NEW YORK STATE INSURANCE FUND
ELECTRONIC RECEIPT OF FIRST REPORT OF INJURY
PROJECT PLAN

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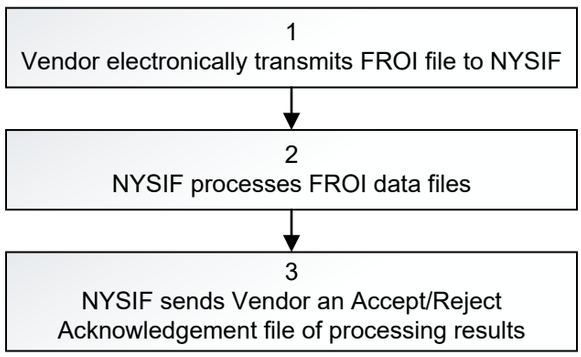
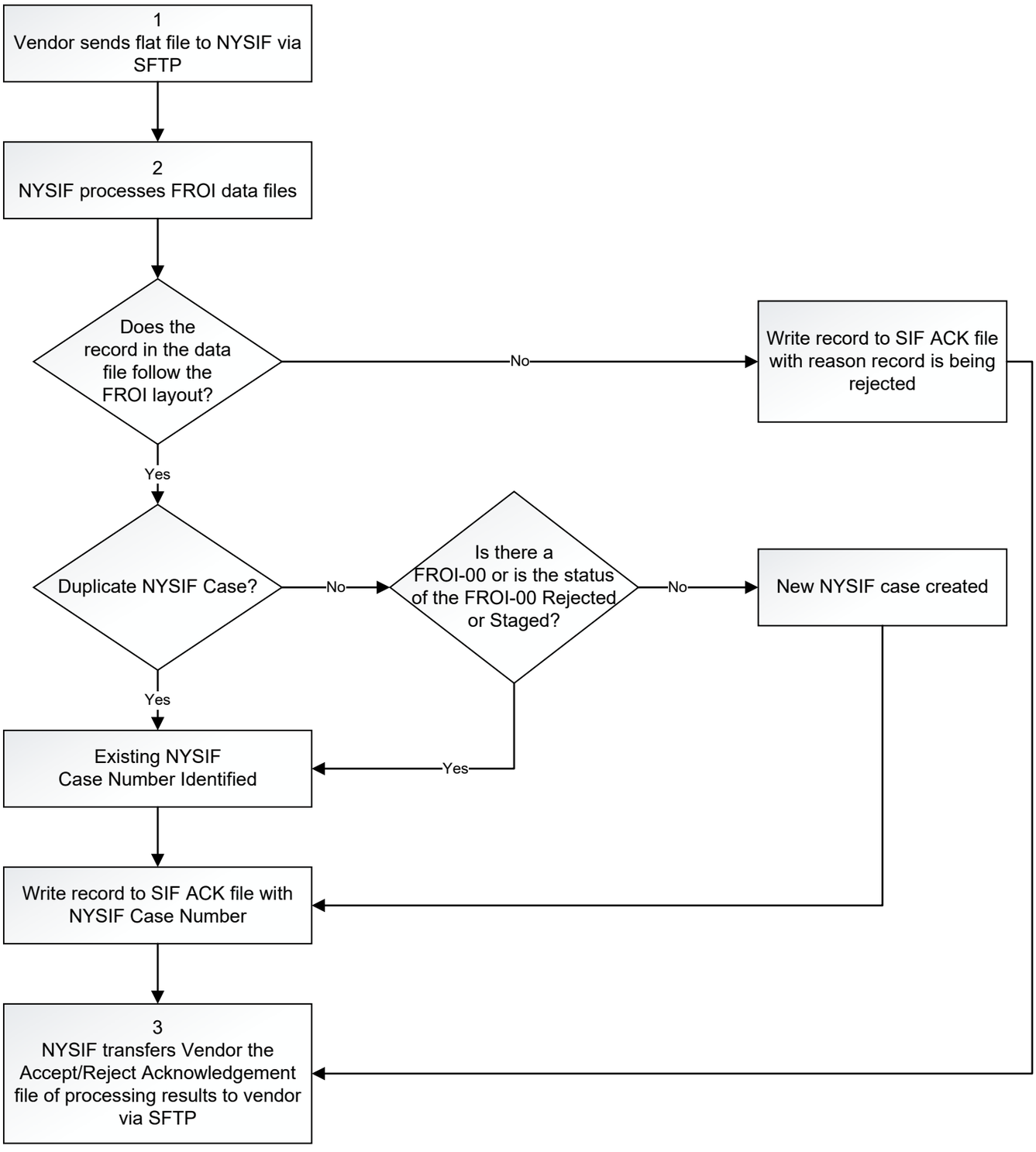
NYSIF/Vendor Electronic Submission of FROI High Level Process



Detailed FROI EDI File Processing



ATTACHMENT 5
FROI EDI SYSTEM FILE LAYOUT

Technical Specifications for Vendor FROI EDI Process

Purpose:

This process will ensure that the vendor electronically submits to NYSIF only those First Report of Injury data that are in accordance with the defined NYSIF business rules for electronic Data Exchange.

The vendor shall:

- Create a FROI data file for any received First Report of Injury with FROI File layout
- Name the FROI data file using the FROI File Naming Convention as defined below
- Encrypt FROI file using an agreed upon encryption methodology
- Transmit the FROI file via SFTP
- Transmit the FROI file daily, every hour, at a to be determined time
- Send an empty data file with no FROI data when there are no FROI to process for that hour

NYSIF shall:

- Reject the entire file back to vendor if the file is not valid
- Process the FROI file in accordance with NYSIF business rules
- Create an acknowledgement file (Accept/Reject Report) indicating the results of processing the vendor FROI file
- Encrypt the Accept/Reject Report file using an agreed upon encryption methodology
- Transmit the Accept/Reject Report file via SFTP
- Transmit Accept/Reject Report file daily, every hour, at a to be determined time
- If NYSIF receives an empty data file with no FROI data, no ACK file will be sent back for that hour

Vendor FROI Data File Naming Convention

<VENDORNAME>_<YYYYMMDD>_FROI_<YYYYMMDDHIMMSS>_<FILENUM>.TXT

Sample: VENDORNAME_20210714_FROI_20210714070101_01.TXT

Name	Type & Length	Description
Vendor Name	Char(10)	<VENDOR_NAME>
8 Digit Date	Char(8)	YYYYMMDD - Date of FROI txt file creation and submission
Constant - FROI	Char(5)	FROI
Date and Timestamp	Char(14)	YYYYMMDDHHMMSS - Timestamp of the FROI file submission
File Number or Unique Number	Char(2)	Sequence number of file
Extension	Char	.TXT

FROI File Layout - HEADER

Rec	*DN*	*Data Element Name*	*Format*	*Length*	*Beg*	*End*	*Notes*	*Req.*	*Conditionally Required Fields*
Header Record									
	0001	Transaction Set ID	A/N	3	1	3	Fixed value:"HD1"		
	0098	Sender ID	A/N	25	4	28			
		Sender FEIN	A/N	9	4	12	Fixed value:"146013200"		
		Filler - Future Defined Usage	A/N	7	13	19			
		Sender Postal Code	A/N	9	20	28	Fixed value:"12201"		
	0099	Receiver ID	A/N	25	29	53			
		Receiver FEIN	A/N	9	29	37	Fixed value:"146013200"		
		Filler - Future Defined Usage	A/N	7	38	44			
		Sender Postal Code	A/N	9	45	53	Fixed value:"100071100"		
	0100	Date Transmission Sent	DATE	8	54	61			
	0101	Time Transmission Sent	TIME	6	62	67			
	0102	Original Transmission Date	DATE	8	68	75			
	0103	Original Transmission Time	TIME	6	76	81			
	0104	Test/Production Code	A/N	1	82	82	P for Production or T for Test		
	0105	Interchange Version ID	A/N	5	83	87			
		Batch Type Code	A/N	3	83	85			
		Release Number	A/N	1	86	86	1		
		Version Number	A/N	1	87	87	1		

Sample Header Line:

HD1146013200 12201 146013200 10007110012172025110041121720251100 41P1234512311

FROI File Layout - DETAIL

Detail Record - 148 Data Elements									
148	0001	Transaction Set ID	A/N	3	1	3	148	F	
148	0002	Maintenance Type Code	A/N	2	4	5	00	F	
148	0003	Maintenance Type Code Date	DATE	8	6	13	Date report sent to carrier (NYSIF)	F	
148	0004	Jurisdiction Code	A/N	2	14	15		F	
148	0005	Jurisdiction Claim Number	A/N	25	16	40		IA	
148	0006	Insurer FEIN	A/N	9	41	49	146013200	F	
148	n/a	Vendor Unique Claim Number	A/N	25	50	74	Vendor Unique Claim Number	M	

Rec	DN	Data Element Name	Format	Length	Beg	End	Notes	Req.	Conditionally Required Fields
Detail Record - 148 Data Elements Continued									
148	n/a	Filler (Not for Use)	A/N	104	75	178	Leave blank		
148	0012	Claim Administrator City	A/N	15	179	193	New York City	M	
148	0013	Claim Administrator State Code	A/N	2	194	195	NY	M	
148	0014	Claim Administrator Postal Code	A/N	9	196	204	100071100	F	
148	0015	Claim Administrator Claim Number	A/N	25	205	229	Leave blank (NYSIF will set value on their side)	F	
148	0016	Employer FEIN	A/N	9	230	238		MC	
148	n/a	Filler (Not for Use)	A/N	120	239	358	Leave blank		
148	0021	Employer Physical City	A/N	15	359	373		MC	
148	0022	Employer Physical State Code	A/N	2	374	375		MC	
148	0023	Employer Physical Postal Code	A/N	9	376	384		MC	
148	n/a	Filler (Not for Use)	A/N	1	385	385	Leave blank		
148	0025	Industry Code	A/N	6	386	391	NAIC code	MC	
148	n/a	Filler (Not for Use)	A/N	10	392	401	Leave blank		
148	0027	Insured Location Identifier	A/N	15	402	416		IA	
148	0028	Policy Number Identifier	A/N	18	417	434		M	
148	n/a	Filler (Not for Use)	A/N	12	435	446	Leave blank		
148	0029	Policy Effective Date	DATE	8	447	454		IA	
148	0030	Policy Expiration Date	DATE	8	455	462		IA	
148	0031	Date of Injury	DATE	8	463	470		M	
148	0032	Time of Injury	TIME	4	471	474		IA	
148	0033	Accident Site Postal Code	A/N	9	475	483		MC	
148	n/a	Filler (Not for Use)	A/N	1	484	484	Leave blank		
148	0035	Nature of Injury Code	A/N	4	485	488	Refer to the NCCI Code	MC	
148	n/a	Filler (Not for Use)	A/N	4	489	492	Leave blank		
148	0037	Cause of Injury Code	A/N	4	493	496	Refer to the NCCI Code	MC	
148	n/a	Filler (Not for Use)	A/N	150	497	646	Leave blank		
148	0039	Initial Treatment Code	A/N	2	647	648	0, 1, 2, 3, 4, 5 (Quick Code Ref. List)	MC	
148	0040	Date Employer Had Knowledge of the Injury	DATE	8	649	656		M	
148	0041	Date Claim Administrator Had Knowledge of the Injury	DATE	8	657	664	Date report sent to carrier (NYSIF)	M	
148	0042	Employee SSN	N	9	665	673		IA	
148	n/a	Filler (Not for Use)	A/N	30	674	703	Leave blank		
148	0044	Employee First Name	A/N	30	704	733		M	
148	n/a	Filler (Not for Use)	A/N	61	734	794	Leave blank		
148	0048	Employee Mailing City	A/N	20	795	814		M	
148	0049	Employee Mailing State Code	A/N	2	815	816		MC	
148	0050	Employee Mailing Postal Code	A/N	9	817	825		M	
148	n/a	Filler (Not for Use)	A/N	10	826	835	Leave blank		
148	0052	Employee Date of Birth	DATE	8	836	843	YYYYMMDD format	MC	
148	0053	Employee Gender Code	A/N	1	844	844	F - Female, M - Male, U - Unknown, X - Nonbinary/Unspecified	M	
148	0054	Employee Marital Status Code	A/N	1	845	845	Leave blank	NA	
148	0055	Employee Number of Dependents	N	2	846	847	Leave blank	IA	
148	0056	Initial Date Disability Began	DATE	8	848	855		MC	
148	0057	Employee Date of Death	DATE	8	856	863		MC	
148	0058	Employment Status Code	A/N	2	864	865	1, 2, 7, 8, 9 (Quick Code Ref. List)	MC	
148	0059	Manual Classification Code	A/N	4	866	869		M	
148	n/a	Filler (Not for Use)	A/N	30	870	899	Leave blank		
148	0061	Employee Date of Hire	DATE	8	900	907	YYYYMMDD format	IA	
148	0062	Wage	$9.20	11	908	918	Average Weekly Wage (without $ or decimal)	MC	
148	0063	Wage Period Code	A/N	2	919	920	01 = Weekly	MC	
148	0064	Number of Days Worked Per Week	N	1	921	921		IA	
148	0065	Initial Date Last Day Worked	DATE	8	922	929	Disability Begin Date	IA	

ATTACHMENT 5
FROI EDI SYSTEM FILE LAYOUT

Rec	DN	Data Element Name	Format	Length	Beg	End	Notes	Req.	Conditionally Required Fields
Detail Record - 148 Data Elements Continued									
148	0066	Full Wages Paid for Date of Injury Indicator	A/N	1	930	930	"Y" or "N"	MC	
148	n/a	Filler (Not for Use)	A/N	1	931	931	Leave blank		
148	0068	Initial Return to Work Date	DATE	8	932	939	YYYYMMDD format	MC	
		End 148 Elements							
Detail Record - R21 Data Elements									
R21	0001	Transaction Set ID	A/N	3	1	3	R21	F	
R21	0295	Maintenance Type Correction Code	A/N	2	4	5	00	X	
R21	0296	Maintenance Type Correction Code Date	DATE	8	6	13	Date report sent to carrier (NYSIF)	X	
R21	n/a	Filler - Future Defined Usage	A/N	8	14	21	Leave blank		
R21	0186	Jurisdiction Branch Office Code	A/N	2	22	23	Leave blank	NA	
R21	0015	Claim Administrator Claim Number	A/N	25	24	48	Vendor Unique Claim Number	F	
R21	0187	Claim Administrator FEIN	A/N	9	49	57	146013200	F	
R21	0188	Claim Administrator Name	A/N	40	58	97	New York State Insurance Fund	M	
R21	0135	Claim Administrator Information/ Attention Line	A/N	50	98	147	Leave blank	IA	
R21	0010	Claim Administrator Primary Address	A/N	40	148	187	199 Church St	M	
R21	0011	Claim Administrator Secondary Address	A/N	40	188	227	Leave blank	IA	
R21	0136	Claim Administrator Country Code	A/N	3	228	230	USA	MC	
R21	0270	Employee ID Type Qualifier	A/N	1	231	231	S	M	
R21	*	Employee ID	A/N	15	232	246	Employee SSN (send 000000000 if unknown)	M	
R21	0255	Employee Last Name Suffix	A/N	4	247	250	Leave blank	IA	
R21	0150	Employee Authorization to Release Medical Records	A/N	1	251	251	Leave blank	NA	
R21	0157	Employee Social Security Number Release Indicator	A/N	1	252	252	Leave blank	NA	
R21	0043	Employee Last Name	A/N	40	253	292	Claimant Last Name	M	
R21	0045	Employee Middle Name/Initial	A/N	15	293	307	Claimant Middle Initial	IA	
R21	0046	Employee Mailing Primary Address	A/N	40	308	347	Claimant Addr Line1	M	
R21	0047	Employee Mailing Secondary Address	A/N	40	348	387	Claimant Addr Line2	IA	
R21	0155	Employee Mailing Country Code	A/N	3	388	390	Claimant Country Code	MC	
R21	0051	Employee Phone Number	A/N	15	391	405	Claimant Phone Number	IA	
R21	0146	Death Result of Injury Code	A/N	1	406	406		MC	
R21	0290	Type of Loss Code	A/N	2	407	408	01, 02, 03 (Quick Code Ref. List)	MC	
R21	0228	Return To Work With Same Employer Indicator	A/N	1	409	409	Y - Yes, N - No, U - Unknown	MC	
R21	0189	Return To Work Type Code	A/N	1	410	410	If the return to work date (DN 68) is not blank set this field to "A" for Actual otherwise leave blank.	MC	Required if DN 68 Initial Return to Work Date is present
R21	0224	Physical Restrictions Indicator	A/N	1	411	411	Y - Yes, N - No, U - Unknown	MC	Required if DN 68 Initial Return to Work Date is present
R21	0314	Insured FEIN	A/N	9	412	420		MC	
R21	0017	Insured Name	A/N	40	421	460		MC	
R21	0184	Insured Type Code	A/N	1	461	461		MC	
R21	0026	Insured Report Number	A/N	25	462	486	Leave blank	NA	
R21	0204	Work Week Type Code	A/N	1	487	487	S, F or V		
R21	0205	Work Days Scheduled Code	A/N	7	488	494	SSSSSNN (S: Scheduled, N: Not Scheduled)	MC	
R21	n/a	Filler - Future Defined Usage	A/N	1	495	495	Leave blank		
R21	0007	Insurer Name	A/N	40	496	535	New York State Insurance Fund	M	
R21	0185	Insurer Type Code	A/N	1	536	536		IA	
R21	0292	Insolvent Insurer FEIN	A/N	9	537	545	Leave blank	NA	
R21	0200	Claim Administrator Alternate Postal Code	A/N	9	546	554	100071100	M	

Rec	DN	Data Element Name	Format	Length	Beg	End	Notes	Req.	Conditionally Required Fields
Detail Record - R21 Data Elements (Continued)									
R21	n/a	Filler - Future Defined Usage	A/N	23	555	577	Leave blank		
R21	0249	Accident Premises Code	A/N	1	578	578	E, L, X (Quick Code Ref. List)	MC	
R21	0118	Accident Site County/Parish	A/N	30	579	608		MC	
R21	0119	Accident Site Location Narrative	A/N	50	609	658		MC	
R21	0120	Accident Site Organization Name	A/N	50	659	708		MC	
R21	0121	Accident Site City	A/N	15	709	723		MC	
R21	0122	Accident Site Street	A/N	40	724	763		MC	
R21	0123	Accident Site State Code	A/N	2	764	765		MC	
R21	0280	Accident Site Country Code	A/N	3	766	768		MC	
R21	0281	Date Employer Had Knowledge of Date of Disability	DATE	8	769	776		MC	
R21	n/a	Filler - Future Defined Usage	A/N	1	777	777	Leave blank		
R21	0018	Employer Name	A/N	40	778	817		M	
R21	0329	Employer UI Number	A/N	15	818	832		IA	
R21	0019	Employer Physical Primary Address	A/N	40	833	872	Employer Location Addr Line1	MC	
R21	0020	Employer Physical Secondary Address	A/N	40	873	912	Employer Location Addr Line2	IA	
R21	0164	Employer Physical Country Code	A/N	3	913	915	Employer Location Country Code	MC	
R21	0159	Employer Contact Business Phone Number	A/N	15	916	930	Employer Phone Number	MC	
R21	0160	Employer Contact Name	A/N	40	931	970	Prepared by Name	MC	
R21	n/a	Filler - Future Defined Usage	A/N	90	971	1060	Leave blank		
R21	0163	Employer Mailing Information/Attention Line	A/N	50	1061	1110		IA	
R21	0165	Employer Mailing City	A/N	15	1111	1125		M	
R21	0166	Employer Mailing Country Code	A/N	3	1126	1128		MC	
R21	0167	Employer Mailing Postal Code	A/N	9	1129	1137		M	
R21	0168	Employer Mailing Primary Address	A/N	40	1138	1177	Employer Mailing Addr Line1	M	
R21	0169	Employer Mailing Secondary Address	A/N	40	1178	1217	Employer Mailing Addr Line2	IA	
R21	0170	Employer Mailing State Code	A/N	2	1218	1219		M	
R21	n/a	Filler - Future Defined Usage	A/N	50	1220	1269	Leave blank		
R21	0060	Occupation Description	A/N	50	1270	1319		M	
R21	0199	Full Denial Effective Date	DATE	8	1320	1327	Leave blank	X	
R21	n/a	Filler - Future Defined Usage	A/N	163	1328	1490	Leave blank		
R21	0073	Claim Status Code	A/N	1	1491	1491	Leave blank	NA	
R21	0074	Claim Type Code	A/N	1	1492	1492	Leave blank (NYSIF will set value on their side)	M	
R21	0077	Late Reason Code	A/N	2	1493	1494		IA	
R21	0273	Employer Paid Salary in Lieu of Compensation Indicator	A/N	1	1495	1495		IA	
R21	n/a	Filler - Future Defined Usage	A/N	105	1496	1600	Leave blank		
		Variable Segment Counters							
R21	0274	Number of Accident/Injury Description Narratives	N	2	1601	1602		F	
R21	0277	Number of Full Denial Reason Codes	N	2	1603	1604		F	
R21	0276	Number of Denial Reason Narratives	N	2	1605	1606		F	
R21	0278	Number of Managed Care Organizations	N	2	1607	1608		F	
R21	0279	Number of Witnesses	N	2	1609	1610		F	
		NYSIF Required Fields							
R21	n/a	Filler - Future Defined Usage	A/N	8	1611	1618	Leave blank		
R21	n/a	Insurance Agent Last Name	A/N	30	1619	1648	Leave blank	IA	

Rec	DN	Data Element Name	Format	Length	Beg	End	Notes	Req.	Conditionally Required Fields
Detail Record - R21 Data Elements (Continued)									
NYSIF Required Fields (Continued)									
R21	n/a	Insurance Agent First Name	A/N	30	1649	1678	Leave blank	MC	Required if Insurance Agent Last Name is not blank
R21	n/a	Insurance Agent Phone Number	A/N	15	1679	1693	Leave blank	MC	Required if Insurance Agent Last Name is not blank
R21	n/a	Time Employee Began Work	N	4	1694	1697		IA	
R21	n/a	Time Began Work AM	N	1	1698	1698		IA	
R21	n/a	Time Began Work PM	N	1	1699	1699		IA	
R21	n/a	Oral Notice Given	A/N	1	1700	1700		IA	
R21	n/a	Written Notice Given	A/N	1	1701	1701		IA	
R21	n/a	Gave Claimant Info Packet Yes	A/N	1	1702	1702		IA	
R21	n/a	Gave Claimant Info Packet No	A/N	1	1703	1703		IA	
R21	n/a	Date Gave Claimant Info Packet	N	8	1704	1711		IA	
R21	n/a	Supervisor Witness Yes	A/N	1	1712	1712		M	One of these is required to be set
R21	n/a	Supervisor Witness No	A/N	1	1713	1713		M	
R21	n/a	Supervisor Witness Unknown	A/N	1	1714	1714		M	
R21	n/a	Witness to Injury Yes	A/N	1	1715	1715		M	One of these is required to be set
R21	n/a	Witness to Injury No	A/N	1	1716	1716			
R21	n/a	Witness to Injury Unknown	A/N	1	1717	1717			
R21	n/a	Object Involved Yes	A/N	1	1718	1718		M	One of these is required to be set
R21	n/a	Object Involved No	A/N	1	1719	1719			
R21	n/a	Object Involved	A/N	50	1720	1769		IA	If Object Involved Yes = Y then this field is required
R21	n/a	Injury Result of Motor Vehicle Yes	A	1	1770	1770		M	One of these is required to be set
R21	n/a	Injury Result of Motor Vehicle No	A	1	1771	1771			
R21	n/a	Vehicle Owned By Employee	A	1	1772	1772		MC	One of these is required if Injury-Result of Motor Vehicle Yes = "Y"
R21	n/a	Vehicle Owned By Employer	A	1	1773	1773		MC	
R21	n/a	Vehicle Owned By Other	A	1	1774	1774		MC	
R21	n/a	Vehicle License Plate Number	A/N	12	1775	1786		IA	
R21	n/a	Auto Ins Carrier Name	A/N	30	1787	1816		IA	
R21	n/a	Auto Ins Carrier Addr1	A/N	30	1817	1846		IA	
R21	n/a	Auto Ins Carrier Addr2	A/N	30	1847	1876		IA	
R21	n/a	Auto Ins Carrier City	A/N	20	1877	1896		IA	
R21	n/a	Auto Ins Carrier State	A/N	2	1897	1898		IA	
R21	n/a	Auto Ins Carrier Zip	A/N	9	1899	1907		IA	
R21	n/a	Auto Ins Carrier Country	A/N	3	1908	1910		IA	
R21	n/a	Nearest Relative Last Name	A/N	30	1911	1940		IA	
R21	n/a	Nearest Relative First Name	A/N	30	1941	1970		IA	
R21	n/a	Nearest Relative Mail Addr 1	A/N	30	1971	2000		IA	
R21	n/a	Nearest Relative Mail Addr 2	A/N	30	2001	2030		IA	
R21	n/a	Nearest Relative Mail City	A/N	20	2031	2050		IA	
R21	n/a	Nearest Relative Mail State	A/N	2	2051	2052		IA	
R21	n/a	Nearest Relative Mail Zip	A/N	9	2053	2061		IA	
R21	n/a	Nearest Relative Mail Country	A/N	3	2062	2064		IA	
R21	n/a	Treated By Name	A/N	60	2065	2124		IA	
R21	n/a	Treated At Place	A/N	60	2125	2184		IA	
R21	n/a	Treatment Continuing Yes	A/N	1	2185	2185		MC	If Treated By Name or Treated at Place provided, one of these fields is required
R21	n/a	Treatment Continuing No	A/N	1	2186	2186		MC	
R21	n/a	Treatment Continuing Unknown	A/N	1	2187	2187		MC	
R21	n/a	Doctor Last Name	A/N	30	2188	2217		IA	

Rec	DN	Data Element Name	Format	Length	Beg	End	Notes	Req.	Conditionally Required Fields
Detail Record - R21 Data Elements (Continued)									
		NYSIF Required Fields (Continued)							
R21	n/a	Doctor First Name	A/N	30	2218	2247		IA	
R21	n/a	Doc mail Addr1	A/N	30	2248	2277		IA	
R21	n/a	Doc mail Addr2	A/N	30	2278	2307		IA	
R21	n/a	Doc mail City	A/N	20	2308	2327		IA	
R21	n/a	Doc mail State	A/N	2	2328	2329		IA	
R21	n/a	Doc mail Zip	A/N	9	2330	2338		IA	
R21	n/a	Doc mail Country	A/N	3	2339	2341		IA	
R21	n/a	Doctor2 Last Name	A/N	30	2342	2371		IA	
R21	n/a	Doctor2 First Name	A/N	30	2372	2401		IA	
R21	n/a	Doc2 mail Addr1	A/N	30	2402	2431		IA	
R21	n/a	Doc2 mail Addr2	A/N	30	2432	2461		IA	
R21	n/a	Doc2 mail City	A/N	20	2462	2481		IA	
R21	n/a	Doc2 mail State	A/N	2	2482	2483		IA	
R21	n/a	Doc2 mail Zip	A/N	9	2484	2492		IA	
R21	n/a	Doc2 mail Country	A/N	3	2493	2495		IA	
R21	n/a	Doctor3 Last Name	A/N	30	2496	2525		IA	
R21	n/a	Doctor3 First Name	A/N	30	2526	2555		IA	
R21	n/a	Doc3 mail Addr1	A/N	30	2556	2585		IA	
R21	n/a	Doc3 mail Addr2	A/N	30	2586	2615		IA	
R21	n/a	Doc3 mail City	A/N	20	2616	2635		IA	
R21	n/a	Doc3 mail State	A/N	2	2636	2637		IA	
R21	n/a	Doc3 mail Zip	A/N	9	2638	2646		IA	
R21	n/a	Doc3 mail Country	A/N	3	2647	2649		IA	
R21	n/a	Previous Injury Illness Yes	A/N	1	2650	2650		M	One of these is required to be set
R21	n/a	Previous Injury Illness No	A/N	1	2651	2651			
R21	n/a	Previous Injury Treated by Doctor Info	A/N	200	2652	2851		IA	
R21	n/a	Return to work Gross Pay	N	9	2852	2860		IA	
R21	n/a	Activity Other Description	A/N	200	2861	3060		IA	
R21	n/a	Addition to Pay Yes	A/N	1	3061	3061		M	One of these is required to be set
R21	n/a	Addition to Pay No	A/N	1	3062	3062			
R21	n/a	Addition to Pay Description	A/N	100	3063	3162		IA	If Addition To Pay Yes is set, then this is required
R21	n/a	Affirmation	A/N	1	3163	3163		M	One is these is required to be provided
R21	n/a	Prepared by Last Name	A/N	30	3164	3193		IA	
R21	n/a	Prepared by First Name	A/N	30	3194	3223		IA	
R21	n/a	Prepared by Middle Initial	A/N	1	3224	3224		IA	
R21	n/a	Prepared by Date	N	8	3225	3232		IA	
R21	n/a	Prepared by Title	A/N	30	3233	3262		IA	
R21	n/a	Preparer Phone Number	A/N	15	3263	3277		MC	Required if Prepared By Last Name is completed.
R21	n/a	Third Party Contact Last Name	A/N	30	3278	3307		IA	One of these is required to be provided
R21	n/a	Third Party Contact First Name	A/N	30	3308	3337		IA	
R21	n/a	Third Party Contact Middle Initial	A/N	1	3338	3338		IA	
R21	n/a	Third Party Contact Date	N	8	3339	3346		IA	
R21	n/a	Third Party Contact Title	A/N	30	3347	3376		IA	
R21	n/a	Third Party Contact Phone Number	A/N	15	3377	3391		MC	Required if Third Party Last Name is completed.
R21	n/a	Third Party Company Name	A/N	30	3392	3421		MC	Required if Third Party Last Name is completed.

Rec	DN	Data Element Name	Format	Length	Beg	End	Notes	Req.	Conditionally Required Fields
Detail Record - R21 Data Elements (Continued)									
NYSIF Required Fields (Continued)					1	0			
R21	n/a	Third Party Company Addr1	A/N	30	3422	3451		MC	Required if Third Party Last Name is completed.
R21	n/a	Third Party Company Addr2	A/N	30	3452	3481		IA	
R21	n/a	Third Party Company City	A/N	20	3482	3501		MC	Required if Third Party Last Name is completed.
R21	n/a	Third Party Company State	A/N	2	3502	3503		MC	Required if Third Party Last Name is completed and the country is USA.
R21	n/a	Third Party Company Zip	A/N	9	3504	3512		MC	If Third-Party-Last-Name is completed, required for US and Canada
R21	n/a	Third Party Company Country	A/N	3	3513	3515		MC	Required if Third Party Last Name is completed
R21	n/a	Provider Of Form Info Last Name	A/N	30	3516	3545		IA	
R21	n/a	Provider Of Form Info First Name	A/N	30	3546	3575		IA	
R21	n/a	Date Stamp	A/N	8	3576	3583		M	
R21	n/a	Time Stamp	N	4	3584	3587		M	
R21	n/a	User ID	A/N	40	3588	3627			
R21	n/a	Benefit Unit	A/N	2	3628	3629			
R21	n/a	Employee Entity Number	N	5	3630	3634		NA	
R21	n/a	Claimant Mail Addr 1	A/N	30	3635	3664			
R21	n/a	Claimant Mail Addr 2	A/N	30	3665	3694			
R21	n/a	Claimant Mail City	A/N	20	3695	3714			
R21	n/a	Claimant Mail State	A/N	2	3715	3716			
R21	n/a	Claimant Mail Zip	N	9	3717	3725			
R21	n/a	Seasonal Worker Indicator	A/N	1	3726	3726			
R21	n/a	Multiple Body parts Indicator	A/N	1	3727	3727			
R21	n/a	Still Hospitalized	A/N	1	3728	3728			
R21	n/a	Claimant Mail Country	A/N	3	3729	3731			
R21	n/a	Date Employee Removed from Payroll	N	8	3732	3739			
R21	n/a	Employee Disputes Claim	A/N	1	3740	3740			
R21	n/a	Benefit Plan	A/N	3	3741	3743			
R21	n/a	Benefit Plan Description	A/N	13	3744	3756			
R21	n/a	Employee lose more than one week of work	A/N	1	3757	3757	Employee lost more than or is anticipated to lose more than one week of work	MC	Based on lost time = Yes
R21	n/a	Filler - Future Defined Usage	A/N	200	3758	3957	Leave blank		
R21	n/a	Filler - Future Defined Usage	A/N	200	3958	4157	Leave blank		
R21	n/a	Parts-Body	A/N	400	4158	4557	At least one body part to report.	M	
R21	n/a	Filler - Future Defined Usage	A/N	9	4558	4566	Leave blank		
Variable Segments					4558	4557			
Accident/Injury Description Narratives Occur Number of Accident/Injury Description Narratives Times			*Occ 10*		4558	4557			
R21	0038	Accident/Injury Description Narrative	A/N	500	4567	5066		M	
Full Denial Reason Codes Occur Number of Full Denial Reason Codes Times			*Occ 5*		5067	5066			
R21	0198	Full Denial Reason Code	A/N	10	5067	5076		X	
Denial Reason Narratives Occur Number of Denial Reason Narratives Times			*Occ 3*		5077	5076			
R21	0197	Denial Reason Narrative	A/N	150	5077	5226		X	

Rec	DN	Data Element Name	Format	Length	Beg	End	Notes	Req.	Conditionally Required Fields
Detail Record - R21 Data Elements (Continued)									
Variable Segments Continued					5077	5076			
Managed Care Organizations Occur Number of Managed Care Organizations Times			*Occ 2*		5227	5226			
R21	0207	Managed Care Organization Code	A/N	4	5227	5230		IA	
R21	0209	Managed Care Organization Name	A/N	80	5231	5310		NA	
R21	0208	Managed Care Organization Identification Number	A/N	18	5311	5328	Leave blank	MC	
R21	n/a	Filler - Future Defined Usage	A/N	40	5329	5368			
Witnesses Occur Number of Witnesses Times			***Occ 5***		**5369**	**5368**			
R21	0238	Witness Name	A/N	200	5369	5568		IA	
R21	0237	Witness Business Phone Number	A/N	75	5569	5643		IA	
R21	n/a	Filler - Future Defined Usage	A/N	100	5644	5743	Leave blank		
End R21 Elements									

FROI File Layout - FOOTER

Footer Record									
	0001	Transaction Set ID	A/N	3	1	3	Fixed value:"TR2"		
	0106	Detail Record Count	N	9	4	12			
	0191	Transaction Count	N	9	13	21			

Sample Footer Line:
TR20000000002000000001

Legend:

F (Fatal)	IA (if Applicable)	X (Exclude)
M (Mandatory)	AA (If Applicable/Available Transaction Accepted)	
MC (Mandatory/Conditional)	AE (If Applicable/Available Transaction Accepted with Errors)	
E (Expected)	AR (If Applicable/Available Transaction Rejected)	
EC (Expected/Conditional)	AR (If Applicable/Available Transaction Rejected)	
IA (if Applicable)	NA (Not Applicable)	

Technical Specifications for NYSIF Accept/Reject Report File Layout

Purpose:

The purpose of the SIF ACK (Acknowledgment) Process is to let the vendor know that data sent by vendor is accepted or rejected by NYSIF.

NYSIF shall:

- Create a report of the accepted/rejected cases based on the business rules defined by the NYSIF Claims Department for every FROI file sent by the Vendor
- The Accept/Reject Report file will contain the vendor unique claim number and NYSIF unique number
- Create an acknowledgement file with the Accept/Reject Report results in CSV format
- Create the CSV file using the below Accept/Reject Report file layout format
- Name the CSV file using the below Accept/Reject Report File Naming Convention format

Vendor shall:

- For any cases that are rejected by NYSIF, Vendor must gather missing or incorrect data and resend corrected data in a subsequent file

Accept/Reject Report File Naming Convention

<VENDORNAME>_<YYYYMMDD>_FROI_<YYYYMMDDHIMMSS>_ACK_SIF.CSV
Sample File Name: <VendorName>_20210721_FROI_20210721090101_ACK_SIF.csv

Field Name	Type & Length	Null	Description/Example
Vendor Name	Char(10)	Not Null	Vendor name
8 Digit Date	Char(8)	Not Null	YYYYMMDD
Constant - FROI	Char(5)	Not Null	FROI
Timestamp Digit Date	Char(14)	Not Null	Timestamp of the ACK file
Constant – ACK_SIF	Char(6)	Not Null	ACK_SIF

ATTACHMENT 5
FROI EDI SYSTEM FILE LAYOUT

Accept/Reject Report File Data Layout

Field Name	Description/Example
Header Record	
Vendor File Name the ACK refers to	<VendorName>_20230208_FROI_20230208091910_01.txt
Date of the ACK file	MM/DD/YYYY
Total Records	Total number of records in the input file
Detail Record	
Vendor Unique Claim Number	Vendor unique number
Claim Adminstrator Claim Number (NYSIF Unique Claim Number)	Only populated with NYSIF internal claim number if record is accepted by NYSIF
Record Status	FROI EDI Accepted by NYSIF - or - FROI EDI Rejected by NYSIF
Status Description	Only populated if record is rejected by NYSIF; will provide all error reasons why the record was rejected

Possible Rejection Reasons:

- Vendor record fails the NYSIF edits.
- New record not in a new line or wrong data format.
- Injury was already reported to NYSIF through other means

Appendix

eClaims Quick Reference Code Lists:

A – Go to WCB eClaims – NY Requirements Tables – EDI R3.1

http://www.wcb.ny.gov./content/ebiz/eclaims/edi-r3-1/ny-requirement-tables.jsp

B – Locate and open Edit Matrix

NYS R3.1 Edit Matrix Rev. 03/08/2021 (MS Excel): This table defines the edits that will be applied to the data elements and events defined in the Event and Element Requirements Tables. Edits will be applied to individual data elements as well as the sequence or order in which FROI and SROI submissions are received. The Edit Matrix also provides the standard error messages associated with these edits.

Quick Reference Codes list are on tabs – Valid Value Detail Page 1 and Valid Value Detail Page 2,

Body Part Code

ID	NCCI_ CODE	NCCITEXT
1	11	Skull
2	12	Brain
3	13	Ear(s) [Includes: hearing, inside eardrum]
4	14	Eye(s) [Includes: optic nerves, vision, eye lids]
5	15	Nose [Includes: Nasal passage, Sinus, Sense of Smell]
6	16	Teeth
7	17	Mouth [Includes: Lips, Tongue, Throat, Taste]
8	18	Soft Tissue
9	19	Facial Bones [Includes: Jaw]
10	21	Vertebrae [Includes: Spinal Column Bone, "Cervical Segment"
11	22	Disc [Includes: Spinal Column Cartilage, "Cervical Segment"
12	23	Spinal Cord [Includes: Nerve, Nerve Tissue, "Cervical Segment"
13	24	Larynx [Includes: Cartilage and Vocal Cords]
14	25	Soft Tissue (other than Larynx or Trachea)
15	31	Upper Arm [Humerus and corresponding muscles, excluding clavicle and scapula]
16	32	Elbow [Radial Head]
17	33	Lower Arm [Fore Arm - Radius, Ulna and Corresponding muscles]
18	34	Wrist [Carpals and Corresponding Muscles]
19	35	Hand [Metacarpals and corresponding muscles - excluding wrist or fingers]
20	36	Finger(s) [other than Thumb and corresponding muscles]
21	37	Thumb
22	38	Shoulder(s) [Armpit, Rotator Cuff, Trapezius, Clavicle, Scapula]
23	41	Upper Back Area [(Thoracic Area) Upper Back Muscles, Excluding Vertebrae, Disc, Spinal]
24	42	Lower Back Area [(Lumbar Area and Lumbo Sacral) Lower Back Muscles, Excluding Sacrum, Coccyx, Pelvis, Vertebrae, Disc, Spinal Cord]
25	43	Disc [Spinal Column Cartilage other than Cervical Segment]
26	44	Chest [Including Ribs, Sternum, Soft Tissue]
27	45	Sacrum and Coccyx [Final Nine Vertebrae-Fused]
28	46	Pelvis
29	47	Spinal Cord [Nerve Tissue other than Cervical Segment]
30	48	Internal Organs [Other than Heart and Lungs]
31	49	Heart
32	60	Lungs
33	61	Abdomen [Including Groin; excluding injury to Internal Organs]
34	62	Buttocks Soft Tissue
35	63	Lumbar &/or Sacral Vertebrae [Vertebra NOC Trunk; Bone Portion of the Spinal Column]
36	51	Hip
37	52	Upper Leg [Femur and corresponding muscles]

Body Part Code Continued

ID	NCCI_CODE	NCCITEXT
38	53	Knee [Patella]
39	54	Lower Leg [Tibia, Fibula and Corresponding Muscles]
40	55	Ankle [Tarsals]
41	56	Foot [Metatarsals, Heel, Achilles Tendon and Corresponding Muscles - Excluding Ankle or Toes]
50	30	MULTIPLE UPPER EXTREMITIES
51	39	WRIST(S) AND HAND(S)
52	40	MULTIPLE TRUNK
41	56	Foot [Metatarsals, Heel, Achilles Tendon and Corresponding Muscles - Excluding Ankle or Toes]
50	30	MULTIPLE UPPER EXTREMITIES
51	39	WRIST(S) AND HAND(S)
52	40	MULTIPLE TRUNK

Nature of Injury Code

ID	NCCI_CODE	NCCITEXT
1	1	No Physical Injury (i.e., Glasses, Contact Lenses, Artificial Appliance, Replacement of Artificial Appliance)
2	2	Amputation (Cut-off Extremity, Digit, Protruding Part of Body, usually by surgery, i.e., leg, arm)
3	4	Burn (Heat - burns or scalding; the effect of contact with hot substances. Chemical - tissue damage resulting from the corrosive action of chemicals, fumes, i.e., acids, alkalies.)
4	10	Contusion (Bruise - intact skin surface. Hematoma.)
5	13	Crushing (To grind, pound or break into small bits.)
6	19	Electric Shock (Electrocution)
7	25	Foreign Body
8	30	Freezing (Frostbite and other effects or exposure to low temperature.)
9	31	Hearing Loss or Impairment (Traumatic only. A separate injury, not the sequelae of another injury.)
10	32	Heat Prostration (Heat stroke, sun stroke, heat exhaustion, heat cramps and other effects of environmental heat.)
11	36	Infection (The invasion of a host by organisms such as bacteria, fungi, viruses, protozoa or insects, with or without manifest disease.
12	37	Inflammation (The reaction of tisue of injury characterized clinically by heat, swelling, redness and pain.)
13	40	Laceration (Cut, scratches, abrasions, superficial wounds, calluses. Wound by tearing.)
14	42	Poisoning - General (Not OD or Cumulative Injury) (A systemic morbid condition resulting from the inhalation, ingestion, or skin absorption of a toxic substance affecting the metabolic system, the nervous system, the circulatory system, the digestive syst
15	43	Puncture (A hole made by the piercing of a pointed instrument.)
16	49	Sprain (A trauma or wrenching of a joint, producing pain and disability depending upon degree of injury of ligaments.)
17	52	Strain (Internal derangement, the trauma to the muscle or the musculotendinous unit from violent contraction or excessive forcible stretch.)
18	53	Syncope (Swooning, fainting, passing out; no other injury)
19	55	Vascular (Cerebrovascular and other conditions of circulatory systems, NOC. Excludes heart and hemorrhoids. Includes strokes, varicose veins - non-toxic.)
20	58	Vision Loss
21	59	All other specific injuries, NOC
22	65	Respiratory Disorders (Gasses, fumes, chemicals, etc.)
23	66	Poisoning (Chemical, other than metals, man made or organic)
24	67	Poisoning (metals, man made)
25	70	Radiation (All forms of damage to tissue, bones or body fluids produced by exposure to radiation.)
26	71	All other occupational disease injury, NOC
27	72	Loss of Hearing
28	73	Contagious Disease
29	80	All other cumulative injury, NOC
30	90	Multiple Physical Injuries Only
31	91	Multiple Injuries including both physical and physiological

Cause of Injury Code

ID	NCCI_CODE	NCCITEXT
1	1	Contact with Chemicals
2	2	Contact with Hot Objects or Substances
3	3	Contact with Temperature Extremes
4	4	Contact with Fire or Flame
5	5	Contact with Steam or Hot Fluids
6	6	Contact with Dust, Gasses, Fumes or Vapors
7	7	Contact with Welding Operation
8	8	Contact with Radiation
9	9	Contact with, NOC
10	11	Contact with Cold Objects or Substances

Cause of Injury Code (Continued)

ID	NCCI_CODE	NCCITEXT
11	14	Abnormal Air Pressure
12	84	Electrical Current
13	10	Machine or Machinery
14	12	Object Handled
15	13	Caught in, under or between, NOC
16	20	Collapsing Materials, either man made or natural (i.e., slides of earth)
17	15	Broken Glass
18	16	Hand tool, utensil; not powered
19	17	Object being lifted or handled
20	18	Powered hand tool, appliance
21	19	Caught, puncture, scrape, NOC
22	25	From different level elevation (off wall, catwalk, bridge, etc.)
23	26	From ladder or scaffolding
24	27	From liquid or grease spills
25	28	Into openings (shafts, excavations, floor openings, etc.)
26	29	On same level
27	30	Slipped, do not fall
28	31	Fall, Slip or Trip, NOC
29	32	On ice or snow
30	33	On Stairs
31	40	Crash of water vehicle
32	41	Crash of rail vehicle
33	45	Collision or sideswipe with another vehicle (both vehicles in motion)
34	46	Collision with a fixed object (standing vehicle or stationary object)
35	47	Crash of Airplane
36	48	Vehicle Upset (overturned or jackknifed)
37	50	Motor vehicle, NOC
38	52	Continual noise
39	53	Twisting
40	54	Jumping
41	55	Holding or carrying
42	56	Lifting
43	57	Pushing or pulling
44	58	Reaching
45	59	Using tool or machinery
46	60	Strain or injury by, NOC
47	61	Wielding or throwing
48	97	Repetitive motion (Carpel Tunnel Syndrome)
49	65	Moving part of machine
50	66	Object being lifted or handled
51	67	Sanding, scraping, cleaning operation
52	68	Stationary object
53	69	Stepping on sharp object
54	70	Striking against or stepping on, NOC
55	74	Fellow worker; patient (not in act of a crime)
56	75	Falling or flying object
57	76	Hand tool or machine in use
58	77	Motor vehicle
59	78	Moving parts of machine
60	79	Object being lifted or handled
61	80	Object handled by others
62	81	Struck or injured, NOC (includes kicked, stabbed, bit, etc.)
63	85	Animal or insect
64	86	Explosion or flare back
65	94	Repetitive motion (callous, blister, etc.)
66	95	Rubbed or abraded, NOC
67	82	Absorption, Ingestion or Inhalation, NOC
68	87	Foreign Matter (body) in eyes
69	88	Natural Disasters
70	89	Person in act of a crime (robbery or criminal assault)
71	90	Other than physical cause of injury
72	91	Mold
73	96	Terrorism
74	98	Cumulative, NOC (all other)
75	99	Other - miscellaneous, NOC
76	83	Pandemic