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EDI OVERVIEW

INTRODUCTION

In the workers' compensation environment, Electronic Data Interchange (EDI) is the electronic transmission of First Reports (FROI) and Subsequent Reports (SROI). Insurance carriers, self-insured employers and third party administrators send the claim information electronically to the jurisdiction and the jurisdiction acknowledges that the filing is accepted or rejected. The International Association of Industrial Boards and Commissions (IAIABC) "EDI Implementation Guide" is the recommended reference for claims administrators in implementing EDI processing of workers' compensation information in Tennessee. This overview will provide a better understanding of the Tennessee specific guidelines for EDI Claims implementation.

The electronic transmission is a standard that insurers, self insured employers and third party administrators can use to implement EDI Claims in any state that uses the IAIABC implementation guide. The standard consists of a set number of fields (data elements) and each data element is a fixed length in the appropriate format. Edits are applied to the data elements to ensure that the data in that field are in the correct format. For instance, date fields are in a standard date format. (20030701) is a date field that is in CCYYMMDD meaning the first two numbers are for the century, the next two numbers are for the year, the next two are for the month and the last two are for the day. So the date is July 1, 2003.

There are charts and tables that provide the data element names, length, format and edits. The tables also show the data elements that Tennessee considers mandatory, conditional or optional. A mandatory field must not be blank and it must be in the correct format. If these conditions are not met the record will be rejected.

EDI REQUIRED CAPABILITIES

The sender administrator that will file electronically with Tennessee must have the capability to:

- Extract a data file from their system for the data elements defined in the IAIABC Standard for Release 1.
- The extracted file should be in flat file format for the following transactions.
148 FROI transaction
A49 SROI
AK1 Acknowledgement
- Transmit the data file through Virtual Private Network (VPN) or Value Added Network (VAN) or SFTP.
- Provide the data in the correct format and within the defined edits.

READING THE ACKNOWLEDGMENT RECORD

The claims administrator submitting the transactions are responsible for reviewing the acknowledgment records to ensure that all the reports sent to the Division were processed. "TR" records need further action by the claims administrator. The following transaction codes are used to determine the status of the claim data submitted:

- TR = Rejected due to critical errors in processing, must be corrected and resubmitted.
- TE = field value is invalid, field value changed to blank, no further action is needed.
- TA = Accepted, no errors.

ERROR PROCESSING

Basic Edit Check matches the claimant, claim, Insurer FEIN & Name, TPA FEIN & Name and the Employer FEIN and Name. If Self Insured indicator (DN24) equals YES then the Self Insured Parent FEIN and Name are included in the Basic Edit Check. If the transaction fails the Basic Edit Check it will be rejected and the Detailed Edit Check will not be done. If one match is found, the transaction passes the Basic Edit Check and then goes through a Detailed Edit Check.

- Claimant – If claimant does not exist, the claimant will be added. If multiple potential matches are found, the record will be sent to the manual queue.
- Claim – If SSN and DOI match are not found and the transaction is a FROI 00, 04 or AU, the claim will be established.
- Insurer FEIN & Name – If Insurer FEIN & Name are not found, the filing will be rejected as DN6 Insurer FEIN, Error #39, No Match on Database.

- Self Insured Parent FEIN & Name – If Self Insured Indicator equals YES, then Insurer FEIN & Name must be the Self Insured Parent FEIN & Name. If Self Insured Parent FEIN & Name are not found, the filing will be rejected as DN6 Insurer FEIN, Error #39, No Match on Database.
- TPA FEIN & Name – If the TPA FEIN & Name are not found, the filing will be rejected as DN 8 TPA FEIN, Error # 39, No Match on Database.
- Employer FEIN & Name – If Employer FEIN & Name are not found, the employer will be added to the database.

Detailed Edit Check checks each field value in the transaction. For error details see the FROI Detail Edit Matrix and the SROI Detail Edit Matrix tables in the Appendix.

MATCHING REQUIREMENTS

The Division uses the injured worker's Social Security Number and date of injury to establish a unique claim file. The MTC 00, AU and the FROI 04 can add a claimant to the Division's database and establish a claim. For these transactions the first step is to identify the claimant.

Claimant identification begins with the Social Security Number. If the SSN exists, then the Last Name, First Name, Date of Birth and address are considered. If the Last and First name do not match, the transaction is sent to a manual queue for resolution. The manual queue has tools to locate a near match on the SSN, Last and First Name and address. If no match is found, the claimant is added to the database.

A claim identification process checks SSN and date of injury for a match. If a match is found, the process moves on to the transaction process. If a match is not found, the process checks for a date of injury 15 days before and 15 days after the date of injury. If one or more matches are found the transaction is sent to manual queue to verify the Date of Injury.

Manual Queue – the queue has a five day maximum time for resolution. Only those records that could indicate duplicate claims or claimants are sent to manual queue. Most of these records will be resolved by comparison of data in the manual queue but if it is not resolved within the five day timeframe the record is rejected with an appropriate rejection reason. In some instances, the Division will have to contact the claim administrator to verify the information needed to resolve the record.

Free Form Text Field – When the claim identification fails, the Free Form Text Field will contain notes regarding the failure. For example, if a claim is found and the SSN and Date of Injury match but the Agency Claim Number does not match then the transaction is rejected and the Free Form Text Field will contain the following: "Correct ACN=##### for SSN=##### and DOI=CCYYMMDD. The claim administrator is not required to manually review the information in the Free Form Text Field. But, if needed, it can be used to for your information regarding the rejection.

SELF INSURED EMPLOYERS AND GROUPS

Choosing a method of transmission.

Self Insured Employers will be required to report first and subsequent reports electronically to the Division. You have the option of reporting directly to the Division or reporting through a third party administrator.

Direct reporting - If you choose to report directly to the Division your system must be capable of extracting data in the format required by the IAIABC standard and transmitting the data via SFTP, FTP/VPN or VAN. The data format includes field length and value requirements. If you are currently reporting directly to the Division and you do not report a high volume of claims to Tennessee you may want to consider filing through a third party vendor. There are vendors that have programs that you can key the claims online or report by telephone and the vendor will then send the filings electronically to the Division. There is a cost for this service but it will probably be much less than developing your own program.

Reporting through a third party administrator – If you currently use a third party administrator, the third party administrator will report electronically for you. You can continue to report the claims to the third party administrator as usual.

SELF INSURED EMPLOYERS AND GROUPS

Filing Requirements

There are special rules for filing for a self insured employer or group. The Division uses a parent/child relationship to define self insured entities. A self insured parent is the company that applied for and received self insured status with Commerce & Insurance. A self insured child is a company that is covered under the self insured parent. The self insured parent must be given as the Insurer Name when reporting for a self insured child. A self insured child cannot be given as the Insurer Name. It must be given in Data Element 18.

Insurer FEIN (DN6): the FEIN of the Self Insured Parent. It cannot be the FEIN of a self insured child. The filing will be rejected if the FEIN and Name do not match the Division's self insured parent table.

Insurer Name (DN7): the Name of the Self Insured Parent. It cannot be the FEIN of a self insured child.

Note: Employers with a high deductible policy are not considered self insured in Tennessee. For high deductible policies, DN 6 and 7 must be the FEIN and Name of the insurance carrier.

Third Party Administrator FEIN (DN8): The Federal Identification Number of the Claims Administrator contracted by the insurance carrier or self-insured employer to adjust and file claim information with jurisdiction.

Third Party Administrator Name (DN9): The name of the Claims Administrator handling the claim on behalf of the insurance carrier or self-insured employer.

Claims Administrator Address (DN 10/15): The mailing address of the reporting party submitting transactions to the Division.

Employer FEIN (DN16): the FEIN of the entity that employs the claimant. It can be a self insured parent or child.

Employer Name (DN18): the name of the employer that employs the claimant. It can be a self insured parent or child.

Self Insurance Indicator: (DN24): If self insured indicator equals YES then DN 6 and 7 must be a self insured parent on file with the Division. If self insured indicator equals NO then DN 6 and 7 must be the FEIN and Name of a valid insurance carrier.

Note: Employers with a high deductible policy are not considered self insured in Tennessee. For high deductible policies, DN24 must be NO.

ELECTRONIC DATA INTERCHANGE RESOURCES

The list of vendors below can assist in the processing and transmission of EDI Claims in Tennessee. This list should not be considered an endorsement for the companies listed and it should not be considered a complete list.

Telephonic Reporting

Quality Resource Management Inc	Nita Chisari	615-285-1919
Quality Resource Management Inc	Lori Molinari	615-285-9850

Online Reporting

Insurance Services Office Inc	Larry Gross	609-799-1800
Mitchell Workers' Compensation Solutions	Pat Cannon	858-368-7131
Mitchell Workers' Compensation Solutions	Kyle Devereaux, Sales	858-368-7593

Third Party Adjustment

Cambridge Integrated Services Group Inc	Michelle Gullick	614-825-2409
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EDI Products and Services

Insurance Services Office Inc	Larry Gross	609-799-1800
Ebix Inc	Matthew Abbitt	614-344-4645
Mitchell Workers' Compensation Solutions	Pat Cannon	1-866-363-4297
Mitchell Workers' Compensation Solutions	Kyle Devereaux, Sales	858-368-7593

Documentation required for EDI implementation:

EDI Implementation Guide for Release I can be obtained from the IAIABC at www.iaabc.org

See the Appendix for the EDI Trading Partner Agreement, Edit Matrix, etc.

PAPER FORMS COMPARISON WITH FROI AND SROI EDI FILING REQUIREMENTS

Tennessee law requires that a First Report of Work Injury be filed within 14 days of the date of injury or date of notification of injury. Subsequent reports are required throughout the life of the claim and timeframes exist for those filings also. The specifics on timeframes can be found in the FROI and SROI Event Tables. These timeframes must be met with electronic filing as in paper filings. Organizations filing by EDI become the agent of the employer and are under the same legal filing requirements as the employer. Once the claims administrator has entered into a written EDI filing agreement and has passed the testing requirements, the claim administrator no longer files a paper copy with the Division.

Paper forms that have an equivalent electronic filing

C20	First Report of Work Injury	FROI MTC 00
C21	Monthly Report of Noncompensable Injuries	FROI MTC 00 must be filed for each claim that was required to be reported on the C21. SROI MTC IP = First Payment SROI MTC RB = Reinstatement
C22	Notice of First Payment	FROI MTC 04, SROI MTC 04, SROI 4P
C23	Notice of Denial	SROI MTC CA = Change Benefits
C26	Notice of Change/Termination of Benefits	SROI MTC S1/S9 = Termination of Benefit
C29	Notice of Final Payment	SROI MTC FN

Note: The C29/FN must be filed on all claims that do not result in permanency (settlement). All cases that result in permanency will require the filing of the SD1. The SD1 must be filed with the court or with the Division at the time of settlement.

Note: C23 Notice of Denial clarification: Notice of Denial MUST be filed on paper. It can be filed via EDI but must still be filed on paper because the reason for denial cannot be captured through EDI.

Paper forms that will continue to be filed with the Division

C27	Notice of Controversy
C28	Notice of Lawsuit
C30	Attending Physician's Report
C30A	Final Medical Report
C41	Wage Statement
SD1	Statistical Data Report
C42	Choice of Physicians form is not required to be filed with the division unless requested. However, the choice of physician form should be completed and kept on file by the employer to prove that a choice of physician was given to the injured employee.

Required EDI transactions that have no paper equivalent

PY	report of all payments other than indemnity, such as medical payments. This report is due when the first medical payment is made on the claim. Data Element Number 74, Claim Type should = Med Only.
AN	<i>Annual Report</i> - for all claims that are open on June 30 th each year. The report is due by September. Open claim means a SROI FN has not been filed or a paper Form SD1 or Court Order has not been filed.

C21, Monthly Report of Non-compensable Claims

The implementation of EDI claims will bring a new requirement for claims that were reported on the C21, Monthly Report of Non-Compensable Injuries. The First Report of Injury, MTC 00 will be required on medical only and loss time less than 8 days. To report a medical only or loss time less than 8 days, file MTC 00 within 14 days showing *Date Last Day Worked* and *Date of Return to Work*, then file a MTC PY when the First Medical Payment is made. Data Element Number 74, Claim Type should = Med Only, Became Med Only or Notification Only. The Final Report (FN) is required to close the claim and to show all medicals paid on the claim. If no medical payments are made, file the FROI MTC 01 to close the claim.

(note: The instructions in this section were changed in March 2005 at the request of the IAIABC. The instructions prior to this were to file a Final Report on all First Reports, if no medical payments were made on the claim, the Final should contain a physician payment segment with an amount of zero to indicate that no medical was paid on

the claim. The IAIABC requested that we change this requirement of filing the Final Report to a requirement of filing a FROI 01 to close the First Report when no medical was paid.)

Employee Notifications

The claim administrator must continue to notify the claimant in accordance with the Claims Handling Standards. The carrier has been and still will be required to notify claimant of C22 First Pay, C23 Denial, C26 Change/Termination of Benefits and C29 Final Payment.

If the claim is denied, the claimant and the Division must be notified within 10 days of denial. File the Denial, MTC 04, electronically and then copy the Division with the claimant notification. Providing a copy of the claimant notification is required because the MTC 04 does not give the Division the date of denial or the reason for denial.

FIRST REPORT OF INJURY

FROI TECHNICAL FILING REQUIREMENTS

The FROI filings are for establishing a claim with the Division.

- ❖ MTC 00 establishes a claim and creates a First Report.
- ❖ MTC 01 cancels a previously filed First Report.
- ❖ MTC 02 changes the information on a previously filed First Report
- ❖ MTC 04 denies a claim when no payments have been made. The Denial will establish a claim if no claim is on file and a Notice of Denial will be created.
- ❖ MTC CO corrects the information on a previously filed First Report that the Division accepts with errors.
- ❖ MTC AU changes the Third Party Administrator on a First Report.

MAINTENANCE TYPE CODE DEFINITIONS AND REQUIREMENTS

00: (First Report) Submit this transaction for the original first report and for the re-transmission of an original first report that was rejected due to critical errors. All mandatory fields must be completed for transmission of the record. The 00 is the electronic equivalent to the paper First Report of Work Injury, Form C20.

01: (Cancellation) Submit this transaction if the original first report was sent in error and is now required to be eliminated from the Division's data base. A previous original report must have been filed. All mandatory fields must be completed for transmission of the record. The result will be that the claim will be closed and reason for closing will be 'Cancelled by FROI 01'. There is no paper equivalent of this transaction.

02: (Change) Submit this transaction to make a change to the original first report. A previous original report must have been filed. All mandatory fields must be completed for transmission of the record.

Key Fields Update: Changes to the both the SSN and Date of Injury within the same FROI MTC 02 filing will result in manual intervention by the Division including contacting the claims administrator for clarification of intent. There is no paper equivalent of this transaction.

Data Element #	Element Name
42	Social Security Number
31	Date of injury
43	Employee Last Name
44	Employee First Name
06	Insurer FEIN
07	Insurer Name
08	TPA Fein (except for FROI AU to change the TPA)
09	TPA Name
16	Employer FEIN
17	Employer Name

Fields that the SROI 02 will also update the FROI Details:

Data Element #	Element Name
015	Claim Administrator Claim Number
026	Insured Report Number
055	Number of Dependents

057	Employee Date of Death
067	Salary Continued Indicator

- 04:** (Denial) Submit this transaction to deny a claim when no payments have been made. Used by the reporting party to indicate that the employer denies an injury or illness is compensable. The Denial can be the first filing made on the claim. If the First Report 00 is not on file, a claim will be established, an Agency Claim Number will be assigned and a Notice of Denial will be created. All mandatory fields must be completed for transmission of the record. The 04 is the electronic equivalent of the paper form C23, Notice of Denial.
- CO:** (Correction) This transaction is not required in Tennessee. If sent it should be submitted to correct a field that was acknowledged as TE Accepted with Errors. Tennessee has two FROI fields that can result in a TE, the SIC Code and the Time of Injury. The TE will be given if the values in these fields are invalid. The record will load with these fields as blank. Neither of these fields is mandatory so a TE is given to show the claim administrator that the fields are invalid. The claims administrator is not required to send the CO to correct these fields. If sent the CO must have all mandatory fields to be accepted. There is no paper equivalent of this transaction.
- AU:** (Acquired) Submit this transaction when a Third Party Administrator acquires a claim. If the First Report of Injury (MTC 00) is present, then the AU must have a TPA FEIN and Name that are different from the 00. Agency Claim Number is not required on the AU. MTC AU can establish a claim, assign an Agency Claim Number and create a First Report if claim or First Report does not exist. The AU can be the electronic equivalent of a First Report.

DATA ELEMENT REQUIREMENTS

M = Mandatory field. This field is a required field and the entire transaction will be rejected if the field is not present or the value of the field is invalid.

C = Conditional field. This field is required if a certain condition is met. Otherwise the field is not required.

O = Optional field. This field is optional but if given it must be a valid value.

FROI DATA ELEMENTS DEFINITIONS AND REQUIREMENTS

- (001) *Transaction Set ID:* Identifies the transaction being sent by the reporting party. For the FROI, Transaction Set ID = 148.
- (002) *Maintenance Type Code:* Defines the specific purpose of individual records within the transaction being transmitted.
 Values: 00 = Original
 01 = Cancel
 02 = Change
 04 = Denial
 CO = Correction
 AU = Acquired
- (003) *Maintenance Type Code Date* (Previously Maintenance Reason Code Date): Designates the date corresponding to the Maintenance Type Code. {format CCYYMMDD}
- (004) *Jurisdiction:* The governing body or territory whose statutes apply to the complaint, claim or work injury. In Tennessee, Jurisdiction = TN.
- (005) *Agency claim Number:* The number assigned by the Tennessee Workers' Compensation Division to identify a specific claim. Historically, in Tennessee it has been called the State File Number. An Agency Claim Number will be assigned when the 00 First Report, AU Acquired Claim or 04 Denial without payment is processed if the ACN has not already been assigned. The format for the ACN is xxxxxxccyy without spaces or hyphens. The leading zeros will be dropped. ACN 0001332003 would be sent as 1332003.
- (006) *Insurer FEIN:* The Federal Identification Number of the Insurance Company or Self-Insured handling the claim financially (financially responsible party).
- (007) *Insurer's Name:* The name of the insurance carrier or self-insured employer financially responsible for handling the claim or potential claim.

- (008) *Third Party Administrator FEIN*: The Federal Identification Number of the Claims Administrator contracted by the insurance carrier or self-insured employer to adjust and file claim information with jurisdiction.
- (009) *Third Party Administrator Name*: The name of the Claims Administrator handling the claim on behalf of the insurance carrier or self-insured employer.
- (010/011) *Claims Administrator Address, Lines 1 and 2*: The mailing address of the reporting party submitting transactions to the Division.
- (012) *Claims Administrator City*: The city of the reporting party's processing facility's mailing address.
- (013) *Claims Administrator State*: The state of the reporting party's processing facility's mailing address.
- (014) *Claims Administrator Postal Code*: The zip/postal code of the reporting party's processing facility's mailing address.
- (015) *Claims Administrator Claim Number*: This number is assigned by the claims administrator or third party administrator for identifying a specific claim within their system. This field is not required and will not be used for claim identification.
- (016) *Employer FEIN*: Federal Identification Number of the injured worker's employer.
- (017) *Insured Name*: The name insured of the policy, typically the parent company in a hierarchically structured organization.
- (018) *Employer Name*: The name of the business entity employing or statutorily responsible for the claimant.
- (019/020) *Employer Address, Lines 1 and 2*: The mailing address of the injured worker's employer responsible for submitting the FROI to the claims administrator.
- (021) *Employer City*: The city address location of the injured worker's employer.
- (022) *Employer State*: The state address location of the injured worker's employer.
- (023) *Employer Postal Code*: The zip/postal code of the injured worker's employer.
- (024) *Self-Insurance Indicator*: Identifies the employer as one who retains the risks arising from its operation and bears the financial responsibility. {Values: Y = yes, N = No}.
- (025) *NAICS Code (North American Industrial Classification System)*: The code representing the nature of the employer's business. These codes are assigned from the NAICS manual published by the Federal Office of Management and Budget. These codes are typically assigned by the U.S. Department of Labor. (Note: SIC codes still may be provided until 1/1/2002).
- (026) *Insured Report Number*: A number determined by the insured to identify a specific claim.
- (027) *Insured Location Number*: A code defined by the employer to identify the location of the accident.
- (028) *Policy Number*: The unique number assigned to the contract/policy by the insurance carrier or third party administrator for that employer or association group.
- (029) *Policy Effective*: Date that the contract/policy under which the claim occurred became effective. {Format CCYYMMDD}.
- (030) *Policy Expiration*: Date that the contract/policy under which the claim occurred expired. {Format CCYYMMDD}.
- (031) *Date of Injury*: For traumatic injury (injury resulting from a single incident), the date on which the accident occurred. For occupational disease or cumulative injury, the date of last injurious exposure to the cause or substance creating the condition. In Tennessee, for a traumatic injury, enter the date of occurrence. For an occupational illness arising from the workers' activity or exposure over an extended period, enter the date of diagnosis or the date first reported to the employer as possibly work-related, whichever is earlier. The item is very important because it is used along with the Social Security Number for identification and computer tacking of the FROI. It is a primary key in establishing a claim within the workers' compensation system. {Format CCYYMMDD}.
- (032) *Time of Injury*: For traumatic injury, the time at which the accident occurred. {Format HHMMSS}.

- (033) *Postal Code of Injury Site*: The zip/postal code that corresponds to the location where the injury occurred. This information is checked for a valid code and it is a mandatory field. The Division requires the county of injury and this field will be used to get that value.
- (034) *Employer's Premises Indicator*: The Values: Y = Yes, N = No indicates if the accident occurred at the employer's place of business. It is a mandatory field that is used in conjunction with the Postal Code of Injury site to obtain the county of injury.
- (035) *Nature of Injury Code*: Code corresponding to the major characteristic of the injury such as a sprain, fracture, burn, etc. (See Appendix 1, Figure A for list of codes).
- (036) *Part of Body Injury Code*: Corresponds to the claimant's part of body injured. (See Appendix A, Figure B for list of codes).
- (037) *Cause of Injury Code*: Corresponds to what caused the accident or illness, or how it occurred. (See Appendix A, Figure C for list of codes).
- (038) *Accident Description/Cause*: Text description of how the accident happened, or what caused the illness. This description can be up to 150 characters.
- (039) *Initial Treatment*: The code used to identify the extent of medical treatment received by the claimant immediately following the accident. The code is used to determine the severity of the injury and to inform medical cost containment programs.
 Values: 00 = No medical treatment
 01 = Minor on-site remedies by employer medical
 02 = Minor clinic/hospital medical remedies and diagnostic testing
 03 = Emergency evaluation, diagnostic testing and medical procedures
 04 = Hospitalization > 24 hours
 05 = Future major medical/lost time anticipated (i.e., hernia case)
- (040) *Date Reported to Employer*: The date the injured worker reported an accident or illness to a representative of the employer. {Format CCYYMMDD}.
- (041) *Date Reported to Claims Administrator*: The date the claims administrator received notice of the accident. {Format CCYYMMDD}.
- (042) *Social Security Number*: Identification number assigned the injured worker by the Social Security Administration. This data element is a primary key in identifying workers' compensation claim within the Division's database.
- (043) *Employee Last Name*: The legal last name of the injured worker at the time of the accident or illness.
- (044) *Employee First Name*: The legal first name of the injured worker at the time of the accident or illness.
- (045) *Employee Middle Initial*: The first letter character of the injured worker's middle name.
- (046/047) *Employee Address, Lines 1 and 2*: The current mailing address of the injured worker.
- (048) *Employee City*: The current city location of the injured worker.
- (049) *Employee State*: The current state location of the injured worker.
- (050) *Employee Postal Code*: The current zip/postal code of the injured worker.
- (051) *Employee Phone*: The current telephone number of the injured worker.
- (052) *Date of Birth*: The birth date of the injured worker. This date must be older than the date of hire or the date of injury. {Format CCYYMMDD}.
- (053) *Gender Code*:
 Values: M = Male
 F = Female
 U = Unknown
- (054) *Marital Status Code*:
 Values: U = Widowed, Divorced, Single, Unmarried
 M = Married

S = Separated
K = Unknown

- (055) *Date disability Began*: The first day on which the claimant originally lost time from work due to the occupational injury or illness.
- (057) *Date of Death*: The date the claimant died. In Tennessee, this date is more specifically defined to be the date that the injured worker died due to his or her work-related injury or illness reported. {Format CCYYMMDD}.
- (058) *Employment Status Code*: A code used to indicate the employee's primary work code status at the time of the injury with the covered employer. Tennessee uses the ANSI values.
- | | | |
|--------|----------------------|-------------------------------|
| Values | PW = Piece Worker | VO = Volunteer |
| | SL = Seasonal Worker | AD = Apprenticeship Full Time |
| | FT = Full Time | AP = Apprenticeship Part Time |
| | PT = Part Time | RT = Retired |
| | NE = Not Employed | DS = Disabled |
| | OS = On Strike | ZZ = Other |
- (059) *Class Code*: Corresponds to the primary occupation in which the claimant was engaged at the time of the accident or illness. The values are obtained through the NCCI Class Code Classification Manual. (See References).
- (060) *Occupation Description*: A descriptive text identifying the primary occupation of the claimant at the time of the accident, injury or illness. (Example: Janitor, Laborer, Supervisor dock area). Please be as specific as possible.
- (061) *Date of Hire*: The date the injured worker began his or her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this is the beginning date of the current employment period.
- (062) *Wage*: The claimant's reported pre-injury wage for the wage period defined. This amount may include estimated commissions and living or travel allotment earnings. (For Tennessee, the default value for the FROI when a wage amount is unknown is 0.00).
- (063) *Wage Period*: A code assigned indicating the time period during which the wage is earned.
- | | |
|---------|----------------|
| Values: | 01 = Weekly |
| | 02 = Bi-Weekly |
| | 04 = Monthly |
| | 06 = Daily |
- (064) *Number of Days Worked*: The number of the injured worker's regular scheduled workdays per week. {Values: 1, 2, 3, 4, 5, 6, 7}.
- (065) *Date Last Day Worked*: The date the employee last worked. This date will not reflect dates on which the employee was absent from work in a paid status; vacation, comp time, sick leave, military leave, etc. {Format CCYYMMDD}.
- (066) *Full Wages Paid for Date of Injury*: Defines whether full wages for the date of the accident or illness were paid to the injured worker by the employer. {Values: Y = Yes, N = No}.
- (067) *Salary Continued Indicator*: For workers' compensation – indicates whether the employer is continuing to pay the injured worker's regular wages without charge to employee benefits (vacation time, sick leave, etc.) during an absence caused by a work injury. This indicator is also used to indicate if the injured worker is being paid by the employer under an injury time program. { Y = Yes, N = No}.
- (068) *Date of Return to Work*: The date, following the most recent disability period, on which the claimant returned to work.

SUBSEQUENT REPORT OF INJURY

MAINTENANCE TYPE CODE DEFINITIONS AND REQUIREMENTS

(02) *Change*: A change is made to the header portion of a Subsequent report. Fields that can be changed with SROI MTC 02 are:

Data Element #	Element Name
015	Claim Administrator Claim Number
055	Number Of Dependents
057	Employee Date Of Death
067	Salary Continued Indicator
069	Pre Existing Disability
070	Date Of Maximum Medical Improvement
071	Return To Work Qualifier
072	Date Of Return/Release To Work
073	Claim Status
074	Claim Type
075	Agreement To Compensate Code
076	Date Of Representation
077	Late Reason Code

Fields that the SROI 02 will also update the FROI Details:

Data Element #	Element Name
015	Claim Administrator Claim Number
026	Insured Report Number
055	Number of Dependents
057	Employee Date of Death
067	Salary Continued Indicator

Fields in SROI that require a FROI 02 to make a change. If these fields contain a different value than the value in the FROI the record will be rejected and an error message 'Value not consistent with value previously reported' will be given as reason for rejection.

Data Element #	Element Name
005	Agency Claim Number (cannot be changed, system generated)
006	Insurer FEIN (Requires the FROI 02 to change)
008	Third Party Administrator FEIN (Requires the FROI 02 or the SROI AU)
014	Claim Administrator Postal Code (Requires the FROI 02 to change)
042	Social Security Number (Requires the FROI 02 to change)
031	Date Of Injury (Requires the FROI 02 to change)
056	Date Disability Began (Should be allowed to be changed conditionally. If the Date Disability Began is blank in the identified claim, then it can be changed/updated else reject the transaction)
062	Wage (Requires the FROI 02 to change)
063	Wage Period (Requires the FROI 02 to change)
064	Number Of Days Worked (Requires the FROI 02 to change)

(04) *Denial* The SROI MTC 04 Denial should be filed when payments have been made on the claim and now the claim administrator finds that the claim should be denied. The SROI MTC 04 should have at least one segment, the Pay/Adjust segment and/or the Paid to Date segment.

(4P) *Partial Denial*: The MTC 4P can be sent when a claim administrator is denying a part of the benefits such as medical is denied but indemnity continues. This is a new transaction for Tennessee. It is not required but must meet the filing requirements if sent.

(AP) *Acquired Claim*: This code is used to indicate that indemnity benefits have been paid by the acquiring claims administrator. An AU report for a FROI must have been sent to update the claims administrator information.

(CA) *Change in Benefit Amount*: or Change in Weekly Compensation Rate. Send the CA when the Weekly Compensation Rate has been changed due to the receipt of a Wage Statement, etc. Within the MTC CA the field Weekly Amount will update the Division's database as the new Weekly Compensation Rate.

- (CB) Change in Indemnity Benefits: A change in Payment/Adjustment Code has been made or a new indemnity transaction of an additional Payment/Adjustment Code has occurred. This code is used in the following situation: A claim is paid for more than one disability type at different times during the payment period of the claim. For example, a claim has payment beginning for TTD benefits and after MMI, the claim is paid under Permanent Partial Disability PPD benefits. An accepted IP Notice of Benefit Payment has been filed for the same worker SSN and Injury Date prior to the filing of the change in indemnity benefits.
- (CD) Compensable Death This transaction is not required but if sent it must meet the filing requirements. Submit this transaction if an employee has died as a result of a work related injury or illness and the claim administrator is notifying the jurisdiction that they are accepting the claim. This transaction will be accepted without any of the five segments being present so the filing can be made when no payments have been made by the carrier.
- (CO) Correction: A field that is not mandatory has an invalid value. The transaction has been accepted and the fields have been set as blank. No further action is needed but if a CO is sent it must meet the filing requirements. Currently there are no TE, Accepted With Errors in SROI.
- (FN) Closing Payment: This report should show all payment types and payment amounts for the life of the claim. Payment types include indemnity benefits and medical benefits. Medical Only should have at least 1 occurrence of the Paid to Date segment. Medical only claims should be closed after 180 days of no action from the last payment date.
- (FS) Full Salary Submit this transaction if the employer is paying the claimant full salary and the claim administrator is not paying any indemnity benefits.
- (IP) *Initial Payment*: Submit this transaction to show that the initial payment of compensation has been made or for the retransmission of a rejected IP.
- (P1-PJ) *Partial Suspension* This transaction is not currently used in Tennessee. If sent it will be accepted if the filing requirements are met. P1/PJ codes are for stopping indemnity payments. In Tennessee, indemnity benefits can be stopped for medical non-compliance. Please use MTC S2 for this situation. At least one occurrence of the Pay/Adjust segment OR the Paid to Date segment must be present.
- (PY) *Payment*: PY report of all payments other than indemnity, such as medical payments. This report is due when the first medical payment is made on the claim. Data Element Number 74, Claim Type should = Med Only.
- (RB) *Reinstatement of Benefits* Submit this transaction after a P1/PJ or S1/SJ has been submitted to the Division and now the benefits have been reinstated. At least one occurrence of the Pay/Adjust segment must be present. IP, S1/SJ, and RB transactions must be in sequence.
- (RE) *Reduced Earnings* This MTC is not required. If the claim administrator plans to use this MTC the administrator should send test data during testing. The Division will review the use of the transaction and give approval if appropriate.
- (SI-SJ) *Termination of Benefits* This transaction is equivalent to the C26, Notice of Change/Termination of Benefits. 00, IP or AP or FS. Consecutive Suspension not allowed, RB or AP required between suspensions.
- (VE) *Volunteer* This MTC is not required. If sent it will be accepted if the filing requirements are met. This transaction will be accepted without any of the five segments being present.
- (AN) *Annual Report* Submit this transaction for all claims open on June 30th each year. Open means that a FN, SD1 or Court Order has not been filed with the Division. The AN is due by September 1st each year.
- (UR, BM, BW, MN, QT, SA) – Tennessee will not accept these maintenance type codes.

SROI DATA ELEMENT DEFINITIONS AND VALUES

(DN001) *Transaction Set ID*: Identifies the transaction being sent by the reporting party. For all subsequent reports, Transaction Set ID = A49.

(DN002) *Maintenance Type Code*: Defines the type of transaction that is being sent to the jurisdiction.

Values:	02	Change
	04	Denial after payments have been made
	4P	Partial Denial

AN	Annual Report
AP	Acquired Payment
CA	Change in Benefit Amount (Weekly Comp Rate)
CB	Change in Benefit Payments
CD	Compensable Death No Dependents/Payees
CO	Correction
FN	Final Notice, Closing Payment of medical or indemnity benefits
FS	Full Salary
P1/PJ	Partial suspensions
PY	Initial Payment of medical-only benefits or attorney fees or funeral expenses
RB	Reinstatement of Benefits
RE	Reduced Earnings
S1/SJ	Suspension of Benefits
IP	Initial Payment
VE	Volunteer

(DN003) *Maintenance Type Code Date (Maintenance Reason Code Date)*: For most transactions it is the date the claim administrator flags the file to be sent to the jurisdiction. For the following MTC codes the date has a different meaning:

CO	MTC date should be the original transaction date of the transaction that it is correcting. If the CO is correcting the 00 transaction it is the MTC date of the 00 transaction.
AP	MTC date is the issue date of initial indemnity benefit check after acquiring the file.
CA	MTC date is the date the change in Pay/Adjust amount was effective.
IP	MTC date is the issue date of initial indemnity benefit check.
P1/PJ	MTC date is the last date through which indemnity benefits are due.
PY	MTC date is the issue date of payment.
RB	MTC date is the issue date of the check reinstating indemnity benefits.
S1/SJ	MTC date is the last date through which indemnity benefits are due.

(DN004) *Jurisdiction*: The governing body or territory whose statutes apply to the complaint, claim or work injury. In Tennessee, Jurisdiction = TN.

(DN005) *Agency Claim Number*: The number assigned by the Tennessee Workers' Compensation Division to identify a specific claim. Historically in Tennessee it has been called the State File Number. An Agency Claim Number will be assigned when the 00 First Report, AU Acquired Claim or 04 Denial without payment is processed if the ACN has not already been assigned. The format for the ACN is xxxxxxxcyy without spaces or hyphens. The leading zeros will be dropped. ACN 0001332003 would be sent as 1332003.

(DN006) *Insurer FEIN*: The Federal Employer's Identification Number of the carrier or self-insured assuming the employer's financial responsibility for workers' compensation claim(s).

(DN008) *Third Party Administrator FEIN (Claims Administrator FEIN)*: The Federal Identification Number of the Third Party Administrator (TPA), Independent Adjuster or Claims Administrator that adjusts the claim on behalf of the carrier, self-insured employer, group or pool.

(DN014) *Claims Administrator Postal Code*: The Zip Code of the claims administrator's or Third Party Administrator's processing facility's mailing address for the FROI, Notice of Benefit Payment report or claim. The code has the 5 digit base with a possible 4 digit extension.

(DN015) *Claim Administrator's Claim Number*: This number is assigned by the claims administrator or third party administrator for identifying a specific claim within their system. This field is not required and will not be used for claim identification.

(DN026) *Insured Report Number*: A number determined by the employer to identify a specific claim. This field is not required and will not be used for claim identification.

(DN031) *Date of Injury*: For traumatic injury, the date on which the accident occurred (date of occurrence). In some cases for occupational disease or cumulative injury, this is the date of last injurious exposure to the cause or substance creating the condition. For an occupational illness, arising from the worker's activity or exposure over an extended period, enter the date of diagnosis. The rule of thumb is that if the employee no longer

works for that employer, use the last date worked at the employer who is the source of the disease. If the employee still works for that employer, use the date of diagnosis.

(DN042) *Social Security Number*: Identification number assigned to the injured worker by the Social Security Administration. This field is a primary key in identifying a workers' compensation claim within the Division's database.

(DN055) *Number of Dependents*: The number of dependents for a worker that dies from a work related injury or illness.

(DN056) *Date Disability Began*: The first day on which the employee lost time from work due to the injury or illness.

(DN057) *Employee Date of Death*: The date the worker died as a result of a work related injury or illness.

(DN062) *Wage*: The average wage of the employee at the time of the injury as calculated by the Claims Administrator for the wage period.

(DN063) *Wage Period*: A code assigned indicating the time period during which the wage is earned.

Values: 01 = Weekly; 04 = Monthly

(DN064) *Number of Days Worked*: The number of the injured worker's regularly scheduled workdays per week.
Values: 1, 2, 3, 4, 5, 6, 7.

(DN067) *Salary Continued Indicator*: Indicates whether the employer is continuing to pay the claimant regular wages. Values: Y = Yes, N = No.

(DN069) *Pre-Existing Disability*: This data element is not used in Tennessee and this field will not be loaded into the Division's database.

(DN070) *Date of Maximum Medical Improvement*: The date, indicated by the treating physician, after which further recovery from or lasting improvements to an injury or disease can no longer be anticipated, based upon reasonable medical probability.

(DN071) *Return to Work Qualifier*: A code identifying the employee's return to work status, with or without physical restrictions.

Values: 1 - Actual RTW without physical restrictions
2 - Actual RTW with physical restrictions
5 - Released to RTW without physical restrictions
6 - Released to RTW with physical restrictions

(DN072) *Date of Return/Release to Work*: The date, following the most recent disability period, on which the employee actually returned to work, or was released to return to work, as identified by the Return to Work Qualifier. If Return to Work Qualifier code is 1 or 2, then DN072 is the Return to Work Date. If Return to Work Qualifier code is 5 or 6, then DN072 is the Release to Return to Work.

(DN073) *Claims Status*: A code representing the current status of the claim.

Values: O = Open:	Future benefit payments are anticipated.
C = Closed:	Future indemnity payments are not anticipated.
R = Reopen:	Claim was closed but is reopened for future payments not anticipated.
X = Reopened/Closed:	Claim was reopened for one additional payment. No future payments anticipated.

(DN074) *Claim Type*: A code representing the current benefit classification of the claim.

Values: M = Medical-only:	This claim has only medical benefits paid in behalf of the injured or ill worker.
I = Indemnity:	This claim is identified by the payment of any disability compensation paid to the worker during the life of the claim.
N = Notification only:	For initial payment of attorney fees or funeral expenses without any medical or indemnity benefits being paid.
L = Became lost time:	The claim began as a medical-only claim and became an indemnity claim after more than seven days of work time was lost by the worker as a result of the accident.

(DN075) *Agreement to Compensate Code*: A code used to identify the condition under which compensation benefits are being paid. Values: Without Liability = W, With Liability = L.

(DN076) *Date of Representation*: The date the claims administrator recognizes that the claimant has secured legal representation.

(DN077) *Late Reason Code*: A code which identifies the reason a payment/report was not made within Tennessee's requirements.

Values:

L1	No excuse
L2	Late notification, employer
L3	Late notification, employee
L5	Late notification, health care provider
L6	Late notification, assigned risk
L7	Late investigation
L8	Technical processing delay or computer failure
L5	Manual processing delay
C1	Coverage, lack of information
E1	Wrongful determination of no coverage
E2	Errors from employer
E3	Errors from employee
E4	Errors from state
E5	Errors from health care providers
E6	Errors from other claim administrator
D1	Dispute concerning coverage
D2	Dispute concerning compensability, in whole
D3	Dispute concerning compensability, in part
D4	Dispute concerning disability, in whole
D5	Dispute concerning disability, in part
D6	Dispute concerning impairment

VARIABLE COUNTER SEGMENT

(DN078) *Number of Permanent Impairments*: Number of permanent impairment occurrences (values 0 -10).

(DN079) *Number of Payments/Adjustments*: Number of weekly payments/adjustments occurrences (values 0 -10).

Note: Tennessee requires Payments/Adjustments information.

(DN080) *Number of Benefit Adjustments*: Number of benefit adjustment occurrences (values 0 - 10). Note: Tennessee does not currently have a scenario that would require this information.

(DN081) *Number of PTD/Reduced Earnings/Recoveries*: Number of paid to date/reduced earnings/recovery occurrences (values 0 -25). Note: Tennessee requires this information.

(DN082) *Number of Death Dependent/Payee Relationships*: Number of death/dependent payee segment occurrences (values 0 - 12). Tennessee requires this information.

PERMANENT IMPAIRMENT SEGMENT

(DN083) *Permanent Impairment Body Part Code*: All cases that result in permanency must be reported on the manual form SD1. If reported through EDI it will be accepted but the requirement will not be met. The SD1 will still be required.

(DN084) *Permanent Impairment Percent*: All cases that result in permanency must be reported on the manual form SD1. If reported through EDI it will be accepted but the requirement will not be met. The SD1 will still be required.

PAYMENT ADJUSTMENT SEGMENT

(DN085) *Payment/Adjustment Code*: Code that identifies the payment or adjustment being made. This segment is for reporting indemnity payments or adjustments. See Appendix for codes.

(DN086) *Payment/Adjustment Paid to Date*: The cumulative amount paid for the payment/adjustment identified by the associated payment/adjustment code. This total should be the total amount paid to date for the code identified in DN085.

(DN087) *Payment/Adjustment Weekly Amount*:

Payment: The net weekly rate for the payment/adjustment code being paid as modified by any applicable benefit adjustments. This field is for the Weekly Compensation Rate.

Change of Benefits: If MTC = CA then the Weekly Compensation Rate will be updated in the Division's database and Form C26 Notice of Change of Benefits will be created.

(DN088) *Payment/Adjustment Start Date*:

For Weekly Benefits: The first Start Date of a benefit period for which benefits were paid.

For Adjustments: The first date for which the adjustment is applied.

(DN089) *Payment/Adjustment End Date*:

For Weekly Benefits: The last date of a benefit period for which benefits were paid.

For Adjustments: The last date for which the adjustment is applied.

(DN090) *Payment/Adjustment Weeks Paid*: The number of whole weeks paid for a specific payment/adjustment code.

(DN091) *Payment/Adjustment Days Paid*: The number of days paid for a specific payment/adjustment code. Values are 0 through 6.

BENEFIT ADJUSTMENT SEGMENT

(DN92) *Benefit Adjustment Code*: A codes used to identify an adjustment being applied to a weekly payment/adjustment amount, still in effect (non-suspension).

(DN93) *Benefit Adjustment Weekly Amount*: The weekly amount of benefit adjustment applied per payment/adjustment code.

(DN94) *Benefit Adjustment Start Date*: The first date a benefit adjustment was applied.

PTD/REDUCED EARNINGS/RECOVERIES SEGMENT

(DN095) *Paid to Date/Reduced Earnings/Recovery Code*: This code identifies those benefits paid in behalf of the injured or ill worker that is additional to possible disability payments as defined in the payment adjustment codes. These benefits include medical services, attorney fees, vocational rehabilitation and funeral expenses.

Code Description

300 = Funeral expenses paid to date

310 = Penalties paid to date

320 = Interest paid to date

330 = Employer's legal expenses paid to date

340 = Claimant's legal expenses paid to date

350 = Total payments to physicians paid to date

360 = Hospital costs paid to date

370 = Other medical paid to date

380 = Vocational rehabilitation evaluation paid to date

390 = Vocational rehabilitation education paid to date

400 = Other vocational rehabilitation paid to date

420 = Expert witnesses fees paid to date

430 = Unallocated Prior Indemnity Benefits paid to date

440 = Unallocated Prior Medical paid to date

800 = Special Fund Recovery

810 = Deductibles Recovery

820 = Subrogation Recovery

830 = Overpayment Recovery

840 = Unspecified Recovery

(DN096) *Paid to Date/Reduced Earnings/Recovery Amount* - The amount defined by the Paid to Date/Reduced Earnings/Recovery Amount codes.

DEATH/DEPENDENT PAYEE RELATIONSHIP SEGMENT

(DN097) *Dependent/Payee Relationship* - The relationship of the dependent/Payee to the deceased employee; to which relationship and benefit entitlement may be determined by an adjudicator's decision for distribution of the death benefit.

FREQUENTLY ASKED QUESTIONS

Acquired Claim

Is the Agency Claim Number required on an Acquired Claim?

The Agency Claim number is not required on an AU. The Division will acknowledge the claim with the correct ACN.

Annual Report

Will an Annual Report be due during the July-Sept 2003 time frame?

TN will not require the annual report in 2003. The first year it will be due is 2004.

Annual Report

For the annual report, will the cumulative total be just for the preceding 12 months or a total for the life of the claim to date?

It should be the total for the life of the claim.

Annual Report

SROI MTC AN - Can we just develop a program to read our database and report the information that way or does this have to go thru the EDI process?

It will need to come through EDI so that it will load into our system.

Annual Report

Is the AN supposed to be sent on medical-only claims?

If a FN has not been filed.

Benefit Adjustment Segment

Why are benefit adjustments mandatory on CAs and ANs? The Weekly Amount can change without applying an on-going adjustment.

Not mandatory on 'AN' corrected on the 'CA'. The Payment Adjustment segment is required for the 'CA'.

Body Parts

Do you want the individual body parts with their assigned percentages or a single "Whole Body" percentage?

Either the individual body parts OR the whole body

Body Parts

Is Tennessee a "whole body" state and is DN83-Permanent Impairment Body Part Code allowed to be "99" or are ratings only done on individual body parts?

TN allows 99 for Whole Body

Carrier Name Change

FROI processing -Sometimes a carrier will shift a claim to another carrier within their group. Does the AU (Acquired/Unallocated) MTC apply in this situation.

You can send an 02 to change the carrier name. The AU is only for changing the third party administrator.

Claim Status

What's your definition of an "Open" Claim Status?

A claim that a FN Final Payment, a Court Order or a SD1 Statistical Data form has not been received by the Division.

Claimant Notification

From your "Cross walk", please detail which of these paper "C" forms must continue to be supplied to the injured worker once we're in EDI production.

The carrier has been and still will be required to notify claimant of C22 First Pay, C23 Denial, C26 Change/Termination of Benefits and C29 Final Payment. The Denial thru EDI does not supply the information that we have been capturing, Date and Reason of Denial. You will be required to furnish this information by sending a copy of the claimant notification to Division. Upon receipt of the copy of the claimant notification the Division will update the date of denial and the reason of denial but will retain the date received of the MTC 04.

Codes

Are there any particular Benefit Adjustment Codes, Benefit Type Codes, PTD Codes that are not valid in Tennessee?

Tennessee will accept any of the IAIABC codes at this time. We may make adjustments to this in the future.

Compensable Death

The purpose of a CD is to inform the jurisdiction that the death was compensable but there are no dependents.

Why is DN55-# of Dependents required on the CD when the CD implies there are none?

This has been corrected. It will not be mandatory for the CD. A value of zero is allowed in that field.

Date of Injury

How do I file if a claimant has two injuries on the same date?

The division's system will not allow multiple state files for the same date of injury. It will allow multiple injuries on the same date of injury. For EDI purposes you will have to file one report and on the report for body part, nature, and cause of injury you will need to code as follows:

Body Part = Multiple Body Parts (90)

Nature = either Multiple Injuries (90) or Multiple Phy & Psy (91)

Cause = Miscellaneous Causes (99)

Then in the injury description you can give a narrative about the 2 injuries.

Death Dependent Relationship Segment

For DN97, the first position is a relationship code, the second position is the numerical birth order. The IAIABC valid values for the second position is 1-9 (spaces not allowed). Therefore, if the dependent is a widow, the code value sent will be "21". We have found most jurisdictions don't realize this and they have to make a programming change.

Yes, our system accepts these codes as per the IAIABC standard.

Denial

Will I still be required to notify the claimant of denial?

YES

Denial

Will the EDI denial satisfy a timely denial reporting requirements?

The EDI denial will satisfy the timely filing.

Denial

Which Date do you use from the EDI report to determine timely filing measurements?

The MTC date will be used as the effective date of the denial. If additional details about the denial are received after that date the denial will be updated to reflect the date of denial and reason of denial. The received date will not change.

Denial

Are we supposed to send 148-04s on medical-only claims?

YES, if you deny the claim you should send the 04.

Denial

Once we are in production, does a corresponding paper form still need to be submitted to others such as the claimant or his representative?

You do not have to file the paper form of C23 but do file the EDI Denial. You are still required to notify the claimant of the denial. Also, because the reason for denial and the date of denial are not received through EDI you will need to copy the Division when notifying the claimant. Upon receipt of the copy of the claimant notification the Division will update the date of denial and the reason of denial but will retain the date received of the MTC 04.

Denial

SROI MTC 04 - Does this apply even if payments may have been issued?

Yes, the SROI 04 is to deny a claim after payments have been made. If no payments have been made and you want to deny the claim, file a FROI 04.

Field edits for amount and week/days

Why would we ever get an error 058 (invalid code, ID, or value) on the following DNs (all are amount fields or weeks/days)? DN86, 87

The codes must be in the IAIABC standard. The dates must be after the date of injury.

Field edits for dates

What do we report if a date is not present, zeroes or blanks?

All zeros will result in a blank field. If the field is not mandatory the filing will be accepted.

Final Pay

A claim is closed and we send in a Final. After the claim is closed another payment was issued on the claim. Again I need to know what TN will be expecting. The way other states handle that situation is, we send them another Final Report.

Tennessee only accepts 1 final pay. If further payments are made, you need to file an amended FN. It will completely overwrite the first FN sent so make sure that the amended FN contains a cumulative total of all payments for the life of the claim.

Final Pay

SROI MTC FN - The state indicates they want us to notify them when a final payment has been processed and the claim will be closed. Should we report this information when the claim is closed or when we issue the final indemnity payment? In some situations we have issued a final indemnity payment but we still have the Medical line open, so the claim is not closed!

File the FN within 30 days of final indemnity payment. File an updated FN if additional payments of \$2,500 have been made. The updated FN should show all payments made for the life of the claim, not just payments made after the first FN was filed.

Final Pay

Since the SROI Event Table indicates that the prerequisite for an FN is an IP or AP, does that mean FNs are not to be sent on medical-only claims?

For Medical Only claims the FN will be accepted without the IP or AP being on file. The Claim Type (DN74) must contain the value 'Medical Only' or the filing will reject for 'No matching subsequent report' because for all other claim types the IP or AP must be on file before the FN will be accepted. The FN for Med Only must show all medical costs incurred.

Final Pay

The SROI Event Table indicates that there is a report limit of 1 for the FN. If the claim reopens for additional indemnity payments, we will send an RB. When the claim closes again, doesn't the Division want another FN to be sent?

Tennessee will want an amended Final Pay and it will replace the first filing. The second FN must have cumulative totals for the life of the claim, not just the payments made after the first filing.

First Report

What claims are reportable for FROI; all claims no matter if there was no medical and just 1 doctor visit, just claims with loss time from work?

File all claims with loss time greater than zero and all claims that incur medical as well.

Key Fields update

Will you accept the 148/02 Change to update a change in the SSN and/or DOI? If not, then how do we notify you when it does change?

YES

Key Fields update

What do we need to do if the employee name, SSN or date of Injury changes? Do we need to fill out a form, call you, etc.?

You can submit an '02' change to change any of these fields. If both the SSN and the date of injury are being changed on the same '02', the filing will require manual intervention on our part to make sure the transaction should be changed. The manual intervention may include contact with the carrier for clarification of intent.

Loss Time

How do you file a loss time claim with no medical or physician expenses? For example, the employer has medical staff onsite and the claimant was taken off work for a day or two by that medical staff.

If the employee was treated by the employer's medical staff and is taken off work for 1 to 7 days and no costs are incurred, file the First Report then file a Final Report with a paid to date code of 350 Total Payments made to physician to date and give all zeros for the amount of the payment.

Mandate

Does your state mandate EDI for FROIs and/or SROIs. If so, please list the effective dates. If not, please indicate if and when you will be mandating EDI submissions.

Both FROI and SROI are mandated for July 1, 2003.

Mandate

Regardless of whether or not you mandate EDI, please indicate if a paper copy of the FROI or SROI must be sent in to the state.

After successful testing only the EDI transaction will be required.

Mandate

If your state is currently accepting EDI of FROIs and SROIs on a voluntary basis, do you require the paper copy of the reports also be sent?

The Division will continue to accept paper until the carrier completes the test and pilot phase or until July 1, 2003, whichever comes first.

Mandate

When do I stop filing paper and begin filing EDI?

You may begin sending FROI on all dates of injury. You may begin sending FROI and SROI transactions for all previously filed paper First Reports. Our system will match on the SSN and Date of Injury.

Mandate

Does the mandate apply to all open claims or are we only supposed to submit EDI on claims with a certain date of injury or reported date forward?

All open claims

Mandate

Is all the claim data previously submitted on paper currently residing in the same database at the Division where the EDI data will be loaded?

YES

Mandate

Once we are in production, will the Division accept any paper forms from us (C-20, C-21, C-22, C-23, C-26, or C-29)?

File the FROI '00' for each med only claim instead of C21. After implementation we will no longer accept the paper forms C20, C21, C22, C23, C26 and C29.

Medical Only Claims

If a FROI is sent but no indemnity payments are made, what does the state want the carrier to send?

File an '00 within 14 days showing Date Last Day Worked and Date of Return to Work, then file a 'FN' and for Claim Type = Med Only and report all medical payments.

Med Only Claims

Is the state expecting to see claims for Loss Time & Medical Only?

File a 00 for loss time >0 and for medical only claims.

Medical Only No loss of Time claims

Are incidents required to be reported via EDI? According to the FAQ on the internet, only injuries needing medical attention are required to be reported on paper. If only first aid is provided by employer's in house staff, must those claims be sent on a 00?

NO, only claims that incur medical and/or indemnity costs. The only exception is a No Loss Time less than 8 days that does not incur medical or physician payments.

Medical Expense and Loss Time

What fields do you want to see when there is both medical and loss time 1 thru 7 days?

For loss time 1 thru 7 days, file a 00 with Date Last Day Worked and Date Return to Work, then file a Final Report (FN) with Claim Type = Med Only and show all medical costs incurred.

No loss of time and no medicals paid

What do I need to file if the claimant was treated by onsite medical staff and the treatment included time off less than eight days but no medical was incurred?

File a 'FN' and with Paid to Date segment code 350, physician payment and give the value of zero. Also, Claim Type = Med Only

Paid to Date/Reduced Earning Segment

Why are PTD/RE/Recoveries mandatory on VEs?

The only situation that a 'VE' would apply is for volunteer firemen that are only due medical benefits so if you file a 'VE' it should be to report medical benefits for a volunteer fireman.

Paper filings

As of 7/1/2003 we will have a large number of manual (paper) claims in effect. Many of these do not have a state assigned claim number yet. Is it acceptable to allow these to continue as manual claims until they have all run off? If not, It may be quite an effort on our part to convert these to EDI, contact the state for claim numbers where not known (which reportedly is a high percentage) and electronically attach the numbers to the files.

We do not want to continue with the paper after July 1. A report of claims and their Agency Claim Number/ State File Number can be generated for your company.

Paper requirements

Are there any situations where the Division requires paper to be sent instead of EDI?

Notice of Controversy, Lawsuit, Attending Phy, Final Medical, and Statistical Data Forms must still be filed on paper.

Payment Report

When should the PY be sent?

On medical only claims when the First Medical payment is made.

Policy Number, eff/exp dates

Please confirm that for Self-Insured Employers reports, that since there's no fully insured WC Policy written, that you understand there will be no Policy Number or Effective/Expirations Dates data elements present on the EDI Reports.

Policy Number and Eff/Exp dates are not required fields. However, if one of the three are given then all three are required.

Policy Number, eff/exp dates

If DN24-Self Insured Indicator is "N", are DN28-30-Policy # and Dates required?

NO, DN 28, 29 & 30 are not required elements. However, if one of the fields is given then all three must be given.

Reinstatement of Benefits

I noticed that you listed the C-22 - Notice of First Payment as the form equivalent to the A49-RB -Re-instatement of Benefits. Is that the form that our claims offices complete today for a reinstatement? Is it a dual purpose forms for the Initial/First Payment and Reinstatement?

It has been a dual purpose form. We do not have a reinstatement of benefits form. The C22 paper form has a field to indicate if it is the first payment or a reinstatement. So, we will be able to indicate the same from EDI.

Reporting

EDI reporting - Is it acceptable to combine the data for carriers within a group? Or do we need to report each carrier's data separately?

A vendor is the name, FEIN, and zip of the reporter. A vendor can submit for multiple carriers. So, no you do not need to send separately for each carrier name.

SIC code

Will you accept the "SC" pad on the 5th and 6th positions?

YES

SIC/NAICS

Does the Division follow the IAIABC standard regarding DN25-SIC Code and accept 4-digit SIC codes with the "SC" suffix and accept 5- and 6-digit NAICS Codes?

Yes, the Division will accept the suffix 'SC' and will also accept NAICS codes.

Telephone number for employee.

Can Tennessee handle a default phone number? On some of the MTC's it is mandatory to have a telephone number. Some of our claimants may not have telephone numbers. How should we handle these type situations?

The field 'Employee Phone' is not required on any EDI Claims form.

Reporting

What do we do with claims that come in with a date of injury before July 1 2003?

When testing is complete with your company you may begin sending FROI on all dates of injury. You will stop sending paper and begin sending electronically. When testing is complete for SROI you may begin sending SROI for all previously filed paper first reports and all FROI reported electronically.

Testing

Will there be separate testing of FROIs and SROIs.

YES, but they can be done back to back. After completion of FROI testing you can move directly to SROI testing.

Testing

Testing Process - Is there a specific procedure to be followed when testing with the Division? Sending only certain MTCs? Sending a certain number of claims/MTCs? Separate testing of FROIs versus SROIs. Since mandate is July 1, 2003 when must testing begin to be in production by the deadline? If production is not attained by the deadline, what happens?

Testing for FROI and SROI will be separately but can be done back to back. Please see the Testing Requirements document for details.

Trading Partner Profile

As a third party administrator, Gallagher Bassett handles claims for several carriers and self-insured employers. The Trading Partner Profile seems to request that we provide a list of these carriers and self-insureds along with their FEIN. Why must we supply their Postal Code?

You do not have to provide the postal code on this form except for the postal code that will be used in the Header for transmission. We do need the FEINs and Names for all entities you will be reporting for so we can make sure they exist in our system and that the information matches. If DN8 is present then DN14 should be the postal code of the TPA.

Volunteer

Why are PTD/RE/Recoveries mandatory on VEs?

The only situation that a 'VE' would apply is for volunteer firemen that are only due medical benefits so if you file a 'VE' it should be to report medical benefits for a volunteer fireman.

Wage Fields

DN64-# of Days Worked is defined as the number of days the employee regularly works. This field can be populated in claim administrators' systems on medical only claims but Wage and Wage Period is not. Why assume that these three fields must always come together?

The Division needs all three fields to calculate the average weekly wage.

Wage Fields

DN64 is numeric, we will be sending a zero rather than a space on medical-only claims.

If #Days Worked equals '0' then Wage and Wage Period will not be required.

Wage Statement

Since EDI replaces forms C-22 and C-23, is a paper wage statement still required to be sent to the Division?

The Claims Handling Standards require the Wage Statement to be furnished to the Division.

Sequence Scenarios

1. *Scenario:* Claim is reported, 3 weeks of TTD, Benefits Suspended for Return to Work, Medicals incurred, claim is closed, no further payments are expected.

FROI Requirements:

00/AU within 15 days of date of injury or date of notification.

SROI Requirements:

IP/AP File within 15 days of date of First Payment

Payment Adjustment (Segment 2) to report TTD payments has begun.

Paid to Date (Segment 4) with all medical types and amounts paid.

S1 File within 15 days of date of suspension

Payment Adjustment (Segment 2) to report TTD payments paid to date.

Paid to Date (Segment 4) with all medical types and amounts paid.

FN File within 30 days of final payment of compensation.

Payment Adjustment (Segment 2) to show all indemnity types and amounts paid

Paid to Date (Segment 4) with all medical types and amounts paid.

The FN must include totals for all payments for the life of the claim.

2. *Scenario:* Claim is reported, 3 weeks of TTD, Benefits Suspended for Return to Work, Medicals incurred, claim was closed, additional medicals paid after FN was filed is greater than \$2500.

FROI Requirements:

00/AU within 15 days of date of injury or date of notification.

SROI Requirements:

IP/AP File within 15 days of date of First Payment

Payment Adjustment (Segment 2) to report TTD payments has begun.

Paid to Date (Segment 4) with all medical types and amounts paid.

S1 File within 15 days of date of suspension

Payment Adjustment (Segment 2) to report TTD payments paid to date.

Paid to Date (Segment 4) with all medical types and amounts paid.

FN File within 30 days of final payment of compensation.

Payment Adjustment (Segment 2) to show all indemnity types and amounts paid

Paid to Date (Segment 4) with all medical types and amounts paid.

The FN must include totals for all payments for the life of the claim.

FN File when additional medicals paid after FN was filed is greater than \$2500.

Payment Adjustment Segment should include all applicable payments for:

Paid to Date segment Adjust your totals to include the additional medical payments

All payments for the life of the claim should be reported on the replacement FN. The original FN will be overwritten by the second FN. The Division maintains one FN.

3. *Scenario:* Claim is reported, claim is denied, no medical or indemnity payments have been made.
FROI Requirements:
 04 within 10 days of date of denial.
 Employee Notification – Employee must be notified of the denial within 10 days of the denial. A copy of this notification must be mailed to the Division. The notification must contain the date of the denial and the reason for denial.
SROI Requirements:
 NO SROI is required.
4. *Scenario:* Claim is reported, indemnity payments are made, claim is denied.
FROI Requirements:
 00/AU within 15 days of date of injury or date of notification.
SROI Requirements:
 IP/AP File within 15 days of date of First Payment
Payment Adjustment (Segment 2) to report TTD payments has begun.
Paid to Date (Segment 4) with all medical types and amounts paid.
 04 File within 10 days of denial.
Payment Adjustment (Segment 2) to report TTD payments paid to date.
Paid to Date (Segment 4) with all medical types and amounts paid.
 Report all payments paid to date, then FN is not required.
 Employee Notification – Employee must be notified of the denial within 10 days of the denial. A copy of this notification must be mailed to the Division. The notification must contain the date of the denial and the reason for denial.
5. *Scenario:* Claim is reported, medical payments are made, claim is denied.
FROI Requirements:
 00/AP within 15 days of date of injury or date of notification.
SROI Requirements:
 PY *Paid to Date* (Segment 4) with all medical types and amounts paid.
 04 File within 10 days of denial.
Paid to Date (Segment 4) with all medical types and amounts paid.
 Report all payments paid to date, then FN is not required.
 Employee Notification – Employee must be notified of the denial within 10 days of the denial. A copy of this notification must be mailed to the Division. The notification must contain the date of the denial and the reason for denial.
6. *Scenario:* Claim is reported, 5 days loss time, medical payments are made, claim is closed.
FROI Requirements:
 00 within 15 days of date of injury or date of notification.
 (DN 65) Date Last Day Worked should be given.
 (DN 68) Date of Return to Work should be given.
SROI Requirements:
 PY *Paid to Date* (Segment 4) with all medical types and amounts paid.
 (DN 74) Claim Type must be present.
 FN File within 30 days of final payment of compensation.
Paid to Date (Segment 4) with all medical types and amounts paid.

7. *Scenario:* Claim is reported, 5 days loss time, no medical payments are made, claim is closed. (In house medical staff ordered the loss time)
FROI Requirements:
- 00 within 15 days of date of injury or date of notification.
(DN 65) Date Last Day Worked should be given, if known.
(DN 68) Date of Return to Work should be given, if known.
 - 01 Cancel (filed to reflect that original 00 should not have been filed because no indemnity or medical payments have been made).
8. *Scenario:* Claim is reported, indemnity payments are made, claims administrator receives wage statement, weekly compensation rate is changed, .benefits terminated for return to work, claim is closed.
FROI Requirements:
- 00/AP within 15 days of date of injury or date of notification.
- SROI Requirements:*
- IP/AP File within 15 days of date of First Payment
Payment Adjustment (Segment 2) to report TTD payments has begun.
Paid to Date (Segment 4) with all medical types and amounts paid.
 - CA within 15 days of date of change
(DN 87) will update the weekly compensation rate on file with the Division.
 - S1 File within 15 days of date of suspension
Payment Adjustment (Segment 2) to report TTD payments paid to date.
Paid to Date (Segment 4) with all medical types and amounts paid.
 - FN File within 30 days of final payment of compensation.
Payment Adjustment (Segment 2) to show all indemnity types and amounts paid
Paid to Date (Segment 4) with all medical types and amounts paid.
The FN must include totals for all payments for the life of the claim.
9. *Scenario:* Claim is reported, TTD and medicals are ongoing, claim has been open for 12 months or longer, claim is open on June 30th.
FROI Requirements:
- 00/AU within 15 days of date of injury or date of notification.
- SROI Requirements:*
- IP/AP File within 15 days of date of First Payment
Payment Adjustment (Segment 2) to report TTD payments has begun.
Paid to Date (Segment 4) with all medical types and amounts paid.
 - AN File by September 1st.
Payment Adjustment (Segment 2) to report TTD payments paid to date.
Paid to Date (Segment 4) with all medical types and amounts paid.
The AN must include totals for all payments paid to date for the claim.
10. *Scenario:* Claim is reported, TTD and medicals are ongoing, claim was opened on 7/1 and closed on the following June 28th.
FROI Requirements:
- 00/AU within 15 days of date of injury or date of notification.
- SROI Requirements:*
- IP/AP File within 15 days of date of First Payment
Payment Adjustment (Segment 2) to report TTD payments has begun.
Paid to Date (Segment 4) with all medical types and amounts paid.
 - AN The AN is not required because the claim has not been open for over 12 months.
11. *Scenario:* Claim is reported, TTD and medicals are ongoing, claim has been open for 12 months or longer, claim is open on June 30th, benefits terminated for return to work, claim is closed.

FROI Requirements:

00/AU within 15 days of date of injury or date of notification.

SROI Requirements:

IP/AP File within 15 days of date of First Payment

Payment Adjustment (Segment 2) to report TTD payments has begun.

Paid to Date (Segment 4) with all medical types and amounts paid.

AN File by September 1st.

Payment Adjustment (Segment 2) to report TTD payments paid to date.

Paid to Date (Segment 4) with all medical types and amounts paid.

The AN must include totals for all payments paid to date for the claim.

The AN must be filed each year until the claim is closed.

S1 File within 15 days of date of suspension

Payment Adjustment (Segment 2) to report TTD payments paid to date.

Paid to Date (Segment 4) with all medical types and amounts paid.

FN File within 30 days of final payment of compensation.

Payment Adjustment (Segment 2) to show all indemnity types and amounts paid

Paid to Date (Segment 4) with all medical types and amounts paid.

12. *Scenario:* Death Claim is reported, claim is compensable, dependents exist, death benefits, medicals, funeral expenses paid, claim is closed.

FROI Requirements:

00 within 15 days of date of notification.

Number of Dependents If Employee Date of Death exists, Number of Dependents is required, use '0' zero if no dependents.

Employee Date of Death Give employee date of death

SROI Requirements:

IP File within 15 days of date of First Payment

Payment Adjustment (Segment 2), Payment Code 010 to report Death Benefits have begun or to show payment made to the estate if deceased employee has no dependents.

Paid to Date (Segment 4) with applicable Payment Codes. 300 Funeral Expenses, 350 Physician Payments, 360 Hospital Costs, 370 Other Medical Costs.

Death Dependant Payee Relationship (Segment 5) Not required. If given, it must be a valid value.

FN File within 30 days of final payment of compensation.

Payment Adjustment (Segment 2) to show all indemnity types and amounts paid

Paid to Date (Segment 4) with all medical types and amounts paid.

The FN must include totals for all payments for the life of the claim.

13. *Scenario:* Death Claim is reported, claim is compensable, deceased employee has no dependents, death benefits paid to estate, medicals, funeral expenses paid, claim is closed.

FROI Requirements:

00 within 15 days of date of injury or date of notification.

Number of Dependents If Employee Date of Death exists, Number of Dependents is required, use '0' zero if no dependents.

Employee Date of Death Give employee date of death

SROI Requirements:

IP File within 15 days of date of payment to the estate.

Payment Adjustment (Segment 2), Payment Code 010 to report Death Benefits have begun (in this case it will be to report the death benefit paid to the estate of the deceased employee).

Paid to Date (Segment 4) with applicable Payment Codes. 300 Funeral Expenses, 350 Physician Payments, 360 Hospital Costs, 370 Other Medical Costs.

Death Dependant Payee Relationship (Segment 5) Not required. If given, it must be a valid value.

- CD This form is not required. File the MTC IP. File this form if deceased employee has no dependents. The CD will be accepted without any of the 5 segments being present.
- FN File within 30 days of final payment of compensation.
Payment Adjustment (Segment 2) to show all indemnity types and amounts paid
Paid to Date (Segment 4) with all medical types and amounts paid.
 The FN must include totals for all payments for the life of the claim.
14. *Scenario:* Claim is reported, claim is compensable, employer is paying Full Salary, then employer stops FS and carrier starts indemnity payment, claim is closed.
FROI Requirements:
 00/AU within 15 days of date of injury or date of notification.
SROI Requirements:
- FS File within 15 days of date of first payment made by employer.
Payment Adjustment (Segment 2), Payment Code 240 Employer Paid, to report payments made by Employer.
Paid to Date (Segment 4) with applicable Payment Codes. 300 Funeral Expenses, 350 Physician Payments, 360 Hospital Costs, 370 Other Medical Costs.
- CB *Payment Adjustment* (Segment 2), Payment Code 050 for TTD, 070 for TPD, etc.
- FN File within 30 days of final payment of compensation.
Payment Adjustment (Segment 2) to show all indemnity types and amounts paid
Paid to Date (Segment 4) with all medical types and amounts paid.
 The FN must include totals for all payments for the life of the claim.
15. *Scenario:* Claim is reported, claim is compensable, employer is paying Full Salary, payments are suspended, carrier begins making TTD payments.
FROI Requirements:
 00/AU within 15 days of date of injury or date of notification.
SROI Requirements:
- FS File within 15 days of date of first payment made by employer.
Payment Adjustment (Segment 2), Payment Code 240 Employer Paid, to report payments made by Employer.
Paid to Date (Segment 4) with applicable Payment Codes. 300 Funeral Expenses, 350 Physician Payments, 360 Hospital Costs, 370 Other Medical Costs.
- S1 File within 15 days of date of suspension
Payment Adjustment (Segment 2) to report TTD payments paid to date.
Paid to Date (Segment 4) with all medical types and amounts paid.
- IP File within 15 days of date of payment to the estate.
Payment Adjustment (Segment 2), Payment Code 010 to report Death Benefits have begun (in this case it will be to report the death benefit paid to the estate of the deceased employee).
Paid to Date (Segment 4) with applicable Payment Codes. 300 Funeral Expenses, 350 Physician Payments, 360 Hospital Costs, 370 Other Medical Costs.
Death Dependant Payee Relationship (Segment 5) Not required. If given, it must be a valid value.
16. *Scenario:* Claim is reported, claim is compensable, medical benefits are paid, no indemnity payments made, permanent partial benefits are awarded or lump sum is paid.
FROI Requirements:
 00/AU within 15 days of date of injury or date of notification.
SROI Requirements:
- PY *Paid to Date* (Segment 4) with all medical types and amounts paid.
 (DN 74) Claim Type must be present.
- SD1 SD1 is a paper form that is reported by the attorney or the adjuster and is required to be presented at the time of settlement. The SD1 is required in all cases of permanent

disability. The FN is required for all medical only claims and for all claims that do NOT result in permanent disability.

Court Order The court order/settlement papers must also be filed with the division.

Note: The SD1 and Court Order/settlement papers will most likely be filed by your legal staff.