



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 pricing and research studies
- Medical data validation test approach, results, and communication with data providers

Chapter 1: Purpose of the Medical Data Call

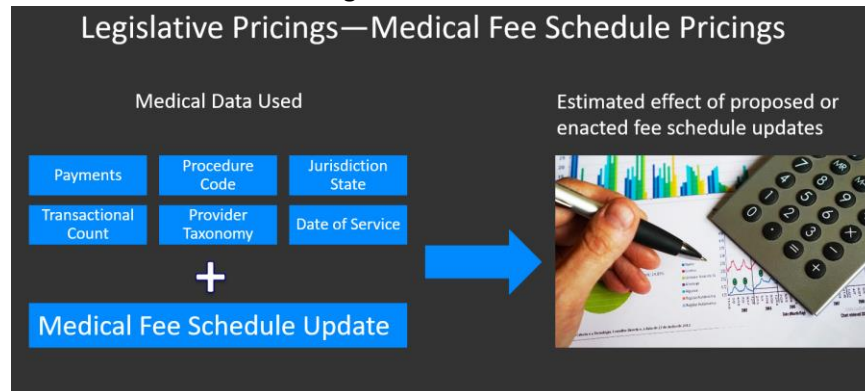
- Legislative Analysis and Pricings
- Regulator Requests
- Research
- Informational Resources

Legislative Pricings

Medical Fee Schedule

- Definition—list of prices for medical services
- 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

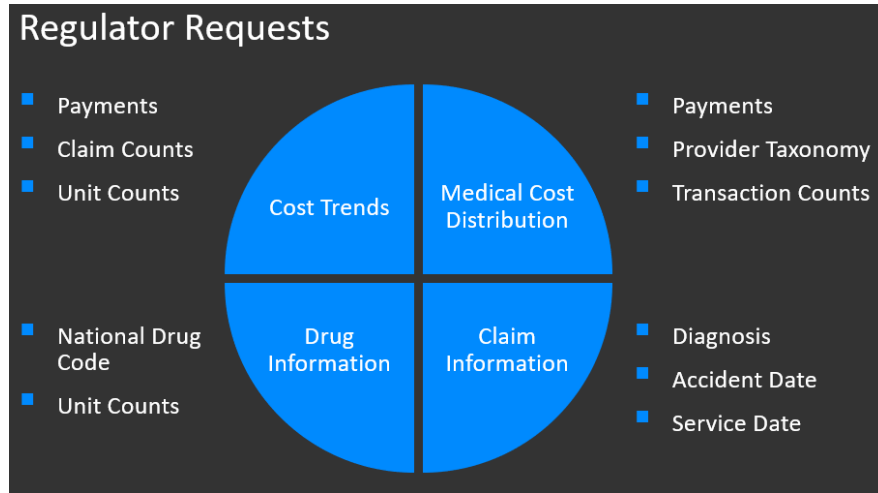


Medical Data Call provides the data elements necessary to price updates.



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Regulator Requests



Requests for information to provide insight on a specific question.

Research: Recent Articles

September 2021



Insights » Research & Briefs

Article Link: www.ncci.com/Articles/Pages/Insights-Comparing-Utilization-Physician-Services.aspx

NCCI taps into data from employer-sponsored group health (GH) programs as a source of information that might be critical to maintaining a viable workers compensation (WC) benefit delivery system.



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August 2021



Insights » Research & Briefs

Article Link: www.ncci.com/Articles/Pages/Insights-Latest-Trends-Time-Treatment.aspx

This study explores the impact of the COVID-19 pandemic on time to treatment for injured workers. We also associate costs with the time to treatment for some common WC injuries based on historical information.

Key Findings—The Latest Trends in Time to Treatment

- Compares 2020 data to 2019 time to treatment and the potential cost impact of the COVID-19 pandemic
- With respect to time to treatment, the pandemic:
 - Did not adversely impact access to care, as measured by the time from injury to initial treatment
 - Produced a backlog of surgeries in April and May 2020 that diminished throughout the summer
 - May have resulted in greater use of noninvasive treatments that, with comparable outcomes, are often preferred over invasive procedures

Informational Resources

October 2021



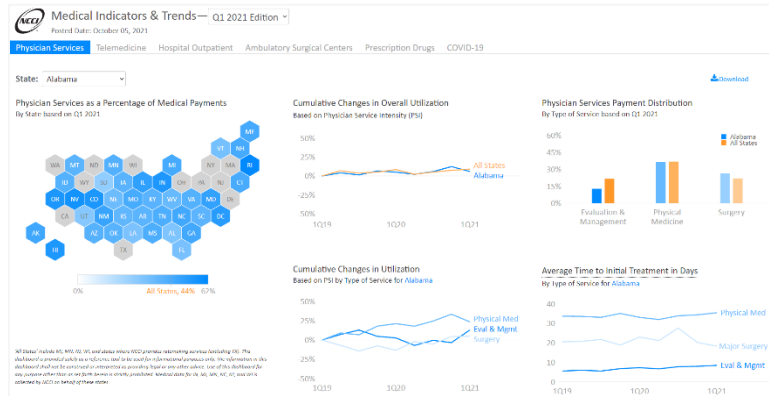
Insights » What's Trending

Article Link: www.ncci.com/Articles/Pages/Insights-Medical-Indicators-Trends-Dashboard.aspx



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The Medical Indicators & Trends dashboard—Q1 2021 Edition is part of NCCI’s ongoing strategy to deliver more medical data insight for your analysis. It provides an interactive way to visualize medical services provided before and after the spread of the pandemic.



Chapter 2: Validation Processes

Aggregate Data Quality

Process approximately:

- 80 Million Transactions
- 3 Million Claims

Data Quality—A Layered Approach

Submission File Editing

- Tens of millions of records received each quarter
- NCCI’s editing strategy is to make sure the data can be loaded to our database and provide general feedback on the structure of the data reported
- All edit results are available for review in the **Medical Data Collection** tool immediately after the data file completes processing

Quarterly Aggregate Review

- Occurs after end of a quarter
- Data for each group is compared to the rest of reported data to identify outlier reporting behavior

Usage Specific Review

- Occurs before use of the data, especially when a new analysis is performed



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- More detailed slice of the data that may not be part of our general data quality reviews

Submission File Editing

Limited Record Rejects—Key Field Errors

Define Bill Lines

Carrier Code Policy Number Policy Effective Date Claim Number Bill ID Line ID

Organize Bill Line Transactions

Transaction Date Transaction Code

- Ensures data can be loaded into NCCI's database
- The six Medical Data Key Fields are: Carrier Code, Policy Number, Policy Effective Date, Claim Number, Bill ID, and Line ID
- The Transaction Code identifies the type of transaction being submitted
- The Transaction Date is the date the information in the medical transaction was processed as established by the original source of the data
 - Original source of the data is defined as the entity initially responsible for administering the medical bill(s)
 - This may be an insurer, TPA bill review vendor, pharmacy benefit manager, or other entity that is responsible for medical claim management
- This information uniquely identifies a bill line and allows NCCI to process updates correctly using the key field information
- If the key fields do not match (example: missing claim number, invalid Policy Effective Data, invalid Transaction Code), it will result in individual records being returned
- If a significant number of records in a single file have these types of errors, the file will be rejected in its entirety



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Quality Tracking Edits

- Quality edits provide immediate, high-level feedback on how fields are populated in a file
- Edit results show how many data elements are blank or have an invalid value in a record
- Results can be reviewed immediately after a file has completed processing
- The **Medical Data Collection** tool displays minimum expectations (threshold) to help identify potential issues



Quality Validation Edits

Quality Validation Edits

Reasonability checks:

- Compare Fields on the Same Record
- Compare Records to the Database

Amount Charged by Provider	Paid Amount
\$100	\$100
Amount Charged by Provider	Paid Amount
\$100	\$120
Primary ICD Diagnostic Code	Secondary ICD Diagnostic Code
	S52.01

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

Quality validation edit conditions may not always indicate incorrect reporting on an individual record. NCCI does not expect to see a high frequency of these types of edits.

This information can be monitored in the **Medical Data Collection** tool.



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Quality Validation Edits

Reasonability checks:

- Compare Fields on the Same Record
- Compare Record to the Database

Submitted Replacement Record

Transaction Code	Transaction Date
03	10/1/2019

Record to Be Replaced

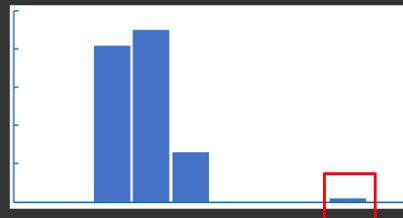
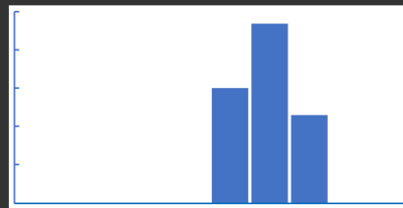
Transaction Code	Transaction Date
01	10/1/2019

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

Validation Tests

Validation Tests

- Percentage of quarterly data meeting test criteria
- Compare group to industry to identify outliers
- Examples of tests
 - Paid Duplicate Transactions
 - Jurisdiction State-to-Provider State Comparison
 - Common National Drug Code (NDC) Units



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.



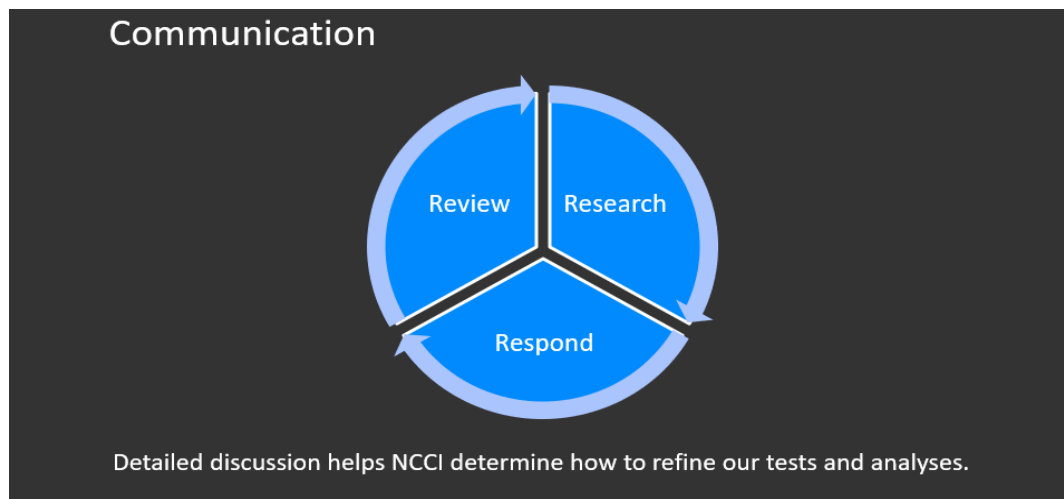
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Upon submission of a medical data file, our systems will look across the medical database into the policy and units, checking the following fields:

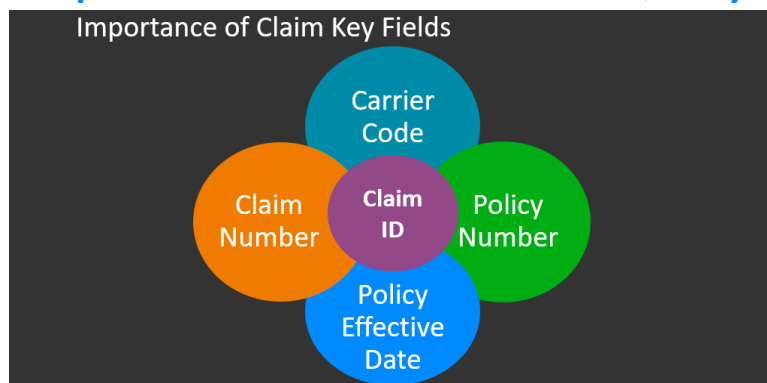
- Carrier Code
- Policy Number
- Policy Effective Date
- Claim Number

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

Communication



Chapter 3: 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



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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.

Medical Data Claims

Carrier

Claim ID: 123

Carrier Code: 99990
Policy Number: ABC123
Effective Date: 1/1/2021
Claim Number: WC111

Claim ID: 124

Carrier Code: 99990
Policy Number: ABC123
Effective Date: 1/1/1960
Claim Number: WC111

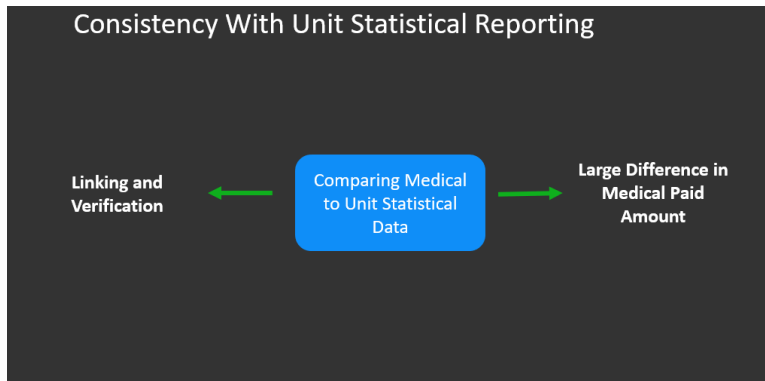
Medical Data
Provider 1

Carrier Code: 99990
Policy Number: ABC123
Effective Date: 1/1/2021
Claim Number: WC111

Medical Data
Provider 2

Key data elements must be consistent on a per-claimant basis from all submitters.

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.



Reporting key fields consistently allows NCCI to associate data across data types allowing for a more in-depth analysis.

Medical Data Call Transactions

Medical Call Transaction Codes

Transaction Code	Description
01	Original
02	Cancellation
03	Replacement
04	Key Field Change

The next data quality occurrence topic is duplicate transactions.



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Medical Data Call Transactions

Transaction Date

- **Date** the medical transaction was **originally processed** and paid by the **administering entity**
- **Date** the medical transaction was **updated** in the **administering entity's system**
- Bill line keys on cancellations and replacements must match previous reported transactions
- Replacements must report all values cumulatively

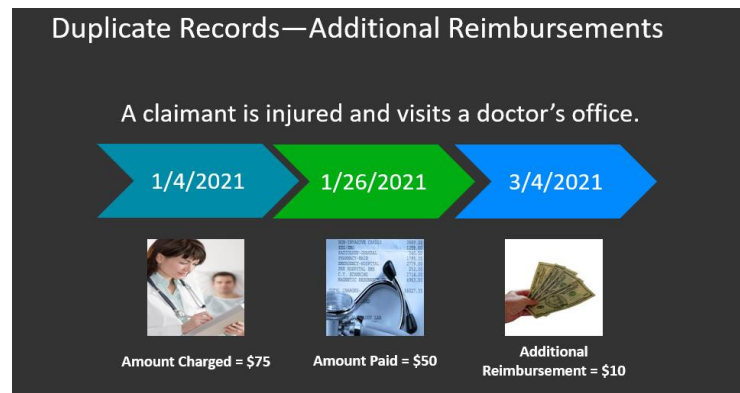
Do not use the date the record is extracted or the date you're going to submit it to NCCI. The Transaction Date should be tied to activity on the bill in your system.

Duplicate Record

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.

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:



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.



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Reporting Option #1—Submit one **Original Transaction**

Field Name	Original Reported As
Claim Number	12345
Transaction Date	3/4/2021
Transaction Code	01
Bill ID	101
Line ID	1
Paid Procedure Code	99201
Amount Charged by Provider	\$75
Paid Amount	\$60

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 \$60, not \$10
- The Transaction Date of the replacement record is the date that the additional reimbursement was made in the payer's system

Additional Reimbursements		
Reporting Option #2—Submit a Replacement Transaction		
Field Name	Original Reported As	Replacement Reported As
Claim Number	12345	12345
Transaction Date	1/26/2021	3/4/2021
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

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



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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	1/26/2021	3/4/2021	3/4/2021
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

Duplicate Billing


1/4/2021


1/26/2021

3/4/2021



**First Notice
Bill ID 101**





**Second Notice
Payer's System
Bill ID 201**

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.



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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.

Duplicate Billing
Common example of how this might be incorrectly reported:

Field Name	Original Reported As	Original Reported As
Claim Number	12345	12345
Transaction Date	1/1/2021	2/1/2021
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 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

Duplicate Billing—Cancellation

Field Name	Original Reported As	Cancellation Reported As	New Original Reported As
Claim Number	12345	12345	12345
Transaction Date	1/1/2021	2/1/2021	2/1/2021
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

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



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fee scheduled change. Duplicates may lead to carrier data being excluded from legislative pricing and research.

Duplicate Transactions—Example

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	12/19/2017	BillAAA1	Line 1	10/29/2017	99203	491.00	274.09	722.0	Provider1
01	3/3/2018	BillAAA2	Line1	10/29/2017	99203	491.00	274.09	722.0	Provider1

Can you identify why NCCI might indicate that these two bill lines represent the same payment?

Duplicate Transactions—Example

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
3/28/2018	BillABC1	Line 1	3/12/2018	97140	76.20	37.34	727.05	Provider1	2
5/7/2018	BillABC2	Line1	3/12/2018	97140	38.10	37.34	727.05	Provider1	1
5/7/2018	BillABC2	Line2	3/12/2018	97140	38.10	37.34	727.05	Provider1	1

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.

Diagnosis Related Group (DRGs)

The DRG Code is the Diagnostic Related Group Code, which is a method of reimbursement for inpatient hospital stays dependent on factors related to the diagnosis.

DRGs Versus Hospital Revenue 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!

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



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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.

Inpatient Hospital Bills

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 report 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 the duplicate records.

Inpatient Hospital Bills

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

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	1/30/2021	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	\$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



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To correctly unbundle, report:

Method 1: DRG payment record with total charges (Revenue Code transactions reported with no charges)

Inpatient Hospital Bills						
Method 1						
Report DRG payment record with total charges —Revenue Code transaction 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)

Inpatient Hospital Bills						
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




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Provider Zip Code

A medical provider could have multiple zip codes associated with its practice.

Provider Zip Code

Report Zip Code	Hierarchy
Zip code that impact reimbursement	1
Zip code where service was performed	2
Billing zip code, unless billing house or pharmacy benefit manager	3



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:

1. Report the provider zip code of the location where the service was performed
2. If the zip code of the actual location is unavailable, provide the zip code of the billing address
3. If the billing address is a billing house, then leave the **provider zip code blank**
 - a. Pharmacy Benefit Managers (PBMs) are considered billing houses by NCCI

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

Jurisdiction to Provider State

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

Jurisdiction to Provider State

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



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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	3/29/2018	3/12/2018	00405452802	333600000X	Provider1
27	NV	303	GA	8/14/2018	7/28/2018	00405452802	333600000X	Provider1
27	NV	303	GA	6/16/2018	5/30/2018	66336002790	333600000X	Provider1
27	NV	303	GA	9/5/2018	8/19/2018	00185540001	333600000X	Provider1
43	UT	303	GA	11/8/2018	10/22/2018	00781570110	333600000X	Provider2
43	UT	303	GA	6/9/2018	5/23/2018	33358023360	333600000X	Provider2
11	ID	303	GA	1/31/2018	1/14/2018	66336002790	333600000X	Provider3
11	ID	303	GA	3/19/2018	3/2/2018	66336002790	333600000X	Provider3
11	ID	303	GA	12/26/2018	12/9/2018	49884086802	333600000X	Provider3

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 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

National Drug Code (NDC) Units

NDC defines the measurement:

- Pill Counts
- Standard Package Count
- Quantity (e.g., milliliters)

