

2015

EDI External Training Aids

The EDI training aids were updated in August 2015 and published to the Virginia Workers' Compensation Commission website as well as distributed to all attendees of the 2015 Educational Seminar.



EDI QA
August 2015



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FROI Key Event Matrix

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Event	FROI							When to Report (Calendar Days From Notification)
	UR	00	01	02	04	AQ	AU	
Employee accident results in Lost Time > 7 Days		●						10
Employee accident results in medical expense > \$1,000		●						10
Employee accident involving Employee Death		●						10
Employee suffers a Permanent Disability		●						10
Employees injury classified as minor (filing reduced data set)	●							30
Employees injury reclassified as major (UR previously filed)		●						Immediate
Employee suffers a Minor Injury (filing full documentation)		●						10
Employee reports an injury which is disputed by employer		●						10
CA denies the entire compensability of the claim (no prior FROI 00)					●			10
CA discovers that claim was filed in error			●					See note below
CA determines a change in one or more data elements is required				●				Immediate
CA acquires an open claim (both Major and Minor)						●		10
An error occurred submitting an AQ (AQ rejected by the VWC).							●	30

Note:

“Major injury” is an injury which meets any of the following criteria:

1. Lost time or partial disability exceeding seven days.
2. Medical expenses exceeding \$1,000.
3. Any denial of compensability.
4. Any disputed issues.
5. An accident that results in death.
6. Any permanent disability or disfigurement.
7. Any specific request made by the commission.

“Minor injury” is an injury that meets none of the above criteria.

“FROI 01” is a transaction that will cancel the entire JCN not the last transaction filed.

- If you believe a FROI 01 Cancel Transaction is due, please contact the Commission’s EDI QA Department before submitting. Refer to the FROI 01 Training Aid #10 for additional information.

Possible Subsequent transactions (FROI/SROI)						
00	S-04	Determined by Previous non-02	Determined by Previous non-02	00	02	02
02	01			02	01	01
01	02			01	AQ	AQ
AQ	AQ			AQ	AU	AU
AU	AU			AU	S-04	S-04
S-04	IP				AP	AP
	EP				PY	PY
	PY					

*This is not to be used as the final guideline for sequencing requirements. All prior transactions must be taken into consideration when determining sequencing. Refer to the Commission’s Implementation Guide (Event Table) for the full requirements on sequencing.



SROI Key Event Matrix

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Event	SROI																			
	04	AP	EP	ER	IP	PY	RB	S1	S2	S3	S4	S5	S6	S7	S8	SD	SJ	QT	CB	UR
CA denies claim after Major Injury Claim Established	●																			
First payment processed for Acquired Claim		●																		
Lost time injury occurs, employer pays benefits			●																	
Employer is reinstating indemnity following suspension				●																
CA pays first payment on a claim after submitting 00					●															
Cumulative Medical > \$1,000 has been paid (No previous IP, EP, or AP)						●														
Order or opinion for a lump sum payment is issued						●														
CA Reinstating benefits which were previously suspended							●													
Employer's request for hearing rejected							●													
Suspension of Benefits (Full and Partial)	Employee Returned to Work							●												
	Employee Determined Qualified to RTW							●												
	Medical Non-Compliance								●											
	Administrative Non-Compliance									●										
	Claimant Death										●									
	Incarceration											●								
	Whereabouts Unknown												●							
	Benefits Exhausted													●						
	Jurisdiction Change														●					
	Judicial order or opinion to suspend															●				
	Pending Appeal or Judicial Review																●			
Payment made during the current quarter and SROI on file (quarterly period is based on the date of injury)																		●		
Reported Benefit Type Code changes without a gap in time																			●	
One time catchup for an active pre-10/01/08 claim																				●

Note:

Partial suspension reports submitted to suspend concurrent benefits follow the same rules as submitting full suspensions.

All transactions should be filed immediately upon notification. However, ten days are allowed for filing of EP, IP & PY and Quarterly reports are due within 45 days from end of the quarter.

*Paper forms are required in addition to all SROI filings except the SROI 04 and QT. An Award Agreement should be sent along with SROI AP, EP, ER, IP, PY, RB and CB. Additional Forms are also required after a Suspension of Benefits: **Termination of Wage Loss** or **Employers Application for Hearing.***

Possible Subsequent transactions *

00	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02
02	01	01	01	01	01	01	01	01	01	01	01	01	01	01	01	01	01	01	01	01
01	AQ																			
AQ	AU																			
AU	S-04																			
AP	PY																			
IP	Sx	Sx	Sx	Sx	RB	Sx	RB	Sx	Sx											
EP	Px	Px	Px	Px	ER	Px	ER	Px	Px											
	QT	QT	QT	QT	Sx	QT	Sx	QT	QT											
	CB	IP	CB	CB	Px	CB												Px		IP
		CB			QT													QT		EP
					IP													IP		CB
					EP													CB		

*This is not to be used as the final guideline for sequencing requirements. All prior transactions must be taken into consideration when determining sequencing. Refer to the Commission's Implementation Guide (Event Table) for the full requirements on sequencing.



Employee ID

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Social Security Number (DN0042)

Preferred Identification Number

If the Social Security Number is unknown, the following will be accepted:

**Employee
Employment Visa
(DN0152)**

**Employee
Green Card
(DN0153)**

**Employee
Passport Number
(DN0156)**

Assigned by Jurisdiction ID (DN0154)

If none of the above valid IDs are known, the "Assigned by Jurisdiction ID" should be composed as follows:

Format

VA/Date of Injury (mmddyy)/Last Name/First Name/Padded with zeros (0)

Examples

For Claimant Name Sean Winterhalter with a Date of Injury of 01/01/08:
VA010108Winterh

For Claimant Name Dan Kim with a Date of Injury of 05/05/10:
VA050510KimDan0



Reporting of Attorney Fees

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When trying to determine how to report the attorney fees awarded to the Claimant's attorney, ask yourself the following question:

Who is responsible for the payment of the attorney fees, the claimant (deducted from compensation or paid directly by the claimant) or the Insurance Carrier (Claim Administrator)?

Claimant's Responsibility – reporting Attorney fees when they are awarded to be deducted from compensation

If the Commission awarded attorney fees to be deducted from the Claimant's compensation (indemnity and/or settlement payments) or they are to be paid directly by the claimant, the segments in your transactions should be completed as follows (this only addresses the amount paid and payee that are required):

Benefit Segment

Benefit Type Amount Paid should include the amount paid to the claimant and the amount deducted for claimant's legal expenses. This is also true when reporting the payment of a settlement. The amount paid to the attorney should be included in the Benefit Type Amount Paid.

Payment Segment

For lump sum/settlements, two payment segments are required. One would list the claimant as the payee with his/her portion of the settlement as the payment amount and the other would list the attorney as the payee with the attorney fee as the payment amount.

ACR Segment

The weekly amount you are deducting from the claimant's compensation and paying to his/her attorney should be listed as the Benefit Redistribution Weekly Amount. If the total amount due to the attorney was paid at one time, the entire amount should be listed. For lump sum/settlements, this segment should not be completed.

Other Benefit Segment

This segment should only be completed to show medical payments. Code 340 should no longer be used to report attorney fees that are deemed the responsibility of the claimant. If the Commission were to award the claimant's attorney a fee to be paid by the Insurance Carrier/Claim Administrator (not deducted from comp) then you would use code 340 - see Responsibility of the Carrier (Claim Administrator) Below

Examples:

Scenario 1: Claimant is due \$5,000.00 in TT. \$500.00 was to be deducted and paid to the attorney. (Attorney fee is responsibility of the claimant but is deducted from ongoing compensation)

- Benefit Segment – Report \$5,000.00 as the Benefit Type Amount Paid for 050
- ACR Segment – Report \$500.00 using the Redistribution Code K – Claimant Attorney Fees.

Scenario 2: Settlement issued and Claimant is due \$10,000. \$1,500.00 was to be deducted and paid to the attorney. (Attorney fee is responsibility of the claimant but is deducted from the settlement)

- Benefit Segment – Report \$10,000.00 as the Benefit Type Amount Paid for 5xx
- ACR Segment – This segment should not be completed for this scenario
- Payment Segment – two payment segments are required:
 1. Report \$8,500 as the Payment Amount for 5xx with payee as the claimant
 2. Report \$1,500 as the Payment Amount for the 5xx with the payee as the attorney



Reporting of Attorney Fees

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Insurance Carrier's Responsibility – reporting Attorney fees when they are awarded to be payable by the Insurance Carrier (Claim Administrator)

If the Commission awarded Claimant attorney fees to be payable by the carrier (claim administrator) and not deducted from the claimant's compensation, the segments in your transactions should be completed as follows (this only addresses the amount paid and payee that are required)

Benefit Segment

The Benefit Type Amount Paid should be the amount paid to the Claimant. Attorney fee amount should not be included.

Payment Segment

For settlements, the payment amount should be the amount paid to the claimant. Attorney fee amount should not be included.

Other Benefit Segment

Code 340 should be used and the amount of the attorney fee should be listed. Any medical payments made should also be reported.

- * The ACR Segment should not be completed for this scenario.

Examples:

Scenario 1: Claimant is due \$5,000.00 in TT. \$500.00 was awarded to Claimant's attorney but assessed against the carrier and not deducted from the claimant's compensation.

- Benefit Segment – Report \$5,000.00 as the Benefit Type Amount Paid for 050
- Other Benefit Segment – Report \$500.00 as the Other Benefit Type Amount paid for 340

- * The ACR Segment should not be completed for this scenario.

Scenario 2: Settlement issued and Claimant is due \$10,000. \$1,500.00 was awarded to Claimant's attorney but assessed against the carrier and not deducted from the claimant's compensation.

- Benefit Segment – Report \$10,000.00 as the Benefit Type Amount Paid for 5xx
- Payment Segment – Report \$10,000 as the Payment Amount for 5xx with payee as the claimant
- Other Benefit Segment – Report \$1,500.00 as the Other Benefit Type Amount paid for 340

- * The ACR Segment should not be completed for this scenario.



Helpful Guidelines for PY Transactions

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Many Trading Partners have questions surrounding the PY Transaction when it should be submitted, and what information should be in each of the reported segments. The following guidelines should help in determining if and when to file a PY transaction.

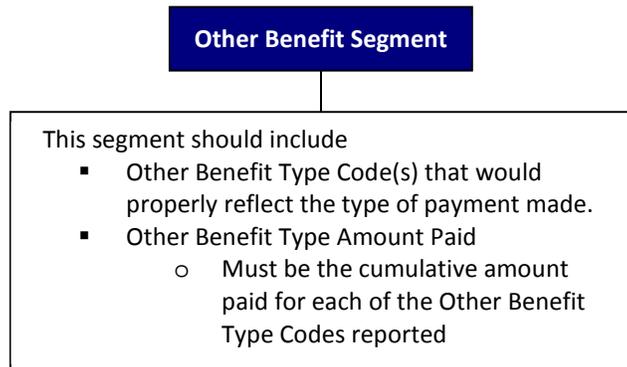
When to file a PY transaction

PY transactions should only be used for two reasons:

1. To report the initial payment of medical benefits on Medical Only Claim
2. To report the payment of a Commission awarded lump sum
 - a. Compromise Settlement
 - b. Permanent Partial Disability awarded by the Commission to be paid in a lump sum.

Medical Only Claims

A medical only claim is when the only payments made are for medical expenses and they total over \$1,000. When the claims you are processing meet this scenario, a PY transaction is required to reflect the initial medical payment. The segments in you PY transaction should be completed as follows:



★ The Benefit, Payment and ACR Segments should not be completed for this scenario.

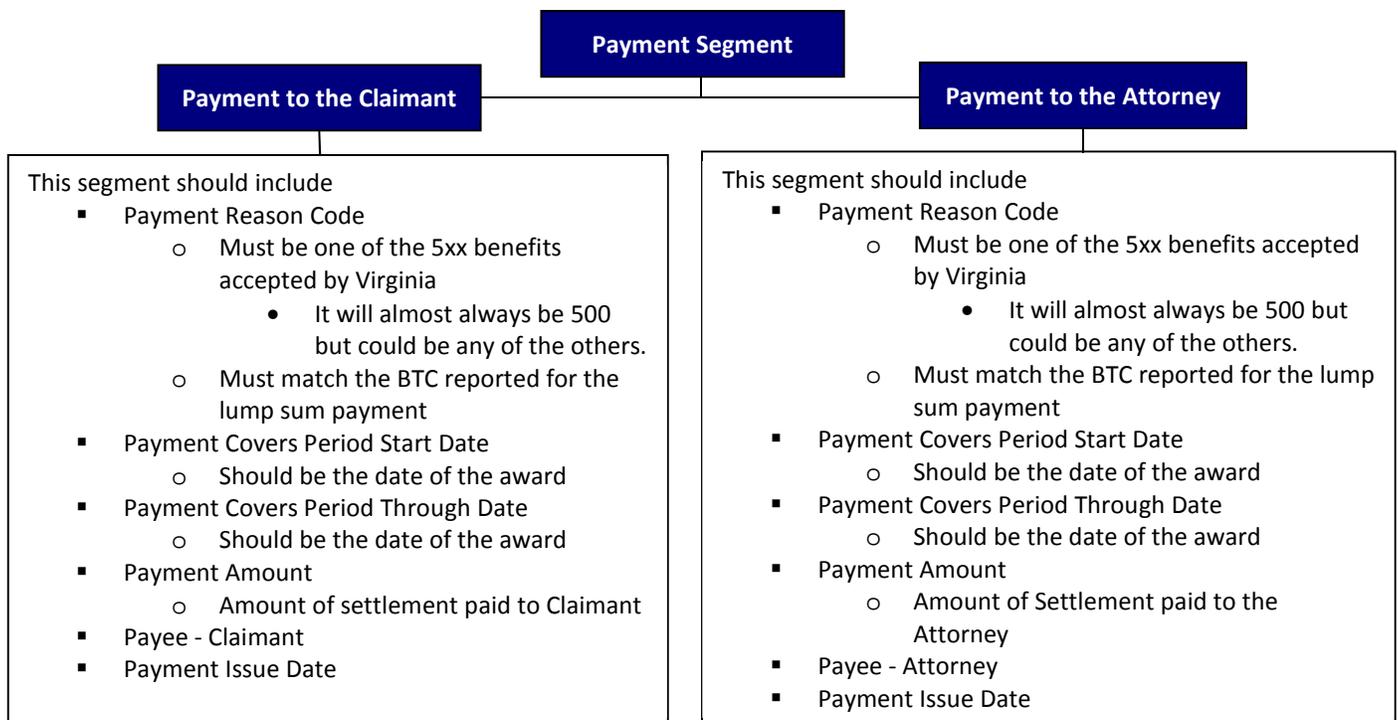
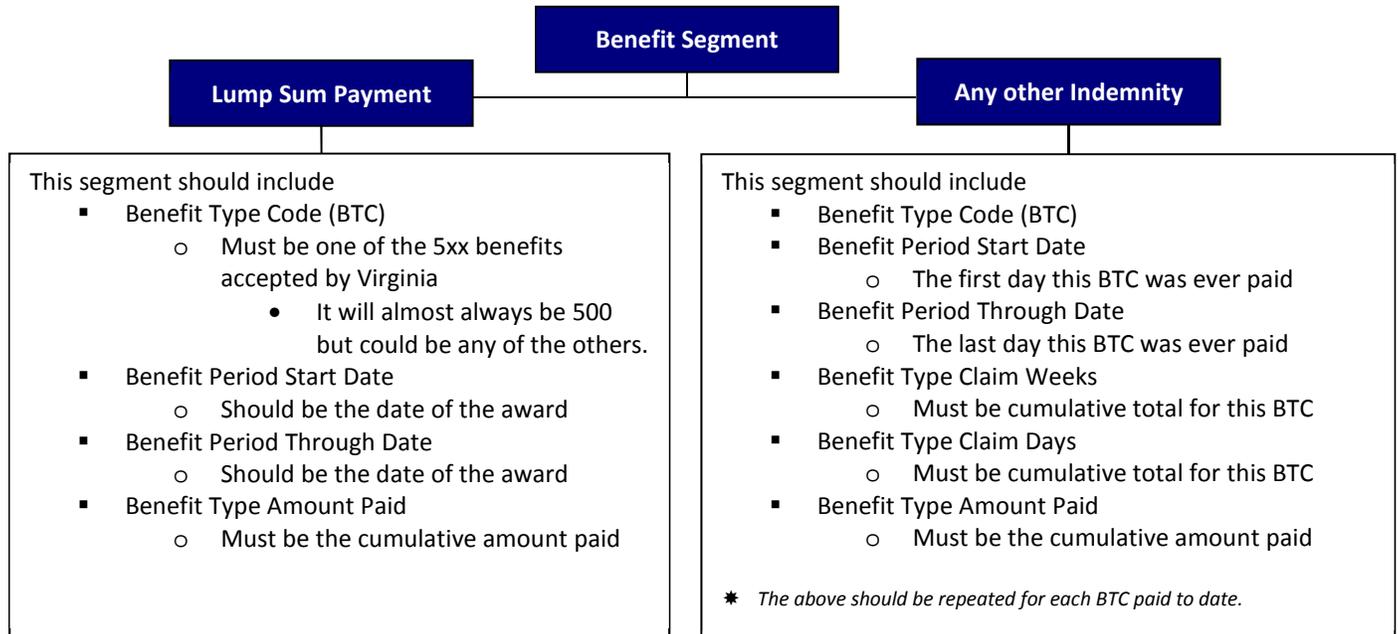


Helpful Guidelines for PY Transactions

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Awarded Lump Sum Payments - Compromise Settlements

If a Compromise Settlement (Petition and Order) was approved and entered by the Commission, a PY transaction is required to reflect the payments made. The segments in you PY transaction should be completed as follows:





Helpful Guidelines for PY Transactions

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Other Benefit Segment

This segment should include

- All Other Benefit Type Code(s) paid to date
- Other Benefit Type Amount Paid
 - Must be the cumulative amount paid for each of the Other Benefit Type Codes reported

* The ACR Segments should not be completed for this scenario.

Awarded Lump Sum Payments – Permanent Partial Disability awarded by the Commission to be paid in a lump sum

If the Commission awarded the Claimant a Permanent Partial Disability (PPD) to be paid in a lump sum, a PY transaction is required to reflect the payments made. The segments in your PY transaction should be completed as follows:

Benefit Segment

Lump Sum Payment

This segment should include

- Benefit Type Code (BTC)
 - Must be one of the 5xx benefits accepted by Virginia
 - It will be either 530 or 590.
- Benefit Period Start Date
 - Should be the beginning date of the PPD award
- Benefit Period Through Date
 - Should be the end date of the PPD award
- Benefit Type Amount Paid
 - Must be the cumulative amount paid

Any other Indemnity

This segment should include

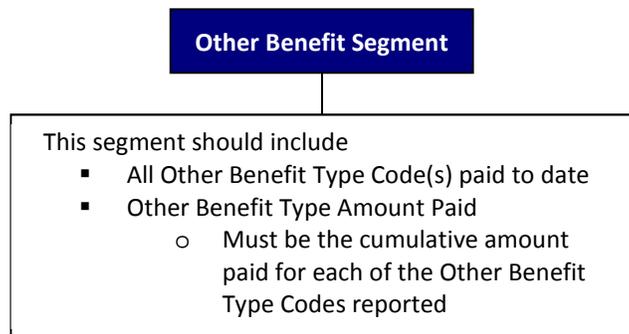
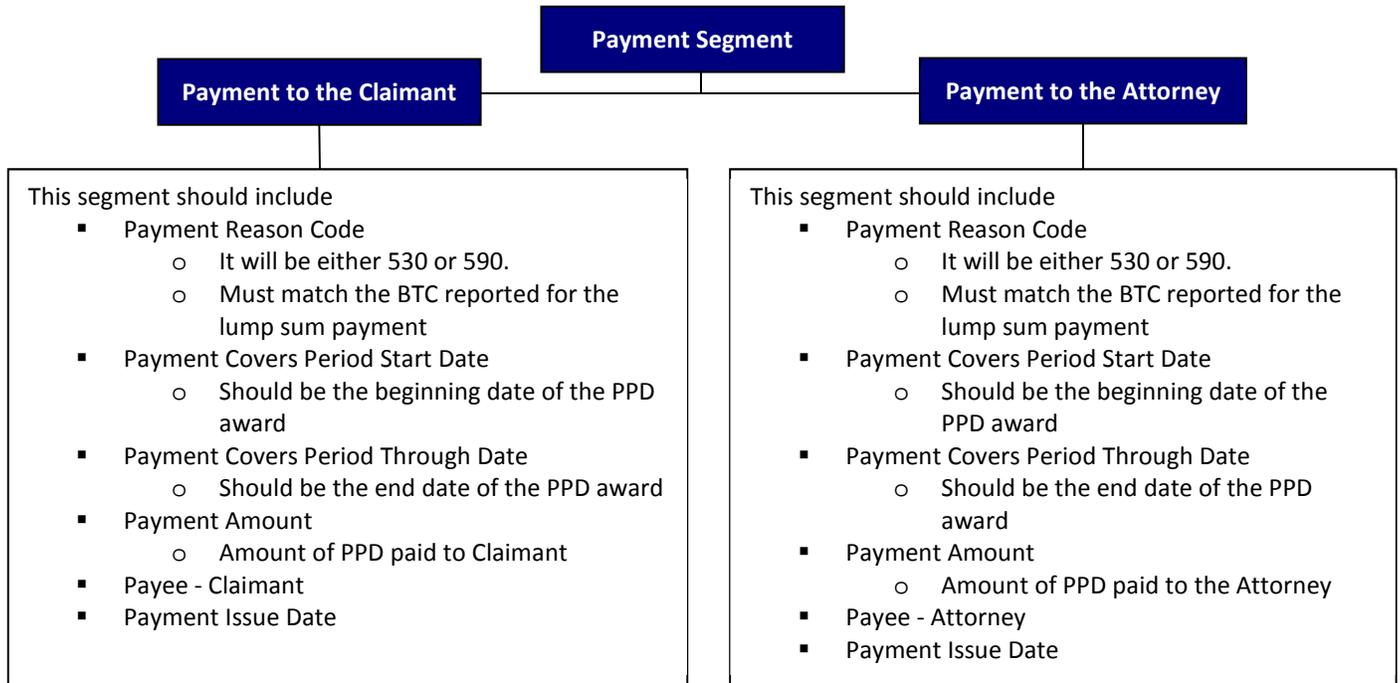
- Benefit Type Code (BTC)
- Benefit Period Start Date
 - The first day this BTC was ever paid
- Benefit Period Through Date
 - The last day this BTC was ever paid
- Benefit Type Claim Weeks
 - Must be cumulative total for this BTC
- Benefit Type Claim Days
 - Must be cumulative total for this BTC
- Benefit Type Amount Paid
 - Must be the cumulative amount paid

* The above should be repeated for each BTC paid to date.



Helpful Guidelines for PY Transactions

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* The ACR Segments should not be completed for this scenario



Benefit Segment

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The Benefit Segment is the section of a SROI transaction where indemnity payments are reported. If indemnity benefits have been paid, this segment should be populated on each SROI transaction submitted.

Benefit Segment(s) must include the following:

Data Element	What to Report	Conditions
Benefit Type Code	One of the BTCs accepted by VA	Must include all benefit types ever paid on the claim
MTC <i>(see challenges)</i>	The current MTC you are filing	The MTC should be omitted on a SROI QT, UR or PY
Benefit Period Start Date	The first day this BTC was ever paid	The only exception is an RB, ER, or CB. For these MTCs, the date is the reinstatement date
Benefit Period Thru Date	The last day this BTC was ever paid	
Benefit Type Claim Weeks & Days	Total weeks & days the BTC was paid	This is always a cumulative figure
Benefit Type Amount Paid	Total amount paid for this BTC	This is always a cumulative figure
Benefit Payment Issue Date	The date the check was issued	This date is only required on the IP and PY

Challenges

- **A specific Benefit Type Code is reported multiple times within the Benefit Segment.**
 - A Benefit Type Code can only be reported once within the Benefit Segment. If multiple periods of a specific benefit type have been paid, then the Benefit Type Code should only be reported once reflecting cumulative information.
- **The MTC in the Benefit Segment**
 - The MTC is sent alongside more than one Benefit Type Code
 - The MTC is only sent alongside the Benefit Type Code that is initiating, reinstating, suspending or changing within a transaction.
 - The MTC populated in the Benefit Segment does not match the SROI MTC transaction being filed which will cause a rejection.

“Event” Transaction vs. “Sweep” Transaction - The difference between an “event” transaction and a “sweep” transaction is whether or not the Maintenance Type Code should be populated in the Benefit Segment of the transaction.

“Event” Transaction	“Sweep” Transaction
MTC should be populated in the Benefit Segment	MTC should not be populated in the Benefit Segment
<i>Specific Event MTC’s: IP, EP, RB, ER, CB, Sx, Px, AP</i>	<i>Specific Sweep MTC’s: 04, PY, QT, UR</i>

- **The Benefit Period Start Date**
 - The Benefit Period Start Date should always be the very first day the benefit type was ever paid.
 - The only exception is when filing a SROI ER, RB, or CB. For these transactions the Benefit Period Start Date is the date in which the benefit is being instated or reinstated for the new period.
- **Previously reported benefit types are missing from current SROI transaction**
 - All SROI transactions must report all benefit types ever paid on the JCN.
 - The only exception is if a Benefit Type Code was previously reported in error.
 - For this scenario, the Benefit Type Code reported in error should be removed from the Benefit Segment and the correct Benefit Type Code listed. A letter should be sent to the Commission advising that this has occurred.



Benefit Segment

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How to complete the Benefit Segment (Scenarios)

Scenario 1: SROI IP

- ▶ First Award
 - TT - \$500 a week beginning 2/1/2013
- ▶ First Payment
 - TT - \$500 a week from 2/1/2013 through 2/15/2013
 - Issued on 2/16/2013
- ▶ First SROI
 - IP to show the first payment

BTC	MTC	Benefit Period Start Date	Benefit Period Thru Date	Benefit Type Claim Weeks	Benefit Type Claim Days	Benefit Type Amount Paid	Benefit Payment Issue Date
050	IP	2/1/2013	2/15/2013	2	1	\$1,071.43	2/16/2013

Scenario 2: SROI CB

- ▶ Prior Info – *see scenario 1*
- ▶ Second Award
 - TP - \$250 a week beginning 5/2/2013
 - ▶ TT benefits were paid through the day before TP began
- ▶ Second Payment
 - TP - \$250 a week beginning 5/2/2013 through 5/12/2013
- ▶ Second SROI
 - CB to show the Change in Benefit Type

BTC	MTC	Benefit Period Start Date	Benefit Period Thru Date	Benefit Type Claim Weeks	Benefit Type Claim Days	Benefit Type Amount Paid	Benefit Payment Issue Date
050		2/1/2013	5/1/2013	12	6	\$6,428.57	
070	CB	5/2/2013	5/12/2013	1	4	\$392.86	

Scenario 3: SROI S1

- ▶ Prior Info – *see scenarios 1 through 2*
- ▶ Benefits are suspended
 - TP - \$250 a week from 5/2/2013 through 5/20/2013
- ▶ Third SROI was a S1 on 5/20/2013

BTC	MTC	Benefit Period Start Date	Benefit Period Thru Date	Benefit Type Claim Weeks	Benefit Type Claim Days	Benefit Type Amount Paid	Benefit Payment Issue Date
050		2/1/2013	5/1/2013	12	6	\$6,428.57	
070	S1	5/2/2013	5/20/2013	2	5	\$678.57	



Benefit Segment

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Scenario 4: SROI RB

- ▶ Prior Info – *see scenarios 1 through 3*
- ▶ Third Award
 - TT - \$500 a week beginning 5/30/2013
- ▶ Next SROI
 - RB to reinstate payment of TT - \$500 a week beginning 5/30/2013 through 6/30/2013

BTC	MTC	Benefit Period Start Date	Benefit Period Thru Date	Benefit Type Claim Weeks	Benefit Type Claim Days	Benefit Type Amount Paid	Benefit Payment Issue Date
050	RB	5/30/2013	6/30/2013	17	4	\$8,714.29	
070		5/2/2013	5/20/2013	2	5	\$678.57	

Scenario 5: SROI QT

- ▶ Prior Info – *see scenarios 1 through 4*
- ▶ Benefits have continued passed 90 day mark
- ▶ QT issued 7/31/2013

BTC	MTC	Benefit Period Start Date	Benefit Period Thru Date	Benefit Type Claim Weeks	Benefit Type Claim Days	Benefit Type Amount Paid	Benefit Payment Issue Date
050		2/1/2013	7/31/2013	21	6	\$10,928.57	
070		5/2/2013	5/20/2013	2	5	\$678.57	



Payment Segment

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The Payment Segment is the section of a SROI transaction where a lump sum/settlement payment is reported. This segment shows the amount paid to each payee, the period the payment covers and the date the payment was issued. The Payment Segment should only be populated on a SROI PY and will only include a 5xx Payment Reason Code that is acceptable in Virginia. When reporting the 5xx Payment Reason Code, there must also be a corresponding Benefit Segment showing the 5xx Benefit Type Code and the total amount of the lump sum/settlement payment.

Payment Segment(s) must include the following:

<u>Data Element</u>	<u>What to Report</u>
Payment Reason Code	5xx code representing the Lump Sum/Settlement Payment
Payee	Name of the individual receiving the payment
Payment Amount	Amount paid for this payment reason code
Payment Covers Period Start Date	The start date for this payment reason code <i>(date the lump sum/settlement was approved)</i>
Payment Covers Period Thru Date	The end date for this payment reason code <i>(date the lump sum/settlement was approved)</i>
Payment Issue Date	The date the check was issued

**For additional information on completing the payment segment, please refer to the "Helpful Guidelines for PY Transactions" Training Aid.*

Corresponding Benefit Segment must include the following:

<u>Data Element</u>	<u>What to Report</u>
Benefit Type Code	5xx code representing the Lump Sum/Settlement Payment
Benefit Period Start Date	The start date for this benefit type code <i>(date the lump sum/settlement was approved)</i>
Benefit Period Thru Date	The end date for this benefit type code <i>(date the lump sum/settlement was approved)</i>
Benefit Type Amount Paid	Total amount paid for this BTC

The Benefit Segment must include all benefit types ever paid on the claim.

**Refer to the "Benefit Segment" Training Aid for information and scenarios on completing the Benefit Segment.*



Payment Segment

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Challenges

- **Sending a Payment Segment on a PY transaction with no corresponding Benefit Segment**
 - When reporting a 5xx Payment Reason Code in the Payment Segment to show the payment of a lump sum/settlement, it must have a corresponding 5xx Benefit Type Code in the Benefit Segment.
- **Lump Sum/Settlement not reported accurately in the Payment Segment**
 - When reporting a lump sum/settlement, the Payment Segment must show each payee that was awarded money in the lump sum/settlement.
 - *Example:* If a claim is settled and the total amount is apportioned out to the Claimant and to his/her Attorney, there should be two Payment Segments; one segment to show the Claimant as the payee with the amount awarded to him/her, and another segment to show the Attorney as the payee with the amount awarded to him/her. *The corresponding Benefit Segment should reflect the total amount of the settlement.*
- **The Payment Segment reporting an invalid Payment Reason Code**
 - The Payment Segment is only used to report the lump sum/settlement payment(s) and must be represented by a 5xx Payment Reason Code on a SROI PY Transaction.
- **Payment Segment does not reflect cumulative**
 - When more than one lump sum/settlement is awarded and paid throughout the life of the claim, the Payment Segment must reflect all payments ever made on the claim. If the same Payment Reason Code applies to both lump sum/settlement payments, the Start Date, End Date, and Payment Amount must reflect a cumulative figure.
- **No Sx filed before PY to report the payment of a Compromise settlement**
 - If the last SROI submitted initiated, reinstated or changed benefits (*SROI IP, EP, RB, RB, CB, or AP*), a SROI suspension (Sx) must be filed prior to the PY to terminate the open benefits. Once the Sx accepts, the PY can be submitted.



Payment Segment

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How to complete the Payment Segment

Scenario 1: Claim settled, no previous indemnity paid

- ▶ Award = Compromise Settlement (Full and Final dated March 25, 2013)
 - \$25,000 awarded with \$5,000 to be deducted and paid to the Claimant's attorney
 - Paid March 27, 2013

Payment Segment on PY

Payment Reason Code	Payment Covers Period Start Date	Payment Covers Period Through Date	Payment Amount	Payee	Payment Issue Date
500	3/25/2013	3/25/2013	\$20,000.00	Claimant's Name	3/27/2013
500	3/25/2013	3/25/2013	\$5,000.00	Attorney's Name	3/27/2013

Must have corresponding Benefit Segment

BTC	MTC	Benefit Period Start Date	Benefit Period Thru Date	Benefit Type Claim Weeks	Benefit Type Claim Days	Benefit Type Amount Paid	Benefit Payment Issue Date
500		3/25/2013	3/25/2013			\$25,000.00	

Scenario 2: Claim settled, previous indemnity paid

- ▶ Prior Info = Multiple SROs filed through the life of the claim
 - Cumulative information:
 - TT from 02/01/2013 through 08/21/2013 for 24 weeks, 6 days and \$12,428.57
 - TP from 05/02/2013 through 05/20/2013 for 2 weeks, 5 days and \$678.57
- ▶ Award = Compromise Settlement (Full and Final dated September 25, 2013)
 - \$25,000 awarded with \$5,000 to be deducted and paid to the Claimant's attorney
 - Paid September 27, 2013

Payment Segment on PY

Payment Reason Code	Payment Covers Period Start Date	Payment Covers Period Through Date	Payment Amount	Payee	Payment Issue Date
500	9/25/2013	9/25/2013	\$20,000.00	Claimant's Name	9/27/2013
500	9/25/2013	9/25/2013	\$5,000.00	Attorney's Name	9/27/2013

Must have corresponding Benefit Segment

BTC	MTC	Benefit Period Start Date	Benefit Period Thru Date	Benefit Type Claim Weeks	Benefit Type Claim Days	Benefit Type Amount Paid	Benefit Payment Issue Date
500		9/25/2013	9/25/2013			\$25,000.00	
050		2/1/2013	8/21/2013	24	6	\$12,428.57	
070		5/2/2013	5/20/2013	2	5	\$678.57	



Duplicate JCNs and Consolidation

Email: EDI.Support@workcomp.virginia.gov | Toll Free: 1-877-664-2566

Duplicate JCNs

Many duplicate Jurisdiction Claim Numbers (JCNs) are created when the Commission receives a paper submission from the claimant or claimant’s attorney before we receive the EDI transaction from the Claim Administrator. This results in the Commission creating a JCN for the paper submission and potentially creating another JCN for the EDI transaction.

How to prevent the creation of duplicate JCNs

File FROI submissions timely

If more than 30 days have passed since the injury occurred, contact the Commission so we can verify whether or not a claim has been set up and if a JCN has been assigned.

Capture existing JCN in your system and use it when filing your initial FROI

The Commission is required to create a claim when a paper submission is received from the claimant or claimant’s attorney. When the Commission creates the claim, the Notification of Injury – Request for FROI, is generated and sent to all known parties.

When you receive this notice, make note of the Jurisdiction Claim Number that is listed and capture it in your system. File the required initial FROI using the assigned JCN.

Duplicate Check Process

The Commission has a “Duplicate Check” process in place to assist in eliminating a large volume of duplicate JCNs.

Duplicate Check

- Checks for SSN
- Looks for Claimant’s First and Last Name and Date of Injury Combo
- The information must be a 100% match

The “Duplicate Check” will return a “Duplicate Transaction/Transmission” error if a JCN already exists for the claim that is being filed. The three key pieces of information must be a 100% match to the information in the Commission’s system for the Duplicate Check to locate duplicate claims. It is important to verify that all information being submitted is accurate.

How to help eliminate additional work when duplicate JCN’s exist.

- Make note of the Jurisdiction Claim Number on all correspondence you receive from the Commission.
- Advise the Commission as soon as you are aware that a duplicate JCN may exist so that we can review promptly.
 - A letter can be mailed or faxed to the Commission
 - E-mail the Commission EDI Support Team
 - Call the Commission’s Customer Contact Center
- The Commission should be notified of a duplicate claim promptly in order to significantly reduce potential additional work for both the Commission and the Claim Administrator.
 - Decreased amount of duplicate transactions the Claim Administrator is responsible for filing
 - Decreased amount of unnecessary or duplicate notifications mailed by the Commission
 - Decreased amount of confusion between parties when the consolidation is performed and only one JCN exists for the injury



Duplicate JCNs and Consolidation

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Consolidations

A process performed by the Commission's EDI Quality Assurance Department when two JCN's are created for the same injury and need to be merged into one.

The Commission's Consolidation Process:	
<p>Step 1: Determine which JCN to keep</p>	<ul style="list-style-type: none"> • We look at: <ul style="list-style-type: none"> ○ Creation Date <ul style="list-style-type: none"> ▪ Was the FROI filed timely? ▪ How many days are between our creation date and the FROI submission? ○ Activity that has occurred on each JCN <ul style="list-style-type: none"> ▪ Is the JCN currently on the hearing docket? ▪ Are there currently any Awards entered?
<p>Step 2: Process Consolidation</p>	<ul style="list-style-type: none"> • If needed, an Order is issued moving or vacating any awards • Issue the Consolidation Letter <ul style="list-style-type: none"> ○ Advise which JCN the files were consolidated into ○ Request EDI transactions, if needed
<p>Step 3: Merge the claims together</p>	<ul style="list-style-type: none"> • All documents from both files are moved into the one active JCN <p><i>EDI transactions cannot merge into a different JCN as EDI transactions are JCN specific</i></p>

Once the Consolidation Letter is received:
<ul style="list-style-type: none"> • All parties should note the JCN that remains active <ul style="list-style-type: none"> ○ The active JCN should be used on all correspondences and EDI transactions going forward. • Claim Administrators should file any requested EDI transactions within the timeframe specified <ul style="list-style-type: none"> ○ Consolidation letters typically ask for the FROI 01 Cancel transaction on the JCN that was not kept and an initial FROI on the JCN that is kept. <ul style="list-style-type: none"> ▪ If the FROI 01 Cancel transaction is requested, it should be filed as requested in order to prevent issues with future EDI filings. If the FROI 01 Cancel transaction is filed on the JCN not requested, it causes more work on both ends. <i>(See FROI 01 Cancel Transaction Training Aid.)</i> ▪ When requested to file an initial FROI, a FROI 02 is not an acceptable FROI to file. The transaction will reject, as there is no initial FROI on file. The JCN cannot be changed by filing a FROI 02. ○ If the Consolidation Letter does not request any EDI FROI transactions to be filed, then no EDI FROI transactions are required at that time. • Claim Administrators should note which file they submitted payments under, if any <ul style="list-style-type: none"> ○ EDI transactions are JCN specific. <ul style="list-style-type: none"> ▪ EDI transactions filed under the old JCN do not move to the active JCN. ○ Any SROI payment transactions filed under the inactive JCN must be re-filed under the active JCN.

**A consolidation will not be performed when multiple JCNs exist and parties want the JCNs combined only for hearing purposes. Those JCNs will be related in our Claims Processing System to alert VWC employees to review each JCN when performing any future action.*



Duplicate JCNs and Consolidation

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Common Pitfalls with Consolidations

<p>Discrepancy in the Date of Injury for the same injury</p>	<ul style="list-style-type: none"> • When notifying the Commission of duplicate claims and there is a discrepancy in the date of injury, you should clarify which date of injury is correct based on your records. • Occupational Disease Claims – the Date of Injury should be the Date of Communication, not the Date of Last Exposure (which is used to determine coverage.)
<p>Different Employer's</p>	<ul style="list-style-type: none"> • This is seen in cases of: <ul style="list-style-type: none"> ○ "Trade Name" or "Doing Business As Name" versus Primary Insured/Parent Corporation ○ Subcontractor versus Statutory Employer ○ Independent Contractor versus an Employee ○ Professional Employer Organization (PEO) versus the Client Company • When notifying the Commission of duplicate claims and there is a discrepancy in the Employer, you should clarify the correct Employer.
<p>Different Insurance Carriers</p>	<ul style="list-style-type: none"> • This is seen when the EDI data is not correct or the Commission did not have the correct information at the time the claim was created. • EDI will reflect the Claim Administrator as both the Claim Administrator and an Insurer or it will reflect the Employer as a self-insured when they are not. • Discrepancy with Employer Information • Make sure you are using the correct Insurance Carrier for the Employer and Date of Injury on your EDI transaction.
<p>Different Claim Administrators</p>	<ul style="list-style-type: none"> • This happens when a Claim Administrator acquires a claim and does not file the FROI AQ on the assigned JCN. <ul style="list-style-type: none"> ○ A call is made to verify who is actually handling the claim, if we do not have documentation in the file. ○ If this happens on a claim where you are notifying the Commission of a duplicate JCN, please clarify who the correct Claim Administrator handling the claim is. • This is also seen when different Insurance Carriers are listed in the JCNs and each have different Claim Administrators.
<p>FROI 01 Cancel transaction is submitted incorrectly on a JCN</p>	<ul style="list-style-type: none"> • When the Commission issues a Consolidation Letter and a FROI 01 Cancel transaction is needed, the Consolidation Letter will specifically request the transaction to be filed on a particular JCN. • Not all Consolidation Letters request the FROI 01 Cancel transaction to be filed. It is important to read the Consolidation Letter and only file the FROI 01 Cancel transaction if it is requested. <p><i>*For more information surrounding the FROI 01 Cancel transaction, refer to the FROI 01 Cancel Transaction Training Aid</i></p>



FROI 01 Cancel Transaction

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A FROI 01 Cancel Transaction is submitted by the Claim Administrator and used when the original first report was sent in error. Many Claim Administrators believe that a FROI 01 cancels the last transaction submitted. **THIS IS NOT CORRECT.** In Virginia, when a FROI 01 is filed, it cancels the JCN in its entirety and renders it invalid. The JCN can no longer be used for EDI filing purposes.

When should a FROI 01 transaction be filed to cancel a JCN?

FROI 01 transaction should only be used for two reasons:

1. When a claim was reported to the wrong jurisdiction.*
2. When requested by the Commission

What to do if....

<p>You believe a FROI 01 Cancel should be filed on a JCN</p>	<ol style="list-style-type: none"> 1. Contact the EDI Quality Assurance Department of the Commission so we can verify if it is appropriate to file the FROI 01. 2. Once approved, send a written letter to the Commission explaining the reason for the cancellation. <p><i>If the claimant has filed in Virginia, the claim must stay active as it is the claimant's right to file. If a FROI 01 has been filed on a claim in which the claimant has filed a Claim for Benefits, we are required to create a new claim with a newly assigned JCN and request the Claim Administrator file a new FROI on the new JCN.</i></p>
<p>A FROI 01 was filed in error and accepted</p>	<ol style="list-style-type: none"> 1. Contact the EDI Quality Assurance Department of the Commission <p><i>The sooner the Commission is advised of the error, the sooner we can get a new claim created and assign a new JCN.</i></p>
<p>You believe a duplicate claim exist</p>	<ol style="list-style-type: none"> 1. Send a letter to the Commission requesting review for possible consolidation. 2. File no further EDI transactions until you receive a Claim Consolidation Letter. <ul style="list-style-type: none"> • The Claim Consolidation Letter will advise you which JCN to use going forward and if any additional EDI transactions are required. If a FROI 01 Cancel transaction is requested, it must be filed on the requested JCN in order to prevent issues with future EDI filings.

What is a Notification of Cancellation?

- An automated letter triggered by the submission and acceptance of the FROI 01.
- Sent to all parties listed on the JCN

*Please contact the EDI Quality Assurance Department to verify it is appropriate to file the FROI 01 transaction, prior to doing so. This will assist in preventing confusion and unnecessary additional work for all parties.



Reporting of Compromise Settlements

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Scenario A - One JCN settled

Compromise Settlement indicates *ONE* amount to cover the JCN

- ▶ One SROI transaction is required
 - Full amount should be reported on the JCN

Scenario B - Two JCNs settled

Compromise Settlement indicates *ONE* amount to cover both JCNs

- ▶ Two SROI transactions are required
 - You should split the amount of the settlement and report half on one JCN and the other half on the other JCN

Compromise Settlement indicates *TWO* separate amounts; *ONE* amount for each JCN

- ▶ Two SROI transactions are required
 - One for each settlement submitted on their respective JCN

Scenario C - Three or More JCNs settled

Compromise Settlement indicates *ONE* amount to cover all JCNs

- ▶ One SROI transaction is required
 - Transaction should be filed on the JCN with the most recent date of injury

Compromise Settlement indicates *TWO* separate amounts:

ONE amount for ONE JCN and ONE amount for TWO JCNs

- ▶ Three SROI transactions are required.
 - One SROI should be filed on the JCN for half the amount of the settlement that covers two JCNs
 - One SROI that covers the other half of the amount for the settlement for the other *JCN*
 - One SROI transaction should be filed on the JCN with the most recent date of injury for the amount that covers 1 one JCN

ONE amount for ONE JCN and another amount to cover multiple (more than 3 JCNs)

- ▶ Two SROI transactions are required
 - One SROI should be filed on the JCN where the settlement covers one JCN
 - One SROI should be filed on the JCN with the most recent date of injury for the settlement that covers three or more JCNs

ONE amount for TWO JCNs and another amount to cover multiple (more than 3 JCNs)

- ▶ Three SROI transactions are required.
 - One SROI should be filed on the JCN for half the amount of the settlement that covers two JCNs
 - One SROI that covers the other half of the amount for the settlement for the other *JCN*
 - One SROI transaction should be filed on the JCN with the most recent date of injury for the amount that covers multiple JCNs

Additional Notes

- A FROI must be filed on each JCN (Date of Injury) reflected in the Compromise Settlement before the SROI is submitted
- When a Compromise Settlement indicates a separate amount for each JCN (Date of Injury) listed, a SROI reflecting the specific amount should be filed in the respective JCN(s)
- If you have an approved Compromise Settlement that does not fit into one of the below scenarios, contact the Commission's EDI QA Department for assistance.