Session 1: August 17, 2021
Organization Determinations, Appeals, and Grievances (ODAG)

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Matthew Guerand: Good afternoon everyone. Thank you all for attending the final MAPD Program Audit User Group Training. Today is part one of a three-part series where we will discuss the final protocols for the Medicare Part C and Part D program audits. Today we will review the Part C program audit program protocol and data requests, and the remaining two sessions, which will occur on August 24th and August 26th, we will review Part D formulary administration and Part D coverage determinations appeals and grievances, Part C and Part D compliance program effectiveness and special needs planned care coordination. All of these sessions will review the program areas protocols included in OMB approved CMS 10717 and will be used for MAPD audits beginning in 2022. It's our hope this training provides further clarity on audit protocols and will assist stakeholders as they prepare their systems for audits next year.

My name is Matt Guerand. I work in Division of Audit Operations, which is a component of the Medicare Oversight and Enforcement Group. We are the division responsible for creating and maintaining the final program audit protocols, as well as administering program audits. Next slide.

All right, let's see. Okay, so before we jump into the heavy part of this presentation, we would like to take just a quick second to know who is attending today's call. Please take a look at the options on the screen and respond to the polling questions with the type of organization you are affiliated with for this call.

All right, very good. Taking a quick look, it looks like everyone should be in the right place. We have about just under 80 percent of the users are affiliated with Medicare Advantage or Prescription Drug Plan, and 16 percent of users are affiliated with the other categories. I hope everyone in that other category are in the right place. All right.

Okay, so, once again, to make sure everyone is in the right place and reviewing the same tools, today we are reviewing the Part C Organization Determinations, Appeals, and Grievances Program Audit Protocol that is part of OMB-approved CMS 10717 and will be used to conduct Medicare Part C and Part D program audits in 2022. The ODAG protocol is broken down into two sections, the program audit protocol and the program audit request. The program audit protocol section includes the method of evaluation CMS uses to assess a plan's compliance to CMS requirements. The program audit data request section includes the tools CMS uses to perform its audit activity.

The goal of today's training is to ensure a uniform understanding of our ODAG audit process. To begin, we will review the compliance standards included in the program audit protocol, focusing primarily on our method of evaluation in an effort to help stakeholders gain insight on our ODAG process and set expectations for when an audit occurs. Afterward, we will review the program audit data request, focusing on the technical specifications for many of the fields in the ODAG record layout. We will not review every field in all of the record layouts.

We aim to address all of the ODAG topics that were submitted in advance of today's presentation, as well as topics we know have caused misunderstandings in the past. If a field is not covered during today's presentation, stakeholders may submit questions to our policy mailbox at part_c_part_d_audit@cms.hhs.gov. I will share this e-mail again in the last slide of this presentation, and you can also see us it in the Q&A box, I guess, on the screen.

Throughout today's presentation, we will identify measures included in this protocol that will be used to test the sponsor's compliance to the new regulations and the associated field within the record layout. Additionally,

I will be using the term "sponsor" to refer to the organizations that participate in the Part C and Part D programs. These are also sometimes referred to a plan sponsoring organization, Medicare advantage organizations, or prescription drug plans. Finally, when I refer to a Part C request, I am referring to a Part C service or item request. If I happen to say Part B and forget to say drug after it, please know that I am always referring to Part B drugs. Next slide.

As a note, the data collection specifications and tools described in the program audit protocols, including the record layout instructions, are used for auditing and monitoring activities and, by themselves, should not be used to interpret policy. Not all points within each record are used to determine the sponsor's compliance with CMS requirements. Any policy questions regarding Part C organization determinations, appeals, and grievances should be directed to the appropriate CMS policy mailbox.

Now, without any further delay, let's begin by jumping into the program audit protocol portion of today's training. The program audit protocol has three audit elements; timeliness, processing offal coverage requests, and classification of requests. You can see these on the screen. On the screen as well, when you see the program audit protocol section at the top of that page, that's what I'm referring to when I refer to the program audit protocol. This is where it has all of our regulations and methods of evaluation that we use to audit plans during our audit season.

The purpose of the review is to evaluate performance in these areas related to Part C organization and determinations of the open grievances. CMS performs its program audit activities in accordance with the ODAG program audit data request and applying the compliance standards outlined in the protocols and the program audit process over these documents. At a minimum, CMS will evaluate cases against the criteria listed within the protocols. CMS may review factors not specifically addressed if it is determined that there are other related ODAG requirements not being met. Next slide. There we go.

All ODAG universes must be submitted to CMS within 15 business days of the audit engagement letter. Once received, CMS will do an initial

check on each universe to identify potential discrepancies. For example, CMS will look to make sure there are no blank fields within a universe, that all contracts are accounted for, and that the universes were populated according to the appropriate universe timeframe. Once complete, CMS will conduct a universe integrity test to verify the accuracy of data within the universe submission and to confirm effectuation of approved requests. To do this, CMS will select ten cases from each universe for review. Many organizations will have a total of 60 cases reviewed during integrity testing; however, organizations offering dual-eligible special needs plans who have not been identified as an applicable integrated plan, do not complete Table 6, and will have a total of 50 cases selected for review. The integrity test will occur prior to audit field work.

The ten samples chosen for each record layout accounts for the consolidation of universes CMS 10717. Sample selection is not specific to a certain number of types of cases. For instance, CMS will not select an even number of standard and expedited cases from the OD record layout. Rather, CMS will objectively review each universe and select samples that may not align with the data request to ensure universes were populated according to the record layout instructions. At a minimum, CMS will verify the dates and times provided in each universe during the integrity testing but retain the right to review any and all fields within universe submissions.

Sponsors will have a maximum of three attempts to provide complete and accurate universes. These attempts may occur prior to or after the entrance conference, depending on when the issue is identified. However, three attempts may not always be feasible depending on when the data issues are identified and the impact that the universe free submission request could have on the audit schedule and/or the integrity of the audit findings.

For example, sponsors will not be allowed to resubmit universes after CMS's shared time limit test results with the sponsor. When multiple attempts are made, CMS will only use the last universe submitted. If the sponsor fails to provide accurate and timely universe submissions twice, CMS will document this as an observation in the sponsor's program

report. After the third failed attempt or when the sponsor determined that there are fewer attempts, that it is unable to provide an accurate universe within the timeframe specified during the audit, the sponsor will be cited and invalid data submission condition for each element that cannot be tested, grouped by the type of case. This information can be found in the Annual Program Audit Process Overview document located on the program audit website.

CMS is no longer testing timeliness effectuation rate for ODM consideration cases. However, during universe integrity testing, CMS will ensure sponsors are effectuating approved organization determinations and overturn to reconsideration decision. This process for validating universe submissions has proven useful in determining the quality of data received in order to accurately and successfully conduct program audits. Samples selected during integrity testing does not preclude CMS from selecting the same samples for review during the field portion of the audit. Once integrity testing is complete and all universes have been accepted, CMS will conduct its timeliness test to determine a sponsor's compliance with CMS continuation.

Compliance standards of 1.1, 1.2, 1.3, and 1.4 are timeliness measurements. You can see them here on the screen. For each of these compliance standards, CMS conducts a timeliness test that ensures an organization notified an enrollee of their preservice organization determination within the appropriate timeframe. Timeliness is based on the date of receipt of the request to the date the sponsor provided notice of their decision to enrollee. Cases are considered timely if notification was made within the following timeframe: For standard Part C service request, 14 days or 28 days with an applicable extension; for expedited Part C request, 72 hours or 17 days with applicable extension; for part B drug requests, a case is considered timely if notice was provided within 72 hours for standard requests or 24 hours for expedited requests. Extensions do not apply to part B drug requests.

ODAG timeliness tests account for all requirements and allowances identified in regulations. For instance, an adverse decision is considered timely if written notification of the decision is provided within the

aforementioned timeframe. Furthermore, for adverse expedited decisions, the timeliness test takes into account the additional three-day allowance to provide written notification following successful verbal notification.

For cases submitted by an authorized representative, CMS ensures notification was provided within the appropriate timeframes from the date of valid AORs received by the plan. Please note, for organizations identified as an applicable integrated plan, the additional three-day allowance to notify an enrollee of an adverse decision of expedited cases does not apply. CMS will ensure when notice is provided to the enrollee within three days of receipt or 17 days if an action is taken. Next slide.

All right, compliance standards 1.5, 1.6, 1.7 and 1.8 are timeliness measurements specific to pre-service reconsideration requests. For these standards, notification timeliness is assessed on an overturned reconsideration and upheld reconsiderations differently. For both Part C and Part B drug overturned to reconsideration, CMS ensures sponsors send in written notice from the overturned reconsideration to the enrollee timely. For upheld reconsiderations, CMS ensures plans forwarded the upheld reconsideration to the IRE timely. Overturned reconsideration cases are considered timely if notification was provided to the enrollee within the following time frame: For standard Part C requests, 30 days or 44 days with applicable extensions; for expedited Part C requests, 72 hours or 17 days with applicable extension; for standard Part B drug requests, seven days, for expedited Part B drug requests, 72 hours. Again, extensions are not applicable to Part B drugs.

For upheld reconsiderations, cases are considered timely if notification was forwarded to the IRE within the following timeframes: For standard Part C services and Part B drug requests, within 24 hours after affirmation of a sponsor's decision; for expedited Part C requests, within 24 hours after affirmation of a sponsor's decision or 96 hours if the sponsor failed to provide notice of its overturned decision within the required timeframe. If an extension was taken and the deadline was met, a case is timely if it was forwarded to the IRE within 18 days. In other words, 24 hours after the end of the 17-day extension timeframe if the deadline is missed.

For expedited Part B drug requests, cases are considered timely if they are forwarded to the IRE within 24 hours after affirmation of the decision or no later than 96 hours if the sponsor fails to provide written notice within the required timeframe. The same logic that applies to OD requests is applied to reconsideration requests. In other words, to consider an overturned decision timely, CMS ensures written notification was provided to the enrollee. Also, the timeliness test takes into account the additional three-day allowance to provide written notification of overturned decisions if successful verbal notification is made first on expedited reconsideration.

For cases submitted by an authorized address, CMS ensures notification was provided within the appropriate timeframe from the date a valid AOR is received by the plan. Please note, for organizations that are DSNP AIPs, CMS will ensure health decisions are forwarded to the IRE and the enrollee if notified of this decision. Next slide.

All right, for those who haven't been able to join the webinar, we are now on Slide 9. Compliance standard 1.9 is a timeliness measure that ensures sponsors are either paying or denying claims submitted by enrollees and non-contract providers timely. Here, depending on who submitted the claim, CMS ensures sponsors issue payment to the enrollee or provider for approved claims or provide a notification of a denial within 60 days. This succeeding timeframe is significant to CMS program audits only. Outside of these audits, sponsors should be adhering to the prompt pay provision located at 42 C.F.R. 422520. Next slide.

Compliance standard 1.10 is a timeliness measure that ensures sponsors are paying or denying payment reconsider submitted by enrollees and non-contract providers timely. To be considered timely, CMS ensures that overturned payment reconsiderations were paid to the enrollee or provider, depending on who submitted the request, within 60 days for MAPD enrollees. For upheld reconsiderations, CMS ensures sponsors forwarded to the upheld decision to the IRE within 60 days of receipt of the request. For DSNP AIPs, CMS ensures enrollee submitted payment reconsiderations and provider submitted payment reconsiderations are paid within 30 days of receipt or forwarded to the IRE within 30 days.

Moving along to compliance standards 1.11 through 1.15, these are timeliness measures that ensure sponsors effectuate overturned decisions made by the IRE within the appropriate timeframe. CMS uses the date the organization received the overturned decision from the IRE as the basis for determining timely effectuation. For standard Part C service requests, CMS confirms effectuation occurred within 14 days of receipt of the IRE's decision. For expedited requests, effectuation of the IRE's decision is considered timely if it is authorized or provided within 72 hours. For standard Part B drug requests, cases are considered timely if they are effectuated within 72 hours, or within 24 hours for expedited requests. All payment decisions overturned by the IRE CMS verified sponsors effectuated payment within 30 days. All right.

For compliance standards 1.16 and 1.17, these are also timeliness measures that ensure sponsors are effectuating overturned decisions made by the ALG or MAC timely. Again, CMS uses the date the organization received the overturned decision from the ALG or MAC to determine effectuations' timeliness. For both standard and expedited Part C pre-service requests and payment requests, CMS considers cases timely if the ALJ or MAC decision was effectuated within 60 days of receipt. For Part B drug request, standard cases are considered timely if they are authorized or provided within 72 hours, or for expedited request within 24 hours. Next slide.

Okay, compliance standard 1.18 and 1.19 are timeliness tests that ensure sponsors are providing responses to standard and expedited grievances timely. For standard grievances, CMS ensures sponsors provide a notification to the enrollee within 30 days or 44 days if an applicable extension is taken. Depending on the circumstance, CMS will check to ensure written notification was provided when required. Compliance standard 1.19 ensures a response is provided for expedited grievances within 24 hours. Next slide.

Okay, again, for those following who haven't been able to join the webinar and are just following based on the slides, we are on Slide 14. Compliance standard 1.20, 1.21, and 1.22 are new measures in 2022 that apply to DSNP AIPs only. These timeliness measures apply to the

reduction, suspension, or termination of previously approved services and the associated appeals of these actions by the enrollee, if applicable. For compliance standard 1.20, CMS ensures enrollees are notified of the DSNP AIP decision to reduce, suspend, or terminate previously approved services no later than ten calendar days prior to the intended action. If an enrollee appeals these decisions, compliance standards 1.21 and 1.22 are notification timeliness tests that ensure a sponsor timely notifies enrollees of its decision. To be considered timely, CMS ensures DSNP AIPs notify enrollees of its standard reconsidered decision within 30 days or 44 days, with applicable extension, or as seen here in compliance standard 1.22, within 72 hours or 17 days with extension for expedited appeals. This the last of our timeliness element. Next, we will move on to processing of coverage requests audit element. Next slide.

The processing of coverage requests element ensures sponsors adhere to CMS requirements pertaining to coverage decisions. This includes a review of a sponsor's decision-making process regarding requests for Medicare covered services, decisions to transfer requests made under the expedited timeframe to standards, appropriate notification of denied requests, and, beginning in 2022, the appropriate application of such therapy for Part B drugs and appropriate processing of integrated organization determinations of previously approved services.

To conduct this review, CMS will select 30 denied samples from the OD, RECON, and payment fee universes. The sample set represents various medical services; for instance, ER services, outpatient hospital, inpatient hospital, and urgent care. There is not a specific number of samples that will be taken from each universe. For plans that have been identified as a DSNP AIP, five additional samples will be selected from Table 6. Samples will be provided to the sponsoring organization one hour before the start of the review. For compliance standard 2.1, in each case reviewed, if the enrollee identified a representative, CMS will review case files to determine if notification was sent to the enrollees represented. If a provider submitted the request on behalf of the enrollee, CMS will ensure the enrollee was notified, as well as the provider, of its determination. Okay, next slide.

Okay, for compliance standard 2.2, CMS will ensure a physician or other appropriate health-care professional with sufficient medical and other expertise reviewed the case prior to the organization issuing its adverse determination. For reconsiderations, CMS will ensure a person or persons who are not involved in making the organization determination conducted the reconsideration.

Moving to compliance standard 2.3, for each denied sample, CMS will review the case file documentation for clinical accuracy. CMS will review each case to determine if sponsors adhered to national coverage determination or, when applicable, local coverage determinations when making their decisions. When there are no NCDs or LCDs, CMS will verify a sponsor followed internal coverage policies to see how the organization came about its decision. In other words, CMS will ensure sponsors adhere to the criteria used in coming about the decision of request for service.

During the review of the reconsideration cases, CMS auditors may request the IDM from the initial decision to understand why the case was generally denied. CMS will rely on this denial rationale provided to the enrollee to determine if the enrollee met the requirements needed to obtain the service on their appeal. CMS may determine the initial decision was incorrect. Next slide.

All right, for each denied case, CMS will review the denial notification in accordance with the applicable regulation. Specifically, CMS will ensure sponsors use the approved notice language in a readable and understandable form that is safe, with specific reasons for denial, informs the enrollee of his or her right to a reconsideration for service, item, or Part B drug denial subscribes both the standard and expedited reconsideration process, including the enrollee's right to and conditions for obtaining an expedited reconsideration, and the rest of the appeals process as applicable, and that it complies with any other notice requirements specified by CMS.

For DSNP AIPs, preservice denial notices will be reviewed to ensure they adhere to 42 C.F.R. 422631(b), and that form CMS 10003 review. If a

sponsor took an extension, CMS will ensure the reasons for the extension were justified. For instance, CMS will review the case to see if the enrollee requested the extension, if the extension was in the enrollee's interest to the need for additional medical evidence from a non-contract provider that may change an MA organization's decision to deny an item or service, or was taken due to an extraordinary, exigent, or other non-routine circumstance and is in the enrollee's interest. Furthermore, CMS will ensure written notice of the extension was provided to the enrollee and that the notice informed the enrollee of the right to file an expedited grievance if he or she disagrees with the sponsor's decision to take an extension. Okay, next slide.

Next, in compliance standard 2.5, if the sponsor denied a request for an expedited determination, CMS will ensure to automatically transfer the question for the standard timeframe and provided a written letter that explained the MA organization will process the request using the 14-day timeframe, inform the enrollee to file an expedited grievance if he or she disagrees with the sponsor's decision not to expedite the case and provided instructions about the grievance process and its timeframe.

CMS received a question regarding expedited Part B drugs that are transferred to the standard timeframe. CMS was asked how cases such as these would be audited, since a letter explaining the transferring of the request to the standard timeframe wouldn't arrive in time to matter. During an audit, CMS will review these cases in accordance with the regulations at 422570 and 422584. For more information about these requests, please contact the policy mailbox. Next slide.

All right, next up are compliance standard 2.6 and 2.7. For those who haven't been able to attend the webinar, I am on Slide, looks like, 19. Both of these standards are new measures CMS is reviewing in 2022. Compliance standard 2.6 tested the compliance of Part B step therapy, and compliance standard 2.7 tested sponsor's compliance with the continuation of benefits for members enrolled in DSNP plans offered by AIP.

For compliance standard 2.6, CMS will review Part B drugs denied because of step therapy requirements to ensure sponsors only applied step therapy to new administrations of Part B drugs using at least a 365-day look-back period. For compliance standard 2.7, CMS will ensure sponsors continued benefits for enrollees in a DSNP AIP if all of the following occurred: the enrollee filed a request for integrated appeal timely and in accordance with 422633(d), the integrated appeal involved determination, dissention, or reduction of previously approved services, the services were ordered by an authorized provider, the period covered by the original authorization has not expired, and, finally, that the enrollee timely filed for continuation of benefits, in other words, that the enrollee specifically asked for benefits to continue. If the organization did not continue benefits, CMS will ensure this decision was appropriate. If, at the enrollee's request, benefits are continued or reinstated, CMS will ensure benefits continue until the enrollee withdraws the request for an integrated reconsideration or the applicable integrated plan issues an integrated reconsideration that is unfavorable to the enrollee related to the benefits that had been continued. Okay, next slide, please.

All right, that was the last. There we have it. Okay, that was the last of our processing of coverage request audit elements. We are now on Slide 20, and we are moving to classification of requests. CMS will select ten dismissed samples from Tables 1 through 3 to determine if the request was appropriately dismissed or whether it should have been treated as a coverage request for grievance. Additionally, as part of compliance standard 3.1, CMS will review the contents of the sponsor's dismissal notice to ensure all these regulatory requires. This will be measured by CMS in accordance with the applicable regulations.

For example, for organization determination requests, CMS would look to 42 C.F.R. or 422568(g) and (h) to determine if the request was appropriately dismissed and will also review the content of the dismissal notice to ensure all regulatory requirements were followed. Next slide.

Okay, for compliance standard 3.2, CMS will select 20 grievance sample cases from Table 5. CMS will sample both verbal and written grievances and will target samples that appear to relate to quality of care, involve

multiple issues and do not appear in the OD or RECON universes, and appear to be misclassified requests. CMS will review sample case file documentation in accordance with the applicable regulations to determine if proper notification was provided. For example, if the grievance was submitted in writing, CMS will review to determine if it was responded to in writing. If the grievance was submitted orally, CMS will review to determine if it was responded to either orally or in writing. However, if the grievance was submitted orally and the enrollee requested a written response, CMS will review to determine if it was responded to in writing.

If the grievance relates to quality of care, regardless of how the grievance is filed, CMS will determine if the grievance report responded to in writing. CMS will also ensure the response includes a description of the enrollees right to file a written complaint to QIO. If a sponsor extended the grievance deadline, CMS will review the case file for documentation stating how the delay is in the interest of the enrollee, and for written notification, to the enrollee of the reason for the delay. If the enrollee identified a representative, CMS will review the case file to determine if notification was sent to the enrollee's representative. Grievance sample selections will be provided to the sponsor approximately one hour prior to the scheduled webinar. This concludes our review of the program audit protocol. Now we will take a quick minute and then jump into the program audit data request.

Okay. All right, so as you can see on the screen here, the program audit data request begins after compliance standard 3.2. For everyone following at home, we are on Slide 23. And then if you're looking in the protocols and not looking at the screen itself, if you go to the end, where compliance edit 3.2 is, we are right there at the bottom of it where it says "Program data audit request."

All sponsors must submit universe Tables 1 through 5, comprehensive of all contracts and plan benefit packages identified in the audit engagement letter. Only those sponsors determined to be an applicable integrated must submit universe Table 6. All universes must be submitted in either Microsoft Excel file format with the header row, or text file format without a header row. Descriptions and clarifications of what must be included in

each submission and data field are outlined in the individual universe record layout. Characters are required in all requested fields unless otherwise specified, and data must be limited to the request specified in each record layout.

Sponsors must provide accurate and timely universe submissions within 15 business days of the audit engagement letter. Submissions deemed not strictly adhered to the layout specifications will be rejected. However, throughout all ODAG record layouts, sponsors have the option to enter data in a field even if it is not required per the field description. For instance, for standard Part C service requests, sponsors may enter "None" in the time written notification provided to enrollee field, or sponsors may enter the time within this field instead of none. Next slide.

ODAG universe periods are based on a sponsors Medicare Advantage only and Medicare Advantage prescription drug enrollment at the time of the engagement letter. To determine enrollment, CMS relies on data from HPMS. PDP-only enrollees and MMP enrollees are excluded from the enrollment count for ODAG purposes. Sponsors should immediately inform CMS if they disagree the universe period timeframe. Sponsors within MA/MAPD enrollment of less than 50,000 enrollees must submit 12 weeks of data. Organizations with enrollment greater than 50,000 enrollees but less than 250,000 will submit eight weeks of data. Sponsors with more than 250,000 enrollees but less than 500,000 will submit four weeks of data, and, finally, no sponsors with 500,000 enrollees will submit two weeks of data. CMS will continue to provide the audit submission checklist, which identifies the universe period for each program area. Sponsors must populate all ODAG tables using the same enrollment period. Okay, next slide.

ODAG has six record layouts. They are universe Table 1, standard and expedited pre-service organization determinations record layout, also known as the OD record layout, and Universe Table 2, standard and expedited pre-service reconsiderations record layout, also known as the RECON record layout. Both of these tables are populated based on the date of the plan's determination, which is column P. Sponsors must include all requests for services, including supplemental services, items,

and Part B drugs the organization approved, denied, or dismissed during universe period. Cases that have not been adjudicated within the universe timeframe, including cases that are past the decision timeframe, should be excluded.

Universe Table 3, payment organization determinations and reconsiderations record layout, also in a moment as the PYMT C layout, this population is based on the determination of the request and who submitted the question. For payment ODs submitted by non-contracted providers, submit based on the date the claim was paid, which is column O, for notification of this denial to the provider, column Q. For payment ODs submitted by the enrollee, submit based on the date the claim was paid, again, which was column O, or notification date of this denial to the enrollee, which is column P.

For payment reconsideration submitted by either NCPs or enrollee, submit based on the date the claim was paid, again, column O, or the date the request was forwarded to the IRE. It is important to note that the payment C record layout no longer includes claims submitted by contracted providers. Additionally, claims submitted by authorized representatives must be included in the payment C record layout -- excuse me, payment C universe. Cases where payment has not been issued or notification of its denial has not been provided within the universe timeframe should be excluded.

Universe Table 4, Part C effectuations of overturned decisions by the IRE, ALJ, or MAC, which is also known as the EFF C record layout, this table is based on the date of the plan's receipt of the IRE, ALJ, or MAC decision that requires effectuation. In other words, sponsors must include all pre-service requests and payment requests that were overturned by the IRE ALJ, or MAC, and received within the universe timeframe. Sponsors must include all decisions requiring an effectuation, even if the IRE has since reopened and overturned the case.

Universe Table 5, Part C standard and expedited grievances, also known as the grievance C record layout, this universe was populated based on the date of sponsor's notification to the enrollee, which is either column

IDQ or F. This date must fall within the universe period, exclude all cases where notification has not been provided within the universe period.

Finally, universe Table 6, dual eligible special need plans, applicable integrated plan reductions, suspensions, and terminations, also known at the AIP record layout. Populate this table based on the date the DSNP AIP notified the enrollee of its decision to reduce, defend, or terminate previously approved services for column IDH. The date of this notification must fall within the universe request period. For requests that have multiple services that are rolled up into a single line, all decision dates for each request must fall within the universe request period.

Okay, now we'll go over some quick record layout instructions. First and foremost, all time fields must be populated in the same time zone within a line. Subjects must include each case with applicable record layout according to how the plan processed the request. Sponsors may exclude requests that do not require a prior authorization. However, if an enrollee submits a request to the plan asking for a determination on services that do not require a prior authorization and the plan makes the determination on these cases, then they must be included within the applicable record layout. The submit requests no longer has their own table. Sponsors should include dismiss requests within the OD, RECON, payment C, grievance C, or AIP record layout according to how the request was received.

Withdrawn cases are excluded from the ODAG record layout, including dismissals that are the result of a withdrawn request. Sponsors should exclude reopened cases from all ODAG universes. Again, sponsors are not required to include requests that are pending a decision within any of the universe submissions. Value-added items and services are excluded from all record layouts. Please see Chapter 4 of the Medicare Managed Care Manual for more information on what are considered value-added items.

CMS has received questions about what CMS considers a retrospective review. CMS does not have a strict definition of a retrospective review. This is what practice organizations utilize to understand the facts of a

service, item, or drug that was given to an enrollee without prior authorization from the organization. These reviews typically do not result in a decision but may allow a claim to be paid once it is submitted by a provider. These types of retrospective reviews should be excluded from all record layouts.

Finally, include all requests for Part B drugs that were processed by a sponsor's Medicare Advantage final decision. We have received a question on whether or not claims for Part B drug submitted by contracted providers should be included in the payment C record layout. We clarified that all claims submitted by contracted providers should be excluded from the payment C record layout, including those submitted for Part B drugs. Next slide.

Okay, we are now on Slide 27, and what I'll do now is begin going through some of the field descriptions. So, starting with the enrollee ID field, beginning January 1st, 2020, all Medicare Advantage and prescription drug plans were required to use the Medicare beneficiary identifier for Medicare transactions. Sponsoring organizations must answer NBI in the field. This number must be submitted with alphabetic and numeric characters only and exclude hyphens or dashes. Next slide.

All right, the authorization or claim number field is in the OD, RECON, payment C, effectuation C, and AIP record layout. This field allows CMS to ensure they are looking at the appropriate record for each line within the universe. Sponsors must enter the associated authorization or claim number for the request in this field. If an authorization or claim number is not available, enter the internal tracking or case number associated with the request. Enter "None" if there is no authorization, claim, or other tracking number available. Next slide.

Okay, for the date the request was received field, populate the date the request was received by the sponsor, whether it was orally, electronically, or written. If a sponsoring organization utilizes delegated entities to process ODs, appeals, or grievances, the date the delegated entity received the request must be entered in this field. In the RECON and payment C record layout, if the sponsor obtained information that

established good cause and a request after the 60-day filing timeframe, enter the date the organization received information establishing good cause. Next slide.

Okay, the next field we will discuss is the time the request was received field. In the OD record layout, enter the time the request was received for expedited Part C requests and all Part B drug requests. Sponsors may enter none in this field for standard Part C requests and dismiss requests. However, as I previously mentioned, if a sponsor wants to include the time for standard and dismissed requests, it may do so if desired.

In the RECON record layout, sponsors should enter the time the request was received for both expedited Part C service requests and Part B drug requests. If the sponsor obtained information that established good cause on a request after the 60-day filing timeframe, enter the time the organization received information establishing good cause. Enter none for standard Part C service reconsideration request, Part B drug reconsideration request, and dismissals. Again, if a sponsoring organization utilizes delegated entities to process either OD or reconsideration requests, enter the time the delegated entity received the request when applicable. Okay, next slide.

The part B drug request field is in the OD, RECON, and effectuation C record layout. This field is included to determine a sponsor's compliance with the relatively new Part B drug timeframe regulations that with effective January 1st, 2020. For the field, sponsors should enter "Y" for yes if the request for a Part B drug is primary and processed by their Part B line of business. Enter "None" for all other requests. Next slide.

Okay, we are now on Slide 32. Next up is the AOR equivalent notice receipt date field. The description for this field has been updated for simplicity and consistency purposes. The NA option has been eliminated. For requests received from a purported representative, populate this field with the date the appointment of representative form or equivalent written notice was received by the sponsor, regardless of whether the representative documentation was received prior to the date of request or grievance. Sponsors may enter "None" for this field when no AOR or

equivalent written notice was received or required and for dismissed request. Next slide.

All right, the next field is the AOR equivalent notice receipt time field. For requests received from a purported representative, the AOR equivalent notice received time field should be populated with the time the appointment of representative form or equivalent written notice was received by the sponsor. If the representative documentation was received prior to the date of the request or grievance, sponsors may enter "None." In all other the scenarios, the following applies: In the OD record layout, enter the time the AOR was received for expedited Part C requests and all Part B drug requests. Sponsors may enter "None" in this field if an AOR was not received or required. Sponsors may enter none in this field if an AOR was not received or required for standard Part C requests and dismissed requests.

In the RECON record layout, sponsors should enter the time the AOR was received for both expedited Part C service requests and Part B drug requests. Enter "None" for standard Part C service reconsideration requests, part B drug reconsideration requests, and dismissals. Sponsors may enter "None" for all of their requests, including when an AOR or promote written notice was not received or required.

In the grievance C record layout, enter the time the AOR form or equivalent written notice was received by the sponsor for expedited grievances. Enter none if an AOR was no not received or required, and for standard requests submitted by a board or representative. Next slide.

Okay, so, next is the request determination field. This field has been streamlined to encompass all cases that were sent to the IRE into a single of response. This now includes cases that were forwarded to the IRE due to untimely decisions and auto-forwarded because of upheld decisions. Next slide.

Next is the date of the determination field. This field is in the OD, RECON, payment C, and the AIP record layout. However, in the AIP record layout, this field is titled "Date of DSNP AIP decision, not determination." As

previously mentioned, the OD and RECON universes are populated based on this field. The date in this field must fall within the universe period for those record layouts. For dismissed request, in each record layout, enter the dates the sponsoring organization dismissed the question. In the payment record C record layout, sponsors should enter the date a claim was approved or denied. For approval, it may be the date a claim was determined payable or it may match the date a claim was paid. Since requests denied in whole or in part must be entered as denied, sponsors should enter the date of their determination to deny in whole or in part in this field. In the AIP record layout, sponsors should populate this field with the date of the sponsor's reconsidered determination. Next slide.

Okay, next up is the time list determination field. For the OD record layout, sponsors must enter a time for all expedited Part C organization determination requests in both standard and expedited Part B drug requests. Enter "None" for standard parts of request and dismiss request. In the RECON record layout, enter a time for all expedited Part C and Part B drug reconsideration requests. Enter "None" for standard requests and dismissed requests. Next slide.

Okay, we are now on slide 37. The next field we will discuss is the date oral notification provided to enrollee field. If a sponsor provided successful oral notification of their determination, populate the date oral notification was provided. Enter "None" if no oral notification was provided. Per 10.5.3 of the Part C and D enrollee grievances organization coverage determination and appeals guidance, oral notification is considered timely under date and time, if applicable, a plan speaks directly to or leaves a voicemail for an enrollee or an enrollee's representative. Next slide.

All right, as I'm sure you all guessed, the next field we will discuss is the time oral notification provided to enrollee field. For the OD record layout, if a sponsor provided successful oral notification of their determination, enter the time of oral notification in this field for all expedited Part C requests and both standard and expedited Part B drug requests. Enter

none for standard and dismissed requests or if no oral notification is provided.

For the RECON record layout, enter the time of oral notification for all expedited reconsiderations for both Part C and Part B drug requests. Enter "None" for standard Part C service and part B drug requests, specific request, or if no notification was made.

In the grievance record layout, enter the time the successful oral notification for expedited grievances advances. If oral notification is not provided, enter "None." Again, for 10.5.3 of the combined manual, oral notification is considered delivered on the date and time, if applicable, a plan speaks directly to, leaves a voicemail for an enrollee or an enrollee's representative. Okay, next slide.

All right, now we will discuss the date written notification provided to enrollee field. This field is populated differently depending on the scenario, so everyone bear with me here. First and foremost, CMS will accept the written notification date based on Section 10.5.3 of the combined manual so long as permitted by guidance. In the OD record layout, sponsors must enter the date where notification was provided for all requests when applicable. For dismissed requests, populate the date written notification of the dismissal is provided to the enrollee. Enter "None" if notification was not provided.

In the RECON record layout, enter the date where a notification was provided to the enrollee. Enter "None" for upheld reconsiders that were forwarded to the IRE or if no written notification was sent. For dismissed cases, populate the date written notification of the dismissal was provided to the enrollee.

In the payment C record layout for approved claims submitted by enrollee, this field may be the same as the date the claim for reconsideration was paid. For approved claims submitted by a provider, enter the date the explanation of benefits was sent to the enrollee. For denied enrollee or provider-submitted claims, populate the date the

integrated denial notice was provided. Enter "None" if no written notification was sent or the EOB will be issued at a future date.

For the grievance C record layout, enter the date written notice of the grievance resolution was provided to the enrollee. Please keep in mind, this date must be the date written notice was provided. Do not enter a date, a letter is generated or printed. Next slide.

Okay, time written notification provided to enrollees. In the OD record layout, enter the time written notification was provided for all expedited requests and standard Part B drug organization determination requests when applicable. Enter "None" for standard Part C requests or if no written notification was provided. In the RECON record layout, enter the time written notification was provided for all expedited requests when applicable. In the grievance C record layout, again, enter the time written notification was provided for expedited grievances. And, of course, one more time, just remember that the time entered here must be the time written notice was provided. Do not enter the time that the letter was generated or printed. Okay, next slide.

All right, we are now on Slide 41, and we are discussing the field date reconsideration for determination effectuated in the system. This field is found in the RECON record layout only. If the sponsor overturned its decision, enter the date the determination was effectuated in the system for both standard and expedited request. Enter "None" if the decision was upheld, dismissed or not effectuated. Next slide.

All rights. Okay, next, as you might expect, is the time reconsidered determination effectuated in the system. Sponsors must enter the time the reconsidered determination was effectuated in the system for expedited Part C requests and Part B drug requests that were overturned. Enter "None" as the decision was upheld, dismissed, or not effectuated. All right, next. There we go.

Okay, the date forwarded to IRE field is found in the RECON, payment C, and AIP record layouts. Here, sponsors should enter the date upheld reconsiderations afforded to the IRE. Enter "None" if the enrollee was

notified of approved reconsideration, if the request was not forwarded to the IRE, or for dismissed requests. Next slide.

All right, the next field is the time for IRE field. This field is found in the RECON record layout. Sponsors must enter the time upheld to reconsideration forwarded to the IRE for all expedited Part C and Part B drug reconsideration requests. Enter "None" for standard and dismissed requests. Next slide.

Okay, for the issue description and type of service field, sponsors must provide a brief description of the service requested and why it was requested if no. For denials, sponsors should provide an explanation of why the pre-service request was denied. Sponsors may include a CPT HCPCS or NDC within the description but may not use these codes as the sole descriptor for this field. For dismissed requests, provide the reason for dismissal, such as untimely filing or no waiver of liability received. Next slide.

All right, now we are on Slide 46. Okay, for the was an expedited request made but processed as standard feel, if an expedited request was received, the transfer to the standard timeframe, sponsoring organizations should enter why. Sponsors should enter "N" for all of the requests, including dismiss requests. Next slide.

All right, for the was request denied for lack of medical necessity field, please note this field is now in the OD record layout only. If the request was denied for lack of medical necessity, enter "Y" for yes or "N" for no. Enter "None" for all other cases. We have received questions on how to interpret this field based on various scenarios and whether or not CMS would consider certain denials as denied for lack of medical necessity. CMS does not strictly medical necessity. Sponsors should apply their definition of lack of medical necessity and populate the field according to that definition. Next slide.

Okay, now the next field we're discussing is, was the initial organization determination request denied for lack of medical necessity? Please note, and you can see it here on screen, that this field is found in the RECON

and payment C record layouts only. This field has been updated to align with the CDAG protocols. Sponsoring organizations should populate "Y" for yes if the initial organization determination was denied for lack of medical necessity. The initial organization determination may fall outside of the universe timeframe. For the payment C record layout, sponsors must only respond to this question if the request was processed and identified in the universe as a reconsideration. If the request was processed as an OD, sponsors should enter "N" for no. Okay, next slide.

All right. Okay, next slide to discuss is the date claim reconsideration was paid field. This field is found in the payment C record layout. Sponsors must enter the date a claim was paid to an enrollee or provider for both payment ODs and payment reconsideration. So long as guidance allows, sponsors should populate this field according to 10.5.3 of the combined manual. Enter "None" if the payment was not provided, if the request was denied, or if the request was dismissed.

We received a question regarding zero paid claims. In instances where claims are approved but no payment is made due to recoupment of funds, enter the date of a remitted advice identifying real dollar payment or a voided zero-dollar check is provided. CMS recognizes these situations occur and will work with organization- to ensure they know what to put in this field, if neither an RA or a voided check is sent. Okay, next slide.

Okay, we are now on Slide 50. The date written notification provided to provider field is in the payment C record layout. For approved claims, enter the date notice was provided to the provider. This may be the same date as the date the claims were paid at reconsideration was paid or the date of a remittance advice or explanation of payment. For denied payment OD requests, sponsors should enter the date the organization notified the provider of the denied claim. For denied payment reconsider, enter "None" if notice was not issued to the provider. However, an organization may enter the date of notification to the provider if desired. Enter "None" if the enrollee submitted the claim. Next slide.

Okay, here we have the was it a clean claims field? This field is also in the payment C record layout only. Sponsoring organizations must

populate this field based on the status of the claim upon receipt. For payment reconsideration, enter "None." Next slide.

Okay, next slide is the first tier, downstream, and related entity field. This field is used to improve the efficiency of an audit. If a sponsor utilizes a delegated entity to process a request, sponsors should populate the name of the FDR that processed the request in this field. CMS will inform the organization of which FDRs will be required to attend that day's session if a sample is selected that was processed by a specific FDR. Next slide.

Okay, the type of reconsideration case field is in the effectuation fee record layout only. Sponsors should enter the type of case that was overturned by the IRE, ALJ, or MAC. For preservice cases identify whether or not it was a standard or expedited request. For post-service cases, enter payment. Next slide.

Okay, the date the overturned decision was effectuated field was effectuated field. This is also found in the effectuation C record layout only. It is very similar to the date reconsidered determination effectuated in system field and the RECON record layout. Here, enter the date the overturned decision was effectuated in the system for all plan decisions that were overturned by the IRE, ALJ, or MAC. For expedited requests, this date may be the date the plan authorized or provided the service or drugs. Okay. Next slide.

All right, we are now on Slide 55. Let's see, okay, coinciding with the date overturned decision or payment was effectuated in the system is, of course, the time overturned decision or payment effectuated the system. Again, this is only found in the ESFC record layout. In this field, sponsors must enter the time the overturned decision was effectuated in the system for all expedited Part C requests overturned by the IRE and all Part B drug requests overturned by the ILB, ALJ, or MAC. For expedited requests, sponsoring organizations may enter their time in the plan authorized or provided for the service or drug. Enter "None" if the decision was not effectuated and for standard service request -- forgive me. Enter

"None" if the decision was not effectuated and for standard service requests and payment requests. Okay, next slide.

Okay, the date the grievance was received field is found in the grievance C record layout only. Enter the date a grievance was received for both standard and expedited oral or written grievances. If a delegated entity received a request, enter the date the delegated entity received the request in this field. Next slide.

Okay, the time the grievance was received field, again, it's only in the grievance received record layout. Enter the time the grievance was received for all expedited grievances. Enter "None" for standard grievances. Next slide.

Okay, for the category of the issue field, indicate the category the issue the grievance falls under per the organization's internal labeling system. CMS does not dispute how an organization classifies grievances but does expect each organization to adhere to their own class specification system as they populate this field. Next slide.

Okay, now we are on Slide 59. The remaining fields are all found in the AIP record layout. This record layout will be used for the first time in 2022 to test dual eligible special needs plans, applicable integrated plans, compliance with regulation effective January 1st, 2021.

The first field we will discuss is the date the DSNP AIP notified enrollee decision to reduce, suspend, or terminate services field. In this field, enter the date the AIP notified the enrollee that previously approved services were being reduced, suspended, or terminated. Similar to pre-notice certification, CMS will accept a notification date based on Section 10.5.3(a) of the addendum to the Part C and D enrollee grievances organization coverage determinations and appeals guidance. Next slide.

For the effective date of reduction, suspension, or termination of services field, enter the intended date the organization expects to reduce, suspend, or terminate previously approved services. This field should match the date in the notice that inform the enrollee of the plan's decision; however, it may not always line with that notice. Next slide.

Okay, for the was the decision appealed field, AIPs must respond "Yes" or "No," depending on whether or not the enrollee appealed the organization's decision. If the response in this field is "N" for no, all subsequent fields in the AIP's record layout may be populated with "None." Next slide.

All right, for the did the enrollee request continuation of benefits field, the AIP must respond "Yes" or "No" based on whether or not the enrollee, him or herself, requests a continuation of benefits. If all other scenarios, enter "N" for no. We recognize other individuals can request continuation of benefits, such as authorized representative or physicians that have appropriate documentation. However, for this field, we only want to know if the enrollee him or herself requested continuation of benefits. Next slide.

In the where the benefits under appeal provided to the enrollee during the plan level appeal process field, sponsors should enter "Yes" or "No" based on whether or not benefits under appeal were provided to the enrollee during the reconsideration process. Here, we want to know if benefits were continued whether or not the request to continue benefits was made by the enrollee him or herself. This field does not pertain solely to enrollee requests for continuation of benefits. If continuation of benefits does was not requested, enter "None." If the decision was not appealed, enter "None."

All right, for the date reconsideration determination effectuated in the DSNP-AIP System field, enter the date the plan effectuated services that were reduced, suspended, or terminated when the enrollee did not request continuation of benefits but successfully appealed the sponsor's decision. Enter none for upheld decisions or if the decision was not appealed, as indicated by "M" in column IDJ. Next slide.

All right. Okay, if the reconsider was upheld, enter the date previously approved services were reduced, suspended, or terminated. This date might fall prior to the plan to reconsider a decision if continuation of benefits was not requested. Enter "None" if the decision was not appealed. Okay, next slide. There we are.

Okay, so now we will discuss the ODAG impact analysis submission. When noncompliance with contract requirements is identified on audits, sponsors must submit each requested impact analysis comprehensive of all contracts and plan benefit packages identified in the audit engagement letter using one of the ODAG universe record layouts, as specified by CMS. The information collected as a result of identifying decision fees will mirror the existing ODAG universe record layout. Final slide.

Okay, this concludes our Part C organization determination appeals and grievances section of the final MAPD audit protocol training. We aim to address all of the ODAG topics that were submitted in advance of today's presentation. If you have any additional program audit process-related questions following today's presentation, please send them to the e-mail box listed on this slide. As noted previously, policy questions should be directed to the appropriate CMS policy mailbox. Thank you for attending and have a great rest of the day.

Moderator: At this time, your browser window will open and take you directly to the participant survey. Thank you for taking the time to join us today everyone, and this concludes today's webinar.