

60-day Package

There were two reporting sections with no subsections- Initial Determinations and Appeals

Reporting Elements for all Initial Determination Requests:

- OD Number
- Contract number and PBP
- Parent organization
- Provider NPI
- Enrollee MBI
- Requested service codes (CPT/HCPCS)
- Name of service associated with CPT/HCPCS
- Submitted diagnosis codes (e.g., ICD-10, HIPPS codes)
- Processing priority (standard or expedited)
- Submission date (7/1)

Revised/New in 30-day Package

There are now two subsections for each reporting section - Initial Determinations (coverage decisions), Initial Determinations (payment), Reconsiderations (coverage decisions), Reconsiderations (payment)
Revised Reporting Elements for Initial Determinations (coverage decisions):

- Organization Determination Number
- Contract Number
- Plan Benefit Package (PBP)
- Enrollee MBI
- Requesting Party
- Provider NPI
- Item/Service/Part B Drug Code
- Item/Service/Part B Drug Description
- Diagnosis Codes
- Was prior authorization required?
- Was this a concurrent review decision?
- Processing Priority
- Was expedited processing requested?
- Date Request Received
- Date of Decision Notification
- Disposition
- Dismissal Rationale (if applicable)
- Decision Rationale
- Reviewer Qualifications
- Were internal plan coverage criteria applied?
- Did a third-party vendor participate, in any capacity, in the determination’s review or decision-making?

Reason for Change

Previously, there were elements that only applied to either a coverage request or a payment request and this could have been confusing to report. This change was also in response to comments related to whether the reporting applies to both pre-service and payment requests. By separating each section this clarifies the expectation for reporting of both pre-service/coverage and payment requests.

Based on comments and upon further review, there have been several revisions to the elements. We have reworded/rephrased some elements to improve clarity and the addition of new elements in each reporting section will allow CMS to broaden the scope of review for each case. Many commenters requested clarification around what is a "voluntary pre-service request". As a result, we revised this element to avoid confusion and will gather the information needed by asking if prior-authorization was required. We have also added "reviewer qualification" at the initial determination level based on several comments received.

Service location (ZIP)

Date of service

Provider status (contracted or non-contracted)

Approved or denied

Date request received

Date of decision

Decision rationale

Were internal plan criteria applied?

Was PA requested?

If element R is yes, provide OD number for PA (claims only)

If element R is yes, was PA request required?

If element R is yes, was a voluntary pre-service request received?

Place of service, if applicable <https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>

(payment):

Organization Determination Number

Contract Number

Plan Benefit Package (PBP)

Enrollee MBI

Requesting Party

Item/Service/Part B Drug Code

Item/Service/Part B Drug Description

Diagnosis Codes

Service Location

Place of Service

Date of Service

Provider NPI

Date Claim Received

Date of Decision

Date Claim was Paid

Was it a clean claim?

Disposition

Dismissal Rationale (if applicable)

Decision Rationale

Reviewer Qualifications

Were internal plan coverage criteria applied?

Was prior approval (e.g., a prior authorization or voluntary pre-service request) requested?

If element V is yes, provide the organization determination number for associated prior approval request

Revised Elements for Reconsiderations (coverage decisions):

- Associated Organization Determination Number
- Appeal Number
- Contract Number
- Plan Benefit Package (PBP)
- Enrollee MBI
- Date Request Received
- Date of Decision Notification
- Processing Priority
- Was expedited processing requested?
- Is this an appeal of an organization determination dismissal?
- Disposition
- Dismissal Rationale (if applicable)
- Decision Rationale
- Was the initial organization determination request denied for lack of medical necessity?
- Was the reconsideration request reviewed by a physician?
- Did a third-party vendor participate, in any capacity, in the determination’s review or decision-making?

Reporting Elements for Reconsiderations:

- Applicable initial determination number (to link to initial decision)
- Approved/denied
- Date request received
- Date of decision

Date of decision

Processing priority (standard or expedited)

Decision rationale

Reviewer qualifications

Revised Elements for Reconsiderations (payment):

Associated Organization Determination Number

Appeal Number

Contract Number

Plan Benefit Package (PBP)

Enrollee MBI

Date Request Received

Date of Decision Notification

Date Claim was Paid

Is this an appeal of an organization determination dismissal?

Disposition

Dismissal Rationale (if applicable)

Decision Rationale

Was the initial organization determination request denied for lack of medical necessity?

Was the reconsideration request reviewed by a physician?

Did a third-party vendor participate, in any capacity, in the determination’s review or decision-making?

Background read:

"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."

Revised to read:

"The Part C Reporting Requirements, as set forth in 42 CFR § 422.516(a), provide CMS with the ability to collect data on plan procedures related to, and utilization of, its items and services. This includes collecting service-level data related to plan coverage and appeal decisions that are processed in accordance with the requirements of part 422, subpart M. 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."

The revised language is more clear and concise as it relates to the intent and general expectation of the data collection.

Included due dates for each quarterly submission

To ensure plans are aware of CMS' expectation for timely submission of the data.