Objectives

Review the basic reporting rules and requirements for the Medical Data Call as outlined in the *Medical Data Call Reporting Guidebook*. You will also become familiar with using the *Medical Data Collection* tool to monitor the reporting of your medical data.
Medical Data Call Overview

General Rules and Call Structure

Editing and Validation

Medical Data Call Compliance Overview

Medical Data Collection Tool

Additional Resources
Medical Data Call

Each medical service that occurs due to an employee’s job-related injury, including:

- Hospital Stay
- Physical Therapy
- MRI
- Office Visit
- Prescription Drugs
- X-ray

Driving Force of the Medical Call—Legislative Analysis

Recently, more than 30% of legislative activity is medical related

States have been proposing and/or enacting more comprehensive cost controls in these areas:

- Physician Fee Schedules
- Inpatient/Outpatient Hospitals
- Ambulatory Surgical Centers
- Prescription Drugs
Workers Compensation Medical Losses

1987
- Indemnity: 54%
- Medical: 46%

1997–2001
- Indemnity: 43%
- Medical: 57%

2005–2014
- Indemnity: 47%
- Medical: 53%

Medical Data Call
Core Resources
Core Resources—ncci.com

- **Medical Data Call Reporting Guidebook** contains the rules and requirements for reporting Medical Call data, including record layouts, data definitions, and the edit matrix.

- **Electronic Transmission User’s Guide** contains the requirements for preparing and submitting test and production files for all NCCI data types.

- **Medical Incentive Program (MIP)** evaluates the completeness and accuracy of medical data in accordance with the program requirements. Refer to Part 2 of the **Data Quality Guidebook**.

- **Medical Data Collection** is the tool that provides you with the ability to view the status of your Medical Call data submissions to NCCI, in one centralized location. This tool also allows you to monitor the quality and completeness of your submissions as well as your **Medical Incentive Program (MIP)** results.

---

**Medical Data Call Reporting Guidebook**

The **Medical Data Call Reporting Guidebook** is your primary reference for the instructions needed to accurately complete your Medical Data Call reporting.
Accessing the Medical Data Call Reporting Guidebook

Data Reporting

REGISTER NOW
NCCI’s 2016 Data Educational Program

GBLUEPRINT
for data reporting services
January 26-27, 2016

Tools
- Circles
- Data Manager Dashboard
- Data Transfer
- On the Internet
- Resources
- Medical Data Collection
- Data Insight

Learning Center
- NCCI’s Medical Data Call—Overview—Webinar on Demand
- Medical Data Call—Guidance and Validation—Webinar on Demand
- Medical Data Call—Validation and Certification—Webinar on Demand
- Medical Data Call—Medical Data Collection Tool—Webinar on Demand

Publications/Reports
- Tier-1 Lists—Implementation October 1, 2013
-
# Medical Data Call Reporting Guidebook—Table of Contents

<table>
<thead>
<tr>
<th>Medical Data Call Reporting Guidebook</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Tracking Guide</td>
</tr>
<tr>
<td>Part 1—Medical Data Call Reporting Guidebook</td>
</tr>
<tr>
<td>Part 2—General Rules</td>
</tr>
<tr>
<td>Part 3—Medical Data Call Structure</td>
</tr>
<tr>
<td>Part 4—Record Layouts</td>
</tr>
<tr>
<td>Part 5—Data Dictionary</td>
</tr>
<tr>
<td>Part 6—Reporting Rules</td>
</tr>
<tr>
<td>Part 7—Editing and Other Validation Procedures</td>
</tr>
<tr>
<td>Part 8—Data Quality Programs</td>
</tr>
<tr>
<td>Part 9—Glossary</td>
</tr>
<tr>
<td>Part 10—Appendix</td>
</tr>
<tr>
<td>Manual in PDF Format</td>
</tr>
</tbody>
</table>
General Rules

Report all medical transactions associated with workers compensation claims in any Medical Data Call state.

The Jurisdiction State is the state under whose workers compensation act the claimant’s benefits are being paid.

Applicable States

Participating NCCI States
Participating Independent Bureaus
Nonparticipating Using WCMEU Format
Nonparticipating
Eligibility Overview

- Single contract
- Includes individual coverage providers
- Data representing 15% or less of gross premium
- 1% market share (three-year average) in any one applicable state
- Report for all Medical Data Call states in which they write
- Continue to report indefinitely

Reporting Responsibility

- Submit Directly
- Authorize Vendor
- Combination of Both

Regardless of who submits the data, the quality, timeliness, and completeness of the data is the responsibility of the carrier.
Vendor Business Partners

Companies differ in handling medical data:

- Carrier keeps all medical claim handling in-house.
- Carrier uses business partners for various aspects of medical claim handling, including third party administrators (TPAs), medical bill review vendors, etc.
- Carrier retains some internal claim handling and uses business partners for some aspects.

Mergers and Acquisitions

Current participants:
- Required to continue reporting data after any merger.

Nonparticipating companies that merge with participating companies:
- Not required to report Medical Call data until a future participation evaluation deems it eligible.
## Merger Examples

<table>
<thead>
<tr>
<th>If ...</th>
<th>And ...</th>
<th>Then ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier A currently reports the Call</td>
<td>Merges with Carrier B, which <strong>does not</strong> currently report the Call</td>
<td>Only Carrier A reports the Call unless a future participation deems AB eligible</td>
</tr>
<tr>
<td>Carrier A <strong>does not</strong> currently report the Call</td>
<td>Merges with Carrier B, which currently reports the Call</td>
<td>Only Carrier B reports the Call unless a future participation deems AB eligible</td>
</tr>
<tr>
<td>Carrier A currently reports the Call as part of Reporting Group B</td>
<td>Leaves Group B</td>
<td>Both Carrier A and Group B continue to report the Call</td>
</tr>
</tbody>
</table>

## Merger Examples

<table>
<thead>
<tr>
<th>If ...</th>
<th>And ...</th>
<th>Then ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier A currently reports the Call</td>
<td>Merges with Carrier B, which currently reports the Call</td>
<td>Both Carrier A and Carrier B continue to report the Call</td>
</tr>
<tr>
<td>Carrier A <strong>does not</strong> currently report the Call</td>
<td>Merges with Carrier B, which <strong>does not</strong> currently report the Call</td>
<td>Neither Carrier A nor B reports the Call unless a future participation deems AB eligible</td>
</tr>
</tbody>
</table>
**Reporting Frequency**

- **Quarterly**
  - One submission due by the end of the following quarter

  - July, August, September sent in October
  - 3rd Quarter data due December 31

- **Monthly**
  - Partial quarter’s data sent in reporting quarter
  - Three months data due at the end of the following quarter

  - July transactions sent in August
  - August transactions sent in September
  - September transactions sent in October
  - 3rd Quarter data due December 31
Due Dates

All medical transactions (existing claims and new claims) that occur within a specific quarter, based on Transaction Date, must be reported in that quarter’s submission.

New Claim

Transaction Date 1/1/2015

Include in Q1 Submission

Existing Claim

Transaction Date 2/15/2015

Due by End of Q2

Duration of Reporting

Transactions must continue to be reported until:

Transactions no longer occur, or

30 years from accident date
Reporting Duration Example 1

- Accident Date: February 1, 2006
- Report transaction with 1st Quarter 2016 data
- Medical transaction occurs: January 1, 2016
- New transactions would continue to be reported until January 31, 2036

Reporting Duration Example 2

- Accident Date: February 1, 1985
- Report transaction with 1st Quarter 2015 data
- Medical transaction occurs: January 1, 2015
- No further transactions are expected to be reported for this claim after February 1, 2015
# Medical Data Call Structure

## Part 3—Call Structure

### 28 Medical Data Elements

<table>
<thead>
<tr>
<th>Carrier Code</th>
<th>Policy Number Identifier</th>
<th>Policy Effective Date</th>
<th>Claim Number Identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transaction Code</td>
<td>Jurisdiction State Code</td>
<td>Claimant Gender Code</td>
<td>Birth Year</td>
</tr>
<tr>
<td>Accident Date</td>
<td>Transaction Date</td>
<td>Bill ID Number</td>
<td>Line ID Number</td>
</tr>
<tr>
<td>Service Date</td>
<td>Service From Date</td>
<td>Service To Date</td>
<td>Paid Procedure Code</td>
</tr>
<tr>
<td>Paid Procedure Code Modifier</td>
<td>Amount Charged by Provider</td>
<td>Paid Amount</td>
<td>Primary ICD Diagnostic Code</td>
</tr>
<tr>
<td>Secondary ICD Diagnostic Code</td>
<td>Provider Taxonomy Code</td>
<td>Provider ID Number</td>
<td>Provider Postal (ZIP) Code</td>
</tr>
<tr>
<td>Network Service Code</td>
<td>Quantity/No. of Units Per Procedure</td>
<td>Place of Service Code</td>
<td>Secondary Procedure Code</td>
</tr>
</tbody>
</table>
Key Partnership

<table>
<thead>
<tr>
<th>Carrier Group</th>
<th>Medical Data Call</th>
<th>Vendor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Code</td>
<td>Carrier Code</td>
<td></td>
</tr>
<tr>
<td>Policy Number ID</td>
<td>Policy Number ID</td>
<td></td>
</tr>
<tr>
<td>Policy Effective Date</td>
<td>Policy Effective Date</td>
<td></td>
</tr>
<tr>
<td>Claim Number ID</td>
<td>Claim Number ID</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bill ID Number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Line ID Number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service Provider Information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Procedure Information</td>
<td></td>
</tr>
</tbody>
</table>

Medical Data Call Record Layout

For specific data element reporting instructions, refer to the Data Dictionary section (Part 5) of the Medical Data Call Reporting Guidebook.
The Data Dictionary section of the Medical Data Reporting Guidebook contains alphabetized and numbered metadata.

### 14. Place of Service Code

**Field(s):** 27

**Position(s):** 282-289

**Class:** Alphanumeric (AN)—Field contains alphanumeric and numeric characters

**Bytes:** 3

**Format:** AN/9, this field must be left justified and blank-filled to right of the last number or character when the Place of Service Code is less than 8 bytes. Include leading zeros when part of the code. If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if the system stores 9 for a code that is listed as 09 on the code list, insert a zero to the left of the 9 when reporting to NCCI.

**Definition:** A code that indicates where the medical service was performed.

**Reporting Requirement:** Report the Place of Service Codes from the Place of Service list, that indicates where the medical service was performed. Do not report Place of Service Code 99 (Other Place of Service) when the place of service is unavailable. Instead, leave this field blank.

For facility and hospital services, the Place of Service Crosswalk was developed to provide a mapping of the Type of Bill code to the Place of Service code. Online readers can click to viewprint details: Place of Service Crosswalk (pdf).

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Pharmacy</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>02</td>
<td>Unassigned—Not valid for NCCI</td>
<td>34</td>
</tr>
<tr>
<td>03</td>
<td>School</td>
<td>35-40</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
<td>41</td>
</tr>
<tr>
<td>05</td>
<td>Indian Health Service—Free-Standing Facility</td>
<td>42</td>
</tr>
</tbody>
</table>
**Data Dictionary**

14. **Place of Service Code**

| Field(s): | 27 |
| Position(s): | 282–289 |
| Class: | Alphanumeric (AN) – Field contains alphabetic and numeric characters |
| Bytes: | 8 |

**Format:** AN 18. This field must be left justified and blank-filled to the right of the last number or character when the Place of Service Code is less than 8 bytes. Include leading zeros when part of the code. If converting a code from a system that does not store leading zeros, ensure that the leading zero(s) are inserted correctly. For example, if the system stores 9 for a code that is listed as 09 on the code list, insert a zero to the left of the 9 when reporting to NCCI.

**Definition:** A code that indicates where the medical service was performed.

**Reporting Requirement:** Report the Place of Service Code from the Place of Service list, that indicates where the medical service was performed. Do not report Place of Service Code 99 (Other Place of Service) when the place of service is unavailable. Instead, leave this field blank.

For facility and hospital services, the Place of Service Crosswalk was developed to provide a mapping of the Type of Bill code to the Place of Service code. Online readers may click to view/viewpoint details: Place of Service Crosswalk (pdf).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>02</td>
<td>Unassigned—Not valid for NCCI</td>
</tr>
<tr>
<td>03</td>
<td>School</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
</tr>
<tr>
<td>05</td>
<td>Indian Health Service—Free-Standing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Outpatient Care Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospital</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance—Land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance—Air or Water</td>
</tr>
</tbody>
</table>

**Place of Service Crosswalk**

<table>
<thead>
<tr>
<th>Type of Bill Position 1 (Type of Facility)</th>
<th>Type of Bill Position 2 (Bill Classification)</th>
<th>Place of Service Code</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X Hospital</td>
<td>Inpatient</td>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>12X Hospital</td>
<td>Inpatient</td>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>13X Hospital</td>
<td>Outpatient</td>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>14X Hospital</td>
<td>Other</td>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>18X Hospital</td>
<td>Swing Bed</td>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>21X Skilled Nursing</td>
<td>Inpatient</td>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>22X Skilled Nursing</td>
<td>Inpatient</td>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>23X Skilled Nursing</td>
<td>Outpatient</td>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>28X Skilled Nursing</td>
<td>Swing Bed</td>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>32X Home Health</td>
<td>Inpatient</td>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>33X Home Health</td>
<td>Outpatient</td>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>34X Home Health</td>
<td>Other</td>
<td>12</td>
<td>Home</td>
</tr>
</tbody>
</table>
## Medical Call Transactions

<table>
<thead>
<tr>
<th>Transaction Code</th>
<th>Use</th>
<th>Transaction Date</th>
</tr>
</thead>
</table>
| 01—Original      | • The first reporting of a medical transaction  
                     • Only one may be submitted for a medical transaction | The date the medical transaction was originally processed and paid by the administering entity |
| 02—Cancellation  | • Used to delete or cancel record(s)  
                     • Apply to prior record(s) or record(s) in same submission | The date the medical transaction was cancelled in the administering entities system, not the date the cancellation record was sent to NCCI |
| 03—Replacement   | • Used to revise non-key field values  
                     • Apply to prior record(s) or record(s) in same submission | The date the medical transaction was revised in the administering entities system not the date the replacement record was sent to NCCI. Must be after the Transaction date of the record it is intended to replace. |

- All previously reported fields must be reported, even if there is no change  
  • Report current cumulative values, not change in value
Replacement Record Use

- Correcting a data entry issue
- Replacement record must include all data elements, even if they do not change
- Delete a prior record or multiple records

Changes via a replacement record can only be made to nonkey fields.

Replacement File Use

- Correcting a major systemic programming issue
- Remove all records from Original File and add records in Replacement File
- Delete a prior File

Do not use for data entry issues—use Replacement Records instead.
Replacement Examples

1. All of the Transaction Dates in the file show the date the records were submitted to NCCI—not the date the transactions occurred.

2. The data provider reported units, instead of minutes, for all anesthesia transactions, which is a relatively small subset of the total number of transactions submitted.

3. Need to replace any data greater than 24 months old.

---

Submitting Medical Data Files

- File Naming Convention:
  - Production—Medical.30characters.txt
  - Certification—Medical.30characters.tst
- The prefix “medical.” must precede any additional characters in the file name.
- Valid characters in the file name include 0 through 9, A through Z, dash '-', underscore '-', or period '.'.
- The file must contain only one submission control record.
- The number of records and headers in the file must match the submission control record.
- The record length maximum is 350 characters.
Certification/Testing

Ensures that test data files meet minimum formatting and quality requirements prior to production reporting

- Applied to each certification test file as if it were received in production
- Requirements

- Medical data providers are required to pass certification testing for each carrier group
- Certify all new medical data providers and whenever system changes are made

Certification Process

Three-Step Process

- Setup: Required forms are completed and submitted
- Testing: Test file is created and submitted
- Approval: The quality of the data is acceptable
Electronic Transmission User’s Guide

- Medical Data Call Program
- Submitting Files to NCCI
- Data Tools and Resources
- Certification Process and Testing Requirements

Provides the necessary requirements, forms, and instructions for preparing and submitting test and production files.

TPA Requirements

For each TPA/vendor/medical data provider:

- Data Provider Profile Form
- Service Provider Agreement
- Service Provider Data Tool Access Addendum

Contact NCCI’s Customer Service Center at 800-NCCI-123 to verify that appropriate authorization is on file.
**“Pre-Edit”**

- Submit a file using the certification/test file identifier
  - Medical.30characters.tst
- Edits applied to the file as if it were in production
  - Results are displayed in the *Medical Data Collection* tool
- Does not include Quarter End Validation

---

**Editing and Validation**

*YOUR BLUEPRINT for data reporting success*
Three Stages of Editing

**File Acceptance**
- Submission, field, relational edits
- Pass or reject and return file/records

**Quality Tracking**
- Field, logical, relational edits
- Count occurrences
- Results available for viewing in Medical Data Collection tool

**Quarter End Validation**
- Logical and relational edits, distributions
- Count occurrences are aggregated
- Results available for viewing in Medical Data Collection tool
Edit Types

Each edit is classified as a specific edit type:

Submission Edits

Can we process the file?

- Data provider information is valid
- File naming convention is correct
- Record length is correct and contains only valid characters
- Contains a Submission Control Record with valid values
- Record count balances
- Key fields are populated
Field Edits

Are the formats and values acceptable?

- Formatting is correct by field class
- Date fields are formatted YYYYMMDD
- Data is reported and values are valid

  Alpha fields are only A through Z or blank spaces

  Numeric fields are only 0 through 9

Logical Edits

Does the data make sense compared to other fields in the record?

- Dates are in logical order
- Conditional fields are reported when condition exists
- Paid fields align with charged fields
- Primary field is reported when its associated secondary field is reported
Relational Edits

Does the data make sense compared to previously submitted records?

- Original, replacement, and cancellation transactions occur in a logical order
- Transactions are reported in chronological order by transaction date

Edit Categories

<table>
<thead>
<tr>
<th>Critical (C)</th>
<th>Elements necessary for a transaction to have value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority (P)</td>
<td>Elements needed for legislative analysis</td>
</tr>
<tr>
<td>Supplemental/ Low (L)</td>
<td>Elements used in specialized studies</td>
</tr>
</tbody>
</table>
Elements by Category

<table>
<thead>
<tr>
<th>Critical</th>
<th>Priority</th>
<th>Supplemental/Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Date</td>
<td>Network Service Code</td>
<td>Birth Year</td>
</tr>
<tr>
<td>Amount Charged by Provider</td>
<td>Provider Identification Number</td>
<td>Claimant Gender Code</td>
</tr>
<tr>
<td>Paid Amount</td>
<td>Quantity</td>
<td>Secondary ICD Diagnostic Code</td>
</tr>
<tr>
<td>Place of Service Code</td>
<td>Provider Taxonomy Code</td>
<td>Primary ICD Diagnostic Code</td>
</tr>
<tr>
<td>Amount Charged by Provider</td>
<td>Provider Identification Number</td>
<td>Secondary ICD Diagnostic Code</td>
</tr>
</tbody>
</table>

Edit Matrix

Medical Data Call Edits

<table>
<thead>
<tr>
<th>Edit #</th>
<th>Date Paid</th>
<th>Edit Message</th>
<th>Edit Type</th>
<th>Rule Code</th>
<th>Rule Code</th>
<th>Effective Date</th>
<th>Outcome</th>
<th>Update Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0820-01</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-02</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-03</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-04</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-05</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-06</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-07</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-08</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-09</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-10</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-11</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-12</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-13</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-14</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-15</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-16</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-17</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-18</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-19</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-20</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-21</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-22</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-23</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-24</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-25</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-26</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-27</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-28</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-29</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>0820-30</td>
<td>03</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
</tbody>
</table>

© Copyright 2016 National Council on Compensation Insurance, Inc. All Rights Reserved.
Reporting Issue—Linking

Inconsistent Reporting of Key Fields—Policy Number, Policy Effective Date, and/or Claim Number

- Most common cause for this issue is:
  - Multiple data provider systems
  - Resubmission of prior quarters to resolve may be required

Reported Key Fields should match in Units and Medical

Reporting Issue—Missing Data

Missing Portions of Data—Pharmacy and/or Large Loss Claims

- Pharmacy
  - Pharmacy transactions are often handled by a separate vendor
- Large Loss Claims
  - Often a specialty Third Party Administrator (TPA) takes over management of these claims
Reporting Issue—Duplicates

Duplicate claims are reported

Often caused by:
- Changing Systems
- Changing Vendors

Refer to Part 6 (Section D) of the Medical Data Call Reporting Guidebook

Reporting Issue—Network Service

Incorrect Reporting of Network Service Code

- Defaulting
- Pharmacy Bill Reporting
  - Use of Pharmacy Benefits Manager (PBM)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>HMO—the medical service provider belongs to a Health Maintenance Organization</td>
</tr>
<tr>
<td>N</td>
<td>No Agreement—the medical service provider does not belong to a provider network</td>
</tr>
<tr>
<td>P</td>
<td>Participation Agreement—the medical service provider is part of an agreement that is not an HMO or PPO</td>
</tr>
<tr>
<td>Y</td>
<td>PPO Agreement—the medical service provider belongs to a Preferred Provider Organization agreement</td>
</tr>
</tbody>
</table>
Reporting Issue—ICD-10

Incorrect Reporting of ICD Diagnostic Code

- The most common cause for this issue is:
  - System upgrade or reprogramming issue
- Testing is recommended to identify and correct issue prior to submitting the file in production

Report the ICD Diagnostic Code (ICD-9 or ICD-10) as indicated on the medical bill.

ICD-10 Implementation 10/01/2015

- In January 2014, NCCI began accepting both ICD-9 and ICD-10 Codes
- Continue to report the diagnosis codes reported by the medical provider
- No translation or mapping to ICD-10 from ICD-9 is necessary when reporting Medical Call data

For additional detailed information, please refer to the Medical Data Call Reporting Guidebook.
Medical Data Call Compliance Overview

Compliance Programs

- **Medical Incentive Program (MIP)**—Applies monetary assessments for failure to meet minimum expectations

- **Carrier Data Quality Report Program (Report Card)** Medical Addendum—Criterion utilizes the Medical Incentive Program Completeness and Quality components

<table>
<thead>
<tr>
<th>State</th>
<th>State</th>
<th>State</th>
<th>State</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Florida</td>
<td>Kentucky</td>
<td>Nebraska</td>
<td>South Carolina</td>
</tr>
<tr>
<td>Alaska</td>
<td>Georgia</td>
<td>Louisiana</td>
<td>Nevada</td>
<td>South Dakota</td>
</tr>
<tr>
<td>Arizona</td>
<td>Hawaii</td>
<td>Maine</td>
<td>New Hampshire</td>
<td>Tennessee</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Idaho</td>
<td>Maryland</td>
<td>New Mexico</td>
<td>Utah</td>
</tr>
<tr>
<td>Colorado</td>
<td>Illinois</td>
<td>Mississippi</td>
<td>Oklahoma</td>
<td>Vermont</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Iowa</td>
<td>Missouri</td>
<td>Oregon</td>
<td>Virginia</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Kansas</td>
<td>Montana</td>
<td>Rhode Island</td>
<td>West Virginia</td>
</tr>
</tbody>
</table>
Medical Incentive Program Objectives

- Ensure the full scope of submissions are sent by due date
- Identify extreme outliers of reporting behavior
- Ensure the data meets or exceeds quality tracking criteria

Medical Incentive Program Components

1. Completeness
2. Quality
3. Insufficient Data

Refer to the Medical Incentive Program section of the Data Quality Guidebook in the Manuals Library on ncci.com for additional information.
Carrier Data Quality Report Program (Report Card) Objectives

**Report Card**
- Evaluates data provider groups’ overall annual reporting performance
- Grading Pass or Fail based on Completeness/Quality

Carrier Data Quality Report Medical Data Addendum

Refer to the **Carrier Data Quality Report Program** section of the **Data Quality Guidebook** in the Manuals Library on ncci.com for additional information.
Compliance Resources—nccicom

- **Medical Incentive Program**
- **Carrier Data Quality Report Program**

Refer to Part 2 (Sections F and G) of the Data Quality Guidebook in the Manuals Library on ncci.com.
Accessing the Data Quality Guidebook

**MIP—Section F**

1. Overview
2. Applicability
3. Assessment
4. Assessment Evaluation and Billing
5. Fine Multiplier
6. Incentive Program Criteria
7. Insufficient Data Assessment
8. Viewing Performance Statistics Online Using Medical Data Collection
9. Medical Incentive Program (MIP) Workflow
10. Carrier Data Quality Report Program
11. Data Quality Remediation Program Manual in PDF Format

**G. Carrier Data Quality Report Program**

1. Overview
2. Applicable States
3. Evaluations by Data Type
4. Carrier Report Card—Example
5. Medical Data Addendum
6. Report Card Distribution
7. Carrier Review
8. Regulators’ Report on Carrier Data Quality
9. Report Card Sample Packet
11. Data Quality Remediation Program Manual in PDF Format
Independent Bureaus

Annual or Semiannual Data Extract
Quarterly Compliance Report

Completeness:
- State
- Coverage Provider
- Medical Service—Pharmacy
- Service Date Distribution

Quality:
- Critical Elements
- Priority Elements

Medical Data Collection Tool
Usage Benefits

- **Medical Data Collection** allows you to monitor the status and completeness of your submissions throughout the editing process.
- Enables you to manage your medical data reporting quality more efficiently.
- Targets areas that need improvement.

Submitter/Vendor Workflow

**Prepare Data and Submit File**
- Per the Medical Data Call Reporting Guidebook and the Electronic Transmission User’s Guide
- Upload your data file through Data Transfer via the Internet (DTVI)

**Submission Tracking**
- Review the Submission Tracking Results through the Medical Data Collection tool
- Ensure that the submission status of all files is marked as Completed

**Quality Tracking**
- Review the Quality Tracking Results at the individual file or aggregate level
- Compare edit results to expected thresholds for each data element

Receive Status Email Notification
- Review Rejected Files
- View Validation Results
Manager/Carrier Workflow

Submission Tracking
- Review the submission results through the Medical Data Collection tool
- Ensure that all medical data providers have submitted for the quarter

Quarter End Validation
- Review the Completeness and Quality results for NCCI compliance states and applicable independent bureau states

Incentive Program
- Incentive Fines are displayed based on the Completeness and Quality results for NCCI compliance states only

Follow up on rejected files

Review Quality Tracking results at group/provider level

Invoices are issued the 2nd month after each quarter

Medical Data Collection—ncci.com

Data Reporting

Tools
- Circulators
- Data Manager Dashboard
- Data Transfer via the Internet
- Reference Library
  - Medical Data Collection
- State Guides

Resources
- Medical Edit Metrics
- Medical Data Call Reporting Metrics
- Medical Data Call Tools and Resources (MDCT)

Learning Center
- Medical Data Call—Overview—Webinar on Demand
- Medical Data Call—Coding and Validation—Webinar on Demand
- Medical Data Call—File Submission and Certification—Webinar on Demand
- Medical Data Call—Medical Data Collection Tool—Webinar on Demand

Publications/Reports
- ICD-10 Code—Implementation October 1, 2015
NCCI offers a number of resources to provide you with reporting requirements and information for the Medical Data Call. These resources can be found at ncci.com.

- **Data Reporting** contains the following Web sections:
  - **Medical Call** houses Web articles, guides, and additional resources
  - **Data Quality** provides you with information about NCCI’s Data Quality Compliance Programs
- **Circulars/FYI Plus Releases** address topics that are especially time-sensitive. These documents may include a call for action and/or announce important information necessary for reporting timely and quality data.
Additional Resources—ncci.com

Learning Center

NCCI offers web-based education designed to enhance your knowledge of workers compensation. Through our online education modules, you can learn the fundamentals of workers compensation and determine your exposure to workers compensation risks. Whether you are responsible for reporting data to NCCI, or have other workers compensation responsibilities, you can benefit from our web-based training.

Click on a topic below to view webinars related to that topic:

- General Data Reporting
- Policy & POC
- Unit Statistical Data
- Financial Calls
- Detailed Claim Information
- Medical Call
- Pool Data

For more information, visit ncci.com.
Medical Data Call Webinars

- Medical Data Call—Overview
- Medical Data Call—Editing and Validation
- Medical Data Call—File Submission and Certification
- Medical Data Call—Medical Data Collection tool

Training Opportunities

- **Data Educational Program**
  - NCCI’s annual training event provides education and instruction on the latest data reporting requirements and tools
- **Webinars on Demand**
  - NCCI’s Webinars on Demand are online training modules that you can view and listen to at your convenience
Contact Us

- Visit our kiosk
- Contact your assigned validator directly
- Call our Customer Service Center
  - 800-NCCI-123 (800-622-4123)
  - We’re here to assist you Monday–Friday, 8:00 a.m.–8:00 p.m. ET
- Visit ncci.com and choose Contact Us
  - Customer Service will respond to your request within 24 hours of receipt

Questions
Supplemental Information
**Presenter Biographies**

**Kristin Champagne** joined the Medical Data Validation Department as a senior data analyst in 2012. Her primary responsibilities include identifying, developing, and implementing solutions to data quality issues impacting data used for NCCI’s core products, research, and legislative analyses. Prior to joining the Medical Data Team, she worked for two years on the Proof of Coverage Team, where she primarily led the resolution of complex POC data issues, in addition to providing support to system changes. She began her career in workers compensation eight years ago, as an experience rating analyst.

Kristin holds a bachelor’s degree in finance from Florida Atlantic University.

**Grace Arrieche** joined the Medical and DCI Operations Department as a data analyst in 2013. Grace currently holds the position of senior data analyst, where she is primarily responsible for validating Medical Call data. Prior to that, Grace worked as an analyst in the Assigned Risk Department, where she processed residual market applications ensuring coverage eligibility and binder quality. She also participated in several operational review projects and process improvement initiatives. She began her career at NCCI in 2008 as a customer service specialist in Classification.

Before joining NCCI, Grace was a mortgage professional, specializing in residential lending. She has held various operational positions, including residential due diligence contract underwriter, quality control underwriter, and account manager.