

SERVICE LEVEL DATA COLLECTION FOR INITIAL DETERMINATIONS AND APPEALS

Effective January 1, 20XX

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is [0938-New]. This information collection will provide key data to CMS on the utilization of benefits, enhance audit activities to ensure plans are operating in accordance with CMS guidelines, and ensure appropriate access to covered services and benefits. The time required to complete this information collection is estimated to average less than 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under §§ 422.516(a) and 423.514(a). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Background and Introduction

The Part C Reporting Requirements, as set forth in § 422.516(a), provide CMS with the ability to collect more granular data related to all plan activities regarding adjudicating requests for coverage and plan procedures related to making service utilization decisions. This includes collecting more timely data with greater frequency or closer in real-time. Pursuant to that authority, each MAO must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires.

Organizations for which these specifications apply are required to collect these data. Reporting will vary depending on the plan type. All reporting sections will be reported quarterly.

National PACE Plans and 1833 Cost Plans are excluded from reporting the data in this collection.

Overview of the parameters for data elements in this collection.

Reporting Section	Organization Types Required to Report	Report Frequency Level	Report Period	Due Date(s)
Initial Determinations	CCP; PFFS; 1876 Cost; MSAs, Religious Fraternal Benefit (RFB) PFFS; (includes all 800 series plans), Employer/Union Direct Contracts should also report this section regardless of organization type.	4/Year Contract	1/1- 3/31 4/1- 6/30 7/1- 9/30 10/1- 12/31	
Appeals	CCP; PFFS; 1876 Cost; MSAs, Religious Fraternal Benefit (RFB) PFFS; (includes all 800 series plans), Employer/Union Direct Contracts should also report this section regardless of organization type.	4/Year Contract	1/1- 3/31 4/1- 6/30 7/1- 9/30 10/1- 12/31	

REPORTING SECTIONS

Section I. Service Level Data for all Initial Determinations

Data Element ID	Data Element Description
A.	OD Number
B.	Contract number and PBP
C.	Parent organization
D.	Provider NPI
E.	Enrollee MBI
F.	Requested service codes (CPT/HCPCS)
G.	Name of service associated with CPT/HCPCS
H.	Submitted diagnosis codes (e.g., ICD-10, HIPPS codes)
I.	Processing priority (standard or expedited)
J.	Service location (Zip)
K.	Date of service
L.	Provider status (contracted or non-contracted)
M.	Approved or denied
N.	Date request received
O.	Date of decision
P.	Decision rationale
Q.	Were internal plan criteria applied?
R.	Was PA requested?
S.	If element R is yes, provide OD number for PA (claims only)
T.	If element R is yes, was PA request required?
U.	If element R is yes, was a voluntary pre-service request received?
V.	Place of service, if applicable https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

Section II. Service Level Data for all Appeals

Data Element ID	Data Element Description
A.	Applicable initial determination number (to link to initial decision)
B.	Approved/denied
C.	Date request received
D.	Date of decision
E.	Processing priority (standard or expedited)
F.	Decision rationale
G.	Reviewer qualifications