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**Kentucky Workers' Claims
Claims Release 3
First Report of Injury Element Requirements**

* Legacy -TE's prior to 1/16/09. As of 10/27/2011, no longer accepting MTC CO.											
1 - This MTC is only accepted for legacy claims therefore jurisdiction claim number is always required.											
2 - KY uses this as a means to match the Employer.											
3 - This MTC is only accepted for legacy claims therefore Employer FEIN is always required.											
E (Expected)											
M (Mandatory)											
MC (Mandatory/Conditional)											
EC (Expected/Conditional)											
IA (If Applicable/Available)											
NA (Not Applicable)											
F (Fatal Technical)											
X (Exclude)											
FY (Fatal yes change) Essential data elements which are necessary for a transmission/ transaction that can be changed on a MTC 02.											
Y (Change allowed) limited to 02 Change											
N (No Change) limited to 02 Change											
Note: For MTC 02, per the Match Data Rules, only one Match Data element can be changed per transaction.											
Claim Administrator Postal Code (DN0014) and related address fields should be populated with: <input type="radio"/> Mailing or <input checked="" type="radio"/> Physical											
Migration Considerations:											
Refer to Claims R1 to R3 Migration http://www.iaibc.org/i4a/pages/index.cfm?pageid=3347											
Refer to Element Requirement Table Instructions											
											FROI MTC'S
REC	DN#	DATA ELEMENT NAME	Format	00	01	02	04	AQ	AU	UI	CO
148	0001	Transaction Set ID	3 A/N	F	F	F	F	F	F	F	F
148	0002	Maintenance Type Code	2A/N	F	F	F	F	F	F	F	F
148	0003	Maintenance Type Code Date	Date	F	F	F	F	F	F	F	F
148	0004	Jurisdiction Code	2A/N	F	F	F	F	F	F	F	F
148	0005	Jurisdiction Claim Number	25 A/N	MC	M	N	MC	IA	IA	NA	M ⁻¹
148	0006	Insurer FEIN	9 A/N	F	F	FY	F	F	F	F	F
148	0012	Claim Administrator City	15 A/N	NA	NA	Y	NA	NA	NA	NA	\$
148	0013	Claim Administrator State Code	2 A/N	NA	NA	Y	NA	NA	NA	NA	\$

**Kentucky Workers' Claims
Claims Release 3
First Report of Injury Element Requirements**

REC	DN#	DATA ELEMENT NAME	Format	FROI MTC'S							CO
				00	01	02	04	AQ	AU	UI	
148	0014	Claim Administrator Postal Code	9 A/N	F	F	FY	F	F	F	F	F
148	0015	Claim Administrator Claim Number (Key Match)	25 A/N	F	F	FY	F	F	F	F	F
148	0016	Employer FEIN	9 A/N	M	M	Y	M ²	M	M	M	M ³
148	0021	Employer Physical City	15 A/N	M	NA	Y	M	IA	M	IA	\$
148	0022	Employer Physical State Code	2 A/N	M	NA	Y	M	IA	M	IA	\$
148	0023	Employer Physical Postal Code	9 A/N	M	NA	Y	M	IA	M	IA	\$
148	0025	Industry Code	6 A/N	M	NA	Y	M	IA	M	IA	\$
148	0027	Insured Location Identifier	15 A/N	IA	NA	Y	IA	IA	IA	IA	\$
148	0028	Policy Number Identifier	18 A/N	MC	NA	Y	MC	MC	MC	IA	\$
148	0029	Policy Effective Date	Date	NA	NA	Y	NA	NA	NA	NA	\$
148	0030	Policy Expiration Date	Date	NA	NA	Y	NA	NA	NA	NA	\$
148	0031	Date of Injury	Date	M	M	y	M	M	M	M	M
148	0032	Time of Injury	HHMM	M	NA	Y	MC	IA	MC	IA	\$
148	0033	Accident Site Postal Code	9 A/N	M	NA	Y	M	NA	M	NA	\$
148	0035	Nature of Injury Code	2 A/N	M	NA	y	M	IA	M	IA	\$
148	0036	Part of Body Injury Code	2 A/N	M	NA	Y	M	IA	M	IA	\$
148	0037	Cause of Injury Code	2 A/N	M	NA	Y	M	IA	M	IA	\$
148	0039	Initial Treatment Code	2 A/N	IA	NA	Y	NA	IA	IA	IA	\$
148	0040	Date Employer Had Knowledge of the Injury	Date	M	NA	Y	M	IA	M	IA	\$
148	0041	Date Claim Administrator Had Knowledge of Injury	Date	M	NA	Y	M	IA	M	IA	\$
148	0044	Employee First Name	15 A/N	M	M	Y	M	M	M	M	M
148	0048	Employee Mailing City	15 A/N	M	NA	Y	M	IA	M	MC	\$
148	0049	Employee Mailing State Code	2 A/N	M	NA	Y	M	IA	M	MC	\$
148	0050	Employee Mailing Postal Code	9 A/N	M	NA	Y	M	IA	M	MC	\$
148	0052	Employee Date of Birth	Date	M	NA	Y	M	IA	M	M	\$
148	0053	Employee Gender Code	1 A/N	M	NA	Y	M	IA	M	IA	\$
148	0054	Employee Marital Status Code	1 A/N	IA	NA	Y	IA	IA	IA	IA	\$
148	0055	Employee Number of Dependents	2 N	MC	NA	Y	MC	IA	MC	IA	\$
148	0056	Initial Date Disability Began	Date	MC	NA	Y	MC	IA	MC	IA	\$
148	0057	Employee Date of Death	Date	MC	NA	Y	MC	IA	MC	IA	\$
148	0058	Employment Status Code	2 A/N	M	NA	Y	M	IA	M	IA	\$
148	0059	Manual Classification Code	4 A/N	M	NA	Y	M	NA	M	NA	\$

**Kentucky Workers' Claims
Claims Release 3
First Report of Injury Element Requirements**

REC	DN#	DATA ELEMENT NAME	Format	FROI MTC'S							CO
				00	01	02	04	AQ	AU	UI	
148	0061	Employee Date of Hire	Date	M	NA	Y	M	IA	IA	IA	\$
148	0062	Wage	\$9.20	MC	NA	Y	MC	IA	MC	IA	\$
148	0063	Wage Period Code	2 A/N	MC	NA	Y	MC	IA	MC	IA	\$
148	0064	Number of Days Worked Per Week	1 N	IA	NA	Y	IA	IA	IA	IA	\$
148	0065	Initial Date Last Day Worked	Date	MC	NA	Y	MC	IA	MC	IA	\$
148	0066	Full Wages Paid for Date of Injury Indicator	1 A/N	NA	NA	Y	NA	NA	NA	NA	\$
148	0068	Initial Return to Work Date	Date	IA	NA	Y	IA	IA	IA	IA	\$
R21	0001	Transaction Set ID	3 A/N	F	F	F	F	F	F	F	F
R21	0295	Maintenance Type Correction Code	2 A/N	X	X	X	X	X	X	X	F
R21	0296	Maintenance Type Correction Code Date	Date	X	X	X	X	X	X	X	F
R21	0186	Jurisdiction Branch Office Code	2 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0015	Claim Administrator Claim Number	25 A/N	F	F	FY	F	F	F	F	F
R21	0187	Claim Administrator FEIN	9 A/N	F	F	FY	F	F	F	F	F
R21	0188	Claim Administrator Name	40 A/N	M	NA	Y	M	M	M	M	\$
R21	0135	Claim Administrator Information/Attention Line	50 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0010	Claim Administrator Primary Address	40 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0011	Claim Administrator Secondary Address	40 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0136	Claim Administrator Country Code	3 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0270	Employee ID Type Qualifier	1 A/N	M	M	Y	M	M	M	M	M
R21	*	Employee ID	15 A/N	*One of the following Employee ID types may be populated in positions 232-246							
	0042	Employee SSN	**	MC	MC	y	MC	MC	MC	MC	MC
	0152	Employee Employment Visa		NA	NA	Y	NA	NA	NA	NA	NA
	0153	Employee Green Card	**	MC	MC	y	MC	MC	MC	MC	MC
	0154	Employee ID Assigned by Jurisdiction	**	IA	MC	y	MC	MC	MC	MC	MC
	0156	Employee Passport Number		NA	NA	Y	NA	NA	NA	NA	NA
R21	0255	Employee Last Name Suffix	4 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0150	Employee Authorization to Release Medical Records Indicator	1 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0157	Employee Social Security Number Release Indicator	1 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0043	Employee Last Name	40 A/N	M	M	Y	M	M	M	M	M
R21	0045	Employee Middle Name/Initial	15 A/N	IA	IA	Y	IA	IA	IA	IA	\$

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Claims Release 3
First Report of Injury Element Requirements**

REC	DN#	DATA ELEMENT NAME	Format	FROI MTC'S							CO
				00	01	02	04	AQ	AU	UI	
R21	0046	Employee Mailing Primary Address	40 A/N	M	NA	Y	M	IA	M	IA	\$
R21	0047	Employee Mailing Secondary Address	40 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0155	Employee Mailing Country Code	3 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0051	Employee Phone Number	15 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0146	Death Result of Injury Code	1 A/N	MC	NA	Y	MC	NA	MC	NA	\$
R21	0290	Type of Loss	2 A/N	MC	NA	Y	MC	NA	MC	NA	\$
R21	0228	Return to Work with Same Employer Indicator	1 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0189	Return to Work Type Code	1 A/N	MC	NA	Y	MC	MC	MC	MC	\$
R21	0224	Physical Restrictions Indicator	1 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0314	Insured FEIN	9 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0017	Insured Name	40 A/N	M	NA	Y	MC	IA	M	IA	\$
R21	0184	Insured Type Code	1 A/N	M	NA	Y	MC	IA	M	IA	\$
R21	0026	Insured Report Number	25 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0007	Insurer Name	40 A/N	M	NA	Y	MC	M	M	M	\$
R21	0185	Insurer Type Code	1 A/N	M	NA	Y	MC	IA	M	IA	\$
R21	0292	Insolvent Insurer FEIN	9 A/N	IA	IA	Y	IA	IA	IA	IA	\$
R21	0200	Claim Administrator Alternate Postal Code	9 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0249	Accident Premises Code	1 A/N	M	NA	Y	MC	IA	M	IA	\$
R21	0118	Accident Site County/Parish	20 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0119	Accident Site Location Narrative	50 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0120	Accident Site Organization Name	50 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0121	Accident Site City	15 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0122	Accident Site Street	40 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0123	Accident Site State Code	2 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0280	Accident Site Country Code	3 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0281	Date Employer Had Knowledge of Date of Disability	Date	NA	NA	Y	NA	NA	NA	NA	\$
R21	0018	Employer Name	40 A/N	M	M	Y	M	M	M	M	\$
R21	0329	Employer UI Number	15 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0019	Employer Physical Primary Address	40 A/N	M	NA	Y	M	IA	M	IA	\$
R21	0020	Employer Physical Secondary Address	40 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0164	Employer Physical Country Code	3 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0159	Employer Contact Business Phone Number	15 A/N	IA	NA	Y	IA	IA	IA	IA	\$

**Kentucky Workers' Claims
Claims Release 3
First Report of Injury Element Requirements**

REC	DN#	DATA ELEMENT NAME	Format	FROI MTC'S							CO
				00	01	02	04	AQ	AU	UI	
R21	0160	Employer Contact Name	40 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0163	Employer Mailing Information/Attention Line	50 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0165	Employer Mailing City	15 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0166	Employer Mailing Country Code	3 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0167	Employer Mailing Postal Code	9 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0168	Employer Mailing Primary Address	40 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0169	Employer Mailing Secondary Address	40 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0170	Employer Mailing State Code	2 A/N	MC	NA	Y	MC	IA	MC	IA	\$
R21	0060	Occupation Description	50 A/N	IA	NA	Y	IA	IA	IA	IA	\$
R21	0199	Full Denial Effective Date	Date	X	NA	Y	M	X	X	X	\$
R21	0073	Claim Status Code	1 A/N	M	NA	Y	M	M	M	NA	\$
R21	0074	Claim Type Code	1 A/N	M	NA	Y	M	M	M	NA	\$
R21	0077	Late Reason Code	2 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0204	Work Week Type Code	1 A/N	IA	IA	Y	IA	IA	IA	IA	\$
R21	0205	Work Days Scheduled Code	7 A/N	IA	IA	Y	IA	IA	IA	IA	\$
R21	0206	Employee Security ID	15 A/N	IA	IA	Y	IA	IA	IA	IA	\$
R21	0273	Employer Paid Salary in Lieu of Compensation Indicator	1 A/N	NA	NA	Y	NA	NA	NA	NA	\$
Variable Segment Counters											
R21	0274	Number of Accident/Injury Description Narratives	2 N	F	F	F	F	F	F	F	F
R21	0277	Number of Full Denial Reason Codes	2 N	F	F	F	F	F	F	F	F
R21	0276	Number of Denial Reason Narratives	2 N	F	F	F	F	F	F	F	F
R21	0278	Number of Managed Care Organizations	2 N	F	F	F	F	F	F	F	F
R21	0279	Number of Witnesses	2 N	F	F	F	F	F	F	F	F
Variable Segments											
Accident/Injury Description Narratives											
R21	0038	Accident/Injury Description Narrative	50 A/N	M	NA	Y	M	IA	M	IA	\$
Full Denial Reason Codes											
R21	0198	Full Denial Reason Code	2 A/N	X	NA	Y	M	X	X	X	\$
Full Denial Reason Narratives											
R21	0197	Denial Reason Narrative	50 A/N	X	NA	Y	M	X	X	X	\$
Managed Care Organizations											
R21	0207	Managed Care Organization Code	2 A/N	NA	NA	Y	NA	NA	NA	NA	\$

**Kentucky Workers' Claims
Claims Release 3
First Report of Injury Element Requirements**

REC	DN#	DATA ELEMENT NAME	Format	FROI MTC'S							CO
				00	01	02	04	AQ	AU	UI	
R21	0209	Managed Care Organization Name	40 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0208	Managed Care Organization Identification Number	9 A/N	NA	NA	Y	NA	NA	NA	NA	\$
Witnesses											
R21	0238	Witness Name	40 A/N	NA	NA	Y	NA	NA	NA	NA	\$
R21	0237	Witness Business Phone Number	15 A/N	NA	NA	Y	NA	NA	NA	NA	\$

**Kentucky Workers' Claims
Claims Release 3
First Report of Injury Conditional Requirements**

FROI DATA ELEMENT			
DN#	DATA ELEMENT NAME	BUSINESS CONDITION(S)	TECHNICAL CONDITION(S)
0005	Jurisdiction Claim Number	If MTC 04 previously reported and accepted, and JCN assigned. If FROI 00 or FROI 04 follows a FROI UI, then it is mandatory.	If DN0002 = 00 or 04.
0007	Insurer Name	If the 04 is the Org. FROI then the Insurer Name is mandatory.	If DN0002 = 04 and is establishing document.
0017	Insured Name	If the 04 is the original FROI and the Full Denial Reason Code (DN0198) is not = to 3E, then the Insured Name is mandatory.	If DN0002 = 04 and is establishing document and DN0198 is not = to 3E.
0019	Employer Physical Primary Address	Required when the responsible party is an Insured.	If DN0184 Insured Type Code = I Insured then mandatory.
0021	Employer Physical City	Required when the responsible party is an Insured.	If DN0184 Insured Type Code = I Insured then mandatory.
0022	Employer Physical State Code	Required when the responsible party is an Insured.	If DN0184 Insured Type Code = I Insured then mandatory.
0023	Employer Physical Postal Code	Required when the responsible party is an Insured.	If DN0184 Insured Type Code = I Insured then mandatory.
0027	Insured Location Identifier	Required when Insured Type Code not = 'S'. On MTC 04, Full denial reason code does not = 3E - no coverage or 3D - no coverage, no	If DN0184 Insured Type Code not = S Self Insured then mandatory. On MTC 04, DN0198 not = 3E or
0028	Policy Number Identifier	Required when Insured Type Code not = 'S'. On MTC 04, Full denial reason code does not = 3E- no coverage or 3D - no coverage, no jurisdiction.	If DN0184 Insured Type Code not = S-Self Insured then mandatory. On MTC 04, DN0198 not = 3E or 3D
0032	Time of Injury	If the 04 or AU is the Org. FROI then the Time of Injury is mandatory.	If DN0002 = 04 or DN0002 = AU, and is establishing document.
0042	Employee SSN	Required if Green Card or Employee ID Assigned by Jurisdiction not entered.	If DN 0270 Employee ID Type Qualifier = S.
0048	Employee Mailing City	M if DN49 or DN50 is populated.	M if DN49 or DN50 is populated.
0049	Employee Mailing State	M if DN48 or DN50 is populated.	M if DN48 or DN50 is populated.
0050	Employee Mailing Zip	M if DN48 or DN49 is populated.	M if DN48 or DN49 is populated.
0055	Employee Number of Dependents	If a date of death is populated, then mandatory.	If DN0057 Employee Date of Death is present, then mandatory.
0056	Initial Date Disability Began	Mandatory when claim is lost time.	If DN0073 Claim Status Code is O or R and DN0074 Claim Type Code is I, L, or W.
0057	Employee Date of Death	If the Benefit Type Code is fatal (010) or Death Result of Injury Code = Y.	If DN0085 = 010 or DN0146 = Y.
0062	Wage	Required for Lost Time Claims.	DN0063 Wage Period Code is present or DN0074 Claim Type Code is I, L, or W.

**Kentucky Workers' Claims
Claims Release 3
First Report of Injury Conditional Requirements**

FROI DATA ELEMENT			
DN#	DATA ELEMENT NAME	BUSINESS CONDITION(S)	TECHNICAL CONDITION(S)
0063	Wage Period Code	M if first FROI and Claim Type Code (DN0074) = I or L.	M if first FROI and DN0074 Claim Type Code is I, L, or W.
0065	Initial Date Last Day Worked	Required for Lost Time Claims.	DN0073 Claim Status Code is O or R and DN0074 Claim Type Code is I, L, or W.
0120	Accident Site Organization Name	Required if the location of injury is a Lessee. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0249 Accident Premises Code = L.
0121	Accident Site City	Required if the location of injury is a Lessee. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0249 Accident Premises Code = L.
0122	Accident Site Street	Required if the location of injury is a Lessee. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0249 Accident Premises Code = L.
0123	Accident Site State Code	Required if the location of injury is a Lessee. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0249 Accident Premises Code = L.
0146	Death Result of Injury Code	Required if death is a result of the injury. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0057 Employee Date of Death is present.
0153	Employee Green Card	Required if SSN or Employee ID Assigned by Jurisdiction not entered.	If DN0270 Employee ID Type Qualifier = G.
0154	Employee ID Assigned by Jurisdiction	Required if Employee Green Card or SSN not entered.	When DN0270 Employee ID Type Qualifier = A, then mandatory.
0165	Employer Mailing City	Required when the responsible party is an Insured. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0184 Insured Type Code = I Insured then mandatory. Migration from R1 to R3.
0167	Employer Mailing Postal Code	Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	Migration from R1 to R3.
0168	Employer Mailing Primary Address	Required when the responsible party is an Insured. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0184 Insured Type Code = I Insured then mandatory. Migration from R1 to R3.
0170	Employer Mailing State Code	Required when the responsible party is an Insured. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0184 Insured Type Code = I Insured then mandatory. Migration from R1 to R3.

**Kentucky Workers' Claims
Claims Release 3
First Report of Injury Conditional Requirements**

FROI DATA ELEMENT			
DN#	DATA ELEMENT NAME	BUSINESS CONDITION(S)	TECHNICAL CONDITION(S)
0184	Insured Type Code	If the 04 is the Org. FROI and the Full Denial Reason Code is not = to 3E the Insured Type Code is mandatory.	If DN0002 = 04 and is establishing document and DN0198 does not = 3E.
0185	Insurer Type Code	If the 04 is the Org. FROI then the Insurer Type Code is mandatory.	If DN0002 = 04 and is establishing document.
0189	Return to Work Type Code	Required if injured worker released to RTW or actually returned to work.	If DN0068 Initial Return to Work Date is present.
0224	Physical Restrictions Indicator	Required if physical restrictions in place upon release and or RTW.	If DN0068 Initial Return to Work Date is present.
0249	Accident Premises Code	If the 04 is the Org. FROI then the Accident Premises Code is mandatory.	If DN0002 = 04 and is establishing document.
0290	Type of Loss	Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	Migration from R1 to R3.
0314	Insured FEIN	If the 04 is the Org. FROI then the Insured FEIN is mandatory. Mandatory if 00, 04 or AU is the originating FROI or it follows the UI. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0002 = 00, 04 or AU and is establishing document or follows UI.

**Kentucky Workers' Claims
Claims Release 3
Subsequent Report of Injury Requirements**

M (Mandatory)
 MC (Mandatory/Conditional)
 E (Expected)
 EC (Expected/Conditional)
 IA (If Applicable/Available)
 NA (Not Applicable)
 R (Restricted)
 F (Fatal Technical)
 X (Exclude)
 FC (Fatal/Conditional) - Limited to 02 Change. **Essential data elements that are required for a variable segment to be processed. These data elements must be**
 FY (Fatal yes change) **Essential data elements which are necessary for a transmission/transaction that can be changed on a MTC 02.**
 Y (Yes Change) **limited to 02 Change**
 YC (Yes Change/conditional) **limited to 02 Change**
 N (No Change) **limited to 02 Change**
 Note: For MTC 02, per the Match Data Rules, only one Match Data element can be changed per transaction. Lower case
 Claim Administrator Postal Code (DN0014) and related address fields should be populated with:
Mailing or Physical

Migration Considerations:

Refer to Claims R1 to R3 Migration <http://www.iaabc.org/i4a/pages/index.cfm?pageid=3347>
 Refer to Element Requirement Table Instructions

REC	DN#	DATA ELEMENT NAME	FORMAT	Migration Consideration	Format	SROI MTC'S																							PERIODIC MTC'S												
						02	04	AB	AP	CA	CB	CD	EP	ER	FN	IP	P1	P4	P7	PD	PY	RB	S1	S2	S3	S4	S6	S7	S8	S9	SD	VE	BM								
A49	0001	Transaction Set ID	3 A/N	NI		F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	
A49	0002	Maintenance Type Code	2 A/N	NI		F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	
A49	0003	Maintenance Type Code Date	DATE	NI		F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	
A49	0004	Jurisdiction Code	2 A/N	NI		F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	
A49	0006	Insurer FEIN	9 A/N	NI		FY	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	
A49	0014	Claim Administrator Postal Code	9 A/N	NI		FY	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	
A49	0055	Employee Number of Dependents	2 N	NI		Y	MC	MC	MC	MC	MC	MC	NA	NA	MC	MC	NA	MC	NA	MC	NA	NA	NA	NA	MC	NA	NA	NA	NA	NA	MC	NA	NA	NA	NA	MC	NA	NA	NA		
A49	0069	Pre-existing Disability Code	1 A/N	NI		Y	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	
A49	0056	Initial Date Disability Began	DATE	NI		Y	MC	MC	IA	IA	IA	M	M	NA	IA	M	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	IA	
A49	0070	Date of Maximum Medical Improvement	DATE	NI		Y	X	NA	IA	NA	NA	NA	NA	IA	NA	IA	NA	NA	NA	IA	MC	NA	NA	NA	NA	IA	MC	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
A49	0072	Current Return to Work Date Latest Return to Work Status Date	DATE	NI		Y	NA	NA	NA	IA	IA	X	NA	NA	IA	NA	MC	IA	IA	IA	IA	X	MC	IA	IA	NA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	
A49	0057	Employee Date of Death	DATE	NI		Y	MC	MC	MC	MC	MC	M	NA	NA	MC	MC	X	M	NA	NA	IA	NA	X	NA	NA	M	X	NA	NA	NA	IA	NA	NA	IA	NA	NA	NA	NA	NA		
A49	0063	Wage Period Code	2 A/N	NI		Y	IA	M	M	IA	IA	IA	M	IA	IA	M	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	M	
A49	0064	Number of Days Worked Per Week	1 N	NI		Y	NA	M	M	IA	IA	IA	M	IA	IA	M	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	M		
A49	0031	Date of Injury	DATE	NI		n	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
A49	0026	Insured Report Number	25 A/N	NI		Y	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
A49	0015	Claim Administrator Claim Number	25 A/N	NI		FY	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	
A49	0005	Jurisdiction Claim Number	25 A/N	NI		n	M	M	IA	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
A49	0073	Claim Status Code	1 A/N	NI		Y	M	M	IA	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	NA	M
A49	0074	Claim Type Code	1 A/N	NI		Y	M	M	MC	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
A49	0075	Agreement to Compensate Code	1 A/N	NI		Y	X	IA	IA	IA	IA	X	X	IA	NA	NA	NA	NA	IA	NA	IA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
A49	0076	Date Claim Administrator Notified of Employee Representation	DATE	NI		Y	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	
A49	0077	Late Reason Code	2 A/N	NI		Y	NA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	
Variable Segment Counters																																									
A49	0078	Number of Permanent Impairments	2 N	NI		F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F		
A49	0082	Number of Death Dependent/Payee Relationships	2 N	NI		F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	
Variable Segments																																									
Permanent Impairments Jurisdictions must require DN0083 - Permanent Impairment Body Part Code if any of the following Permanent Impairments data elements are requested																																									
A49	0083	Permanent Impairment Body Part Code	NA	NI		FC	X	MC	IA	NA	MC	X	NA	NA	IA	MC	NA	NA	NA	IA	MC	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	IA		
A49	0084	Permanent Impairment Percentage	3.2 N	NI		Y	X	MC	IA	NA	MC	X	NA	NA	IA	MC	NA	NA	NA	IA	MC	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	IA		
Death/Dependent/Payee Relationships																																									
A49	0097	Dependent/Payee Relationship Code	2 A/N	NI		Y	X	IA	MC	MC	MC	X	IA	IA	IA	MC	X	X	IA	IA	IA	IA	X	X	IA	X	X	IA	X	X	IA	IA	IA	IA	IA	X	IA	IA	IA		
R22	0001	Transaction Set ID	3 A/N	NI		F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F		
R22	0295	Maintenance Type Correction Code	2 A/N	NI		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

**Kentucky Workers' Claims
Claims Release 3
Subsequent Report of Injury Requirements**

				SROI MTC'S																							PERIODIC MTC'S						
REC	DN#	DATA ELEMENT NAME	FORMAT	Migration Consideration	Format	02	04	AB	AP	CA	CB	CD	EP	ER	FN	IP	P1	P4	P7	PD	PY	RB	S1	S2	S3	S4	S6	S7	S8	S9	SD	VE	BM
Recoveries			Jurisdictions must require DN0226 - Recovery Code if any of the following Recoveries data elements are requested																														
R22	0226	Recovery Code	3 A/N	NI		FC	MC	MC	MC	MC	MC	MC	MC	MC	IA	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
R22	0225	Recovery Amount	\$9.2	NI		Y	MC	MC	MC	MC	MC	MC	MC	MC	IA	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
Reduced Earnings			Jurisdictions must require DN0242 - Reduced Earnings Week Number if any of the following Reduced Earnings data elements are requested																														
R22	0242	Reduced Earnings Week Number	2 N	NI		X	X	NA	NA	X	NA	X	X	X	X	NA	NA	NA	NA	X	X	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	X	X
R22	0124	Actual Reduced Earnings	\$9.2	NI		X	X	NA	NA	X	NA	X	X	X	X	NA	NA	NA	NA	X	X	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	X	X
R22	0147	Deemed Reduced Earnings	\$9.2	NI		X	X	NA	NA	X	NA	X	X	X	X	NA	NA	NA	NA	X	X	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	X	X
Concurrent Employers			Jurisdictions must require DN0141 - Concurrent Employer Name if any of the following Concurrent Employers data elements are requested																														
R22	0141	Concurrent Employer Name	40 A/N	L		FC	MC	MC	MC	MC	MC	MC	MC	MC	IA	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
R22	0142	Concurrent Employer Contact Business Phone	15 A/N	L		Y	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA
R22	0143	Concurrent Employer Wage	\$9.2	L		Y	MC	MC	MC	MC	MC	MC	MC	MC	IA	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC	MC
Denial Reason Codes																																	
R22	0198	Full Denial Reason Code	2 A/N	NI		Y	MC	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Denial Reasons																																	
R22	0197	Denial Reason Narrative	50 A/N	NI		Y	MC	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Suspension Narratives																																	
R22	0233	Suspension Narrative	50 A/N	NI		Y	X	X	X	X	X	X	X	X	X	X	IA	IA	IA	X	X	X	IA	IA	IA	IA	IA	IA	IA	IA	IA	X	X

**Kentucky Workers' Claims
Claims Release 3
Subsequent Report of Injury Conditional Requirements**

SROI DATA ELEMENT

DN#	DATA ELEMENT NAME	BUSINESS CONDITION(S)	TECHNICAL CONDITION(S)
0042	Employee SSN	Mandatory if reporting a SSN, selected in Employee ID Type Qualifier.	When DN0270 Employee ID Type Qualifier = S, then mandatory
0055	Employee Number of Dependents	If Employee Date of Death is populated, then DN0055 is Mandatory.	If DN0057 is present, then this is mandatory.
0056	Initial Date Disability Began	If the Claim Type Code is I or L this is mandatory and Claim Status Code is O or R.	If DN0074 = I or L and DN0073 = O or R.
0057	Employee Date of Death	If the Benefit Type Code is fatal (010) or Death Result of Injury Code = Y.	If DN0085 = 010 or DN0146 = Y.
0068	Initial Return to Work Date	If this is the first suspension of benefits. Mandatory if employee has RTW and DN70 Date Maximum Medical Improvement Date is NOT populated.	If there are no prior MTC P1 or S1 on file, then mandatory. M if DN 70 is not populated.
0070	Date of Maximum Medical Improvement	M if employee has "NOT" RTW, but has reached MMI. M if DN68 Initial RTW Date or DN72 Current RTW Date is blank.	M if DN68 or DN72 is blank.
0072	Current Return to Work Date Latest Return to Work Status Date	This is required when there are broken periods of disability and there is a second RTW date after the initial RTW date. Mandatory if employee has RTW and DN70 Date Maximum Medical Improvement Date is NOT populated	If prior MTC P1 or S1 on file, then mandatory. M if DN 70 is not populated.
0074	Claim Type Code	Conditional based on new Insurer/Carrier (DN0006) submitting their first payment information. M if AP is the first SROI.	If DN0006 does not equal previous DN0006. M if AP is first SROI.
0083	Permanent Impairment Body Part Code	Mandatory if there are permanent impairments.	If DN0078 > 0, this is mandatory.
0084	Permanent Impairment Percentage	Mandatory if there are permanent impairments.	If DN0078 > 0, this is mandatory.
0092	Benefit Adjustment Code	If Number of Benefit ACR is greater than 0, and Benefit Credit Code and Benefit Redistribution Code are empty, this is mandatory.	If DN0289 > 0 and DN0126, DN0130 are empty, this is mandatory.
0093	Benefit Adjustment Weekly Amount	If Benefit Adjustment Code is populated, this is mandatory.	If DN0092 is populated, this is mandatory.
0094	Benefit Adjustment Start Date	If Benefit Adjustment Code is populated, this is mandatory.	If DN0092 is populated, this is mandatory.
0097	Dependent/Payee Relationship Code	Mandatory if Injured Worker is dead.	If DN0057 is present.
0124	Actual Reduced Earnings	If reduced earnings week number is present (DN0242), actual reduced earnings (DN0124) is mandatory.	If DN0242 is populated, this is mandatory.
0126	Benefit Credit Code	If Number of Benefit ACR is greater than 0, and Benefit Adjustment Code and Benefit Redistribution Code are empty, this is mandatory.	If DN0289 > 0, and DN0092, DN0130 are empty, this is mandatory.
0127	Benefit Credit Start Date	If Benefit Credit Code is populated, this is mandatory.	If DN0126 is populated, this is mandatory.
0129	Benefit Credit Weekly Amount	If Benefit Credit Code is populated, this is mandatory.	If DN0126 is populated, this is mandatory.
0130	Benefit Redistribution Code	If Number of Benefit ACR is greater than 0, and Benefit Adjustment Code and Benefit Credit Code are empty, this is mandatory.	If DN0289 > 0, and DN0126, DN0092 are empty, this is mandatory.
0131	Benefit Redistribution Start Date	If Benefit Redistribution Code is populated, this is mandatory.	If DN0130 is populated, this is mandatory.
0133	Benefit Redistribution Weekly Amount	If Benefit Redistribution Code is populated, this is mandatory.	If DN0130 is populated, this is mandatory.
0141	Concurrent Employer Name	If Number of Concurrent Employers is greater than 0, this is mandatory. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0275 > 0, this is mandatory.
0143	Concurrent Employer Wage	If Number of Concurrent Employers is greater than 0, and Claim Type Code is an I or L this is mandatory. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0275 > 0 and DN0074 = I or L this is mandatory.
0144	Current Date Disability Began	Required if subsequent period of disability occurs and if current date last day worked is present. Mandatory if DN56 Initial Date Last Day Worked Initial Date Disability Began is present. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date. Mandatory if there are broken periods of disability and there is a second date of disability after the Initial RTW date (DN68).	If DN0145 is present, and DN0144 does not = DN0056. M if DN0056 Initial Date Last Day Worked Initial Date Disability Began is present. Mandatory if prior P1 or S1 on file.
0146	Death Result of Injury Code	If Date of Death is populated, this is mandatory. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0057 is populated, this is mandatory.

**Kentucky Workers' Claims
Claims Release 3
Subsequent Report of Injury Conditional Requirements**

SROI DATA ELEMENT

DN#	DATA ELEMENT NAME	BUSINESS CONDITION(S)	TECHNICAL CONDITION(S)
0153	Employee Green Card	Mandatory if reporting a Green Card, selected in Employee ID Type Qualifier.	When DN0270 Employee ID Type Qualifier = G, then mandatory
0154	Employee ID Assigned by Jurisdiction	Mandatory if reporting an ID Assigned by Jurisdiction, selected in Employee ID Type Qualifier.	When DN0270 Employee ID Type Qualifier = A, then mandatory
0189	Return to Work Type Code	Only if injured worker returns to work or is released to return to work.	If prior DN0072 or DN0068 are populated, then mandatory.
0495	Payment Issue Date	If Payment Reason Code is populated, this is mandatory.	If DN0222 is populated, this is mandatory.
0197	Denial Reason Narrative	If Number of Denial Reason Narratives is greater than 0, this is mandatory.	If DN0276 > 0, this is mandatory.
0198	Denial Reason Code	If Number of Full Denial Reason Codes is greater than 0, this is mandatory.	If DN0277 > 0, this is mandatory.
0215	Other Benefit Type Amount	If Number of Other Benefits is greater than 0, this is mandatory.	If DN0282 > 0, this is mandatory.
0216	Other Benefit Type Code	If Other Benefit Type Amount is populated, this is mandatory.	If DN0215 is populated, this is mandatory.
0217	Payee	If Payment Reason Code is populated, this is mandatory.	If DN0222 is populated, this is mandatory.
0219	Payment Covers Period Start Date	If Payment Reason Code is populated, this is mandatory.	If DN0222 is populated, this is mandatory.
0220	Payment Covers Period End Date	If Payment Reason Code is populated, this is mandatory.	If DN0222 is populated, this is mandatory.
0223	Permanent Impairment Minimum Payment Indicator	If Permanent Impairment Percentage is greater than 0, Benefit Type Code is 030, 040, this is mandatory. If Benefit Type Code is 530 or 540, this is mandatory. Mandatory if the Date Claim Administrator had knowledge of the injury is on or after the R3 implementation date.	If DN0084 is greater than zero and DN0085 = 030, 040, this is mandatory. If DN0085 = 530, 540, this is mandatory
0224	Physical Restrictions Indicator	If the Initial Return to Work Date or Current Return to Work Date is populated.	If DN0068 or DN0072 is present.
0225	Recovery Amount	If Recovery Code is populated, this is mandatory.	If DN0226 is populated, this is mandatory.
0226	Recovery Code	If Number of Recoveries is greater than 0, this is mandatory.	If DN0284 > 0, this is mandatory.
0242	Reduced Earnings Week Number	If Number of Reduced Earnings is greater than 0, this is mandatory.	If DN0285 > 0, this is mandatory.
0293	Lump Sum Payment/Settlement Code	If Payment Reason Code is of 5xx series, then this is mandatory but not = to 510 and DN97 Dependent/Payee Relation Code is not = 80, then M.	If DN0222 = 5xx, then this is mandatory but not = to 510 and DN97 is not = to 80, then M.

**Kentucky Workers' Claims
Claims Release 3
Subsequent Report of Injury
Event Benefits Segment Element Requirements**

For MTC's: AB, AP, CB, EP, ER, IP, PY (Benefit Type Codes other than 5XX), RB, CA, RE 02, CO, CB, P1-P9, PJ, S1-9, SD, SJ												
Legend: E = Expected EC = Expected/Conditional F = Fatal Technical M = Mandatory MC = Mandatory/Conditional NA = Not applicable R = Restricted RC = Restricted/Conditional X = Exclude	Benefit Type	0085 Benefit Type Code	0002 MTC	0174 Gross Weekly Amount	0175 Gross Wkly Amt Eff Date	0087 Net Weekly Amount	0211 Net Wkly Amt Eff Date	0088 Ben Period Start Date	0089 Ben Period Thru Date	0090 Ben Type Claim Weeks	0091 Ben Type Claim Days	0086 Ben Type Amount Paid
Migration Considerations		NI	NI	V1	V1	NI	V1	NI	NI	NI	NI	NI
Fatal	010	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Permanent Total	020	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Permanent Total Supplemental	021	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Permanent Partial Scheduled	030	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Permanent Partial Unscheduled	040	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Temporary Total	050	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Temporary Total Catastrophic	051	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Temporary Partial	070	R	F	NA	NA	NA	NA	NA	NA	NA	NA	NA
Employer's Liability	080	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Permanent Partial Disfigurement	090	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Employer Paid Fatal Benefits	210	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Employer Paid Permanent Partial Scheduled	230	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Employer Paid Unspecified	240	MC	F	X	X	X	X	MC	MC	X	X	X
Employer Paid Vocational Rehab Maintenance	242	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Employer Paid Temporary Total	250	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Employer Paid Temporary Total Catastrophic	251	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Employer Paid Temporary Partial	270	R	F	NA	NA	NA	NA	NA	NA	NA	NA	NA
Vocational Rehabilitation Maintenance	410	MC	F	MC	MC	MC	MC	MC	MC	MC	MC	MC
Lump Sum Payment/Settlement	5xx	MC	F	X	X	X	X	NA	NA	NA	NA	M

**Kentucky Workers' Claims
Claims Release 3
Subsequent Report of Injury
Event Benefit Conditional Requirements**

BENEFIT DATA ELEMENT			
DN#	DATA ELEMENT NAME	BUSINESS CONDITION(S)	TECHNICAL CONDITION(S)
0085	Benefit Type Code	Mandatory if Number of Benefits is greater than zero. For MTC Codes EP and ER must be Benefit Type Code 2xx. For MTC Code IP Benefit Type Code cannot be 2xx.	If DN0288 > 0, this is mandatory. Benefit Type Code must = 2xx if MTC = EP or ER. Benefit Type Code must != 2xx if MTC = IP.
0086	Benefit Type Amount Paid	Mandatory if Benefit Type Code is not 240	If DN0085 not = 240, this is mandatory.
0087	Net Weekly Amount	For MTC Codes EP and ER Mandatory if Benefit Type Code is 2xx, but not 240. For all other MTC Codes Mandatory if Benefit Type Code is 0xx or 410.	If MTC Code = EP or ER, and DN0085 = 2xx and not = 240, this is mandatory. If MTC Code does not = EP or ER and DN0085 = 0xx or 410, this is mandatory.
0088	Benefit Period Start Date	Mandatory if Benefit Type Code is present.	If DN0085 is present.
0089	Benefit Period Through Date	Mandatory if Benefit Type Code is present. Mandatory if benefits have been suspended.	If DN0085 is present. M if prior Pxx or Sxx on file.
0090	Benefit Type Claim Weeks	Mandatory if Benefit Type Code is not = 240 or 5xx.	If DN0085 is not = 240 or 5xx, this is mandatory.
0091	Benefit Type Claim Days	Mandatory if Benefit Type Code is not = 240 or 5xx.	If DN0085 is not = 240 or 5xx, this is mandatory.
0174	Gross Weekly Amount	For MTC Codes EP and ER Mandatory if Benefit Type Code is 2xx, but not 240. For all other MTC Codes Mandatory if Benefit Type Code is 0xx or 410.	If MTC Code = EP or ER, and DN0085 = 2xx and not = 240, this is mandatory. If MTC Code does not = EP or ER and DN0085 = 0xx or 410, this is mandatory.
0175	Gross Weekly Amount Effective Date	For MTC Codes EP and ER Mandatory if Benefit Type Code is 2xx, but not 240. For all other MTC Codes Mandatory if Benefit Type Code is 0xx or 410.	If MTC Code = EP or ER, and DN0085 = 2xx and not = 240, this is mandatory. If MTC Code does not = EP or ER and DN0085 = 0xx or 410, this is mandatory.
0192	Benefit Payment Issue Date	Mandatory if Benefit Type Code is present and MTC = IP, AP, PY, RB, 02 or CO (legacy). THIS CONDITION DOES NOT APPLY TO SWEEPS.	If DN0085 is present and if MTC = IP, AP, PY, RB, 02 or CO.