Data Now Program (DNP)

Usages of the Medical Data Call and the Importance of Quality

Key Takeaways

To gain a better understanding of NCCI's:

- Need for high-quality Medical data to perform legislative analysis and public policy research
- Medical data validation test approach, results, and communication with data providers

Topics

- Purpose of the Medical Data Call
- Validation Process
- Common Medical Data Quality Topics

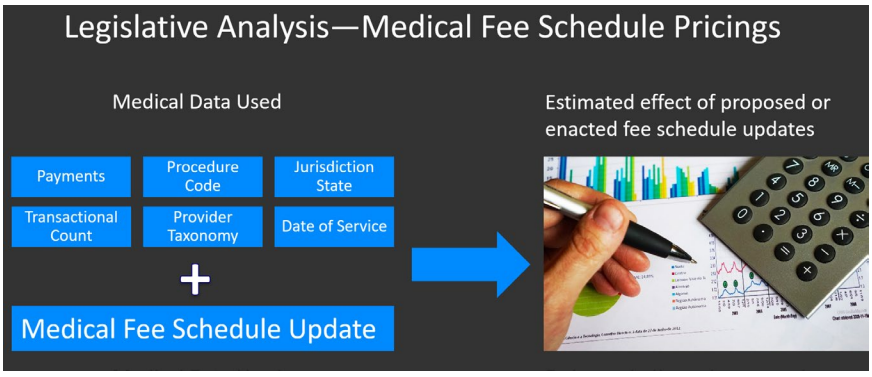
Purpose of the Medical Data Call

- Legislative Analysis
- Regulator Requests
- Research
- Informational Resources

Legislative Analysis—Medical Fee Schedules

- Sets maximum reimbursement on a fee-for-service basis
- Periodic updates by regulation or legislation
- NCCI analyzes the impact of proposed or enacted updates on system costs

Medical Fee Schedule Pricing



Medical Data Call provides the data elements necessary to price updates.

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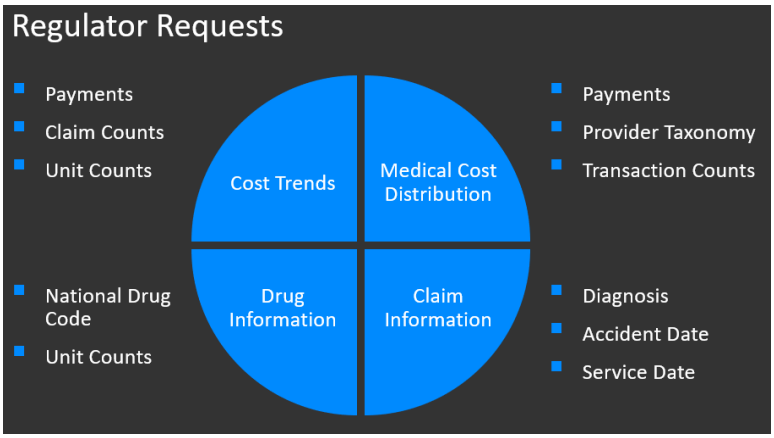
Regulator Requests



Requests for information to provide insight on a specific question.

The Cost Conundrum: How Medical Utilization Shapes Future Costs

Insights » AIS 2025 Highlights Report » The Cost Conundrum: How Medical Utilization Shapes Future Costs

Medical Costs—Price vs. Utilization

NCCI leverages the Medical Data Call for a variety of research purposes. NCCI reviews data to build a thorough understanding of how medical practices and costs are changing.

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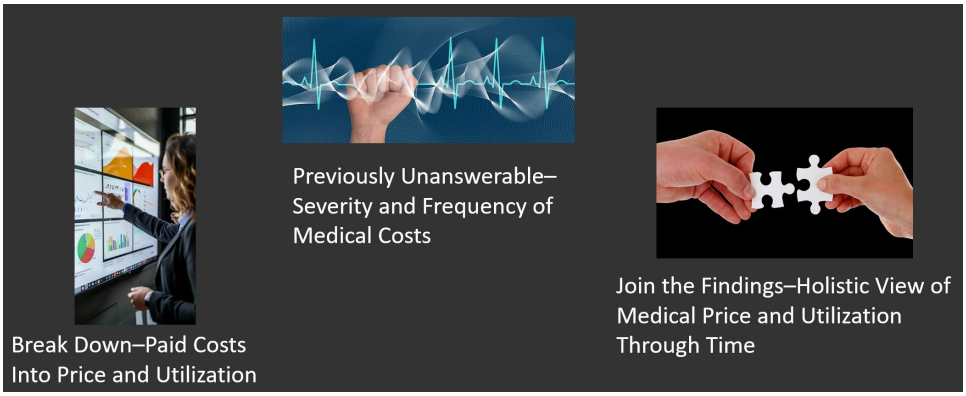
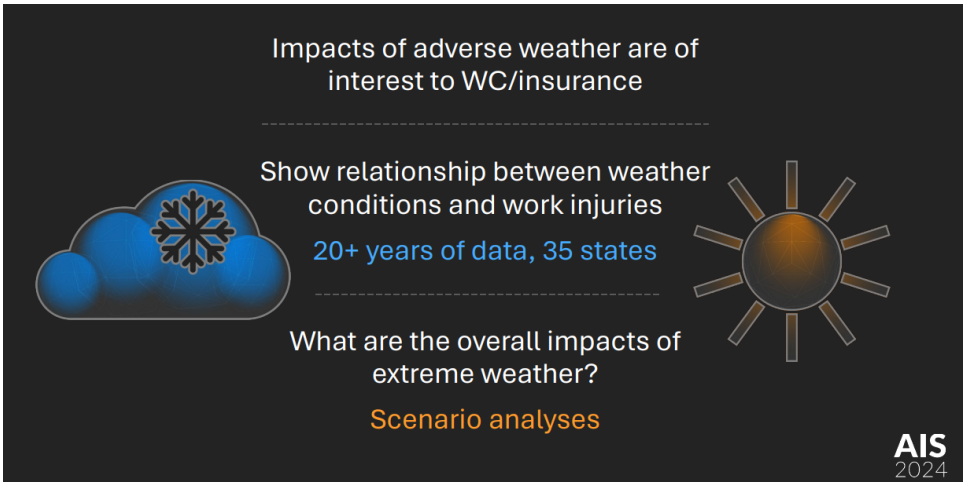
Research Goals



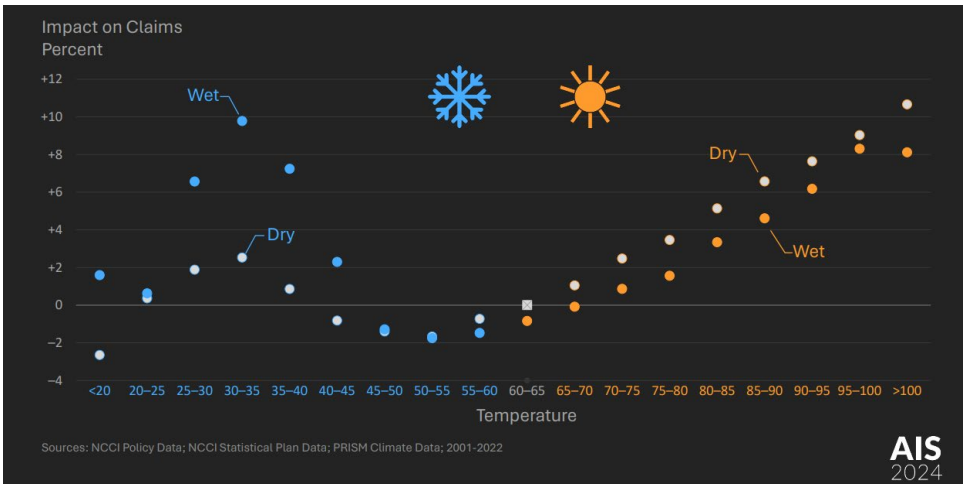
Data quality is essential!

Extreme Weather and Work Injuries

Research analyzing the impact of weather, both temperature and precipitation, on claim frequency.



Impact on Claims: Temperature and Precipitation



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Usages of the Medical Data Call and the Importance of Quality

Claims Data Dashboard

- Medical and Indemnity Data
- For Carriers and Regulators
- Quality of Data
- Usable Insights

Medical Data Plays a Key Role

Accurate and timely reporting is important.

Validation Processes

Aggregate Data Quality

- The Medical data validation process takes a practical approach for data quality
- Medical data is transactional
  - 53 million transactions in 2024
  - covering approximately 3 million claims

Data Quality—A Layered Approach

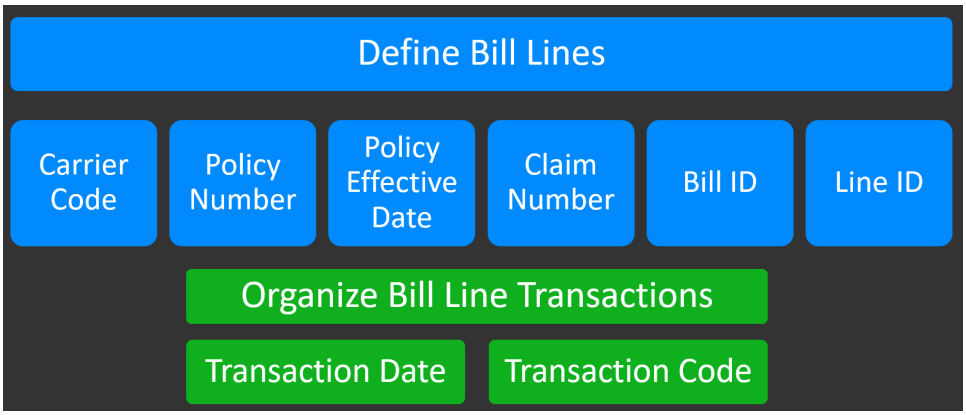
- Submission File Editing
- Quarterly Aggregate Reviews
- Usage-Specific Reviews

Limited Record Rejects—Key Field Errors

- The first layer, submission editing, ensures that data can be loaded into NCCI's database
- Six key fields
- Key fields define a single line of a bill
- Report transactions with the same values in key fields
- Transaction Date provides processing order
- Transaction Code identifies the type of transaction submitted

Uniquely identifying bill line data enables NCCI to process updates correctly.

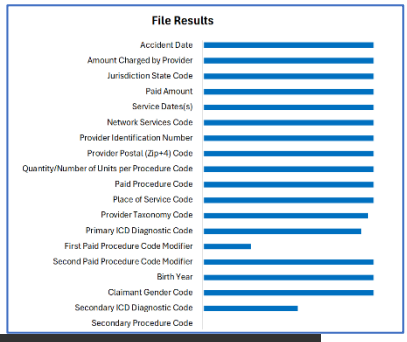
Usages of the Medical Data Call and the Importance of Quality



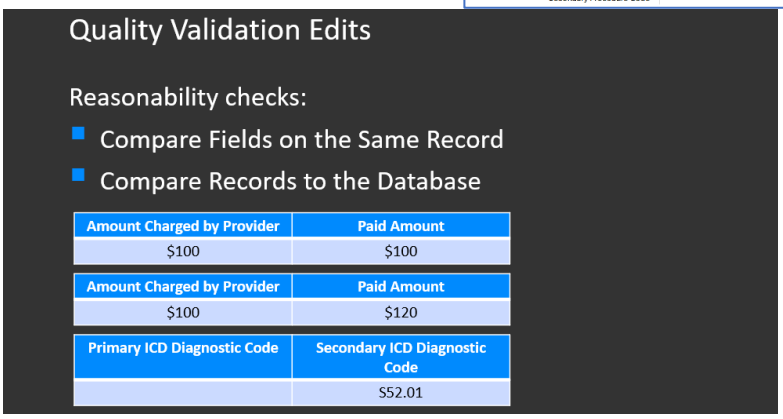
Quality Tracking Edits

Identify records reporting:

- Missing Values
- Invalid Values

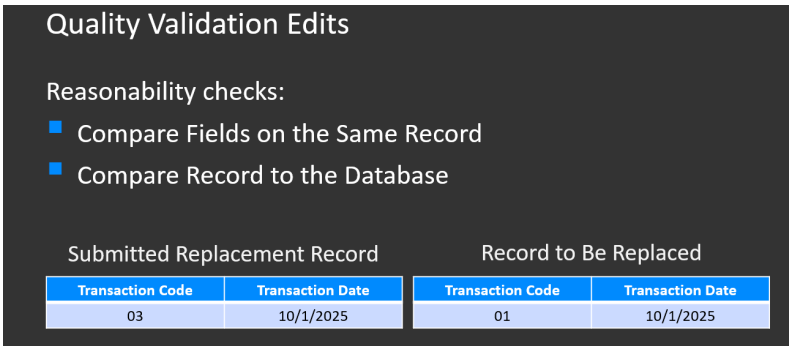


Quality Validation Edits



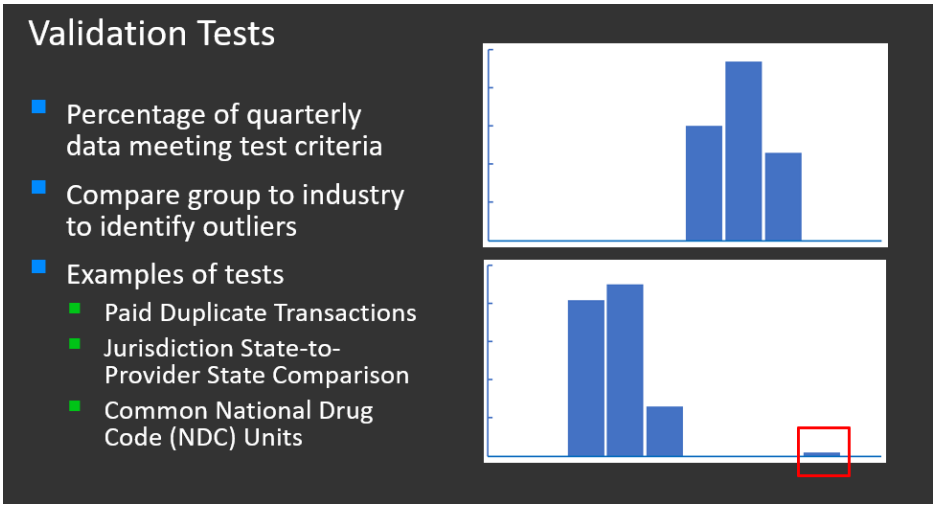
Quality validation edits look for reasonability of data by making logical comparisons between reported fields. NCCI uses two types of Quality Validation edits that check for:

- Logical conditions on a reported record
- Logical relationships to transactions already on NCCI's database



The second set of Quality Validation Edits checks incoming records versus records already on the database.

Validation Tests



NCCI has a suite of validation tests that run against the most recent quarter's submitted data. Each test looks for:

- Specific scenarios within the data
- Identifies how often the scenarios occur

Key Field Verification

Key Field Verification is a type of validation where our system compares unique Medical Data Call claim keys with the corresponding keys in Policy Data and Unit Data.

Upon submission of a Medical data file, our systems will look across the medical database into the policy and units, checking the following fields:

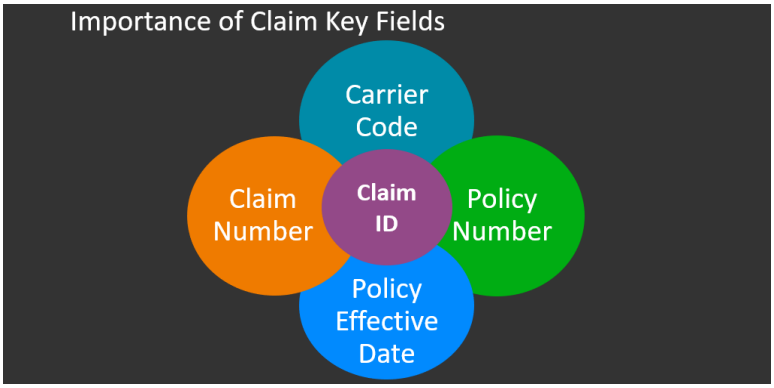
- Carrier Code
- Policy Number
- Policy Effective Date
- Claim Number

This validation may require a carrier to work across multiple teams to identify the sources for these important fields.

Communication

Detailed discussion helps NCCI determine how to refine our tests and analyses.

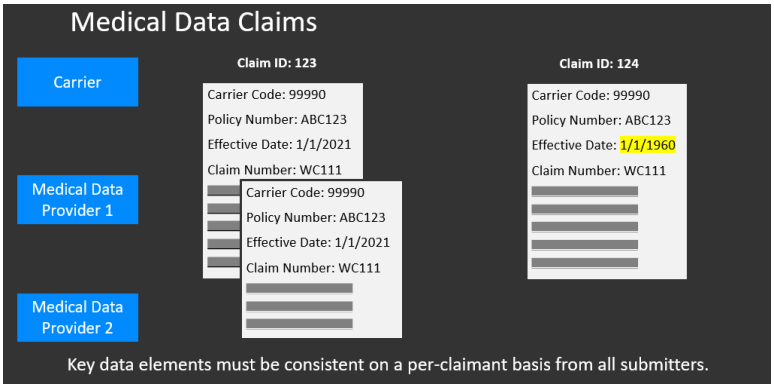
Common Medical Data Quality Topics



Four fields used to identify transactions associated with a unique claim:

- Carrier Code
- Policy Number
- Policy Effective Date
- Claim Number

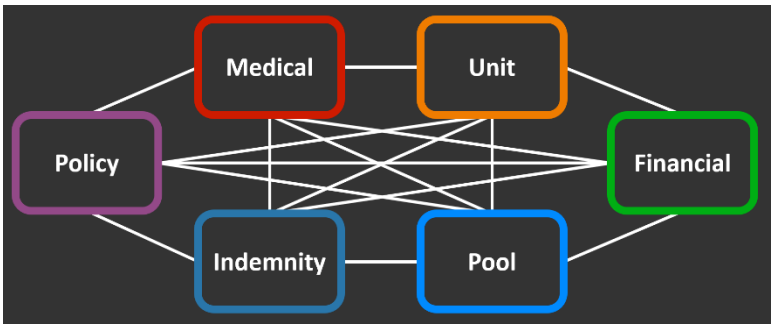
NCCI uses these four fields to create a Claim ID within our database. In our system, the Claim ID is what holds all the payments and services together for the life of a particular claim.



The four key fields must be consistently reported. Inconsistent reporting can create new claim IDs and does not allow accurate tracking of all the medical transactions associated with a claim.

Usages of the Medical Data Call and the Importance of Quality

Linking Across Data Types



Consistent claim key reporting is also important across data types. NCCI expects the Medical Data Call claim keys to be consistent with Unit Statistical reporting.

Medical Data Call Transactions

The different transaction types include:

- 01—Original: Initial report of the record
- 02—Cancellation: Deletes a previously submitted record
- 03—Replacement: Changes a previously submitted record, provided the elements are not key field values
- 04—Key Field Change: Revises claim key values and is only used with a Key Field Change record

Medical Data Call Transaction Date

The **Date** the medical transaction was **originally processed, updated,** and **paid** by the administering entity's system

If Transaction Code is …	Then Report …
01—Original	The date the information was originally processed by the administering entity
02—Cancellation	The date the cancellation was performed in the system of the administering entity
03—Replacement	The date that the information was changed or corrected in the system of the administering entity

Duplicate Records

Duplicate records are two or more records that refer to a single service that was performed by a medical provider. Duplicates can affect medical analysis by overstating utilization. Therefore, submitters are responsible for filtering out duplicates before sending data to NCCI.

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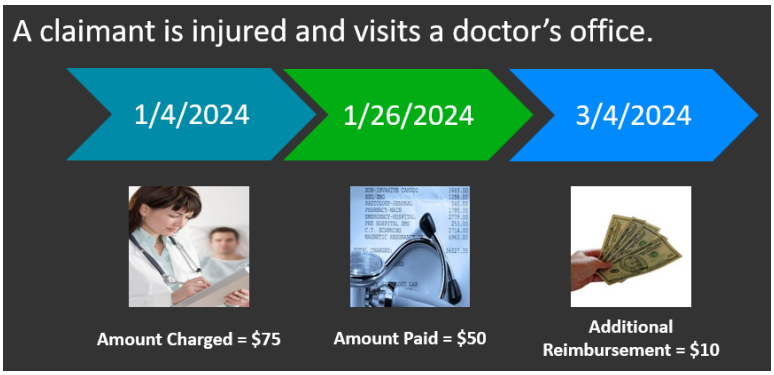


Additional Reimbursement example: A claimant visits a doctor's office. The service provider bills the payer $75 and is paid $50. Shortly after, the payer pays an additional $10 reimbursement, bringing the total amount paid for the bill to $60. NCCI requires the transactions to reflect the total payment of $60. Here are three reporting options for this situation:

Reporting Option #1: If both records are created in the same quarter and the first has not yet been reported, do not submit the first record to NCCI. Simply submit an original transaction with the paid amount of $60. The original record will be considered the current record of the database.

Reporting Option #1—Submit one Original Transaction

Field Name	Original Reported As
Claim Number	12345
Transaction Date	3/4/2024
Transaction Code	01
Bill ID	101
Line ID	1
Paid Procedure Code	99201
Amount Charged by Provider	$75
Paid Amount	$60

Reporting Option #2: If both records are created and the first has been reported, submit a replacement record.

- Submit the same key fields including Bill ID and Bill Line ID on the replacement record
- Current cumulative Paid Amount is $60, not $10
- The Transaction Date of the replacement record is the date that the additional reimbursement was made in the payer's system

Reporting Option #2—Submit a Replacement Transaction

Field Name	Original Reported As	Replacement Reported As
Claim Number	12345	12345
Transaction Date	1/26/2024	3/4/2024
Transaction Code	01	03
Bill ID	101	101
Line ID	1	1
Paid Procedure Code	99201	99201
Amount Charged by Provider	$75	$75
Paid Amount	$50	$60

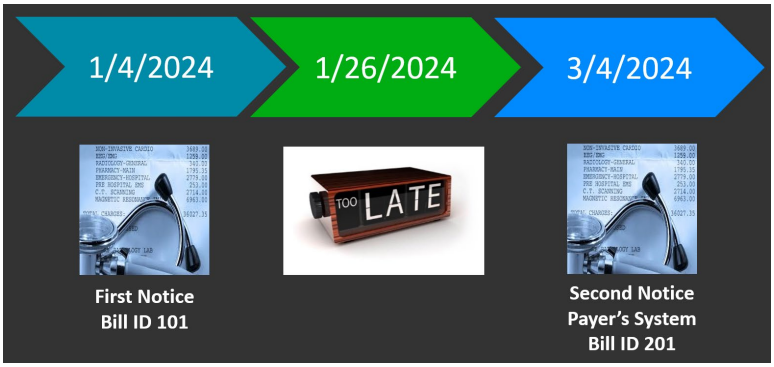
Reporting Option #3: Submit a **cancellation** record and a new original.

- Submit the same key fields on the cancellation record as the original record
- Submit the current key fields on the new original record
- Current cumulative Paid Amount on the new original is $60
- The Transaction Date of the cancellation record and new original record is the date that the additional reimbursement was made in the payer's system

Reporting Option #3—Submit a Cancellation record and a New Original

Field Name	Original Reported As	Cancellation Reported As	New Original Reported As
Claim Number	12345	12345	12345
Transaction Date	1/26/2024	3/4/2024	3/4/2024
Transaction Code	01	02	01
Bill ID	101	101	102
Line ID	1	1	1
Paid Procedure Code	99201	99201	99201
Amount Charged by Provider	$75	$75	$75
Paid Amount	$50	$50	$60

Duplicate Billing



Example: A claimant visits a doctor's office. The service provider bills the payer (Bill ID 101) but does not get paid immediately. The following month, the service provider sends another bill to the payer with the charge for the original office visit, and the payer's system assigns Bill ID 201 to the second notice.

There are two options to avoid incorrect reporting in this situation.

Option #1: Do not submit both records to NCCI.

Submit one of the two bills/records; if both bills are created in the same quarter and the first has not been reported, submit the second bill only.

Common example of how this might be incorrectly reported:

Field Name	Original Reported As	Original Reported As
Claim Number	12345	12345
Transaction Date	1/1/2024	2/1/2024
Transaction Code	01	01
Bill ID	101	201
Line ID	1	1
Paid Procedure Code	99201	99201
Amount Charged by Provider	$100	$100
Paid Amount	$75	$75

Option #2: Submit a Cancellation record and new Original record.

Billing systems typically can identify these duplicates so erroneous double-payments are not made. From a reporting standpoint, we don't want duplicate records. If we see two bills reported like this, our system sees them as two separate bills. We calculate a total reimbursement of $150, when the reality is only one payment of $75 was made.

To report correctly:

- Original must be in the same submission or on NCCI's database
- The Transaction Date of the cancellation and new original records is the date that the second bill was created in the payer's system

Field Name	Original Reported As	Cancellation Reported As	New Original Reported As
Claim Number	12345	12345	12345
Transaction Date	1/1/2024	2/1/2024	2/1/2024
Transaction Code	01	02	01
Bill ID	101	101	201
Line ID	1	1	1
Paid Procedure Code	99201	99201	99201
Amount Charged by Provider	$100	$100	$100
Paid Amount	$75	$75	$75

Duplicate Validation

Not properly creating Cancellation/Replacements

- Additional Reimbursement
- Duplicate Billings

In this first example, duplication will cause the “appearance” of additional dollars being reported and inflate costs for that claim. A large amount of duplication for a given procedure code could affect the estimated impact of the fee schedule change. Duplicates may lead to carrier data being excluded from legislative pricing and research.

Transaction Code	Transaction Date	Bill ID Number	Line ID Number	Service Date	Paid Procedure Code	Amount Charged by Provider	Paid Amount	Primary ICD Diagnostic Code	Provider ID Number
01	12/19/2023	BillAAA1	Line 1	10/29/2023	99203	491.00	274.09	722.0	NPI
01	3/3/2024	BillAAA2	Line1	10/29/2023	99203	491.00	274.09	722.0	NPI

In this example, the repetition of values across lines points to a potential duplication of transactions. This scenario shows where one therapy bill reported two units as a single line, and a second bill reported the therapy broken out on two lines.

The records below have the same claim keys.

Transaction Date	Bill ID Number	Line ID Number	Service Date	Paid Procedure Code	Amount Charged by Provider	Paid Amount	Primary ICD Diagnostic Code	Provider ID Number	Unit Count
3/28/2024	BillABC1	Line 1	3/12/2024	97140	76.20	37.34	727.05	NPI	2
5/7/2024	BillABC2	Line1	3/12/2024	97140	38.10	37.34	727.05	NPI	1
5/7/2024	BillABC2	Line2	3/12/2024	97140	38.10	37.34	727.05	NPI	1

Diagnosis-Related Group (DRGs)

- Diagnosis-driven reimbursement for the entire stay
- CMS and several states use MS-DRGs

When a state changes to DRG reimbursement, reporting systems may need to be updated.

DRGs Versus Hospital Revenue Codes

DRG
Applies to inpatient stays
Calculated by the payer
A single DRG summarizes the payment
3-byte numeric code

- Both DRGs and Revenue Codes come from hospital bills
- Revenue codes "may" apply to inpatient stays

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!

DRG Description	DRG Code	Revenue Code	Revenue Code Description
Heart Transplant or Implant of Heart Assist System With MCC	001	0001	Total Charged
Percutaneous Cardiovascular Procedures Without Coronary Artery Stent With MCC	250	0250	Pharmacy

Inpatient Hospital Bills

Hospital bills representing multiple services may be reimbursed in several different ways. A company may be bundling—paying at the bill level, rather than the individual service level.

If it's bundling, it's consolidating its payments into a single payment, which can be placed on a single line (record) for reporting with the appropriate DRG code as the paid procedure code.

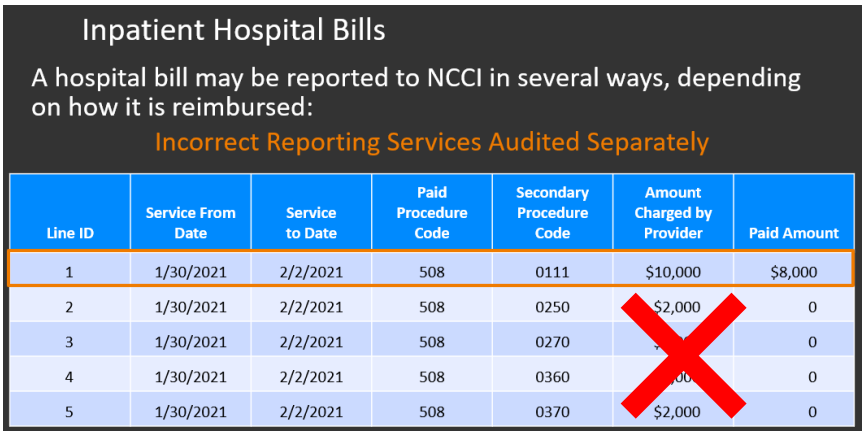
A hospital bill may be reported to NCCI in several ways, depending on how it is reimbursed:

Line ID	Service From Date	Service to Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	1/30/2021	2/2/2021	508	0111	$10,000	$8,000

For this period of the hospital stay, $10,000 was charged and $8,000 was paid.

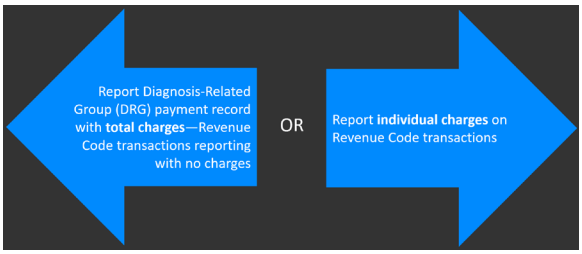
Do not report the underlying records that were bundled and already reported with the paid dollars. If the underlying records are reported, then use the same DRG across the records and include the paid amount on one record only.

The charged amounts are reported similarly to paid amounts. If you are bundling the services on a single record and are bundling the charged amount on the same record, do not report the charged amount for the individual services on those records.



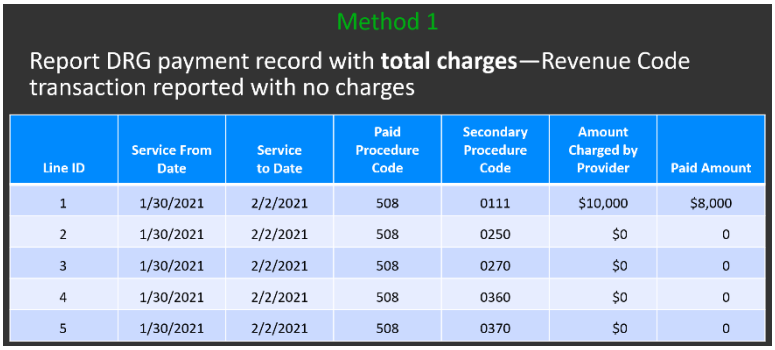
Line ID	Service From Date	Service to Date	Paid Procedure Code	Secondary Procedure Code	Amount Charged by Provider	Paid Amount
1	1/30/2021	2/2/2021	508	0111	$10,000	$8,000
2	1/30/2021	2/2/2021	508	0250	$2,000	0
3	1/30/2021	2/2/2021	508	0270		0
4	1/30/2021	2/2/2021	508	0360		0
5	1/30/2021	2/2/2021	508	0370	$2,000	0

Reporting Services Audited Separately



To correctly unbundle, report:

Method 1: DRG payment record with total charges (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	1/30/2021	2/2/2021	508	0111	$10,000	$8,000
2	1/30/2021	2/2/2021	508	0250	$0	0
3	1/30/2021	2/2/2021	508	0270	$0	0
4	1/30/2021	2/2/2021	508	0360	$0	0
5	1/30/2021	2/2/2021	508	0370	$0	0

OR

Method 2: Report individual charges on Revenue Code transactions (DRG payment record reporting with no charges)

Method 2

Report **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	1/30/2021	2/2/2021	508	0111	$2,000	$8,000
2	1/30/2021	2/2/2021	508	0250	$2,000	0
3	1/30/2021	2/2/2021	508	0270	$2,000	0
4	1/30/2021	2/2/2021	508	0360	$2,000	0
5	1/30/2021	2/2/2021	508	0370	$2,000	0

Provider ZIP Code (+4)

A medical provider could have multiple ZIP Codes associated with its practice.

Report ZIP Code	Hierarchy
ZIP Code that impacts reimbursement	1
ZIP Code where service was performed	2
Billing ZIP Code, unless billing house or pharmacy benefit manager	3

If the 9-digit ZIP Code is known, report the 9-digit ZIP Code. If only the standard 5-digit ZIP Code is known, report the 5-digit ZIP Code. These changes will go into effect for 4Q24 data due end of March 2025. However, carriers are currently able to report this element and the validation results can be seen in our ***Medical Data Collection*** tool.

Certain states break fee schedules down by geographical areas using ZIP Code. Data reporters are to submit the provider ZIP Code used to determine reimbursement.

In cases where a provider's ZIP Code does not impact the reimbursement:

Report the provider ZIP Code of the location where the service was performed
If the ZIP Code of the actual location is unavailable, provide the ZIP Code of the billing address
If the billing address is a billing house, then leave the **provider ZIP Code blank**

NOTE: Pharmacy Benefit Managers (PBMs) are considered billing houses by NCCI

Hospital billings follow the same hierarchy—do not report billing ZIP (unless it drives reimbursement or is the physical location of the facility where the service was performed).

Usages of the Medical Data Call and the Importance of Quality

Jurisdiction to Provider State

Comparison of Jurisdiction State to Provider State. Which example stands out?

Jurisdiction State	Provider State	Comparison
Florida	Florida	Match
South Carolina	Georgia	Reasonable
Maine	Iowa	Less Likely

State Comparison—Example

Jurisdiction State Code	Jurisdiction State	Provider Postal Zip Code	Provider State	Transaction Date	Service Date	Paid Procedure Code	Provider Taxonomy Code	Provider ID Number
27	NV	303	GA	3/29/2024	3/12/2024	00405452802	333600000X	NPI1
27	NV	303	GA	8/14/2024	7/28/2024	00405452802	333600000X	NPI1
27	NV	303	GA	6/16/2024	5/30/2024	66336002790	333600000X	NPI1
27	NV	303	GA	9/5/2024	8/19/2024	00185540001	333600000X	NPI1
43	UT	303	GA	11/8/2024	10/22/2024	00781570110	333600000X	NPI2
43	UT	303	GA	6/9/2024	5/23/2024	33358023360	333600000X	NPI2
11	ID	303	GA	1/31/2024	1/14/2024	66336002790	333600000X	NPI3
11	ID	303	GA	3/19/2024	3/2/2024	66336002790	333600000X	NPI3
11	ID	303	GA	12/26/2024	12/9/2024	49884086802	333600000X	NPI3

This is an example of a “billing house” or PBM, where the state of the “billing house” or PBM was reported in lieu of the actual pharmacy.

Quality/Number of Units per Procedure Code

Report the number of units of service performed or the quantity of drugs dispensed. Use the base quantity specified by the applicable procedure code to determine the quantity or number to report.

Units per Procedure Code

- Supplies
  - Three pairs of gloves on a “per pair” code: three units
- Physical Therapy
  - One session of 30 minutes on a “per-15 minute” procedure: two units

Units per Anesthesia Code

- Basis of reimbursement
  - Base rate
  - Modifiers
  - Time
- Report minutes for anesthesia CPTs that use time units
- Report unit counts for modifying anesthesia codes

Usages of the Medical Data Call and the Importance of Quality