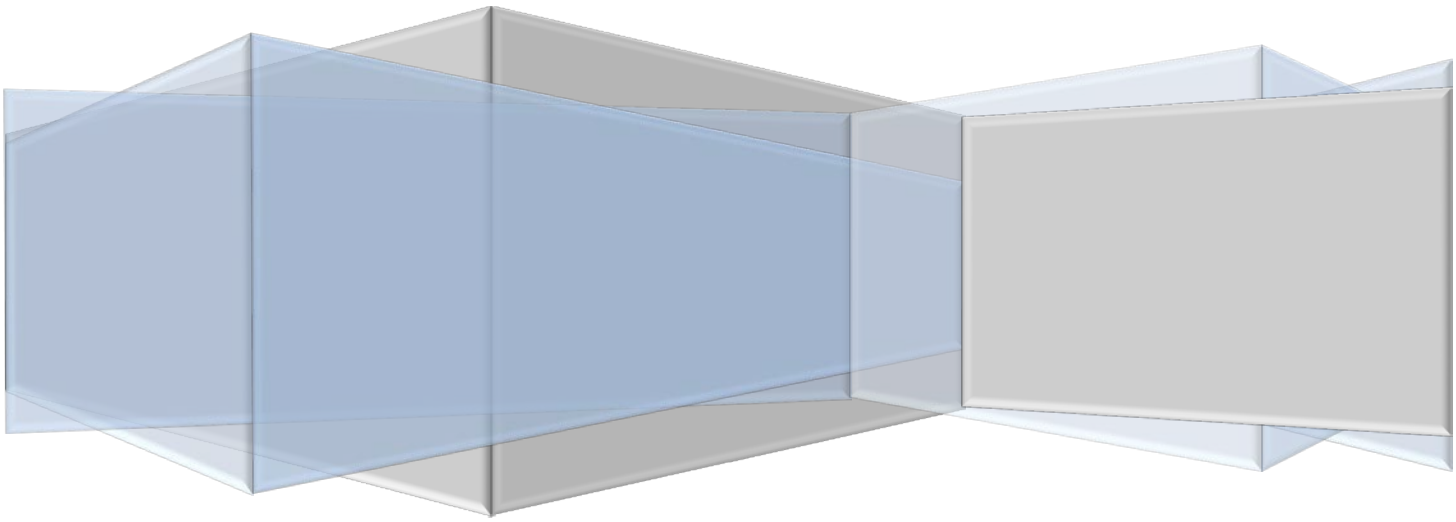
Part C Organization Determinations, Appeals, and Grievances (ODAG)

PROGRAM AUDIT PROTOCOL AND DATA REQUEST



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Program Audit Protocol

Purpose

To evaluate performance in the areas outlined in this Program Audit Protocol and Data Request related to Part C Organization Determinations, Appeals and Grievances (ODAG). The Centers for Medicare and Medicaid Services (CMS) performs its program audit activities in accordance with the ODAG Program Audit Data Request and applying the compliance standards outlined in this Program Audit Protocol and the Program Audit Process Overview document. At a minimum, CMS will evaluate cases against the criteria listed below. CMS may review factors not specifically addressed below if it is determined that there are other related ODAG requirements not being met.

Audit Elements Tested

1. Timeliness
2. Processing of Coverage Requests
3. Classification of Requests

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Not Applicable	Universe Integrity Testing	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-Service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C) Universe Table 5: Part C Standard and Expedited Grievances (GRV_C) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	Select 10 cases from each universe, Tables 1 through 6, for a total of 60 cases. Prior to field work, CMS will schedule a webinar with the Sponsoring organization to verify accuracy of data within the universe submissions, and to confirm effectuation of approved requests, for each of the sampled cases. Review all cases selected for universe integrity testing. The integrity of the universe will be questioned if data points specific to the sample case(s) are incomplete, do not match, or cannot be verified by viewing the Sponsoring organization's systems and/or other supporting documentation. Sample selections will be provided to the Sponsoring organization approximately one hour prior to the scheduled webinar.	42 CFR § 422.504(e) 42 CFR § 422.504(f)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.1	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD)	Conduct timeliness test at the universe level on standard pre-service organization determinations to determine whether the Sponsoring organization provided notification of the determination no later than 14 calendar days after the date the Sponsoring organization received the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notification of the determination no later than 28 calendar days after the date the Sponsoring organization received the request.	42 CFR § 422.568(b) 42 CFR § 422.631(d)
Timeliness	1.2	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD)	Conduct timeliness test at the universe level on standard organization determination requests for Part B drugs to determine whether the Sponsoring organization provided notification of the determination no later than 72 hours after receipt of the request.	42 CFR § 422.568(b) 42 CFR § 422.629(a)
Timeliness	1.3	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD)	Conduct timeliness test at the universe level on expedited pre-service organization determinations to determine whether the Sponsoring organization provided notification of the determination no later than 72 hours after receipt of the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notification of the determination no later than 17 calendar days after receipt of the request. For Dual Eligible Special Needs Plans – Applicable Integrated Plans (DSNP-AIP), written notice of the denial must be provided within 3 days of receipt of the request. The additional 3 day allowance to deliver the written notification after providing oral notice does not apply.	42 CFR § 422.572(a) 42 CFR § 422.572(b) 42 CFR § 422.572(c) 42 CFR § 422.631(d)
Timeliness	1.4	Universe Table 1: Standard and Expedited Pre-Service Organization Determinations (OD)	Conduct timeliness test at the universe level on expedited organization determination requests for Part B drugs to determine whether the Sponsoring organization provided notification of the determination no later than 24 hours after the Sponsoring organization received the request.	42 CFR § 422.572(a) 42 CFR § 422.572(c) 42 CFR § 422.629(a)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.5	Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	Conduct timeliness test at the universe level on standard pre-service reconsideration requests to determine whether the Sponsoring organization provided notification of its overturned determination or forwarded its upheld decision to the IRE no later than 30 calendar days after the date the Sponsoring organization received the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notification of the overturned determination or forwarded its upheld decision to the IRE no later than 44 calendar days after receipt of the request. For DSNP-AIPs, the timeliness assessment will ensure written notification of the upheld reconsideration decision was provided to the enrollee in addition to being forwarded to the IRE no later than 30 calendar days or 44 days with extension after receipt of the request.	42 CFR § 422.590(a) 42 CFR § 422.590(d) 42 CFR § 422.590(f) 42 CFR § 422.633(f)
Timeliness	1.6	Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	Conduct timeliness test at the universe level on standard reconsideration requests for Part B drugs to determine whether the Sponsoring organization provided notification of its overturned determination or forwarded its upheld decision to the IRE no later than 7 calendar days after receipt of the request.	42 CFR § 422.590(c) 42 CFR § 422.590(d) 42 CFR § 422.629(a)

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Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.7	Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	Conduct timeliness test at the universe level on expedited pre-service reconsideration requests to determine whether the Sponsoring organization provided notification of its overturned decision no later than 72 hours after receipt of the request or forwarded its upheld decision to the IRE no later than 24 hours after affirmation of the determination or no later than 96 hours if the Sponsoring organization failed to provide the enrollee with the results of its reconsideration within the required timeframe. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notification of its overturned decision no later than 17 calendar days after receipt of the request or forwarded its upheld decision to the IRE no later than 24 hours after the affirmation of the determination or no later than 18 calendar days if the Sponsoring organization failed to provide the enrollee with the results of its reconsideration within the required timeframe. For DSNP-AIPs, the timeliness test will ensure written notification of the upheld reconsideration decision was also provided to the enrollee no later than 72 hours or 17 calendar days after receipt of the request.	42 CFR § 422.590(e) 42 CFR § 422.590(f) 42 CFR § 422.590(g) 42 CFR § 422.633(f) 42 CFR § 422.634(a)
Timeliness	1.8	Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	Conduct timeliness test at the universe level on expedited reconsideration requests for Part B drugs to determine whether the Sponsoring organization provided notification of its overturned decision no later than 72 hours after receipt of the request or forwarded its upheld decision to the IRE no later than 24 hours after affirmation of the determination or no later than 96 hours if the Sponsoring organization failed to provide the enrollee with the results of its reconsideration within the required timeframe. For DSNP-AIPs, the timeliness test will ensure written notification of the upheld reconsideration decision was also provided to the enrollee no later than 72 hours after receipt of the request.	42 CFR § 422.590(e) 42 CFR § 422.590(g) 42 CFR § 422.629(a)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.9	Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C)	Conduct timeliness test at the universe level on payment organization determinations to determine whether the Sponsoring organization paid or denied claims from non-contracted providers and enrollees no later than 60 calendar days after receipt of the request.	42 CFR § 422.568(c) 42 CFR § 422.520(a)
Timeliness	1.10	Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C)	Conduct timeliness test at the universe level on payment reconsiderations to determine whether the Sponsoring organization paid overturned reconsideration claims from non-contracted providers and enrollees or forwarded its upheld decision to the IRE no later than 60 calendar days after receipt of the request. For DSNP-AIPs, the timeliness assessment will ensure whether the Sponsoring organization paid overturned reconsideration claims from non-contracted providers and enrollees or forwarded its upheld decision to the IRE no later than 30 calendar days after receipt of the request.	42 CFR § 422.590(b) 42 CFR § 422.618(a) 42 CFR § 422.633(f)
Timeliness	1.11	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on standard pre-service IRE cases in which the Sponsoring organization's determination was reversed in whole or in part by the IRE to determine whether the Sponsoring organization effectuated the decision within 14 calendar days after receipt of the notice reversing the determination.	42 CFR § 422.618(b) 42 CFR § 422.634(d)
Timeliness	1.12	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on standard Part B drug request IRE cases in which the Sponsoring organization's determination was reversed in whole or in part by the IRE to determine whether the Sponsoring organization authorized or provided the Part B drug under dispute within 72 hours after receipt of the notice reversing the determination.	42 CFR § 422.618(b) 42 CFR § 422.634(d)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.13	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on expedited pre-service IRE cases in which the Sponsoring organization's determination was reversed in whole or in part by the IRE to determine whether the Sponsoring organization effectuated the decision within 72 hours after receipt of the notice reversing the determination.	42 CFR § 422.619(b) 42 CFR § 422.634(d)
Timeliness	1.14	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on expedited Part B drug request IRE cases in which the Sponsoring organization's determination was reversed in whole or in part by the IRE to determine whether the Sponsoring organization authorized or provided the Part B drug under dispute within 24 hours after receipt of the notice reversing the determination.	42 CFR § 422.619(b) 42 CFR § 422.634(d)
Timeliness	1.15	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on payment decisions reversed in whole or in part by the IRE to determine whether the Sponsoring organization paid for the service no later than 30 calendar days after receipt of the notice reversing the determination.	42 CFR § 422.618(b) 42 CFR § 422.634(d)
Timeliness	1.16	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on standard and expedited decisions overturned by an ALJ or the MAC to determine whether the Sponsoring organization authorized or provided the service under dispute no later than 60 calendar days after receipt of the notice of determination reversal.	42 CFR § 422.618(c) 42 CFR § 422.619(c) 42 CFR § 422.634(d)
Timeliness	1.17	Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C)	Conduct timeliness test at the universe level on standard and expedited Part B drug request decisions overturned by an ALJ or the MAC to determine whether the Sponsoring organization authorized or provided the Part B drug under dispute no later than 72 hours for standard requests or 24 hours for expedited requests after receipt of the notice of determination reversal.	42 CFR § 422.619(c) 42 CFR § 422.634(d)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.18	Universe Table 5: Part C Standard and Expedited Grievances (GRV_C)	Conduct timeliness test at the universe level on standard grievances to determine whether the Sponsoring organization notified the enrollee of its decision no later than 30 days after receipt of the grievance. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization notified the enrollee of its decision no later than 44 days after receipt of the grievance.	42 CFR § 422.564(e) 42 CFR § 422.630(e)
Timeliness	1.19	Universe Table 5: Part C Standard and Expedited Grievances (GRV_C)	Conduct timeliness test at the universe level on expedited grievances to determine whether the Sponsoring organization responded to the enrollee's grievance no later than 24 hours after receipt of the grievance.	42 CFR § 422.564(f) 42 CFR § 422.630(d)
Timeliness	1.20	Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP).	Conduct timeliness test at the universe level on adverse integrated organization determinations to determine whether the DSNP-AIP notified the enrollee of the decision to terminate, suspend, or reduce services no later than 10 calendar days prior to the action (that is, before the date on which a termination, suspension, or reduction of previously approved services becomes effective).	42 CFR § 422.631(d)
Timeliness	1.21	Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP).	Conduct timeliness test at the universe level on standard integrated reconsideration requests to determine whether the Applicable Integrated Plan provided written notice of its resolution to enrollees no later than 30 calendar days after the date the DSNP-AIP received the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notice of the resolution no later than 44 calendar days after receipt of the request.	42 CFR § 422.633(f)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Timeliness	1.22	Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	Conduct timeliness test at the universe level on expedited integrated reconsideration requests to determine whether the DSNP-AIP provided written notice of its resolution to enrollees no later than 72 hours after the date the Applicable Integrated Plan received the request. If the Sponsoring organization extended the timeframe, determine whether the Sponsoring organization provided notice of the resolution no later than 17 calendar days after receipt of the request.	42 CFR § 422.633(f)
Processing of Coverage Requests	2.1	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	Select 30 denied requests from tables 1-3. The number of cases per record layout will vary. Additionally, select 5 denial cases from Table 6. Ensure sample set represents various medical services (e.g., ER services, outpatient hospital, inpatient hospital, urgent care, etc.). For each denial case, review case file documentation for proper notification of the denial decision. If the enrollee identified a representative, review case file to determine if notification was sent to the enrollee's representative. If a provider requested the coverage, review case file to determine if notification of decision was also sent to provider. Sample selections will be provided to the Sponsoring organization approximately one hour prior to the scheduled webinar.	42 CFR § 422.568(d) 42 CFR § 422.568(e) 42 CFR § 422.561 42 CFR § 422.572(a) 42 CFR § 422.590(d) 42 CFR § 422.631(d)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Processing of Coverage Requests	2.2	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	For the sampled cases review case file documentation to ensure a physician or other appropriate health care professional with sufficient medical and other expertise reviewed the determination.	42 CFR § 422.566(d) 42 CFR § 422.590(g) 42 CFR § 422.629(k)
Processing of Coverage Requests	2.3	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C)	For each sampled denial case, review case file documentation for clinical accuracy.	42 CFR § 422.101(a) 42 CFR § 422.101(b) 42 CFR § 422.100(c)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Processing of Coverage Requests	2.4	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	For each sampled case, review case file for documentation to ensure an extension was appropriate.	42 CFR § 422.568(b) 42 CFR § 422.572(b) 42 CFR § 422.590(e) 42 CFR § 422.631(d)
Processing of Coverage Requests	2.5	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	For each case sampled, review case file documentation for proper downgrade from an expedited determination request to a standard determination and for proper notification to the enrollee that explains that the MA organization will process the request using the 14-day timeframe for standard determinations, informs the enrollee of the right to file an expedited grievance, informs the enrollee of the right to resubmit a request for an expedited determination with any physician's support, and provides instructions about the grievance process and timeframes.	42 CFR § 422.570(c) 42 CFR § 422.570(d) 42 CFR § 422.584(c) 42 CFR § 422.584(d) 42 CFR §422.631(d) 42 CFR §422.633(e)

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Processing of Coverage Requests	2.6	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON)	For each sampled case, review case file to determine if the Sponsoring organization applied step therapy only to new administrations of Part B drugs using at least a 365-day look back period.	42 CFR § 422.136(a)
Processing of Coverage Requests	2.7	Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)	For each sampled case, review case file to determine if the Applicable Integrated Plan continued benefits to enrollees who filed an appeal involving the termination, suspension, or reduction of a previously authorized service.	42 CFR §422.632
Classification of Requests	3.1	Universe Table 1: Standard and expedited Pre-Service Organization Determinations (OD) Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C)	Select 10 dismissed requests from Tables 1-3. Review case file documentation to determine if the request was appropriately dismissed or whether it should have been treated as a coverage request or grievance. Sample selections will be provided to the Sponsoring organization approximately one hour prior to the scheduled webinar.	42 CFR § 422.566 42 CFR § 422.578 42 CFR § 422.582 42 CFR § 422.584 42 CFR § 422.590 42 CFR § 423.564 42 CFR § 422.630

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria Effective 01/01/2021
Classification of Requests	3.2	Universe Table 5: Part C Standard and Expedited Grievances (GRV_C)	Select 20 grievance sample cases from Table 5. Sample both verbal and written grievances. Target samples that appear to: relate to quality of care; involve multiple issues and do not appear in the organization determination and reconsideration universes; and appear to be misclassified requests. Review case file documentation to determine if proper notification (i.e., written or verbal) was provided. If the Sponsoring organization extended the deadline, review case file for documentation stating how the delay is in the interest of the enrollee. Also review case file for written notification to the enrollee of the reason(s) for the delay. If the enrollee identified a representative, review case file to determine if notification was sent to the enrollee's representative.	42 CFR § 422.564(a) 42 CFR § 422.564(e) 42 CFR § 422.564(f) 42 CFR § 422.564(g) 42 CFR § 422.561 42 CFR §422.630

Program Audit Data Request

Audit Engagement and Universe Submission Phase

Universe Submissions

Sponsoring organizations must submit universe tables 1 - 5, comprehensive of all contracts and Plan Benefit Packages (PBP), identified in the audit engagement letter, in either Microsoft Excel (.xlsx) file format with a header row or Text (.txt) file format without a header row. Sponsoring organizations determined to be an Applicable Integrated Plan (AIP) must submit universe table 6 comprehensive of all contracts and/or PBPs offered as Dual Eligible Special Needs Plans only. Descriptions and clarifications of what must be included in each submission and data field are outlined in the individual universe record layouts below. Characters are required in all requested fields, unless otherwise specified, and data must be limited to the request specified in each record layout. Sponsoring organizations must provide accurate and timely universe submissions within 15 business days of the audit engagement letter date. Submissions that do not strictly adhere to the record layout specifications will be rejected. Sponsoring organizations may however enter the time within universes instead of 'None' if the time is not required per the field description.

Universe Requests

1. Universe Table 1: Standard and Expedited Pre-service Organization Determinations (OD) Record Layout
2. Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Record Layout
3. Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Record Layout
4. Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C) Record Layout
5. Universe Table 5: Part C Standard and Expedited Grievances (GRV_C) Record Layout
6. Universe Table 6: Dual Eligible Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP)

Universe Record Layout	Scope of Universe Request*
Table 1 Table 2 Table 3 Table 4 Table 5 Table 6	Sponsoring organizations with MA/MAPD enrollment of – • <50,000 enrollees: submit the 12-week period preceding, and including, the date of the audit engagement letter. • ≥50,000 but <250,000 enrollees: submit the 8-week period preceding, and including, the date of the audit engagement letter. • ≥250,000 but <500,000 enrollees: submit the 4-week period preceding, and including, the date of the audit engagement letter. • ≥500,000 enrollees: submit the 2-week period preceding, and including, the date of the audit engagement letter.

***** CMS reserves the right to expand the review period to ensure sufficient universe size.

Please use the guidance below for the following record layout:

Universe Table 1: Standard and Expedited Pre-service Organization Determinations (OD) Record Layout

- Include all pre-service organization determination requests the Sponsoring organization approved, denied or dismissed during the universe request period. The date of the Sponsoring organization's determination (Column ID P) must fall within the universe request period.
- Include all pre-service requests for supplemental services that meet the criteria defined in 42 CFR § 422.100(c)(2).
- Include all pre-service organization determination requests for Part B drugs.
- If a pre-service organization determination includes more than one service, include all of the request's line items in a single row and enter the multiple line items as a single organization determination request.
    - Enter any request denied in whole or in part as denied.
- Enter all fields for a single request in the same time zone. For example, if the Sponsoring organization has systems in EST and CST, all data in a single line item must be in the same time zone.
- Exclude all requests processed as reconsiderations, payments, reopenings, and withdrawals.
    - Exclude all concurrent reviews for inpatient hospital services and inpatient SNF services, and notifications of admissions.
    - Exclude all requests for Value Added Items and Services.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	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.

Column ID	Field Name	Field Type	Field Length	Description
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	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.
G	Authorization or Claim Number	CHAR Always Required	40	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.
H	Date the request was received	CHAR Always Required	10	Enter the date the request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01). If a standard request was upgraded to expedited, enter the date the request was upgraded.

Column ID	Field Name	Field Type	Field Length	Description
I	Time the request was received	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time the request was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). If a standard request was upgraded to expedited, enter the time the request was upgraded. Enter None for standard service requests and dismissed requests.
J	Part B Drug Request?	CHAR Always Required	1	Enter: • Y for Yes • N for No
K	AOR/Equivalent notice Receipt Date	CHAR Always Required	10	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 if no AOR or equivalent written notice was received or required.
L	AOR/Equivalent notice Receipt Time	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in HH:MM:SS format (e.g., 23:59:59). Enter None for standard service requests or if no AOR or equivalent written notice was received or required.
M	Request Determination	CHAR Always Required	9	Enter: • Approved • Denied • Dismissed

Column ID	Field Name	Field Type	Field Length	Description
N	Was the request processed as Standard or Expedited?	CHAR Always Required	1	Enter the manner by which the request was processed: • S for Standard • E for Expedited
O	Was a timeframe extension taken?	CHAR Always Required	1	Enter: • Y for Yes • N for No
P	Date of Determination	CHAR Always Required	10	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). For dismissed requests, enter the date the Sponsoring organization dismissed the request.
Q	Time of Determination	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests and dismissed requests.
R	Date oral notification provided to enrollee	CHAR Always Required	10	Enter the date oral notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no oral notification was provided.
S	Time oral notification provided to enrollee	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time oral notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no oral notification was provided.
T	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification of determination was provided to enrollee. 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.

Column ID	Field Name	Field Type	Field Length	Description
U	Time written notification provided to enrollee	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time written notification of determination was provided to enrollee. Do not enter the time a letter was generated or printed. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no written notification was provided.
V	Who made the request?	CHAR Always Required	3	Enter who made the request: • E for enrollee • ER for enrollee's representative or purported representative • CP for requests by a contract provider/facility • NCP for requests by a non-contract provider/facility
W	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service or item requested and why it was requested (if known). For denials, also provide an explanation of why the pre-service request was denied. For dismissed requests, provide the reason for dismissal.
X	Was an expedited request made but processed as standard?	CHAR Always Required	4	Enter: • Y for Yes if an expedited request was received but downgraded to standard • None for all other requests (e.g. the request was received as expedited and processed as expedited, the request was received as standard)
Y	Was the request denied for lack of medical necessity?	CHAR Always Required	4	Enter: • Y for Yes • N for No • None if the request was approved or dismissed.

Please use the guidance below for the following record layout:

Universe Table 2: Standard and Expedited Pre-service Reconsiderations (RECON) Record Layout

- Include all pre-service reconsideration requests the Sponsoring organization approved, denied, auto-forwarded to the IRE or dismissed during the universe request period. The date of the Sponsoring organization's determination (Column ID P) must fall within the universe request period.
- Include all pre-service reconsideration requests for supplemental services that meet the criteria defined at 42 CFR § 422.100(c)(2).
- Include all pre-service reconsideration requests for Part B drugs.
- If a pre-service reconsideration includes more than one service, include all of the request's line items in a single row and enter multiple line items as a single reconsideration request. Enter any request denied in whole or in part as denied.
- Enter all fields for a single request in the same time zone. For example, if the Sponsoring organization has systems in EST and CST, all data in a single line item must be in a single time zone.
- Exclude all requests processed as organization determinations, payment requests, reopenings, and withdrawals.
- Exclude all requests for concurrent reviews for inpatient hospital and inpatient SNF services, and notifications of admissions.
- Exclude all requests for Value Added Items and Services.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	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.

Column ID	Field Name	Field Type	Field Length	Description
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	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.
G	Authorization or Claim Number	CHAR Always Required	40	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.

Column ID	Field Name	Field Type	Field Length	Description
H	Date the request was received	CHAR Always Required	10	Enter the date the reconsideration request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01). If a standard request was upgraded to expedited, enter the date the request was upgraded. If the Sponsoring organization obtained information establishing good cause after the 60-day filing timeframe, enter the date the Sponsoring organization received the information establishing good cause.
I	Time the request was received	CHAR Always Required	8	For all expedited requests, enter the time the reconsideration request was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). If a standard request was upgraded to expedited, enter the time the request was upgraded. If the Sponsoring organization obtained information establishing good cause after the 60-day filing timeframe, enter the time the Sponsoring organization received the information establishing good cause. Enter None for standard and dismissed requests.

Column ID	Field Name	Field Type	Field Length	Description
J	Part B Drug Request?	CHAR Always Required	1	Enter: • Y for Yes • N for No
K	AOR/Equivalent Notice Receipt Date	CHAR Always Required	10	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 if no AOR or equivalent written notice was received or required.
L	AOR/Equivalent Notice Receipt Time	CHAR Always Required	8	For all expedited requests, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in HH:MM:SS format (e.g., 23:59:59). Enter None for standard requests or if no AOR or equivalent written notice was received or required.
M	Request Determination	CHAR Always Required	9	Enter: • Approved • Denied • Dismissed
N	Was the request processed as Standard or Expedited?	CHAR Always Required	1	Enter the manner by which the request was processed: • S for Standard • E for Expedited
O	Was a timeframe extension taken?	CHAR Always Required	1	Enter: • Y for Yes • N for No
P	Date of Determination	CHAR Always Required	10	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). For dismissed requests, enter the date the Sponsor dismissed the request.

Column ID	Field Name	Field Type	Field Length	Description
Q	Time of Determination	CHAR Always Required	8	For all expedited requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard and dismissed requests.
R	Date oral notification provided to enrollee	CHAR Always Required	10	Enter the date oral notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for dismissed requests or if no oral notification was provided.
S	Time oral notification provided to enrollee	CHAR Always Required	8	For all expedited requests, , enter the time oral notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard requests, dismissed requests, or if no oral notification was provided.
T	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification was provided to enrollee. 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.
U	Time written notification provided to enrollee	CHAR Always Required	8	For all expedited requests, enter the time written notification was provided to enrollee. Do not enter the time a letter is generated or printed. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard requests, dismissed requests, or if no written notification was provided.

Column ID	Field Name	Field Type	Field Length	Description
V	Date reconsidered determination effectuated in the system	CHAR Always Required	10	Enter the date the reconsidered determination was effectuated in the system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the determination was denied or dismissed.
W	Time reconsidered determination effectuated in the system	CHAR Always Required	8	For all expedited requests, enter the time the reconsidered determination was effectuated in the system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard cases, dismissed cases, or if the request was denied.
X	Date forwarded to IRE	CHAR Always Required	10	Enter the date the request was forwarded to the IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the enrollee was notified of the approved reconsideration or if the request was not forwarded to the IRE.
Y	Time forwarded to IRE	CHAR Always Required	10	For all expedited requests, enter the time the request was forwarded to the IRE. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None if the enrollee was notified of the approved reconsideration, if the request was not forwarded to the IRE, or for standard requests.

Column ID	Field Name	Field Type	Field Length	Description
Z	Who made the request?	CHAR Always Required	3	Enter the person who made the request: • E for enrollee • ER for enrollee's representative or purported representative • CP for requests by a contract provider/facility • NCP for requests by a non-contract provider/facility
AA	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service or item requested and why it was requested (if known). For denials, also provide an explanation of why the pre-service request was denied. For dismissed requests, provide the reason for dismissal.
AB	Was an expedited request made but processed as standard?	CHAR Always Required	4	Enter: • Y for Yes if an expedited request was received but downgraded to standard • None for all other cases (e.g. the request was received as expedited and processed as expedited, the request was received as standard, or the request was dismissed).
AC	Was the initial organization determination request denied for lack of medical necessity?	CHAR Always Required	1	Enter: • Y for Yes • N for No

Please use the guidance below for the following record layout:

Universe Table 3: Payment Organization Determinations and Reconsiderations (PYMT_C) Record Layout

- Include all payment organization determinations and payment reconsiderations the Sponsoring organization approved, denied or dismissed from non-contract providers, enrollees, and non-contract pharmacies during the universe request period.

  Submit payment organization determinations (claims) based on the date the claim was paid (Column O) or notification of the denial to the provider (if provider submitted the claim - Column Q) or enrollee (if the enrollee submitted the claim – Column P). Submit payment reconsiderations based on the date the overturned reconsideration was paid or, for upheld reconsiderations, submit based on the date the case was forwarded to the IRE. Submit dismissed requests based on the date of the decision to dismiss (Column N).
- Include all payment requests for Part B drugs if applicable.
- Include all payment requests for supplemental services that meet the criteria defined at 42 CFR § 422.100(c)(2).
- If a payment organization determination or reconsideration includes more than one service, include all of the request's line items in a single row and enter the multiple line items as a single organization determination or reconsideration request.
  - Enter any request denied in whole or in part as denied.

  Enter all fields for a single case in the same time zone. For example, if the Sponsoring organization has systems in EST and CST, all data in a single line item must be in a single time zone.
- Exclude all payment requests processed as:
  - duplicate claims,
  - payment adjustments,
  - reopenings,
  - withdrawals, and
  - retrospective reviews.
- Exclude all requests for Value Added Items and Services.
- Exclude any payment requests that were denied due to:
  - invalid billing codes,
  - eligibility (i.e., enrollees who were not enrolled on the date of service, providers not accepting assignment), or
  - recoupment of payment, including pending determination of other primary insurance such as automobile, worker's compensation, etc.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.

Column ID	Field Name	Field Type	Field Length	Description
C	Enrollee ID	CHAR Always Required	11	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.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	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.
G	Authorization or Claim Number	CHAR Always Required	40	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.

Column ID	Field Name	Field Type	Field Length	Description
H	Date the request was received	CHAR Always Required	10	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 Sponsoring organization received the information establishing good cause. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
I	AOR/Equivalent notice Receipt Date	CHAR Always Required	10	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.
J	Waiver of Liability (WOL) Receipt Date	CHAR Always Required	10	Enter the date the WOL form was received for non- contracted 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.
K	Was it a clean claim?	CHAR Always Required	4	Enter: • Y for clean claim • N for unclean claim • None for payment reconsiderations
L	Was the request processed as an OD or Recon?	CHAR Always Required	5	Enter the manner by which the request was processed: • OD • Recon

Column ID	Field Name	Field Type	Field Length	Description
M	Request Determination	CHAR Always Required	9	Enter: • Approved • Denied • Dismissed
N	Date of Determination	CHAR Always Required	10	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.
O	Date claim/reconsideration was paid	CHAR Always Required	10	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.
P	Date written notification provided to enrollee	CHAR Always Required	10	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.
Q	Date written notification provided to provider	CHAR Always Required	10	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.

Column ID	Field Name	Field Type	Field Length	Description
R	Date forwarded to IRE	CHAR Always Required	10	Enter the date the reconsideration request 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.
S	Who made the request?	CHAR Always Required	3	Enter who made the request: • E for enrollee • ER for enrollee's representative or purported representative • NCP for requests by a non-contract provider/pharmacy
T	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service or item requested and why it was requested (if known). For denials, also provide an explanation of why the payment organization determination or payment reconsideration request was denied. For dismissed requests, please provide the reason for dismissal.
U	Was the initial organization determination request denied for lack of medical necessity?	CHAR Always Required	4	Enter: • Y for Yes • N for No • None if the request was approved or dismissed.

The following fields are required by IEHP:

V	Date of Service	CHAR Always Required	10	The beginning Date of Service for this Claim. Please submit in CCYY/MM/DD format (e.g., 2020/01/01). This field is not in the CMS protocol but IEHP requires it to determine eligibility on the date of service.
W	If unclean, Request For Information (RFI) Date	CHAR Always Required	10	Enter the date the request for information (RFI) was sent. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no RFI was sent.
X	Interest Paid	CHAR Always Required	1	If interest was paid enter: • Y for Yes • N for No
Y	Provider Name	CHAR Always Required	255	Enter the name of the Provider of service.

Z	Provider NPI	CHAR Always Required	10	Enter the NPI number of the Provider of service.
AA	Place of Service	CHAR Always Required	2	Provide the place of service billed. Valid values include, but are not limited to: • 11 for Office visit • 12 for Home Health • 21 for Inpatient Hospital • 22 for Outpatient Hospital • 23 for Emergency Room
AB	Diagnosis	CHAR Always Required	1000	Provide the ICD-10 diagnosis code billed. If there are multiple diagnosis, list them all delimited by a comma.

Please use the guidance below for the following record layout:

Universe Table 4: Part C Effectuations of Overturned Decisions by IRE, ALJ, or MAC (EFF_C) Record Layout

- Include all reconsiderations fully or partially overturned by the IRE, ALJ, or MAC requiring an effectuation as pre-service or post-service (payment) that were received from the IRE, ALJ, or MAC during the universe request period. The date of the Sponsoring organization's receipt of the overturn decision (Column ID J) must fall within the universe request period.
- Exclude any cases that were dismissed or upheld by the IRE, ALJ, or MAC.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	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.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).

Column ID	Field Name	Field Type	Field Length	Description
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	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.
G	Authorization or Claim Number	CHAR Always Required	40	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.
H	Type of reconsideration case	CHAR Always Required	9	Enter the type of reconsideration case submitted to IRE/ALJ/MAC: • Standard • Expedited • Payment For pre-service cases, enter Standard or Expedited. For post-service cases, enter Payment.
I	Review Entity	CHAR Always Required	3	Enter the entity that overturned the decision: • IRE • ALJ • MAC

Column ID	Field Name	Field Type	Field Length	Description
J	Date the overturned decision was received	CHAR Always Required	10	Enter the date the overturned decision was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
K	Time the overturned decision was received	CHAR Always Required	8	For expedited requests and Part B drug requests, enter the time the overturned decision was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for Standard (pre-service) and Payment reconsideration cases.
L	Part B Drug Request?	CHAR Always Required	1	Enter: • Y for Yes • N for No
M	Date overturned decision or payment effectuated in the system	CHAR Always Required	10	Enter the date overturned decision effectuated in the system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the overturned decision was not effectuated.
N	Time overturned decision or payment effectuated in the system	CHAR Always Required	8	For expedited requests and Part B drug requests, enter the time the overturned decision was effectuated in the system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests and payment reconsideration cases, or if the overturned decision was not effectuated.

Please use the guidance below for the following record layout:

Universe Table 5: Part C Standard and Expedited Grievances (GRV_C) Record Layout

- Include all grievances the Sponsoring organization responded to during the universe request period. The date of the Sponsoring organization's notification (Column ID Q or S) must fall within the universe request period.
- Grievances with multiple issues must be entered as a single line item, unless the Sponsoring organization issued separate notifications.
- Exclude all grievances that were withdrawn and dismissed during the universe request period.
- Exclude complaints filed only within the Complaints Tracking Module (CTM) in HPMS. If a complaint was processed both within the CTM and was also received as a grievance, exclude the CTM complaint but include the grievance as processed by the Sponsoring organization.
- Sponsoring organizations determined to be an applicable integrated plan as defined by 42 CFR § 422.561 should populate the universe with grievances related to Medicare coverage only.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	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.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).

Column ID	Field Name	Field Type	Field Length	Description
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	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 grievance. Enter None if the Sponsoring organization processed the grievance.
G	Date the grievance was received	CHAR Always Required	10	Enter the date the grievance was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
H	Time the grievance was received	CHAR Always Required	8	Enter the time the grievance was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard cases.
I	AOR/Equivalent notice Receipt Date	CHAR Always Required	10	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 if no AOR or equivalent written notice was received or required.

Column ID	Field Name	Field Type	Field Length	Description
J	AOR/Equivalent notice Receipt Time	CHAR Always Required	8	For expedited grievances, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in HH:MM:SS format (e.g., 23:59:59). Enter None for standard grievances or if an AOR or equivalent written notice was not received or required.
K	How was the grievance received?	CHAR Always Required	7	Enter the method of receipt of the grievance: • Oral • Written
L	Was the grievance processed as Standard or Expedited?	CHAR Always Required	1	Enter how the grievance was processed: • S for Standard • E for Expedited
M	Category of the issue	CHAR Always Required	50	Enter the category of the grievance as assigned by the Sponsoring organization. Enter based on the Sponsoring organization's internal labeling system.
N	Grievance Description	CHAR Always Required	1,800	Enter a description of the grievance.
O	Was this processed as a quality of care grievance?	CHAR Always Required	1	Enter: • Y for Yes • N for No
P	Was a timeframe extension taken?	CHAR Always Required	1	Enter: • Y for Yes • N for No
Q	Date oral notification provided to enrollee	CHAR Always Required	10	Enter the date oral notification was provided to the enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no oral notification was provided.

Column ID	Field Name	Field Type	Field Length	Description
R	Time oral notification provided to enrollee	CHAR Always Required	8	Enter the time oral notification was provided to the enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard grievances, or if no oral notification was provided.
S	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification was provided to enrollee. 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 a written notification was not provided.
T	Time written notification provided to enrollee	CHAR Always Required	8	Enter the time written notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard cases, or if written notification was not provided.
U	Who made the request?	CHAR Always Required	2	Enter who made the request: • E for enrollee • ER for enrollee's representative or purported representative

Please use the guidance below for the following record layout:

Universe Table 6: Dual Special Needs Plan – Applicable Integrated Plan Reductions, Suspensions, and Terminations (AIP) Record Layout

- The AIP record layout must be submitted by all Sponsoring organizations determined to be an applicable integrated plan as defined by 42 CFR § 422.561 and have been notified by CMS of their status.
- Include all integrated organization determination cases ***where a previously approved service is being reduced, suspended, or terminated by the DSNP-AIP***. The date the DSNP-AIP notified the enrollee must fall within the universe request period (Column ID H).
- Populate this Table with requests involving Medicare-coverable benefits only.
- Exclude all pre-service cases.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee ID	CHAR Always Required	11	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.
D	Contract ID	CHAR Always Required	5	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).

Column ID	Field Name	Field Type	Field Length	Description
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	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.
G	Authorization or Claim Number	CHAR Always Required	40	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.
H	Date DSNP-AIP notified enrollee of its decision to reduce, suspend or terminate services	CHAR Always Required	10	Enter the date the DSNP-AIP notified the enrollee of the reduction, suspension, or termination. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
I	Effective date of reduction, suspension, or termination of services	CHAR Always Required	10	Indicate the intended date of action (that is, the date on which reduction, suspension, or termination became effective). Submit in CCYY/MM/DD format (e.g., 2020/01/01).
J	Was the decision appealed?	CHAR Always Required	1	Enter: • Y for Yes • N for No If 'N' is entered, populate all remaining fields with None.

Column ID	Field Name	Field Type	Field Length	Description
K	Who made the request?	CHAR Always Required	4	Enter who made the plan level appeal: • E for enrollee • ER for enrollee's representative or purported representative • CP for requests by a contract provider/facility • NCP for requests by a non-contract provider/facility Enter None if the decision was not appealed as indicated by N in column ID J.
L	Date the appeal was received	CHAR Always Required	10	Enter the date the request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the decision was not appealed as indicated by N in column ID J.
M	AOR/Equivalent notice receipt date	CHAR Always Required	10	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, if no AOR or equivalent written notice was received or required, or if the decision was not appealed as indicated by N in column ID J.
N	Was the appeal processed as Standard or Expedited?	CHAR Always Required	4	Enter the manner by which the appeal was processed: • S for Standard • E for Expedited Enter None if the decision was not appealed as indicated by N in column ID J.

Column ID	Field Name	Field Type	Field Length	Description
O	Was appeal made under the expedited timeframe but processed by the plan under the standard timeframe?	CHAR Always Required	4	Yes (Y)/No (N) indicator of whether the request was received as expedited but was downgraded and processed under the standard timeframe (e.g., based on the DSNP-AIP deciding that the expedited plan level appeal was unnecessary). Enter None if the request was received as a standard request or if the decision was not appealed as indicated by N in column ID J.
P	Was a timeframe extension taken?	CHAR Always Required	4	Yes (Y)/No (N) indicator of whether the DSNP-AIP extended the timeframe to make the appeal decision. Enter None if the decision was not appealed as indicated by N in column ID J.
Q	Did the enrollee request continuation of benefits?	CHAR Always Required	4	Yes (Y)/No (N) indicator of whether the enrollee requested continuation of benefits. Enter None if someone other than the enrollee requested continuation of benefits or if the decision was not appealed as indicated by N in column ID J.
R	Were the benefits under appeal provided to the enrollee during the plan level appeal process?	CHAR Always Required	4	Yes (Y)/No (N) indicator of whether the benefits under appeal were provided to the enrollee during the reconsideration process. Enter None if no request for continuation of benefits was made or if the decision was not appealed as indicated by N in column ID J.

Column ID	Field Name	Field Type	Field Length	Description
S	Request Disposition	CHAR Always Required	9	Enter: • Approved • Denied • Dismissed Enter None if the decision was not appealed as indicated by N in column ID J.
T	Date of DSNP- AIP decision	CHAR Always Required	10	Date of the DSNP-AIP decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the decision was not appealed as indicated by N in column ID J.
U	Date oral notification provided to enrollee	CHAR Always Required	10	Date oral notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no oral notification provided or if the decision was not appealed as indicated by N in column ID J.
V	Date written notification provided to enrollee/provider	CHAR Always Required	10	Date written notification provided to enrollee, or if applicable the non-contract provider. Do not enter the date when a letter is generated or printed within the DSNP-AIP's organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no written notification was provided or if the decision was not appealed as indicated by N in column ID J.

Column ID	Field Name	Field Type	Field Length	Description
W	Date reconsidered determination effectuated in the DSNP-AIP system	CHAR Always Required	10	Date reconsidered determination effectuated in the DSNP-AIP 's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for denials and or if the decision was not appealed as indicated by N in column ID J.
X	Date forwarded to IRE if denied or untimely	CHAR Always Required	10	Date the AIP forwarded request to the IRE if request for Medicare service was denied or processed untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if approved or not forwarded to IRE or if the decision was not appealed as indicated by N in column ID J.
Y	If request denied, date services were terminated, reduced, suspended	CHAR Always Required	10	Enter the date the services were terminated, reduced, suspended. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if the reconsideration was approved or if the decision was not appealed as indicated by N in column ID J.

Audit Field Work Phase

Supporting Documentation Submissions

Each case will be evaluated to determine whether the Sponsoring organization is compliant with its Part C contract requirements. To facilitate this review, the Sponsoring organization must have access to, and the ability to save and upload screenshots of, supporting documentation and data relevant for a particular case, including, but not limited to:

- Original pre-service or payment (i.e., claim or reimbursement request) or reconsideration request.
  - If request was received via fax/mail/email, copy of original request including date/time stamp of receipt.
  - If request was received via phone, copy of Customer Service Representative (CSR) notes and/or documentation of call including date/time stamp of call and call details.
  - If a request was received via a chat feature that is available on the sponsoring organization's website, copy of the transcript.
  - If request was received from a representative or NCP (payment reconsiderations), copy of the AOR or equivalent written notice/WOL received.
- Letters, emails or documentation confirming the Sponsoring organization's receipt of the request:
  - If request was received via fax/mail/email, copy of original request.
  - If request was received via phone, copy of CSR notes and/or documentation of call.
- Description of the service/benefit requested from the provider/physician or the enrollee.
- Notices, letters, call logs or other documentation showing the Sponsoring organization requested additional information (if applicable) from the requesting provider/physician, including type of communication. If the request was made via phone call, copy of the call log detailing what was communicated to the physician/provider.
- All supplemental information submitted by the requesting provider/physician or enrollee.
  - If information was received via fax/mail/email, copy of original request.
  - If information was received via phone, copy of CSR notes and/or documentation of call.
- Documentation of case review steps including name and title of final reviewer; clinical criteria that supports rationale for denial; any reference to CMS guidance, Federal Regulations, clinical criteria, peer reviewed literature (where allowed), and Sponsoring organization documents (e.g., EOC); or any other documentation used when considering the request.
- Documentation of effectuation including approval in organization determinations/reconsiderations systems and evidence of effectuation in Sponsoring organization's claims adjudication system.
- Documentation showing approval notification to the enrollee and/or their representative and physician/provider, as applicable.
  - Copy of the written decision letter;
  - If oral notification was given, copy of CSR notes and/or documentation of call.
- Records indicating that payments were made/issued such as EFT records.
- Documentation showing denial notification to the enrollee and/or their representative and provider/physician, if applicable:
  - Copy of written decision letter;
  - If oral notification was given, copy of CSR notes and/or documentation of call.

- Documentation showing reconsideration denial notification to the enrollee and/or their representative and provider/physician, if applicable:
  - Copy of written decision letter;
  - If oral notification was given, copy of CSR notes and/or documentation of call.
- If applicable, all documentation to support the Sponsoring organization's decision to process an expedited request under the standard timeframe, including any pertinent medical documentation, and any associated notices provided to the enrollee and the requesting provider/physician.
- If applicable, providing timely notification of dismissed requests to enrollees or another party, and informing enrollees and other parties about the right to request IRE review of the dismissed request since Sponsoring organizations will no longer automatically forward such reconsideration cases to the IRE for review.
- ANOC/EOC to support application of Step Therapy to Part B drugs
- For reconsiderations, all documentation outlined for both the original determination and the reconsideration.
- If reconsidered case was untimely, include the following:
  - Documentation showing the Sponsoring organization auto-forwarded the request to the IRE.
- Copy of overturn notice from IRE/ALJ/MAC.
- Copy of effectuation notice sent to IRE.
- Initial Complaint and any other supplemental documentation explaining the issue:
  - If complaint was received via fax/mail/email, copy of original complaint including date/time stamp of receipt;
  - If complaint was received via phone, copy of CSR notes and/or documentation of call including date/time of call and call details.
- Where applicable, copy of all notices, letters, call logs, or other documentation showing when the Sponsoring organization acknowledged receipt of the grievance to the enrollee, and/or requested additional information from the enrollee and/or their representative, including the date and time of the acknowledgement. If the request was made via phone call, copy of the CSR notes and/or documentation of call, as well as what was communicated to the enrollee.
- Documentation of all supplemental information submitted by enrollee and/or their representative:
  - If information was received via fax/mail/email, copy of documentation provided including date/time stamp of receipt;
  - If information was received via phone, copy of CSR notes and/or documentation of call including date/time of call and call details.
- Documentation showing the steps the Sponsoring organization took to resolve the issue and a description of the final resolution. Documentation showing the steps the Sponsoring organization took to resolve the issue may include, but is not limited to, appropriate correspondence with other departments within the organization; referral to the Sponsoring organization's fraud, waste, and abuse department; and outreach to providers.
- Documentation showing the Sponsoring organization's investigation, follow-up steps, and description of the final grievance outcome. Include all notices, letters, and enrollee communications.
- Documentation showing resolution notification to the enrollee and/or their representative:
  - Copy of the written decision letter sent and documentation of date/time letter was printed and mailed.

  - If oral notification was given, copy of CSR notes and/or documentation of call including date/time stamp.
- Documentation that supports a Sponsoring organizations record layout population (e.g. mailroom policies).

Sponsoring organizations are expected to submit supporting documentation within two business days of the request.

Root Cause Analysis Submissions
Sponsoring organizations may be required to provide a root cause analysis using the Root Cause Template provided by CMS. Sponsoring organizations have two business days from the date of the request to respond.

Impact Analysis Submissions
When non-compliance with contract requirements is identified on audit, Sponsoring organizations must submit each requested impact analysis, comprehensive of all contracts and Plan Benefit Packages (PBP) identified in the audit engagement letter, in either Microsoft Excel (.xlsx) file format with a header row or Text (.txt) file format without a header row using one of the universe record layouts above, as specified by CMS. The Sponsoring organization must include all requests impacted by the issue of non-compliance during the impact analysis request period. Sponsoring organizations must provide accurate and timely impact analysis submissions within 10 business days of the request. Submissions that do not strictly adhere to the record layout specifications will be rejected.

Verification of Information Collected: CMS may conduct integrity tests to validate the accuracy of all universes, impact analyses, and other related documentation submitted in furtherance of the audit. If data integrity issues are noted, Sponsoring organizations may be required to resubmit their data.