

FAQs about Virginia's EDI Program

What is EDI?

EDI stands for Electronic Data Interchange and is the electronic exchange of information from one entity to another. For Workers' Compensation, it is the electronic exchange of workers' compensation claims data from a Claims Administrator to the Commission.

What is the IAIABC?

IAIABC stands for International Association of Industrial Accident Boards and Commissions. This organization developed the EDI standard for workers' compensation reporting. They are comprised of many committees made up of jurisdictions, providers, vendors and other stakeholders who help develop, implement, and promote the use of the standards for EDI reporting.

When did the Commission switch to EDI?

In 2006, the Commission began a research project to determine where we were with our claims processing system. We learned that we were behind the times in technology, our processes were insufficient and we were not in line with industry trends. The recommendation was presented to the Commission to move to a paperless system and implement the IAIABC's EDI Release 3 standard for reporting workers' compensation claims. On October 1st 2008, the Commission went live with its new paperless system and the first phase of our EDI Program. All Claim Administrators were online and reporting via EDI by July 2009.

Why did the Commission decide to pull the proposed Awards Process regulations?

We heard from the insurance legal community that there were some jurisdictional constraints on the proposed procedures to do away with certain legal forms. Rather than risk agreement forms generated by EDI being undermined and potentially struck down, the Commission decided not to retire these agreement forms. Therefore, you will (via EDI) submit FROI and SROI reports, but you will also continue to submit paper agreement forms in cases where you make payments according to existing procedures. Agreement forms are NOT part of the forms being retired.

Where can I find the Trading Partner Documents that are required in order to be approved to submit EDI to Virginia?

The Trading Partner document can be located in our Implementation Guide and can be downloaded by clicking on the links to the right on the EDI page of the Commission's website.

Who should complete and submit trading partner agreement forms?

These forms are for all entities that are sending electronic data via EDI to VA.

What accidents/injuries are required to be reported to the Commission via EDI?

All accidents, regardless of their severity, must be reported to the Commission and as of 10/1/2008, must be reported via EDI. For any claims with a date of injury prior to 10/1/08, only those that are still considered open and active are required to be reported via EDI.

What forms were retired with the implementation of Virginia's EDI program?

In the IAIABC format, the FROI (First Report of Injury) and SROI (Subsequent Report of Injury) are used to report accident and payment data. The forms that were retired were the Employers Accident Report, the 45A and the 45G forms. Details about which current VA forms were replaced by a particular FROI and SROI report are covered in the EDI Implementation Guide.

Will we be able to print the electronic form that is used to submit data?

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This depends on how your organization handles the report submission. There is not a "form" for the data submission. The data that needs to be collected should be analyzed and submitted either directly out of your systems or submitted to a reporting service, who then forwards it to the Commission. Depending on the reporting service, there are various ways of collecting the needed data—some have a web browser with questions that you answer. The Commission also will have a small-volume filer option through the web. We will also have a "FROI" form that insured's can use to collect the data necessary to file a FROI with us. This form should not be filed with us, but will be helpful to a supervisor in an insured's workplace collecting accident info

Where can we find all of the requirements for Virginia's EDI reporting?

All of the requirements need to submit EDI transactions to Virginia can be located in the Commission Implementation Guide which can be downloaded from this website.

What are the ramifications or fines for being out of compliance?

The Virginia Workers' Compensation Act stipulates required reports. To address the ramifications for being out of compliance, the Act also contains a fine structure. See Section 65.2.902 for details.

Why are some of the FROI/SROI submissions rejecting?

As part of the EDI Release 3 standard implemented by the Commission, there is a list of requirements for each transaction submitted. If any of those requirements are not met, the transaction will reject and the Claim Admin will be required to resubmit. The requirements for each transaction can be located in the Commission EDI Implementation Guide.

What does the EDI message "waiting on acknowledgement of claim" mean?

This error means that you have not received the acknowledgement record for the transaction submitted to the VWC. The Commission's vendor sends the acknowledgement records on our behalf. If you have not received your acknowledgement record then you should immediately contact the VWC so we can follow-up with our vendor. If the Acknowledgement contains a rejection then it is because something was submitted incorrectly from the Claim Administrator. They should correct the mistake based on the error text contained in the acknowledgement.

What is required when reporting on claims with dates of accident prior to 10/1/08?

As of July 2012, EDI transmissions are required on all open, active claims for dates of accident prior to 10/1/08. The Commission will require an initial FROI with one catch-up SROI. Normal SROI reports may be required thereafter.

What happens if multiple JCNs exist for the same injury?

When the Commission receives notification of an injury and a FROI has not been filed, we create a JCN for that injury. We then request a FROI and require that it contain the JCN we assigned. If a duplicate JCN is created because the FROI is submitted without the assigned JCN, a consolidation must be performed. The Commission uses different criteria are used to determine which number is used and a letter is sent to all parties advising of the consolidation and any follow-up information or transactions that may be needed.

Defense attorneys have expressed concern over calls from clients indicating FROIs had been filed but they could not tell if it had been received. What should their clients do in this situation?

Every EDI transaction (FROI and SROI) is acknowledged by the Commission through our vendor. Regardless whether the transaction is accepted or rejected, an acknowledgment record is issued back to

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the submitter. If an adjuster does not see this record, they should check with their IT or EDI team. If for some reason, the acknowledgment record was not received, they should immediately contact the Commission's EDI Team.

How can an EDI transaction be filed and yet VWC does not have it?

When an EDI transaction is submitted, it is initially sent to our vendor. The commission receives the EDI transactions from the vendor every night. So, if a customer is contacting the Commission the day the transaction was submitted, we will not have it in our system yet. If the customer is contacting us days later and is completely sure that an EDI transaction was submitted but they are advised by the Commission that there is no record of it, they should ask to speak to someone in the EDI Quality Assurance Department so we can investigate further. Many times, we have the transaction but it is not visible in our system for other departments to see due to problems within the transaction. The EDI QA Department must research these transactions to resolve the issue prior to it being reflected in our system.

Is the method for filing the FROI & SROI transactions going to be the same regardless of how many non-minor claims you handle per year?

The number of non-minor claims determines if you will be required to submit your transactions using EDI or if you will be able to use a VWC provided web browser based application. The timing and data requirements are identical regardless the method of submission.

How will you have access if you are a TPA taking over claims from another TPA?

In EDI, you are required to report to us that you have taken over a claim. You will need to file an acquiring transaction that indicates that you have taken over the claim. Once this is filed and accepted, you will be able to see the history of what's happened to that claim using the Commission's WebFile system.

Will the Commission be able to enter more than one Claim Administrator for an individual employer or carrier?

The Commission does not track which employers/Carriers use Claim Administrators and which ones they use. One Claim Administrator will be assigned to each specific JCN pursuant to the EDI transaction(s) filed.

For two injuries that occur in the same day, should these be reported as two separate claims (different Claim Administrator Claim Number), or as one claim?

These should be reported as two different claims with two different CACNs so that the Commission can assign two distinct JCNs and process the claims separately.

How are voluntary payments dealt with?

Assuming you mean that you are paying, but also denying the claim, you would file a denial. You can continue to make payments, but the claimant would be informed that the claim is denied, and VWC would provide dispute resolution help on request. If you are not denying the claim but are voluntarily making payments without the entry of an award, those payments should be reported via EDI. Once reported, the Commission will send the 20-Day Order Payments Made requesting the status of the agreement forms.

Our organization administers its own claims and has a very small volume of claims in Virginia; will we be expected to comply with the EDI Program requirements?

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All organizations who currently report to the Virginia Commission will be moving to electronic reports, either through EDI or through web-based submissions. If your organization was required to report on 100 or more "non-minor" claims annually, you must report via EDI. If you are a Claims Administrator (TPA), your reporting requirements are based on what you report in total for all companies you represent.

Our organization uses a Third Party Administrator (Claims Administrator) for all claims handling and data reporting; are we impacted by the EDI Initiative?

An insurance carrier or self-insured organization who utilizes a TPA for reporting should see no impact from this EDI initiative, provided the organization continues to utilize the TPA's services for reporting. Ultimately, of course, it is the insurance carrier or self-insured organization that is responsible for compliance.

We are a self-insured entity, who administers its own workers' compensation claims. We want to continue to adjust our own claims, and also continue to fulfill our reporting requirements. Our volume indicates we will have to use EDI; what should we do?

You have several choices. You can build an EDI reporting system. If you choose to go this route, please know that Virginia is using industry-standard reporting formats, so if you report in other jurisdictions, this investment should be able to be leveraged elsewhere. You can also get assistance. There are third parties who assist with EDI transmissions to workers' compensation jurisdictions, who will also assist you for a fee, which is outside our control. Also, it is standard in the industry for third-party administrators (TPAs), in addition to EDI vendors, to perform EDI services for carrier and self-insured customers. The Commission is not promoting any particular vendor or TPA. On our Website, the Commission has posted a list of vendors who have successfully submitted EDI reports in an IAIABC format.

How will VA receive claims reports?

The Virginia EDI initiative involves using a "clearinghouse" to collect reports from our customers, test the reports for accuracy, and forward to the agency's databases. The Commission's vendor will perform this "clearinghouse" service. All EDI reports will first go to our vendor in an FTP, flat-file format, and then IAIABC Claims Release 3.0 edits, pursuant to the Virginia Implementation Guide, will be applied. The reports will then be sent to the Commission, and the submitter will receive an acknowledgement.

How quickly will acknowledgements (AKCs) be sent back?

Within 24 hours.

Will there be TEs?

No, Virginia will only accept or reject transactions, we will not issue TEs.

When does VWC consider a transaction received?

Transactions must be received by 8:00 PM EST to be included with the current business day. Any transaction received after 8pm will be included and processed with the next business day's transactions. PLEASE NOTE: An Acknowledgement (AKC) does not mean that your report satisfies all reporting requirements for Virginia, but that your report has passed automated data edits.

Will the Commission continue to send the guide and claim for benefits form to the Claimant if you are notified of the injury from a FROI submission?

Yes, these notices will still be sent to the claimant.

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If the claim administrator and/or the insurer name changes, but not the FEIN, how do we report it?

Changes to Claim Administrator or Insurer name or address should be submitted in writing to the Commission and your Trading Partner documents should also be updated.

If our claim designation changes how do we report it?

When a claim is transitioning from minor to non-minor status, the Claim Type Code should change when the FROI 00 is sent to replace the FROI UR.

How should we report any changes to the FROI data previously reported to the Commission?

All changes to data submitted on a FROI should be updated using a FROI 02 transaction.

Where can I find the list of standard Nature, Part of Body, and Cause Codes required for VA's EDI system?

VA will be using the WCIO Standard for these codes. You can find a link to the WCIO codes from the IAIABC website (www.iaabc.org)

Does Virginia utilize the NAICS Codes or SIC Codes?

VA will use the 2007 NAICS national codes (6 digits only).

Will a FROI generate a notification letter?

Yes, a FROI will generate a notification letter.

What does the Commission consider a Medical Only claim to be? Some Claim Administrators refer to minor injuries where meds are less than a \$1,000 as a Medical Only claim and therefore submit a FROI UR with that Claim Type Code and the transaction rejects. Why does that occur?

A Medical Only Claim is when you are only paying medical benefits and those benefits have exceeded \$1,000. A FROI UR should only be used for minor injuries where medical benefits are less than \$1,000 and there is no indemnity. When submitting the FROI UR, you should use Claim Type Code of 'N' for Notification Only to advise the Commission that it is a minor injury. Claim Type Code of 'M' for medical only should only be submitted on a FROI 00 when the medical expenses have exceeded \$1,000 and no indemnity is being paid.

I do not understand the SROI filing when there is no indemnity, even when payments exceed \$1,000. Please explain?

This refers to medical payments exceeding \$1000. There are 7 criteria which define a "non-minor" injury. The two relevant ones for this answer are: 1) if medical costs exceed \$1,000 or 2) if indemnity occurs greater than 7 days. Therefore, if the claim is no longer considered a minor injury, the SROI transactions are required which is similar to the reporting of the 45G form from our legacy paper based process.

Why are some originating FROI transactions rejecting with an error indicating a duplicate?

There are two reasons for this rejection:

1. A prior FROI transaction was already submitted and accepted.
2. A JCN already exists for the claimant noted on your FROI. Sometimes, the claimant will notify us of his accident prior to the FROI submission. When this occurs, we create a claim and assign a JCN. That JCN is then required on your FROI and if the FROI is submitted

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without, our system will see that a JCN already exists and therefore thinks you are attempting to create a duplicate and a rejection is issued. When this occurs, you should resubmit your FROI with the assigned JCN.

Can I file a 00 and IP or PY together?

You should wait until the ACK is received for the 00 before any SROI is submitted.

What is the difference between an AU and AQ transactions used when acquiring a claim from a prior Claim Administrator?

An AQ is filed when the claim has been previously reported to VA and a JCN assigned. An AU is filed when the claim was not previously reported and therefore a JCN does not exist.

When you acquire a claim and your AU/AQ has been accepted, what is the first SROI you should file?

The first SROI should be the SROI AP to show the first payment made by the acquiring Claim Administrator. Even though a PY transaction may not reject if submitted, in most cases that is not the proper transaction to submit.

When reporting the payments made in the benefit segment of a SROI transaction, what is required?

Below is a chart showing exactly what is required in the benefit segment.

<u>Data Element</u>	<u>What to report</u>	<u>Conditions</u>
Benefit Type Code	One of the BTCs accepted by VA	This segment must include all benefit types ever paid on the claim
MTC	The current MTC you are filing	The MTC should be omitted on a SROI QT or UR
Benefit Period Start Date	The first day this BTC was ever paid	The only exception is an RB or ER. For these MTC, the date is the reinstatement date
Benefit Period Thru Date	The last day the BTC was ever paid	
Benefit Type Claim Weeks & Days	Total weeks and days the BTC was paid	This is always a cumulative figure. This is not required when submitting BTC 5xx.
Benefit Type Amount Paid	Total amount paid for this BTC	This is always a cumulative amount.
Benefit Payment Issue Date	The date the check was issued	This date is only required on the IP and PY. This is not required when submitting BTC 5xx.

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When reporting the lump sum payments made in the payment segment of a SROI transaction, what is required?

Below is a chart showing exactly what is required in the payment segment.

<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
Payment Covers Period Thru Date	The end date for this payment reason code
Payment Issue Date	The date the check was issued

What are the scenarios in which a PY transaction should be filed?

There are only two instances when a PY transaction should be filed with the Commission. They are:

1. To show the first payment on a medical only claim when the medical benefits have exceed \$1,000.
2. To report the payment of an awarded lump sum. If the lump sum payment was made voluntarily and not awarded this way by the Commission, it should not be filed as a lump sum payment on the PY transaction. The only two instances of an awarded lump sum are:
 - a. PPD awarded to paid in a lump sum and 4% discount taken
 - b. Approved Compromise Settlement

What codes are acceptable on a PY transaction?

For Medical Only Claims, you would use the following Other Benefit Type Codes Only:

- 350 – Total Payments to Physician
- 360 – Total Hospital Costs
- 370 – Total Other Medical
- 450 – Total Pharmaceutical Costs
- 455 – Total Dental Expenses
- 460 – Total Physical Therapy Costs
- 465 – Total Chiropractic Expenses

For PPD Lump Sum awards, you would use the following Benefit Type Codes only:

- 530 – PPD
- 590 – Disfigurement

For Compromise Settlement awards, you would use the following Benefit Type Codes Only:

- 500 – Unspecified Lump Sum Payment/Settlement – This code should be used when there is a full and final settlement and the CS award is settling out all benefits and not just one.

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- 501 – Medical Lump Sum Payment/Settlement – This code should be used when there is a settlement that is only settling medical benefits.
- 510 – Fatal Lump Sum Payment/Settlement – This code should be used when there is a settlement that is only settling Fatal Benefits
- 520 – Permanent Total Lump Sum Payment/Settlement – This code should be used when there is a settlement that is only settling Permanent Total Benefits
- 524 – Employer Paid Lump Sum Payment/Settlement – This code should be used when the employer paid the settlement
- 530 – Permanent Partial Lump Sum Payment/Settlement – This code should be used when there is a settlement that is only settling Permanent Partial Benefits
- 550 – Temporary Total Lump Sum Payment/Settlement – This code should be used when there is a settlement that is only settling Temporary Total Benefits
- 570 – Temporary Partial Lump Sum Payment/Settlement – This code should be used when there is a settlement that is only settling Temporary Partial Benefits
- 590 – Permanent Partial Disfigurement Lump Sum Payment/Settlement – This code should be used when there is a settlement that is only settling Disfigurement benefits.

When submitting a PY transaction, what should be in the benefit and payment segments?

The benefit segment must contain all benefits ever paid on the claim including the 5xx code for the lump sum payment/settlement. The amounts reported for each benefit type code must be the cumulative amount showing everything that has been paid to date. The payment segment must contain the 5xx code for the lump sum payment/settlement.

When should a QT transaction be filed?

A Quarterly (QT) transaction should be filed every 90 days based on the date of injury if:

- In a medical only claim, additional payments have been made since the last filing (PY or QT), or
- In an indemnity claim, the last transaction was something other than a suspension, or
- In an indemnity claim, additional medical payments have been made since the suspension was filed, or
- To update or correct previously reported payment information (not to show additional periods of disability). For example, the Commission shows an underpayment but the Claim Administrator shows that the claimant has been paid in full but the full dollar amount paid was not reported. The Claim Administrator can file a QT to update this information.

Once PPD has been paid in full, should a suspension be filed?

Yes. The suspension indicates benefits have been paid in full. A SROI transaction should be filed rather than a letter notifying Commission that the PPD Award has been paid. In most situations, the correct suspension to file for PPD will be an S7 for Benefit Exhausted.

If you decide to report medical payments that are less than \$1000.00 thinking that they may get past the \$1000.00 threshold would that be a problem?

No, this will not be a problem.

Are we to file SROI CBs for change in benefits from TT to TP as well as paper forms?

No, the Implementation Guide does not require SROI CBs. If moving from Temporary Total to Temporary Partial, file the paper forms if the change in benefits is different than what's listed in the open agreement with the claimant. We will receive a Quarterly Report which will alert us to what's paid under Temporary Total and what's paid under Temporary Partial.

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When should we submit the SROI UR transactions?

The SROI UR transaction is only used to “catch-up” a pre-10/1/08 claim that is now required to be submitted via EDI. It is a one time transaction that allows you to submit all payments ever made on a claim and it can only be submitted after the originating FROI 00.

Why is the Commission generating the Notice of Invalid Insurer FEIN?

The Commission has what we refer to as a Master Data Record for each Insurance carrier. These records list the correct FEIN, Legal Name, current mailing address and the Designated Representative for that Insurance Carrier. When an EDI transaction is submitted, our system takes the Insurer FEIN contained in the transaction and compares it to our Master Data Records. If a match is found, the information within that record is associated with the JCN. If a match is not found, the letter, Notice of Invalid Insurer FEIN, is generated to alert the parties that the proper carrier information was not submitted. We are asking you to research your file to determine the correct FEIN and submit a FROI 02 transaction to correct the information.

What does Virginia require for accidents that occur in another jurisdiction?

You may or may not be subject to Virginia jurisdiction, depending on certain legal facts and conclusions-- you should continue to consult your attorney to determine this. If your position is that you are subject to Virginia jurisdiction, then you must file appropriate EDI reports. If your position is that you are not subject to Virginia jurisdiction, then you are not required to file any Virginia EDI reports at this time; however, you may do so and indicate your denial for “no jurisdiction.” Of course the injured worker might not agree with this position and file a Virginia claim for the injury. If it is determined that you indeed were subject to Virginia jurisdiction, then you would at a minimum be required to “catch up” all appropriate EDI reports, and may be subject to penalties for non-compliance.

How do I inform the VWC that we've closed the claim?

Virginia doesn't ever consider a claim closed unless there has been a full and final settlement so we do not require the Claim Administrators to notify us when they have closed their claim. Once you have completed payments in an indemnity claim and filed the suspension transaction, no further EDI is required unless the claimant later become entitled to additional medical or indemnity benefits in which case, the appropriate EDI transaction would be required. In medical only claims, your last transaction would be a QT to show the total paid to date. If not additional medical payments are made, no further EDI transactions are required. If additional medical is paid at a later time, you would follow-up with an additional QT transaction.