NCCI'S 2016 DATA EDUCATIONAL PROGRAM

YOUR BLUEPRINT for data reporting success

Basics of Medical Data Call Reporting

January 26–29, 2016

Palm Beach County Convention Center
West Palm Beach, FL

Basics of Medical Data Call Reporting

Presented by:

Grace Arrieche and Kristin Champagne

2016 DATA EDUCATIONAL PROGRAM

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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.

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Agenda

- Medical Data Call Overview
- Medical Data Call Core Resources
- General Rules and Call Structure
- Editing and Validation
- Medical Data Call Compliance Overview
- Medical Data Collection Tool
- Additional Resources

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Medical Data Call Overview

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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

Workers Compensation Medical Payment Transactions

Bill Line Detail

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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

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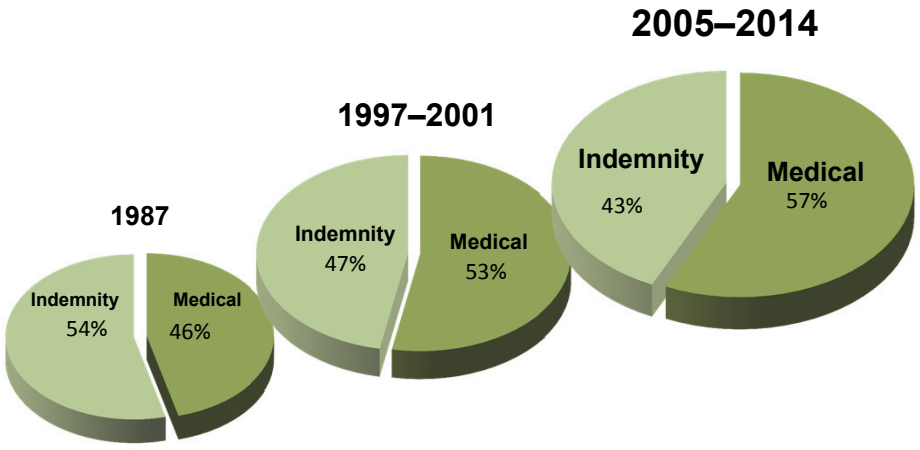
Workers Compensation Medical Losses



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Medical Data Call Core Resources

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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.

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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.

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Accessing the Medical Data Call Reporting Guidebook

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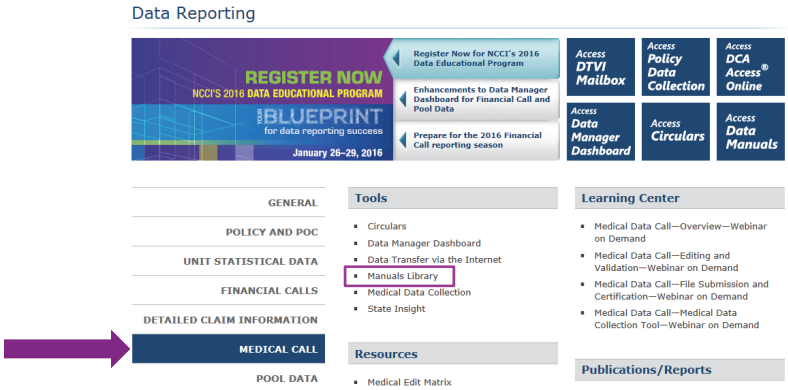
Accessing the Medical Data Call Reporting Guidebook



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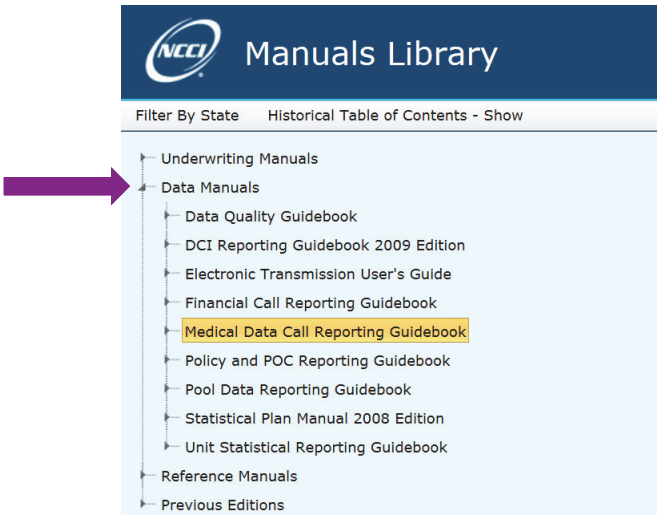
Accessing the Medical Data Call Reporting Guidebook



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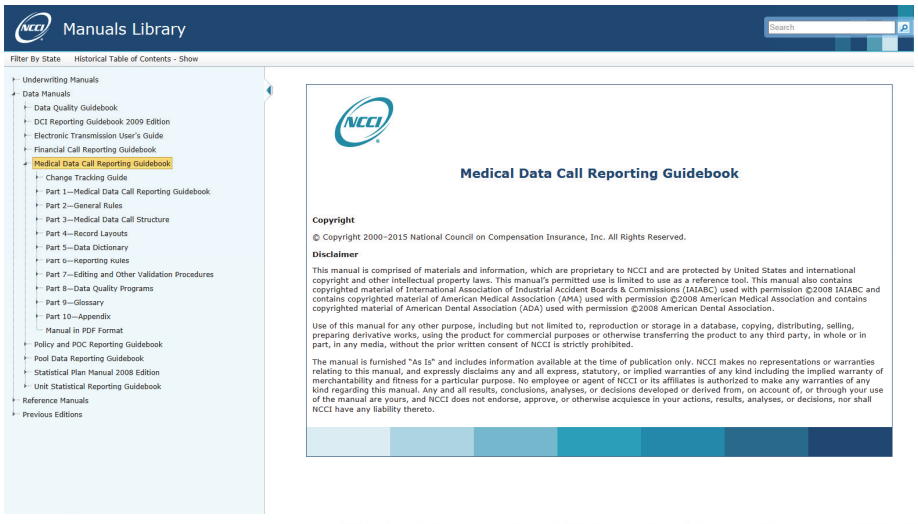
Accessing the Medical Data Call Reporting Guidebook



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Medical Data Call Reporting Guidebook—Table of Contents

- Medical Data Call Reporting Guidebook
  - Change Tracking Guide
  - Part 1—Medical Data Call Reporting Guidebook
  - Part 2—General Rules
  - Part 3—Medical Data Call Structure
  - Part 4—Record Layouts
  - Part 5—Data Dictionary
  - Part 6—Reporting Rules
  - Part 7—Editing and Other Validation Procedures
  - Part 8—Data Quality Programs
  - Part 9—Glossary
  - Part 10—Appendix
  - Manual in PDF Format

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Medical Data Call General Rules

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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

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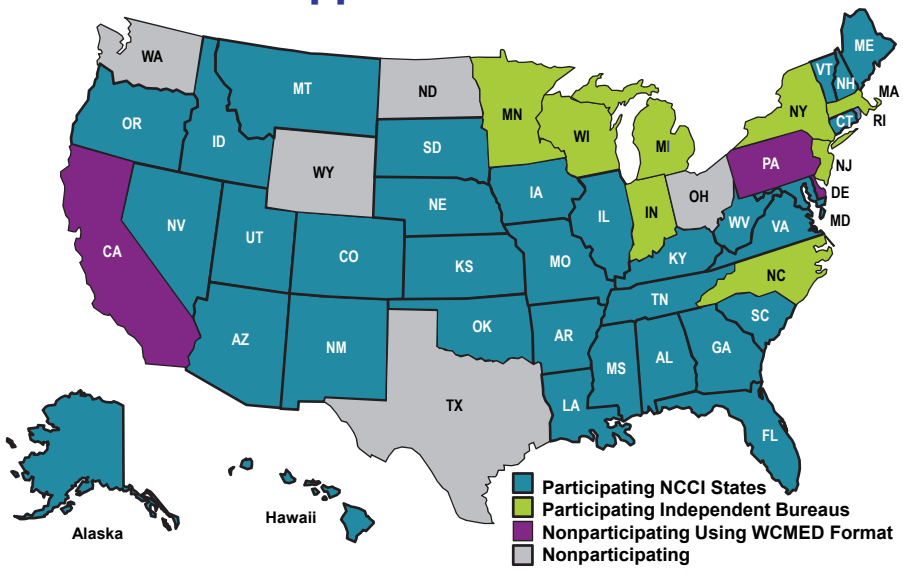
Applicable States



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Eligibility Overview

Part 2—General Rules

- Single contract
- Includes individual coverage providers

Affiliate Group Level

Market Share

- 1% market share (three-year average) in any one applicable state

Exclusion Option

- Data representing 15% or less of gross premium

Medical Data Call States

- Report for all Medical Data Call states in which they write
- Continue to report indefinitely

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Reporting Responsibility

Part 2—General Rules

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.

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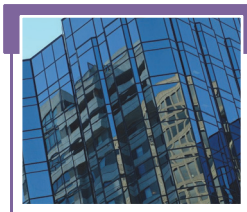
Vendor Business Partners

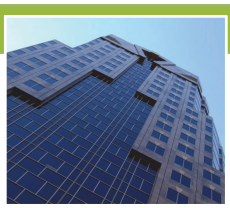
Part 2—General Rules

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

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Mergers and Acquisitions

Part 2—General Rules

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

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Merger Examples

If …	And …	Then …
Carrier A currently reports the Call	Merges with Carrier B, which **does not** currently report the Call	Only Carrier A reports the Call unless a future participation deems AB eligible
Carrier A **does not** currently report the Call	Merges with Carrier B, which currently reports the Call	Only Carrier B reports the Call unless a future participation deems AB eligible
Carrier A currently reports the Call as part of Reporting Group B	Leaves Group B	Both Carrier A and Group B continue to report the Call

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Merger Examples

If …	And …	Then …
Carrier A currently reports the Call	Merges with Carrier B, which currently reports the Call	Both Carrier A and Carrier B continue to report the Call
Carrier A **does not** currently report the Call	Merges with Carrier B, which **does not** currently report the Call	Neither Carrier A nor B reports the Call unless a future participation deems AB eligible

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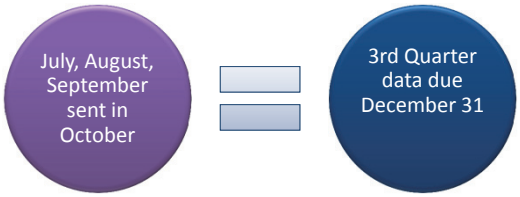
Reporting Frequency

Part 2—General Rules

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



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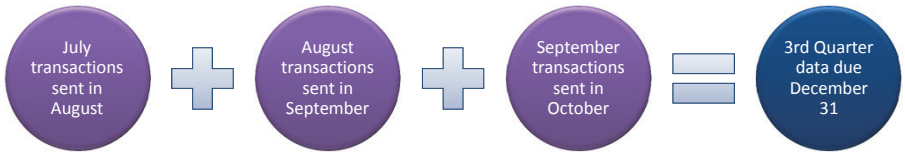
Reporting Frequency

Part 2—General Rules

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



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Due Dates

Part 2—General Rules

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

Existing Claim → Transaction Date 2/15/2015

Include in Q1 Submission

Due by End of Q2

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Duration of Reporting

Part 2—General Rules

Transactions must continue to be reported until:

Transactions no longer occur, or

30 years from accident date

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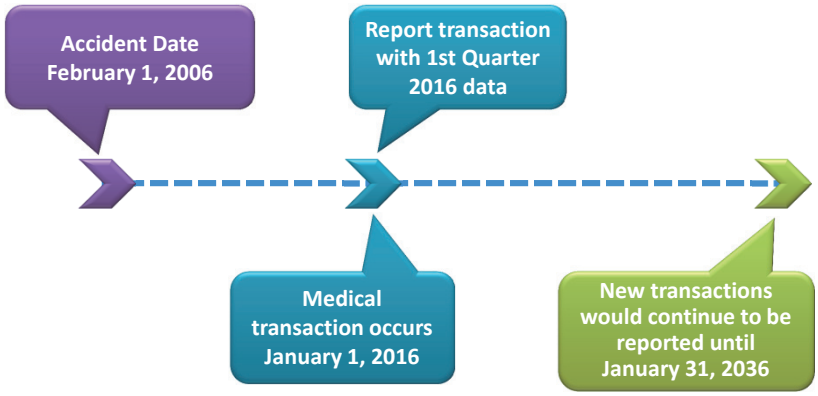
Reporting Duration Example 1

Part 2—General Rules



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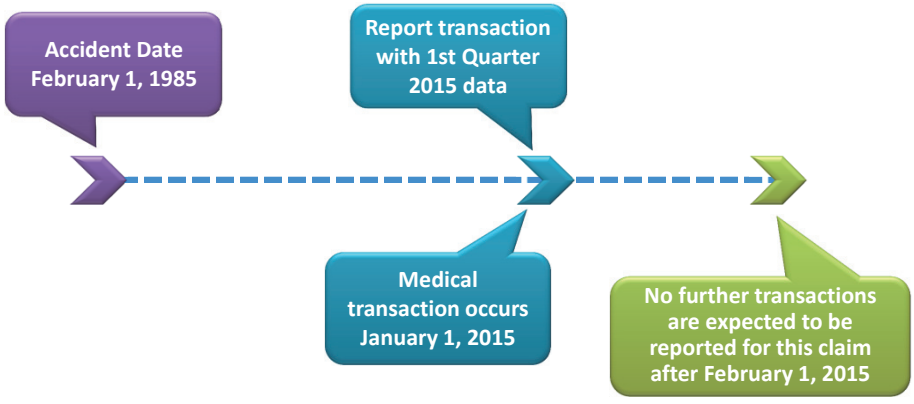
Reporting Duration Example 2

Part 2—General Rules



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Medical Data Call Structure

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28 Medical Data Elements

Part 3—Call Structure

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

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Key Partnership

Carrier Group	Medical Data Call	Vendor
Carrier Code	Carrier Code	
Policy Number ID	Policy Number ID	
Policy Effective Date	Policy Effective Date	
Claim Number ID	Claim Number ID	Claim Number ID
	Bill ID Number	Bill ID Number
	Line ID Number	Line ID Number
	Service Provider Information	Service Provider Information
	Procedure Information	Procedure Information

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Medical Data Call Record Layout

Part 4—Record Layout

Medical Data Call Record Layout

Field No.	Field Title/ Description	Class	Position	Bytes	Header/ Detail	Source
1	Carrier Code*	N	1–5	5	H	Payer
2	Policy Number Identifier*	AN	6–23	18	H	CMS 11
3	Policy Effective Date*	N	24–31	8	H	
4	Claim Number Identifier*	AN	32–43	12	H	Payer
5	Transaction Code	N	44–45	2	D	Payer
6	Jurisdiction State Code	N	46–47	2	H	Payer
7	Claimant Gender Code	AN	48	1	H	CMS 3 UB 11
8	Birth Year	N	49–52	4	H	CMS 3 UB 10
9	Accident Date	N	53–60	8	H	CMS 14
10	Transaction Date	N	61–68	8	D	Payer
11	Bill Identification Number*	AN	69–98	30	H	Payer
12	Line Identification Number*	AN	99–128	30	D	Payer
13	Service Date	N	129–136	8	D	CMS 24A UB 45
14	Service From Date	N	137–144	8	H	CMS 18 UB 6

For specific data element reporting instructions, refer to the Data Dictionary section (Part 5) of the ***Medical Data Call Reporting Guidebook***.

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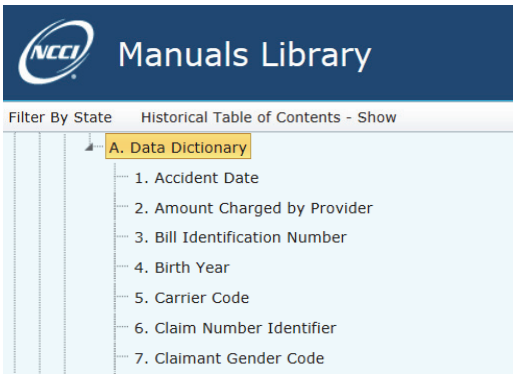
Data Dictionary

Part 5—Data Dictionary



The Data Dictionary section of the ***Medical Data Reporting Guidebook*** contains alphabetized and numbered metadata.

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Data Dictionary

Part 5—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:	A/N 8, 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 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 can click to view/print details: Place of Service Crosswalk (pdf).

Place of Service[*]			
Code	**Description**	**Code**	**Description**
01	Pharmacy	33	Custodial Care Facility
02	Unassigned—Not valid for NCCI	34	Hospice
03	School	35–40	Unassigned—Not valid for NCCI
04	Homeless Shelter	41	Ambulance—Land
05	Indian Health Service—Free-Standing Facility	42	Ambulance—Air or Water

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Data Dictionary

Part 5—Data Dictionary

14. Place of Service Code

Field(s):	27
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05	Indian Health Service—Free-Standing Facility	42	Ambulance—Air or Water

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Data Dictionary

Part 5—Data Dictionary

Place of Service Crosswalk				
Type of Bill	**Type of Bill Position 1 (Type of Facility)**	**Type of Bill Position 2 (Bill Classification)**	**Place of Service***	**Place of Service Description**
11X	Hospital	Inpatient	21	Inpatient Hospital
12X	Hospital	Inpatient	21	Inpatient Hospital
13X	Hospital	Outpatient	22	Outpatient Hospital
14X	Hospital	Other	22	Outpatient Hospital
18X	Hospital	Swing Bed	21	Inpatient Hospital
21X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility
22X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility
23X	Skilled Nursing	Outpatient	32	Nursing Facility
28X	Skilled Nursing	Swing Bed	32	Nursing Facility
32X	Home Health	Inpatient	12	Home
33X	Home Health	Outpatient	12	Home
34X	Home Health	Other	12	Home

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Medical Call Transactions

Part 6—Reporting Rules

Transaction Code	Use	Transaction Date
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.

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Medical Call Transactions

Part 6—Reporting Rules

Transaction Code	Use	Transaction Date
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	• All previously reported fields must be reported, even if there is no change • Report current cumulative values, not change in value	

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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.

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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.

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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

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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

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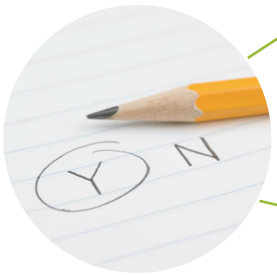
Certification/Testing

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



Edits

- 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

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Certification Process

Three-Step Process

Setup

Testing

Approval

Required forms are completed and submitted

Test file is created and submitted

The quality of the data is acceptable

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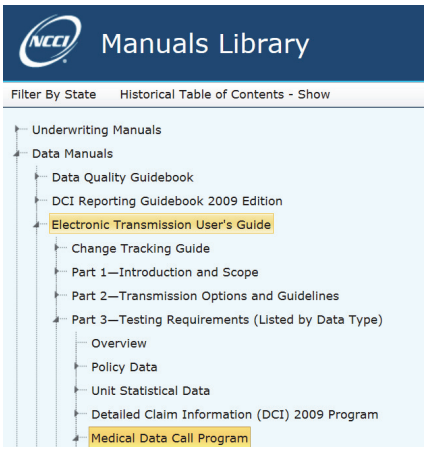
Electronic Transmission User's Guide



- 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.

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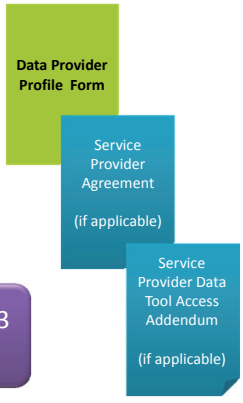
TPA Requirements

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.

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"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

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Editing and Validation

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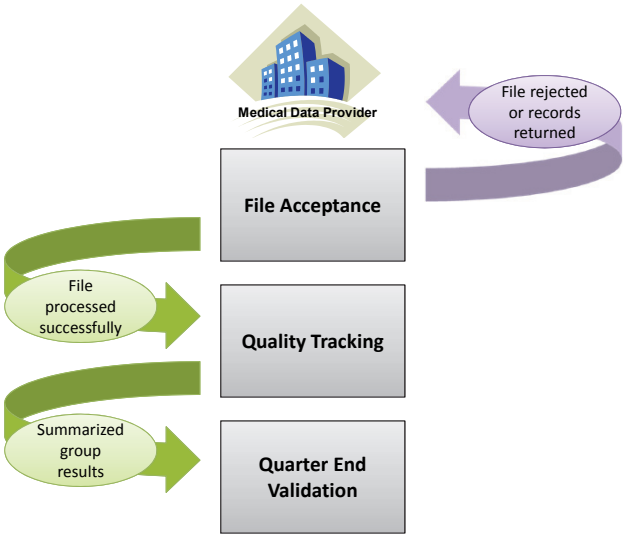
Editing Flow



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Three Stages of Editing

Part 7—Editing and Other Validation Procedures

File Acceptance	Quality Tracking	Quarter End Validation
• Submission, field, relational edits • Pass or reject and return file/records	• Field, logical, relational edits • Count occurrences • Results available for viewing in ***Medical Data Collection*** tool	• Logical and relational edits, distributions • Count occurrences are aggregated • Results available for viewing in ***Medical Data Collection*** tool

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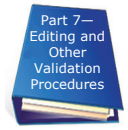
Edit Types



Each edit is classified as a specific edit type:

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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

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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

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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

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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

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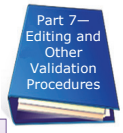
Edit Categories



Critical (C)	Elements necessary for a transaction to have value
Priority (P)	Elements needed for legislative analysis
Supplemental/ Low (L)	Elements used in specialized studies

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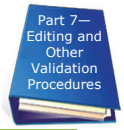
Elements by Category



Critical	Priority	Supplemental/Low
Accident Date	Network Service Code	Birth Year
Amount Charged by Provider	Provider Identification Number	Claimant Gender Code
Jurisdiction State Code	Provider Postal Zip Code	Second Paid Procedure Code Modifier
Paid Amount	Quantity	Secondary ICD Diagnostic Code
Service Dates	Paid Procedure Code	Secondary Procedure Code
	Place of Service Code	
	Provider Taxonomy Code	
	Primary ICD Diagnostic Code	
	First Paid Procedure Code Modifier	

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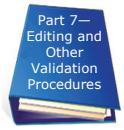
Edit Matrix



Medical Data Call Edits

MEDICAL DATA CALL EDIT MATRIX—ALL EDITS IN PRODUCTION (August 20, 2015 release)

Edit #	Data Field	Edit Message	Trans Code	Edit Type	Stage of Editing	Outcome	Effective Date	Update Date	Changes
0001-01	Accident Date	Accident Date is missing, or not a valid date.	01 03	F	Quality Tracking	Count occurrences	04/01/2010	04/01/2010	Edit added.
0028-01	Carrier Code	Carrier Code is missing or not a valid carrier code.	01 02 03	F	File Acceptance	Return record /Reject file	04/01/2010	04/01/2010	Edit added.
0028-02	Carrier Code	Medical Data Provider is not certified for Carrier Code.	01 02 03	S	File Acceptance	Reject file	04/01/2010	04/01/2010	Edit added.
0028-04	Carrier Code	Carrier Code is not associated with the Carrier Group in the submission.	01 02 03	S	File Acceptance	Reject file	04/01/2010	04/01/2010	Edit added.
0033-01	Claim Number Identifier	Claim Number Identifier is invalid, missing, or all zeros.	01 02 03	F	File Acceptance	Return record /Reject file	04/01/2010	04/01/2010	Edit added.
0108-01	Jurisdiction State Code	Jurisdiction State Code is missing.	01 03	F	Quality Tracking	Count occurrences	04/01/2010	04/01/2010	Edit added.
0108-02	Jurisdiction State Code	Jurisdiction State Code is not valid.	01 03	F	Quality Tracking	Count occurrences	04/01/2010	04/01/2010	Edit added.
0108-04	Jurisdiction State Code	Jurisdiction State Code is not an applicable jurisdiction.	01 03	F	Quality Tracking	Count occurrences	04/01/2010	04/01/2010	Edit added.
0153-01	Policy Effective Date	Policy Effective Date is missing or not a valid date.	01 02 03	F	File Acceptance	Return record/ Reject file	04/01/2010	05/03/2010 04/01/2010	Policy Effective Date is now a key field, and supporting changes have been made. Edit added.

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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

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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

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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***

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Reporting Issue—Network Service

Incorrect Reporting of Network Service Code

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

Code	Description
H	HMO—the medical service provider belongs to a Health Maintenance Organization
N	No Agreement—the medical service provider does not belong to a provider network
P	Participation Agreement—the medical service provider is part of an agreement that is not an HMO or PPO
Y	PPO Agreement—the medical service provider belongs to a Preferred Provider Organization agreement

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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.

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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***.

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Medical Data Call Compliance Overview

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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

Alabama	Florida	Kentucky	Nebraska	South Carolina
Alaska	Georgia	Louisiana	Nevada	South Dakota
Arizona	Hawaii	Maine	New Hampshire	Tennessee
Arkansas	Idaho	Maryland	New Mexico	Utah
Colorado	Illinois	Mississippi	Oklahoma	Vermont
Connecticut	Iowa	Missouri	Oregon	Virginia
District of Columbia	Kansas	Montana	Rhode Island	West Virginia

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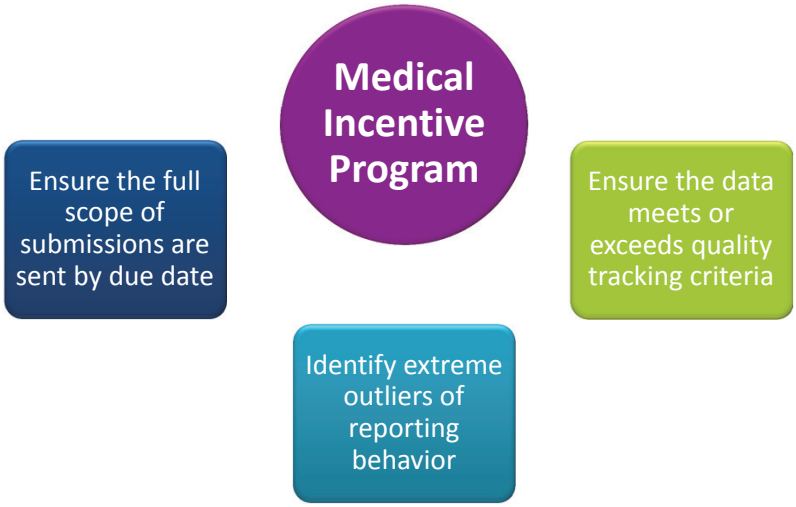
Medical Incentive Program Objectives



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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.

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Carrier Data Quality Report Program (Report Card) Objectives

Report Card

Evaluates data provider groups' overall annual reporting performance

Medical Addendum

Grading Pass or Fail based on Completeness/ Quality

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Carrier Data Quality Report Medical Data Addendum

Carrier Data Quality Report (Report Card)
Company Specific Data Availability Results – Data Due in 2012
(Sample Medical Data Addendum)

Carrier Group Code: XXXXX
Carrier Group Name: XXXXX

Evaluation Date: 01/01/2013
Creation Date: 01/15/2013

		Completeness			Quality				
Reporting Quarter	Due Date	% Categories Completed on Time	Quarters Completed on Time	Grade	Critical Elements	Priority Elements	Low Elements	Quarters Passing	Grade

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

Completeness Grading	Quality Grading
Completeness Grading is based on the number of **Quarters Completed on Time**. A quarter is complete when 100% of categories are completed by the Due Date. PASS >= 3 quarter(s) completed on time FAIL < 3 quarter(s) completed on time	Quality Grade is based on the number of **Quarters Passing**. A quarter passes if: • 0 Fined Critical Elements • <=2 Fined Priority Elements • <=2 Fined Low Elements PASS >= 3 quarter(s) passing FAIL < 3 quarter(s) passing

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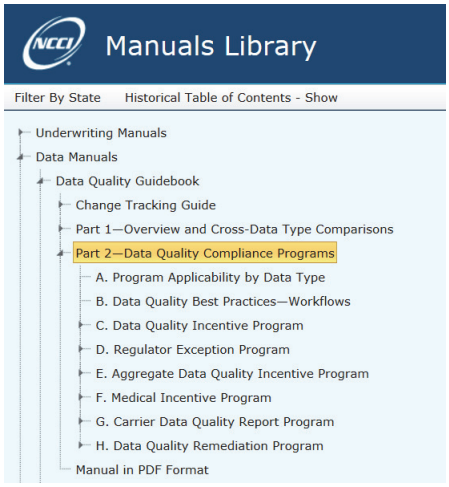
Compliance Resources—ncci.com

- ***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**.



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Compliance Resources—ncci.com

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Accessing the Data Quality Guidebook

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Accessing the Data Quality Guidebook

MIP—Section F

- F. Medical Incentive Program
  - 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
- G. Carrier Data Quality Report Program
- H. Data Quality Remediation Program

Manual in PDF Format

Report Card—Section G

- 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
  - 10. Carrier Data Quality Report Program (Report Card) Workflow
- H. Data Quality Remediation Program

Manual in PDF Format

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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

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Medical Data Collection Tool

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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

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Submitter/Vendor Workflow

Prepare Data and Submit File	Submission Tracking	Quality Tracking
• 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)***	• Review the Submission Tracking Results through the ***Medical Data Collection*** tool • Ensure that the submission status of all files is marked as Completed	• 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

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Manager/Carrier Workflow

Submission Tracking	Quarter End Validation	Incentive Program
• Review the submission results through the ***Medical Data Collection*** tool • Ensure that all medical data providers have submitted for the quarter	• Review the Completeness and Quality results for NCCI compliance states and applicable independent bureau states	• 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

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Medical Data Collection—ncci.com

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Additional Resources

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Additional Resources

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.

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Additional Resources—ncci.com

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Additional Resources—ncci.com

Data Reporting

- GENERAL
- POLICY AND POC
- UNIT STATISTICAL DATA
- FINANCIAL CALLS
- DETAILED CLAIM INFORMATION
- MEDICAL CALL
- POOL DATA

Tools

- Circulars
- Data Manager Dashboard
- Data Transfer via the Internet
- Manuals Library
- Medical Data Collection
- State Insight

Resources

- Medical Edit Matrix
- Medical Data Call Reporting FAQs
- Medical Data Call Tools and Resources (PDF)

Learning Center

- Medical Data Call—Overview—Webinar on Demand
- Medical Data Call—Editing 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 Codes—Implementation October 1, 2015

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Additional Resources—ncci.com

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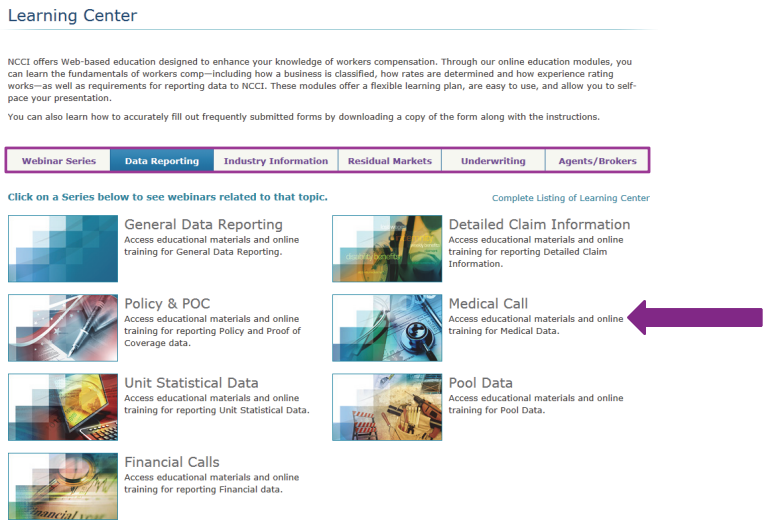
Additional Resources—ncci.com



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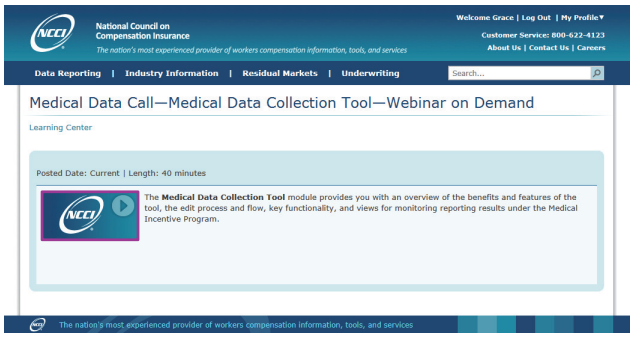
Medical Data Call Webinars

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



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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

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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

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Questions

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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 lead 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.