While fighting the fire from the interior of the residence, a piece of ceiling fell and injured VFF Smith's head. Chief Richard Jones was on scene and witnessed the injury. VFF Smith was immediately sent by ambulance to Saratoga Hospital for treatment of his head injury. VFF Smith was examined by hospital staff and determined to suffer **no disability from employment** and was allowed to return to his regular job as a construction foreman the next business day. Chief Jones **reported the injury on August 3, 2012** to the Insurer / Claim Administrator.

On August 8, 2012, the Claim Administrator determined that the claim is compensable. The Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **August 8, 2012**.

The FROI 00 includes **DN0058 (Employment Status Code) with 9 (Volunteer) populated** and **DN0059 (Manual Classification Code) with 7711 (VFF) populated**, which indicates that this is a VFF case.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report

<u>NOTE</u>: For Volunteer Firefighter (VFF) and Volunteer Ambulance Worker (VAW) cases: Insured FEIN (DN0314) and Insured Name (DN0017) are the actual Fire or Ambulance Service (i.e., Providence Volunteer Ambulance Corps); Employer FEIN (DN0016) and Employer Name (DN0018) are the Political Subdivision/Fire District (i.e., Town of Providence).

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	MIDDLE GROVE		359	373
	Employer Physical State Code	NY		374	375
	Employer Physical Postal Code	12850		376	384
	Filler			385	385
0025	Industry Code	922160	Fire & Ambulance Services	386	391
	Filler			392	401
0027	Insured Location Identifier	RU102	Call Run 102	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
	Policy Expiration Date	20130101	January 1, 2013	455	462
	Date of Injury	20120801	August 1, 2012	463	470
	Time of Injury	1900	7:00 p.m.	471	474
0033	Accident Site Postal Code	12850	·	475	483
	Filler			484	484
0035	Nature of Injury Code	07	Concussion	485	486
	Part of Body Injured Code	11	Skull	487	488
	Cause of Injury Code	13	Caught In, Under, or Between - NOC	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	MICHAEL		698	712
	Filler			713	773
0048	Employee Mailing City	MIDDLE GROVE		774	788
	Employee Mailing State Code	NY		789	790

00 -	00 – First Report Event Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End	
0050	Employee Mailing Postal Code	12850		791	799	
	Filler			800	809	
0052	Employee Date of Birth	19771101	November 1, 1977	810	817	
0053	Employee Gender Code	Μ	Male	818	818	
0054	Employee Marital Status Code		N/A	819	819	
0055	Employee Number of Dependents			820	821	
0056	Initial Date Disability Began			822	829	
0057	Employee Date of Death			830	837	
0058	Employment Status Code	9	Volunteer	838	839	
0059	Manual Classification Code	7711	Volunteer Firefighter	840	843	
	Filler			844	873	
0061	Employee Date of Hire	20010401	April 1, 2001	874	881	
0062	Wage	0000000000	\$00.00	882	892	
0063	Wage Period Code	01	Weekly	893	894	
0064	Number of Days Worked Per Week	5		895	895	
0065	Initial Date Last Day Worked			896	903	
0066	Full Wages Paid for Date of Injury Indicator	N	No	904	904	
	Filler			905	905	
0068	Initial Return to Work Date			906	913	
0004		ata Elements	First Day art	4	0	
	Transaction Set ID	R21	First Report Companion Record	1	3	
	Maintenance Type Correction Code			4	5	
	Maintenance Type Correction Code Date			6	13	
	Denial Rescission Date			14	21	
	Jurisdiction Branch Office Code			22	23	
	Claim Administrator Claim Number	TW0892356		24	48	
	Claim Administrator FEIN	141456789		49	57	
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97	
0135	Claim Administrator Information/Attention Line			98	147	
0010	Claim Administrator Primary Address	PO BOX 12345		148	187	
	Claim Administrator Secondary Address			188	227	
	Claim Administrator Country Code			228	230	
	Employee ID Type Qualifier	S	Social Security Number	231	231	
					246	
0042	Employee SSN	324556745		232	246	
	Employee SSN Employee Last Name Suffix	324556745		232 247	246	
0255		324556745				

00 –	- First Report Event	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0043	Employee Last Name	SMITH		253	292
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
0314	Insured FEIN	099965423		412	420
0017	Insured Name	PROVIDENCE VOLUNTEER FIRE COMPANY		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
)204	Work Week Type Code	S	Standard Work Week	487	487
)205	Work Days Scheduled	NSSSSSN		488	494
)229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	SARATOGA		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	PROVIDENCE		699	713
0122	Accident Site Street	1801 LANCASTER STREET		714	753
0123	Accident Site State Code	NY		754	755
	Accident Site Country Code			756	758
	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler		. .	767	767
	Employer Name	TOWN OF PROVIDENCE		768	807
0329	Employer UI Number	16-10000		808	822
	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
	Employer Physical Secondary Address			863	902
0020	LIIIpioyer Filysical Secondary Address			00.3	

00 -	- First Report Event	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
0160	Employer Contact Name	JANE SMITH		921	960
)230	Employer ID Assigned by Jurisdiction			961	975
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	MIDDLE GROVE		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12850		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	FIREFIGHTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	М	Medical Only	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation			1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	01	1 Occurrence	1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	FF SMITH WAS FIGHTING RESIDENTIAL FIRE. WHILE INS		1601	1650
0038	Accident/Injury Description Narrative	IDE RESIDENCE PART OF CEILING COLLAPSED ON HIM.		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations		1 Occurrence			
0207	Managed Care Organization Code	03		1701	1702	
0209	Managed Care Organization Name			1703	1742	
0208	Managed Care Organization Identification Number	00000004		1743	1751	
	Filler			1752	1771	
	Witnesses		1 Occurrence			
0238	Witness Name	CHIEF RICHARD JONES		1772	1811	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1812	1826	
	Filler			1827	1846	
	End R21 Elements			•		

NYS Workers' Compensation Board eClaims Business Scenarios Scenario 6-2

Volunteer Firefighter (VFF) Initial Payment – MTC 00/IP

(Claimant is disabled from employment)

NARRATIVE:

Volunteer Firefighter (VFF) Michael Smith responded to a residential fire at 1801 Lancaster Street, Providence, NY on **August 1, 2012** at 7:00 p.m. While fighting the fire from the interior of the residence, a piece of ceiling fell and injured VFF Smith's head. Chief Richard Jones was on scene and witnessed the injury. VFF Smith was immediately sent by ambulance to Saratoga Hospital for treatment of his head injury. VFF Smith was examined by hospital staff and determined to have a **Total Disability** and was not allowed to return to his regular job as a construction foreman the next business day. Chief Jones **reported the injury on August 3, 2012** to the Insurer/Claim Administrator.

On August 8, 2012, the Claim Administrator determined that the claim is compensable. The Claim Administrator issued a check on August 8, 2012 to the injured employee, for Temporary Total Disability Benefits, for the period August 1, 2012 through August 8, 2012 and continuing.

The Claim Administrator reported the loss and initial payment information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (FROI 00) and Initial Payment (SROI IP) to the NYSWCB on August 8, 2012. The FROI 00 included DN0058 (Employment Status Code) with 9 (Volunteer) populated and DN0059 (Manual Classification Code) with 7711 (VFF) populated, which indicates that this is a VFF case.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>NOTE</u>: For Volunteer Firefighter (VFF) and Volunteer Ambulance Worker (VAW) cases: Insured FEIN (DN0314) and Insured Name (DN0017) are the actual Fire or Ambulance Service (i.e., Providence Volunteer Ambulance Corps); Employer FEIN (DN0016) and Employer Name (DN0018) are the Political Subdivision/Fire District (i.e., Town of Providence).

00 -	- First Report Event	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	MIDDLE GROVE		359	373
	Employer Physical State Code	NY		374	375
	Employer Physical Postal Code	12850		376	384
	Filler			385	385
0025	Industry Code	922160	Fire & Ambulance Services	386	391
	Filler			392	401
0027	Insured Location Identifier	RU102	Call Run 102	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
	Policy Expiration Date	20130101	January 1, 2013	455	462
	Date of Injury	20120801	August 1, 2012	463	470
	Time of Injury	1900	7:00 p.m.	471	474
0033	Accident Site Postal Code	12850	·	475	483
	Filler			484	484
0035	Nature of Injury Code	07	Concussion	485	486
	Part of Body Injured Code	11	Skull	487	488
	Cause of Injury Code	13	Caught In, Under, or Between - NOC	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	MICHAEL		698	712
	Filler			713	773
0048	Employee Mailing City	MIDDLE GROVE		774	788
	Employee Mailing State Code	NY		789	790

<u> </u>	- First Report Event	.ayout	t		
	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12850		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began	20120801	August 1, 2012	822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	9	Volunteer	838	839
0059	Manual Classification Code	7711	Volunteer Firefighter	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
0062	Wage	0000000000	\$00.00	882	892
0063	Wage Period Code	01	Weekly	893	894
0064	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked	20120801	August 1, 2012	896	903
0066	Full Wages Paid for Date of Injury Indicator	Ν	No	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
		148 Elements			
0001	R21 D	ata Elements	First Papart	1	2
	R21 D Transaction Set ID		First Report Companion Record	1	3
0295	R21 D Transaction Set ID Maintenance Type Correction Code	ata Elements		4	5
0295 0296	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date	ata Elements		4	5 13
0295 0296 0196	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date	ata Elements		4 6 14	5 13 21
0295 0296 0196 0186	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code	Pata Elements R21		4 6 14 22	5 13 21 23
0295 0296 0196 0186 0015	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number	R21 R21 TW0892356		4 6 14 22 24	5 13 21 23 48
0295 0296 0196 0186 0015 0187	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code	Ata Elements R21 TW0892356 141456789 ALL AMERICAN INSURANCE		4 6 14 22	5 13 21 23
0295 0296 0196 0186 0015 0187 0188	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN	Pata Elements R21 TW0892356 141456789 ALL AMERICAN		4 6 14 22 24 49	5 13 21 23 48 57
0295 0296 0196 0186 0015 0187 0188 0135	R21 D Transaction Set IDMaintenance Type Correction CodeMaintenance Type Correction Code DateDenial Rescission DateJurisdiction Branch Office CodeClaim Administrator Claim NumberClaim Administrator FEINClaim Administrator NameClaim Administrator Information/Attention Line	Ata Elements R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY		4 6 14 22 24 49 58	5 13 21 23 48 57 97
0295 0296 0196 0186 0015 0187 0188 0135 0010	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name	Ata Elements R21 TW0892356 141456789 ALL AMERICAN INSURANCE		4 6 14 22 24 49 58 98	5 13 21 23 48 57 97
0295 0296 0196 0186 0015 0187 0187 0188 0135 0010 0011	R21 D Transaction Set IDMaintenance Type Correction CodeMaintenance Type Correction Code DateDenial Rescission DateJurisdiction Branch Office CodeClaim Administrator Claim NumberClaim Administrator FEINClaim Administrator NameClaim Administrator Information/Attention LineClaim Administrator Primary AddressClaim Administrator Secondary Address	Ata Elements R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY		4 6 14 22 24 49 58 98 148	5 13 21 23 48 57 97 147 187 227
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0011	R21 D Transaction Set IDMaintenance Type Correction CodeMaintenance Type Correction Code DateDenial Rescission DateJurisdiction Branch Office CodeClaim Administrator Claim NumberClaim Administrator FEINClaim Administrator NameClaim Administrator Information/Attention LineClaim Administrator Primary Address	Ata Elements R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY		4 6 14 22 24 49 58 58 98 148 188	5 13 21 23 48 57 97 147 187 227 230
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0136 0270	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code	Pata Elements R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345	Companion Record	4 6 14 22 24 49 58 58 98 148 188 228	5 13 21 23 48 57 97 147 187 227 230 231
0295 0296 0196 0186 0015 0187 0187 0188 0135 0010 0011 0136 0270 0042	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier	Pata Elements R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345 S	Companion Record	4 6 14 22 24 49 58 58 98 148 148 188 228 231	5 13 21 23 48 57 97 147 187
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0136 0270 0042 0255	R21 D Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier	Pata Elements R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345 S	Companion Record	4 6 14 22 24 49 58 98 148 188 228 231 232	5 13 21 23 48 57 97 147 187 227 230 231 246

00 -	First Report Event	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0043	Employee Last Name	SMITH		253	292
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
	Insured FEIN	099965423		412	420
0017	Insured Name	PROVIDENCE VOLUNTEER FIRE COMPANY		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
)204	Work Week Type Code	S	Standard Work Week	487	487
)205	Work Days Scheduled	NSSSSSN		488	494
)229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
)206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	SARATOGA		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	PROVIDENCE		699	713
0122	Accident Site Street	1801 LANCASTER STREET		714	753
0123	Accident Site State Code	NY		754	755
	Accident Site Country Code			756	758
	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler		<u> </u>	767	767
0018	Employer Name	TOWN OF PROVIDENCE		768	807
0329	Employer UI Number	16-10000		808	822
	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
	Employer Physical Secondary Address			863	902
	Employer Physical Country Code			903	905

00 -	- First Report Event	Transaction La	yout		
DN	Data Element Name	Data	Description	Beg	End
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
0160	Employer Contact Name	JANE SMITH		921	960
0230	Employer ID Assigned by Jurisdiction			961	975
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	MIDDLE GROVE		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12850		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	FIREFIGHTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	I	Indemnity	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation Indicator	Ν	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00	1 Occurrence	1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				-
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	FF SMITH WAS FIGHTING RESIDENTIAL FIRE. WHILE INS		1601	1650
0038	Accident/Injury Description Narrative	IDE RESIDENCE PART OF CEILING COLLAPSED ON HIM.		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations		1 Occurrence			
0207	Managed Care Organization Code	03		1701	1702	
0209	Managed Care Organization Name			1703	1742	
0208	Managed Care Organization Identification Number	00000004		1743	1751	
	Filler			1752	1771	
	Witnesses		1 Occurrence			
0238	Witness Name	CHIEF RICHARD JONES		1772	1811	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1812	1826	
	Filler			1827	1846	
	End R21 Elements			•		

IP –	Initial Payment, Event 2	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	IP	Initial Payment	4	5	
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents			52	53	
0069	Pre-Existing Disability Code	Ν	No	54	54	
0056	Initial Date Disability Began	20120801	August 01, 2012	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date			72	79	
0057	Employee Date of Death			80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
0064	Number of Days Worked Per Week	5		101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number			111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code	I	Indemnity	187	187	
	Agreement to Compensate Code	L	With Liability	188	188	
	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
	Permanent Impairment Body Part Code					
	Permanent Impairment Percentage					
	Death/Dependent/Payee Relationships			1		
	Dependent/Payee Relationship Code					
	End A49 Elements					

IP –	Initial Payment, Event 2	Transaction L			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
-	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	SMITH		259	298
0044	Employee First Name	MICHAEL		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	099965423		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked	20120801	August 01, 2012	413	420
0189	Return To Work Type Code			421	421

IP –	Initial Payment, Event 2	Transaction	n Layout		
	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000040000	\$400.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	9	Volunteer	480	481
	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
	Full Wages Paid For Date Of Injury Indicator	N	No	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	N	No		
0286	Average Wage	0000060000	\$600.00	495	505
0297	Initial Date of Lost Time	20120801	August 01, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
	Number of Payments	01	1 Occurrence	632	633
	Number of Other Benefits	00		634	635
	Number of Benefit ACR	000		636	638
	Number of Recoveries	00		639	640
	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
0207	Variable Segments	00		045	000
	Benefits		1 Occurrence		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	IP	Initial Payment	654	655
	Gross Weekly Amount	00000040000	\$400.00	656	666
	Gross Weekly Amount Effective Date		August 01, 2012	667	674
		20120801	\$400.00	-	
	Net Weekly Amount	00000040000		675	685
0211	Net Weekly Amount Effective Date	20120801	August 01, 2012	686	693

P –	Initial Payment, Event 2	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
8800	Benefit Period Start Date	20120801	August 01, 2012	694	701
0089	Benefit Period Through Date	20120808	August 08, 2012	702	709
0090	Benefit Type Claim Weeks	0001		710	713
0091	Benefit Type Claim Days	1		714	714
0086	Benefit Type Amount Paid	00000048000	\$480.00	715	725
0192	Benefit Payment Issue Date	20120808	August 08, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	050	Temporary Total	754	756
0217	Payee	MICHAEL SMITH		757	796
0218	Payment Amount	00000048000	\$480.00	797	807
0219	Payment Covers Period Start Date	20120801	August 01, 2012	808	815
0220	Payment Covers Period Through Date	20120808	August 08, 2012	816	823
0195	Payment Issue Date	20120808	August 08, 2012	824	831
	Filler		_	832	851
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name			1	
	Concurrent Employer Contact Business Phone			1	
	Concurrent Employer Wage				[

I <u>P</u> – I	Initial Payment, Event 2	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives					
0233	Suspension Narrative					
	End R22 Elements					

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 6-3

Volunteer Ambulance Worker (VAW) Medical Only – MTC 00

(Claimant is not disabled from employment and continues treatment for the injury)

NARRATIVE:

Volunteer Ambulance Worker (VAW) David Jones responded to an accident of an injured firefighter at 1801 Lancaster Street, Providence, NY on **August 1, 2012** at 7:00 p.m. While administering intravenous medications to the injured firefighter, VAW Jones stuck his own right index finger with a needle. Chief Richard Jones of the Providence Fire Department was on scene and witnessed the injury. VAW Jones continued his duties and transported the injured firefighter to Saratoga Hospital. While at the hospital, VAW Jones had blood work done and had his finger examined by Emergency Room staff. It was determined that VAW Jones suffered **no disability from employment** and was allowed to return to his regular job as a police officer the next business day. The President of the Volunteer Ambulance Corp **reported the injury on August 3, 2012** to the Insurer/Claim Administrator.

On August 8, 2012, the Claim Administrator determined that the claim is compensable. The Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **August 8, 2012**. The FROI 00 includes **DN0058 (Employment Status Code) with 9 (Volunteer) populated** and **DN0059 (Manual Classification Code) with 7370 (VAW) populated**, which indicates that this is a VAW case.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report

<u>NOTE</u>: For Volunteer Firefighter (VFF) and Volunteer Ambulance Worker (VAW) cases: Insured FEIN (DN0314) and Insured Name (DN0017) are the actual Fire or Ambulance Service (i.e., Providence Volunteer Ambulance Corps); Employer FEIN (DN0016) and Employer Name (DN0018) are the Political Subdivision/Fire District (i.e., Town of Providence).

00 -	- First Report Event	.ayout			
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20120808	August 08, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	MIDDLE GROVE		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12850		376	384
	Filler			385	385
0025	Industry Code	922160	Fire & Ambulance Services	386	391
	Filler			392	401
0027	Insured Location Identifier	RU102	Call Run 102	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20120101	January 1, 2012	447	454
0030	Policy Expiration Date	20130101	January 1, 2013	455	462
0031	Date of Injury	20120801	August 1, 2012	463	470
0032	Time of Injury	1900	7:00 p.m.	471	474
0033	Accident Site Postal Code	12850		475	483
	Filler			484	484
0035	Nature of Injury Code	43	Puncture	485	486
0036	Part of Body Injured Code	36	Finger(s), other than Thumb	487	488
0037	Cause of Injury Code	79	Object Being Lifted or Handled	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
0040	Date Employer Had Knowledge of the Injury	20120801	August 1, 2012	643	650
	Date Claim Administrator Had Knowledge of the Injury	20120803	August 3, 2012	651	658
	Filler			659	697
0044	Employee First Name	DAVID		698	712
	Filler			713	773
0048	Employee Mailing City	MIDDLE GROVE		774	788

00 -	- First Report Event	Transaction L	Layout		
	Data Element Name	Data	Description	Beg	End
0049	Employee Mailing State Code	NY		789	790
0050	Employee Mailing Postal Code	12850		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
	Employment Status Code	9	Volunteer	838	839
	Manual Classification Code	7370	Volunteer Ambulance Worker	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
0062	Wage	0000000000	\$00.00	882	892
0063	Wage Period Code	01	Weekly	893	894
0064	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked			896	903
0066	Full Wages Paid for Date of Injury Indicator	N	No	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
	R21 D	ata Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
	Employee ID Type Qualifier	S	Social Security Number	231	231
	Employee SSN	324556745		232	246
	Employee Last Name Suffix			247	250
0150	Employee Authorization to Release Medical Records Indicator			251	251

00 -	0 – First Report Event Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
0157	Employee Social Security Number Release Indicator			252	252
0043	Employee Last Name	JONES		253	292
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
0314	Insured FEIN	099965423		412	420
0017	Insured Name	PROVIDENCE AMBULANCE CORPS		421	460
0184	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	s	Standard Work Week	487	487
0205	Work Days Scheduled	NSSSSSN		488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	SARATOGA		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
0121	Accident Site City	PROVIDENCE		699	713
0122	Accident Site Street	1801 LANCASTER STREET		714	753
0123	Accident Site State Code	NY		754	755
	Accident Site Country Code			756	758
	Date Employer Had Knowledge of Date of Disability	20120801	August 1, 2012	759	766
	Filler			767	767
0018	Employer Name	TOWN OF PROVIDENCE		768	807
0329	Employer UI Number	16-10000		808	822
	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
	Employer Physical Secondary Address			863	902

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
0164	Employer Physical Country Code			903	905	
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920	
0160	Employer Contact Name	JANE SMITH		921	960	
0230	Employer ID Assigned by Jurisdiction			961	975	
0231	Manual Classification Sub-Code			976	977	
	Filler			978	1050	
0163	Employer Mailing Information/Attention Line			1051	1100	
0165	Employer Mailing City	MIDDLE GROVE		1101	1115	
	Employer Mailing Country Code			1116	1118	
	Employer Mailing Postal Code	12850		1119	1127	
	Employer Mailing Primary Address	PO BOX 1587		1128	1167	
	Employer Mailing Secondary Address			1168	1207	
	Employer Mailing State Code	NY		1208	1209	
	Filler				1259	
0060	Occupation Description	EMERGENCY MEDICAL TECHNICICAN		1260	1309	
0199	Full Denial Effective Date			1310	1317	
	Filler			1318	1480	
0073	Claim Status Code		N/A	1481		
	Claim Type Code	M	Medical Only		1482	
	Late Reason Code		,	-	1484	
	Employer Paid Salary in Lieu of Compensation				1485	
	Filler			1486	1590	
	Variable Segment Counters			•		
0274	Number of Accident/Injury Description Narratives	03	3 Occurrences	1591	1592	
0277	Number of Full Denial Reason Codes	00		1593	1594	
0276	Number of Denial Reason Narratives	00		1595	1596	
0278	Number of Managed Care Organizations	01	1 Occurrence	1597	1598	
0279	Number of Witnesses	01	1 Occurrence	1599	1600	
	Variable Segments					
	Accident/Injury Description Narratives		3 Occurrences			
	Accident/Injury Description Narrative	EMT JONES WAS ADMINISTERING IV TO INJURED FIREFIGH		1601	1650	
0038	Accident/Injury Description Narrative	TER WHEN EMT JONES STUCK HIMSELF IN RIGHT INDEX FI		1651	1700	
0038	Accident/Injury Description Narrative	NGER WITH NEEDLE				

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Full Denial Reason Codes					
0198	Full Denial Reason Code					
	Full Denial Reason Narratives					
0197	Denial Reason Narrative					
	Managed Care Organizations		1 Occurrence			
0207	Managed Care Organization Code	03				
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number	00000004				
	Witnesses		1 Occurrence			
0238	Witness Name	CHIEF RICHARD JONES				
0237	Witness Business Phone Number	5184029394	(518) 402-9394			
	End P21 Elements				<u> </u>	

End R21 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 7-1

Section 32 Settlement – Payment Report – MTC PY

(Section 32 Settlement closes medical and indemnity)

NARRATIVE:

Employee John Doe, from **Scenario 2-1**, continued out of work for several months and retained an attorney. On November 13, 2012, the Claim Administrator decided to offer the claimant a Section 32 Settlement in the amount of \$20,000 (including a \$2,000 attorney's fee) to settle the medical and indemnity on the claim as well as suspend the continuing payments on the date of the hearing. John Doe accepted the Claim Administrator's offer. The signed paperwork was forwarded to the NYSWCB immediately.

A hearing was held on **December 14, 2012**, in which the agreement was **approved** by the Board and the **Notice of Approval was issued on December 31, 2012**. The Claim Administrator reported the suspension of claimant's weekly payments as of December 14, 2012 to the NYS Workers' Compensation Board by sending a Suspension (**SROI SD**) transaction report to the NYSWCB on **December 18, 2012**.

On January 3, 2013, the Claim Administrator received the Notice of Decision, issued payment to the claimant and claimant's attorney, and reported the payments to the NYS Workers' Compensation Board by sending Payment Report (**SROI PY**) transaction report to the NYSWCB on **January 3, 2013**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 7-1</u> Event 3: SROI MTC SD – Suspension, Directed by Jurisdiction Event 4: SROI MTC PY – Payment Report

	– Suspension, Directed, Event 3	Transactio	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	SD	Suspension, Directed by Jurisdiction	4	5
0003	Maintenance Type Code Date	20121218	December 18, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents		N/A	52	53
0069	Pre-Existing Disability Code		N/A	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death		N/A	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week		N/A	101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number		N/A	111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				<u> </u>
0083	Permanent Impairment Body Part Code		N/A		<u> </u>
	Permanent Impairment Percentage		N/A		
	Death/Dependent/Payee Relationships				├
0007					<u> </u>
0097	Dependent/Payee Relationship Code End A49 Elements				

eCLAIMS BUSINESS SCENARIOS

SD – Suspension, Directed, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements		-		
	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code		N/A	4	5
	Maintenance Type Correction Code Date		N/A	6	13
	Date Claim Administrator Had Knowledge of Lost		N/A	14	21
0186	Jurisdiction Branch Office Code		N/A	22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level		N/A	342	343
0213	Employee Number of Entitled Exemptions		N/A	344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code		N/A	348	348
0146	Death Result of Injury Code		N/A	349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN		N/A	359	367
	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code		N/A	377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code		N/A	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked		N/A	397	404
0144	Current Date Disability Began		N/A	405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code			421	421

SD – Suspension, Directed, Event 3	Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	Physical Restrictions Indicator	- • • •		422	422
0224				422	422
0193	Suspension Effective Date	20121214	December 14, 2012	423	430
0199	Full Denial Effective Date		N/A	431	438
0196	Denial Rescission Date		N/A	439	446
0294	Partial Denial Code		N/A	447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
	Wage Effective Date		N/A	459	466
	Discontinued Fringe Benefits		N/A	467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator		N/A	482	482
	Initial Return to Work Date			483	490
	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code		N/A	492	493
0273	Employer Paid Salary in Lieu of Compensation			494	494
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time		N/A	506	513
-	Award/Order Date	20121231	December 31, 2012	514	521
	Claim Administrator Alternate Postal Code		N/A	522	530
	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
-	Number of Payments	00	N/A	632	633
	Number of Other Benefits	00		634	635
	Number of Benefit ACR	000		636	638
	Number of Recoveries	00		639	640
	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	02	2 Occurrences	649	650
	Variable Segments				
	Benefits		1 Occurrence		
	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code	SD	Suspension, Directed by Jurisdiction	654	655
0174	Gross Weekly Amount	00000070000	\$700.00	656	666
-	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674

SD ·	– Suspension, Directed, Event 3	n Layout			
	Data Element Name	Data	Description	Beg	End
0087	Net Weekly Amount	0000070000	\$700.00	675	685
	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20121214	December 14, 2012	702	709
0090	Benefit Type Claim Weeks	0019		710	713
0091	Benefit Type Claim Days	02		714	714
0086	Benefit Type Amount Paid	00001334000	\$13340.00	715	725
0192	Benefit Payment Issue Date	20121214	December 14, 2012	726	733
	Filler			734	753
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
	Benefit Credit Code				
	Benefit Credit Start Date				
	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
-	Benefit Redistribution Code				
	Benefit Redistribution Start Date				
	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount	_			
	Recoveries				
	Recovery Code				
0225	Recovery Amount	_			
	Reduced Earnings				
	Reduced Earnings Week Number				
	Actual Reduced Earnings				
0147	Deemed Reduced Earnings	-			
	Concurrent Employers				
	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				

SD – Suspension, Directed, Event 3		Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives		2 Occurrences			
0233	Suspension Narrative	PAYMENTS SUSPENDED PER APPROVAL OF SECTION 32 AGRE		754	803	
0233	Suspension Narrative	EMENT		804	853	
	End R22 Elements			1		

<u> </u>	– Payment Report, Event 4	Transactio	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	PY	Payment Report	4	5
0003	Maintenance Type Code Date	20130103	January 03, 2013	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code	-			
0031	End A49 Elements				

PY-	– Payment Report, Event 4 Transaction Layout				
	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked	20120801	August 01, 2012	413	420
0189	Return To Work Type Code			421	421

PY-	- Payment Report, Event 4	Transaction	n Layout		
	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
0293	Lump Sum Payment/Settlement Code	SF	Settlement Full	492	493
	Employer Paid Salary in Lieu of Compensation Indicator	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date	20121231	December 31, 2012	514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	2 Occurrences	630	631
0283	Number of Payments	02	2 Occurrences	632	633
0282	Number of Other Benefits	01	1 Occurrence	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Variable Segments Benefits		2 Occurrences		
		500	Unspecified Lump Sum	651	653
0085	Benefits Benefit Type Code		Unspecified Lump Sum Payment/Settlement		
0085 0002	Benefits	500 PY	Unspecified Lump Sum	651 654 656	653 655 666

PY	– Payment Report, Event 4	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0087	Net Weekly Amount		N/A	675	685
0211	Net Weekly Amount Effective Date		N/A	686	693
0088	Benefit Period Start Date	20130103	January 3, 2013	694	701
0089	Benefit Period Through Date	20130103	January 3, 2013	702	709
0090	Benefit Type Claim Weeks		N/A	710	713
0091	Benefit Type Claim Days		N/A	714	714
0086	Benefit Type Amount Paid	00001800000	\$18000.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	050	Temporary Total	754	756
	Maintenance Type Code		N/A	757	758
	Gross Weekly Amount		N/A	759	769
	Gross Weekly Amount Effective Date		N/A	770	777
	Net Weekly Amount		N/A	778	788
	Net Weekly Amount Effective Date		N/A	789	796
	Benefit Period Start Date	20120802	August 02, 2012	797	804
	Benefit Period Through Date	20121214	December 14, 2012	805	812
	Benefit Type Claim Weeks	0019		813	816
	Benefit Type Claim Days	2		817	817
	Benefit Type Amount Paid	00001334000	\$13340.00	818	828
	Benefit Payment Issue Date	00001004000	N/A	829	836
0102	Filler		14/7	837	856
	Payments		2 Occurrences	001	000
0222	Payment Reason Code	500	Unspecified Lump Sum Payment/Settlement	857	859
0217	Payee	JOHN DOE		860	899
	Payment Amount	00001800000	\$18,000.00	900	910
	Payment Covers Period Start Date	20130103	January 3, 2013	911	918
	Payment Covers Period Through Date	20130103	January 3, 2013	919	926
	Payment Issue Date	20130103	January 3, 2013	927	934
	Filler			935	954
0222	Payment Reason Code	340	Total Claimant's Legal Expense	955	957
0217	Payee	ATTORNEY DOE	-	958	997
	Payment Amount	00000200000	\$2,000.00	998	1008
	Payment Covers Period Start Date	20130103	January 3, 2013	1009	1016
	Payment Covers Period Through Date	20130103	January 3, 2013	1017	1024
	Payment Issue Date	20130103	January 3, 2013	1025	1032
	Filler			1033	1052
	FINEI				
			1 Occurrence		
0216	Other Benefits Other Benefit Type Code	340	1 Occurrence Total Claimant's Legal Expense	1053	1055
	Other Benefits	340		1053 1056	1055 1066

PΥ·	– Payment Report, Event 4	Transacti	ion Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements	•		•	

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 7-2

Partial Section 32 Settlement – Payment Report – MTC PY

(Section 32 Settlement closes indemnity, medical remains OPEN)

NARRATIVE:

Employee John Doe, from **Scenario 2-1**, continued out of work for several months and retained an attorney. On November 13, 2012, the Claim Administrator decided to offer the claimant a Section 32 Settlement in the amount of \$20,000 (including a \$2,000 attorney's fee) **to settle ONLY the indemnity portion of the claim** as well as suspend the continuing payments on the date of the hearing. John Doe accepted the Claim Administrator's offer. The signed paperwork was forwarded to the NYSWCB immediately.

A hearing was held on **December 14, 2012**, in which the agreement was **approved** by the Board and the **Notice of Approval was issued on December 31, 2012**. The Claim Administrator reported the suspension of claimant's weekly payments as of December 14, 2012 to the NYS Workers' Compensation Board by sending a Suspension (**SROI SD**) transaction report to the NYSWCB on **December 18, 2012**.

On January 3, 2013, the Claim Administrator received the Notice of Decision and issued payment to the claimant and claimant's attorney and reported the payments to the NYS Workers' Compensation Board by sending Payment Report (**SROI PY**) transaction report to the NYSWCB on **January 3, 2013**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 7-2</u> Event 3: SROI MTC SD – Suspension, Directed by Jurisdiction See Scenario 7-1 for Example of SROI-SD submission. Event 4: SROI MTC PY – Payment Report

ΡΥ-	- Payment Report, Event 4	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	PY	Payment Report	4	5
0003	Maintenance Type Code Date	20130103	January 03, 2013	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0031	Dependent/Payee Relationship Code End A49 Elements				

eClaims Business Scenarios

PY-	- Payment Report, Event 4	Transaction Layout			
	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
-	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked			413	420
0189	Return To Work Type Code			421	421

eCLAIMS BUSINESS SCENARIOS

PY-	- Payment Report, Event 4	Transaction	n Layout		
	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
0293	Lump Sum Payment/Settlement Code	SP	Settlement Partial	492	493
	Employer Paid Salary in Lieu of Compensation Indicator	N	No	494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date	20121231	December 31, 2012	514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	02	2 Occurrences	632	633
0282	Number of Other Benefits	01	1 Occurrence	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		2 Occurrences		
0085	Benefit Type Code	500	Unspecified Lump Sum Payment/Settlement	651	653
0002	Maintenance Type Code	PY	Payment Report	654	655
		1			
0174	Gross Weekly Amount		N/A	656	666

PY – Paymen	t Report, Event 4	Transaction	Layout		
DN Data Element	t Name	Data	Description	Beg	End
0087 Net Weekly A	mount		N/A	675	685
0211 Net Weekly A	mount Effective Date		N/A	686	693
0088 Benefit Period	Start Date	20130103	January 3, 2013	694	701
0089 Benefit Period	Through Date	20130103	January 3, 2013	702	709
0090 Benefit Type (Claim Weeks		N/A	710	713
0091 Benefit Type (Claim Days		N/A	714	714
0086 Benefit Type /	Amount Paid	00001800000	\$18000.00	715	725
0192 Benefit Payme	ent Issue Date		N/A	726	733
Filler				734	753
0085 Benefit Type (Code	050	Temporary Total	754	756
0002 Maintenance			N/A	757	758
0174 Gross Weekly	•••		N/A	759	769
0175 Gross Weekly	Amount Effective Date		N/A	770	777
0087 Net Weekly A			N/A	778	788
	mount Effective Date		N/A	789	796
0088 Benefit Period		20120802	August 02, 2012	797	804
0089 Benefit Perioc		20121214	December 14, 2012	805	812
0090 Benefit Type (0019		813	816
0091 Benefit Type (2		817	817
0086 Benefit Type /		00001334000	\$13340.00	818	828
0192 Benefit Payme		00001004000	N/A	829	836
Filler				837	856
Payments			2 Occurrences	007	000
0222 Payment Rea	son Code	500	Unspecified Lump Sum Payment/Settlement	857	859
0217 Payee		JOHN DOE		860	899
0218 Payment Amo	punt	00001800000	\$18,000.00	900	910
	ers Period Start Date	20130103	January 3, 2013	911	918
	ers Period Through Date	20130103	January 3, 2013	919	926
0195 Payment Issu		20130103	January 3, 2013	927	934
Filler				935	954
0222 Payment Rea	son Code	340	Total Claimant's Legal Expense	955	957
0217 Payee		ATTORNEY DOE		958	997
0218 Payment Amo	punt	00000200000	\$2,000.00	998	1008
	ers Period Start Date	20130103	January 3, 2013	1009	1016
	ers Period Through Date	20130103	January 3, 2013	1017	1024
0195 Payment Issu	•	20130103	January 3, 2013	1025	1032
Filler			, ,	1033	1052
Other Benefi	ts		1 Occurrence		
0216 Other Benefit		340	Total Claimant's Legal Expense	1053	1055
0215 Other Benefit	Type Amount	00000200000	\$2,000.00	1056	1066
	V1		, -,	1067	1086

eCLAIMS BUSINESS SCENARIOS

PΥ·	– Payment Report, Event 4	Transacti	ion Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements	•		•	

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 7-3

Section 32 Settlement – Payment Report – MTC PY

(Section 32 Settlement closes medical and indemnity in additional files)

NARRATIVE:

Employee John Doe, from Scenario 7-1, had another date of injury for the right leg from **October 1, 2010** with the same employer. In the October 1, 2010 date of accident, the claimant lost time from his employment, received payment from the Claim Administrator, and subsequently returned to work at full duty.

The Claim Administrator was the **same on both cases**. As part of the Section 32 agreement to settle his August 1, 2012 date of injury, the parties agreed to include the October 1, 2010 date of injury in the Section 32 agreement as well. The Section 32 agreement indicated that **all monies will be paid out of the August 1, 2012 date of accident**.

The Claim Administrator had previously accepted the October 1, 2010 injury and had previously transmitted a FROI 00, SROI IP and SROI S1 to the NYSWCB.

A hearing was held on **December 14, 2012**, in which the agreement was **approved** by the Board and the **Notice of Approval was issued on December 31, 2012**.

On January 3, 2013, the Claim Administrator received the Notice of Decision and issued payment in the August 1, 2012 date of accident. As the October 1, 2010 date of accident was settled in the agreement, the Claim Administrator notified the NYS Workers' Compensation Board by sending Payment Report (SROI PY) transaction report to the NYSWCB on January 3, 2013. In the SROI PY the Claim Administrator indicated "S" (Claim Settled Under Another DOI) under DN0202 (Reduced Benefit Amount Code).

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Previously Submitted (See Scenario 2-6 for Similar Reports)</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment Event 3: SROI MTC S1 – Suspension, Returned to Work, or Medically Determined/Qualified to Return to Work

<u>Scenario 7-3</u> Event 4: SROI MTC PY – Payment Report

NOTE: If the additional claim being settled has **NOT** been assembled by the NYSWCB then a **FROI 00** submission **MUST** be submitted. The SROI PY would otherwise be **rejected** as there was no FROI 00 on file.

PY-	- Payment Report, Event 4	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	PY	Payment Report	4	5	
0003	Maintenance Type Code Date	20130103	January 03, 2013	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents			52	53	
0069	Pre-Existing Disability Code	Ν	No	54	54	
0056	Initial Date Disability Began	20101002	October 02, 2010	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date			72	79	
0057	Employee Date of Death			80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
0064	Number of Days Worked Per Week	5		101	101	
	Filler			102	102	
0031	Date of Injury	20101001	October 01, 2010	103	110	
0026	Insured Report Number			111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	5000000		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code	I	Indemnity	187	187	
	Agreement to Compensate Code	L	With Liability	188	188	
0076	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
0083	Permanent Impairment Body Part Code					
	Permanent Impairment Percentage					
	Death/Dependent/Payee Relationships					
0007						
0091	Dependent/Payee Relationship Code End A49 Elements					

PY-	- Payment Report, Event 4	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code	S	Claim Settled Under Another DOI	347	347
0158	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
		201001001	October 01, 2010	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412

eCLAIMS BUSINESS SCENARIOS

PY-	- Payment Report, Event 4	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0065	Initial Date Last Day Worked			413	420
0189	Return To Work Type Code			421	421
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
0293	Lump Sum Payment/Settlement Code	SF	Settlement Full	492	493
	Employer Paid Salary in Lieu of Compensation Indicator			494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20101002	October 02, 2010	506	513
0299	Award/Order Date	20121231	December 31, 2012	514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	00		630	631
0283	Number of Payments	00		632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
-	Variable Segments			-	
	Benefits				
0085	Benefit Type Code				
0002	Maintenance Type Code				

eCLAIMS BUSINESS SCENARIOS

PY-	– Payment Report, Event 4	Transact	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End		
0174	Gross Weekly Amount						
0175	Gross Weekly Amount Effective Date						
0087	Net Weekly Amount						
0211	Net Weekly Amount Effective Date						
0088	Benefit Period Start Date						
0089	Benefit Period Through Date						
0090	Benefit Type Claim Weeks						
0091	Benefit Type Claim Days						
0086	Benefit Type Amount Paid						
0192	Benefit Payment Issue Date						
	Filler						
	Payments						
0222	Payment Reason Code						
	2						
-	Payee						
	Payment Amount						
-	Payment Covers Period Start Date						
	Payment Covers Period Through Date						
0195	Payment Issue Date				ļ		
	Other Benefits				ļ		
-	Other Benefit Type Code				l		
0215	Other Benefit Type Amount				l		
	Benefit Adjustments				ļ		
-	Benefit Adjustment Code				l		
	Benefit Adjustment Start Date						
	Benefit Adjustment End Date				ļ		
0093	Benefit Adjustment Weekly Amount				ļ		
	Benefit Credits						
	Benefit Credit Code						
	Benefit Credit Start Date						
	Benefit Credit End Date						
0129	Benefit Credit Weekly Amount						
	Benefit Redistribution						
	Benefit Redistribution Code						
	Benefit Redistribution Start Date						
0132	Benefit Redistribution End Date						
0133	Benefit Redistribution Weekly Amount						
	Recoveries						
0226	Recovery Code						
0225	Recovery Amount						
	Reduced Earnings						
0242	Reduced Earnings Week Number						
0124	Actual Reduced Earnings						
0147	Deemed Reduced Earnings						

PY-	– Payment Report, Event 4	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 8-1

Board Ordered Suspension – MTC SD

(Board directs Claim Administrator to suspend continuing payments)

NARRATIVE:

Employee John Doe, from **Scenario 2-5**, retained an attorney soon after seeing his doctor and having his payments reduced. The attorney requested a hearing before the Board on various issues.

On November 14, 2012, a hearing was held and continuing payments at the same rate as well as an attorney's fee of \$100.00 were directed by the Workers' Compensation Law Judge. The Notice of Decision was issued on November 16, 2012. After the hearing the Claim Administrator reported the payment information to the NYS Workers' Compensation Board by sending the Payment Report (SROI PY) transaction report to the NYSWCB on November 19, 2012.

Several weeks after the hearing, the claimant missed his follow-up appointment with his doctor. On **December 20, 2012**, the Claim Administrator filed a Request for Further Action (RFA-2) to suspend payments. On **January 18, 2013**, another hearing was held and John Doe failed to appear at the hearing. The **Workers' Compensation Law Judge suspended John Doe's payments effective January 18, 2013**. The Board issued the Notice of Decision on January 23, 2013.

The Claim Administrator reported the suspension and payment information to the NYS Workers' Compensation Board by sending the Suspension, Directed by Jurisdiction (SROI SD) transaction report to the NYSWCB on January 24, 2013.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-5</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment Event 3: SROI MTC CB – Change in Benefit Type

<u>Scenario 8-1</u> Event 4: SROI MTC PY – Payment Report Event 5: SROI MTC SD – Suspension, Directed by Jurisdiction

	– Payment Report, Event 4 Data Element Name	Transactio	Description	Beg	End
DN		Dala	Description	Беу	Enc
2004	A49 Data Elements	4.40	Subaaguant Dapart	4	2
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	PY	Payment Report	4	5 13
	Maintenance Type Code Date	20121119	November 19, 2012	6	
		NY		14	15
0006	Insurer FEIN Filler	141456789		16	24
004.4	Claim Administrator Postal Code	40440		25	33 42
0014	Filler	12110		34	42 51
0055				43 52	53
	Employee Number of Dependents	N	No	52 54	53 54
	Pre-Existing Disability Code Initial Date Disability Began	N	August 02, 2012	55	54 62
	Date of Maximum Medical Improvement	20120802	August 02, 2012	63	
0070	Filler			71	70 71
0072	Latest Return to Work Status Date			72	71
					87
0057	Employee Date of Death Filler			80 88	87 98
0062		01	Weekly	99	90 100
	Wage Period Code Number of Days Worked Per Week	5	VVEEKIY	101	100
0004	Filler	5		101	101
0021	Date of Injury	20120801	August 01, 2012	102	1102
	Insured Report Number	20120601	August 01, 2012	103	135
	Claim Administrator Claim Number	TW0892356		136	160
	Jurisdiction Claim Number	G0055555		161	185
	Claim Status Code	G0055555	N/A	186	185
	Claim Type Code		Indemnity	187	187
	Agreement to Compensate Code	1	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation		With Liability	189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
5004					
0007	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code End A49 Elements				

PY-	- Payment Report, Event 4	Transaction Layout			
	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
-	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked			413	420

PY-	- Payment Report, Event 4	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0189	Return To Work Type Code			421	421
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation			494	494
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date	20121116	November 16, 2012	514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	01	1 Occurrence	632	633
0282	Number of Other Benefits	01	1 Occurrence	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments	·			
	Benefits		2 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code		N/A	654	655
0174	Gross Weekly Amount		N/A	656	666
0175	Gross Weekly Amount Effective Date		N/A	667	674
0087	Net Weekly Amount		N/A	675	685

PY – Payment Report, Event 4 Transaction Layout							
DN	Data Element Name	Data	Description	Beg	End		
0211	Net Weekly Amount Effective Date		N/A	686	693		
8800	Benefit Period Start Date	20120802	August 02, 2012	694	701		
0089	Benefit Period Through Date	20120904	September 04, 2012	702	709		
0090	Benefit Type Claim Weeks	0004		710	713		
0091	Benefit Type Claim Days	4		714	714		
0086	Benefit Type Amount Paid	00000336000	\$3,360.00	715	725		
0192	Benefit Payment Issue Date		N/A	726	733		
	Filler			734	753		
0085	Benefit Type Code	070	Temporary Partial	754	756		
0002	Maintenance Type Code		N/A	757	758		
0174	Gross Weekly Amount		N/A	759	769		
0175	Gross Weekly Amount Effective Date		N/A	770	777		
0087	Net Weekly Amount		N/A	778	788		
0211	Net Weekly Amount Effective Date		N/A	789	796		
8800	Benefit Period Start Date	20120905	September 05, 2012	797	804		
0089	Benefit Period Through Date	20121114	November 14, 2012	805	812		
0090	Benefit Type Claim Weeks	0010		813	816		
0091	Benefit Type Claim Days	0		817	817		
0086	Benefit Type Amount Paid	00000350000	\$3,500.00	818	828		
0192	Benefit Payment Issue Date		N/A	829	836		
	Filler			837	856		
	Payments		1 Occurrence				
0222	Payment Reason Code	340	Total Claimant's Legal Expenses	857	859		
0217	Payee	ATTORNEY DOE		860	899		
0218	Payment Amount	0000010000	\$100.00	900	910		
0219	Payment Covers Period Start Date	20121114	November 14, 2012	911	918		
0220	Payment Covers Period Through Date	20121114	November 14, 2012	919	926		
0195	Payment Issue Date	20121119	November 19, 2012	927	934		
	Filler			935	954		
	Other Benefits		1 Occurrence				
0216	Other Benefit Type Code	340	Total Claimant's Legal Expenses	955	957		
0215	Other Benefit Type Amount	00000010000	\$100.00	958	968		
	Filler			969	988		

eCLAIMS BUSINESS SCENARIOS

PY-	– Payment Report, Event 4	Transacti	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

	9 – Suspension, Directed, Event 5 Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	SD	Suspension, Directed by Jurisdiction	4	5	
0003	Maintenance Type Code Date	20130124	January 24, 2013	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents		N/A	52	53	
0069	Pre-Existing Disability Code		N/A	54	54	
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date			72	79	
0057	Employee Date of Death		N/A	80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
0064	Number of Days Worked Per Week		N/A	101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number		N/A	111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code	I	Indemnity	187	187	
0075	Agreement to Compensate Code	L	With Liability	188	188	
	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
	Permanent Impairment Body Part Code		N/A			
	Permanent Impairment Percentage		N/A			
5504			IN/A			
0007	Death/Dependent/Payee Relationships					
0097	Dependent/Payee Relationship Code End A49 Elements					

<u>SD</u> -	SD – Suspension, Directed, Event 5 Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End	
	R22 Data Elements					
0001	Transaction Set ID	R22	Subsequent Report	1	3	
0295	Maintenance Type Correction Code		N/A	4	5	
0296	Maintenance Type Correction Code Date		N/A	6	13	
0298	Date Claim Administrator Had Knowledge of Lost		N/A	14	21	
0186	Jurisdiction Branch Office Code		N/A	22	23	
0015	Claim Administrator Claim Number	TW0892356		24	48	
0187	Claim Administrator FEIN	141456789		49	57	
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97	
	Claim Administrator Claim Representative Name	MARY CLARK		98	137	
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152	
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232	
0139	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242	
0270	Employee ID Type Qualifier	S	Social Security Number	243	243	
0042	Employee SSN	324556745		244	258	
0043	Employee Last Name	DOE		259	298	
0044	Employee First Name	JOHN		299	313	
0045	Employee Middle Name/Initial			314	328	
0255	Employee Last Name Suffix			329	332	
0052	Employee Date of Birth	19771101	November 1, 1977	333	340	
0054	Employee Marital Status Code		N/A	341	341	
0151	Employee Education Level		N/A	342	343	
	Employee Number of Entitled Exemptions		N/A	344	345	
	Anticipated Wage Loss Indicator			346	346	
0202	Reduced Benefit Amount Code			347	347	
0158	Employee Tax Filing Status Code		N/A	348	348	
0146	Death Result of Injury Code		N/A	349	349	
0314	Insured FEIN	089898765		350	358	
0292	Insolvent Insurer FEIN		N/A	359	367	
0016	Employer FEIN	089898765		368	376	
0023	Employer Physical Postal Code		N/A	377	385	
	Return To Work With Same Employer Indicator			386	386	
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394	
0212	Non-Consecutive Period Code		N/A	395	395	
0172	Estimated Gross Weekly Amount Indicator			396	396	
0145	Current Date Last Day Worked		N/A	397	404	
0144	Current Date Disability Began		N/A	405	412	
0065	Initial Date Last Day Worked		N/A	413	420	
0189	Return To Work Type Code			421	421	

SD -	- Suspension, Directed, Event 5	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
0224	Physical Restrictions Indicator			422	422	
	Suspension Effective Date	20130118	January 18, 2013	423	430	
0199	Full Denial Effective Date		N/A	431	438	
0196	Denial Rescission Date		N/A	439	446	
0294	Partial Denial Code		N/A	447	447	
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458	
0256	Wage Effective Date		N/A	459	466	
0149	Discontinued Fringe Benefits		N/A	467	477	
0290	Type of Loss Code	01	Trauma	478	479	
	Employment Status Code	1	Full Time	480	481	
	Permanent Impairment Minimum Payment Indicator		N/A	482	482	
	Initial Return to Work Date			483	490	
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491	
	Lump Sum Payment/Settlement Code		N/A	492	493	
0273	Employer Paid Salary in Lieu of Compensation	N	No	494	494	
	Average Wage	00000105000	\$1050.00	495	505	
	Initial Date of Lost Time		N/A	506	513	
0299	Award/Order Date	20130123	January 23, 2013	514	521	
0200	Claim Administrator Alternate Postal Code		N/A	522	530	
0203	Employer Paid Salary Prior to Acquisition Code			531	531	
0204	Work Week Type Code	s	Standard Work Week	532	532	
0205	Work Days Scheduled	NSSSSSN		533	539	
	Employee Security ID			540	554	
	Injury Severity Code			555	555	
	Filler			556	629	
	Variable Segment Counters					
0288	Number of Benefits	02	2 Occurrences	630	631	
0283	Number of Payments	00	N/A	632	633	
0282	Number of Other Benefits	00		634	635	
0289	Number of Benefit ACR	000		636	638	
0284	Number of Recoveries	00		639	640	
0285	Number of Reduced Earnings	00		641	642	
0275	Number of Concurrent Employers	00		643	644	
0277	Number of Full Denial Reason Code	00		645	646	
0276	Number of Denial Reason Narratives	00		647	648	
0287	Number of Suspension Narratives	01	1 Occurrence	649	650	
	Variable Segments			•		
	Benefits		2 Occurrences			
0085	Benefit Type Code	050	Temporary Total	651	653	
0002	Maintenance Type Code		N/A	654	655	
0174	Gross Weekly Amount		N/A	656	666	
0175	Gross Weekly Amount Effective Date		N/A	667	674	
	Net Weekly Amount		N/A	675	685	
0211	Net Weekly Amount Effective Date		N/A	686	693	

eCLAIMS BUSINESS SCENARIOS

SD –	Suspension, Directed, Event 5	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120904	September 04, 2012	702	709
0090	Benefit Type Claim Weeks	0004		710	713
0091	Benefit Type Claim Days	04		714	714
0086	Benefit Type Amount Paid	00001334000	\$13340.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	070	Temporary Partial	754	756
0002	Maintenance Type Code	SD	Suspension, Directed by Jurisdiction	757	758
0174	Gross Weekly Amount	00000035000	\$350.00	759	769
0175	Gross Weekly Amount Effective Date	20120905	September 05, 2012	770	777
0087	Net Weekly Amount	0000035000	\$350.00	778	788
0211	Net Weekly Amount Effective Date	20120905	September 05, 2012	789	796
0088	Benefit Period Start Date	20120905	September 05, 2012	797	804
0089	Benefit Period Through Date	20130118	January 18, 2013	805	812
0090	Benefit Type Claim Weeks	0019		813	816
0091	Benefit Type Claim Days	2		817	817
	Benefit Type Amount Paid	00000679000	\$6,790.00	818	828
0192	Benefit Payment Issue Date	20130124	January 24, 2013	829	836
	Filler			837	856
	Payments				
	Payment Reason Code		N/A		
	Payee				
	Payment Amount				
	Payment Covers Period Start Date				
	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				

eClaims Business Scenarios

- Suspension, Directed, Event 5	I ransaction Layout			
Data Element Name	Data	Description	Beg	End
Benefit Redistribution				
Benefit Redistribution Code				
Benefit Redistribution Start Date				
Benefit Redistribution End Date				
Benefit Redistribution Weekly Amount				
Recoveries				
Recovery Code				
Recovery Amount				
Reduced Earnings				
Reduced Earnings Week Number				
Actual Reduced Earnings				
Deemed Reduced Earnings				
Concurrent Employers				
Concurrent Employer Name				
Concurrent Employer Contact Business Phone				
Concurrent Employer Wage				
Denial Reason Codes				
Full Denial Reason Code				
Denial Reasons				
Denial Reason Narrative				
Suspension Narratives		1 Occurrence		
Suspension Narrative	PAYMENTS SUSPENDED PER 1/23/13 NOD ISSUED BY WCB		857	906
	Data Element Name Benefit Redistribution Benefit Redistribution Code Benefit Redistribution Start Date Benefit Redistribution End Date Benefit Redistribution Weekly Amount Recoveries Recovery Code Recovery Amount Reduced Earnings Reduced Earnings Reduced Earnings Deemed Reduced Earnings Denemed Reduced Earnings Concurrent Employers Concurrent Employer Name Concurrent Employer Wage Denial Reason Codes Full Denial Reason Code Denial Reason Narrative Suspension Narratives	Data Element NameDataBenefit RedistributionBenefit Redistribution CodeBenefit Redistribution Start DateBenefit Redistribution End DateBenefit Redistribution End DateBenefit Redistribution Weekly AmountRecoveriesRecoveriesRecovery CodeRecovery CodeReduced EarningsReduced EarningsDeemed Reduced EarningsDeemed Reduced EarningsDeemed Reduced EarningsConcurrent Employer NameConcurrent Employer Contact Business PhoneConcurrent Employer WageDenial Reason CodesFull Denial Reason CodeSuspension NarrativePAYMENTS SUSPENDED PER 1/23/13 NOD	Data Element NameDataDescriptionBenefit RedistributionBenefit Redistribution CodeBenefit Redistribution Start DateBenefit Redistribution End DateBenefit Redistribution Weekly AmountRecoveriesRecovery CodeReduced EarningsReduced EarningsDeemed Reduced EarningsDeemed Reduced EarningsConcurrent EmployersConcurrent Employer NameConcurrent Employer WageDenial Reason CodesFull Denial Reason NarrativeSuspension NarrativeSuspension NarrativePart Mark Suspension Narrative<	Data Element NameDataDescriptionBegBenefit RedistributionBenefit Redistribution CodeBenefit Redistribution Start DateBenefit Redistribution End DateBenefit Redistribution Weekly AmountRecoveries </td

End R22 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 8-2

Claim Administrator Appeal, Payments Suspended – MTC SJ

(Claim Administrator suspends payments pending outcome of appeal)

NARRATIVE:

Employee John Doe, from **Scenario 2-5**, retained an attorney soon after seeing his doctor and having his payments reduced. The attorney requested a hearing before the Board on various issues.

On November 14, 2012, a hearing was held and continuing payments at the same rate as well as an attorney's fee of \$100.00 were directed by the Workers' Compensation Law Judge. The Notice of Decision was issued on November 16, 2012. After the hearing, the Claim Administrator reported the payment information to the NYS Workers' Compensation Board by sending the Payment Report (**SROI PY**) transaction report to the NYSWCB on **November 20, 2012**.

Several weeks after the hearing, the claimant missed his follow-up appointment with his doctor. On **December 20, 2012**, the Claim Administrator filed a Request for Further Action (RFA-2) to suspend payments. On **January 18, 2013**, another hearing was held. The Judge declined to suspend payments and continued payments to the claimant at the same rate. The Board issued the Notice of Decision on January 23, 2013.

The Claim Administrator disagreed with the Notice of Decision and immediately requested their attorney draft an RB-89 Appeal of the Notice of Decision and **did NOT continue payments pending the outcome of the appeal**. The Claim Administrator reported the suspension pending appeal outcome to the NYS Workers' Compensation Board by sending the Suspended, Pending Appeal or Judicial Review (**SROI SJ**) transaction report to the NYSWCB on **January 24, 2013**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-5</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment Event 3: SROI MTC CB – Change in Benefit Type

<u>Scenario 8-2</u> Event 4: SROI MTC PY – Payment Report See Scenario 8-1 for example of SROI-PY submission. Event 5: SROI MTC SJ – Suspended, Pending Appeal or Judicial Review

eCLAIMS BUSINESS SCENARIOS

	- Suspension, Appeal, Event 5 Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	SJ	Suspension, Pending Appeal	4	5	
0003	Maintenance Type Code Date	20130124	January 24, 2013	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents		N/A	52	53	
0069	Pre-Existing Disability Code		N/A	54	54	
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date			72	79	
0057	Employee Date of Death		N/A	80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
0064	Number of Days Worked Per Week		N/A	101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number		N/A	111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code	I	Indemnity	187	187	
0075	Agreement to Compensate Code	L	With Liability	188	188	
	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments				1	
0083	Permanent Impairment Body Part Code		N/A		<u> </u>	
	Permanent Impairment Percentage		N/A		<u> </u>	
	Death/Dependent/Payee Relationships				<u> </u>	
0097	Dependent/Payee Relationship Code				<u> </u>	
5551	End A49 Elements					

eCLAIMS BUSINESS SCENARIOS

	- Suspension, Appeal, Event 5	Transaction L	_		
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				-
	Transaction Set ID	R22	Subsequent Report	1	3
	Maintenance Type Correction Code		N/A	4	5
	Maintenance Type Correction Code Date		N/A	6	13
0298	Date Claim Administrator Had Knowledge of Lost		N/A	14	21
0186	Jurisdiction Branch Office Code		N/A	22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level		N/A	342	343
0213	Employee Number of Entitled Exemptions		N/A	344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code		N/A	348	348
0146	Death Result of Injury Code		N/A	349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN		N/A	359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code		N/A	377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code		N/A	395	395
	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked		N/A	397	404
	Current Date Disability Began		N/A	405	412
	Initial Date Last Day Worked		N/A	413	420
	Return To Work Type Code			421	421

SJ – Suspension, Appeal, Event 5 Transaction Layout						
DN	Data Element Name	Data	Description	Beg	End	
0224	Physical Restrictions Indicator			422	422	
0193	Suspension Effective Date	20130118	January 18, 2013	423	430	
0199	Full Denial Effective Date		N/A	431	438	
0196	Denial Rescission Date		N/A	439	446	
0294	Partial Denial Code		N/A	447	447	
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458	
0256	Wage Effective Date		N/A	459	466	
0149	Discontinued Fringe Benefits		N/A	467	477	
0290	Type of Loss Code	01	Trauma	478	479	
0058	Employment Status Code	1	Full Time	480	481	
	Permanent Impairment Minimum Payment Indicator		N/A	482	482	
	Initial Return to Work Date			483	490	
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491	
	Lump Sum Payment/Settlement Code		N/A	492	493	
0273	Employer Paid Salary in Lieu of Compensation			494	494	
0286	Average Wage	00000105000	\$1050.00	495	505	
	Initial Date of Lost Time		N/A	506	513	
0299	Award/Order Date	20130123	January 23, 2013	514	521	
0200	Claim Administrator Alternate Postal Code		N/A	522	530	
	Employer Paid Salary Prior to Acquisition Code			531	531	
	Work Week Type Code	S	Standard Work Week	532	532	
0205	Work Days Scheduled	NSSSSSN		533	539	
	Employee Security ID			540	554	
	Injury Severity Code			555	555	
	Filler			556	629	
	Variable Segment Counters					
0288	Number of Benefits	01	2 Occurrences	630	631	
0283	Number of Payments	00	N/A	632	633	
0282	Number of Other Benefits	00		634	635	
0289	Number of Benefit ACR	000		636	638	
0284	Number of Recoveries	00		639	640	
0285	Number of Reduced Earnings	00		641	642	
	Number of Concurrent Employers	00		643	644	
	Number of Full Denial Reason Code	00		645	646	
0276	Number of Denial Reason Narratives	00		647	648	
0287	Number of Suspension Narratives	02	2 Occurrences	649	650	
	Variable Segments					
	Benefits		2 Occurrences			
0085	Benefit Type Code	050	Temporary Total	651	653	
-	Maintenance Type Code		N/A	654	655	
0174	Gross Weekly Amount		N/A	656	666	
-	Gross Weekly Amount Effective Date		N/A	667	674	
	Net Weekly Amount		N/A	675	685	
	Net Weekly Amount Effective Date		N/A	686	693	

SJ	– Suspension, Appeal, Event 5	Transactio	n Layout		
	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120904	September 04, 2012	702	709
0090	Benefit Type Claim Weeks	0004		710	713
0091	Benefit Type Claim Days	04		714	714
0086	Benefit Type Amount Paid	00001334000	\$13340.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	070	Temporary Partial	754	756
0002	Maintenance Type Code	SJ	Suspension, Pending Appeal	757	758
0174	Gross Weekly Amount	0000035000	\$350.00	759	769
0175	Gross Weekly Amount Effective Date	20120905	September 05, 2012	770	777
0087	Net Weekly Amount	0000035000	\$350.00	778	788
0211	Net Weekly Amount Effective Date	20120905	September 05, 2012	789	796
0088	Benefit Period Start Date	20120905	September 05, 2012	797	804
0089	Benefit Period Through Date	20130118	January 18, 2013	805	812
0090	Benefit Type Claim Weeks	0019		813	816
0091	Benefit Type Claim Days	2		817	817
0086	Benefit Type Amount Paid	00000679000	\$6,790.00	818	828
0192	Benefit Payment Issue Date	20130124	January 24, 2013	829	836
	Filler			837	856
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				

eClaims Business Scenarios

SJ -	- Suspension, Appeal, Event 5	Transaction L	ayout		
	Data Element Name	Data	Description	Beg	End
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives		2 Occurrences		
0233	Suspension Narrative	PAYMENTS SUSPENDED AS CARRIER APPEALING CCP DIRECT		857	906
0233	Suspension Narrative	ION IN 1/23/13 NOD ISSUED BY WCB		907	956

End R22 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 8-3

Permanent Partial Disability (PPD) Benefits Cap Suspension, Benefits Exhausted – MTC S7

(Claimant is classified as PPD and exhausts their benefits)

NARRATIVE:

Employee John Doe, from **Scenario 2-5 and Scenario 9-1**, continued to remain out of work for two years, at which point the Claim Administrator sent John Doe to an Independent Medical Exam (IME) regarding permanency. Subsequently, John Doe's doctor agreed with the IME opinion.

On August 15, 2012, a hearing was held and it was determined by the Workers' Compensation Law Judge that the claimant had a permanent partial disability (PPD) with a 50% loss of wage earning capacity. Continuing payments at the PPD rate began on August 15, 2012 and were **subject to a statutory benefits cap of 300 weeks**. The Notice of Decision was issued on August 20, 2012. After the hearing, the Claim Administrator reported the payment information to the NYS Workers' Compensation Board by sending the Payment Report (**SROI CB**) transaction report to the NYSWCB on **August 23, 2012**.

Over the next several years, the Claim Administrator meets its obligation of Sub-Annual Reports for No Further Action Claims by submitting the **SROI SA** as per Board Filing Requirements **every 180 days from the date of accident and subsequent SROI SA filings**. On **May 15, 2018**, the Claim Administrator determines that the claimant has been paid 300 weeks of compensation and has exhausted further compensation benefits and stopped payment to the claimant.

The Claim Administrator reported the suspension to the NYS Workers' Compensation Board by sending the Suspension, Benefits Exhausted (SROI S7) transaction report to the NYSWCB on May 22, 2018.

<u>Scenario 2-5</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment Event 3: SROI MTC CB – Change in Benefit Type

<u>Scenario 9-1</u> Event 4 (ongoing): SROI MTC SA – Sub Annual Report (Ongoing Every 180 Days)

<u>Scenario 8-3</u> Event 5: SROI MTC CB – Change in Benefit Type (to PPD) Event 6: SROI MTC SA – Sub Annual Report (Ongoing Every 180 Days) See Scenarios 9-1 & 9-2 for examples of SROI-SA submissions. Event 7: SROI MTC S7 – Suspension, Benefits Exhausted

NOTE: For this scenario, it is assumed that the Date of Accident AND all other transaction dates occurred in the year **2010** for **Scenario 2-5** AND occurred in the year **2011** for **Scenario 9-1**. It is also assumed that eClaims has been in place during this entire Scenario.

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	СВ	Change in Benefit Type	4	5
0003	Maintenance Type Code Date	20120823	August 23, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code			54	54
0056	Initial Date Disability Began			55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week			101	101
	Filler			102	102
0031	Date of Injury	20100801	August 01, 2010	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				<u> </u>
0078	Number of Permanent Impairments	01		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				<u> </u>
0083	Permanent Impairment Body Part Code	54	Lower Leg	209	211
	Permanent Impairment Percentage	05000	50.00%	212	216
	Death/Dependent/Payee Relationships		00.0070	~1~	210
0007					
0097	Dependent/Payee Relationship Code End A49 Elements				

eClaims Business Scenarios

DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
	1, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,	20100801	August 01, 2010	387	394
	Non-Consecutive Period Code			395	395
	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked			413	420
0189	Return To Work Type Code			421	421

eClaims Business Scenarios

DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	Ν	No		
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20100802	August 02, 2010	506	513
0299	Award/Order Date	20120820	August 20, 2012	514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	03	3 Occurrences	630	631
0283	Number of Payments	00	N/A	632	633
	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
-	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		3 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
-	Maintenance Type Code		N/A	654	655
0174	Gross Weekly Amount		N/A	656	666
	Gross Weekly Amount Effective Date		N/A	667	674
	Net Weekly Amount		N/A	675	685

eClaims Business Scenarios

	– Change in Benefit Type, Event				
DN	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date		N/A	686	693
0088	Benefit Period Start Date	20100802	August 02, 2010	694	701
0089	Benefit Period Through Date	20100904	September 04, 2010	702	709
0090	Benefit Type Claim Weeks	0004		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000336000	\$3360.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	070	Temporary Partial	754	756
0002	Maintenance Type Code	СВ	Change in Benefit Type	757	758
0174	Gross Weekly Amount	0000035000	\$350.00	759	769
0175	Gross Weekly Amount Effective Date	20100905	September 05, 2010	770	777
0087	Net Weekly Amount	0000035000	\$350.00	778	788
0211	Net Weekly Amount Effective Date	20100905	September 05, 2010	789	796
0088	Benefit Period Start Date	20100905	September 05, 2010	797	804
0089	Benefit Period Through Date	20120814	August 14, 2012	805	812
0090	Benefit Type Claim Weeks	0101		813	816
0091	Benefit Type Claim Days	2		817	817
0086	Benefit Type Amount Paid	00003549000	\$35490.00	818	828
	Benefit Payment Issue Date	20120823	August 23, 2012	829	836
	Filler			837	856
0085	Benefit Type Code	030	Permanent Partial Scheduled	857	859
0002	Maintenance Type Code	СВ	Change in Benefit Type	860	861
0174	Gross Weekly Amount	0000035000	\$350.00	862	872
0175	Gross Weekly Amount Effective Date	20120815	August 15, 2012	873	880
0087	Net Weekly Amount	0000035000	\$350.00	881	891
0211	Net Weekly Amount Effective Date	20120815	August 15, 2012	892	899
0088	Benefit Period Start Date	20120815	August 15, 2012	900	907
0089	Benefit Period Through Date	20120823	August 23, 2012	908	915
0090	Benefit Type Claim Weeks	0001		916	919
0091	Benefit Type Claim Days	2		920	920
0086	Benefit Type Amount Paid	00000049000	\$490.00	921	931
0192	Benefit Payment Issue Date	20120823	August 23, 2012	932	939
	Filler			940	959
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
	Payment Amount				
	Payment Covers Period Start Date				
	Payment Covers Period Through Date				
	Payment Issue Date				
	Payment Reason Code				1
	Payee				

eClaims Business Scenarios

DN	Data Element Name	Data	Description	Beg	End
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative			1	
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements	1		- i	

eCLAIMS BUSINESS SCENARIOS

	- Benefits Exhausted, Event 7	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	S7	Suspension, Benefits Exhausted	4	5
0003	Maintenance Type Code Date	20180522	May 22, 2018	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents		N/A	52	53
0069	Pre-Existing Disability Code		N/A	54	54
0056	Initial Date Disability Began	20100802	August 02, 2010	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death		N/A	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week		N/A	101	101
	Filler			102	102
0031	Date of Injury	20100801	August 01, 2010	103	110
0026	Insured Report Number		N/A	111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	01		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code	54	Lower Leg	209	211
	Permanent Impairment Percentage	05000	50%	212	216
	Death/Dependent/Payee Relationships	03000	5070	~ 1 ~	210
0091	Dependent/Payee Relationship Code End A49 Elements				

eClaims Business Scenarios

<u> 87 -</u>	– Benefits Exhausted, Event 7 Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code		N/A	4	5
0296	Maintenance Type Correction Code Date		N/A	6	13
0298	Date Claim Administrator Had Knowledge of Lost		N/A	14	21
0186	Jurisdiction Branch Office Code		N/A	22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level		N/A	342	343
0213	Employee Number of Entitled Exemptions		N/A	344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code		N/A	348	348
0146	Death Result of Injury Code		N/A	349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN		N/A	359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code		N/A	377	385
0228	Return To Work With Same Employer Indicator	Y	Yes	386	386
0281	Date Employer Had Knowledge of Date of Disability	20100801	August 01, 2010	387	394
0212	Non-Consecutive Period Code		N/A	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked		N/A	397	404
0144	Current Date Disability Began		N/A	405	412
0065	Initial Date Last Day Worked		N/A	413	420
	Return To Work Type Code			421	421

eCLAIMS BUSINESS SCENARIOS

	- Benefits Exhausted, Event 7	Transaction		D	_
	Data Element Name	Data	Description	Beg	End
	Physical Restrictions Indicator			422	422
	Suspension Effective Date	20180522	May 22, 2018	423	430
0199	Full Denial Effective Date		N/A	431	438
0196	Denial Rescission Date		N/A	439	446
0294	Partial Denial Code		N/A	447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits		N/A	467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator		N/A	482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code		N/A	492	493
	Employer Paid Salary in Lieu of Compensation			494	494
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time		N/A	506	513
	Award/Order Date	20120820	August 20, 2012	514	521
	Claim Administrator Alternate Postal Code		N/A	522	530
	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	S	Standard Work Week	532	532
)205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	03	3 Occurrences	630	631
	Number of Payments	00	N/A	632	633
	Number of Other Benefits	00		634	635
	Number of Benefit ACR	000		636	638
	Number of Recoveries	00		639	640
	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
			2.022		
0287	Number of Suspension Narratives	02	2 Occurrences	649	650
	Variable Segments Benefits				1
0005		050	3 Occurrences	GE 1	650
	Benefit Type Code	050	Temporary Total N/A	651	653
	Maintenance Type Code			654	655
	Gross Weekly Amount		N/A	656	666
	Gross Weekly Amount Effective Date		N/A	667	674
	Net Weekly Amount		N/A	675	685
)211	Net Weekly Amount Effective Date		N/A	686	693

S7 -	- Benefits Exhausted, Event 7	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20100802	August 02, 2010	694	701
0089	Benefit Period Through Date	20100904	September 04, 2010	702	709
0090	Benefit Type Claim Weeks	0004		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000336000	\$3360.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
	Benefit Type Code	070	Temporary Partial	754	756
0002	Maintenance Type Code		N/A	757	758
0174	Gross Weekly Amount		N/A	759	769
0175	Gross Weekly Amount Effective Date		N/A	770	777
0087	Net Weekly Amount		N/A	778	788
	Net Weekly Amount Effective Date		N/A	789	796
0088	Benefit Period Start Date	20100905	September 05, 2010	797	804
0089	Benefit Period Through Date	20120814	August 14, 2012	805	812
0090	Benefit Type Claim Weeks	0101		813	816
0091	Benefit Type Claim Days	2		817	817
0086	Benefit Type Amount Paid	00003549000	\$35490.00	818	828
0192	Benefit Payment Issue Date		N/A	829	836
	Filler			837	856
0085	Benefit Type Code	030	Permanent Partial Scheduled	857	859
0002	Maintenance Type Code	S7	Suspension, Benefits Exhausted	860	861
0174	Gross Weekly Amount	0000035000	\$350.00	862	872
0175	Gross Weekly Amount Effective Date	20120815	August 15, 2012	873	880
0087	Net Weekly Amount	0000035000	\$350.00	881	891
0211	Net Weekly Amount Effective Date	20120815	August 15, 2012	892	899
0088	Benefit Period Start Date	20120815	August 15, 2012	900	907
0089	Benefit Period Through Date	20180515	May 15, 2018	908	915
0090	Benefit Type Claim Weeks	0300		916	919
0091	Benefit Type Claim Days	0		920	920
0086	Benefit Type Amount Paid	00010500000	\$105,000.00	921	931
0192	Benefit Payment Issue Date	20180522	May 22, 2018	932	939
	Filler			940	959
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
	Payment Amount				
	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
0222	Payment Reason Code				
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				

eCLAIMS BUSINESS SCENARIOS

<u> 87 -</u>	- Benefits Exhausted, Event 7	Transaction La	ayout		
DN	Data Element Name	Data	Description	Beg	End
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone				
	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative	CLT REACHED CAP ON PPD BENEFITS. CLT CLASSIFIED 50%		960	1009
0233	Suspension Narrative	PPD PER 08/15/12 HEARING, CAP/MAX OF 300 WEEKS.		1010	1059
	End R22 Elements			•	

End R22 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 8-4

Reinstatement of Benefits – MTC RB

(Claim Administrator reinstates payments to claimant)

NARRATIVE:

Employee John Doe, from Scenario 2-5 and 8-1, followed up with his medical provider on February 1, 2013 and was referred to an orthopedic surgeon the same day. The orthopedic surgeon opined a Temporary Total Disability as John Doe was now in need of emergent surgery. The Claim Administrator determined, based upon the medical report, that the treatment was related to the claim and they would begin payment to the claimant without a hearing.

The Claim Administrator mailed a check to the claimant on **February 12, 2013** paying him **Temporary Total Benefits** for the period **February 1, 2013 through February 12, 2013.** The Claim Administrator reported the reinstatement of benefits to the NYS Workers' Compensation Board by sending a Reinstatement of Benefit (**SROI RB**) transaction report to the NYSWCB on **February 12, 2013**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-5</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment Event 3: SROI MTC CB – Change in Benefit Type

<u>Scenario 8-1</u> Event 4: SROI MTC PY – Payment Report Event 5: SROI MTC SD – Suspension, Directed by Jurisdiction

Scenario 8-4 Event 6: SROI MTC RB – Reinstatement of Benefit

RB ·	– Reinstatement, Event 6	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	RB	Reinstatement of Benefit	4	5
0003	Maintenance Type Code Date	20130212	February 12, 2013	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code			54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week			101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements				

eCLAIMS BUSINESS SCENARIOS

RB – Reinstatement, Event 6Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
	Employee Education Level			342	343
	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began	20130201	February 1, 2013	405	412
0065	Initial Date Last Day Worked			413	420

eCLAIMS BUSINESS SCENARIOS

RB ·	– Reinstatement, Event 6	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0189	Return To Work Type Code			421	421
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	N	No		
	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	01	1 Occurrence	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		2 Occurrences		
0085	Benefit Type Code	070	Temporary Partial	651	653
0002	Maintenance Type Code		N/A	654	655
	Gross Weekly Amount		N/A	656	666
0175	Gross Weekly Amount Effective Date		N/A	667	674
0087	Net Weekly Amount		N/A	675	685

RB	– Reinstatement, Event 6	Transactior	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date		N/A	686	693
8800	Benefit Period Start Date	20120905	September 05, 2012	694	701
0089	Benefit Period Through Date	20130118	January 18, 2013	702	709
0090	Benefit Type Claim Weeks	0019		710	713
0091	Benefit Type Claim Days	3		714	714
0086	Benefit Type Amount Paid	00000679000	\$6,790.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	050	Temporary Total	754	756
0002	Maintenance Type Code	RB	Reinstatement of Benefit	757	758
0174	Gross Weekly Amount	0000070000	\$700.00	759	769
0175	Gross Weekly Amount Effective Date	20120802	August 02, 2012	770	777
0087	Net Weekly Amount	0000070000	\$700.00	778	788
0211	Net Weekly Amount Effective Date	20120802	August 02, 2012	789	796
8800	Benefit Period Start Date	20130201	February 01, 2013	797	804
0089	Benefit Period Through Date	20130212	February 12, 2013	805	812
0090	Benefit Type Claim Weeks	0006		813	816
0091	Benefit Type Claim Days	2		817	817
0086	Benefit Type Amount Paid	00000448000	\$4,480.00	818	828
0192	Benefit Payment Issue Date	20130212	February 12, 2013	829	836
	Filler			837	856
	Payments		1 Occurrences		
0222	Payment Reason Code	050	Temporary Total	857	859
0217	Payee	JOHN DOE		860	899
0218	Payment Amount	00000112000	\$1,120.00	900	910
0219	Payment Covers Period Start Date	20130201	February 01, 2013	911	918
0220	Payment Covers Period Through Date	20130212	February 12, 2013	919	926
0195	Payment Issue Date	20130212	February 12, 2013	927	934
	Filler			935	954
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				

eCLAIMS BUSINESS SCENARIOS

RB ·	– Reinstatement, Event 6	Transacti	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 9-1

Sub-Annual Report for Open Claims – MTC SA

(Claimant remains out of work and continues receiving payments 180 days from date of accident)

NARRATIVE:

Employee John Doe, from **Scenario 2-5**, continued out of work on a Temporary Partial Disability at the same rate. On February 1, 2013, the claimant had been out of work for 180 days and per Board Filing Requirements the Claim Administrator was due to file a Sub-Annual Report due to the continuing payments.

The Claim Administrator reported the Sub-Annual Report to the NYS Workers' Compensation Board by sending a Sub-Annual Report (**SROI SA**) transaction report to the NYSWCB on **February 1, 2013**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-5</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment Event 3: SROI MTC CB – Change in Benefit Type

<u>Scenario 9-1</u> Event 4 (ongoing): SROI MTC SA – Sub Annual Report (Ongoing Every 180 Days)

eCLAIMS BUSINESS SCENARIOS

	– Sub-Annual (OPEN), Event 4 Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	SA	Sub-Annual	4	5	
0003	Maintenance Type Code Date	20130201	February 01, 2013	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents			52	53	
0069	Pre-Existing Disability Code			54	54	
	Initial Date Disability Began		N/A	55	62	
0070	Date of Maximum Medical Improvement		N/A	63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date		N/A	72	79	
0057	Employee Date of Death		N/A	80	87	
	Filler			88	98	
0063	Wage Period Code		N/A	99	100	
0064	Number of Days Worked Per Week		N/A	101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number			111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code		N/A	187	187	
0075	Agreement to Compensate Code		N/A	188	188	
0076	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code		N/A	197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
0083	Permanent Impairment Body Part Code					
	Permanent Impairment Percentage					
	Death/Dependent/Payee Relationships					
0097	Dependent/Payee Relationship Code					
0031	End A49 Elements					

eCLAIMS BUSINESS SCENARIOS

SA -	– Sub-Annual (OPEN), Event 4	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
	Date Employer Had Knowledge of Date of Disability		N/A	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code			421	421

SA -	– Sub-Annual (OPEN), Event 4	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount		N/A	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code		N/A	478	479
0058	Employment Status Code		N/A	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator		N/A	491	491
0293	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation Indicator		N/A	494	494
0286	Average Wage		N/A	495	505
0297	Initial Date of Lost Time		N/A	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	s	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	03	3 Occurrences	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		2 Occurrences		
	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code		N/A	654	655
0174	Gross Weekly Amount		N/A	656	666
	Gross Weekly Amount Effective Date		N/A	667	674
0087	Net Weekly Amount		N/A	675	685

eClaims Business Scenarios

<u>SA</u> ·	– Sub-Annual (OPEN), Event 4	Transaction Layout				
	Data Element Name	Data	Description	Beg	End	
0211	Net Weekly Amount Effective Date		N/A	686	693	
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701	
0089	Benefit Period Through Date	20120904	September 04, 2012	702	709	
	Benefit Type Claim Weeks	0004		710	713	
	Benefit Type Claim Days	4		714	714	
	Benefit Type Amount Paid	00000336000	\$3360.00	715	725	
	Benefit Payment Issue Date		N/A	726	733	
	Filler			734	753	
0085	Benefit Type Code	070	Temporary Partial	754	756	
	Maintenance Type Code		N/A	757	758	
0174	Gross Weekly Amount		N/A	759	769	
	Gross Weekly Amount Effective Date		N/A	770	777	
	Net Weekly Amount		N/A	778	788	
0211	Net Weekly Amount Effective Date		N/A	789	796	
0088	Benefit Period Start Date	20120905	September 05, 2012	797	804	
0089	Benefit Period Through Date	20130201	February 01, 2013	805	812	
	Benefit Type Claim Weeks	0021		813	816	
	Benefit Type Claim Days	3		817	817	
	Benefit Type Amount Paid	00000756000	\$7560.00	818	828	
	Benefit Payment Issue Date		N/A	829	836	
	Filler			837	856	
	Payments					
0222	Payment Reason Code		N/A			
	Payee					
0218	Payment Amount					
	Payment Covers Period Start Date					
0220	Payment Covers Period Through Date					
0195	Payment Issue Date					
	Other Benefits		3 Occurrences			
0216	Other Benefit Type Code	350	Total Payment to Physicians	857	859	
0215	Other Benefit Type Amount	00000156000	\$1560.00	860	870	
	Filler			871	890	
0216	Other Benefit Type Code	360	Total Hospital Costs	891	893	
	Other Benefit Type Amount	00000212000	\$2120.00	894	904	
	Filler			905	924	
0216	Other Benefit Type Code	450	Total Pharmaceutical Costs	925	927	
0215	Other Benefit Type Amount	0000035600	\$356.00	928	938	
	Filler			939	958	

eClaims Business Scenarios

<u>SA</u>	– Sub-Annual (OPEN), Event 4	Transactio	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative			1	
	Suspension Narratives			1	
0233	Suspension Narrative				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 9-2

Sub-Annual Report for No Further Action Claims – MTC SA

(Claimant remains out of work and continues receiving payments 180 days from date of accident)

NARRATIVE:

Employee John Doe, from **Scenario 2-5**, continued out of work on a Temporary Partial Disability at the same rate. John Doe retained an attorney who requested a hearing on various outstanding issues.

On November 14, 2012 a hearing was held and continuing payments at the same rate were directed by the Workers' Compensation Law Judge. The claimant's attorney was awarded a \$100.00 fee at the hearing. The Notice of Decision was issued on November 16, 2012. After the hearing, the Claim Administrator reported the payment information to the NYS Workers' Compensation Board by sending the Payment Report (**SROI PY**) transaction report to the NYSWCB on **November 20, 2012**.

On February 1, 2013, the claimant had been out of work for 180 days and per Board Filing Requirements the Claim Administrator was due to file a Sub-Annual Report due to the continuing payments.

The Claim Administrator reported the Sub-Annual Report to the NYS Workers' Compensation Board by sending a Sub-Annual Report (**SROI SA**) transaction report to the NYSWCB on **February 1, 2013**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-5</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment Event 3: SROI MTC CB – Change in Benefit Type

<u>Scenario 9-2</u> Event 4: SROI MTC PY – Payment Report Event 5 (ongoing): SROI MTC SA – Sub Annual Report (Ongoing Every 180 Days)

	– Payment Report, Event 4	Transactio		-	
DN	Data Element Name	Data	Description	Beg	Ena
	A49 Data Elements				
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	PY	Payment Report	4	5
	Maintenance Type Code Date	20121120	November 20, 2012	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements				-

PY-	- Payment Report, Event 4	Transaction Layout			
	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
-		20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
-	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked			413	420

PY-	- Payment Report, Event 4	Transactior	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0189	Return To Work Type Code			421	421
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation	N	No	494	494
	Average Wage	N 00000105000	No \$1050.00	495	505
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
	Award/Order Date	20120802	November 16, 2012	500	513
	Claim Administrator Alternate Postal Code	20121110		522	530
	Employer Paid Salary Prior to Acquisition Code			522	530
	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	01	1 Occurrence	632	633
	Number of Other Benefits	03	3 Occurrences	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		2 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code		N/A	654	655
0174	Gross Weekly Amount		N/A	656	666
0175	Gross Weekly Amount Effective Date		N/A	667	674
0087	Net Weekly Amount		N/A	675	685

PY-	– Payment Report, Event 4	Transaction	Layout		
	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date		N/A	686	693
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120904	September 04, 2012	702	709
0090	Benefit Type Claim Weeks	0004		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000336000	\$3,360.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	070	Temporary Partial	754	756
0002	Maintenance Type Code		N/A	757	758
0174	Gross Weekly Amount		N/A	759	769
0175	Gross Weekly Amount Effective Date		N/A	770	777
0087	Net Weekly Amount		N/A	778	788
0211	Net Weekly Amount Effective Date		N/A	789	796
0088	Benefit Period Start Date	20120905	September 05, 2012	797	804
0089	Benefit Period Through Date	20121114	November 14, 2012	805	812
0090	Benefit Type Claim Weeks	0010		813	816
0091	Benefit Type Claim Days	0		817	817
0086	Benefit Type Amount Paid	00000350000	\$3,500.00	818	828
0192	Benefit Payment Issue Date		N/A	829	836
	Filler			837	856
	Payments		1 Occurrence		
0222	Payment Reason Code	340	Claimant's Legal Expense	857	859
0217	Payee	ATTORNEY DOE		860	899
0218	Payment Amount	0000010000	\$100.00	900	910
0219	Payment Covers Period Start Date	20121120	November 20, 2012	911	918
0220	Payment Covers Period Through Date	20121120	November 20, 2012	919	926
0195	Payment Issue Date	20121120	November 20, 2012	927	934
	Filler			935	954
	Other Benefits		3 Occurrences		
0216	Other Benefit Type Code	340	Total Claimant's Legal Expenses	955	957
0215	Other Benefit Type Amount	0000010000	\$100.00	958	968
	Filler			969	988
0216	Other Benefit Type Code	350	Total Payment to Physicians	989	991
0215	Other Benefit Type Amount	0000096600	\$966.00	992	1002
	Filler			1003	1022

DN	Data Element Name	Data	Description	Beg	End
0216	Other Benefit Type Code	450	Total		
			Pharmaceutical	1023	1025
			Costs		
0215	Other Benefit Type Amount	00000022600	\$226.00	1026	1036
	Filler			1037	1056
	Benefit Adjustments				
	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				

eCLAIMS BUSINESS SCENARIOS

	– Sub-Annual (NFA), Event 5	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	SA	Sub-Annual	4	5	
0003	Maintenance Type Code Date	20130201	February 01, 2013	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents			52	53	
0069	Pre-Existing Disability Code			54	54	
0056	Initial Date Disability Began		N/A	55	62	
0070	Date of Maximum Medical Improvement		N/A	63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date		N/A	72	79	
0057	Employee Date of Death		N/A	80	87	
	Filler			88	98	
0063	Wage Period Code		N/A	99	100	
0064	Number of Days Worked Per Week		N/A	101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number			111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code		N/A	187	187	
0075	Agreement to Compensate Code		N/A	188	188	
0076	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code		N/A	197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
0083	Permanent Impairment Body Part Code					
	Permanent Impairment Percentage					
	Death/Dependent/Payee Relationships					
0007	Dependent/Payee Relationship Code					
0031	End A49 Elements					

eCLAIMS BUSINESS SCENARIOS

<u>SA -</u>	– Sub-Annual (NFA), Event 5	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
	Date Employer Had Knowledge of Date of Disability		N/A	387	394
	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code			421	421

eClaims Business Scenarios

<u>SA –</u>	· Sub-Annual (NFA), Event 5	Transactio	n Layout		
DN L	Data Element Name	Data	Description	Beg	End
0224 F	Physical Restrictions Indicator			422	422
0193 S	Suspension Effective Date			423	430
0199 F	Full Denial Effective Date			431	438
0196 E	Denial Rescission Date			439	446
0294 F	Partial Denial Code			447	447
0134 C	Calculated Weekly Compensation Amount		N/A	448	458
0256 V	Vage Effective Date		N/A	459	466
0149 C	Discontinued Fringe Benefits			467	477
0290 T	Type of Loss Code		N/A	478	479
0058 E	Employment Status Code		N/A	480	481
0223 F	Permanent Impairment Minimum Payment Indicator			482	482
0068 I	nitial Return to Work Date			483	490
0066 F	Full Wages Paid For Date Of Injury Indicator		N/A	491	491
0293 L	ump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation ndicator		N/A	494	494
0286 A	Average Wage		N/A	495	505
	nitial Date of Lost Time		N/A	506	513
0299 A	Award/Order Date			514	521
0200 C	Claim Administrator Alternate Postal Code			522	530
)203 E	Employer Paid Salary Prior to Acquisition Code			531	531
)204 V	Work Week Type Code	s	Standard Work Week	532	532
)205 V	Nork Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	njury Severity Code			555	555
F	Filler			556	629
١	Variable Segment Counters				
0288 N	Number of Benefits	02	2 Occurrences	630	631
0283 N	Number of Payments	00	N/A	632	633
	Number of Other Benefits	03	3 Occurrences	634	635
0289 N	Number of Benefit ACR	000		636	638
0284 N	Number of Recoveries	00		639	640
	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments			1	
	Benefits		2 Occurrences		
	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code		N/A	654	655
0174	Gross Weekly Amount		N/A	656	666
	Gross Weekly Amount Effective Date		N/A	667	674
	Net Weekly Amount		N/A	675	685

eClaims Business Scenarios

SA	– Sub-Annual (NFA), Event 5	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date		N/A	686	693
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120904	September 04, 2012	702	709
0090	Benefit Type Claim Weeks	0004		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000336000	\$3360.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	070	Temporary Partial	754	756
0002	Maintenance Type Code		N/A	757	758
0174	Gross Weekly Amount		N/A	759	769
0175	Gross Weekly Amount Effective Date		N/A	770	777
0087	Net Weekly Amount		N/A	778	788
0211	Net Weekly Amount Effective Date		N/A	789	796
0088	Benefit Period Start Date	20120905	September 05, 2012	797	804
0089	Benefit Period Through Date	20130201	February 01, 2013	805	812
0090	Benefit Type Claim Weeks	0021		813	816
0091	Benefit Type Claim Days	3		817	817
0086	Benefit Type Amount Paid	00000756000	\$7560.00	818	828
0192	Benefit Payment Issue Date		N/A	829	836
	Filler			837	856
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
0222	Payment Reason Code				
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				

eCLAIMS BUSINESS SCENARIOS

	– Sub-Annual (NFA), Event 5	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	Other Benefits		3 Occurrences		
0216	Other Benefit Type Code	340	Total Claimant's Legal Expenses	857	859
0215	Other Benefit Type Amount	0000010000	\$100.00	860	870
	Filler			871	890
0216	Other Benefit Type Code	350	Total Payment to Physicians	891	893
0215	Other Benefit Type Amount	00000156000	\$1560.00	894	904
	Filler			905	924
0216	Other Benefit Type Code	450	Total Pharmaceutical	925	927
0215	Other Benefit Type Amount	00000035600	\$356.00	928	938
	Filler			939	958
	Benefit Adjustments				
0092	Benefit Adjustment Code				
	Benefit Adjustment Start Date				
	Benefit Adjustment End Date				
	Benefit Adjustment Weekly Amount				
	Benefit Credit Code				
0127	Benefit Credit Start Date				
	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone				
	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
-	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
	Suspension Narrative			<u> </u>	

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 9-3

Schedule Loss of Use Award – MTC PY Late Payment of Award - Penalties – MTC PY

(SLU Award, then Claim Administrator paid award late, subject to 20% penalty under §25-3(f))

NARRATIVE:

Employee John Doe, from **Scenario 2-7**, is now one year post-injury for his broken leg. He scheduled a follow-up visit with his orthopedic doctor for a schedule loss of use (SLU) evaluation. The doctor opined a 20% schedule loss of use of the right leg. The carrier, upon receiving a copy of the SLU evaluation, sent the claimant to an Independent Medical Exam (IME) on September 5, 2013. The Claim Administrator's IME opined a 10% SLU. Due to the differing opinions, the Board scheduled a hearing on the file.

On October 9, 2013 a hearing was held and the parties agreed to a 15% SLU award for the right leg. The **Notice of Decision was issued on October 11, 2013**. After the hearing the Claim Administrator issued payment for the SLU on **October 24, 2013**. The Claim Administrator reported the payment information to the NYS Workers' Compensation Board by sending the Payment Report (**SROI PY**) transaction report to the NYSWCB on **October 24, 2013**.

The NYSWCB determined that the Claim Administrator paid the award late as the payment should have been issued and mailed by October 22, 2013. The Board issued an Administrative Penalty (AD-PEN) on November 1, 2013 for a late payment penalty under §25-3(f). The decision awarded the claimant a 20% penalty of \$4.956.00 and a \$50.00 penalty payable to the NYSWCB.

After the decision, the Claim Administrator issued payment for the penalty on **November 8, 2013**. The Claim Administrator reported the payment information to the NYS Workers' Compensation Board by sending the Payment Report (**SROI PY**) transaction report to the NYSWCB on **November 8, 2013**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 2-7</u> Event 3: SROI MTC S1 – Suspension, Returned to Work, or Medically Determined/Qualified to Return to Work

<u>Scenario 9-3</u> Event 4: SROI MTC PY – Payment Report Event 5: SROI MTC PY – Payment Report

	- Payment Report, Event 4	Transactio		F	
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	PY	Payment Report	4	5
	Maintenance Type Code Date	20131024	October 24, 2013	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters		·		
0078	Number of Permanent Impairments	01		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code	54	Lower Leg		
	Permanent Impairment Percentage	01500	15%		
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements			l	1

eClaims Business Scenarios

<u> P</u> Y -	– Payment Report, Event 4	Transaction L	ayout		
	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began			405	412
	Initial Date Last Day Worked			413	420
	Return To Work Type Code	A	Actual	421	421

	– Payment Report, Event 4	Transactio			
DN	Data Element Name	Data	Description	Beg	End
)224	Physical Restrictions Indicator	N	Without Physical Restrictions	422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date	20120926	September 26, 2012	483	490
	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code	-		492	493
	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	N	No	-	_
0286	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date	20131011	October 11, 2013	514	521
0200	Claim Administrator Alternate Postal Code			522	530
	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	s	Standard Work Week	532	532
)205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
)229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	01	1 Occurrence	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments	~~		0.10	000
	Benefits		2 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code		N/A	654	655
	Gross Weekly Amount		N/A	656	666
		1		550	000
	Gross Weekly Amount Effective Date		N/A	667	674

PY	– Payment Report, Event 4	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0211	Net Weekly Amount Effective Date		N/A	686	693
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120825	September 25, 2012	702	709
0090	Benefit Type Claim Weeks	0007		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000546000	\$5460.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	030	Permanent Partial / Scheduled	754	756
0002	Maintenance Type Code	PY	Payment Report	757	758
0174	Gross Weekly Amount	0000070000	\$700.00	759	769
	Gross Weekly Amount Effective Date	20131009	October 09, 2013	770	777
0087	Net Weekly Amount	0000070000	\$700.00	778	788
0211	Net Weekly Amount Effective Date	20131009	October 09, 2013	789	796
0088	Benefit Period Start Date	20131009	October 09, 2013	797	804
0089	Benefit Period Through Date	20131009	October 09, 2013	805	812
0090	Benefit Type Claim Weeks	0035		813	816
0091	Benefit Type Claim Days	2		817	817
0086	Benefit Type Amount Paid	00002478000	\$24780.00	818	828
0192	Benefit Payment Issue Date	20131024	October 24, 2013	829	836
	Filler			837	856
	Payments		1 Occurrence		
0222	Payment Reason Code	030	Permanent Partial / Scheduled	857	859
0217	Payee	JOHN DOE		860	899
0218	Payment Amount	00002478000	\$24,780.00	900	910
0219	Payment Covers Period Start Date	20131009	October 09, 2013	911	918
0220	Payment Covers Period Through Date	20131009	October 09, 2013	919	926
0195	Payment Issue Date	20131024	October 24, 2013	927	934
	Filler			935	954
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				

<u> PY</u> -	PY – Payment Report, Event 4 Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End	
	Benefit Credits					
0126	Benefit Credit Code					
0127	Benefit Credit Start Date					
0128	Benefit Credit End Date					
0129	Benefit Credit Weekly Amount					
	Benefit Redistribution					
0130	Benefit Redistribution Code					
0131	Benefit Redistribution Start Date					
0132	Benefit Redistribution End Date					
0133	Benefit Redistribution Weekly Amount					
	Recoveries					
0226	Recovery Code					
0225	Recovery Amount					
	Reduced Earnings					
0242	Reduced Earnings Week Number					
0124	Actual Reduced Earnings					
0147	Deemed Reduced Earnings					
	Concurrent Employers					
0141	Concurrent Employer Name					
0142	Concurrent Employer Contact Business Phone					
0143	Concurrent Employer Wage					
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives					
0233	Suspension Narrative					
	End R22 Elements					

<u> PY -</u>	– Payment Report, Event 5	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	PY	Payment Report	4	5	
0003	Maintenance Type Code Date	20131108	November 08, 2013	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents			52	53	
0069	Pre-Existing Disability Code	Ν	No	54	54	
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date			72	79	
0057	Employee Date of Death			80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
	Number of Days Worked Per Week	5		101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number			111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code	I	Indemnity	187	187	
0075	Agreement to Compensate Code	L	With Liability	188	188	
	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	00		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
0083	Permanent Impairment Body Part Code	54	Lower Leg			
	Permanent Impairment Percentage	01500	15%			
	Death/Dependent/Payee Relationships					
0097	Dependent/Payee Relationship Code					
5501	End A49 Elements					

PY-	– Payment Report, Event 5	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	R22 Data Elements					
0001	Transaction Set ID	R22	Subsequent Report	1	3	
0295	Maintenance Type Correction Code			4	5	
	Maintenance Type Correction Code Date			6	13	
0298	Date Claim Administrator Had Knowledge of Lost			14	21	
0186	Jurisdiction Branch Office Code			22	23	
0015	Claim Administrator Claim Number	TW0892356		24	48	
0187	Claim Administrator FEIN	141456789		49	57	
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97	
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137	
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152	
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232	
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242	
0270	Employee ID Type Qualifier	S	Social Security Number	243	243	
0042	Employee SSN	324556745		244	258	
0043	Employee Last Name	DOE		259	298	
0044	Employee First Name	JOHN		299	313	
0045	Employee Middle Name/Initial			314	328	
0255	Employee Last Name Suffix			329	332	
0052	Employee Date of Birth	19771101	November 1, 1977	333	340	
0054	Employee Marital Status Code		N/A	341	341	
0151	Employee Education Level			342	343	
0213	Employee Number of Entitled Exemptions			344	345	
0201	Anticipated Wage Loss Indicator			346	346	
0202	Reduced Benefit Amount Code			347	347	
0158	Employee Tax Filing Status Code			348	348	
0146	Death Result of Injury Code			349	349	
0314	Insured FEIN	089898765		350	358	
0292	Insolvent Insurer FEIN			359	367	
0016	Employer FEIN	089898765		368	376	
0023	Employer Physical Postal Code			377	385	
0228	Return To Work With Same Employer Indicator			386	386	
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394	
0212	Non-Consecutive Period Code			395	395	
0172	Estimated Gross Weekly Amount Indicator			396	396	
0145	Current Date Last Day Worked			397	404	
0144	Current Date Disability Began			405	412	
	Initial Date Last Day Worked			413	420	
	Return To Work Type Code	A	Actual	421	421	

PY-	– Payment Report, Event 5	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator	Ν	Without Physical Restrictions	422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date	20120926	September 26, 2012	483	490
	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation	N	No	494	494
	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
	Award/Order Date	20131101	November 01, 2013	514	521
	Claim Administrator Alternate Postal Code	20101101		522	530
	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	02	2 Occurrences	630	631
0283	Number of Payments	02	2 Occurrences	632	633
0282	Number of Other Benefits	02	2 Occurrences	634	635
	Number of Benefit ACR	000		636	638
	Number of Recoveries	00		639	640
	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
	Number of Suspension Narratives	00		649	650
	Variable Segments			0.10	
	Benefits		2 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
	Maintenance Type Code		N/A	654	655
	Gross Weekly Amount		N/A	656	666
	Gross Weekly Amount Effective Date		N/A	667	674
	Net Weekly Amount		N/A	675	685

	– Payment Report, Event 5 Data Element Name	Data		Pag	End
		Data	Description	Beg	End
	Net Weekly Amount Effective Date		N/A	686	693
	Benefit Period Start Date	20120802	August 02, 2012	694	701
	Benefit Period Through Date	20120825	September 25, 2012	702	709
	Benefit Type Claim Weeks	0007		710	713
	Benefit Type Claim Days	4		714	714
	Benefit Type Amount Paid	00000546000	\$5460.00	715	725
0192	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	030	Permanent Partial / Scheduled	754	756
0002	Maintenance Type Code		N/A	757	758
0174	Gross Weekly Amount		N/A	759	769
0175	Gross Weekly Amount Effective Date		N/A	770	777
0087	Net Weekly Amount		N/A	778	788
0211	Net Weekly Amount Effective Date		N/A	789	796
0088	Benefit Period Start Date	20131009	October 09, 2013	797	804
0089	Benefit Period Through Date	20131009	October 09, 2013	805	812
0090	Benefit Type Claim Weeks	0035		813	816
0091	Benefit Type Claim Days	2		817	817
0086	Benefit Type Amount Paid	00002478000	\$24780.00	818	828
0192	Benefit Payment Issue Date		N/A	829	836
	Filler			837	856
	Payments		2 Occurrence		
0222	Payment Reason Code	311	Total Employee Penalties	857	859
0217	Payee	JOHN DOE		860	899
0218	Payment Amount	00000495600	\$4,956.00	900	910
0219	Payment Covers Period Start Date	20131101	November 01, 2013	911	918
0220	Payment Covers Period Through Date	20131101	November 01, 2013	919	926
0195	Payment Issue Date	20131108	November 08, 2013	927	934
	Filler			935	954
0222	Payment Reason Code	310	Total Penalties	955	957
	Payee	NYS WCB		958	997
0218	Payment Amount	0000005000	\$50.00	998	1008
	Payment Covers Period Start Date	20131101	November 01, 2013	1009	1016
	Payment Covers Period Through Date	20131101	November 01, 2013	1017	1024
	Payment Issue Date	20131108	November 08, 2013	1025	1032
	Filler				
	Other Benefits		2 Occurrences		
0216	Other Benefit Type Code	311	Total Employee Penalties	1032	1034
0215	Other Benefit Type Amount	00000495600	\$4,956.00	1035	1045
	Filler		. ,	1046	1065
0216	Other Benefit Type Code	310	Total Penalties	1066	1068
	Other Benefit Type Amount	00000500600	\$5,006.00	1069	1079
	Filler		\$0,000.00	1080	1099

eCLAIMS BUSINESS SCENARIOS

PY-	– Payment Report, Event 5	Transacti	on Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 9-4

Legacy Claim – MTC UR

(Claim Administrator submitted due to unrelated death on legacy claim)

NARRATIVE:

Employee John Doe suffered a work related injury on February 2, 2004. He subsequently remained out of work and had surgery on May 4, 2004. After the surgery the claimant became partially disabled and was also later classified with a Permanent Partial Disability in 2006. He was assigned WCB# 50009999.

A summary of findings and awards to date on the file are as follows:

Injury Site: Back

Average Weekly Wage: \$600.00

Awards:

February 3, 2004 through August 20, 2004 at Temporary Total Disability August 23, 2004 through August 18, 2006 at Moderate Partial Disability August 19, 2006 through November 14, 2012 at Moderate Permanent Partial Disability

Due to the implementation of eClaims by the Worker's Compensation Board, the claimant's case was included in the "Legacy File" sent to the Claim Administrator by the NYSWCB.

On November 15, 2012, the claimant passed away due to unrelated issues. The Claim Administrator reported the Legacy Claim to the NYS Workers' Compensation Board by sending the Legacy First Report of Injury (FROI UR), Legacy Second Report of Injury (SROI UR), and Suspension (SROI S4) to the NYSWCB on November 19, 2012.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 9-4</u> Event 1: FROI MTC UR – Original First Report Event 2: SROI MTC UR – Legacy Claim Event 3: SROI MTC S4 – Suspension, Claimant Death

UR	– First Report, Upon Request	Transaction	ransaction Layout			
DN	Data Element Name	Data	Description	Beg	End	
	148 Data Elements					
0001	Transaction Set ID	148	First Report	1	3	
0002	Maintenance Type Code	UR	Upon Request	4	5	
0003	Maintenance Type Code Date	20121119	November 19, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0005	Jurisdiction Claim Number	50009999		16	40	
0006	Insurer FEIN	141456789		41	49	
	Filler			50	178	
0012	Claim Administrator City	LATHAM		179	193	
0013	Claim Administrator State Code	NY		194	195	
0014	Claim Administrator Postal Code	12110		196	204	
0015	Claim Administrator Claim Number	TW0892356		205	229	
0016	Employer FEIN	089898765		230	238	
	Filler			239	358	
0021	Employer Physical City	ALBANY		359	373	
0022	Employer Physical State Code	NY		374	375	
0023	Employer Physical Postal Code	12241		376	384	
	Filler			385	385	
0025	Industry Code	236116	Multifamily housing Construction	386	391	
	Filler			392	401	
0027	Insured Location Identifier	JS51	Job Site 51	402	416	
0028	Policy Number Identifier	COA65432		417	434	
	Filler			435	446	
0029	Policy Effective Date	20040101	January 1, 2004	447	454	
0030	Policy Expiration Date	20050101	January 1, 2005	455	462	
0031	Date of Injury	20040202	February 2, 2004	463	470	
0032	Time of Injury	1300	1:00 PM	471	474	
0033	Accident Site Postal Code	12204		475	483	
	Filler			484	484	
0035	Nature of Injury Code	28	Fracture	485	486	
0036	Part of Body Injured Code	42	Lower Back Area	487	488	
0037	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490	
	Filler			491	640	
0039	Initial Treatment Code	3	Emergency room	641	642	
0040	Date Employer Had Knowledge of the Injury	20040202	February 2, 2004	643	650	
0041	Date Claim Administrator Had Knowledge of the Injury	20040202	February 2, 2004	651	658	
	Filler			659	697	
0044	Employee First Name	JOHN		698	712	
	Filler			713	773	
0048	Employee Mailing City	SCHENECTADY		774	788	
0049	Employee Mailing State Code	NY		789	790	

<u>UR</u>	– First Report, Upon Request	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
0062	Wage	00000105000	\$1050.00	882	892
	Wage Period Code	01	Weekly	893	894
	Number of Days Worked Per Week	5		895	895
0065	Initial Date Last Day Worked	20040203	February 3, 2004	896	903
0066	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
	End 148	B Elements			1
	R21 Data	a Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
0270	Employee ID Type Qualifier	S	Social Security Number	231	231
0042	Employee SSN	324556745		232	246
0255	Employee Last Name Suffix			247	250
	Employee Authorization to Deleges Medical	Ť		251	251
0150	Employee Authorization to Release Medical Records Indicator				
				252	252

eCLAIMS BUSINESS SCENARIOS

<u>UR</u>	JR – First Report, Upon Request Transaction Layout						
DN	Data Element Name	Data	Description	Beg	End		
0045	Employee Middle Name/Initial	Т		293	307		
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347		
0047	Employee Mailing Secondary Address			348	387		
0155	Employee Mailing Country Code			388	390		
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405		
0146	Death Result of Injury Code			406	406		
0290	Type of Loss Code	01	Trauma	407	408		
0228	Return To Work With Same Employer Indicator			409	409		
0189	Return To Work Type Code			410	410		
0224	Physical Restrictions Indicator			411	411		
0314	Insured FEIN	089898765		412	420		
0017	Insured Name	GREAT ROOFING INC.		421	460		
0184	Insured Type Code	I	Insured	461	461		
0026	Insured Report Number			462	486		
0204	Work Week Type Code	S	Standard Work Week	487	487		
0205	Work Days Scheduled	NSSSSSN		488	494		
	Injury Severity Type Code			495	495		
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535		
	Insurer Type Code	I	Insurer	536	536		
0292	Insolvent Insurer FEIN			537	545		
0200	Claim Administrator Alternate Postal Code			546	554		
0206	Employee Security ID			555	569		
	Filler			570	577		
0249	Accident Premises Code	E	Employer	578	578		
0118	Accident Site County/Parish	ALBANY		579	598		
0119	Accident Site Location Narrative			599	648		
0120	Accident Site Organization Name			649	698		
0121	Accident Site City	ALBANY		699	713		
0122	Accident Site Street	1234 BROADWAY		714	753		
0123	Accident Site State Code	NY		754	755		
0280	Accident Site Country Code			756	758		
0281	Date Employer Had Knowledge of Date of Disability	20040202	February 2, 2004	759	766		
	Filler			767	767		
0018	Employer Name	GREAT ROOFING INC.		768	807		
0329	Employer UI Number	16-10000		808	822		
0019	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862		
0020	Employer Physical Secondary Address			863	902		
0164	Employer Physical Country Code			903	905		
	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920		
	Employer Contact Name	JANE SMITH		921	960		
	Employer ID Assigned by Jurisdiction			961	975		

eCLAIMS BUSINESS SCENARIOS

	– First Report, Upon Request	Transaction La			
	Data Element Name	Data	Description	Beg	
0231	Manual Classification Sub-Code			976	977
	Filler			_	1050
	Employer Mailing Information/Attention Line				1100
	Employer Mailing City	ALBANY			1115
	Employer Mailing Country Code				1118
	Employer Mailing Postal Code	12241			1127
	Employer Mailing Primary Address	PO BOX 1587			1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	l	Indemnity	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation	N	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
	Number of Full Denial Reason Codes	00		-	1594
0276	Number of Denial Reason Narratives	00			1596
	Number of Managed Care Organizations	00		-	1598
	Number of Witnesses	01	1 Occurrence		1600
	Variable Segments	-	1	1	
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS STEPPING OFF A ROOF AND LOST HIS FOOTI		1601	1650
0038	Accident/Injury Description Narrative	NG AND FELL FROM A LADDER INJURING HIS BACK		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

UR ·	– First Report, Upon Request	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1701	1740	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755	
	Filler			1756	1775	
	End R21 Elements					

UR	– SROI, Upon Request, Event 2	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	UR	Upon Request	4	5
0003	Maintenance Type Code Date	20121119	November 19, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code	Ν	No	54	54
0056	Initial Date Disability Began	20040203	February 03, 2004	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death	20121114	November 14, 2012	80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20040202	February 02, 2004	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	50009999		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	01		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code	42	Lower Back Area	209	211
	Permanent Impairment Percentage	05000	50%	212	216
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
5031	End A49 Elements				

eCLAIMS BUSINESS SCENARIOS

UR – SROI, Upon Request, Event 2 Transaction Layout							
DN	Data Element Name	Data	Description	Beg	End		
	R22 Data Elements						
0001	Transaction Set ID	R22	Subsequent Report	1	3		
0295	Maintenance Type Correction Code			4	5		
0296	Maintenance Type Correction Code Date			6	13		
0298	Date Claim Administrator Had Knowledge of Lost			14	21		
0186	Jurisdiction Branch Office Code			22	23		
0015	Claim Administrator Claim Number	TW0892356		24	48		
0187	Claim Administrator FEIN	141456789		49	57		
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97		
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137		
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152		
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232		
0139	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242		
0270	Employee ID Type Qualifier	S	Social Security Number	243	243		
0042	Employee SSN	324556745		244	258		
0043	Employee Last Name	DOE		259	298		
0044	Employee First Name	JOHN		299	313		
0045	Employee Middle Name/Initial			314	328		
0255	Employee Last Name Suffix			329	332		
0052	Employee Date of Birth	19771101	November 1, 1977	333	340		
0054	Employee Marital Status Code		N/A	341	341		
0151	Employee Education Level			342	343		
0213	Employee Number of Entitled Exemptions			344	345		
0201	Anticipated Wage Loss Indicator			346	346		
0202	Reduced Benefit Amount Code			347	347		
0158	Employee Tax Filing Status Code			348	348		
0146	Death Result of Injury Code	Ν	No	349	349		
0314	Insured FEIN	089898765		350	358		
0292	Insolvent Insurer FEIN			359	367		
0016	Employer FEIN	089898765		368	376		
0023	Employer Physical Postal Code			377	385		
0228	Return To Work With Same Employer Indicator			386	386		
0281	Date Employer Had Knowledge of Date of Disability	20040202	February 02, 2004	387	394		
0212	Non-Consecutive Period Code			395	395		
0172	Estimated Gross Weekly Amount Indicator			396	396		
	Current Date Last Day Worked			397	404		
0144	Current Date Disability Began			405	412		
	Initial Date Last Day Worked	20040202	February 02, 2004	413	420		
0189	Return To Work Type Code			421	421		

eCLAIMS BUSINESS SCENARIOS

<u>UR</u>	– SROI, Upon Request, Event 2	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000040000	\$400.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation	N	No	494	494
0286	Average Wage	0000060000	\$600.00	495	505
0297	Initial Date of Lost Time	20040203	February 03, 2004	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	03	3 Occurrences	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		3 Occurrences		
0085	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code		N/A	654	655
0174	Gross Weekly Amount		N/A	656	666
0175	Gross Weekly Amount Effective Date		N/A	667	674
0087	Net Weekly Amount		N/A	675	685
0211	Net Weekly Amount Effective Date		N/A	686	693

eCLAIMS BUSINESS SCENARIOS

UR ·	– SROI, Upon Request, Event 2	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20040203	February 03, 2004	694	701
0089	Benefit Period Through Date	20040820	August 20, 2004	702	709
0090	Benefit Type Claim Weeks	0028		710	713
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00001152000	\$11,520.00	715	725
	Benefit Payment Issue Date		N/A	726	733
	Filler			734	753
0085	Benefit Type Code	070	Temporary Partial	754	756
0002	Maintenance Type Code		N/A	757	758
0174	Gross Weekly Amount		N/A	759	769
0175	Gross Weekly Amount Effective Date		N/A	770	777
0087	Net Weekly Amount		N/A	778	788
0211	Net Weekly Amount Effective Date		N/A	789	796
0088	Benefit Period Start Date	20040823	August 23, 2004	797	804
0089	Benefit Period Through Date	20060818	August 18, 2006	805	812
0090	Benefit Type Claim Weeks	0104		813	816
0091	Benefit Type Claim Days	0		817	817
0086	Benefit Type Amount Paid	00002080000	\$20,800.00	818	828
0192	Benefit Payment Issue Date		N/A	829	836
	Filler			837	856
0085	Benefit Type Code	030	Permanent Partial	857	859
	Maintenance Type Code		N/A	860	861
0174	Gross Weekly Amount		N/A	862	872
	Gross Weekly Amount Effective Date		N/A	873	880
0087	Net Weekly Amount		N/A	881	891
0211	Net Weekly Amount Effective Date		N/A	892	899
8800	Benefit Period Start Date	20060819	August 19, 2006	900	907
0089	Benefit Period Through Date	20121114	November 14, 2012	908	915
0090	Benefit Type Claim Weeks	0325		916	919
0091	Benefit Type Claim Days	2		920	920
0086	Benefit Type Amount Paid	00006508000	\$65,080.00	921	931
0192	Benefit Payment Issue Date		N/A	932	939
	Filler			940	959
	Payments		N/A		
0222	Payment Reason Code				
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
	Other Benefit Type Amount				

eCLAIMS BUSINESS SCENARIOS

UR	– SROI, Upon Request, Event 2	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Benefit Adjustments					
0092	Benefit Adjustment Code					
0094	Benefit Adjustment Start Date					
0125	Benefit Adjustment End Date					
0093	Benefit Adjustment Weekly Amount					
	Benefit Credits					
0126	Benefit Credit Code					
0127	Benefit Credit Start Date					
0128	Benefit Credit End Date					
0129	Benefit Credit Weekly Amount					
	Benefit Redistribution					
0130	Benefit Redistribution Code					
0131	Benefit Redistribution Start Date					
0132	Benefit Redistribution End Date					
0133	Benefit Redistribution Weekly Amount					
	Recoveries					
0226	Recovery Code					
0225	Recovery Amount					
	Reduced Earnings					
0242	Reduced Earnings Week Number					
0124	Actual Reduced Earnings					
0147	Deemed Reduced Earnings					
	Concurrent Employers					
0141	Concurrent Employer Name					
0142	Concurrent Employer Contact Business Phone					
0143	Concurrent Employer Wage					
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives					
0233	Suspension Narrative					
	End R22 Elements					

eCLAIMS BUSINESS SCENARIOS

54 -	- Suspension, Clt Death, Event 3	Transactio	n Layout		
DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	S4	Suspension, Claimant Death	4	5
0003	Maintenance Type Code Date	20121119	November 19, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents		N/A	52	53
0069	Pre-Existing Disability Code		N/A	54	54
	Initial Date Disability Began	20040203	February 03, 2004	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
	Employee Date of Death	20121115	November 15, 2012	80	87
	Filler			88	98
	Wage Period Code	01	Weekly	99	100
	Number of Days Worked Per Week		N/A	101	101
	Filler			102	102
	Date of Injury	20040202	February 02, 2004	103	110
	Insured Report Number		N/A	111	135
	Claim Administrator Claim Number	TW0892356		136	160
	Jurisdiction Claim Number	50009999		161	185
	Claim Status Code		N/A	186	186
	Claim Type Code	 -	Indemnity	187	187
0076	Agreement to Compensate Code Date Claim Administrator Notified of Employee Representation	L	With Liability	188 189	188 196
	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments			199	200
	Filler			201	206
	Number of Death Dependent/Payee Relationships			207	208
	Variable Segments				
	Permanent Impairments				
	Permanent Impairment Body Part Code		N/A		
	Permanent Impairment Percentage		N/A		
500 r	Death/Dependent/Payee Relationships				
0097					
0091	Dependent/Payee Relationship Code <i>End A49 Elements</i>				

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eCLAIMS BUSINESS SCENARIOS

S4 – Suspension, Clt Death, Event 3 Transaction Layout

DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
0138	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
	Employee Marital Status Code		N/A	341	341
	Employee Education Level			342	343
	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code	Ν	N	349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN		N/A	359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code		N/A	377	385
	Return To Work With Same Employer Indicator			386	386
		20040202	February 02, 2004	387	394
0212	Non-Consecutive Period Code		N/A	395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked		N/A	397	404
0144	Current Date Disability Began		N/A	405	412
0065	Initial Date Last Day Worked		N/A	413	420
0189	Return To Work Type Code			421	421

eCLAIMS BUSINESS SCENARIOS

S4 – Suspension, Clt Death, Event 3 Transaction Layout

54 -	- Suspension, Clt Death, Event 3	Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End		
0224	Physical Restrictions Indicator			422	422		
0193	Suspension Effective Date	20121114	November 14, 2012	423	430		
0199	Full Denial Effective Date		N/A	431	438		
0196	Denial Rescission Date		N/A	439	446		
0294	Partial Denial Code		N/A	447	447		
0134	Calculated Weekly Compensation Amount	00000040000	\$400.00	448	458		
0256	Wage Effective Date		N/A	459	466		
0149	Discontinued Fringe Benefits		N/A	467	477		
0290	Type of Loss Code	01	Trauma	478	479		
0058	Employment Status Code	1	Full Time	480	481		
0223	Permanent Impairment Minimum Payment Indicator		N/A	482	482		
0068	Initial Return to Work Date			483	490		
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491		
	Lump Sum Payment/Settlement Code		N/A	492	493		
0273	Employer Paid Salary in Lieu of Compensation			494	494		
0286	Average Wage	00000060000	\$600.00	495	505		
0297	Initial Date of Lost Time		N/A	506	513		
0299	Award/Order Date			514	521		
0200	Claim Administrator Alternate Postal Code		N/A	522	530		
0203	Employer Paid Salary Prior to Acquisition Code			531	531		
0204	Work Week Type Code	S	Standard Work Week	532	532		
0205	Work Days Scheduled	NSSSSSN		533	539		
	Employee Security ID			540	554		
	Injury Severity Code			555	555		
	Filler			556	629		
	Variable Segment Counters						
0288	Number of Benefits	03	3 Occurrences	630	631		
0283	Number of Payments	00	N/A	632	633		
0282	Number of Other Benefits	00		634	635		
	Number of Benefit ACR	000		636	638		
0284	Number of Recoveries	00		639	640		
0285	Number of Reduced Earnings	00		641	642		
	Number of Concurrent Employers	00		643	644		
	Number of Full Denial Reason Code	00		645	646		
	Number of Denial Reason Narratives	00		647	648		
	Number of Suspension Narratives	02	2 Occurrence	649	650		
	Variable Segments	1					
	Benefits		3 Occurrences				
0085	Benefit Type Code	050	Temporary Total	651	653		
	Maintenance Type Code		N/A	654	655		
	Gross Weekly Amount		N/A	656	666		
	Gross Weekly Amount Effective Date		N/A	667	674		
	Net Weekly Amount		N/A	675	685		
	Net Weekly Amount Effective Date		N/A	686	693		

eCLAIMS BUSINESS SCENARIOS

0088 Benefit Period Start Date 20040203 February 03, 2004 694 701 0089 Benefit Type Claim Weeks 0028 714 714 714 0091 Benefit Type Claim Days 4 714 714 714 0091 Benefit Type Claim Days 4 N/A 726 733 0192 Benefit Type Claim Days 4 N/A 726 733 0192 Benefit Type Code N/A 726 733 758 0192 Benefit Type Code N/A 726 733 758 0175 Gross Weekly Amount N/A 775 758 769 0175 Gross Weekly Amount N/A 776 777 777 777 777 777 777 777 777 777 777 777 777 777 777 777 777 777 777 777 778 704 704 704 704 704 704 704 704 704 </th <th>S4 -</th> <th>- Suspension, Clt Death, Event 3</th> <th>Transaction</th> <th>n Layout</th> <th></th> <th></th>	S4 -	- Suspension, Clt Death, Event 3	Transaction	n Layout		
00689 Benefit Period Through Date 20040820 August 20, 2004 702 709 0090 Benefit Type Claim Weeks 0028 710 713 725 0091 Benefit Type Amount Paid 00001152000 \$11,520.00 715 725 0192 Benefit Payment Issue Date 0001152000 \$11,520.00 714 734 758 Seenefit Payment Issue Date 070 Temporary Partial 754 755 0028 Benefit Type Code 070 Temporary Partial 754 756 0174 Gross Weekly Amount 0.01 N/A 757 758 0174 Gross Weekly Amount Effective Date N/A 778 788 0174 Rross Weekly Amount Effective Date N/A 789 798 0175 Gross Weekly Amount Effective Date 20040823 August 23. 2004 813 816 0191 Benefit Type Claim Weeks 0 817 817 817 0080 Benefit Period Start Date 20060818 August 18. 2006	DN	Data Element Name	Data	Description	Beg	End
0090 Benefit Type Claim Weeks 0028 710 713 0091 Benefit Type Claim Days 4 714 714 714 0086 Benefit Type Anount Paid 00001152000 \$11,520.00 715 725 0192 Benefit Type Code N/A 726 733 Filler 734 753 0085 Benefit Type Code N/A 736 756 756 757 758 00175 Gross Weekly Amount N/A 778 788 777 788 0174 Breidt Paynount Effective Date N/A 778 788 787 0175 Gross Weekly Amount N/A 778 788 781 788 0211 Net Weekly Amount Effective Date N/A 778 788 786 0208 Benefit Priod Start Date 20060818 August 18, 2006 805 812 0309 Benefit Pype Claim Weeks 0104 ust 8, 2006 807 817 0309 Benefit Type Claim Days <td>8800</td> <td>Benefit Period Start Date</td> <td>20040203</td> <td>February 03, 2004</td> <td>694</td> <td>701</td>	8800	Benefit Period Start Date	20040203	February 03, 2004	694	701
0091 Benefit Type Claim Days 4 714 714 0086 Benefit Type Amount Paid 00001152000 \$11,520.00 715 725 0192 Benefit Type Code N/A 726 733 Filler 734 753 756 0002 Maintenance Type Code N/A 757 756 0174 Gross Weekly Amount N/A 759 769 0175 Gross Weekly Amount N/A 778 778 0174 Gross Weekly Amount N/A 778 788 0175 Gross Weekly Amount N/A 778 788 0174 Gross Weekly Amount N/A 778 788 0175 Gross Weekly Amount 20040823 August 23, 2004 797 804 0089 Benefit Pyee Claim Days 0 813 816 0090 Benefit Type Claim Days 0 813 816 0192 Benefit Type Code 030 Permanet Partial 857 859 <td>0089</td> <td>Benefit Period Through Date</td> <td>20040820</td> <td>August 20, 2004</td> <td>702</td> <td>709</td>	0089	Benefit Period Through Date	20040820	August 20, 2004	702	709
0086 Benefit Type Amount Paid 00001152000 \$11,520.00 715 725 0192 Benefit Payment Issue Date N/A 726 733 753 0088 Benefit Type Code 070 Temporary Partial 754 753 0074 Gross Weekly Amount 070 Temporary Partial 754 756 0174 Gross Weekly Amount Effective Date 074 770 777 778 0175 Gross Weekly Amount Effective Date 0/A 779 787 0174 Breide Start Date 20040823 August 18, 2006 805 812 0188 Benefit Period Start Date 20040823 August 18, 2006 818 828 0190 Benefit Pyne Claim Weeks 0104 813 816 817 817 0191 Benefit Type Claim Days 0 200508000 \$20,800.00 818 828 0192 Benefit Payment Issue Date N/A 829 856 0193 Benefit Type Code 030 Permanent Part	0090	Benefit Type Claim Weeks	0028		710	713
0192 Benefit Payment Issue Date N/A 726 733 Filler 734 753 756 0085 Benefit Type Code 070 Temporary Partial 754 756 0085 Benefit Type Code N/A 757 758 758 0175 Gross Weekly Amount N/A 759 759 759 0175 Gross Weekly Amount Effective Date N/A 777 778 788 0271 Net Weekly Amount Effective Date N/A 778 788 796 0208 Benefit Period Start Date 20040823 August 23, 2004 797 804 0098 Benefit Type Claim Weeks 0104 813 816 816 805 812 0098 Benefit Type Claim Days 0 817 817 837 0192 Benefit Payment Issue Date N/A 829 836 Filler 030 Permanent Partial 857 859 0002 Maintenance Type Code S4	0091	Benefit Type Claim Days	4		714	714
Filler 734 753 0085 Benefit Type Code 070 Temporary Partial 754 756 0002 Maintenance Type Code 070 Temporary Partial 754 756 0002 Maintenance Type Code N/A 757 758 0174 Gross Weekly Amount N/A 770 777 788 0175 Gross Weekly Amount Effective Date N/A 778 788 0211 Net Weekly Amount Effective Date 20040823 August 23, 2004 797 804 0088 Benefit Preiod Start Date 20060818 August 18, 2006 805 812 0090 Benefit Type Claim Days 0 817 816 0091 Benefit Type Code 030 Permanent Partial 857 859 0192 Benefit Type Code 030 Permanent Partial 857 859 0002 Maintenance Type Code S4 Suspension, Claimant Death 860 881 881 0174 Gross Weekly Amount	0086	Benefit Type Amount Paid	00001152000	\$11,520.00	715	725
0085 Benefit Type Code 070 Temporary Partial 754 756 0002 Maintenance Type Code N/A 757 758 0174 Gross Weekly Amount Effective Date N/A 770 777 0087 Net Weekly Amount Effective Date N/A 778 788 0211 Net Weekly Amount Effective Date N/A 778 788 0211 Net Weekly Amount Effective Date N/A 778 788 0208 Benefit Period Through Date 20040823 August 23, 2004 797 804 0308 Benefit Type Claim Weeks 0104 813 816 0909 Benefit Type Claim Days 0 817 817 0122 Benefit Type Claim Days 0 818 828 0132 Benefit Payment Issue Date N/A 829 836 Filler 030 Permanent Partial 857 859 0020 Maintenance Type Code S4 Suspension, Claimant Death 860 0174	0192	Benefit Payment Issue Date		N/A	726	733
0002 Maintenance Type Code N/A 757 758 0174 Gross Weekly Amount N/A 759 769 0175 Gross Weekly Amount N/A 775 778 0087 Net Weekly Amount Effective Date N/A 778 788 0211 Net Weekly Amount Effective Date N/A 778 788 0211 Net Weekly Amount Effective Date N/A 778 788 0211 Net Weekly Amount Effective Date 20040823 August 23, 2004 797 804 0209 Benefit Type Claim Weeks 0104 813 816 817 817 0090 Benefit Type Claim Weeks 0104 813 816 829 836 0192 Benefit Type Code 030 Permanent Partial 857 859 0000 Maintenance Type Code 030 Sugension, Claimant Death 860 861 0174 Gross Weekly Amount Effective Date 20060819 August 19, 2006 872 873 880		Filler			734	753
114 Gross Weekly Amount N/A 759 769 0175 Gross Weekly Amount Effective Date N/A 770 777 0087 Net Weekly Amount Effective Date N/A 778 788 0211 Net Weekly Amount Effective Date N/A 778 788 0211 Net Weekly Amount Effective Date 20040823 August 23, 2004 797 804 0088 Benefit Period Start Date 20060818 August 18, 2006 805 812 0090 Benefit Type Claim Weeks 0104 813 816 816 0086 Benefit Type Claim Days 0 817 817 0086 Benefit Type Claim Weeks 0104 829 836 0192 Benefit Type Claim Sup Date 0/A 829 836 0082 Benefit Type Code 030 Permanent Partial 857 859 0002 Maintenance Type Code S4 Supension, Claimant Death 860 861 0174 Gross Weekly Amount 0000002000	0085	Benefit Type Code	070	Temporary Partial	754	756
0175 Gross Weekly Amount Effective Date N/A 770 777 0087 Net Weekly Amount Effective Date N/A 778 788 0211 Net Weekly Amount Effective Date 0/A 789 796 0088 Benefit Period Start Date 20040823 August 23, 2004 797 804 0089 Benefit Type Claim Weeks 0104 813 816 817 817 817 0090 Benefit Type Claim Weeks 0104 0002080000 \$20,800.00 818 828 0192 Benefit Type Claim Days 0 N/A 829 836 0192 Benefit Type Claim Days 0 N/A 829 836 0192 Benefit Type Code 030 Permanent Partial 857 856 0002 Maintenance Type Code S4 Suspension, Claimant Death 860 861 0174 Gross Weekly Amount 00000020000 \$200.00 882 899 0087 Net Weekly Amount Effective Date 20060819 A	0002	Maintenance Type Code		N/A	757	758
0087 Net Weekly Amount N/A 778 788 0211 Net Weekly Amount Effective Date N/A 789 796 0088 Benefit Period Start Date 20040823 August 23, 2004 797 804 0089 Benefit Period Start Date 20060818 August 18, 2006 805 812 0090 Benefit Type Claim Weeks 0104 813 816 0091 Benefit Type Claim Days 0 \$17 817 0086 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Payment Issue Date N/A 829 836 Filler 837 856 859 8002 Maintenance Type Code \$34 Claimant Death 860 861 0174 Gross Weekly Amount 00000020000 \$200.00 862 872 0174 Gross Weekly Amount Effective Date 20060819 August 19, 2006 800 890 0087 Net Weekly Amount Effective Date 20060819 August 19, 2	0174	Gross Weekly Amount		N/A	759	769
N/A 789 796 00211 Net Weekly Amount Effective Date 20040823 August 23, 2004 797 804 0089 Benefit Period Start Date 20060818 August 18, 2006 805 812 0090 Benefit Type Claim Weeks 0104 813 816 0091 Benefit Type Claim Days 0 817 817 0086 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Type Code 030 Permanent Partial 857 859 0002 Maintenance Type Code S4 Suspension, Claimant Death 860 861 0174 Gross Weekly Amount 00000020000 \$200.00 881 891 0211 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0008 Benefit Type Claim Though Date 20121114 November 14, 2012 908 915	0175	Gross Weekly Amount Effective Date		N/A	770	777
N/A 789 796 00211 Net Weekly Amount Effective Date 20040823 August 23, 2004 797 804 0089 Benefit Period Start Date 20060818 August 18, 2006 805 812 0090 Benefit Type Claim Weeks 0104 813 816 0091 Benefit Type Claim Days 0 817 817 0086 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Type Code 030 Permanent Partial 857 859 0002 Maintenance Type Code S4 Suspension, Claimant Death 860 861 0174 Gross Weekly Amount 00000020000 \$200.00 881 891 0211 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0008 Benefit Type Claim Though Date 20121114 November 14, 2012 908 915	0087	Net Weekly Amount		N/A	778	788
0089 Benefit Period Through Date 20060818 August 18, 2006 805 812 0090 Benefit Type Claim Weeks 0104 813 816 0091 Benefit Type Claim Days 0 817 817 0086 Benefit Type Claim Days 0 818 828 0192 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Type Code 030 Permanent Partial 857 859 0002 Maintenance Type Code S4 Suspension, Claimant Death 860 861 0174 Gross Weekly Amount 00000000000 \$200.00 822 872 0075 Gross Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0111 Net Weekly Amount Effective Date 20060819 August 19, 2006 900 907 0090 Benefit Type Claim Meeks 0325 916 919				N/A	789	796
0000 Benefit Type Claim Weeks 0104 813 816 0011 Benefit Type Claim Days 0 817 817 0086 Benefit Type Claim Days 0 \$20,800.00 818 828 0192 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Type Code 030 Permanent Partial 857 856 0002 Maintenance Type Code 030 Permanent Partial 860 861 0174 Gross Weekly Amount 0000000000 \$200.00 862 872 0175 Gross Weekly Amount Effective Date 20060819 August 19, 2006 873 880 0211 Net Weekly Amount Effective Date 20060819 August 19, 2006 872 899 0088 Benefit Type Claim Weeks 0325 916 919 900 900 907 920 920 920 920 920 920 920 920 920 920 920 920 920 920 </td <td>0088</td> <td>Benefit Period Start Date</td> <td>20040823</td> <td>August 23, 2004</td> <td>797</td> <td>804</td>	0088	Benefit Period Start Date	20040823	August 23, 2004	797	804
0091 Benefit Type Claim Days 0 817 817 0086 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Payment Issue Date N/A 829 836 Filler 837 856 0002 Maintenance Type Code 030 Permanent Partial 857 0002 Maintenance Type Code S4 Claimant Death 860 0174 Gross Weekly Amount 00000020000 \$200.00 862 872 0175 Gross Weekly Amount 00000020000 \$200.00 881 891 0111 Net Weekly Amount 00000020000 \$200.00 881 891 0211 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0088 Benefit Type Claim Meeks 0325 916 919 0090 Benefit Type Claim Days 2 920 920 0088 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931	0089	Benefit Period Through Date	20060818	August 18, 2006	805	812
00091 Benefit Type Claim Days 0 817 817 0086 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Payment Issue Date N/A 829 836 Filler 837 856 0002 Maintenance Type Code 030 Permanent Partial 857 859 00174 Gross Weekly Amount 00000020000 \$200.00 862 872 0174 Gross Weekly Amount Effective Date 20060819 August 19, 2006 873 880 0087 Net Weekly Amount 00000020000 \$200.00 881 891 0111 Net Weekly Amount 00000020000 \$200.00 881 891 0211 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0088 Benefit Type Claim Weeks 0325 916 919 0090 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931 0192 Benefit Type Amount Paid	0090	Benefit Type Claim Weeks	0104		813	816
0086 Benefit Type Amount Paid 00002080000 \$20,800.00 818 828 0192 Benefit Payment Issue Date N/A 829 836 Filler 030 Permanent Partial 857 859 0002 Maintenance Type Code 030 Permanent Partial 857 859 0002 Maintenance Type Code S4 Suspension, Claimant Death 860 861 0174 Gross Weekly Amount 00000020000 \$200.00 862 872 0175 Gross Weekly Amount Effective Date 20060819 August 19, 2006 873 880 0087 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0188 Benefit Period Through Date 20121114 November 14, 2012 908 915 0190 Benefit Type Claim Days 2 920 920 920 0086 Benefit Payment Issue Date 20121101 November 01, 2012 932 931 0192 Benefit Payment Issue Date 20121010			0		817	817
0192 Benefit Payment Issue Date N/A 829 836 Filler 030 Permanent Partial 857 859 0002 Maintenance Type Code 030 Permanent Partial 857 859 0002 Maintenance Type Code S4 Suspension, Claimant Death 860 861 0174 Gross Weekly Amount 00000020000 \$200.00 862 872 0175 Gross Weekly Amount Effective Date 20060819 August 19, 2006 873 880 0087 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0088 Benefit Period Start Date 20121114 November 14, 2012 908 915 0090 Benefit Type Claim Days 2 920 920 920 0918 Benefit Payment Issue Date 20121101 November 01, 2012 92 930 0919 Benefit Type Claim Days 2 920 920 920 920 920 920 920 920 920 9			00002080000	\$20,800.00	818	828
Filler 837 856 0085 Benefit Type Code 030 Permanent Partial 857 859 0002 Maintenance Type Code S4 Suspension, Claimant Death 860 861 0174 Gross Weekly Amount 00000020000 \$200.00 862 872 0175 Gross Weekly Amount Effective Date 20060819 August 19, 2006 873 880 0087 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0281 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0208 Benefit Period Start Date 20121114 November 14, 2012 908 915 0090 Benefit Type Claim Days 2 920 920 920 0086 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931 0191 Benefit Payment Issue Date 20121101 November 01, 2012 932 939 Filler 940 959 940 959 <				N/A	829	836
ODD Maintenance Type Code S4 Suspension, Claimant Death 860 861 0174 Gross Weekly Amount 0000020000 \$200.00 862 872 0175 Gross Weekly Amount Effective Date 20060819 August 19, 2006 873 880 0087 Net Weekly Amount Effective Date 20060819 August 19, 2006 873 880 0088 Benefit Period Start Date 20060819 August 19, 2006 892 899 0089 Benefit Period Start Date 20060819 August 19, 2006 892 899 0089 Benefit Period Through Date 20121114 November 14, 2012 908 915 0090 Benefit Type Claim Weeks 0325 916 919 920<					837	856
S4 Claimant Death 860 861 0174 Gross Weekly Amount 00000020000 \$200.00 862 872 0175 Gross Weekly Amount Effective Date 20060819 August 19, 2006 873 880 0087 Net Weekly Amount 00000020000 \$200.00 881 891 0211 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0088 Benefit Period Start Date 20060819 August 19, 2006 900 907 0089 Benefit Period Through Date 20121114 November 14, 2012 908 915 0090 Benefit Type Claim Weeks 0325 916 919 0091 Benefit Type Claim Days 2 920 920 920 0192 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931 0192 Benefit Reason Code N/A 940 959 Payments N/A 940 959 0222 Payment Reason Code 1 </td <td>0085</td> <td>Benefit Type Code</td> <td>030</td> <td>Permanent Partial</td> <td>857</td> <td>859</td>	0085	Benefit Type Code	030	Permanent Partial	857	859
0175 Gross Weekly Amount Effective Date 20060819 August 19, 2006 873 880 0087 Net Weekly Amount 00000020000 \$200.00 881 891 0211 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0088 Benefit Period Start Date 20060819 August 19, 2006 900 907 0089 Benefit Period Through Date 20121114 November 14, 2012 908 915 0090 Benefit Type Claim Weeks 0325 916 919 0091 Benefit Type Claim Days 2 920 920 0086 Benefit Type Claim Days 2 920 920 0086 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931 0192 Benefit Payment Issue Date 20121101 November 01, 2012 932 939 Filler 940 959 Payments 0 0 0 0 0217 Payee 0 0 0 <			S4		860	861
0087 Net Weekly Amount 00000020000 \$200.00 881 891 0211 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0088 Benefit Period Start Date 20060819 August 19, 2006 900 907 0089 Benefit Period Through Date 20121114 November 14, 2012 908 915 0090 Benefit Type Claim Weeks 0325 916 919 0091 Benefit Type Claim Days 2 920 920 0086 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931 0192 Benefit Payment Issue Date 20121101 November 01, 2012 932 939 Filler 940 959 940 959 Payments N/A 1022 Payment Reason Code 1020 1021 1021 1021 1021 1021 1021 1021 1021 1021 1021 1021 1021 1021 1021 1021 1021 1021	0174	Gross Weekly Amount	0000020000	\$200.00	862	872
0211 Net Weekly Amount Effective Date 20060819 August 19, 2006 892 899 0088 Benefit Period Start Date 20060819 August 19, 2006 900 907 0089 Benefit Period Through Date 20121114 November 14, 2012 908 915 0090 Benefit Type Claim Weeks 0325 916 919 0091 Benefit Type Claim Days 2 920 920 0086 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931 0192 Benefit Payment Issue Date 20121101 November 01, 2012 932 939 Filler 940 959 940 959 Payments N/A 1022 Payment Reason Code 10000 10000 1000	0175	Gross Weekly Amount Effective Date	20060819	August 19, 2006	873	880
0088 Benefit Period Start Date 20060819 August 19, 2006 900 907 0089 Benefit Period Through Date 20121114 November 14, 2012 908 915 0090 Benefit Type Claim Weeks 0325 916 919 0091 Benefit Type Claim Days 2 920 920 920 0086 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931 0192 Benefit Payment Issue Date 20121101 November 01, 2012 932 939 Filler 940 959 940 959 Payments N/A 940 959 0217 Payee 940 959 0218 Payment Amount 1 1 1 0219 Payment Covers Period Start Date 1 1 1 0219 Payment Covers Period Through Date 1 1 1 0219 Payment Issue Date 1 1 1 1 0219 Payment Issue Date	0087	Net Weekly Amount	0000020000	\$200.00	881	891
O089 Benefit Period Through Date 20121114 November 14, 2012 908 915 0090 Benefit Type Claim Weeks 0325 916 919 919 901 919 920 939 Filler 940 959 Payments 940 959 920 920 921 921 <	0211	Net Weekly Amount Effective Date	20060819	August 19, 2006	892	899
0090 Benefit Type Claim Weeks 0325 916 919 0091 Benefit Type Claim Days 2 920 920 0086 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931 0192 Benefit Payment Issue Date 20121101 November 01, 2012 932 939 Filler 940 959 940 959 Payments N/A 1022 Payment Reason Code 1000 1000 0217 Payee N/A 10000 10000 1000	0088	Benefit Period Start Date	20060819	August 19, 2006	900	907
0091 Benefit Type Claim Days 2 920 920 920 0086 Benefit Type Amount Paid 00006508000 \$65,080.00 921 931 0192 Benefit Payment Issue Date 20121101 November 01, 2012 932 939 Filler 20121101 November 01, 2012 932 939 Payments N/A 940 959 0222 Payment Reason Code N/A 1 0217 Payee 1 1 1 0218 Payment Amount 1 1 1 0219 Payment Covers Period Start Date 1 1 1 0220 Payment Issue Date 1 1 1 1 0219 Payment Covers Period Start Date 1 1 1 1 0220 Payment Issue Date 1 1 1 1 0195 Payment Issue Date 1 1 1 1 0216 Other Benefit Type Code 1 1	0089	Benefit Period Through Date	20121114	November 14, 2012	908	915
0091Benefit Type Claim Days29209200086Benefit Type Amount Paid00006508000\$65,080.009219310192Benefit Payment Issue Date20121101November 01, 2012932939Filler20121101November 01, 2012932939PaymentsN/A9409590222Payment Reason CodeN/A10217Payee1110218Payment Amount1110219Payment Covers Period Start Date1110220Payment Covers Period Through Date1110195Payment Issue Date1110216Other Benefits111	0090	Benefit Type Claim Weeks	0325		916	919
0192Benefit Payment Issue Date20121101November 01, 2012932939Filler940959PaymentsN/A9400222Payment Reason CodeImage: Construction of the second of the seco	0091	Benefit Type Claim Days	2		920	920
Filler 940 959 Payments N/A 940 959 0222 Payment Reason Code N/A 940 959 0212 Payment Reason Code 021 <	0086	Benefit Type Amount Paid	00006508000	\$65,080.00	921	931
PaymentsN/A0222Payment Reason Code0217Payee0218Payment Amount0219Payment Covers Period Start Date0220Payment Covers Period Through Date0195Payment Issue Date0195Other Benefits0216Other Benefit Type Code	0192	Benefit Payment Issue Date	20121101	November 01, 2012	932	939
0222Payment Reason CodeImage: Code0217PayeeImage: CodeImage: Code0218Payment AmountImage: CodeImage: Code0219Payment Covers Period Start DateImage: CodeImage: Code0220Payment Covers Period Through DateImage: CodeImage: Code0195Payment Issue DateImage: CodeImage: Code0216Other BenefitsImage: CodeImage: Code0216Other Benefit Type CodeImage: CodeImage: Code		Filler			940	959
0217 Payee Image: Constraint of the sympthty of the sympthty of the symphtty of t		Payments		N/A		
0218 Payment Amount <						
0219 Payment Covers Period Start Date 0220 Payment Covers Period Through Date 0195 Payment Issue Date 0195 Payment Issue Date 0216 Other Benefit Type Code	0217	Payee				
0220 Payment Covers Period Through Date	0218	Payment Amount				
0220 Payment Covers Period Through Date						
0195 Payment Issue Date Image: Constraint of the second seco						
Other Benefits Image: Control of the second secon						
0216 Other Benefit Type Code						
	0216					
		Other Benefit Type Amount				

eCLAIMS BUSINESS SCENARIOS

S4 -	- Suspension, Clt Death, Event 3	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Benefit Adjustments					
0092	Benefit Adjustment Code					
0094	Benefit Adjustment Start Date					
0125	Benefit Adjustment End Date					
0093	Benefit Adjustment Weekly Amount					
	Benefit Credits					
0126	Benefit Credit Code					
0127	Benefit Credit Start Date					
0128	Benefit Credit End Date					
0129	Benefit Credit Weekly Amount					
	Benefit Redistribution					
0130	Benefit Redistribution Code					
0131	Benefit Redistribution Start Date					
0132	Benefit Redistribution End Date					
0133	Benefit Redistribution Weekly Amount					
	Recoveries					
0226	Recovery Code					
0225	Recovery Amount					
	Reduced Earnings					
0242	Reduced Earnings Week Number					
0124	Actual Reduced Earnings					
0147	Deemed Reduced Earnings					
	Concurrent Employers					
0141	Concurrent Employer Name					
0142	Concurrent Employer Contact Business Phone					
0143	Concurrent Employer Wage					
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives					
0233	Suspension Narrative	Clt passed away on 11/15/2012 due to auto accident		960	1009	
0233	Suspension Narrative	, unrelated to WC injury.		1010	1059	
	End R22 Elements				-	

End R22 Elements

NYS Workers' Compensation Board eClaims Business Scenarios Scenario 9-5

Claim Administrator Acquires Claim – MTC AQ/AP

(New Claim Administrator acquires claim from another Administrator)

NARRATIVE:

The Claim Administrator from **Scenario 9-4** transferred this claim to another Claim Administrator, Great Lakes Claims, on **November 15, 2012.** *** It is assumed for this Scenario that the claimant has NOT passed away. ***

The new Claim Administrator, Great Lakes Claims, reported the acquisition to the NYS Workers' Compensation Board by sending Acquired (**FROI AQ**) and Acquired Payment (**SROI AP**) transaction reports to the NYSWCB on **November 19, 2012**.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 9-4</u> Event 1: FROI MTC UR – Original First Report Event 2: SROI MTC UR – Legacy Claim

<u>Scenario 9-5</u> Event 3: FROI MTC AQ – Acquired Claim, First Report of Injury Event 4: SROI MTC AP – Acquired Payment

AQ	– Acquired Claim, Event 3	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	148 Data Elements					
0001	Transaction Set ID	148	First Report	1	3	
0002	Maintenance Type Code	AQ	Acquired Claim	4	5	
0003	Maintenance Type Code Date	20121119	November 19, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0005	Jurisdiction Claim Number	50009999		16	40	
0006	Insurer FEIN	141456789		41	49	
	Filler			50	178	
0012	Claim Administrator City	GREAT LAKES		179	193	
0013	Claim Administrator State Code	MI		194	195	
0014	Claim Administrator Postal Code	48201		196	204	
0015	Claim Administrator Claim Number	A678B1234		205	229	
0016	Employer FEIN	089898765		230	238	
	Filler			239	358	
0021	Employer Physical City	ALBANY		359	373	
	Employer Physical State Code	NY		374	375	
	Employer Physical Postal Code	12241		376	384	
	Filler			385	385	
0025	Industry Code	236116	Multifamily housing Construction	386	391	
	Filler			392	401	
0027	Insured Location Identifier	JS51	Job Site 51	402	416	
0028	Policy Number Identifier	COA65432		417	434	
	Filler			435	446	
0029	Policy Effective Date	20040101	January 1, 2004	447	454	
0030	Policy Expiration Date	20050101	January 1, 2005	455	462	
0031	Date of Injury	20040202	February 2, 2004	463	470	
0032	Time of Injury	1300	1:00 PM	471	474	
0033	Accident Site Postal Code	12204		475	483	
	Filler			484	484	
0035	Nature of Injury Code	28	Fracture	485	486	
0036	Part of Body Injured Code	42	Lower Back Area	487	488	
0037	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490	
	Filler			491	640	
0039	Initial Treatment Code	3	Emergency room	641	642	
	Date Employer Had Knowledge of the Injury	20040202	February 2, 2004	643	650	
0041	Date Claim Administrator Had Knowledge of the Injury	20040202	February 2, 2004	651	658	
	Filler			659	697	
0044	Employee First Name	JOHN		698	712	
	Filler			713	773	
	Employee Mailing City	SCHENECTADY		774	788	
0049	Employee Mailing State Code	NY		789	790	

AQ	– Acquired Claim, Event 3	Transaction L	Layout		
	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
0059	Manual Classification Code	5645	Carpentry	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
	Wage	00000105000	\$1050.00	882	892
0063	Wage Period Code	01	Weekly	893	894
0064	Number of Days Worked Per Week	5		895	895
	Initial Date Last Day Worked	20040203	February 3, 2004	896	903
	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
	End 148	3 Elements			
	R21 Dat	a Elements			
0001	Transaction Set ID	R21	First Report	1	3
			Companion Record		
	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
	Denial Rescission Date			14	21
	Jurisdiction Branch Office Code			22	23
	Claim Administrator Claim Number	A678B1234		24	48
	Claim Administrator FEIN	146789145		49	57
0188	Claim Administrator Name	GREAT LAKES CLAIMS		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 54321		148	187
0011	Claim Administrator Secondary Address			188	227
				188 228	227 230
0136	Claim Administrator Secondary Address	S	Social Security Number		
0136 0270	Claim Administrator Secondary Address Claim Administrator Country Code	S		228	230
0136 0270 0042	Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier			228 231	230 231
0136 0270 0042 0255	Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN	S		228 231 232	230 231 246
0136 0270 0042 0255 0150	Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN Employee Last Name Suffix Employee Authorization to Release Medical	S 324556745		228 231 232 247	230 231 246 250

	– Acquired Claim, Event 3	Transaction La		_	-
DN	Data Element Name	Data	Description	Beg	End
	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
	Death Result of Injury Code			406	406
	Type of Loss Code	01	Trauma	407	408
	Return To Work With Same Employer Indicator			409	409
	Return To Work Type Code			410	410
	Physical Restrictions Indicator			411	411
	Insured FEIN	089898765		412	420
	Insured Name	GREAT ROOFING INC.		421	460
	Insured Type Code	l	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	s	Standard Work Week	487	487
)205	Work Days Scheduled	NSSSSSN		488	494
)229	Injury Severity Type Code			495	495
	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
	Insurer Type Code	1	Insurer	536	536
	Insolvent Insurer FEIN			537	545
	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
	Accident Premises Code	E	Employer	578	578
	Accident Site County/Parish	ALBANY		579	598
	Accident Site Location Narrative			599	648
	Accident Site Organization Name			649	698
	Accident Site City	ALBANY		699	713
	Accident Site Street	1234 BROADWAY		714	753
	Accident Site State Code	NY		754	755
	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20040202	February 2, 2004	759	766
	Filler			767	767
	Employer Name	GREAT ROOFING INC.		768	807
	Employer UI Number	16-10000		808	822
	Employer Physical Primary Address	1541 CIRCULAR ST.		823	862
0020	Employer Physical Secondary Address			863	902
	Employer Physical Country Code			903	905
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
	Employer Contact Name	JANE SMITH		921	960
0230	Employer ID Assigned by Jurisdiction			961	975

AQ	– Acquired Claim, Event 3	Transaction La	ayout		
DN	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	ALBANY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12241		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CARPENTER		1260	1309
	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code		Indemnity	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation Indicator	N	No	1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments	•	•		•
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS STEPPING OFF A ROOF AND LOST HIS FOOTI		1601	1650
0038	Accident/Injury Description Narrative	NG AND FELL FROM A LADDER INJURING HIS BACK		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

AQ	– Acquired Claim, Event 3	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1701	1740	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755	
	Filler			1756	1775	
	End R21 Elements					

eCLAIMS BUSINESS SCENARIOS

	– Acquired Payment, Event 4 Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	AP	Acquired Payment	4	5	
0003	Maintenance Type Code Date	20121119	November 19, 2012	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	48201		34	42	
	Filler			43	51	
0055	Employee Number of Dependents			52	53	
0069	Pre-Existing Disability Code	N	No	54	54	
	Initial Date Disability Began	20040203	February 03, 2004	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
	Latest Return to Work Status Date			72	79	
0057	Employee Date of Death			80	87	
	Filler			88	98	
	Wage Period Code	01	Weekly	99	100	
0064	Number of Days Worked Per Week	5		101	101	
	Filler			102	102	
	Date of Injury	20040202	February 02, 2004	103	110	
	Insured Report Number			111	135	
	Claim Administrator Claim Number	A678B1234		136	160	
	Jurisdiction Claim Number	50009999		161	185	
	Claim Status Code		N/A	186	186	
	Claim Type Code	1	Indemnity	187	187	
	Agreement to Compensate Code	L	With Liability	188	188	
	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	01		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
	Permanent Impairment Body Part Code	42	Lower Back Area	209	211	
	Permanent Impairment Percentage	05000	50%	212	216	
	Death/Dependent/Payee Relationships		0070	- 1 -	2.10	
	Dependent/Payee Relationship Code					
0031	End A49 Elements					

eCLAIMS BUSINESS SCENARIOS

	– Acquired Payment, Event 4	Transaction L			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
	Transaction Set ID	R22	Subsequent Report	1	3
	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
	Date Claim Administrator Had Knowledge of Lost			14	21
	Jurisdiction Branch Office Code			22	23
	Claim Administrator Claim Number	A678B1234		24	48
	Claim Administrator FEIN	146789145		49	57
0188	Claim Administrator Name	GREAT LAKES CLAIMS		58	97
0140	Claim Administrator Claim Representative Name	MAX SMITH		98	137
0137	Claim Administrator Claim Representative Business Phone Number	8007850024	(800) 785-5024	138	152
0138	Claim Administrator Claim Representative E-Mail Address	msmith@greatlakes claims.com		153	232
0139	Claim Administrator Claim Representative Fax Number	8007855025	(800) 785-5025	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
0054	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
0213	Employee Number of Entitled Exemptions			344	345
0201	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20040202	February 02, 2004	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	Initial Date Last Day Worked	20040202	February 02, 2004	413	420
	Return To Work Type Code			421	421

eCLAIMS BUSINESS SCENARIOS

AP	– Acquired Payment, Event 4	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000040000	\$400.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation	N	No	494	494
0286	Average Wage	00000060000	\$600.00	495	505
0297	Initial Date of Lost Time	20040203	February 03, 2004	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
)203	Employer Paid Salary Prior to Acquisition Code			531	531
)204	Work Week Type Code	S	Standard Work Week	532	532
)205	Work Days Scheduled	NSSSSSN		533	539
)206	Employee Security ID			540	554
)229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrence	630	631
0283	Number of Payments	01	1 Occurrence	632	633
0282	Number of Other Benefits	02	2 Occurrences	634	635
0289	Number of Benefit ACR	000		636	638
0284	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
)275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrence		
	Benefit Type Code	030	Permanent Partial	651	653
	Maintenance Type Code	AP	Acquired Payment	654	655
	Gross Weekly Amount	0000020000	\$200.00	656	666
	Gross Weekly Amount Effective Date	20060819	August 19, 2006	667	674
0087	Net Weekly Amount	00000020000	\$200.00	675	685
0211	Net Weekly Amount Effective Date	20060819	August 19, 2006	686	693

AP	– Acquired Payment, Event 4	Transactior	n Layout		
DN	Data Element Name	Data	Description	Beg	End
8800	Benefit Period Start Date	20121115	November 15, 2012	694	701
0089	Benefit Period Through Date	20121121	November 21, 2012	702	709
0090	Benefit Type Claim Weeks	01		710	713
0091	Benefit Type Claim Days	0		714	714
0086	Benefit Type Amount Paid	0000020000	\$200.00	715	725
0192	Benefit Payment Issue Date	20121121	November 21, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	030	Permanent Partial	754	756
0217	Payee	JOHN DOE		757	796
0218	Payment Amount	0000020000	\$200.00	797	807
0219	Payment Covers Period Start Date	20121115	November 15, 2012	808	815
0220	Payment Covers Period Through Date	20121121	November 21, 2012	816	823
0195	Payment Issue Date	20121121	November 21, 2012	824	831
	Filler			832	851
	Other Benefits				
0216	Other Benefit Type Code	430	Total Unallocated Prior Indemnity Benefits	852	854
0215	Other Benefit Type Amount	00009740000	\$97,400.00	855	865
	Filler			866	885
0216	Other Benefit Type Code	440	Total Unallocated Prior Medical	886	888
0215	Other Benefit Type Amount	00004956130	\$49,561.30	889	899
	Filler			900	919
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
	Recovery Amount				

eClaims Business Scenarios

AP	 Acquired Payment, Event 4 	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Reduced Earnings					
0242	Reduced Earnings Week Number					
0124	Actual Reduced Earnings					
0147	Deemed Reduced Earnings					
	Concurrent Employers					
0141	Concurrent Employer Name					
0142	Concurrent Employer Contact Business Phone					
0143	Concurrent Employer Wage					
	Denial Reason Codes					
0198	Full Denial Reason Code					
	Denial Reasons					
0197	Denial Reason Narrative					
	Suspension Narratives					
0233	Suspension Narrative					
	First DOD Flowerste		·			

End R22 Elements

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 9-6

Additional Lost Time / Credit for Prior Schedule Loss of Use (SLU) – MTC RB

(Claimant is losing additional time and Claim Administrator is taking credit for prior SLU)

NARRATIVE:

Employee John Doe, from **Scenario 9-3**, now requires an additional surgery. The surgery took place on **January 15, 2014**. The Claim Administrator received the operative report but has not begun payments as they have a credit against the prior SLU award paid in October 2013.

The Claim Administrator wants to note the reinstatement of benefits while also taking full credit against the lost time for the prior SLU award.

The Claim Administrator reported the reinstatement and credit information to the NYS Workers' Compensation Board by sending the Reinstatement of Benefits (**SROI RB**) transaction report to the NYSWCB on **January 22, 2014**. The SROI-RB included Benefit Credit Code (DN0126) equal to "P" Advance with a weekly credit of \$700.00 which reflects a full credit against the current payment being made to the claimant.

SEQUENCE OF BUSINESS EVENTS (MTC):

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 2-7</u> Event 3: SROI MTC S1 – Suspension, Returned to Work, or Medically Determined/Qualified to Return to Work

<u>Scenario 9-3</u> Event 4: SROI MTC PY – Payment Report Event 5: SROI MTC PY – Payment Report

<u>Scenario 9-6</u> Event 4: SROI MTC RB – Reinstatement of Benefits

RB ·	– Reinstatement, Event 6	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	A49 Data Elements					
0001	Transaction Set ID	A49	Subsequent Report	1	3	
0002	Maintenance Type Code	RB	Reinstatement of Benefit	4	5	
0003	Maintenance Type Code Date	20140122	January 22, 2014	6	13	
0004	Jurisdiction Code	NY		14	15	
0006	Insurer FEIN	141456789		16	24	
	Filler			25	33	
0014	Claim Administrator Postal Code	12110		34	42	
	Filler			43	51	
0055	Employee Number of Dependents			52	53	
0069	Pre-Existing Disability Code			54	54	
0056	Initial Date Disability Began	20120802	August 02, 2012	55	62	
0070	Date of Maximum Medical Improvement			63	70	
	Filler			71	71	
0072	Latest Return to Work Status Date			72	79	
0057	Employee Date of Death			80	87	
	Filler			88	98	
0063	Wage Period Code	01	Weekly	99	100	
0064	Number of Days Worked Per Week			101	101	
	Filler			102	102	
0031	Date of Injury	20120801	August 01, 2012	103	110	
0026	Insured Report Number			111	135	
0015	Claim Administrator Claim Number	TW0892356		136	160	
0005	Jurisdiction Claim Number	G0055555		161	185	
0073	Claim Status Code		N/A	186	186	
0074	Claim Type Code	I	Indemnity	187	187	
0075	Agreement to Compensate Code	L	With Liability	188	188	
	Date Claim Administrator Notified of Employee Representation			189	196	
0077	Late Reason Code			197	198	
	Variable Segment Counters					
0078	Number of Permanent Impairments	01		199	200	
	Filler			201	206	
0082	Number of Death Dependent/Payee Relationships	00		207	208	
	Variable Segments					
	Permanent Impairments					
0083	Permanent Impairment Body Part Code	54				
	Permanent Impairment Percentage	01500	15%		L	
	Death/Dependent/Payee Relationships			L	L	
0097	Dependent/Payee Relationship Code					
	End A49 Elements					

RB ·	– Reinstatement, Event 6	ent, Event 6 Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140	Claim Administrator Claim Representative Name	MARY CLARK		98	137
0137	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	S	Social Security Number	243	243
	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
	Employee Last Name Suffix			329	332
	Employee Date of Birth	19771101	November 1, 1977	333	340
	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
0158	Employee Tax Filing Status Code			348	348
0146	Death Result of Injury Code			349	349
0314	Insured FEIN	089898765		350	358
0292	Insolvent Insurer FEIN			359	367
0016	Employer FEIN	089898765		368	376
0023	Employer Physical Postal Code			377	385
0228	Return To Work With Same Employer Indicator			386	386
0281	Date Employer Had Knowledge of Date of Disability	20120801	August 01, 2012	387	394
0212	Non-Consecutive Period Code			395	395
0172	Estimated Gross Weekly Amount Indicator			396	396
0145	Current Date Last Day Worked			397	404
0144	Current Date Disability Began	20140115	January 15, 2014	405	412
0065	Initial Date Last Day Worked			413	420

eCLAIMS BUSINESS SCENARIOS

<u> RB</u> ·	– Reinstatement, Event 6	Transaction	n Layout		
DN	Data Element Name	Data	Description	Beg	End
0189	Return To Work Type Code	A	Actual	421	421
0224	Physical Restrictions Indicator	Ν	No Physical Restrictions	422	422
0193	Suspension Effective Date			423	430
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	0000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date	20120926	September 26, 2012	483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
0293	Lump Sum Payment/Settlement Code			492	493
	Employer Paid Salary in Lieu of Compensation			494	494
		N	No Massa aa	10E	505
	Average Wage	00000105000	\$1050.00	495	
	Initial Date of Lost Time	20120802	August 02, 2012	506	513
	Award/Order Date			514	521
	Claim Administrator Alternate Postal Code			522	530 531
0203	Employer Paid Salary Prior to Acquisition Code		Standard Wark	531	
	Work Week Type Code	S	Standard Work Week	532	532
	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
	Number of Benefits	02	2 Occurrences	630	631
	Number of Payments	01	1 Occurrence	632	633
	Number of Other Benefits	02	2 Occurrences	634	635
	Number of Benefit ACR	001	1 Occurrence	636	638
	Number of Recoveries	00		639	640
	Number of Reduced Earnings	00		641	642
	Number of Concurrent Employers	00		643	644
	Number of Full Denial Reason Code	00		645	646
	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments	1			
	Benefits		2 Occurrences		
	Benefit Type Code	030	Permanent Partial / Scheheduled	651	653
	Maintenance Type Code		N/A	654	655
	Gross Weekly Amount		N/A	656	666
0175	Gross Weekly Amount Effective Date		N/A	667	674

<u>RB</u> ·	– Reinstatement, Event 6	Transaction	Layout		_		
DN	Data Element Name	Data	Description	Beg	End		
0087	Net Weekly Amount		N/A	675	685		
0211	Net Weekly Amount Effective Date		N/A	686	693		
8800	Benefit Period Start Date	20131009	October 09, 2013	694	701		
0089	Benefit Period Through Date	20131009	October 09, 2013	702	709		
0090	Benefit Type Claim Weeks	0035		710	713		
0091	Benefit Type Claim Days	2		714	714		
	Benefit Type Amount Paid	00002478000	\$24,780.00	715	725		
	Benefit Payment Issue Date		N/A	726	733		
	Filler			734	753		
0085	Benefit Type Code	050	Temporary Total	754	756		
	Maintenance Type Code	RB	Reinstatement of Benefit	757	758		
0174	Gross Weekly Amount	0000070000	\$700.00	759	769		
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	770	777		
	Net Weekly Amount	00000000000	\$000.00	778	788		
	Net Weekly Amount Effective Date	20120802	August 02, 2012	789	796		
	Benefit Period Start Date	20140115	January 15, 2014	797	804		
	Benefit Period Through Date	20140122	January 22, 2014	805	812		
	Benefit Type Claim Weeks	0008	,,,,	813	816		
	Benefit Type Claim Days	4		817	817		
	Benefit Type Amount Paid	00000616000	\$6,160.00	818	828		
	Benefit Payment Issue Date	20140122	January 22, 2014	829	836		
0.02	Filler	20110122		837	856		
	Payments		1 Occurrences				
0222	Payment Reason Code	050	Temporary Total	857	859		
	Payee	JOHN DOE		860	899		
	Payment Amount	00000000000	\$0.00	900	910		
	Payment Covers Period Start Date	20140115	January 15, 2014	911	918		
	Payment Covers Period Through Date	20140122	January 22, 2014	919	926		
	Payment Issue Date	20140122	January 22, 2014	927	934		
	Filler	20110122		935	954		
	Other Benefits			000			
0216	Other Benefit Type Code	310	Total Penalties	955	957		
0215	Other Benefit Type Amount	00000500600	\$5,006.00	958	968		
0216	Other Benefit Type Code	311	Total Employee Penalties	969	972		
0215	Other Benefit Type Amount	00000495600	\$4,956.00	973	983		
	Benefit Adjustments						
0092	Benefit Adjustment Code						
	Benefit Adjustment Start Date			1			
	Benefit Adjustment End Date						
	Benefit Adjustment Weekly Amount			1			

RB ·	– Reinstatement, Event 6	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
	Benefit Credits				
0126	Benefit Credit Code	Р	Advance	984	984
0127	Benefit Credit Start Date	20140115	January 15, 2014	985	992
0128	Benefit Credit End Date			993	1000
0129	Benefit Credit Weekly Amount	0000070000	\$700.00	1001	1011
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				

NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 10-1

Varying Work Days – MTC 00

(Claimant worked varying work days at time of accident)

NARRATIVE:

Employee John Doe was working at the Carousel USA retail shop in the Schenectady marketplace located at 1234 Broadway, Schenectady, NY. He missed the last step getting off a ladder after stocking shelves and sprained his right ankle on **April 1, 2014** at 1:00 p.m. He started work at 7:00 a.m. Doe's supervisor, Jane Smith, witnessed the accident. The employee **continued to work that day**. Mr. Doe began experiencing worsening pain after leaving work at the end of his shift and sought treatment **beyond ordinary first aid**. Mr. Doe was initially treated and released from the Emergency Room of Ellis Hospital. The employee was **paid for the date of the injury and returned to work full duty the next day**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week *on varying days of the week* depending upon the retail locations scheduling needs for that specific week. Doe's supervisor **reported the injury on April 3, 2014** to the Insurer / Claim Administrator.

On April 8, 2014, the Claim Administrator determined that the claim is compensable. The Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **April 8, 2014**. Within the FROI 00, the Claim Administrator reported DN0204 as Varied Work Week, however, did not report anything within DN0205 due to the varied work week.

SEQUENCE OF BUSINESS EVENTS (MTC):

Event 1: FROI MTC 00 – Original First Report

<u>NOTE</u>: "Pass Days" is primarily used by State Insurance Fund and select Claim Administrators to report work weeks that exist but are not the Standard Work Week (Monday through Friday). This information is utilized in calculating awards.

DN0204 (Work Week Type Code) is required if Number of Days Worked per Week is a value other than 5 and Date of Injury is on or after 3/1/14 and Type of Loss Code is either 01 (Traumatic Injury) or is not present and Claim Type Code is either I or L (Indemnity or Became Lost Time).

DN0205 Work Days Scheduled is a Mandatory Conditional field and required is Work Week Type Code equals Fixed.

If a 5 day work week is reported and DN0204 and DN0205 are not populated, it is assumed this is a Monday through Friday worker and awards will be calculated as they are currently by the Board.

eClaims Business Scenarios

00 -	- First Report Event	ayout			
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20140408	April 08, 2014	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	SCHENECTADY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12305		376	384
	Filler			385	385
0025	Industry Code		All Other	386	391
		453998	Miscellaneous		
	-		Store Retailers		
~~~~	Filler			392	401
	Insured Location Identifier	JS51	Store 51	402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
	Policy Effective Date	20140101	January 1, 2014	447	454
	Policy Expiration Date	20150101	January 1, 2015	455	462
	Date of Injury	20140401	April 1, 2014	463	470
	Time of Injury	0700	7:00 AM	471	474
0033	Accident Site Postal Code	12305		475	483
	Filler			484	484
	Nature of Injury Code	49	Sprain	485	486
	Part of Body Injured Code	55	Ankle	487	488
0037	Cause of Injury Code	26	Fall, Slip or Trip from ladder	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
	Date Employer Had Knowledge of the Injury	20140401	April 1, 2014	643	650
0041	Date Claim Administrator Had Knowledge of the Injury	20140403	April 3, 2014	651	658
	Filler			659	697
0044	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
0049	Employee Mailing State Code	NY		789	790

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction L	Layout		
	Data Element Name	Data	Description	Beg	End
0050	Employee Mailing Postal Code	12308		791	799
	Filler			800	809
0052	Employee Date of Birth	19771101	November 1, 1977	810	817
0053	Employee Gender Code	М	Male	818	818
0054	Employee Marital Status Code		N/A	819	819
0055	Employee Number of Dependents			820	821
0056	Initial Date Disability Began			822	829
0057	Employee Date of Death			830	837
0058	Employment Status Code	1	Full Time	838	839
	Manual Classification Code	8017	Retail Store Noc-No Service Of Food	840	843
	Filler			844	873
0061	Employee Date of Hire	20010401	April 1, 2001	874	881
0062	Wage	00000105000	\$1050.00	882	892
0063	Wage Period Code	01	Weekly	893	894
0064	Number of Days Worked Per Week	4		895	895
0065	Initial Date Last Day Worked			896	903
0066	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904
	Filler			905	905
0068	Initial Return to Work Date			906	913
	End 148	3 Elements			
	R21 Data	a Elements			
0001	Transaction Set ID	R21	First Report Companion Record	1	3
0295	Maintenance Type Correction Code			4	5
0296	Maintenance Type Correction Code Date			6	13
0196	Denial Rescission Date			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0135	Claim Administrator Information/Attention Line			98	147
0010	Claim Administrator Primary Address	PO BOX 12345		148	187
0011	Claim Administrator Secondary Address			188	227
0136	Claim Administrator Country Code			228	230
0270	Employee ID Type Qualifier	S	Social Security Number	231	231
0042	Employee SSN	324556745		232	246
0255	Employee Last Name Suffix			247	250
	Employee Authorization to Release Medical Records Indicator			251	251
					050
0157	Employee Social Security Number Release Indicator			252	252

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout			
	Data Element Name	Data	Description	Beg	End
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
0047	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
0051	Employee Phone Number	5185550234	(518) 555-0234	391	405
0146	Death Result of Injury Code			406	406
0290	Type of Loss Code	01	Trauma	407	408
0228	Return To Work With Same Employer Indicator			409	409
0189	Return To Work Type Code			410	410
0224	Physical Restrictions Indicator			411	411
	Insured FEIN	089898765		412	420
0017	Insured Name	CAROUSEL USA INC.		421	460
	Insured Type Code	I	Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	V	Varied Work Week	487	487
0205	Work Days Scheduled			488	494
0229	Injury Severity Type Code			495	495
0007	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
0185	Insurer Type Code	I	Insurer	536	536
0292	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
0249	Accident Premises Code	E	Employer	578	578
0118	Accident Site County/Parish	ALBANY		579	598
0119	Accident Site Location Narrative			599	648
0120	Accident Site Organization Name			649	698
	Accident Site City	SCHENECTADY		699	713
0122	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
0280	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20140401	April 1, 2014	759	766
	Filler			767	767
0018	Employer Name	CAROUSEL USA INC.		768	807
	Employer UI Number	16-10000		808	822
	Employer Physical Primary Address	1234 BROADWAY		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
0160	Employer Contact Name	JANE SMITH		921	960
0230	Employer ID Assigned by Jurisdiction			961	975

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	yout		
	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
0165	Employer Mailing City	SCHENECTADY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12305		1119	1127
0168	Employer Mailing Primary Address	PO BOX 1587		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	INVENTORY SPECIALIST		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	М	Medical Only	1482	1482
	Late Reason Code		-	1483	1484
0273	Employer Paid Salary in Lieu of Compensation			1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
0279	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments	·			
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS DESCENDING A LADDER AND MISSED THE LAS		1601	1650
0038	Accident/Injury Description Narrative	T STEP & INJURED RT ANKLE		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

00 -	- First Report Event	Transaction Layout				
DN	Data Element Name	Data	Description	Beg	End	
	Managed Care Organizations					
0207	Managed Care Organization Code					
0209	Managed Care Organization Name					
0208	Managed Care Organization Identification Number					
	Witnesses		1 Occurrence			
0238	Witness Name	JANE SMITH		1701	1740	
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755	
	Filler			1756	1775	
	End R21 Elements					

## NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 10-2

#### **Fixed Work Days – MTC 00**

(Claimant worked fixed work days, not Monday through Friday)

#### **NARRATIVE:**

Employee John Doe was injured in the line of duty while employed with the Schenectady County Sheriff's Department. Doe was injured when an inmate struck him, causing him to sprain his right ankle on **April 1, 2014** at 1:00 p.m. He started work at 7:00 a.m. Doe's supervisor, Jane Smith, witnessed the accident. The employee **continued to work that day**. Mr. Doe began experiencing worsening pain after leaving work at the end of his shift and sought treatment **beyond ordinary first aid**. Mr. Doe was initially treated and released from the Emergency Room of Ellis Hospital. The employee was **paid for the date of the injury and returned to work full duty the next day**. At the time of injury, Mr. Doe earned \$26.25 an hour and worked 40 hours per week *on a fixed work week* of Wednesday through Sunday to accommodate proper coverage at the county jail. Doe's supervisor **reported the injury on April 3, 2014** to the Insurer / Claim Administrator.

On April 8, 2014, the Claim Administrator determined that the claim is compensable. The Claim Administrator reported the loss information to the NYS Workers' Compensation Board by sending the Original First Report of Injury (**FROI 00**) to the NYSWCB on **April 8, 2014**. Within the FROI 00, the Claim Administrator reported DN0204 as Fixed Work Week and reported DN0205 to indicate the work week of Wednesday through Sunday.

#### **SEQUENCE OF BUSINESS EVENTS (MTC):**

#### **Event 1: FROI MTC 00 – Original First Report**

<u>NOTE</u>: "Pass Days" is primarily used by State Insurance Fund and select Claim Administrators to report work weeks that exist but are not the Standard Work Week (Monday through Friday). This information is utilized in calculating awards.

DN0204 (Work Week Type Code) is required if Number of Days Worked per Week is a value other than 5 and Date of Injury is on or after 3/1/14 and Type of Loss Code is either 01 (Traumatic Injury) or is not present and Claim Type Code is either I or L (Indemnity or Became Lost Time).

DN0205 Work Days Scheduled is a Mandatory Conditional field and required is Work Week Type Code equals Fixed.

If a 5 day work week is reported and DN0204 and DN0205 are not populated, it is assumed this is a Monday through Friday worker and awards will be calculated as they are currently by the Board.

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	148 Data Elements				
0001	Transaction Set ID	148	First Report	1	3
0002	Maintenance Type Code	00	Original	4	5
0003	Maintenance Type Code Date	20140408	April 08, 2014	6	13
0004	Jurisdiction Code	NY		14	15
0005	Jurisdiction Claim Number			16	40
0006	Insurer FEIN	141456789		41	49
	Filler			50	178
0012	Claim Administrator City	LATHAM		179	193
0013	Claim Administrator State Code	NY		194	195
0014	Claim Administrator Postal Code	12110		196	204
0015	Claim Administrator Claim Number	TW0892356		205	229
0016	Employer FEIN	089898765		230	238
	Filler			239	358
0021	Employer Physical City	SCHENECTADY		359	373
0022	Employer Physical State Code	NY		374	375
0023	Employer Physical Postal Code	12305		376	384
	Filler			385	385
0025	Industry Code	922140	Correctional Institutions	386	391
	Filler			392	401
0027	Insured Location Identifier			402	416
0028	Policy Number Identifier	COA65432		417	434
	Filler			435	446
0029	Policy Effective Date	20140101	January 1, 2014	447	454
0030	Policy Expiration Date	20150101	January 1, 2015	455	462
	Date of Injury	20140401	April 1, 2014	463	470
	Time of Injury	0700	7:00 AM	471	474
	Accident Site Postal Code	12305		475	483
	Filler			484	484
	Nature of Injury Code	49	Sprain	485	486
	Part of Body Injured Code	55	Ankle	487	488
	Cause of Injury Code	74	Struck or Injured By – Fellow Workers, Patient or Other Person	489	490
	Filler			491	640
0039	Initial Treatment Code	3	Emergency room	641	642
	Date Employer Had Knowledge of the Injury	20140401	April 1, 2014	643	650
0041	Date Claim Administrator Had Knowledge of the Injury	20140403	April 3, 2014	651	658
	Filler			659	697
	Employee First Name	JOHN		698	712
	Filler			713	773
0048	Employee Mailing City	SCHENECTADY		774	788
0049	Employee Mailing State Code	NY		789	790

	- First Report Event Transaction Layout							
DN	Data Element Name	Data	Description	Beg	End			
0050	Employee Mailing Postal Code	12308		791	799			
	Filler			800	809			
0052	Employee Date of Birth	19771101	November 1, 1977	810	817			
0053	Employee Gender Code	М	Male	818	818			
0054	Employee Marital Status Code		N/A	819	819			
0055	Employee Number of Dependents			820	821			
0056	Initial Date Disability Began			822	829			
0057	Employee Date of Death			830	837			
0058	Employment Status Code	1	Full Time	838	839			
0059	Manual Classification Code	9410	Municipal, Township, County Or State Employee NOC	840	843			
	Filler			844	873			
0061	Employee Date of Hire	20010401	April 1, 2001	874	881			
0062	Wage	00000105000	\$1050.00	882	892			
0063	Wage Period Code	01	Weekly	893	894			
0064	Number of Days Worked Per Week	5		895	895			
0065	Initial Date Last Day Worked			896	903			
0066	Full Wages Paid for Date of Injury Indicator	Y	Yes	904	904			
	Filler			905	905			
0068	Initial Return to Work Date			906	913			
	۱ ۲	48 Elements						
		ata Flamanta						
0001		ata Elements	Eirst Roport	1	3			
	Transaction Set ID	ata Elements R21	First Report Companion Record	1	3			
0295	Transaction Set ID Maintenance Type Correction Code			4	5			
0295 0296	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date			4	5 13			
0295 0296 0196	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date			4 6 14	5 13 21			
0295 0296 0196 0186	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code	R21		4 6 14 22	5 13 21 23			
0295 0296 0196 0186 0015	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number	R21		4 6 14 22 24	5 13 21 23 48			
0295 0296 0196 0186 0015 0187	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN	R21		4 6 14 22 24 49	5 13 21 23 48 57			
0295 0296 0196 0186 0015 0187 0188	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name	R21		4 6 14 22 24	5 13 21 23 48			
0295 0296 0196 0186 0015 0187 0188	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN	R21 TW0892356 141456789 ALL AMERICAN INSURANCE		4 6 14 22 24 49	5 13 21 23 48 57			
0295 0296 0196 0186 0015 0187 0188 0135 0010	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address	R21 TW0892356 141456789 ALL AMERICAN INSURANCE		4 6 14 22 24 49 58	5 13 21 23 48 57 97			
0295 0296 0196 0186 0015 0187 0188 0135 0010	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line	R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY		4 6 14 22 24 49 58 98	5 13 21 23 48 57 97 147			
0295 0296 0196 0186 0015 0187 0187 0188 0135 0010 0011	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address	R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY		4 6 14 22 24 49 58 98 148	5 13 21 23 48 57 97 147 187 227			
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0136	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address	R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY		4 6 14 22 24 49 58 98 148 188	5 13 21 23 48 57 97 147 187 227			
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0136 0270	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code	R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345	Companion Record	4 6 14 22 24 49 58 58 98 148 188 228	5 13 21 23 48 57 97 147 187 227 230 231			
0295 0296 0196 0186 0015 0187 0187 0188 0135 0010 0011 0136 0270 0042	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier	R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345 S	Companion Record	4 6 14 22 24 49 58 58 98 148 148 188 228 231	5 13 21 23 48 57 97 147 187 227 230			
0295 0296 0196 0186 0015 0187 0188 0135 0010 0011 0136 0270 0042 0255	Transaction Set ID Maintenance Type Correction Code Maintenance Type Correction Code Date Denial Rescission Date Jurisdiction Branch Office Code Claim Administrator Claim Number Claim Administrator FEIN Claim Administrator Name Claim Administrator Information/Attention Line Claim Administrator Primary Address Claim Administrator Secondary Address Claim Administrator Country Code Employee ID Type Qualifier Employee SSN	R21 TW0892356 141456789 ALL AMERICAN INSURANCE COMPANY PO BOX 12345 S	Companion Record	4 6 14 22 24 49 58 98 148 188 228 231 232	5 13 21 23 48 57 97 147 187 227 230 231 246			

eCLAIMS BUSINESS SCENARIOS

	First Report Event	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	Employee Last Name	DOE		253	292
0045	Employee Middle Name/Initial	Т		293	307
0046	Employee Mailing Primary Address	123 NOTT STREET		308	347
	Employee Mailing Secondary Address			348	387
0155	Employee Mailing Country Code			388	390
	Employee Phone Number	5185550234	(518) 555-0234	391	405
	Death Result of Injury Code			406	406
	Type of Loss Code	01	Trauma	407	408
	Return To Work With Same Employer Indicator			409	409
	Return To Work Type Code			410	410
	Physical Restrictions Indicator			411	411
	Insured FEIN	089898765		412	420
	Insured Name	COUNTY OF SCHENECTADY		421	460
	Insured Type Code		Insured	461	461
0026	Insured Report Number			462	486
0204	Work Week Type Code	F	Fixed Work Week	487	487
	Work Days Scheduled	SNNSSSS		488	494
	Injury Severity Type Code			495	495
	Insurer Name	ALL AMERICAN INSURANCE COMPANY		496	535
	Insurer Type Code		Insurer	536	536
	Insolvent Insurer FEIN			537	545
0200	Claim Administrator Alternate Postal Code			546	554
0206	Employee Security ID			555	569
	Filler			570	577
	Accident Premises Code	E	Employer	578	578
	Accident Site County/Parish	ALBANY		579	598
	Accident Site Location Narrative			599	648
	Accident Site Organization Name			649	698
	Accident Site City	SCHENECTADY		699	713
	Accident Site Street	1234 BROADWAY		714	753
0123	Accident Site State Code	NY		754	755
	Accident Site Country Code			756	758
0281	Date Employer Had Knowledge of Date of Disability	20140401	April 1, 2014	759	766
	Filler			767	767
0018	Employer Name	COUNTY OF SCHENECTADY		768	807
	Employer UI Number	16-10000		808	822
	Employer Physical Primary Address	1234 BROADWAY		823	862
0020	Employer Physical Secondary Address			863	902
0164	Employer Physical Country Code			903	905
0159	Employer Contact Business Phone Number	5184029394	(518) 402-9394	906	920
	Employer Contact Name	JANE SMITH		921	960
0230	Employer ID Assigned by Jurisdiction			961	975

eCLAIMS BUSINESS SCENARIOS

00 -	- First Report Event	Transaction La	yout		
	Data Element Name	Data	Description	Beg	End
0231	Manual Classification Sub-Code			976	977
	Filler			978	1050
0163	Employer Mailing Information/Attention Line			1051	1100
	Employer Mailing City	SCHENECTADY		1101	1115
0166	Employer Mailing Country Code			1116	1118
0167	Employer Mailing Postal Code	12305		1119	1127
0168	Employer Mailing Primary Address	1234 BROADWAY		1128	1167
0169	Employer Mailing Secondary Address			1168	1207
0170	Employer Mailing State Code	NY		1208	1209
	Filler			1210	1259
0060	Occupation Description	CORRECTIONS OFFICER		1260	1309
0199	Full Denial Effective Date			1310	1317
	Filler			1318	1480
0073	Claim Status Code		N/A	1481	1481
0074	Claim Type Code	М	Medical Only	1482	1482
0077	Late Reason Code			1483	1484
0273	Employer Paid Salary in Lieu of Compensation			1485	1485
	Filler			1486	1590
	Variable Segment Counters				
0274	Number of Accident/Injury Description Narratives	02	2 Occurrences	1591	1592
0277	Number of Full Denial Reason Codes	00		1593	1594
0276	Number of Denial Reason Narratives	00		1595	1596
0278	Number of Managed Care Organizations	00		1597	1598
	Number of Witnesses	01	1 Occurrence	1599	1600
	Variable Segments				
	Accident/Injury Description Narratives		2 Occurrences		
0038	Accident/Injury Description Narrative	MR. DOE WAS INJURED WHEN AN INMATE STRUCK HIM AND		1601	1650
0038	Accident/Injury Description Narrative	CAUSED INJURY TO OFFICER'S RT. ANKLE		1651	1700
	Full Denial Reason Codes				
0198	Full Denial Reason Code				
	Full Denial Reason Narratives				
0197	Denial Reason Narrative				

eCLAIMS BUSINESS SCENARIOS

00 —	First Report Event	Transaction La	ayout		
DN	Data Element Name	Data	Description	Beg	End
	Managed Care Organizations				
0207	Managed Care Organization Code				
0209	Managed Care Organization Name				
0208	Managed Care Organization Identification Number				
	Witnesses		1 Occurrence		
0238	Witness Name	JANE SMITH		1701	1740
0237	Witness Business Phone Number	5184029394	(518) 402-9394	1741	1755
	Filler			1756	1775
	End R21 Elements				

## NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 10-3

### Notification Only, Now Lost Time Payment without Admitting Liability and Without Prejudice per §21(a) – MTC 00/IP

(Claimant has lost time from work and Claim Administrator has begun payment without prejudice per \$21(a))

#### **NARRATIVE**:

Employee John Doe, from Scenario 1-4, sought medical treatment on August 15, 2012, from his primary care physician due to ongoing pain from his injury and difficulty working. The medical provider noted a Temporary Total Disability and a follow up in four weeks for the claimant. After receiving the medical report on August 24, 2012, the Claim Administrator determined that they would begin payments without prejudice per §21(a) to meet their timely filing and first payment requirements. The Claim Administrator mailed a check to the claimant on August 27, 2012 paying him Temporary Total Benefits for the period August 15, 2012 through August 27, 2012.

The Claim Administrator reported the initial payment information to the NYS Workers' Compensation Board by sending an Initial Payment (**SROI IP**) transaction report to the NYSWCB on **August 27, 2012**. The SROI-IP was submitted with Agreement to Compensate (DN0075) Code of "W" (Without Liability) to signify that the Claim Administrator has begun payments without admitting liability as per §21(a).

#### **SEQUENCE OF BUSINESS EVENTS (MTC):**

Scenario 1-4 Event 1: FROI MTC 00 – Original First Report – Notification Only

<u>Scenario 10-3</u> Event 2: SROI MTC IP – Initial Payment – Claim Type Code of "I" (Indemnity); Agreement to Compensation Code "W" (Without Liability)

	Initial Payment, Event 2	Transaction Layout Data Description		Dear	End
DN		Data	Description	Beg	Ena
0004	A49 Data Elements		Outras museus Dan ant		
	Transaction Set ID	A49	Subsequent Report	1	3
	Maintenance Type Code	IP	Initial Payment	4	5
	Maintenance Type Code Date	20120827	August 27, 2012	6	13
	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
	Employee Number of Dependents			52	53
	Pre-Existing Disability Code	Ν	No	54	54
	Initial Date Disability Began	20120815	August 15, 2012	55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week	5		101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
0075	Agreement to Compensate Code	W	Without Liability	188	188
0076	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				
0097	Dependent/Payee Relationship Code				
	End A49 Elements				

IP –	Initial Payment, Event 2	Transaction Layout			
DN	Data Element Name	Data	Description	Beg	End
	R22 Data Elements				
0001	Transaction Set ID	R22	Subsequent Report	1	3
0295	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298	Date Claim Administrator Had Knowledge of Lost			14	21
0186	Jurisdiction Branch Office Code			22	23
0015	Claim Administrator Claim Number	TW0892356		24	48
0187	Claim Administrator FEIN	141456789		49	57
0188	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail Address	mclark@allamerica n.com		153	232
	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270	Employee ID Type Qualifier	s	Social Security Number	243	243
0042	Employee SSN	324556745		244	258
0043	Employee Last Name	DOE		259	298
0044	Employee First Name	JOHN		299	313
0045	Employee Middle Name/Initial			314	328
0255	Employee Last Name Suffix			329	332
0052	Employee Date of Birth	19771101	November 1, 1977	333	340
	Employee Marital Status Code		N/A	341	341
0151	Employee Education Level			342	343
	Employee Number of Entitled Exemptions			344	345
	Anticipated Wage Loss Indicator			346	346
0202	Reduced Benefit Amount Code			347	347
	Employee Tax Filing Status Code			348	348
-	Death Result of Injury Code			349	349
	Insured FEIN	089898765		350	358
	Insolvent Insurer FEIN			359	367
	Employer FEIN	089898765		368	376
	Employer Physical Postal Code			377	385
	Return To Work With Same Employer Indicator			386	386
		20120824	August 24, 2012	387	394
	Non-Consecutive Period Code			395	395
	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	Initial Date Last Day Worked	20120812	August 12, 2012	413	420
	Return To Work Type Code			421	421
	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430

IP –	Layout				
DN	Data Element Name	Data	Description	Beg	End
0199	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
0256	Wage Effective Date		N/A	459	466
0149	Discontinued Fringe Benefits			467	477
0290	Type of Loss Code	01	Trauma	478	479
0058	Employment Status Code	1	Full Time	480	481
0223	Permanent Impairment Minimum Payment Indicator			482	482
0068	Initial Return to Work Date			483	490
0066	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
0293	Lump Sum Payment/Settlement Code			492	493
0273	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	N	No	405	505
	Average Wage	00000105000	\$1050.00	495	505
	Initial Date of Lost Time	20120815	August 15, 2012	506	513
	Award/Order Date			514	521
	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
0204	Work Week Type Code	s	Standard Work Week	532	532
	Work Days Scheduled	NSSSSSN		533	539
	Employee Security ID			540	554
0229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
	Number of Benefits	01	1 Occurrence	630	631
-	Number of Payments	01	1 Occurrence	632	633
	Number of Other Benefits	00		634	635
	Number of Benefit ACR	000		636	638
	Number of Recoveries	00		639	640
0285	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments	-			
	Benefits		1 Occurrence		
	Benefit Type Code	050	Temporary Total	651	653
0002	Maintenance Type Code	IP	Initial Payment	654	655
0174	Gross Weekly Amount	00000070000	\$700.00	656	666
0175	Gross Weekly Amount Effective Date	20120815	August 15, 2012	667	674
0087	Net Weekly Amount	00000070000	\$700.00	675	685
0211	Net Weekly Amount Effective Date	20120815	August 15, 2012	686	693
	Benefit Period Start Date	20120815	August 15, 2012	694	701
0089	Benefit Period Through Date	20120827	August 27, 2012	702	709
0090	Benefit Type Claim Weeks	0001		710	713

	Initial Payment, Event 2	Transaction	Layout		
DN	Data Element Name	Data	Description	Beg	End
0091	Benefit Type Claim Days	4		714	714
0086	Benefit Type Amount Paid	00000126000	\$1260.00	715	725
0192	Benefit Payment Issue Date	20120827	August 27, 2012	726	733
	Filler			734	753
	Payments		1 Occurrence		
0222	Payment Reason Code	050	Temporary Total	754	756
0217	Payee	JOHN DOE		757	796
0218	Payment Amount	00000126000	\$1260.00	797	807
0219	Payment Covers Period Start Date	20120815	August 15, 2012	808	815
0220	Payment Covers Period Through Date	20120827	August 27, 2012	816	823
0195	Payment Issue Date	20120827	August 27, 2012	824	831
	Filler			832	851
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
	Actual Reduced Earnings				
	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
	Concurrent Employer Contact Business Phone			1	
	Concurrent Employer Wage				

IP – I	Initial Payment, Event 2	Transaction Layout					
DN	Data Element Name	Data	Description	Beg	End		
	Denial Reason Codes						
0198	Full Denial Reason Code						
	Denial Reasons						
0197	Denial Reason Narrative						
	Suspension Narratives						
0233	Suspension Narrative						
	End R22 Elements						

## NYS WORKERS' COMPENSATION BOARD eClaims Business Scenarios Scenario 10-4

### **Reclassification of Benefit Due to Misreporting of Initial Benefit Type – MTC CB**

(Claim Administrator reported Benefit Type incorrectly)

#### **NARRATIVE**:

Employee John Doe, from Scenario 2-1, remained out of work.

On **August 22, 2012**, the Claim Administrator realized that they reported the incorrect Benefit Type and the claimant's medical report actually indicated a Marked Temporary Partial Disability. There were no Temporary Total payments due on the claim.

The Claim Administrator reported the reclassification of the Benefit Type from Temporary Total to Temporary Partial by sending the Change in Benefit Type (**SROI CB**) transaction report to the NYSWCB on **August 22, 2012**. The SROI-CB contained Reduced Benefit Amount Code (DN0202) equal to "R" Reclassification of Benefit which allowed the Claim Administrator to remove the Temporary Total Benefits from the SROI-CB transaction.

#### **SEQUENCE OF BUSINESS EVENTS (MTC):**

<u>Scenario 2-1</u> Event 1: FROI MTC 00 – Original First Report Event 2: SROI MTC IP – Initial Payment

<u>Scenario 10-4</u> Event 3: SROI MTC CB – Change in Benefit Type with DN0202 = "R" Reclassification of Benefit

eCLAIMS BUSINESS SCENARIOS

DN	Data Element Name	Data	Description	Beg	End
	A49 Data Elements				
0001	Transaction Set ID	A49	Subsequent Report	1	3
0002	Maintenance Type Code	СВ	Change in Benefit Type	4	5
0003	Maintenance Type Code Date	20120919	September 19, 2012	6	13
0004	Jurisdiction Code	NY		14	15
0006	Insurer FEIN	141456789		16	24
	Filler			25	33
0014	Claim Administrator Postal Code	12110		34	42
	Filler			43	51
0055	Employee Number of Dependents			52	53
0069	Pre-Existing Disability Code			54	54
0056	Initial Date Disability Began			55	62
0070	Date of Maximum Medical Improvement			63	70
	Filler			71	71
0072	Latest Return to Work Status Date			72	79
0057	Employee Date of Death			80	87
	Filler			88	98
0063	Wage Period Code	01	Weekly	99	100
0064	Number of Days Worked Per Week			101	101
	Filler			102	102
0031	Date of Injury	20120801	August 01, 2012	103	110
0026	Insured Report Number			111	135
0015	Claim Administrator Claim Number	TW0892356		136	160
0005	Jurisdiction Claim Number	G0055555		161	185
0073	Claim Status Code		N/A	186	186
0074	Claim Type Code	I	Indemnity	187	187
	Agreement to Compensate Code	L	With Liability	188	188
	Date Claim Administrator Notified of Employee Representation			189	196
0077	Late Reason Code			197	198
	Variable Segment Counters				
0078	Number of Permanent Impairments	00		199	200
	Filler			201	206
0082	Number of Death Dependent/Payee Relationships	00		207	208
	Variable Segments				
	Permanent Impairments				
0083	Permanent Impairment Body Part Code				
	Permanent Impairment Percentage				
	Death/Dependent/Payee Relationships				<u> </u>
0097	Dependent/Payee Relationship Code				
5501	End A49 Elements				

eCLAIMS BUSINESS SCENARIOS

DN L	Data Element Name	Data	Description	Beg	End
F	R22 Data Elements				
0001 T	Transaction Set ID	R22	Subsequent Report	1	3
0295 _N	Maintenance Type Correction Code			4	5
	Maintenance Type Correction Code Date			6	13
0298 C	Date Claim Administrator Had Knowledge of Lost			14	21
0186 J	Iurisdiction Branch Office Code			22	23
0015 C	Claim Administrator Claim Number	TW0892356		24	48
0187 C	Claim Administrator FEIN	141456789		49	57
	Claim Administrator Name	ALL AMERICAN INSURANCE COMPANY		58	97
0140 C	Claim Administrator Claim Representative Name	MARY CLARK		98	137
	Claim Administrator Claim Representative Business Phone Number	5187855000	(518) 785-5000	138	152
	Claim Administrator Claim Representative E-Mail	mclark@allamerica n.com		153	232
N	Claim Administrator Claim Representative Fax Number	5187855001	(518) 785-5001	233	242
0270 E	Employee ID Type Qualifier	s	Social Security Number	243	243
0042 E	Employee SSN	324556745		244	258
0043 E	Employee Last Name	DOE		259	298
0044 E	Employee First Name	JOHN		299	313
0045 E	Employee Middle Name/Initial			314	328
0255 E	Employee Last Name Suffix			329	332
0052 E	Employee Date of Birth	19771101	November 1, 1977	333	340
0054 E	Employee Marital Status Code		N/A	341	341
0151 E	Employee Education Level			342	343
0213 E	Employee Number of Entitled Exemptions			344	345
0201 A	Anticipated Wage Loss Indicator			346	346
0202 F	Reduced Benefit Amount Code	R	Reclassification of Benefit	347	347
0158 E	Employee Tax Filing Status Code			348	348
	Death Result of Injury Code			349	349
0314 Ir	nsured FEIN	089898765		350	358
0292 Ir	nsolvent Insurer FEIN			359	367
0016 E	Employer FEIN	089898765		368	376
0023 E	Employer Physical Postal Code			377	385
0228 F	Return To Work With Same Employer Indicator			386	386
		20120801	August 01, 2012	387	394
	Non-Consecutive Period Code			395	395
0172 E	Estimated Gross Weekly Amount Indicator			396	396
	Current Date Last Day Worked			397	404
	Current Date Disability Began			405	412
	nitial Date Last Day Worked			413	420
	Return To Work Type Code			421	421

eClaims Business Scenarios

DN	Data Element Name	Data	Description	Beg	End
0224	Physical Restrictions Indicator			422	422
0193	Suspension Effective Date			423	430
	Full Denial Effective Date			431	438
0196	Denial Rescission Date			439	446
0294	Partial Denial Code			447	447
0134	Calculated Weekly Compensation Amount	00000070000	\$700.00	448	458
	Wage Effective Date		N/A	459	466
	Discontinued Fringe Benefits			467	477
	Type of Loss Code	01	Trauma	478	479
	Employment Status Code	1	Full Time	480	481
	Permanent Impairment Minimum Payment Indicator	-		482	482
	Initial Return to Work Date			483	490
	Full Wages Paid For Date Of Injury Indicator	Y	Yes	491	491
	Lump Sum Payment/Settlement Code	•		492	493
	Employer Paid Salary in Lieu of Compensation			494	494
	Indicator	N	No	_	_
0286	Average Wage	00000105000	\$1050.00	495	505
0297	Initial Date of Lost Time	20120802	August 02, 2012	506	513
0299	Award/Order Date			514	521
0200	Claim Administrator Alternate Postal Code			522	530
0203	Employer Paid Salary Prior to Acquisition Code			531	531
	Work Week Type Code	S	Standard Work Week	532	532
0205	Work Days Scheduled	NSSSSSN		533	539
0206	Employee Security ID			540	554
)229	Injury Severity Code			555	555
	Filler			556	629
	Variable Segment Counters				
0288	Number of Benefits	01	1 Occurrences	630	631
0283	Number of Payments	00	N/A	632	633
0282	Number of Other Benefits	00		634	635
0289 I	Number of Benefit ACR	000		636	638
0284 I	Number of Recoveries	00		639	640
0285 I	Number of Reduced Earnings	00		641	642
0275	Number of Concurrent Employers	00		643	644
0277	Number of Full Denial Reason Code	00		645	646
0276	Number of Denial Reason Narratives	00		647	648
0287	Number of Suspension Narratives	00		649	650
	Variable Segments				
	Benefits		1 Occurrences		
0085	Benefit Type Code	070	Temporary Partial	651	653
	Maintenance Type Code	СВ	Change in Benefit	654	655
0174	Gross Weekly Amount	00000052500	\$525.00	656	666
	Gross Weekly Amount Effective Date	20120802	August 02, 2012	667	674
	Net Weekly Amount	00000052500	\$525.00	675	685
	Net Weekly Amount Effective Date	20120802	August 02, 2012	686	693

eClaims Business Scenarios

DN	Data Element Name	Data	Description	Beg	End
0088	Benefit Period Start Date	20120802	August 02, 2012	694	701
0089	Benefit Period Through Date	20120822	August 22, 2012	702	709
0090	Benefit Type Claim Weeks	0003		710	713
0091	Benefit Type Claim Days	0		714	714
0086	Benefit Type Amount Paid	00000157500	\$1575.00	715	725
0192	Benefit Payment Issue Date	20120822	August 22, 2012	726	733
	Filler			734	753
	Payments				
0222	Payment Reason Code		N/A		
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
0222	Payment Reason Code				
0217	Payee				
0218	Payment Amount				
0219	Payment Covers Period Start Date				
0220	Payment Covers Period Through Date				
0195	Payment Issue Date				
	Other Benefits				
0216	Other Benefit Type Code				
0215	Other Benefit Type Amount				
	Benefit Adjustments				
0092	Benefit Adjustment Code				
0094	Benefit Adjustment Start Date				
0125	Benefit Adjustment End Date				
0093	Benefit Adjustment Weekly Amount				

eCLAIMS BUSINESS SCENARIOS

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DN	Data Element Name	Data	Description	Beg	End
	Benefit Credits				
0126	Benefit Credit Code				
0127	Benefit Credit Start Date				
0128	Benefit Credit End Date				
0129	Benefit Credit Weekly Amount				
	Filler				
	Benefit Redistribution				
0130	Benefit Redistribution Code				
0131	Benefit Redistribution Start Date				
0132	Benefit Redistribution End Date				
0133	Benefit Redistribution Weekly Amount				
	Recoveries				
0226	Recovery Code				
0225	Recovery Amount				
	Reduced Earnings				
0242	Reduced Earnings Week Number				
0124	Actual Reduced Earnings				
0147	Deemed Reduced Earnings				
	Concurrent Employers				
0141	Concurrent Employer Name				
0142	Concurrent Employer Contact Business Phone				
0143	Concurrent Employer Wage				
	Denial Reason Codes				
0198	Full Denial Reason Code				
	Denial Reasons				
0197	Denial Reason Narrative				
	Suspension Narratives				
0233	Suspension Narrative				
	End R22 Elements				