

State of New York - Workers' Compensation Board**First Report of Injury
Report Type (MTC) 04-Denial**

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Pursuant to 12 NYCRR 300.22, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

Employee Name John T Doe

WCB Case Number (JCN) G2687879

Date of Injury 04/04/2020

Claim Administrator Claim Number BRI-24

Maintenance Type Code Date 10/08/2020

Claim Type I - Indemnity for Lost Time

WCB Received Date 10/08/2020

INSURER INFORMATION

Insurer Name All American Insurance Company

FEIN xxxxx6212

Insurer Type I - Insurer

Insurer ID W212500

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company

Info/Attn John T Doe

Address 12 State St

City Albany

State NY

Postal Code 12202

Country US - UNITED STATES

FEIN xxxxx6212

Claim Admin ID W212500

Late Reason _____

Claim Representative Name Mary Clark

Claim Representative Business Phone Number 5185551212

Claim Representative E-mail Address mclark@allamerican.com

FULL DENIAL REASONS

Full Denial Effective Date 09/01/2020

Full Denial Reason 3A - No Coverage (No Employee/Employer Relationship)

Denial Reason Narrative

Denied for a good reason.

EMPLOYEE INFORMATION

First Name	<u>John</u>	Middle Name/Initial	<u>T</u>
Last Name	<u>Doe</u>	Suffix	<u></u>
Mailing Address	<u>2890 South Pearl St</u>		
City	<u>Albany</u>	State	<u>NY</u>
Postal Code	<u>12202</u>	Country	<u>US - UNITED STATES</u>
Phone Number	<u>5187673535</u>	Gender	<u>F - Female</u>
Date of Birth	<u>09/15/1970</u>	Date of Hire	<u>01/01/2018</u>
Employee ID Type	<u>S - Employee Social Security Number</u>	Employee ID	<u>xxxxx8767</u>
Occupation Description	<u>Watiress</u>		

CLAIM INFORMATION

Time of injury	<u>15:00</u>	Date Employer Had Knowledge of the Injury	<u>04/04/2020</u>							
Employment Status	<u>1 - Regular/Full-time Employee</u>	Date Claim Administrator Had Knowledge of the Injury	<u>04/05/2020</u>							
Wage Period	<u>01 - Weekly</u>	Initial Date Employer Had Knowledge of Date of Disability	<u></u>							
Estimated Wage	<u>\$1,200.00</u>	Current Date Employer had Knowledge of Current Date of Disability	<u></u>							
Work Week Type	<u>S - Standard Work Week</u>	Number of Days Worked Per Week	<u>5</u>							
Date of Denial Rescission	<u></u>	Work Days Scheduled (S-Scheduled N-Non Scheduled)	S M T W T F S <table border="1" style="border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>							

EMPLOYEE INJURY

Full Wages Paid for Date of Injury	<u>No</u>	Employer Paid Salary in Lieu of Compensation	<u>No</u>
Death Result of Injury	<u></u>	Date of Death	<u></u>
		Number of Dependents	<u></u>

Nature of Injury 04 - Burn

Part of Body	Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location
	L - Left	32 - Elbow	

Cause of Injury 02 - Burn or Scald - Heat or Cold Exposures - Contact With - Hot Objects or Substances

Type of Loss 01 - Traumatic Injury

Accident/Injury Description

Bumped into stove.

WORK STATUS

Initial Date Last Day Worked	<u>04/04/2020</u>	Initial RTW Type Code	<u></u>
Initial Date Disability Began	<u>04/05/2020</u>	Initial RTW Physical Restrictions	<u></u>
Initial RTW Date	<u></u>	Initial RTW With Same Employer	<u></u>
Latest RTW Type Code	<u></u>	Latest RTW Physical Restrictions	<u></u>
Latest RTW/Status Date	<u></u>	Latest RTW With Same Employer	<u></u>
Current Date Disability Began	<u></u>	Current Date Last Day Worked	<u></u>
		First Day of Disability After the Waiting Period	<u></u>

ACCIDENT LOCATION AND WITNESSES

Premises	<u>E - Employer</u>		
Organization Name	<u>Great Roofing Inc</u>		
Street	<u>12 Grand St</u>	State	<u>NY</u>
City	<u>Albany</u>	Postal Code	<u>12202</u>
County/Parish	<u>Albany - Albany</u>	Country	<u>US - UNITED STATES</u>
Location Narrative	<u>Diner</u>		
Witnesses	Business Phone Number		
<u></u>	<u></u>		

MEDICAL TREATMENT

Initial Treatment	<u>1 - Minor On-Site Remedies by Employer</u>
Managed Care Org.	<u></u>
Managed Care Org. ID	<u></u>

EMPLOYER INFORMATION

Name	<u>Great Rooting Inc.</u>	Employer FEIN	<u>xxxxx3423</u>
Industry Code	<u>236116</u>	UI Number	<u></u>
Manual Classification	<u>9079 - Restaurants</u>		
Info/Attn	<u></u>		
Mailing Address	<u>12 Grand St</u>		
City	<u>Albany</u>	State	<u>NY</u>
Postal Code	<u>12202</u>	Country	<u>US - UNITED STATES</u>
Physical Addr	<u>12 Grand St</u>		
City	<u>Albany</u>	State	<u>NY</u>
Postal Code	<u>12202</u>	Country	<u>US - UNITED STATES</u>
Contact Name	<u>Bob Smith</u>		
Contact Business Phone Number	<u>5187673434</u>		

INSURED INFORMATION

Insured Name	<u>Great Roofing Inc.</u>	Insured FEIN	<u>xxxxx6543</u>
Insured Type	<u>I - Insured</u>	Insured Location ID	<u></u>
Policy Number ID	<u>23776625</u>		
Policy Effective Date	<u>01/01/2019</u>	Policy Expiration Date	<u></u>

Further Proceedings on this Controverted Claim for Compensation

The following procedure applies:

1. **Pre-Hearing Conference:** If the Board's file contains a medical report referencing an injury, the Board shall conduct a pre-hearing conference within thirty days of receipt of this notice. Parties must comply with all rules, regulations, and statutes regarding the pre-hearing conference.
2. **Pre-Hearing Conference Statement:** The Board directs the parties, except a claimant who has not retained a legal representative, to serve upon all parties of interest, and file with the Board, a pre-hearing conference statement no later than ten days before the date of the pre-hearing conference. If the claimant retains a legal representative ten days or more prior to the conduct of the pre-hearing conference, a pre-hearing conference statement must be served upon all parties of interest, and filed with the Board.
3. **Orders and Directions:** If the claim warrants further proceedings beyond the pre-hearing conference, the Workers' Compensation Law Judge or Conciliator shall make orders and directions, including but not limited to the conduct of depositions. If the insurance carrier requests an opportunity to have the claimant examined by an independent medical examiner (IME), the independent medical examination report must be completed, filed and served in accordance with WCL Section 13-b(4) and 137 and 12 NYCRR 300.2(d) at least three days before the date set by the Workers' Compensation Law Judge or Conciliator for the initial expedited hearing.
4. **Expedited Hearing(s):** The initial expedited hearing shall occur within 30 days following a pre-hearing conference at which the claimant is represented, where the testimony of the claimant and any lay witnesses shall be taken and recorded. Further directions, orders, and hearings may be scheduled according to applicable regulations.

To the Claimant

Please be aware of the following:

1. **Benefits:** The party that filed this notice is disputing your entitlement to compensation and medical benefits.
2. **Legal Representation:** You may wish to retain a legal representative. He/She may not seek to collect payment directly from you. All fees will be set by a Workers' Compensation Law Judge, and deducted from the compensation you may receive.
3. **Pre-Hearing Conference:** As described above, a pre-hearing conference will be scheduled very soon. You must attend the pre-hearing conference, and any other hearings for which you receive notice.
4. **Claim for Compensation:** If you have not already done so, you should file a Claim for Compensation (Form C-3, VF-3 of VAW-3) with the Board. Follow the filing instructions on the appropriate form. Forms are available by calling the Board, or going to the Board's web site, at www.wcb.ny.gov.
5. **Disability Benefits:** Pending the determination of your claim for compensation and medical benefits, you may be entitled to receive certain benefits under the Disability Benefits Law, if your claim is disputed on the grounds that your disability is not the result of an on-the-job injury or illness, or is not the result of a line-of duty injury (in volunteer firefighters' or volunteer ambulance workers' cases). In that event, you may be eligible for disability benefits payments, provided that you have submitted a DB-450 containing a medical report indicating that you are disabled which has been properly completed by your doctor and filed with your employer's Disability Benefits insurance carrier. If you cannot obtain the DB-450 and/or insurance carrier information from your employer, the DB-450 and coverage information are available on our website www.wcb.ny.gov. If these benefits are payable, payments will be made directly by the disability benefits carrier, but such payments will be deducted from any award of workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefits ultimately made. If within 45 days you do not receive disability benefits or do not receive a notice of rejection (Form DB-451), promptly contact the Board.
6. **Medical Bills:** Your doctor bills, hospital bills, and bills for any other treatment or services of a medical nature, will be paid by the employer or carrier, if your claim is found to be compensable. Do not pay these bills yourself pending a determination of compensability. Please note: The Doctor is permitted to ask you to fill out a notice which indicates that you may be responsible for medical costs in the event of your failure to prosecute your claim, or if your compensation claim is disallowed, or if an agreement pursuant to WCL Section 32 is approved (Form A-9).

To the Medical Provider

The liability for this workers' compensation claim has not yet been determined. You will receive a Notice of Decision advising of the outcome. If the Board decides that the Insurance Carrier or Self-Insured Employer is responsible for this claim, you will receive payment and/or a written explanation from the carrier or self-insured employer as to its reasons for non-payment. Should the Board disallow this claim, the patient may be responsible for payment of medical expenses. If your bill has been disputed and if the decision is in your favor and the employer or carrier does not pay the amount awarded or provide a written explanation objecting to value related issue(s) within 30 days from the date of decision, you are entitled to file an HP-1 form applying for an administrative award. Should the carrier provide a written explanation within the 30 day period raising issue(s) of value of medical aid rendered, you are entitled to file for arbitration on Form HP-1, if communication does not resolve the issue(s). **FILING FOR AN ADMINISTRATIVE OR ARBITRATION AWARD (FORM HP-1) PRIOR TO THE RESOLUTION OF THE ISSUE(S) INDICATED ON THIS FORM IS PROHIBITED**

INFORMATION REGARDING eCLAIMS DENIAL CODES

Full Denial Reason Section for Controverted Claim:

1. Translation of current eClaims Denial Codes to traditional C-7 equivalents.

eClaims Denial Code Value	Traditional C-7 Equivalents
1A: No Compensable Accident (Coming and Going)	Accident Arising Out of and In the Course of Employment
1B: No Compensable Accident (Horseplay)	Accident Arising Out of and In the Course of Employment
1C: No Compensable Accident (Willful intent to injure oneself)	Accident Arising Out of and In the Course of Employment
1D: No Compensable Accident (Not WCL Definition of accident)	Accident within meaning of Workers' Compensation Law
1E: No Compensable Accident (Deviation from Employment)	Accident Arising Out Of and In the Course of Employment
1F: No Compensable Accident (Recreational/social activity)	Accident within meaning of Workers' Compensation Law
1I: Presumption Does Not Apply	Accident/Occupational Disease Arising Out of and In the Course of Employment
2C: No Causal Relationship (Stress non-work related)	Accident within meaning of Workers' Compensation Law
2D: No Causal Relationship (No Medical Evidence of Injury)	Prima Facie Medical Evidence
2E: No Causal Relationship (No Injury Per Statutory Definition)	Causally Related Accident or Occupational Disease
3A: No Employer-Employee Relationship	Employer-Employee Relationship
3B: Independent Contractor	Employer-Employee Relationship
3C: Not WCL Definition of Employee	Employer-Employee Relationship
3D: No Jurisdiction	Subject Matter Jurisdiction
3E: No Coverage (No Policy in Effect On Date of Accident)	Cancellation of Coverage
3F: Statute of Limitation Expired	Timely Filing (Section 28)
3G: Statute Exempts Claimant	Employer-Employee Relationship
5A: Failure To Report Accident Timely	Notice (Section 18)

2. Translation from traditional C7 defenses to current eClaims Denial Codes:

- Prima Facie Medical Evidence -- That the medical report submitted on behalf of the claimant fails to reference an injury. Denial Code 2D - No Causal Relationship (No medical evidence of injury)
- Accident within meaning of Workers' Compensation Law -- That the alleged accident is barred, excluded, or not covered within the law. For example, that the accident is: barred by 2(7); an exacerbation of prior injury (no new accident); barred by 10(1), such as intoxication or off-duty athletic activity, or intentionally causing harm to self or others.
Denial Codes:
1D - No Compensable Accident (Not WCL Definition of accident)
2C - No Causal Relationship (Stress non-work related)
1C - No Compensable Accident (Willful intent to injure oneself)
1F - No Compensable Accident (Recreational/social activity)
- Accident Arising Out Of and In the Course of Employment -- That the alleged accident did not occur while in the course of employment, such that it cannot be presumed that the accident arose out of the course of employment; OR that while the accident occurred in the course of employment, there is substantial evidence to rebut the presumption that the accident arose out of the course of employment. For example, that the claimant was injured while outside scope of employment, such as in an off-premises injury which occurred when claimant was not in portal to portal status.
Denial Codes:
1I - Presumption does not apply [new to IAIABC standard in 2013].
1A - No Compensable Accident (Coming and Going)
1E - No Compensable Accident (Deviation from Employment)
1B - No Compensable Accident (Horseplay)
- Occupational Disease within meaning of Workers' Compensation Law -- That the alleged occupational disease is barred, excluded, or not covered within the law. For example, that the disease is not a recognized condition; that there was no distinctive feature of employment. Denial Code 1D - No Compensable Accident (Not WCL Definition of accident)
- Occupational Disease Arising Out of and In the Course of Employment -- That the disease arose outside of employment. For example, the condition was caused by exposure or activity outside that which was experienced in the workplace. Denial Code 1I - Presumption does not apply [new to IAIABC standard in 2013].
- Notice (Section 18) -- That the employer received no notice; that there was improper notice (e.g. to co-workers not supervisor); or that the notice was not timely (beyond 30 days). Denial Code 5A - Failure to report accident timely.

- Notice (Section 45) -- That the employer received no notice, that notice was given to an improper employer entity, or that notice was untimely (more than 2 years from the later of the date disablement or the date claimant knew-or-should-have-known of the occupational disease). Denial Code 5A - Failure to report accident timely.
- Employer-Employee Relationship -- That there was no employer-employee relationship as defined by statute or case law. For example, that claimant was an independent contractor; that there was no covered employment, such as casual employment, certain domestic employment, or certain other activities as defined in WCL Sec. 3 Groups 12 through 24; General Municipal Law Sec. 207-a or c, that claimant does not fit the definition of employee under WCL Sec. 2(4); that claimant was an excluded employee such as a partner or certain corporate officers, or that the Board should be aware that there was more than one employer (dual employment which caused injury), or special-general employment. Note - a claim should not be controverted merely because claimant was concurrently employed at the time of injury as set forth in WCL Sec. 14(6), for determination of wages.

Denial Codes:

3A - No employer/employee relationship

3B - Independent contractor

3C - Not WCL Definition of Employee

3G - Statute Exempts Claimant

- Causally Related Accident or Occupational Disease -- That the medical and/or other evidence does not support the assertion that there is a causal link between the claimant's work and the alleged accident or occupational disease. Denial Code 2E - No Causal Relationship (No Injury Per Statutory Definition).
- Causally Related Death -- That there is no evidence that the decedent died in the course of employment, such that death is not presumed to have arisen out of the course of employment, and/or that the medical or other evidence does not support the assertion that there is a causal link between the decedent's work, or the decedent's established workers' compensation case, and death. Denial Code Use codes for Causally related accident or OD, such as : 1D No Compensable Accident (Not WCL Definition of accident), 2D No Causal Relationship (No Medical Evidence of Injury), or 1I Presumption Does Not Apply.
- Proper Employer Entity -- That the incorrect employer is named in the claim; or that there was more than one employer of the claimant. For example, claimant was not employed by the employer named in the claim; that there was dual employment which caused injury, (in which case, also check employer-employee). Note - a claim should not be controverted merely because claimant was concurrently employed at the time of injury as set forth in WCL Sec. 14(6), for determination of wages. Denial Code 3A - No employer/employee relationship.
- Cancellation of Coverage -- That coverage was cancelled prior to the date of the accident or the date of disablement. For example, the carrier properly served a timely notice of cancellation, or notice of non-renewal, to the employer. Denial Code 3E - No policy in effect on date of accident.
- Proper Carrier -- That coverage did not exist as of the date of the accident or date of disablement. For example, the policy had been cancelled, and new coverage was placed with a subsequent carrier; or that the carrier named had never provided coverage for the employer. Denial Code 3E - No Coverage (No Policy in Effect On Date of Accident).
- Subject Matter Jurisdiction -- That the claim is not compensable under New York law. For example, that the employment did not exist in New York State and the accident occurred outside of New York State, or that claimant should receive federal compensation covering longshoremen, railway, or postal workers; or that General Municipal Law Sec. 207-a or 207-c covers the injury. Denial Code 3D - No jurisdiction.
- Timely Filing (Section 28) -- That the claim was filed beyond two years from the date of accident or the date of disablement. Denial Code 3F - Statute of limitation expired.