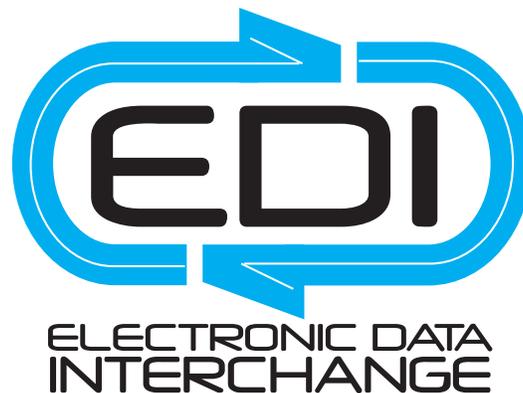


Mandatory EDI/eFROI implementation

As indicated in the Aug. 29, 2012, announcement, the Department of Labor and Industry (DLI) is moving toward implementing mandatory electronic filing of the First Report of Injury (FROI) form. Included below is the tentative timetable for the implementation. More information, including frequently asked questions can be found on the DLI website at www.dli.mn.gov/WC/Edi.asp.



Aug. 29, 2012	Initial announcement of mandating electronic filing for First Report of Injury (FROI) form
Sept. 10, 2012	Freeze testing for new trading partners
Nov. 1, 2012	Notification to mandate electronic filing of FROI forms on Jan. 1, 2014
March 1, 2013	Begin testing EDI requirement changes specified in the implementation guide with current trading partners
May 1, 2013	Testing begins with new EDI trading partners on a voluntary basis
July 1, 2013	Testing of the eFROI Web portal, via the DLI website, begins on a voluntary basis
Oct. 1, 2013	Cut-off date to begin testing for all eFROI and EDI trading partners
Dec. 1, 2013	Completion date for testing of all eFROI and EDI trading partners
Jan. 1, 2014	Electronic filing of FROI forms for reporting entities will be required

Changes to the First Report of Injury form

To prepare for the anticipated implementation date of Jan. 1, 2014, DLI is making changes to the FROI form. The updated FROI form will continue to be a one-page form and its appearance is essentially the same as the current form. However, changes to the form are necessary because DLI is conforming to national standards for electronically filed FROI forms. To capture more of the data that is being received electronically, certain fields were removed and certain fields were added or amended.

Fields that have been removed from the current FROI form

- Box 20 Weekly value of meals, lodging, second income
The instructions to the employer, located on the back of the form, have been updated to indicate that the employer is to include this information to the insurer on a separate sheet.
- Boxes 33-35 Hospital/clinic name and address; ER visit; overnight in-patient
These fields have been replaced with the extent of medical treatment information that is received through EDI, ranging from none to future major medical anticipated.

Draft FROI form with highlighted proposed changes to various fields

MN Department of Labor and Industry
 Workers' Compensation Division
 PO Box 64221
 St. Paul, MN 55164-0221
 (651) 284-5032 or 1-800-342-5354
 Fax: (651) 284-5731

First Report of Injury
 See Instructions on Reverse Side
 PRINT IN INK or TYPE
 ENTER DATES IN MM/DD/YYYY FORMAT

FROI 1
 DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA Case #		3. Time employee began work on date of injury		<input type="checkbox"/> am <input type="checkbox"/> pm	
4. DATE OF CLAIMED INJURY		5. Time of injury		6. Date of death		# of dependents (if death is related to injury)	
7. EMPLOYEE Name (last, suffix , first, middle)				8. Gender		9. Marital Status	
10. Home Address				11. Home phone #		12. Date of birth	
City		State		Zip Code		14. Occupation	
17. Average weekly wage		18. Rate per hour		19. Hours per day		20. Days per week	
13. Date hired		15. Regular department		16. Apprentice?		21. Employment Status	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer	
22. Tell us how the injury occurred and what the employee was doing before the incident (give details). Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."							
How the Injury Occurred (22) has been expanded to allow for inclusion of all 500 characters allowed to be submitted via EDI.			EDI Reporter will supply a Wage, Wage Period Code, and No. of Days Worked per Week in Fields 17, 18 and 20 (e.g. \$500; Weekly; 5)			EDI Reporter can enter up to 5 witness names and numbers. The first will display on form, the remaining will print out on a second page.	
23. What was the injury or illness (include the parts of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.				24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.			
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Date of first day of any lost time		27. Employer paid for lost time on day of injury (DOI)		28. Date employer notified of injury	
Indicate name and address of place of occurrence		29. Date employer notified of lost time		30. Return to work date		31. RTW same employer?	
33. Treating Physician (name)		34. Extent of medical treatment (check all that apply)		32. RTW with restrictions?			
35. Certified Managed Care Organization (if any)		<input type="checkbox"/> None <input type="checkbox"/> Minor on-site by employer's medical staff <input type="checkbox"/> Minor clinic/hospital		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Emergency room <input type="checkbox"/> Hospitalization more than 24 hours					
		<input type="checkbox"/> Future major medical anticipated					
36. EMPLOYER Legal name				37. EMPLOYER DBA name (if different)			
38. Mailing address				39. Employer FEIN		40. Unemployment ID#	
City		State		Zip Code		41. Employer's contact name and phone #	
42. Physical address (if different)				43. Witness (name and phone) - if more than 1 attach a separate sheet			
City		State		Zip Code		44. NAICS code	
						45. Date form completed	
46. INSURER name				51. CLAIMS ADMIN COMPANY (CA) name (check one)			
47. Insured legal name and FEIN				<input type="checkbox"/> Insurer <input type="checkbox"/> TPA			
48. Policy # (including effective dates) or self-insured certificate #				52. CA address			
City		State		Zip Code			
49. Insurer FEIN		50. Date insurer received notice		53. CA FEIN		54. CA claim #	
55. To be completed by the CA		Claim type code		Type of loss code		Late reason code	
						Salary paid in lieu of comp?	
						Death result of injury?	

MN FROI1 (10/12) Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)

Color	Description
Yellow	New fields or additional data included in fields based on data elements received via EDI
Orange	Boxes that have changed location on the form
Blue	Boxes for which there is no corresponding EDI element, but remain on the form for employer-to-insurer reporting purposes
Green	Box that has changed location and has no corresponding EDI element, but remains on the form for employer-to-insurer reporting purposes.

The instructions for completing the FROI form, located on the back of the form, have been updated to reflect the changes made to the various fields.

DLI is anticipating the implementation date for the new version of the FROI form will be July 1, 2013. Additional information will be provided when a more definitive implementation schedule is confirmed.

Questions, comments or concerns about the FROI form can be directed to the EDI/eFROI Implementation Team at dli.edi@state.mn.us.