Att 20 - Payment Organization Determinations and Reconsiderations (PYMT_C)

A	B	C	D	E	F	G	H	I	J	K	L
Enrollee First Name	**Enrollee Last Name**	**Enrollee ID**	**Contract ID**	**Plan Benefit Package (PBP)**	**First Tier, Downstream, and Related Entity.**	**Authorization or Claim Number**	**Date the Request was Received**	**AOR/Equivalent notice Receipt Date**	**Waiver of Liability (WOL) Receipt Date**	**Was it a Clean Claim?**	**Was the request processed as an OD or Recon?**
First name of the enrollee.	Last name of the enrollee.	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.	The contract number of the organization. ***Note: H5355 identifies the CMC line of business***	Enter the PBP. ***Note: IEHP's assigned PBP is 001***	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the sponsoring organization to provide administrative or health care services to an enrollee under the Part C or D program) that processed the request. Enter None if the sponsoring organization processed the request.	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available.	Enter the date the payment request was received. If the sponsoring organization obtained information establishing good cause after the 60-day filing timeframe, enter the date the MMP received the information establishing good cause. Submit in CCYY/MM/DD format (e.g., 2020/01/01).	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for dismissed requests or if no AOR or equivalent written notice was received or required.	Enter the date the WOL form was received for noncontracted provider payment appeals. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** for ODs, enrollee submitted requests, or if a WOL was never received.	Enter **Y** for clean claim, **N** for unclean claim, or **None** for payment reconsiderations.	The manner by which the request was processed. Enter **OD** or **Recon**

M	N	O	P	Q	R	S	T
Request Determination	**Date of Determination**	**Date Claim/Reconsideration was paid**	**Date Written Notification Provided to Enrollee**	**Date Written Notification Provided to Provider**	**Date forwarded to IRE**	**Who made the request?**	**Issue Description and Type of Service**
Status of the request. Valid values are: **Approved**, **Denied** or **Dismissed**	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). This is the date the determination was entered in the system and may be the same as the date claim was paid. For dismissed requests, enter the date the Sponsoring organization dismissed the request.	Enter the date the claim/reconsideration was paid. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** if payment was not provided, if the request was denied, or if the request was dismissed.	Enter the date written notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** if no written notification was provided.	Enter the date written notification was provided to provider. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** if no written notification was provided or if the enrollee submitted the request.	Enter the date the payment appeal was forwarded to the IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter **None** for organization determination requests, or if the reconsideration request was approved, dismissed, or not forwarded to the IRE	Who made the request. Enter **E** for enrollee, **ER** for enrollee's representative or purported representative, or **NCP** for requests by a non-contract provider/pharmacy.	Provide Procedure Code followed directly by a dash (-) with no space, followed directly by the description. If there are multiple services, list them all here as specified above delimited by a comma. For denials, also provide an explanation of why the determination or request was denied. For dismissed requests, provide the reason for dismissal.

U
Was the initial Organization Determination request denied for lack of medical necessity?
Enter **Y** for Yes, **N** for No or **None** if the request was approved or dismissed.