

# Medicare Part C Reporting Requirements: Technical Specifications Document Contract Year 2026

*Effective as of January 1, 2026*

## Organization Determinations / UM

For an explanation of organization determinations, reconsiderations, and re-openings procedures, refer to CMS regulations 42 CFR Part 422, Subpart M, and the 'Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance via the CMS website: <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG>. For information on the integrated appeals process, refer to the Addendum to the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans: <https://www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf>.

### General

- Report completed organization determinations and reconsiderations (i.e., MAO has notified enrollee of its pre-service) during the reporting period, regardless of when the request was received.

### Report:

- Completed organization determinations (i.e., MAO has notified enrollee of its pre-service decision submitted by the enrollee or non-contract provider) during the reporting period, regardless of when the request was received. MAOs are to report organization determinations where a substantive decision has been made, as described in this section and processed in accordance with the organization determination procedures described under 42 C.F.R. Part 422, Subpart M.
- Pre-service organization determination requests submitted by the enrollee, enrollee's representative, or contract provider on behalf of the enrollee, and requests from non-contract providers.
- MAOs are to report fully favorable, partially favorable, and adverse pre-service organization determinations.
- A denial of a Medicare request for coverage (provision) of an item or service as either partially favorable or adverse, regardless of whether Medicaid payment or provision ultimately is provided, in whole or in part, for that item or service. However, D-SNPs that are applicable integrated plans as defined in 42 CFR § 422.561 should report a request for a Medicare item or service based on the outcome of applying both Medicare and Medicaid coverage criteria.
- Denials based on exhaustion of Medicare benefits.
- Dismissals
- Withdrawals

**Do Not Report:**

- Concurrent reviews during hospitalization that do not result in organization determinations.
- Concurrent reviews of Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) care that do not result in organization determinations.
- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.
- A service only covered under the MAO's Medicaid benefits and never covered by Medicare and not covered by the MAO as a supplemental Medicare benefit (such as Medicaid home-and community-based long-term services and supports).