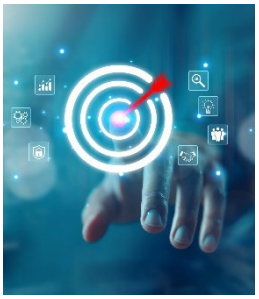
Data Now Program (DNP)

Medical Data Call Reporting Practices and Medical Incentive Program

Key Takeaways



- Key Fields and Preferred Key Field Change Process
- Facility fees and hospital inpatient reporting
- Case management reporting
- Details of the ***Medical Incentive Program (MIP)*** compliance criteria
- Monitor your reporting performance using the ***Medical Data Collection (MDC)*** tool

Medical Data Elements

There are 29 data elements in the Medical Data Call.

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 Identification Number	Line Identification Number
Service Date	Service From Date	Service To Date	Paid Procedure Code
Paid Procedure Code Modifier(s)	Amount Charged by Provider	Paid Amount	Primary ICD Diagnostic Code
Secondary ICD Diagnostic Code	Provider Taxonomy Code	Provider Identification Number	Provider Postal (ZIP) Code
Network Service Code	Quantity/Number of Units per Procedure Code	Place of Service Code	Secondary Procedure Code
Provider Postal (ZIP+4) Code			

Bill Line Transaction Key Fields

Of the 29 Medical Data Call elements, the Medical Bill Line Key Fields include:

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Bill Identification Number
- Line Identification Number

Importance of Claim Key Fields

Carrier Code, Policy Number, Policy Effective Date, and Claim Number are used to identify a unique claim. NCCI uses these four fields to create a Claim ID.

The Claim ID links payments and services together for the life of a particular claim.

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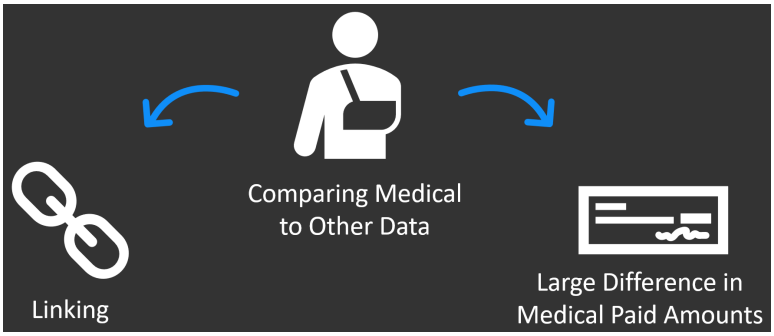
Consistency With Other Reporting

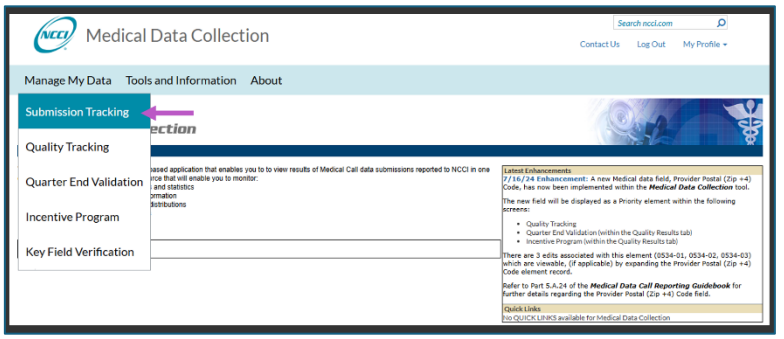
Various elements may be applicable across multiple data types. In the Medical Data Call, NCCI links to other data types that are reported.

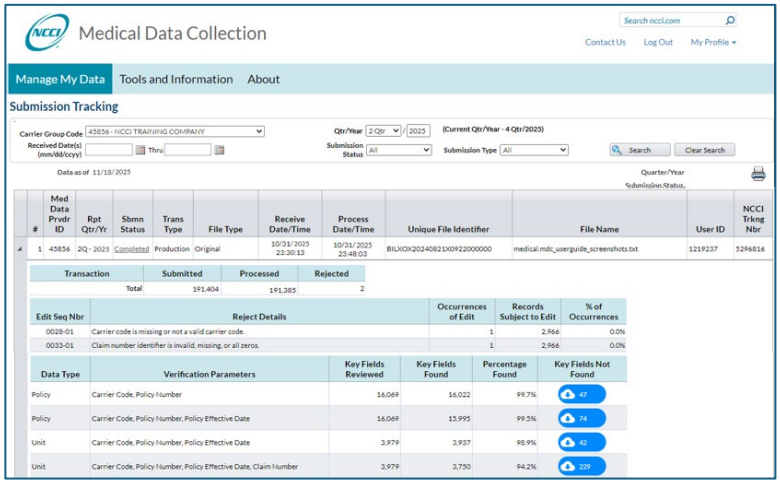
Consistency is "KEY" when reporting!



Submission Tracking: File Level View

The ***Medical Data Collection*** tool's Submission Tracking page provides a list of file submissions for a given Received Date or Quarter/Year.





Submission Tracking provides:

- Submission status (File acceptance or rejection)
- File attributes
- Key Field Verification at the file level

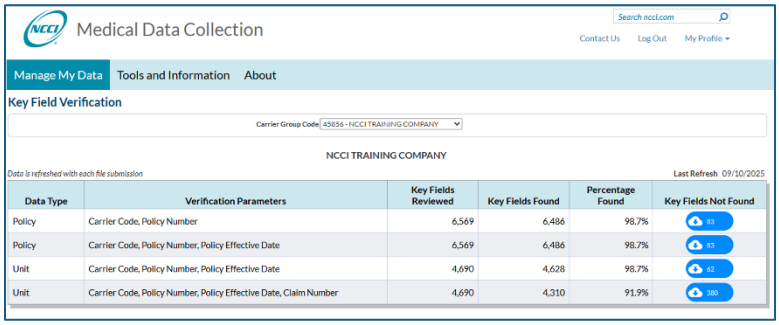
NCCI compares Policy and Unit Statistical Data for specific Policy Effective Date ranges to determine when data is expected by NCCI.

Data Now Program (DNP)

Medical Data Call Reporting Practices and Medical Incentive Program

Key Field Verification—Aggregate at Group Level

The Key Field Verification is aggregated from all data providers for a carrier group. This information is available to carriers and Group Level access providers. It displays Group Level Key Field Verification results.



Data Type	Verification Parameters	Key Fields Reviewed	Key Fields Found	Percentage Found	Key Fields Not Found
Policy	Carrier Code, Policy Number	6,569	6,486	98.7%	83
Policy	Carrier Code, Policy Number, Policy Effective Date	6,569	6,486	98.7%	83
Unit	Carrier Code, Policy Number, Policy Effective Date	4,690	4,628	98.7%	62
Unit	Carrier Code, Policy Number, Policy Effective Date, Claim Number	4,690	4,310	91.9%	380

NCCI reviews Policy Keys and Unit Statistical Claim Keys. We work with the Carrier Group Contact to determine the root cause of key fields not matching.

Medical Data Call Key Field Change Process

Transaction 04—Key Field Change is used to change previously reported Medical Data Call records at the claim key level. This transaction could be used for distinct reasons where the claim keys need to be changed.

- Changing medical keys at the claims level (versus doing so at the transaction level)
- A claim could be matched to the wrong Policy Number
- The Policy Effective Date should be the start of the policy rather than the policy term in which the claim occurred
- The Claim Number could be missing a prefix or suffix (**Note:** Even leading zeros cause a mismatch)

Work with your assigned validator for this type of change!

The Key Field Change file must only include Key Field Change transactions in the record layout.

Medical Data Call—Transaction 04—Key Field Change Record Layout				
Field No.	**Field Title**	**Class**	**Position**	**Bytes**
1	Previous Carrier Code	N	1–5	5
2	Previous Policy Number Identifier	AN	6–23	18
3	Previous Policy Effective Date	N	24–31	8
4	Previous Claim Number Identifier	AN	32–43	12
5	Transaction Code	N	44–45	2
6	Carrier Code	N	46–50	5
7	Policy Number Identifier	AN	51–68	18
8	Policy Effective Date	N	69–76	8
9	Claim Number Identifier	AN	77–88	12
10	Reserved for Future Use		89–350	262

Fields 1 through 4 are the key fields already reported on the Bill Line Detail submission and are in NCCI's database.

Field 5 is "04," indicating a Key Field Change.

Fields 6 through 9 will include the key fields (new keys) as they should be reported going forward. Correctly reporting these fields in the Key Field Change file will allow NCCI to apply these Key Field Changes to all affected records in the medical data call database to update the claim keys.

Future bill line transactions for the claim will need to be reported with the new updated claim keys.

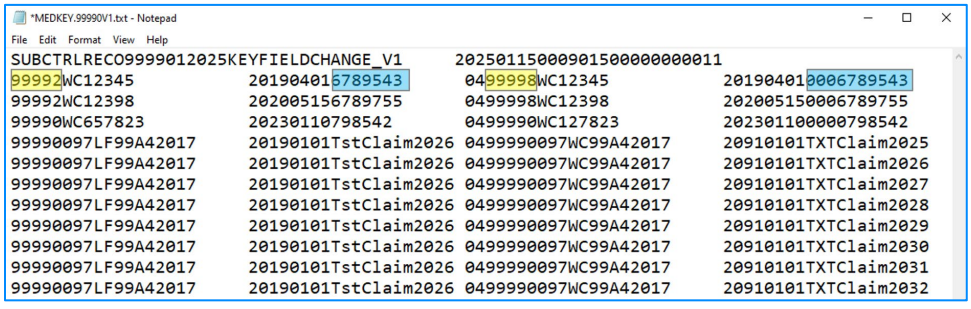
Key Field Change Example

Changing the Carrier Code and Claim Number Identifier:

Field No.	Field Title	Position	Reported As
1	Previous Carrier Code	1–5	99992
2	Previous Policy Number Identifier	6–23	WC12345
3	Previous Policy Effective Date	24–31	20190401
4	Previous Claim Number Identifier	32–43	6789543
5	Transaction Code	44–45	04
6	Carrier Code	46–50	99998
7	Policy Number Identifier	51–68	WC12345
8	Policy Effective Date	69–76	20190401
9	Claim Number Identifier	77–88	0006789543
10	Reserved for Future Use	89–350	

Medical Key Field File—Example

- Previous Carrier Code in positions 1 through 5
- New Carrier Code in positions 46 through 50
- Claim Number, missing the leading zeros, in positions 32 through 43
- New Claim Number with the leading zeros in positions 77 through 88



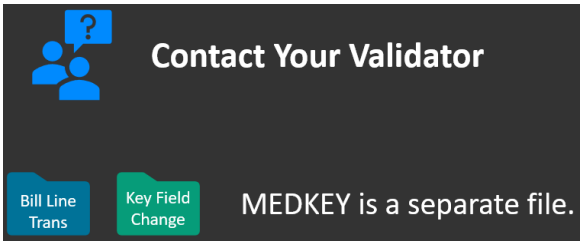
Key Field Change File Submission Overview

- Submit a file using the certifications/test file identifier
- NCCI prefers to receive Key Field Change files as certifications/tests prior to applying the changes in our database
- Use the appropriate file name
- Submission edits are applied to the file to verify the file can be loaded correctly
- Some results are displayed in the ***Medical Data Collection*** tool, Submission Tracking Screen, File Level

Recommended Key Field Change Process

The recommended Key Field Change process is only available to carriers and Group Level access providers.

- Carriers and Group Level providers only
- Does not change the current reporting requirements
- Submit a MEDKEY file containing ONLY the Key Field Changes
- When successful, the Key Field Change is applied across the Medical Data Call database



Duplicate Billing

Duplicate Records

Duplicate records are two or more records that refer to a single service that was performed by a medical provider. These duplicates can:

- Affect medical analysis by overstating utilization
- Inflate costs and impact analysis

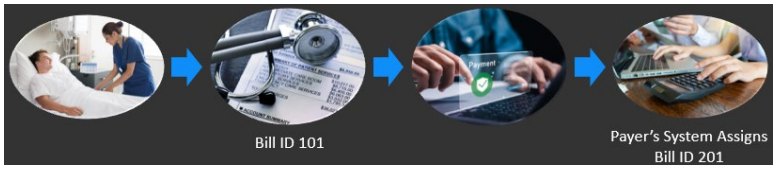
Duplicate Billing—Mirror Duplicates

Mirror duplicates can occur due to the timing between the medical service provider sending the bill and when payment is received or because of additional reimbursements.

Example:

- An injured worker visits a doctor for a medical service
- The doctor then bills the insurance company for the service (Bill ID 101)
- The payment does not make it into the doctor's billing system before the next billing cycle

- Another bill for the same service is submitted to the insurance company, and the payer's system assigns Bill ID 201 to the second notice



Claim #	Trans Code	Trans Date	Bill ID	Line ID	Paid Proc Code	Amount Charged	Paid Amount	Service Date
12345	01	20240102	101	1	99201	00000007500	00000007500	20231215
12345	01	20240201	201	1	99201	00000007500	00000007500	20231215

→ Filter duplicates!

The Bill Identification Numbers differ. The second record does NOT replace the first record in NCCI's database, which results in two records for a single medical service.

Data providers are responsible for filtering out duplicates before sending data to NCCI.

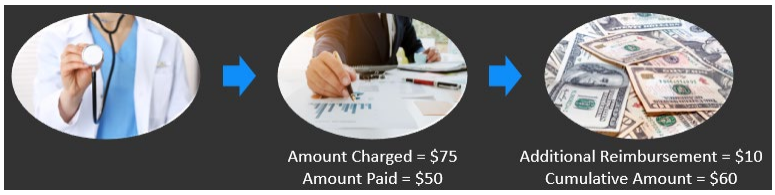
Duplicate Billing—Filtering Out Duplicates

IF …	THEN …
The first record has been submitted …	Do not submit the second record
Both records have been created in the same quarter and the first has not been reported …	Submit the second record only
Both records have been reported in different files …	Cancel the first original record

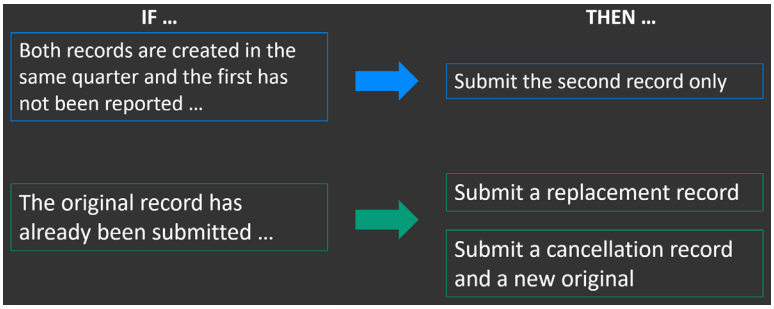
Duplicate Billing—Additional Reimbursements

Example:

- An injured worker visits a doctor for a medical service
- The doctor then bills the insurance company $75 for the service and is paid $50
- The insurance company pays an additional $10 reimbursement, bringing the total paid for the bill to $60



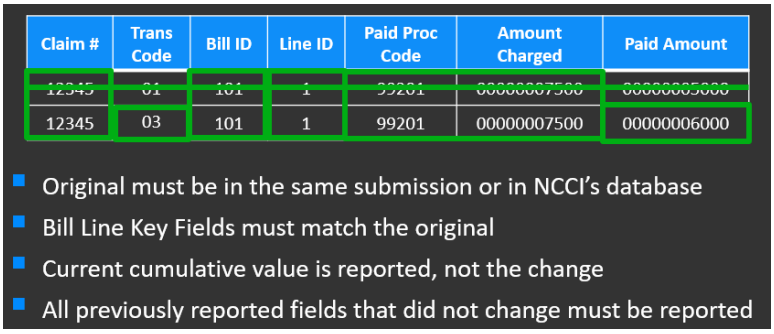
There are three reporting options for this payment situation:



Additional Reimbursements—Replacement Example

Submitting a replacement record (Transaction Code 03) overlays the original record to reflect the additional monies. Keep in mind:

- The original record must be in the same submission as the replacement record, or the original must be in NCCI's database.
- Report the same Bill Line Key Fields as reported on the original Bill ID or Line ID.
- Report the current cumulative value, not the change value. In this example, report the Paid Amount as $60. (**Note**: Reporting the change of $10 is not correct.)
- Because the replacement overlays the previously reported record, all fields must be reported even if no additional changes are needed.



Additional Reimbursements—Cancellation Example

Submitting a cancellation record (Transaction Code 02) deletes the original and then provides a new original (Transaction Code 01). Keep in mind:

- The original record must be in the same submission as the cancellation record, or the original must be in NCCI's database.
- The Bill Line Key Fields on the cancellation record must match the original record. (**Note**: For cancellation records, only the key fields need to be reported.)
- Report the current key fields on the new original. The Bill Identification and Line Identification may be unique.
- Report the cumulative value on the new original, not the change.

Claim #	Trans Code	Bill ID	Line ID	Paid Proc Code	Amount Charged	Paid Amount
~~12345~~	~~01~~	~~101~~	~~1~~	~~99201~~	~~00000007500~~	~~00000005000~~
12345	02	101	1	99201	00000007500	00000005000
12345	01	102	1	99201	00000007500	00000006000

- Original must be in the same submission or in NCCI's Database
- Bill Line Key fields on the cancellation must match the original; all other fields may be blank
- Current Bill Line key fields are reported on the new original
- Cumulative value is reported, not the change

Zero Paid Amounts

Whether a zero paid amount should be reported will depend on the situation.

- When a whole bill is denied because no services were related to a workers compensation claim, the service should not be reported.
- When a paid amount of zero is deemed to be the final payment amount after the transaction has been processed (e.g., a payment is denied because the service wasn't medically necessary) and the reason for a zero paid amount is not due to duplicate billing, this record should be reported.

Void or Stop Pay

For a stop pay or voided transaction, keep these reporting rules in mind:

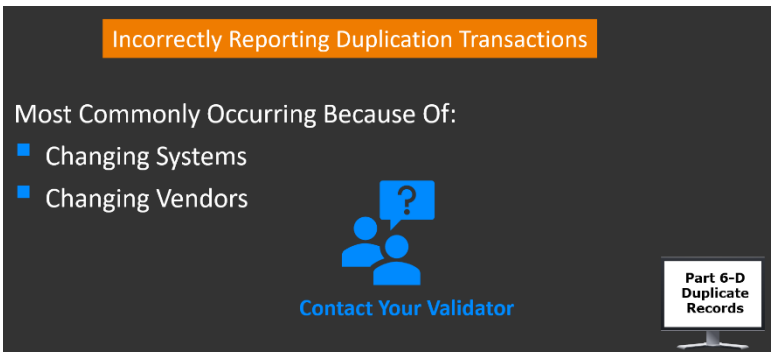
- If the void or stop pay occurs before a transaction is reported to NCCI, do not report it.
- If a payment transaction has been reported to NCCI prior to the void or stop pay, the transaction must be cancelled to remove it from NCCI's database.

Medical Data Call Reporting Guidebook
Part 6—Reporting Rules

Duplicate Billing

Duplicate billing can occur when:

- Implementing a new programming system
- Switching reporting vendors
- Two systems do not talk to each other or the billing history is not converted to the new system



Carriers should have clear start and end dates for the new and old systems, or the new data provider, to prevent issues. Notify NCCI when this occurs.

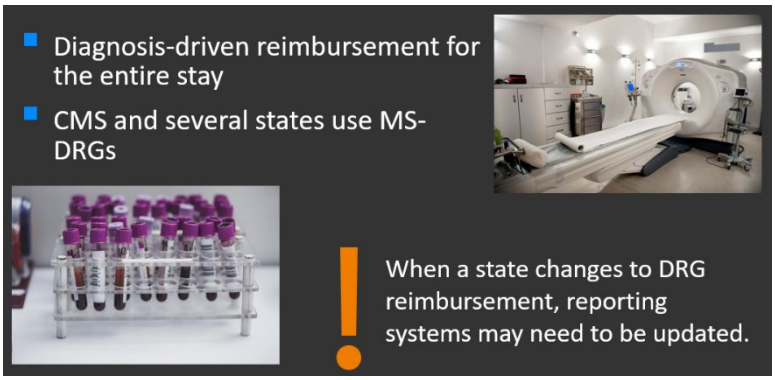
Facility Fees

Diagnosis Related Groups (DRG)

DRGs are a common method of reimbursing inpatient stays. Hospital stays can involve many individual services and materials, and reimbursement at that level can be challenging.

DRGs provide a reimbursement method, used by Medicare and other insurers, that can apply a single payment for the entire stay based on the diagnosis of the patient.

Your bill review vendors/contacts should be aware of when these changes occur. Working with them to make sure the change is reflected in your Medical Data Call is highly suggested.



DRG Versus Hospital Revenue Codes

Another method of reimbursing hospital inpatient stays includes the use of Revenue Codes.

Both DRG and Revenue Codes come from hospitals. Comparing the two codes:

DRG	Revenue Code
Applies to inpatient stays	May apply to inpatient stays
Calculated by the payer	Billed by the facility
A single DRG summarizes the payment	Multiple codes break down the costs
3-byte numeric code	4-byte numeric code

Leading zeros are important!

Note: Revenue Codes may be mistaken for DRGs if reported without the leading zeros.

Example

DRG Description	DRG Code	Revenue Code	Revenue Code Description
Heart Transplant or Implant of Heart Assist System With MCC	001	0001	Total Charges
Percutaneous Cardiovascular Procedure Without Coronary Artery Stent With MCC	250	0250	Pharmacy
Other Circulatory System O.R. Procedures	120	0120	Room-Board/ Semi-Private

Leading zeros are important!

Some inpatient hospital bills are submitted with a Revenue Code (**4-byte code**).

When you report a Revenue Code, whether reporting the code as a Primary Paid Procedure Code or Secondary Procedure Code, it must be reported in the **correct 4-byte format**.

Some hospitals show a Revenue Code on the bill in a **3-byte format**. If you report a Revenue Code in a 3-byte format, it may look like a DRG Code.

DRG is a payment system code used by **Medicare** and other insurers to classify illnesses according to the diagnosis and treatment; **DRGs are used to group all charges** for hospital inpatient services.

Inpatient Hospital Bills

Hospital bills representing multiple services may be reimbursed through several different methods.

Bundled

You may bundle, paying at the bill level (not at the individual service level).

If you're bundling, payments are consolidated into a single payment. It is on a single line (record) and reported with the appropriate DRG Code as the Paid Procedure Code. The DRG Code is the method of reimbursement for inpatient hospital stays that depend on factors related to the diagnosis (instead of paying for the charges, the payment is for the duration).

Example

For this period, $10,000 was charged and $8,000 was paid. The DRG in the Paid Procedure Code field is the code associated with the reimbursement.

Bundled

Line ID	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	1/30/2024	2/2/2024	508	0111	$10,000	$8,000

Incorrect Reporting Services Audited Separately

For services audited separately, do not report underlying records, which were bundled with the paid dollars that are already reflected. If reporting these records, use the same DRG and ensure the paid amount is only on one record.

Incorrect Reporting Services Audited Separately

Line ID	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	1/30/2024	2/2/2024	508	0111	$10,000	$8,000
2	1/30/2024	2/2/2024	508	0250	$0	$0
3	1/30/2024	2/2/2024	508	0270	$0	$0
4	1/30/2024	2/2/2024	508	0360	$0	$0
5	1/30/2024	2/2/2024	508	0370	$0	$0

The charged amount should be treated similarly to the paid amount. If bundling services into a single record, and bundling the charged amount into that record, do not report the charged amount for the individual services duplicated on those records.

Reporting Services Audited Separately

To correctly unbundle, either:

Report DRG payment record with total charges; Revenue Code transactions reported with no charges

OR

Report individual charges on Revenue Code transactions

Inpatient Hospital Bills—Method 1

Example of reporting DRG payment record with total charges, with Revenue Code transactions reported with no charges:

Line ID	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	1/30/2024	2/2/2024	508	0111	$10,000	$8,000
2	1/30/2024	2/2/2024	508	0250	$0	$0
3	1/30/2024	2/2/2024	508	0270	$0	$0
4	1/30/2024	2/2/2024	508	0360	$0	$0
5	1/30/2024	2/2/2024	508	0370	$0	$0

Inpatient Hospital Bills—Method 2

Example of reporting individual charges on Revenue Code transactions:

Line ID	Service From Date	Service To Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	1/30/2024	2/2/2024	508	0111	$2,000	$8,000
2	1/30/2024	2/2/2024	508	0250	$2,000	$0
3	1/30/2024	2/2/2024	508	0270	$2,000	$0
4	1/30/2024	2/2/2024	508	0360	$2,000	$0
5	1/30/2024	2/2/2024	508	0370	$2,000	$0

Service Dates

A Service Date identifies when the medical service was performed. The Medical Data Call record layout contains two reporting methods:

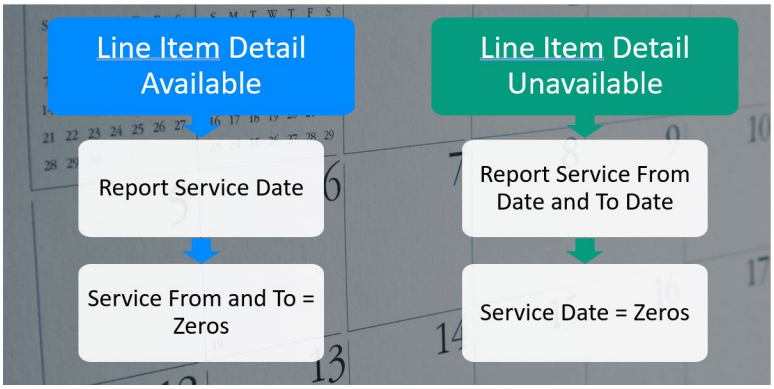
- Service Date
- Service From Date and Service To Date

Note: A Service Date is required for reporting. The method used will depend on whether the specific Service Date (or line item) detail is available.

Line Item Detail

Typically, a medical transaction will represent only one medical service (such as a doctor's office visit), and the date of that service will appear on the bill. The Service Date field should be reported and the Service From and Service To Dates reported as zeros.

However, it's common for inpatient hospital services to span multiple days, and the bill is processed as a bundled transaction. The dates for each service provided do not appear on the bill. In these circumstances, report the Service From Date and Service To Date. The Service Date is reported as zeros.



Service Date—Example

Scenario:

- Weekly physical therapy session
- Monthly bill for four sessions

Report the sessions individually:

Paid Procedure Code	Service Date	Service From Date	Service To Date	Quantity
97110	20240109	00000000	00000000	0000001
97110	20240116	00000000	00000000	0000001
97110	20240123	00000000	00000000	0000001
97110	20240130	00000000	00000000	0000001

Service Date Requirements

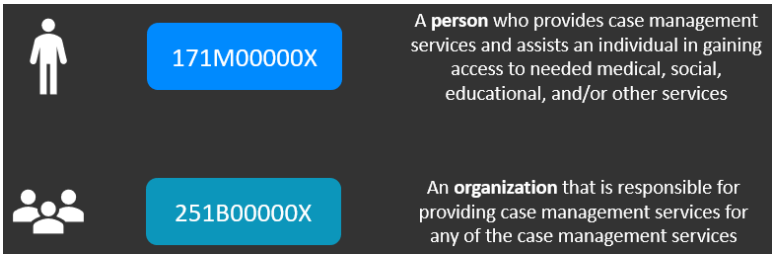
- MUST report either a Service Date or the combination of a Service From Date and Service To Date
- The date must be valid
- There must be a logical relationship between service dates and the Accident Date
  - Service From Date must be before Service To Date
  - All Service Dates must be on or after the Accident Date

Case Management Reporting

Case management services involve a coordinated approach for assessing, planning, and facilitating care or services for individuals to meet their health, social, or other needs. Case managers act as intermediaries between clients and services, ensuring that individuals receive the proper care and support. If the paid dollars are reported as medical dollars in unit reporting, then report medical call transactions.

Provider Taxonomy Code

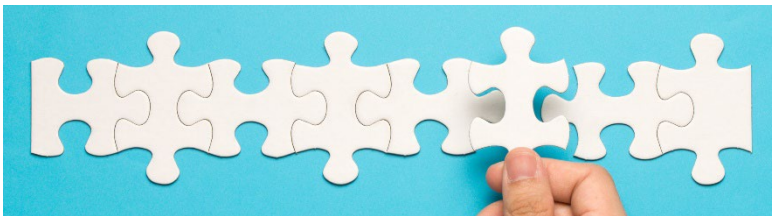
A Provider Taxonomy Code identifies the type of provider that billed for and is being paid for the medical service.



Associated Data Elements

Elements associated with case management reporting include:

- Paid Procedure Codes: Codes associated with reimbursement
- Place of Service: Where the medical service was performed
- Provider Identification Number: Uniquely identifies the service provider



Paid Procedure Codes

The two top codes associated with Case Management Reimbursement include:

- T2022—Case management, per month
- 99199—Unlisted special service

Place of Service

Determine if the services provided are:

- Telephonic services versus in-person services
- Based on monthly fees and not split out by visit

Use appropriate Place of Service (if provided). You may use Place of Service Code 99 if unspecified.

Validation Tests

NCCI has a suite of validation tests that run against the most recent quarter's data. Each test looks for a specific scenario in the data, identifies how often the scenario occurs, and identifies carriers that have that scenario occurring more or less often when compared to the industry.

Jurisdiction State to Provider State

NCCI compares Jurisdiction State to Provider State.

Note: Items such as the ZIP Code reporting of a billing house or central hospital billing location may skew data, making it appear as if more services are provided out of state.

The governing jurisdiction that would administer the claim and whose statutes will apply to the claim adjustment process
ZIP Code to the medical/service provider address where the service was performed

Jurisdiction to Provider State Example

Jurisdiction State	Provider State	Comparison
		MATCH
		Reasonable
		Less Likely

Medical Data Call Compliance

Topics

- Medical Compliance Program
- Incentive Program Components
  - Completeness
  - Quality
- Assessment Calculation
- Review and Appeals

Medical Compliance Programs Overview

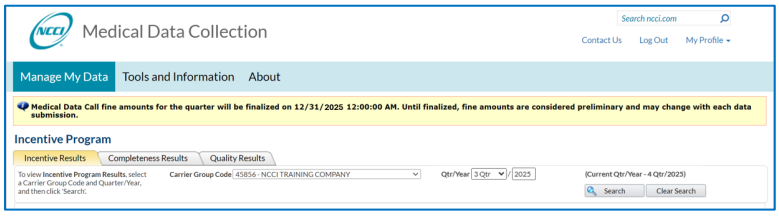
Compliance Programs

Medical Incentive Program	Carrier Data Quality Report Program Medical Data Addendum
■ Quarterly ■ Effective for new Medical Data Reporters after 4 Quarters	■ Annually ■ Included separately in Preliminary and Final

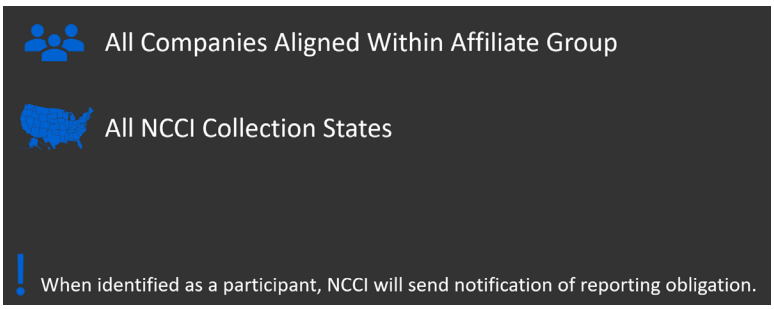
Medical Data Call Reporting Practices and Medical Incentive Program

Medical Incentive Program

Separate criteria for Completeness and Quality.



Medical Data Call Participation



When reporting the call data, all companies aligned within an affiliate group are expected to participate, and this applies across all NCCI collection states. If identified as a participant, NCCI provides notification of the reporting obligation to your company's executives. NCCI defines participation based on the affiliate level, way up at your parent's company of your parent company.

Evaluation Timing

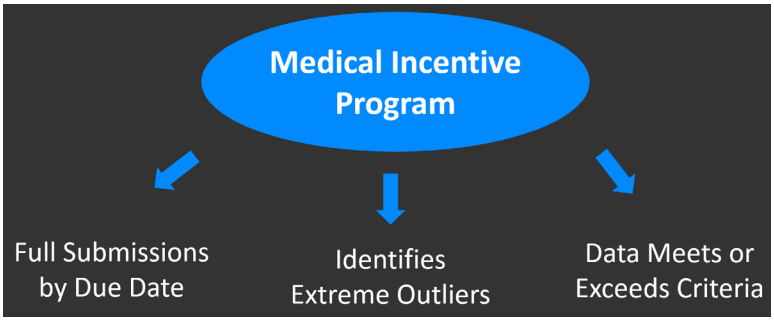
- Evaluate each reporting group quarterly
  - Date received as of due date

Transaction Quarter	Due Date
Q1	June 30
Q2	September 30
Q3	December 31
Q4	March 31

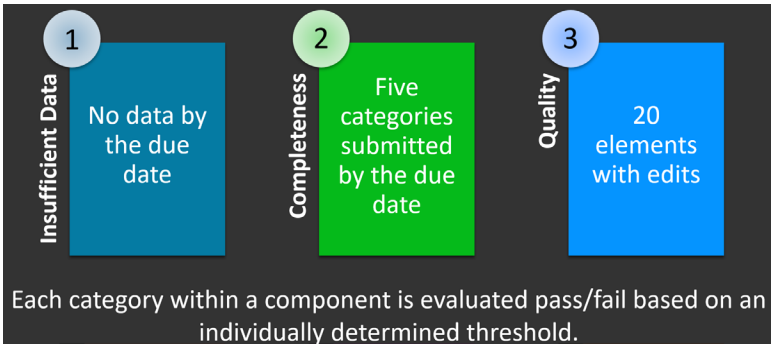
- Assessments (if any) are billed in the second month following the due date

Incentive Program Components

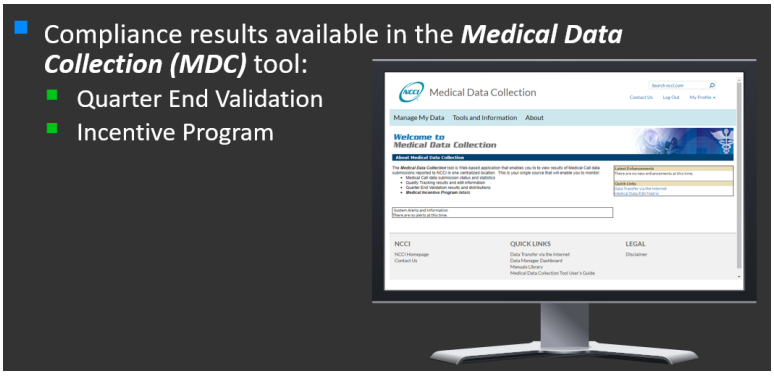
Compliance Objectives



Incentive Program Components



Medical Data Collection Tool



Quarter End Validation

- Displays Compliance Category Results
  - All medical states
  - NCCI compliance states
  - Independent bureau states (individually by state)
- Fine Amounts Are Not Displayed

- Will Show Independent Bureau States: IN, MI, MN, and NC

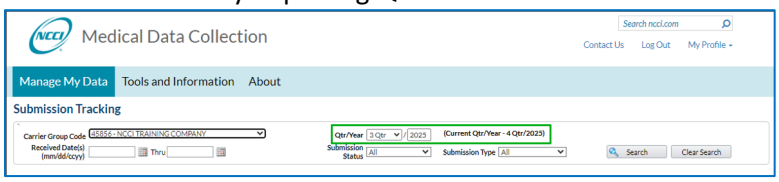
Incentive Program

- Displays Compliance Category Results
  - NCCI Compliance States Only
- Fine Amounts Are Displayed

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

Incentive Results Screen

- Search Results by Reporting Quarter



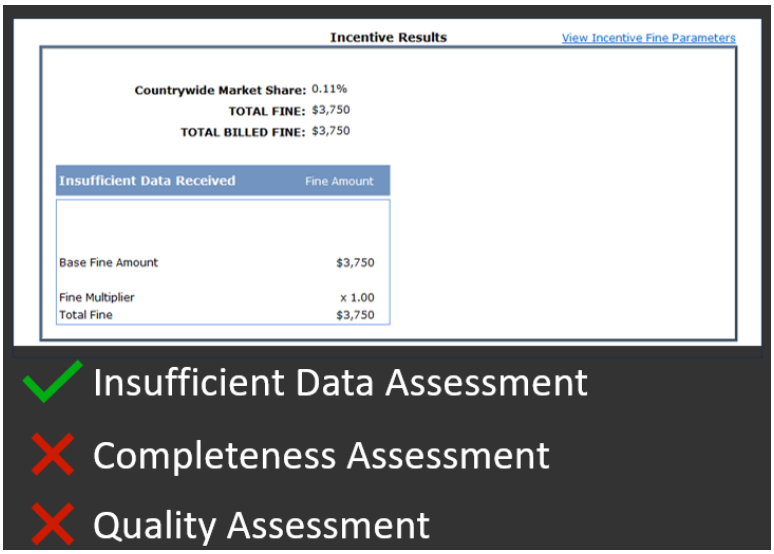
- View the Highest Level of Results
  - Which Components are failing?
  - How much is the fine amount?

Incentive Program Assessment Categories

1. Insufficient Data
2. Completeness
3. Quality

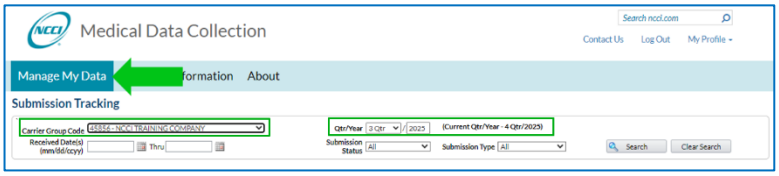
Medical Data Call Reporting Practices and Medical Incentive Program

Insufficient Data Assessment

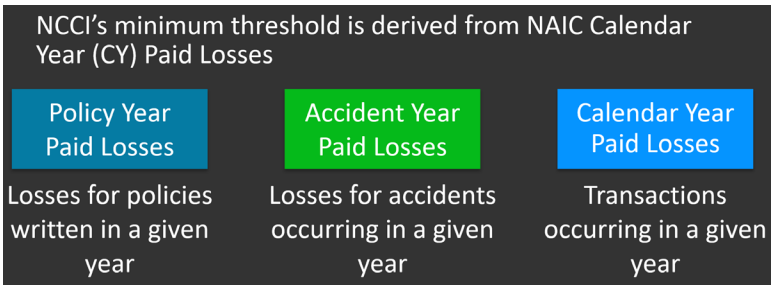


Submission Tracking

- Search Results by Reporting Quarter
- View the Status of Your Submissions
  - Was the file submitted?
  - Was the file processed or rejected?
  - Were any records returned?



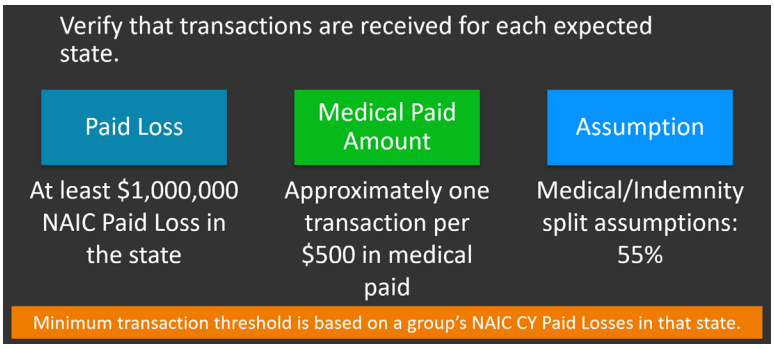
Completeness Components



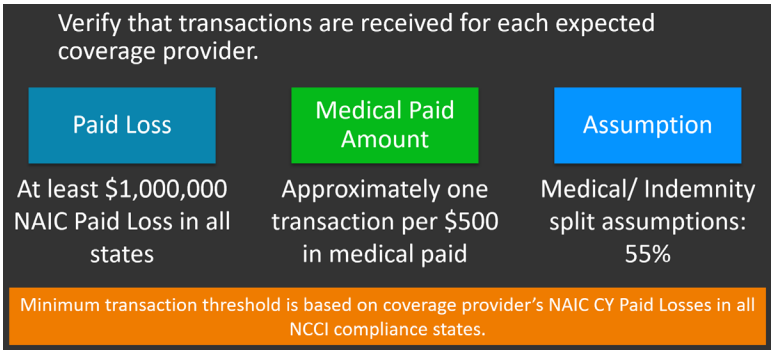
Completeness Components

- State
- Coverage Provider
- Medical Data Provider
- Medical Service
- Service Date Distribution

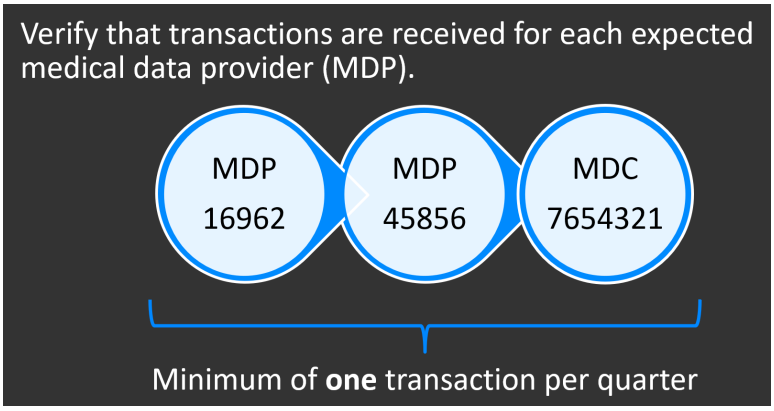
State



Coverage Provider



Medical Data Provider



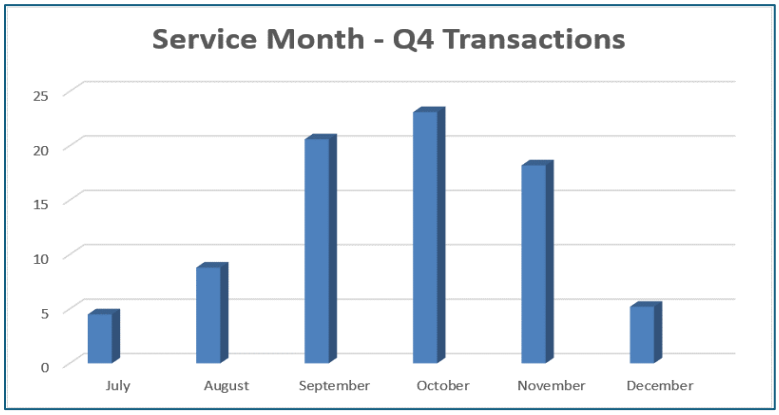
Medical Service

Verify that sufficient pharmacy data has been included in the quarterly data.

$$\frac{\text{\# of Transactions (Place of Service = Pharmacy + Taxonomy = Pharmacist)}}{\text{\# of Transactions Reported for the Quarter}} = \textbf{At least 4\% of transactions}$$

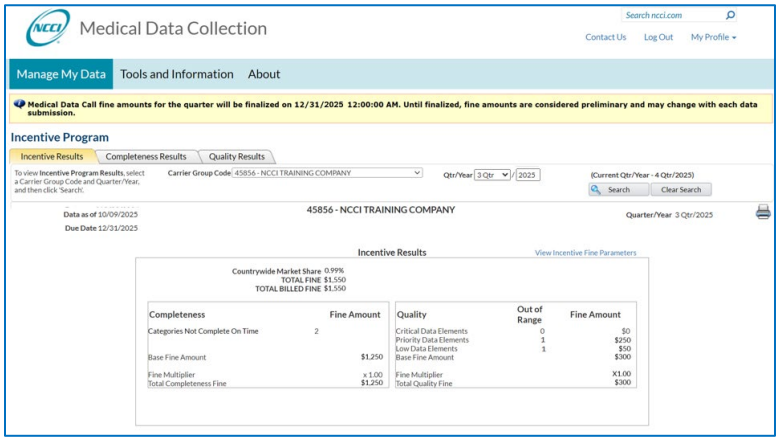
Service Date Distribution

The six most recent service months must have three consecutive months each containing at least 12% of the transactions submitted for the quarter.

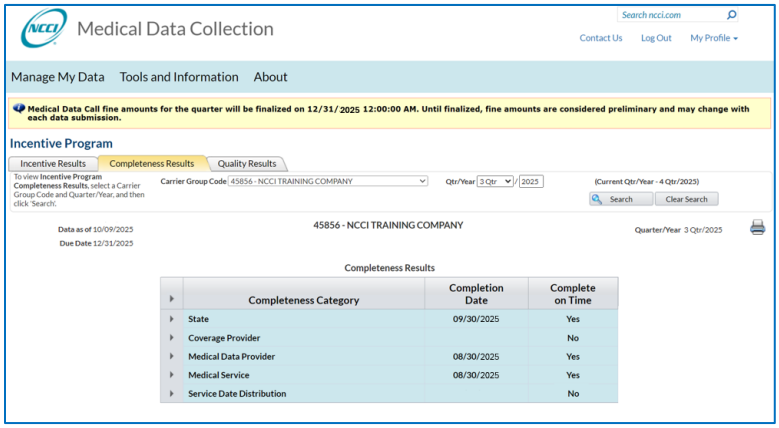


Two components of Completeness are not complete.

Incentive Results—Completeness

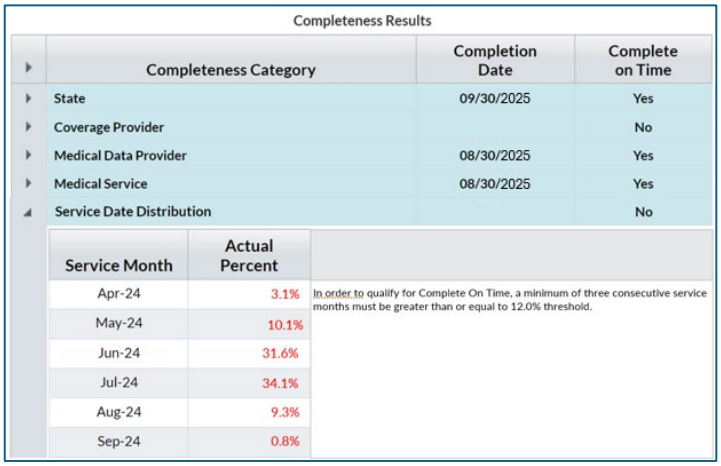


Completeness Results



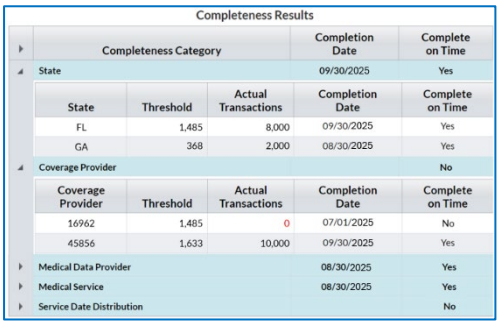
Service Date Distribution

Identifying the gap in service dates can reveal potentially missing transactions for May, August, or September.

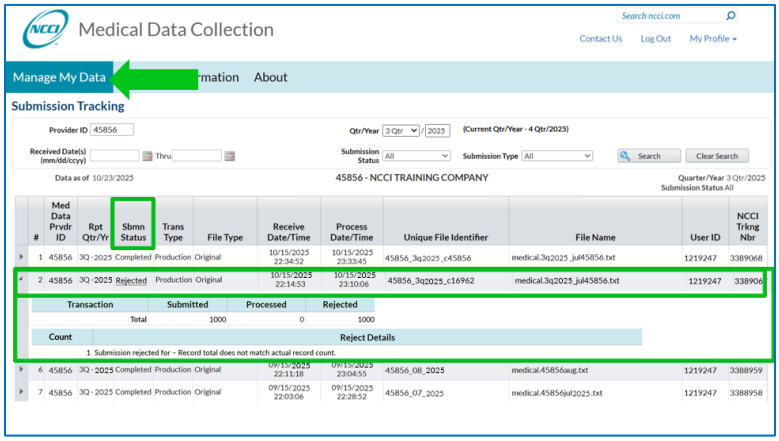


Trending Within a Category

Comparing the count of Actual Transactions to the Threshold for each State or Coverage Provider can reveal a potentially missing file for a Coverage Provider.



Research File Submissions



- Submission Status
- Rejected File
- Research Cause

Quality Components

Quality

Evaluate quality by data element:

Critical

Priority

Supplemental (Low)

Assessment

Based on level of elements below tolerance

Critical Elements

Elements necessary for a transaction to have value:

Element	Tolerance %
Accident Date	95
Amount Charged by Provider	95
Jurisdiction State Code	95
Paid Amount	95
Service Dates	95

Priority Elements

Elements needed for legislative analysis:

Element	Tolerance %
Network Service Code	95
Provider Identification Number (NPI)	**90**
Provider Postal (ZIP+4) Code Provider Postal Zip Code	**95** 0
Quantity/Number of Units per Procedure Code	95
Paid Procedure Code	90
Place of Service Code	80
Provider Taxonomy Code	80
Primary IDC Diagnostic Code	70
(First) Paid Procedure Code Modifier	5

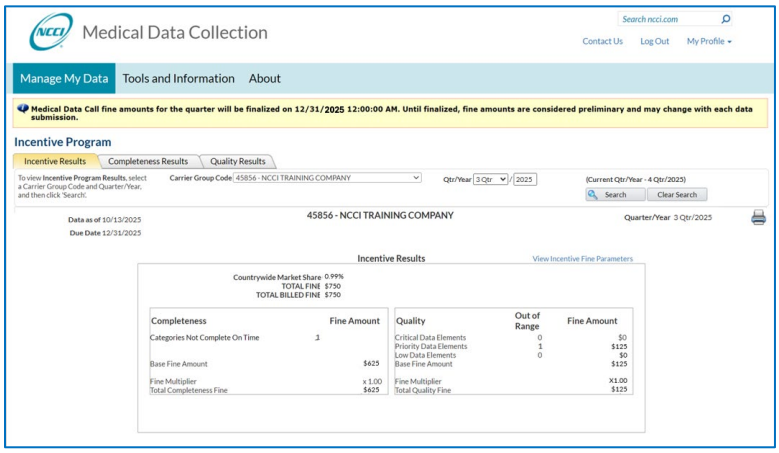
Supplemental (Low) Elements

Elements used in specialized studies:

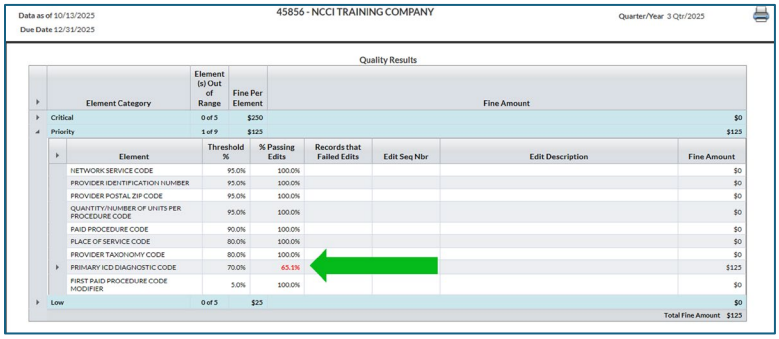
Element	Tolerance %
(Second) Paid Procedure Code Modifier	95
Birth Year	80
Claimant Gender Code	80
Secondary ICD Diagnostic Code	10
Secondary Procedure Code	0

Quality Component Example

- From the Manage My Data tab, select the Incentive Program
- Quality Results on the right
- Priority Data category shows one of the priority data elements does not meet the criteria



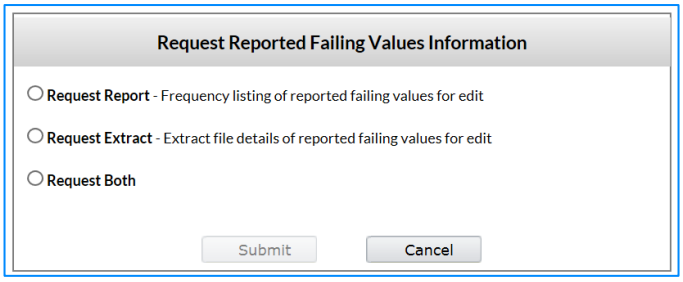
Primary ICD Diagnostic Code Element Example



Quality Results—Review Edit Extracts

Request reports of failing reported values.

- Quarter End Validation
- Incentive Program



Requested edit reports will be sent to your ***Data Transfer via the Internet (DTVI)*** mailbox.

Assessment Levels

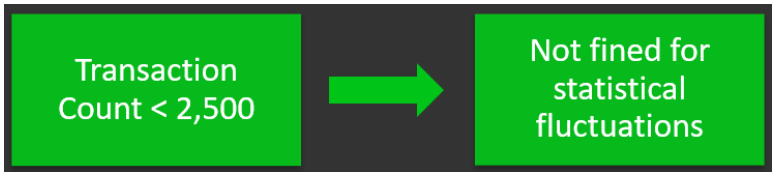
Assessment Level	Market Share Range
1	0.00%–0.25%
2	> 0.25%–1.50%
3	> 1.50%

Assessment Calculation

Assessment amounts are based on countrywide market share tiers:

Volume Eligibility

- Statistical inferences are less reliable for low transaction volumes



- Applies to:
  - Medical Services and Service Date Distribution Completeness categories
  - All Quality data elements

Assessment Amounts—Insufficient Data

Based on the reporting group's market share

Assessment Level	Market Share Range	Insufficient Data Assessment
1	0.00%–0.25%	$ 3,750
2	> 0.25%–1.50%	$ 7,500
3	> 1.50%	$15,000

Insufficient Data = No Files

Assessment Amounts—Completeness

Based on the reporting group's market share and the number of completeness categories that did not pass

Assessment Level	Market Share Range	Total Completeness Assessment Based on Categories Not Complete on Time		
		1	2	3–5
1	0.00%–0.25%	$ 625	$1,250	$ 2,500
2	> 0.25%–1.50%	$1,250	$2,500	$ 5,000
3	> 1.50%	$2,500	$5,000	$10,000

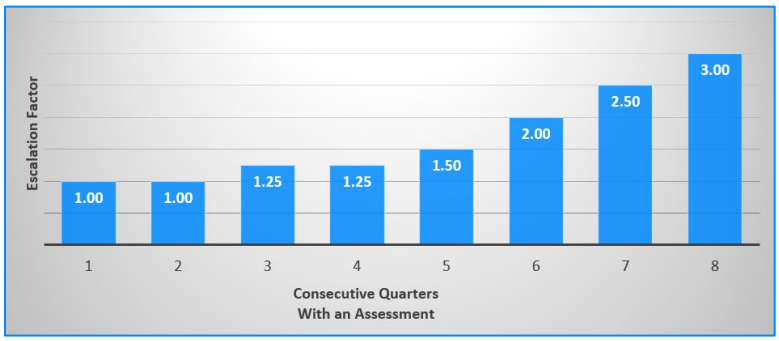
Assessment Amounts—Quality

Quality is based on the reporting group's market share and the tolerance level (Low, Priority, or Critical) of the data element.

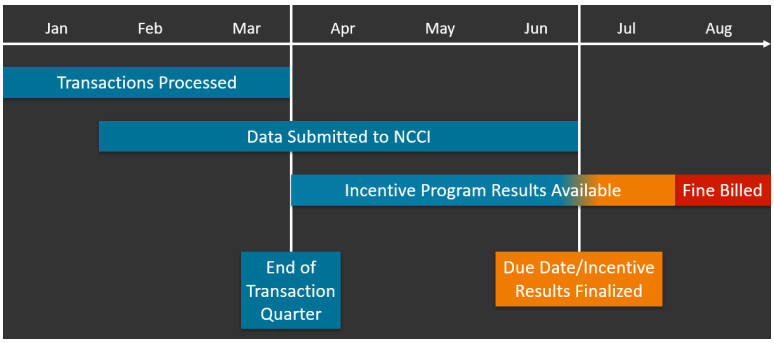
Assessment Level	Market Share Range	Quality Assessment per Data Element Based on Tolerance Level		
		Low	Priority	Critical
1	0.00%–0.25%	$ 25	$125	$ 250
2	> 0.25%–1.50%	$ 50	$250	$ 500
3	> 1.50%	$100	$500	$1,000

Assessment Amounts—Fine Multiplier

Assessment amount increases for groups having multiple consecutive quarters with an assessment.



First Quarter Transactions Timeline

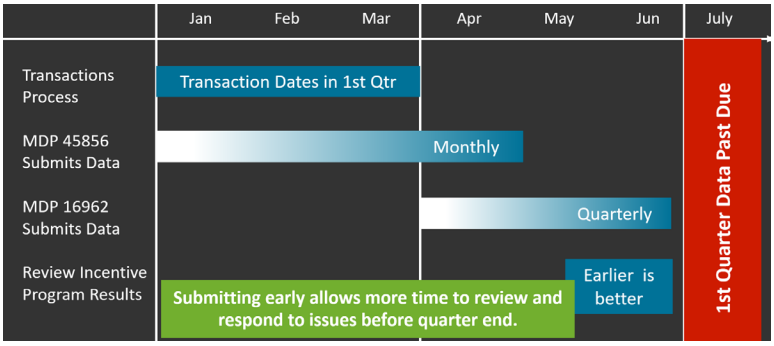


Quarterly Schedule Example

Group 45856—NCCI Training Company

- Small-sized regional carrier
- Provides coverage in Florida and Georgia
- Two coverage providers in the group 45856/16962
- Each carrier is its own Medical Data Provider (MDP)
  - Carrier/MDP 45856 reports monthly
  - Carrier/MDP 16962 reports quarterly

Quarterly Schedule Example



Carrier Data Quality Report—Medical Addendum

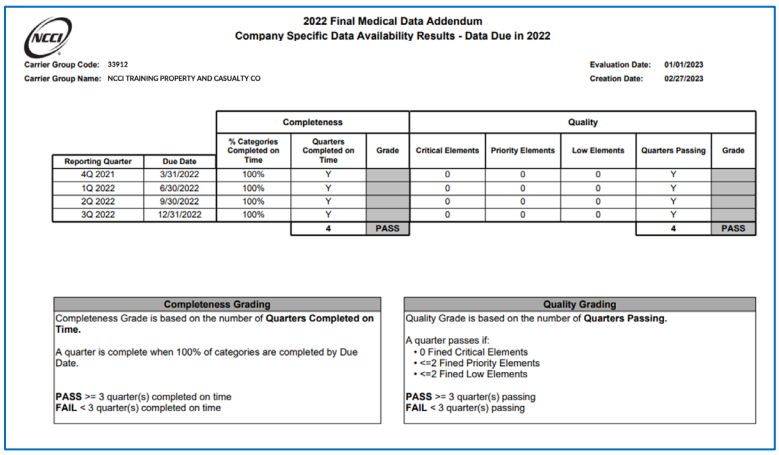
Carrier Data Quality Report Program (Carrier Report Card) Objectives

Medical Addendum

- Evaluates groups' overall annual reporting performance
- Pass or Fail grade is based on Completeness/Quality
- Not sent to regulators

Carrier Data Quality Report—Medical Data Addendum

Example Medical Data Addendum



2022 Final Medical Data Addendum
Company Specific Data Availability Results - Data Due in 2022

Carrier Group Code: 33912
Carrier Group Name: NCCI TRAINING PROPERTY AND CASUALTY CO

Evaluation Date: 01/01/2023
Creation Date: 02/27/2023

		Completeness			Quality				
Reporting Quarter	Due Date	% Categories Completed on Time	Quarters Completed on Time	Grade	Critical Elements	Priority Elements	Low Elements	Quarters Passing	Grade
4Q 2021	3/31/2022	100%	Y		0	0	0	Y	
1Q 2022	6/30/2022	100%	Y		0	0	0	Y	
2Q 2022	9/30/2022	100%	Y		0	0	0	Y	
3Q 2022	12/31/2022	100%	Y		0	0	0	Y	
			4	PASS				4	PASS

Completeness Grading

Completeness Grade is based on the number of **Quarters Completed on Time.**

A quarter is complete when 100% of categories are completed by Due Date.

PASS >= 3 quarter(s) completed on time
FAIL < 3 quarter(s) completed on time

Quality Grading

Quality Grade is based on the number of **Quarters Passing.**

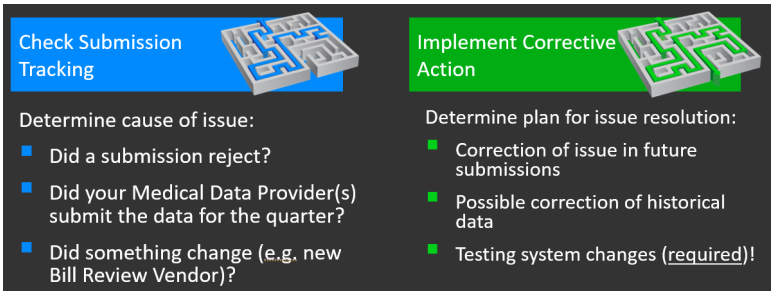
A quarter passes if:
- 0 Fined Critical Elements
- <=2 Fined Priority Elements
- <=2 Fined Low Elements

PASS >= 3 quarter(s) passing
FAIL < 3 quarter(s) passing

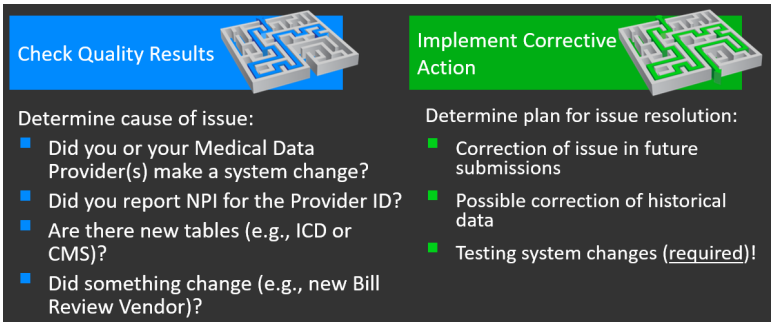
Reviews and Appeals

Research the Issue

Completeness



Quality



Contact NCCI

Contact your validator when the issue is not with your system or processes. NCCI may look at other data types to refine Completeness thresholds.

Medical Data Call Reporting Practices and Medical Incentive Program