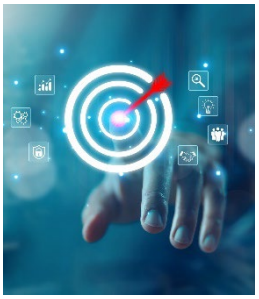
Data Now Program (DNP)

Medical Data Call Reporting Practices

Key Takeaways



- Claim key fields and Key Field Verification
- Preferred Key Field Change process
- Duplicates
- Facility fees and hospital inpatient reporting
- Case management reporting
- New reporting requirements and data elements

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

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Medical Data Call Reporting Practices

Importance of Claim Key Fields

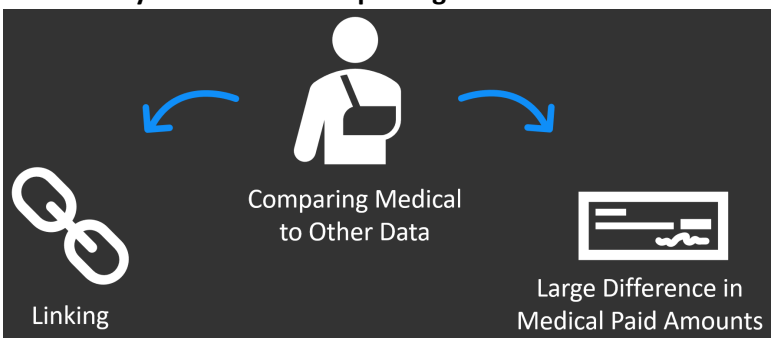
Carrier Code, Policy Number, Policy Effective Date, and Claim Number are used to identify a unique claim. NCCI uses these four fields to create a Claim ID.

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

Consistency With Other Reporting

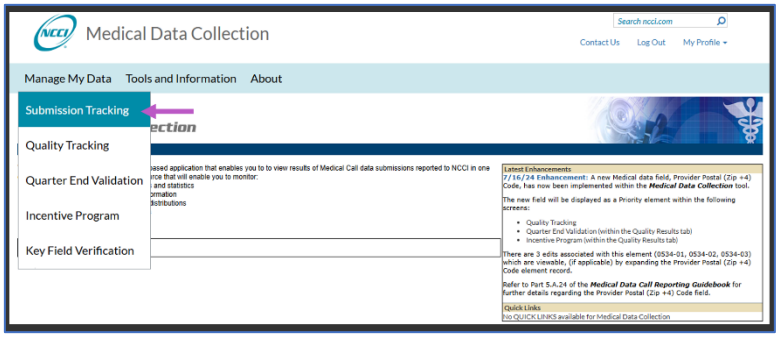
Various elements may be applicable across multiple data types. In the Medical Data Call, NCCI links to other data types that are reported.

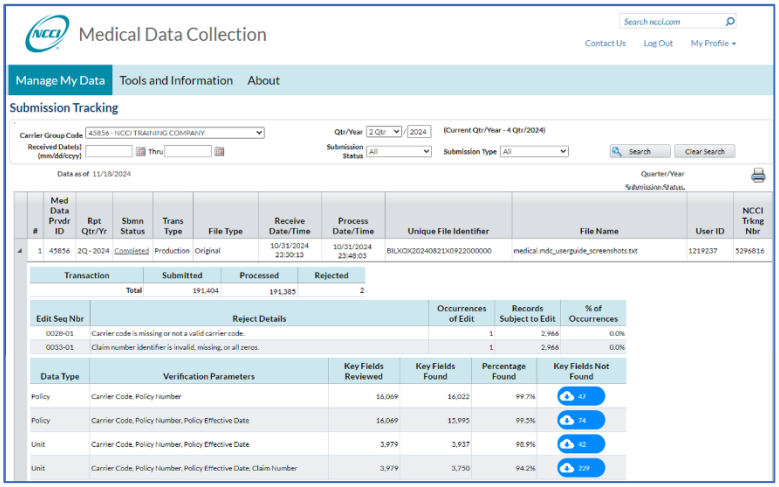
Consistency is "KEY" when reporting!



Submission Tracking: File Level View

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





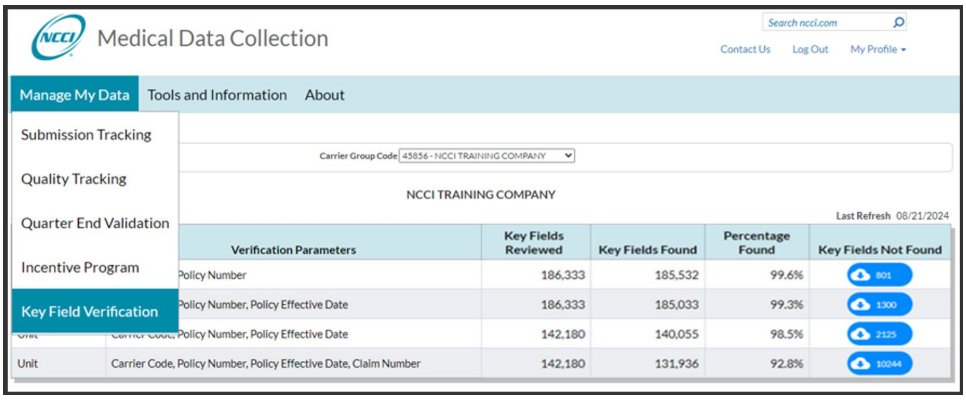
Submission Tracking provides:

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

NCCI compares the Policy and Unit Statistical Data for a specific Policy Effective Date range to determine when data should be expected by NCCI.

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.



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.

Work with your assigned validator for this type of change!

- 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 could 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)

Multiple Sources

The Medical Data Call can have multiple sources for the data. For example, hospital bills may come from one provider and pharmacy transactions may come from a pharmacy benefit manager.

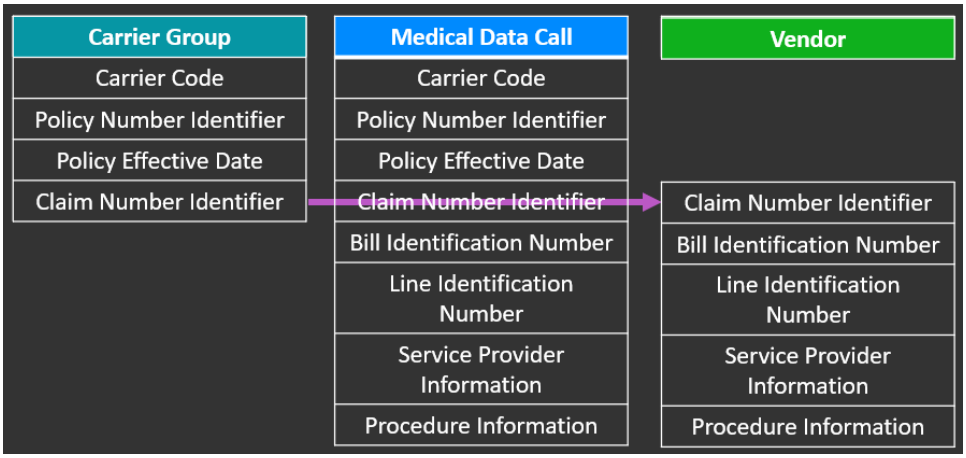
The carrier group assigns the:

- Carrier Code
- Policy Number (Must match Policy Data reporting)
- Policy Effective Date (Must match Policy Data reporting)
- Claim Number (Must match Unit Statistical Data reporting)

The vendor receives the Claim Number from the carrier group and assigns the:

- Bill Identification Number
- Line Identification Number
- Service Provider Information (e.g., Place of Service, Taxonomy, Provider ID, Network Service Code)

- Procedure Information (e.g., Diagnostic Code, Procedure Code)



Some vendors may create their own Claim Numbers. The data reported to NCCI must match the Claim Number that is reported for the Unit Statistical Data.

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.

Transaction Codes

Reported in Medical Data Call record, positions 44–45, this code indicates what type of transaction has been submitted.

- Transaction Code 01—Original
  - First reporting of medical bill line transaction
  - Only one original transaction may be submitted for a given transaction
- Transaction Code 02—Cancellation
  - Delete or cancel bill line transactions
  - Applies to prior record(s) or record(s) in the same submission
- Transaction Code 03—Replacement
  - Replace bill line transactions
  - Applies to previously submitted record(s) or record(s) in the same submission
- Transaction Code 04—Key Field Change
  - Revise existing claim key fields
  - Only used for Key Field Change records; can't combine with bill line transactions

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

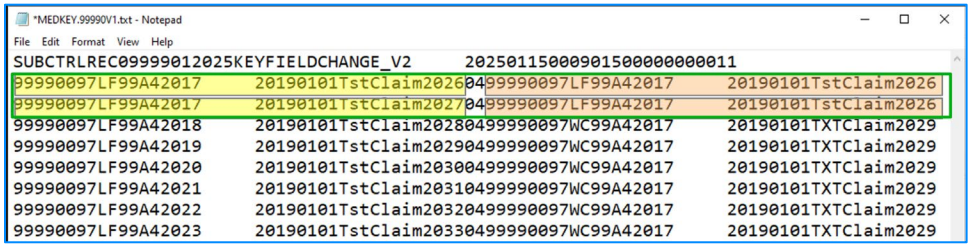
Fields 6 through 9 include the new keys as they should be reported going forward.

Correctly reporting these fields in the Key Field Change file will allow NCCI to apply the changes to all affected records in the Medical Data Call database using “find/replace” to update the claim keys.

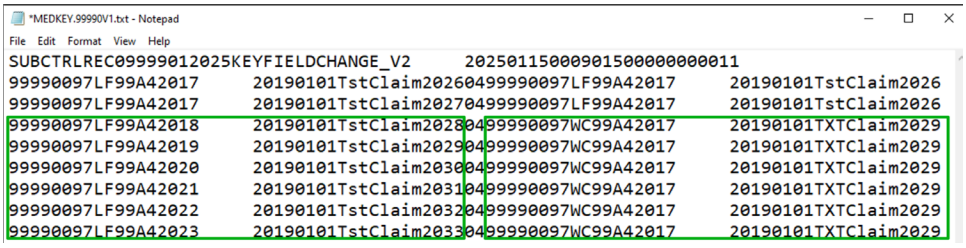
Future bill line transactions that report the claim will need to be reported with the new updated claim keys.

Common Problems Correcting Keys

- Including rows that do not change a key field. Previous and new keys match. No change occurs.



- Submitting rows that combine multiple claims into one claim. This cannot be undone by the Key Field Change process.



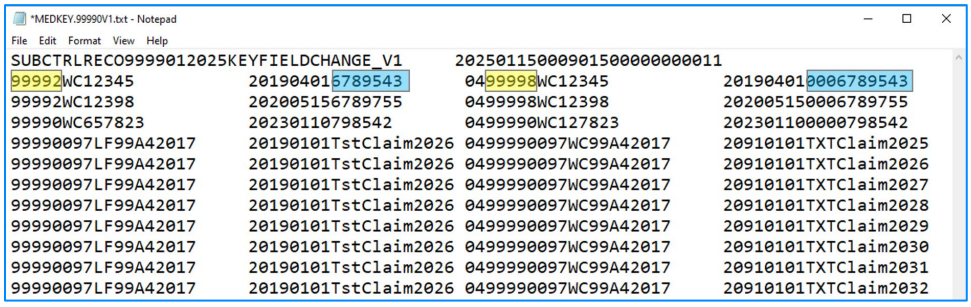
Example

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 45 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 File Submission Overview

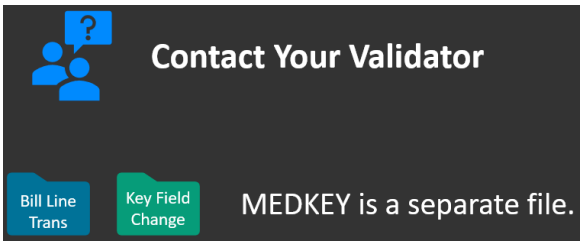
- Submit a file using the certifications/test file identifier
- NCCI prefers to receive Key Field Change files as certifications/tests prior to applying the changes in our database
- Use the appropriate file name

- 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:

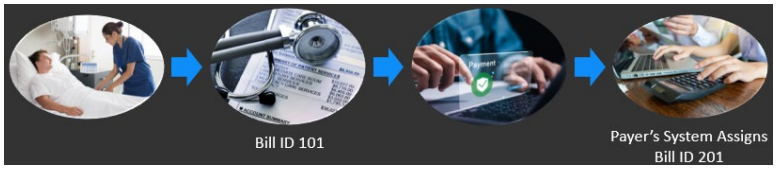
- Affect medical analysis by overstating utilization
- Inflate costs and impact analysis

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.

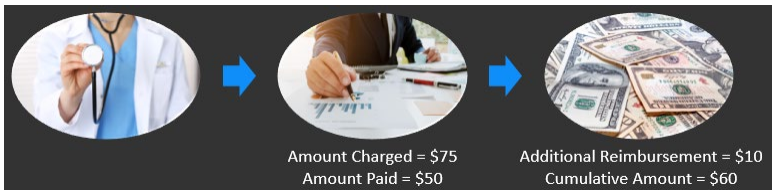
Duplicate Billing—Filtering Out Duplicates

IF …	THEN …
The first record has been submitted …	Do not submit the second record
Both records are created in the same quarter and the first has not been reported …	Submit the second record only
The first record has been submitted …	Do not submit the second 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:

IF …	THEN …
Both records are created in the same quarter and the first has not been reported …	Submit the second record only
The original record has already been submitted …	Submit a replacement record Submit a cancellation record and a new original

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.)

- Since the replacement overlays the previously reported record, all fields must be reported even if no additional changes are needed.

Claim #	Trans Code	Bill ID	Line ID	Paid Proc Code	Amount Charged	Paid Amount
~~12345~~	~~01~~	~~101~~	~~1~~	~~99201~~	~~00000007500~~	~~00000005000~~
12345	03	101	1	99201	00000007500	00000006000

- Original must be in the same submission or in NCCI's database
- Bill Line Key Fields must match the original
- Current cumulative value is reported, not the change
- All previously reported fields that did not change must be reported

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 none of the services were related to a workers compensation claim, the service <u>should not</u> 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 <u>should</u> be reported.

Void or Stop Pay

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

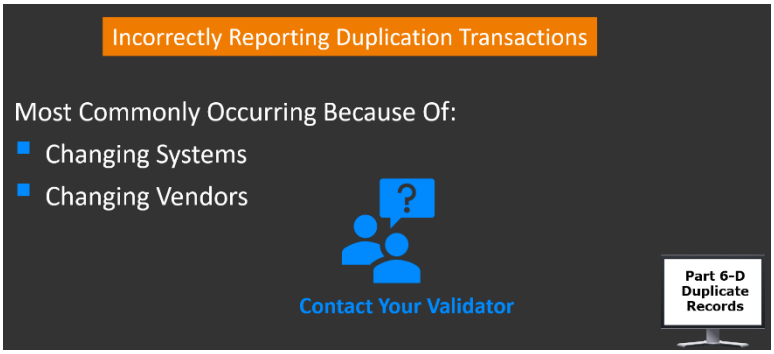
- If the void or stop pay occurs before a transaction is reported to NCCI, do not report it.
- If a payment transaction has been reported to NCCI prior to the void or stop pay, the transaction must be cancelled to remove it from NCCI's database.

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.

Knowledge Check: Two Truths and a Lie

Which statement is NOT correct?

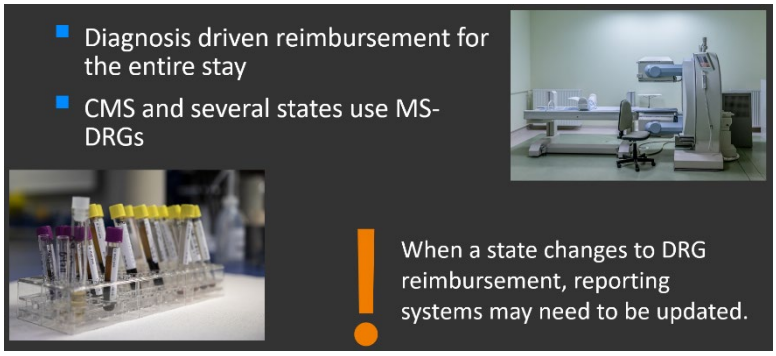
1. Claim keys are reported in the same way across different data types.
2. You can correct Bill Line Payments with the MEDKEY file type.
3. Bill Line Key Fields on a cancellation record must match the original.

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 look like 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, you are paying 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.

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.

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	$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

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

Example Billing

Is there anything you notice about this bill?

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	111		$2,000	$1,000
2	1/30/2024	2/2/2024	250		$2,000	$1,000
3	1/30/2024	2/2/2024	270		$2,000	$1,000
4	1/30/2024	2/2/2024	360		$2,000	$1,500
5	1/30/2024	2/2/2024	370		$2,000	$1,500

Hint: One bill with multiple bill lines

Knowledge Check

Provide the correct response.

1. How many bytes are in a Revenue Code? _____
2. How many bytes are in a DRG Code? _____

Service Dates

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

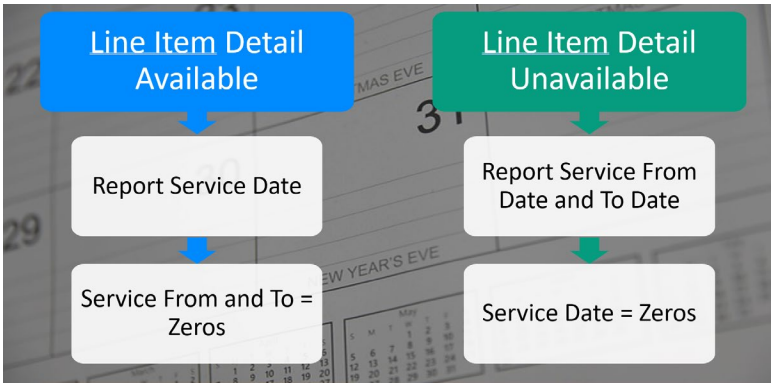
- Service Date
- Service From Date and Service To Date

Note: A Service Date is required for reporting. The method used will depend on if 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, not uncommon are inpatient hospital services that 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

For this scenario, has the data been reported correctly? _____

Paid Procedure Code	Service Date	Service From Date	Service To Date	Quantity
97110	00000000	20240109	20240130	0000004

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 From and Service Date To—Example

Inpatient Hospital Bill—Service Date

- Inpatient hospital bill where each service is **not** audited separately
  - Report one transaction for the entire bill
- Date for each service is **not** available
  - Report Service From Date and Service To Date

Line ID	Service From Date	Service To Date	Service Date	Paid Procedure Code	Secondary Proc Code	Amount Charged	Paid Amount
1	20240201	20240205	00000000	508	0120	00000129138	0000468372

Service Date—Example

Inpatient Hospital Bill—Service Dates

- Inpatient hospital bill where multiple services are audited separately
  - Report each specific service as a separate transaction

Line ID	Service From Date	Service To Date	Service Date	Paid Procedure Code	Secondary Proc Code	Amount Charged	Paid Amount
1	00000000	00000000	20240201	508	0120	00000129138	0000468372
2	00000000	00000000	20240202	508	0250	0000196255	0000000000
3	00000000	00000000	20240205	508	0270	0000147265	0000000000

Service Date Requirements

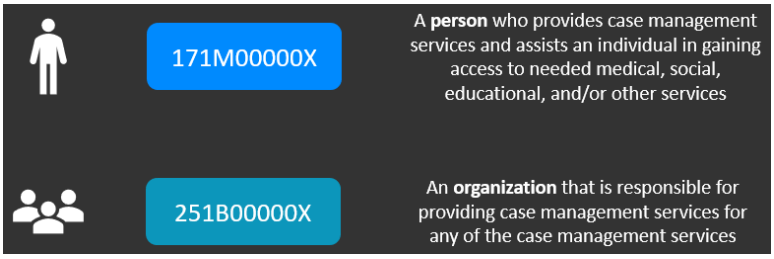
- MUST report either a Service Date or the combination of a Service From Date and Service To Date
- The date must be valid
- There must be a logical relationship between service dates and the Accident Date
  - Service From Date must be before Service To Date
  - All Service Dates must be on or after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

Provider Taxonomy Code

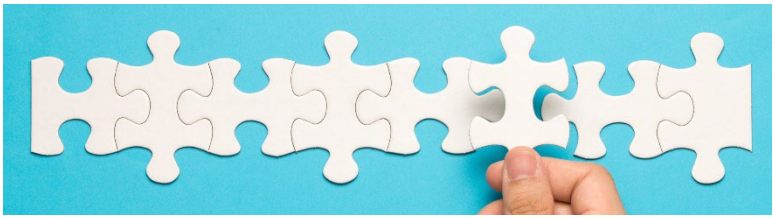
A Provider Taxonomy Code identifies the type of provider that billed for and is being paid for the medical service.



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.

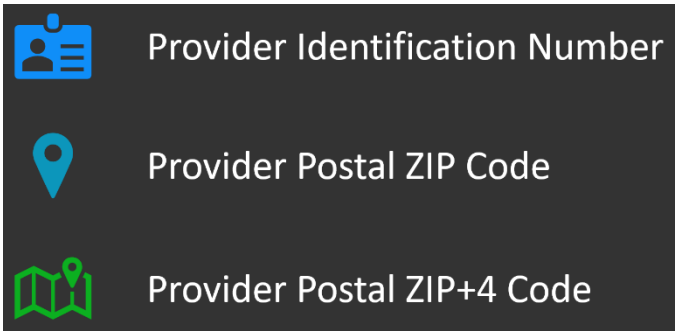
Provider Identification Number

Reporting requirements:

- National Provider Identification (NPI) Number is required
- May not be “true” medical service providers
- If NPI not available, report the federal tax identifier—Federal Employer Identification Number (FEIN)—of service provider

New Data Elements

New Reporting Requirements and Changes



Provider Identification Number

Identifies the medical/service provider that billed for the medical service.

- File layout: Field 23, positions 256–270
- State required number
- NPI required
  - NPI Registry (npiregistry.cms.hhs.gov/search)

The Provider Identification Number must be that of the medical provider, not the billing house.

- For facility bills, report the NPI Number for the **service facility**
- For pharmacy and Durable Medical Equipment (DME), report the dispensing provider
- For billing houses, report the NPI of the medical service provider for whom the billing house is submitting the bill
- When an NPI Number is not assigned to a service provider, report the FEIN of the service provider

Provider Postal ZIP+4 Code

There's a new field to accommodate a 9-byte ZIP+4 Code for providers.

- File layout: Field 29, positions 315–323
- The standard 5-digit ZIP Code with the appended 4-digit code (ZIP+4) assigned by the postal service (USPS or other) to the medical/service provider address where the service was performed
- If the 9-digit code is known, report the 9-digit code
- If only the 5-digit code is known, report the 5-digit code, left justified
- If the service facility or dispensing pharmacy ZIP Code is unavailable, report only the postal (ZIP+4) Code of the provider's billing address unless it is a billing house
- When the billing address is a billing house and the ZIP+4 Code for the medical/service provider address where the service was performed is not available, leave this field blank

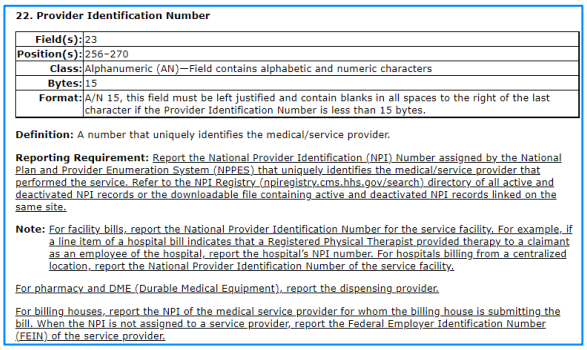
Note: NCCI considers a PBM (pharmacy benefit manager) company to be a billing house. NCCI expects that a PBM will have the dispensing pharmacy ZIP Code.

Edit Matrix—New Edits

Edit Number	Data Field	Edit Message	Transaction Code	Edit Type	Stage of Editing	Outcome
0510-02	Provider Identification Number	Provider Identification Number Is Not Valid Per Table	01, 03	Field	Quality Tracking	Count Occurrences
0534-01	Provider Postal (ZIP+4) Code	ZIP Code (+4) Is Missing	01, 03	Field	Quality Tracking	Count Occurrences
0534-02	Provider Postal (ZIP+4) Code	ZIP Code (+4) Is Not 5 or 9 Digits	01, 03	Field	Quality Tracking	Count Occurrences
0534-03	Provider Postal (ZIP+4) Code	ZIP Code (+4) Is Not Valid Per Table	01, 03	Field	Quality Tracking	Count Occurrences

Data Dictionary

Refer to the ***Medical Data Call Reporting Guidebook***, Part 5, for an alphabetical listing of all Medical Data Call data elements.



22. Provider Identification Number

Field(s):	23
Position(s):	256–270
Class:	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes:	15
Format:	A/N 15, this field must be left justified and contain blanks in all spaces to the right of the last character if the Provider Identification Number is less than 15 bytes.

Definition: A number that uniquely identifies the medical/service provider.

Reporting Requirement: Report the National Provider Identification (NPI) Number assigned by the National Plan and Provider Enumeration System (NPPES) that uniquely identifies the medical/service provider that performed the service. Refer to the NPI Registry (npiregistry.cms.hhs.gov/search) directory of all active and deactivated NPI records or the downloadable file containing active and deactivated NPI records linked on the same site.

Note: For facility bills, report the National Provider Identification Number for the service facility. For example, if a line item of a hospital bill indicates that a Registered Physical Therapist provided therapy to a claimant as an employee of the hospital, report the hospital's NPI number. For hospitals billing from a centralized location, report the National Provider Identification Number of the service facility.

For pharmacy and DME (Durable Medical Equipment), report the dispensing provider.

For billing houses, report the NPI of the medical service provider for whom the billing house is submitting the bill. When the NPI is not assigned to a service provider, report the Federal Employer Identification Number (FEIN) of the service provider.

The dictionary provides:

- Field Name
- Field Number
- Position(s)
- Class
- Bytes
- Format
- Definition
- Reporting Requirements

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. Regulators are provided with an overview of services being provided out of 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

Resources

Available on **ncci.com**:

- ***Medical Data Call Reporting Guidebook***
- ***Electronic Transmission User's Guide***
- ***Data Quality Guidebook***
- ***Medical Data Collection*** tool
- Circulars/FYIs
- ***DNP*** Resource Library/Learning Center