



Data Now Program (DNP) Introduction to Medical Data Call and Reporting Practices

Key Takeaways

- Review the basic reporting rules and requirements for the Medical Data Call as outlined in the **Medical Data Call Reporting Guidebook**
- Demonstrate the features and functionality of the **Medical Data Collection (MDC)** tool
- Duplicate Billing
- Facility Fees and Hospital Inpatient Reporting
- Service Dates
- Case Management Reporting

Chapter 1: Medical Data Call Overview

Medical Data Call

Each medical service that occurs due to an employee's job-related injury.

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



Medical Data Call Uses

- Legislative Analysis
- Regulator Requests
- Research
- Informational Resources

Chapter 2: Medical Data Call Core Resources

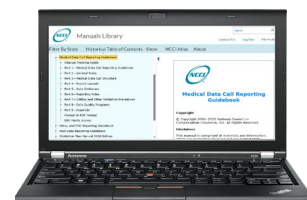
Core Resources—ncci.com

- **Medical Data Call Reporting Guidebook**
- **Electronic Transmission User's Guide**
- **Data Quality Guidebook**
- **MDC** tool
- **Medical Data Collection** Tool User's Guide

Medical Data Call Reporting Guidebook

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

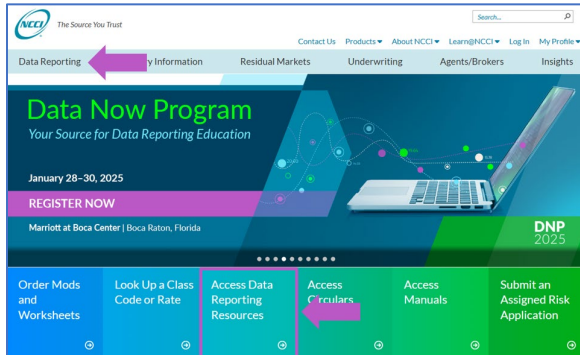
To access the guidebook, log in to ncci.com with your user ID and password.



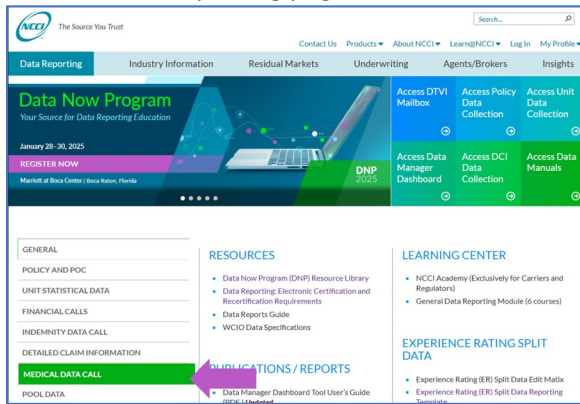


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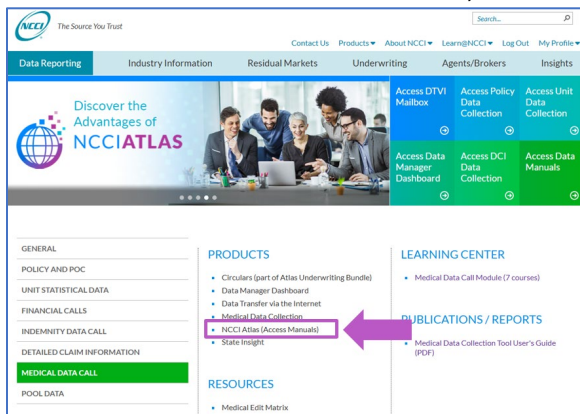
1. From the main page of [ncci.com](https://www.ncci.com), click on Access Data Reporting Resources or Data Reporting



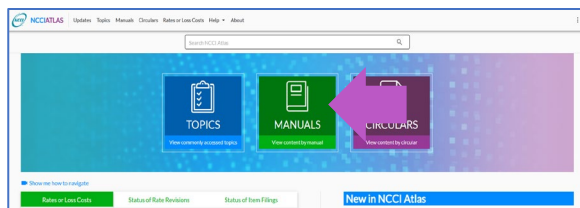
2. The Data Reporting page defaults to General, so select Medical Data Call



3. From the Medical Data Call section, under Products, select **NCCI Atlas** (Access Manuals)



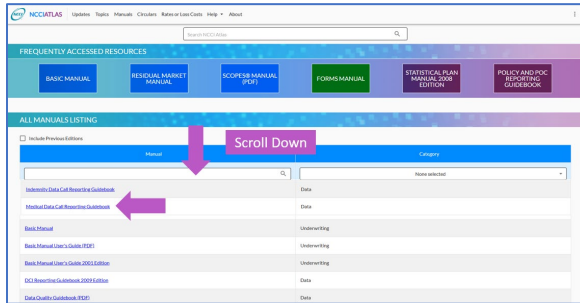
4. From **NCCI Atlas**, click the Manuals section



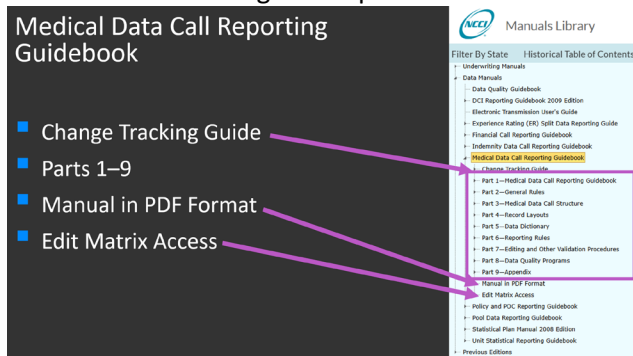


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- From the Manual column (left side), scroll down to **Medical Data Call Reporting Guidebook** and click on the title



- Click on the triangle to expand the list and select the **Medical Data Call Reporting Guidebook**



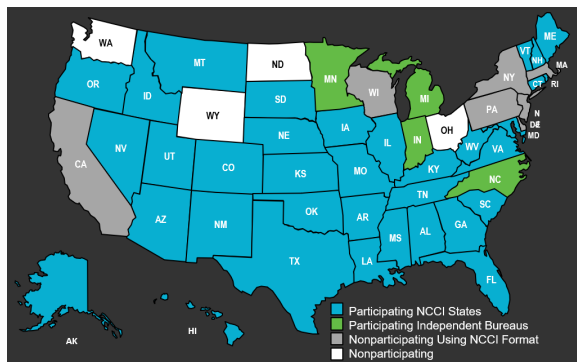
Chapter 3: Medical Data Call General Rules

Medical Transactions

- Report all medical transactions associated with workers compensation claims in any Medical Data Call state.
- The jurisdiction state is the state under whose Workers Compensation (WC) Act the claimant's benefits are being paid.



States



Jurisdiction State—Examples

Enter the jurisdiction state for each example.



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Exposure State Is ...	Accident Occurs in ...	Benefits Paid Under the WC Act in ...	Jurisdiction State Is ...
FL	NM	NM	NM
TX	NM	TX	TX
GA	FL	FL	FL

Eligibility Overview

- Affiliate Group Level
 - Single contract
 - Includes individual coverage providers
- Market Share
 - Applicable market share in any one state
- Medical Data Call States
 - Report for all MDC states in which they write
 - Continue to report indefinitely
- Mergers & Acquisitions
 - All affiliate groups will be required to report

Reporting Responsibility

Participants in the Medical Data Call have the flexibility of meeting reporting requirements:

- Submit directly to NCCI
- Authorize a third-party vendor to submit on their behalf
- A combination of both



Quality, timeliness, and completeness of the Medical data is the responsibility of the carrier.

Knowledge Check

An affiliate reporting the Medical Data Call is required to report data for ...

Select the correct answer:

- A) The largest group
- B) Only companies with at least 0.5% market share
- C) All groups and companies in its affiliation**

Reporting Frequency

All medical transactions that occur on a date within a specific quarter must be reported by the end of the following quarter.



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Transaction Quarter	Due Date
Quarter 1	June 30
Quarter 2	September 30
Quarter 3	December 31
Quarter 4	March 31



Transaction Date

Transaction Date is the date the information in the medical transaction was processed—not the date the information was reported to NCCI

Example:

Physical Therapy 5/11 → Due by → End of 3rd Quarter

Reporting Frequency Options

There is an option to report quarterly or monthly.

Quarterly
One submission due by the end of the following quarter

Jul	Aug	Sep	Oct	Nov	Dec
Transactions Processed			Sent in October	3rd Quarter due by December 31	

Third quarter quarterly data can be sent as early as October.

Monthly
Three submissions due by the end of the following quarter

Jul	Aug	Sep	Oct	Nov	Dec
Jul Transactions	Aug Transactions	Sep Transactions	Sep sent in Oct	3rd Quarter due by December 31	
Jul sent in Aug		Aug sent in Sep			

- Partial quarter data submitted in three separate monthly submissions
- Can begin submitting third quarter data as early as August 1



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Due Date Examples

Fill in the information:

Transaction Date	Include in Quarter ...	Due Date
3/15	Quarter 1	6/30
6/30	Quarter 2	9/30
8/01	Quarter 3	12/31
12/31	Quarter 4	3/31



Report all transactions based on the **Transaction Date**.

Chapter 4: Medical Data Call Structure

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 Provider Postal (ZIP+4) Code
Network Service Code	Quantity/Number of Units per Procedure Code	Place of Service Code	Secondary Procedure Code

Key Fields

- Carrier Code
 - Policy Number Identifier
 - Policy Effective Date
 - Claim Number Identifier
 - Bill Identification Number
 - Line Identification Number
- } **NOTE:** Key fields in Unit Statistical Data and Indemnity Data Call
- } **NOTE:** Additional key fields for Medical Data Call

Bill Header Data Elements

- Carrier Code
- Policy Number Identifier
- Policy Effective Date
- Claim Number Identifier
- Jurisdiction State Code
- Claimant Gender Code
- Birth Year
- Accident Date
- Bill Identification Number
- Service From Date
- Service To Date
- Provider Taxonomy Code
- Provider Identification Number
- Provider Postal (ZIP) Code
- Provider Postal (ZIP+4) Code
- Network Service Code
- Place of Service Code



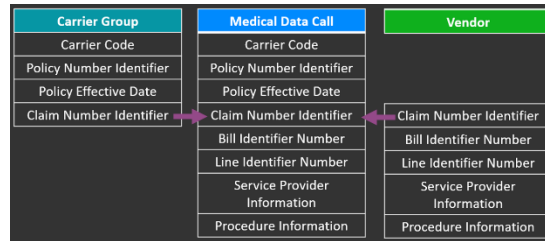
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Bill Detail Data Elements

- Transaction Code
- Transaction Date
- Line Identification Number
- Service Date
- Paid Procedure Code
- Paid Procedure Code Modifier(s)
- Amount Charged by Provider
- Paid Amount
- Primary ICD Diagnostic Code
- Secondary ICD Diagnostic Code
- Quantity/Number of Unit per Procedure Code
- Secondary Procedure Code

Data Elements

- Carrier Group assigns:
 - Carrier Code
 - Policy Number Identifier
 - Policy Effective Date
 - Claim Number Identifier
- Vendor receives the Claim Number Identifier from the carrier and assigns:
 - Bill Identifier Number
 - Line Identifier Number
- Vendor provides:
 - Service Provider Information (e.g., Taxonomy, Provider Identifier, Network Service Code)
 - Procedure Information



The Claim Number Identifier reported must match the Claim Number Identifier reported on the Unit Statistical Data.

Record Layouts

For NCCI to process data submissions, data providers are required to comply with specific requirements when reporting the Medical Data Call:

- Record Layouts
- Data Elements
- Linking Data

Medical Data Call Record Layout						
Field No.	Field Title/Description	Class	Position	Bytes	Header/Detail	Source
1	Carrier Code ^[1]	N	1-5	5	H	Payer
2	Policy Number Identifier ^[1]	AN	6-23	18	H	CMS 11
3	Policy Effective Date ^[1]	N	24-31	8	H	

Information included in layout:

- Field No.: assigned based on the position and number of bytes for the element.
- Field Title/Description: the name of the data element.
- Class: (N) numeric, (AN) alphanumeric, or (A) alpha.
- Position number: the location within the 350-byte record.
- Bytes: the size (number of positions) for the data element.
- Header/Detail: identifies if the data element is part of header information or detailed information.





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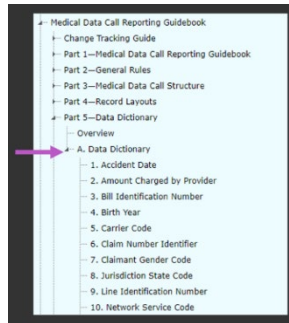
- Source: indicates the element can be found on standardized forms such as CMS or UB bill or from the payer. When data is not on a form, it is provided by the entity that pays the bill.

Data Dictionary

The Data Dictionary section of the *Medical Data Call Reporting Guidebook* (Part 5) is provided in alphabetical order.

For each data element, the data dictionary provides:

- Data Element Name
- Field number from record layout
- Position numbers identifying the location of the element within the 350-byte record
- Class identifies (N) numeric, (AN) alphanumeric, or (A) alpha
- Bytes indicate the size of the data element
- Format provides the class and length of the element along with any additional formatting instructions
- Definition provides the industry standard meaning
- Reporting Requirement provides any special instructions for reporting the data



14. Place of Service Code

Field(s):	27
Position(s):	282-289
Class:	Alphanumeric (AN)—Field contains alphabetic and numeric characters
Bytes:	8
Format:	AN 8; this field must be left justified and blank-filled to right of the last number or character when the Place of Service Code is less than 8 bytes. Include leading zeros when part of the code. If converting codes from a system that does not store leading zeros, ensure that the leading zero(s) is inserted correctly. For example, if the system stores 9 for a code that is listed as 09 on the code list, insert a zero to the left of the 9 when reporting to NCCI.

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

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

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

Place of Service ¹			
Code	Description	Code	Description
01	Pharmacy	33	Custodial Care Facility
02	Telehealth Provided Other Than in Patient's Home	34	Hospice
03	School	35-40	Unassigned—Not Valid for NCCI
04	Homeless Shelter	41	Ambulance—Land
05	Indian Health Service—Free-Standing Facility	42	Ambulance—Air or Water

For the Place of Service Code example, the code values provided are 2 bytes in a field that is 8 bytes. NCCI purposely padded the record layout to allow for future expansion. Source: Centers for Medicare & Medicaid Services (CMS) (www.cms.hhs.gov). The codes listed are valid as of the guidebook issue date. New codes approved by CMS are valid.

Place of Service Crosswalk

NCCI's guidebook will provide additional external references when available. For the Service Code example, the Place of Service Crosswalk for facility and hospital services is provided as a link within the Reporting Requirement.

This was developed to provide a mapping of the Type of Bill code on medical billing form CMS-1450 (UB-04). This is intended for reporting facility and hospital services because the form does not contain Place of Service code information.

Place of Service Crosswalk				
Type of Bill	Type of Bill Position 1 (Type of Facility)	Type of Bill Position 2 (Bill Classification)	Place of Service Code ⁽¹⁾	Place of Service Description
11X	Hospital	Inpatient	21	Inpatient Hospital
12X	Hospital	Inpatient	21	Inpatient Hospital
13X	Hospital	Outpatient	22/19 ⁽²⁾	On-Campus/Off-Campus Outpatient Hospital
14X	Hospital	Other	22/19 ⁽²⁾	On-Campus/Off-Campus Outpatient Hospital
18X	Hospital	Swing Bed	21	Inpatient Hospital
21X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility
22X	Skilled Nursing	Inpatient	31	Skilled Nursing Facility
23X	Skilled Nursing	Outpatient	32	Nursing Facility
28X	Skilled Nursing	Swing Bed	32	Nursing Facility
32X	Home Health	Inpatient	12	Home
33X	Home Health	Outpatient	12	Home
34X	Home Health	Other	12	Home



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Knowledge Check

Which of the following fields is **not** a Key Field in the Medical Data Call?

Select the correct answer:

- A) Policy Effective Date
- B) Bill Identification Number
- C) Accident Date**
- D) Policy Number Identifier

Chapter 5: Medical Data Call Transactions

Record Layout

Within the Record Layout is the Transaction Code. There are three different Transaction that can be submitted at the bill line detail level.

5	Transaction Code	N	44-45	2	D	Payer
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Medical Data Call Transactions

- 01—Original
 - The first reporting of a medical transaction
 - Only one may be submitted for a medical transaction
- 02—Cancellation
 - Used to delete or cancel record(s)
 - Apply to a prior record(s) or record(s) in same submission
- 03—Replacement
 - Used to revise non-key field values
 - Apply to prior record(s) or records(s) in same submission

Cancellation

<p>Transaction 02</p> <p>⚠ It is not necessary to provide any other data elements.</p>	Use	Cancels records on NCCI’s database
	Include	Record MUST include all key fields from prior transaction
	Include	Deletes a prior record or multiple recordings using key fields



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Different Uses of the Cancellation Transaction

- Delete an Original (01) or Replacement (03) Transaction

Record	Carrier Code	Policy Number ID	Policy Effective Date	Claim Number ID	Trans Code	Trans Date	Bill ID Number	Line ID Number	Service Date	Amount Charged by Provider
A	99990	ABC123	20240101	0006	01	20241010	1001	1	20240903	00000010000
B	99990	ABC123	20240101	0006	02	20241010	1001	1	20240903	00000010000

- Used Instead of a Replacement (03) Transaction

Record	Carrier Code	Claim Number ID	Trans Code	Trans Date	Bill ID Number	Line ID Number	Service Date	Amount Charged by Provider	Paid Amount	Provider Postal (ZIP+4) Code
A	99990	A10000	01	20241210	1001	1	20241203	00000010000	00000010000	334870000
B	99990	A10000	02	20241217	1001	1	20241203	00000010000	00000010000	334870000
C	99990	A10000	01	20241217	1001	1	20241203	00000010000	00000010000	334670000

- Update to Key Fields

Scenario	Carrier Code	Claim Number ID	Trans Code	Trans Date	Bill ID Number	Line ID Number	Service Date	Amount Charged by Provider	Paid Amount	Quantity/# of Units
A	99990	1000	01	20241210	1001	1	20241203	00000010000	00000010000	0000001
B	99990	1000	02	20241217	1001	1	20241203	00000010000	00000010000	0000001
C	99990	1	01	20241217	1002	1	20241203	00000010000	00000010000	0000001

Replacement Transaction

<p>Transaction 03</p> <p>Changes via a replacement record can only be made to non-key fields.</p>	Use	Correcting a data entry issue
	Include	Replaces a prior record or multiple records using Transaction Code 03
	Include	Replacement record MUST include all data elements
	Include	Replacements must report all values cumulatively

Replacement Examples

- The data provider reported the incorrect Jurisdiction State Code on all Federal Transactions.

Record	Carrier Code	Policy Number ID	Policy Effective Date	Claim Number ID	Trans Code	Trans Date	Bill ID Number	Line ID Number	Service Date	Jurisdiction State Code
A	99990	ABC123	20240101	0006	01	20241010	1001	1	20240903	10
B	99990	ABC123	20240101	0006	03	20241012	1001	1	20240903	09

- The data provider needs to report an additional reimbursement on a previously reported transaction

Scenario	Carrier Code	Claim Number ID	Trans Code	Trans Date	Bill ID Number	Line ID Number	Service Date	Amount Charged by Provider	Paid Amount	Quantity/# of Units
A	99990	1000	01	20241210	1001	1	20241203	00000010000	0000008999	0000001
B	99990	1000	03	20241217	1001	1	20241203	00000010000	0000009999	0000001

Medical Data Call Transaction Date

The Transaction Date is the **date** the medical transaction was **original processed, updated, and paid** by the administering entity's system.



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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

Medical Data Call Transaction Date

The date the medical transaction was **originally processed, updated, and paid** by the administering entity’s system.

Medical Service on	1/15/2024
Bill Processed and Paid on	1/21/2024
Data Provider Reports Transaction 01 on	4/1/2024
Transaction Date Should Be?	

- The date the medical transaction was **cancelled, changed, or updated** by the administering entity’s system
- **MUST** be **after** the Transaction Date of record being cancelled or replaced

If Transaction Code Is ...	Then Report ...
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

Knowledge Check

True or False

A Replacement record is used to change non-key field values on a previously reported transaction. **True**

ALL data elements from the prior record must be included when submitting a 02 Cancellation Transaction. **False**

Chapter 6: Data Linking

Key Fields

Key fields within the Medical Data Call:

- Carrier Code
- Policy Number Identifier
- Policy Effective Date



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- Claim Number Identifier

Within the Medical Data Call, there are two additional key fields that are checked across transactions on the Bill Line records to link the claim records together:

- Bill ID Number
- Line ID Number

The Bill ID Number reported on any subsequent transaction must match the key fields reported in the original transaction or the record will be rejected.

Edit Number	Data Field	Edit Message	Transaction Code
0519-02	Transaction Code	Cancellation record does not match a previously reported record.	02
0519-04	Transaction Code	Replacement record does not match a previously reported record.	03

Review rejected records and resubmit them with correct key fields.

Importance of Claim Key Fields

Carrier Code, Policy Number, Policy Effective Date, and Claim Number identify all the transactions that identify a unique claim. NCCI uses these four fields to create a Claim ID. The Claim ID holds all payments and services together for the life of a particular claim.



Medical Data Claims

Regardless of who reports the date, the four key fields **must** be consistently reported.

Medical Data Provider 1		Medical Data Provider 3	
Claim ID: 123		Claim ID: 124	
Carrier Code:	99990	Carrier Code:	99990
Policy Number:	ABC123	Policy Number:	ABC123
Policy Eff Date:	20240101	Policy Eff Date:	20240110
Claim Number:	WC111	Claim Number:	WC111

Inconsistency in reporting key fields leads to the creation of new Claim IDs.

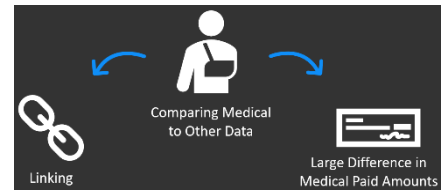


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Consistency With Other Reporting

Consistency is “KEY” when reporting multi-data types.

Consistently reporting linking data values across all data types enables NCCI to use these data elements for the same policy and associated claims.



Consistent Reporting of Multi-Data Type Fields

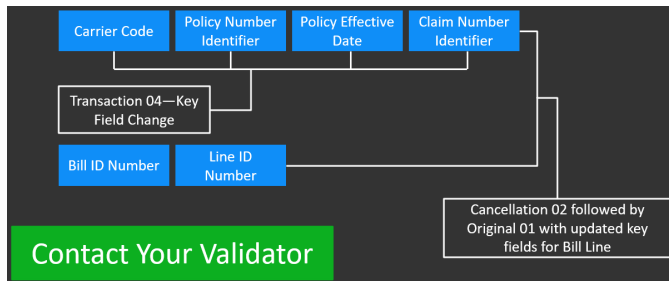
Consistently reporting the field values that NCCI uses for linking within each data type and across all data types enables NCCI to use all data elements for the same policy and associated claims. Below are the fields by data type:

Data Element	Data Type					
	Policy Data	Unit Statistical Data	Financial Calls#18, #1C, #31, #33	Medical Data Call	Indemnity Data Call	Pool Large Loss (LGL) Data
Carrier Code	X	X	X	X	X	X
Policy Number	X	X	X	X	X	X
Policy Effective Date	X	X	X	X	X	X
Exposure State Code	X	X	X		X	X
Claim Number	X	X	X	X	X	X
Accident Date		X	X	X	X	X
Jurisdiction State Code		X		X	X	
Accident State Code					X	

Note: An "X" denotes that the data element is applicable for the data type.

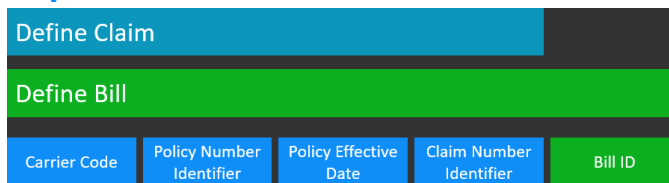
This illustration is found within each data reporting guidebook.

Correcting Key Fields

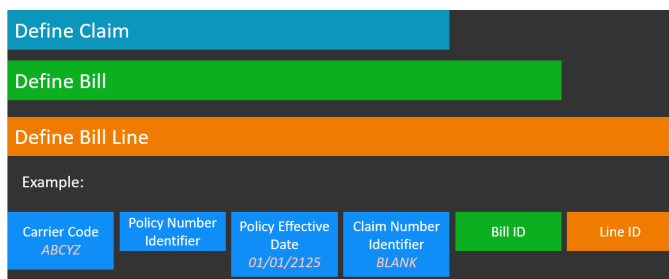


NCCI recommends that you work with your validator if key field changes are needed!

Key Fields—Medical Bill



When the data related to a bill line changes (for example, additional payments), the updated transaction needs to report the same values in these key fields as was reported on the original transaction.





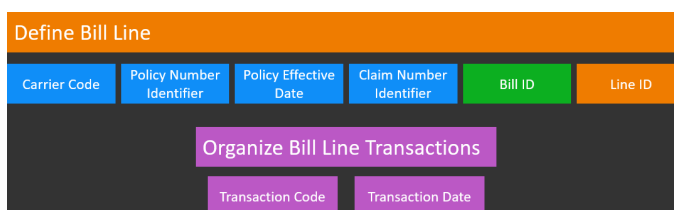
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The ability to uniquely identify a bill line and process updates correctly means NCCI cannot load inconsistent key fields.

Reasons why NCCI may return individual records:

- Blank Claim Numbers
- Invalid Policy Effective Dates
- Carrier Codes That Are Not Recognized

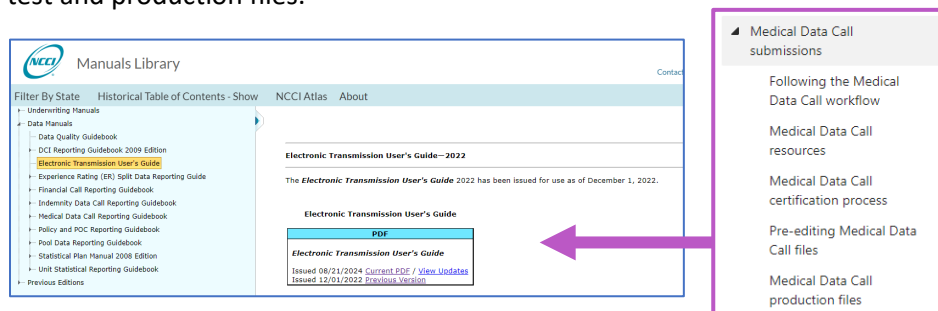
If a significant number of records in a single file have errors, we assume there was an error when creating the file and reject the file.



Additional fields help NCCI determine how to handle updates to a transaction. The Transaction Code indicates if the transactions are to be replaced or cancelled. The Transaction Date provides the order in which the updates should be processed.

Chapter 7: Submitting Data

This manual provides the necessary requirements, forms, and instructions for preparing and submitting test and production files.



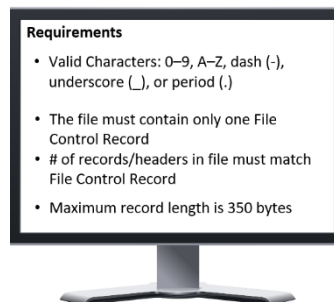
Submitting Medical Data Files

File Naming Conventions for **Production**:

- Bill Line—medical.30charactersmax.txt
- Production KFC—medkey.30charactersmax.txt

File Naming Conventions for **Certification and Test** files:

- Bill Line—medical.30charactersmax.tst
- KFC—medkey.30charactersmax.tst





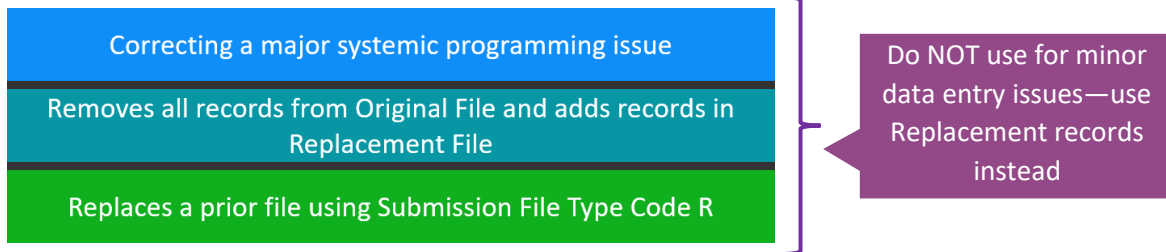
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File Control Record

- Only one File Control Record is required for each file submitted to NCCI
- Place at the beginning or at the end of the Medical file
- The file provides:
 - Submission File Type Code (Original or Replacement)
 - Carrier Group
 - Reporting Quarter Code
 - Reporting Year
 - Record Total (**Note:** If this does not match the actual record count, NCCI will reject the file)

Replacement File Use

Used for correcting major systemic programming issues.



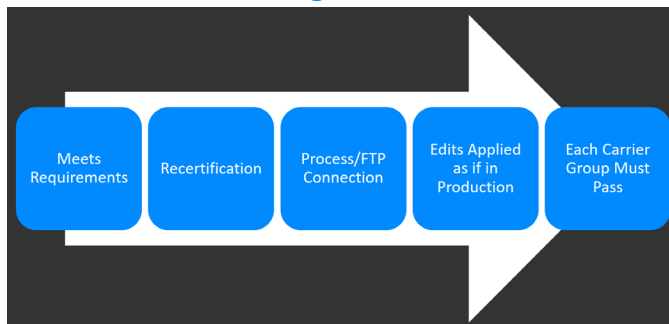
Replacement File Examples

- The data provider reported all Transaction Dates in the file as the date the records were submitted to NCCI, instead of the date the transactions occurred.
- The data provider reported all IDC Diagnostic Codes missing the decimal point, and the spacing in the file is incorrect.



Replacement File?

Certification/Testing



Certification testing ensures that test data files meet minimum formatting and quality requirements prior to production reporting. System changes require recertification as indicated on the affiliation agreement.



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With certification testing:

- Data will meet minimum formatting and quality requirements prior to production reporting
- Edits are applied to each test file as if it were received in production
- The submission process and connection to NCCI is tested
- Edits are applied to test data as if it were production data
- Each carrier group **MUST** pass certification before they are approved to submit production data

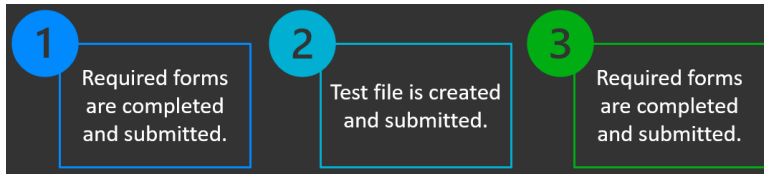
- .TST Extension
- Edits Applied as if Production Edit
- Use Real/Production Data



Contact Your Validator!

Certification Process

Three-step process:



Medical Data Provider (MDP) Requirements

Steps required before reporting Medical data to NCCI:

- Data Provider Profile Form: For carriers that will be utilizing a third-party administrator (TPA), vendor, or other outside MDP
- Service Provider Agreement: Authorizes the TPA or vendor to act on the affiliate’s behalf
- Service Provider Data Tool Access Addendum: Attached to the Service Provider Agreement, it provides access to the data reporting tools and identifies the level of access



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

Pre-Edit

The certification testing can also be used as a Pre-Edit tool by you before submitting for production processing.

- Medical.30characters.tst
- Medkey.30characters.tst
- Edited as if Production data
- Results in **MDC** tool
- Submission and Quality Tracking at file level



Contact Your Validator!



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Knowledge Check

Select the correct answer.

A Replacement **File** is used to:

- A) Update key fields from a prior submission
- B) Update non-key field values from a prior submission
- C) Replace a prior file using Submission File Type Code R**
- D) Cancel a record from a prior submission

Medical Data Call Reporting Practices

Chapter 8: 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:

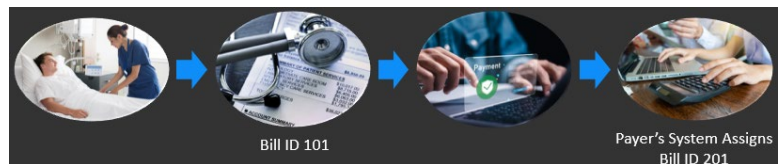
- Affect medical analysis by overstating utilization
- Inflate costs and impact analysis

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.



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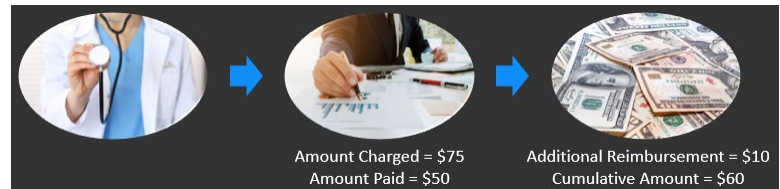
Duplicate Billing—Filtering Out Duplicates

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
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:

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.



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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

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




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Incorrectly Reporting Duplication Transactions

Most Commonly Occurring Because Of:

- Changing Systems
- Changing Vendors



Contact Your Validator

Part 6-D
Duplicate
Records

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

Chapter 9: Unique Payments

Zero Paid Amounts

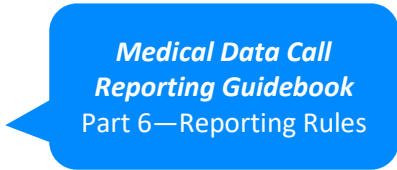
Whether a zero paid amount should be reported will depend on the situation.

- When a whole bill is denied because none of the services were related to a workers compensation claim, the service 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.



Chapter 10: Hospital Inpatient Reporting



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.

- 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.



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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



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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.

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

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



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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

Knowledge Check

Provide the correct response.

1. How many bytes are in a Revenue Code? **4**
2. How many bytes are in a DRG Code? **3**

Chapter 11: Service Dates

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

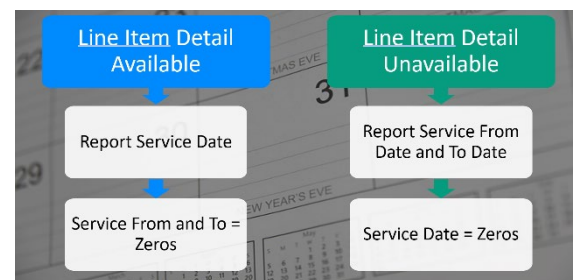


Note: A Service Date is required for reporting. The method used will depend on if the specific Service Date (or line item) detail is available.

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.





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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



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- 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



Chapter 12: Case Management Reporting

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.

	171M00000X	A person who provides case management services and assists an individual in gaining access to needed medical, social, educational, and/or other services
	251B00000X	An organization that is responsible for providing case management services for any of the case management services

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



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.



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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

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