

Nebraska Workers' Compensation Court

SROI R1 Implementation Guide

Electronic Data Interchange (EDI)



Revised

December 15, 2005

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Section One:

Introduction

Overview

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

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

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

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

On May 12, 2004, the Nebraska Workers' Compensation Court adopted an amendment to its Rule 30, Subsequent Report, that provides for mandatory electronic filing of subsequent reports. Trading Partners that do not already file electronic subsequent reports will be contacted to schedule test dates and to create a flexible implementation schedule.

At the time of publication, 99.9 percent of all first reports and 67.4 percent of all subsequent reports are filed electronically. The court will eventually receive versions of its proof of insurance and other forms in an electronic format.

Contact List

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Section Two:

Filing Requirements

EDI Advisory

May 24, 2004

Rule 30 amended to provide for electronic filing of subsequent reports

On May 12, 2004, the Nebraska Workers' Compensation Court adopted an amendment to its Rule 30, Subsequent Report, that provides for mandatory electronic filing of subsequent reports. Following is the text of Rule 30:

RULE 30

SUBSEQUENT REPORT

- A.** A Subsequent Report shall be filed with the court by the employer or its insurer or risk management pool. Such Subsequent Report shall be filed:
1. Within fourteen days following initial payment of workers' compensation benefits. A report must be filed even in cases where only medical or other non-income benefit payments have been made.
 2. Within fourteen days following the denial of a claim or a change to a previous report.
 3. On the semi-annual anniversary of the date of injury, and every 180 days thereafter until the case is closed.
 4. Within fourteen working days following the closing of any case for which benefits have been paid.
 5. Within fourteen days following payment pursuant to a final order, award, or judgment of the court, including an order approving a lump sum settlement or settlement agreement.
 6. Within 30 days of receipt from the court of a notice of error and request for correction of a previously filed Subsequent Report.
- B.** On all Subsequent Reports filed with the court, cumulative weekly, medical, hospital, vocational rehabilitation and other benefit payments shall be included.
- C.** For cases in which the employer has continued to pay full salary, any portion of the full salary payment that was intended to apply to workers' compensation benefits shall be reported in accordance with this rule.
- D.** The Subsequent Report shall be filed in writing or by electronic means, if such electronic means and the content of the electronic filing is approved by the court. Written reports shall be made by means of the Subsequent Report (Form 4), an exact copy of which appears on the two pages following this rule. Facsimile copies will not be accepted. Blank forms for written reports are furnished by the court upon request.
- E.** Beginning no later than October 1, 2004, all Subsequent Reports filed by or on behalf of an insurer, risk management pool, or self insured employer shall be filed electronically in the form and manner and to include the content prescribed by the compensation court. In the alternative, an implementation plan shall be approved by the court no later than October 1, 2004. No report filed by electronic means shall be deemed filed until the electronic transmission has been received and accepted by the court.

Sections 48-144, 48-165, R.R.S. 1998, and 48-163, R.S. Supp., 2002.

Effective date May 12, 2004.

Exceptions to the electronic filing of subsequent reports

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

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

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

Section Three:

Subsequent Report Detailed Claim Information Codes

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

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

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

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

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

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

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

Paid-To-Date Codes

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

Permanent Impairment Part of Body Codes

I. Head

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

II. Neck

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

III. Upper Extremities

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

- 36E: The loss of a second finger and the metacarpal bone there of
- 36F: The loss of a middle finger at the proximal at the proximal joint
- 36G: The loss of a middle finger at the second joint
- 36H: The loss of a middle finger at the distal joint
- 36I: The loss of a third or ring finger and the metacarpal thereof
- 36J: The loss of a ring finger at the proximal joint
- 36K: The loss of a ring finger at the second joint
- 36L: The loss of a ring finger at the distal joint
- 36M: The loss of a little finger and the metacarpal bone thereof
- 36N: The loss of a little finger at the proximal joint
- 36O: The loss of a little finger at the second joint
- 36P: The loss of a little finger at the distal joint

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

- 37A: The loss of a thumb and metacarpal bone thereof
- 37B: The loss of a thumb at the proximal joint
- 37C: The loss of a thumb at the second or distal joint

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

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

IV. Trunk

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

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

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

43. Disc: Spinal column cartilage in the back.

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

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

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

47. Spinal Cord: Nerve tissue in the back.

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

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

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

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

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

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

V. Lower Extremities

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

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

VI. Multiple Body Parts

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

Name Standards

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

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

Section Four:

EDI Trading Partner Requirements

Trading Partner Agreements

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

NWCC EDI EVENT TABLE

(Rev. 05/24/2004)

TRANS	MTC	MTC DESCRIPTION	PROD LEVEL IND	REPORT TRIGGER CRITERIA	TRIGGER VALUE	RPT REQMNT.	VALUE	REPORT DUE CRITERIA	RPT DUE VALUE
A49	IP	Initial Payment	Prod	O = Maint. Type Event	N/A		# Days	A = Upon Issuance of Payment	14 Days
	AP	Acquired Payment	Prod	O = Maint. Type Event	N/A		# Days	A = Upon Issuance of Payment	14 Days
	PY	Medical Only	Prod	O = Maint. Type Event	N/A		# Days	A = Upon Issuance of Payment	14 Days
	02	Change	Prod	O = Maint. Type Event	N/A		# Days	A = After gaining knowledge that match data has changed or by notification from the court	14 Days
	CO	Correction	Prod	O = Maint. Type Event	N/A		# Days	A = Upon Determination	14 Days
	04	Denial	Prod	O = Maint. Type Event	N/A		# Days	A = Upon Determination	14 Days
	SA	Semi-Annual	Prod	O = Maint. Type Event	N/A	C = Date of Injury	# Days	C = Days frm Dt. Acc/Inj	180 Days
	FN	Final	Prod	O = Maint. Type Event	N/A	A = Date Closed B = Lump Sum Settlement Payment	# Days # Days	A = Days from Dt Clsd B = Days from payment date	14 Days 14 Days
	UR	Upon Request	Prod	O = Maint. Type Event	N/A	State Specific	# Days	State Specific	
	S8	Suspension, Jurisdiction Change	Prod	O = Maint. Type Event	N/A		# Days	A = Upon Determination	14 Days
	RB	Reinstatement of Benefit	Prod	O = Maint. Type Event	N/A		# Days	A = To report payments of compensation benefits paid after a claim has been reported closed or Final was submitted	14 Days

Addendum to Event Table

Release1

MTC	Event	Time Report is Due
'IP'	Initial Payment: The first payment of indemnity benefits has been made. A previous Subsequent report (other than IP) may or may not have been filed, but NO previous IP reports have been filed for this claim by the same claim administrator/TPA.	Within 14 days following the initial payment of indemnity benefits.
'AP'	Acquired/Payment: The acquiring claim administrator has made the first payment of indemnity benefits.	Within 14 days following the first payments made on a claim by the acquiring claims administrator.
'PY'	Payment: Identifies payment information for which reporting is required by the jurisdiction. Used for reporting payments other than indemnity benefits - e.g. medical, hospital, vocational rehabilitation, etc.	Defined by Nebraska to be used for reporting non-indemnity benefit payments made on non-indemnity claims (Medical, Hospital, Funeral, etc.). Must be reported within 14 days following the initial payment of non-indemnity benefits.
'02'	Change: A change is made following the submission of a subsequent report. A previous subsequent report must have been filed. All mandatory fields must be completed for transmission of the record. <i>Note: A change is not made as a result of a warning error received from the NWCC in an electronic transaction acknowledgement. This scenario would require a correction, shown below.</i>	Immediately — defined to be the time at which the claims administrator has knowledge of a change in primary match information that includes insurer FEIN, TPA FEIN, social security number, date of injury, claims administrator number, employee date of death, or within 30 days of receipt from the NWCC of a notice of error and request for correction of a previously filed subsequent report.
'CO'	Correction: The trading partner uses this code when a warning-error or non-critical error has been identified by NWCC. Since an original report has previously been filed with NWCC, the trading partner files a correction including all mandatory fields with the transmission.	Immediate — defined to be the time at which the claims administrator receives a warning error from the NWCC (received in a electronic transaction acknowledgement), makes the necessary changes to their internal system, and instructs their system to send the correction in the next transmission.
'04'	Denial: Used by the trading partner to indicate that the claims administrator denies the claim. A previous original report must have been filed. All mandatory fields and non-null required fields must be completed for transmission of the record. Please note that for purposes of first report filing, an Original Denial (04) can still be submitted without previously submitting an Original (00).	Within 14 days — defined to be the time at which the claims administrator determines the claim is to be denied and instructs their system to send the denial request in the next transmission.
'SA'	Semi-Annual: Periodic Report submitted based on the report trigger criteria column located on the event table. This report should include all payment totals paid to date for indemnity and non-indemnity compensation benefits.	On the semi-annual anniversary date of the date of injury, and every 180 days thereafter until the case is closed.
'FN'	Final: Closed claim, no further payments of any kind anticipated. A Final (FN) will not be accepted without a prior IP, AP or PY being received and accepted. This report should include all payment totals paid to date for indemnity and non-indemnity compensation benefits.	Within 14 days following the closing of any claim.
'UR'	Upon Request: Submitted in response to a specific request from the trading partner	To be determined upon mutual agreement between trading partners.
'S8'	Suspension Jurisdiction Change: To report that all payments of compensation benefits have stopped because the jurisdiction has been changed.	Within 14 days — defined to be the time at which the claims administrator determines the claim's jurisdiction has been changed and instructs their system to send the S8 request in the next transmission.
'RB'	Reinstatement of Benefits: To report that compensation benefits have been paid after a claim has been reported closed or final was submitted.	Within 14 days following payment of compensation benefits (ONLY after a Final (FN) or Lump Sum Settlement report has been previously filed to close the claim).

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

(Rev. 08/20/2004)

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

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

(Rev. 08/20/2004)

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

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

Subsequent Report of Injury

Revised 09/01/2005

Element Criteria Codes:

M = Mandatory

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

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

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

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

NE WCC EDIT MATRIX TABLE (Subsequent Reports)

EDIT MATRIX (Rev 12/10/2004)		ERROR MESSAGE																																			
Elem #	Element Description	001	018	019	028	029	030	031	033	034	035	036	037	038	039	040	041	042	044	045	054	055	057	058	059	061	062	063	064	065	066	067	068	100			
SUBSEQUENT REPORT TRANSACTION																																					
001	Transaction Set ID	R																					R	R													
002	Maintenance Type Code	R																R						R				R									
003	Maintenance Type Code Date	R				R													R																		
004	Jurisdiction	R																					R														
005	Agency Claim Num	R													R																						
006	Insurer FEIN	R			R										R	R																					
008	Third Party Administrator FEIN				R										R	R																					
014	Claim Admin Post Code																																				
015	Claim Admin Claim Num	R				R																															
026	Insured Report Num																																				
031	Date of Injury	R				R							R		R																						
042	Social Security Num	R			R										R	R																					
055	Num of Dependents	R																																			
056	Date Disability Began																																				
057	Employee Date of Death					E			E				E																								
062	Wage																																				
063	Wage Period																																				
064	Num of Days Worked																																				
067	Salary Cont Indicator																																				
069	Pre-Existing Disability																																				
070	Date of MMI																																				
071	RTW Qualifier																																				
072	Date Return/Release RTW																																				
073	Claim Status	R																						R													
074	Claim Type																																				
075	Agreement to Comp Code																																				
076	Date of Representation																																				
077	Late Reason Code																																				
078	Num Perm Impairments	R			R																																
079	Num Payment Adjustments	R			R																	R															
080	Num Benefit Adjustments	R			R																																
081	Num PTD Reduced Earns	R			R																																
082	Num Death Dep/Pay Rel	R			R																																
083	Perm Impair Body Part																																				
084	Perm Impair Percentage																																				
085	Pay / Adj Code	R																R						R													

NE WCC EDIT MATRIX TABLE (Subsequent Reports)

EDIT MATRIX (Rev 12/10/2004)		ERROR MESSAGE																																			
Elem #	Element Description	001	018	019	028	029	030	031	033	034	035	036	037	038	039	040	041	042	044	045	054	055	057	058	059	061	062	063	064	065	066	067	068	100			
		Mandatory field not present																																			
		Number of Days worked must be 0-7																																			
		Number of Days must be 0-6																																			
		Must be numeric (0-9)																																			
		Must be a valid date (CCYYMMDD)																																			
		Must be A-Z, 0-9, or spaces																																			
		Must be a valid time (HHMMSS)																																			
		Must be <= Date of Injury																																			
		Must be >= Date of Injury																																			
		Must be >= Date Disability Began																																			
		Must be <= Date of Death																																			
		Must be <= Maintenance Type Code date																																			
		Must be >= Payment Adj Start date																																			
		No match on database																																			
		All digits cannot be the same																																			
		Must be <= Current date																																			
		Not statutorily valid																																			
		Value is > than required by jurisdiction																																			
		Value is < than required by jurisdiction																																			
		Must be valid occurrence for segment																																			
		Must be <= Date of Hire																																			
		Duplicate transmission/transaction																																			
		Code/ID invalid																																			
		Value not consistent with value previously reported																																			
		Event Criteria not met																																			
		Required Segment Not Present																																			
		Invalid event sequence/relationship																																			
		Invalid data sequence/relationship																																			
		Corresponding report/data not found																																			
		Invalid record count																																			
		Must be >= Policy Effective Date																																			
		Must be <= Policy Effective Date																																			
		No Leading / Imbedded Spaces																																			
SUBSEQUENT REPORT TRANSACTION																																					
086	Pay / Adj Paid to Date	R			R																																
087	Pay / Adj Amount	R			R													F		R																	
088	Pay / Adj Start Date	R				R				R																											
089	Pay / Adj End Date	R				R								R						R																	
090	Pay / Adj Weeks Paid	R				R																															
091	Pay / Adj Days Paid	R		R	R																																
092	Benefit Adj Code																																				
093	Benefit Adj Amount																																				
094	Benefit Adj Start Date																																				
095	PTD/Reduced Earn Code																	R						R													
096	PTD/Reduced Earn Amount					R																															
097	Death Depend Payee Relation																																				
098	Sender ID	R			R										R																						
099	Receiver ID	R			R																			R													
100	Date Transm. Sent	R			R	R											R																				
101	Time Transm. Sent	R			R			R																													
102	Original Transm. Date				R	R											R																				
103	Original Transm. Time				R			R																													
104	Test/Prod. Indicator	R																						R													
105	Interchange Vers. ID	R													R									R				R									
106	Detail Rec. Count	R			R																												R				
107	Record Sequence Num.																																				
108	Date Processed																																				
109	Time Processed																																				
110	ACK Transaction Set ID																																				
111	Application ACK Code																																				
112	Request Code																																				
113	Free-Form Text																																				
114	Number of Errors																																				
115	Element Number																																				
116	Elem. Error Number																																				
117	Variable Seg. Number																																				

Match Data Table

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

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

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

Transaction Sequencing

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

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

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

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

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

Process Rules

Sweeping the System in Release 1

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

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

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

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

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

Reporting Intermittent Periods of Disability and Continuing Payments

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

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

Nebraska State Specific Scenarios

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

Narrative:

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

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

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

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

Sample of Payment Input Fields:

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

Sample of "PY" Subsequent Data

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

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

Narrative:

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

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

Sample of Payment Input Fields:

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

Sample of “FN” Subsequent Data

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

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

Narrative:

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

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

Sample of Payment Input Fields:

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

Sample of "PY" Subsequent Data

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

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

Narrative:

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

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

Sample of Payment Input Fields:

AWW: 600.00		Days per week: 5		Weekly Rate:	Daily Rate:
Payment Code	From Date	Thru Date	Weeks (1/7) Paid	Weekly Rate	Total Paid
360					121.54
370					180.88

Sample of “FN” Subsequent Data

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

Scenario 5: FN – Lump Sum Settlement

Narrative:

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

Sample of Payment Input Fields:

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

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

Sample of "FN" Subsequent Data

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

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

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

Section Five:

EDI Certification Test Procedure

Definitions

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

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

NWCC Reportable Injuries and Related Maintenance Type Codes

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

Certification Test Procedure Instructions

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

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

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

Section Six:

SROI Frequently Asked Questions (FAQs)

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

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

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

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

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

A: The Report Purpose field is used to report the reason for the filing of the form in conjunction with the requirements under Rule 30. For example, an initial payment would be an IP and a semi-annual report would be an SA. Indicate PY for the Report Purpose code if this is the first non-indemnity payment. If medical/hospital is to be reported with indemnity payments, the Report Purpose code should be IP, AP, SA, or FN. The SROI Implementation Guide on the court Web site: <http://www.nol.org/workcomp/> has a listing of the valid codes for the Report Purpose field.

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

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

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

A: We strongly encourage you to sign up for access to the court's **Claims Search database** on the State of Nebraska's (Guardian) Secure Extranet Web site for this purpose. Please visit our Web site's EDI page (<http://www.nol.org/workcomp/edi/edi.htm>) to learn more about accessing this database. Also, you can contact the court and we will look up the number by searching secondary match data such as name, social security number and date of injury.

Q: *Will an AP from the acquiring claims administrator be accepted if the acquired claims administrator previously filed an IP?*

A: Yes, during the transition from paper to electronic filing. For paper filings, the court will be providing feedback on the information that should go in the report purpose code and the sequence of reports that should be filed. For example, a semi-annual report cannot be filed without filing an Initial Payment or an Acquired Payment. Once a trading partner starts sending electronically then the report type (Maintenance Type Code) and sequence of reports will be checked and must follow the standards in the SROI Implementation Guide or the reports will be rejected.

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

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

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

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

Please Note: An 02 change is required prior to submitting the SA.

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

A: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A: Yes, except 521, 524, 551, 580, and 590.

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

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

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

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

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

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

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

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

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

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

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

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

A: Nebraska will accept any of the valid Paid-to-Date codes in the R1 Implementation Guide and the Nebraska SROI Implementation Guide on our Web site's EDI page (<http://www.nol.org/workcomp/edi/edi.htm>). A few other examples are: funeral expenses (code 300), claimant legal expenses (code 340), and expert witness fees (code 420). Remember to indicate PY for the Report Purpose code.

Q: *How do I report mileage?*

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

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

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

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

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

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

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

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

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

Q: *What should be done if a claim administrator files a first report and then reports indemnity and non-indemnity payments on subsequent reports only to find out the claim should have been sent to another jurisdiction?*

A: Send in a FROI cancel transaction.

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

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

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

A: No.

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

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