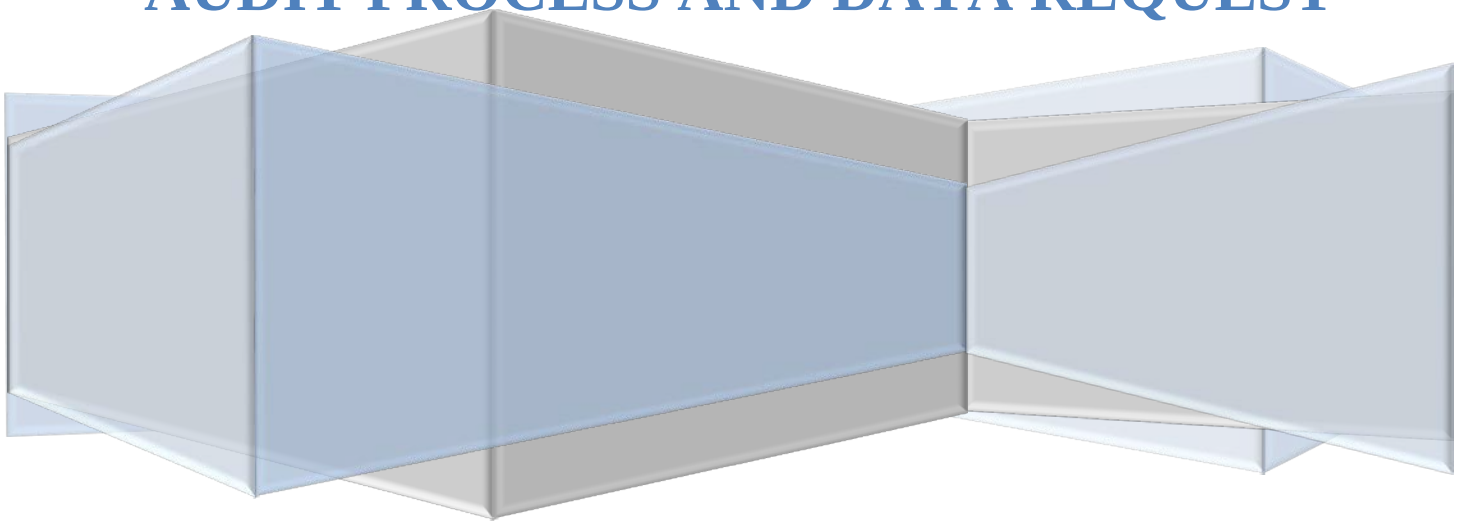
Part C Organization Determinations, Appeals, and Grievances (ODAG) Program Area

AUDIT PROCESS AND DATA REQUEST



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Audit Purpose and General Guidelines

1. **Purpose:** To evaluate performance in the four areas outlined in this protocol related to Part C Organization Determinations, Appeals and Grievances (ODAG). The Centers for Medicare and Medicaid Services (CMS) will perform its audit activities using these instructions (unless otherwise noted).

2. **Review Period:** The review period for the ODAG program area will be decided based on your organization's total enrollment. CMS reserves the right to expand the review period to ensure sufficient universe size.

   - Plans with <50,000 enrollees: The review period will be the 3-month period preceding, and including, the date of the audit engagement letter.
   - Plans with ≥50,000 but <250,000 enrollees: The review period will be the 2-month period preceding, and including, the date of the audit engagement letter.
   - Plans with ≥250,000 enrollees: The review period will be the 1-month period preceding, and including, the date of the audit engagement letter.

3. **Responding to Documentation Requests:** The sponsor is expected to present its supporting documentation during the audit and take screen shots or otherwise upload the supporting documentation, as requested, to the secure site using the designated naming convention and within the timeframe specified by the CMS Audit Team.

4. **Sponsor Disclosed Issues**: Sponsors will be asked to provide a list of all disclosed issues of non-compliance that are relevant to the program areas being audited and may be detected during the audit. A disclosed issue is one that has been reported to CMS prior to the receipt of the audit start notice (which is also known as the "engagement letter"). Issues identified by CMS through on-going monitoring or other account management/oversight activities during the plan year are not considered disclosed.

   Sponsors must provide a description of each disclosed issue as well as the status of correction and remediation using the Pre-Audit Issue Summary template. This template is due within 5 business days after the receipt of the audit start notice. The sponsor's Account Manager will review the summary to validate that "disclosed" issues were known to CMS prior to receipt of the audit start notice.

   When CMS determines that a disclosed issue was promptly identified, corrected (or is actively undergoing correction), and the risk to beneficiaries has been mitigated, CMS will not apply the ICAR condition classification to that condition.

5. **Impact Analysis (IA)**: An impact analysis must be submitted as requested by CMS. The impact analysis must identify all beneficiaries subjected to or impacted by the issue of non-compliance. Sponsors will have up to 10 business days to complete the requested impact analysis templates. CMS may validate the accuracy of the impact analysis submission(s). In the event an impact analysis cannot be produced, CMS will report that the scope of non-compliance could not be fully measured and impacted an unknown number of beneficiaries across all contracts audited.

6. **Calculation of Score:** CMS will determine if each condition cited is an Observation (0 points), Corrective Action Required (CAR) (1 point) or an Immediate Corrective Action Required (ICAR) (2 points). Invalid Data Submission (IDS) conditions will be cited when a sponsor is not able to produce an accurate universe within 3 attempts. IDS conditions will be worth one point.

   CMS will then add the score for that audit element to the scores for the remainder of the audit elements in a given protocol and then divide that number (i.e., total score), by the number of audit elements tested to determine the sponsor's overall ODAG audit score. Some elements and program areas may not apply to certain sponsors and therefore will not be considered when calculating program area and overall audit scores. Observations will be recorded in the draft and final reports, but will not be scored and therefore will not be included in the program area and audit scores.

7. **Informing Sponsor of Results:** CMS will provide daily updates regarding conditions discovered that day (unless the case has been pended for further review). CMS will provide a preliminary summary of its findings at the exit conference. The CMS Audit team will do its best to be as transparent and timely as possible in its communication of audit findings. Sponsors will also receive a draft audit report which they may formally comment on and then a final report will be issued after consideration of a sponsor's comments on the draft.

Universe Preparation & Submission

1. **Responding to Universe Requests:** The sponsor is expected to provide accurate and timely universe submissions within 15 business days of the engagement letter date. CMS may request a revised universe if data issues are identified. The resubmission request may occur before and/or after the entrance conference depending on when the issue was identified. Sponsors will have a maximum of 3 attempts to provide complete and accurate universes, whether these attempts all occur prior to the entrance conference or they include submissions prior to and after the entrance conference. However, 3 attempts may not always be feasible depending on when the data issues are identified and the potential for impact to the audit schedule. 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 audit report. After the third failed attempt, or when the sponsor determines after fewer attempts that they are unable to provide an accurate universe within the timeframe specified during the audit, the sponsor will be cited an Invalid Data Submission (IDS) condition relative to each element that cannot be tested, grouped by the type of case.

2. **Pull Universes:** The universes collected for this program area test whether the sponsor has deficiencies related to timeliness, clinical decision making and appropriateness, dismissals and grievances and the misclassification of requests in the area of ODAG. The sponsor will provide universes of all of its organization determinations (both payment and pre-service, both expedited and standard), all sponsor reconsiderations (both payment and pre-service, both expedited and standard), all requests for direct member reimbursement, all IRE, ALJ and MAC cases that required effectuation, as well as all expedited and standard grievances.

   Instructions for what should be included in each universe are listed above the tables listed in Appendix A. For each respective universe, the sponsor should include all cases that match the description for that universe for all contracts and Plan Benefit Packages (PBPs) in its organization as identified in the audit engagement letter (e.g., all standard ODs for all contracts and PBPs in your organization).

   The universes should be 1) all inclusive, regardless of whether the request was determined to be favorable, partially favorable, unfavorable, auto-forwarded or dismissed and 2) submitted in the appropriate record layout as described in Appendix A. Please note that for audit purposes, partially favorable decisions are treated as denials. These record layouts include:

   - Table 1: Standard Pre-Service Organization Determinations (SOD)
   - Table 2: Expedited Pre-Service Organization Determinations (EOD)
   - Table 3: Requests for Part C Payment Organization Determinations (Claims)
   - Table 4: Direct Member Reimbursement (DMR) Requests
   - Table 5: Standard Pre-Service Reconsiderations (SREC)
   - Table 6: Expedited Pre-Service Reconsiderations (EREC)
   - Table 7: Requests for Payment Reconsiderations (PREC)
   - Table 8: Pre-Service IRE Cases Requiring Effectuation (IREEFF)
   - Table 9: IRE Payment Cases Requiring Effectuation (IREClaimsEFF)
   - Table 10: All ALJ and MAC Cases Requiring Effectuation (ALJMACEFF)
   - Table 11: Part C Oral and Written Standard Grievances (GRV_S)
   - Table 12: Part C Oral and Written Expedited Grievances (GRV_E)

- Table 13: Dismissals (DIS)

3. **Submit Universes to CMS:** Sponsors should submit each universe in the Microsoft Excel (.xlsx) file format with a header row (or Text (.txt) file format without a header row) following the record layouts shown in Appendix A, Tables 1-13. The sponsor should submit its universes in whole and not separately for each contract and PBP. If the sponsor does not have any cases responsive to a particular universe request (e.g., if there were no direct member reimbursement requests during the review period), the sponsor must upload an Excel spreadsheet to the Health Plan Management System (HPMS) at the appropriate universe level that includes a statement explaining it does not have responsive cases for this particular universe during the requested audit period.

4. **Timeliness Tests:** CMS will run the tests indicated below on each universe. For the effectuation tests, auditors will determine percentage of timely cases from a sponsor's approvals (favorable cases). For the notification timeliness tests, auditors will determine the percentage of timely cases from a full universe of approvals and denials, as applicable.

TABLE #	RECORD LAYOUT	UNIVERSE	COMPLIANCE STANDARD TO APPLY	CRITERIA (EFF. JANUARY 1, 2020)	TEST
1	SOD	Standard Pre-service ODs	No later than 14 days, plus 14 days (totaling 28 days) if an extension is used.	42 CFR § 422.568(b)	Decision-Making Notification
2	EOD	Expedited Pre-service ODs	No later than 72 hours, plus 14 days (totaling 17 days) if an extension is used.	42 CFR § 422.572(a) 42 CFR § 422.572(b) 42 CFR § 422.572(c)	Decision-Making Notification
3	Claims	Requests for Part C payment ODs-Claims (designate if the request was a clean claim or an unclean claim)	95% in 30 days for clean claims and 60 days for all other claims from non-contracted providers.	42 CFR § 422.568(c) 42 CFR § 422.520(a)(1) 42 CFR § 422.520(a)(3)	Effectuation Notification
4	DMR	Requests for Payment ODs-Direct Member Reimbursement Requests	No later than 60 days.	42 CFR § 422.568(c) 42 CFR § 422.520(a)(1) 42 CFR § 422.520(a)(3)	Effectuation Notification
5	SREC	Standard Pre-service Reconsiderations	No later than 30 days, plus 14 days (totaling 44 days) if an extension is used for services or items. Late and unfavorable cases must be forwarded to the IRE within these timeframes.	42 CFR § 422.590(a) 42 CFR § 422.590(c) 42 CFR § 422.590(d)	Effectuation IRE Auto-Forward Notification

TABLE #	RECORD LAYOUT	UNIVERSE	COMPLIANCE STANDARD TO APPLY	CRITERIA (EFF. JANUARY 1, 2020)	TEST
6	EREC	Expedited Pre-service Reconsiderations	No later than 72 hours, plus 14 days (totaling 17 days) if an extension is used, for services or items. Late cases must be forwarded to the IRE within these timeframes.	42 CFR § 422.590(e) 42 CFR § 422.590(f) 42 CFR § 422.590(g)	Effectuation IRE Auto-Forward Notification
7	PREC	Requests for Payment Reconsiderations	No later than 60 days. Requests that are processed outside the required timeframe must be forwarded to the IRE within this timeframe.	42 CFR § 422.590(b)	Effectuation IRE Auto-Forward Notification
8	IREEFF	Pre-service IRE Cases Requiring Effectuation	No later than 14 days (for standard requests for service), or 72 hours (for expedited requests for service) after receipt of the notice of IRE reversal.	42 CFR § 422.618(b)(1) 42 CFR § 422.618(b)(3) 42 CFR § 422.619(b)	Effectuation
9	IREClaimsEFF	IRE Payment Cases Requiring Effectuation	Payment must be made no later than 30 days after receipt of the notice of IRE reversal.	42 CFR § 422.618(b)(2)	Effectuation
10	ALJMACEFF	All ALJ and MAC Cases Requiring Effectuation	The sponsor must pay for, authorize, or provide the service under dispute no later than 60 calendar days from the date it receives notice reversing the initial organization determination.	42 CFR § 422.618(c) 42 CFR § 422.619(c)	Effectuation
11	GRV_S	Part C Oral & Written Standard Grievances	No later than 30 days plus 14 days if an extension is used (totaling 44 days).	42 CFR § 422.564(e)(1) 42 CFR § 422.564(e)(2)	Notification
12	GRV_E	Part C Oral & Written Expedited Grievances	No later than 24 hours.	42 CFR § 422.564(f)	Notification

Audit Elements

I. Timeliness - Organization Determinations, Appeals and Grievances (TODAG)

(Performed via webinar prior to the entrance conference, results communicated to sponsor during live portion of the audit)

1. **Select Sample Cases:** CMS will randomly select 5 cases from record layouts 1 through 12 for a total of 60 cases.

2. **Verify Universe Submission:** Prior to the live portion of the audit, CMS or its contractor, when applicable, will schedule a separate webinar with the sponsor to verify that the dates and times provided in the universe submissions are accurate. The sponsor should have available the information and documents necessary to demonstrate that the dates and times provided in the record layouts were accurate. The sponsor will need access to the following documents during the live webinar and CMS may request the sponsor to produce screenshots of any of the following:

   2.1. For requests for organization determinations or reconsiderations:
   - Original pre-service or payment (i.e., claim) or reconsideration request.
   - Letters, emails or documentation confirming the sponsor's receipt of the 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.
   - Description of the service/benefit requested from the provider/physician or the enrollee.
   - Documentation of effectuation including approval in organization determinations/reconsiderations systems and evidence of effectuation in sponsor's claims adjudication system, clearly showing date and time override was entered.
   - Documentation showing approval notification to the enrollee and/or their representative and physician/provider, as applicable.
     - Copy of the written decision letter 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 of call.
   - Records indicating that payments were made/issued such as Electronic Fund Transfer (EFT) records.
   - Documentation showing denial notification to the enrollee and/or their representative and provider/physician, if applicable:
     - Copy of written decision letter 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 of call.
   - If applicable, all documentation to support the sponsor'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 a reconsidered case was untimely, include the following:
     - Documentation showing when the sponsor auto-forwarded the request to the IRE.

   2.2. For cases overturned by the IRE/ALJ/MAC:
   - Copy of overturn notice from IRE/ALJ/MAC including date/time stamp of receipt by sponsor.
   - Documentation of effectuation including approval in organization determinations/reconsiderations system(s) and evidence of effectuation in sponsor claims

system clearly showing date/time the override was entered.

- Copy of reconsideration effectuation notice to IRE including sent date/time stamp.
  - Screen print of all claims for the requested service after approval date
    - If denied, explanation why the service was denied (i.e., exceeds authorized number of visits).
    - If there are no claims for service after date of effectuation, narrative explaining member has not attempted to receive the service since the date of effectuation and a screen print showing all claims for members since date of effectuation.

3. **Apply Compliance Standards:** At a minimum, CMS will evaluate cases against the following criteria. CMS may review factors not specifically addressed in these questions if it is determined that there are other related ODAG requirements not being met.

3.1. Universe Accuracy Standard: CMS will test each of the 12 universes by confirming the data through the 5 selected cases (60 total cases). The integrity of the universe will be questioned if the timeliness data on more than 1 of the 5 selected sample cases observed during the audit does not match the data provided in the universe. If this occurs CMS will request a new universe to test timeliness for that universe. Sponsors will be expected to produce the new universe prior to the live portion of the audit per CMS instructions. If the sponsor cannot produce an accurate universe after three submissions, CMS will cite all applicable IDS conditions relative to timeliness.

3.1.1. Are the dates and times observed during the webinar in the sponsor's systems consistent with the universe submission?

Calculate Universe Timeliness: CMS or its contractor, when applicable, will then calculate the applicable timeliness tests as identified in the record layout chart above. Some universes will have two timeliness tests performed; one for effectuation of approvals and one for notification of all requests. Other universes may only have one timeliness test performed. For each timeliness test in the universe, the number of late cases will be divided by the total number of cases applicable for that test in each universe. For instance, for effectuation of standard organization determinations, all approvals that were effectuated untimely will be divided by all approvals in the universe. Once the percentage of late cases is determined, CMS will calculate the percentage of timely cases (100% - % late cases) and apply the compliance threshold for that test.

CMS has determined 3 timeliness thresholds that apply to every test in each universe. Sponsors that fall at or above the first threshold will generally not be cited a condition. Sponsors that fall within the second threshold will generally be cited for a corrective action required (CAR) for unmet timeliness requirements. Sponsors falling below the third threshold may be cited an immediate corrective action (ICAR) for unmet timeliness requirements.

3.2.1. Are the sponsor's universes timely in accordance with the CMS compliance standards referenced in the table above?

4. **Inform Sponsor of Results:** CMS will inform the sponsor of the results of its analysis for each of the 12 universes supplied during the live audit portion of the review; including if any conditions will be cited, and if so which condition(s).

II. Appropriateness of Clinical Decision-Making & Compliance with Organization Determinations and Appeals Processing Requirements

1. **Select Sample Cases:** CMS will select a targeted sample of 35 cases total that appear clinically significant from the pre-service and payment requests and IRE/ALJ/MAC reversal record layouts (Appendix A, Tables 1 through 10). CMS will attempt to ensure, to the extent possible, that the sample set is representative of various medical services (e.g., ER services, outpatient hospital, inpatient hospital, urgent care, etc.). CMS will generally select the sample set from the universe categories as follows:

   - 10 organization determination denials (5 pre-service and 5 payment);
   - 10 reconsideration denials (5 pre-service and 5 payment);
   - 10 IRE, ALJ, or MAC overturns (5 pre-service and 5 payment); and
   - 5 reconsideration approvals (standard and expedited).

   Note: For audit purposes, partially favorable decisions are treated as denials.

2. **Review Sample Case Documentation:** CMS will review all sample case file documentation for proper notification and clinical appropriateness of the decision. The sponsor will need access to the following documents during the live webinar and CMS may request the sponsor to produce screenshots of any of the following:

   2.1. For requests for organization determinations or reconsiderations:
   - Original pre-service or payment (i.e., claim or reimbursement request) or reconsideration request.
   - Letters, emails or documentation confirming the sponsor'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 sponsor 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; rationale for denial; any reference to CMS guidance, Federal Regulations, clinical criteria, peer reviewed literature (where allowed), and sponsor 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 sponsor'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 sponsor'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 reconsidered case was untimely, include the following:
  - Documentation showing the sponsor auto-forwarded the request to the IRE.

2.2. IRE, ALJ or MAC Overturns:

- Copy of overturn notice from IRE/ALJ/MAC.
- Documentation of effectuation including approval in organization determinations/reconsiderations system(s) and evidence of effectuation in sponsor claims system.
- Copy of effectuation notice to IRE.
  - Screen print of all claims for the requested service after approval date
    - If denied, explanation why the service was denied (i.e., exceeds authorized number of visits).
    - If there are no claims for service after date of effectuation, narrative explaining member has not attempted to receive the service since the date of effectuation and a screen print showing all claims for members since date of effectuation.

3. <u>Apply Compliance Standard</u>: At a minimum, CMS will evaluate cases against the following criteria. CMS may review factors not specifically addressed in these questions if it is determined that there are other related ODAG requirements not being met.

3.1. Clinical Appropriateness/Approvals:

3.1.1. Was appropriate notification (i.e., correct notice and approval language understandable for enrollee) provided to the enrollee (or representative) and provider/physician, if applicable?
3.1.2. If representative received response, was an appointment of representative (AOR), or other conforming instrument, on file?
3.1.3. Did the sponsor appropriately consider clinical information and comply with CMS coverage and notification requirements?
3.1.4. Did the sponsor make reasonable and diligent efforts to obtain all medical records and other pertinent documentation within the required timeframes, as necessary?
3.1.5. Did the sponsor effectuate the request in its system?

3.2. Clinical Appropriateness/Denials:

3.2.1. Was appropriate notification (i.e., correct notice and denial language understandable for enrollee; appeal rights for non-contract providers) provided to the enrollee (or representative) and provider/physician, if applicable?

3.2.2. If representative received response, was an appointment of representative (AOR), or other conforming instrument, on file?
3.2.3. Was the organization determination request reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise including knowledge of Medicare coverage criteria?
3.2.4. Was the reconsideration reviewed by a different physician with expertise in the field of medicine that is appropriate for the services at issue?
3.2.5. Did the sponsor appropriately consider clinical information and comply with CMS coverage and notification requirements?
3.2.6. Did the sponsor make reasonable and diligent efforts to obtain all medical records and other pertinent documentation within the required timeframes, as necessary?
3.2.7. If care or services were provided by a contract provider or a provider referred by a contract provider, was the member held harmless, unless notice was provided that services would not be covered?

3.3. IRE, ALJ or MAC Overturns: If a reviewer determines the IRE, ALJ or MAC reversal was in error, the case will pass. For all other IRE, ALJ and MAC cases, apply the following compliance criteria:

3.3.1. Did the IRE, ALJ or MAC receive additional information that would have changed the sponsor's decision to deny the case?
3.3.2. Did the sponsor attempt to obtain that information?

4. **Sample Case Results:** CMS will test each of the 35 cases. If CMS requirements are not met, conditions (findings) are cited. If CMS requirements are met, no conditions (findings) are cited.

NOTE: Cases and conditions may have a one-to-one or a one-to-many relationship. For example, one case may have a single condition or multiple conditions of non-compliance.

III. Grievances and Misclassification of Requests

1. **Select Sample Cases:** CMS will select a targeted sample of 20 total grievances: 15 from the standard grievances record layout and 5 from the expedited grievances record layout (Appendix A, Tables 11 and 12). If the sponsor does not have enough expedited grievances, the auditors sample additional cases from the standard grievance universe.

2. **Review Sample Case Documentation:** CMS will review all sample case file documentation to determine that grievances were appropriately classified and that the notification properly addressed the issue raised in the grievance. The sponsor will need access to the following documents or audio files during the live webinar and CMS may request the sponsor to produce screenshots or transcripts of any of the following:

   2.1. For Grievances:
   - Initial Complaint:
     - 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.
   - Any documentation explaining the issue.
   - Where applicable, copy of all notices, letters, call logs, or other documentation 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 sponsor took to resolve the issue and a description of the final resolution. Documentation showing the steps the sponsor took to resolve the issue may include, but is not limited to, appropriate correspondence with other departments within the organization; referral to the sponsor's fraud, waste, and abuse department; and outreach to providers.
   - Documentation showing the sponsor's investigation, follow-up steps, and description of the final grievance outcome. Include all notices, letters, and beneficiary 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.
   - For quality of care grievances: provide documentation that supports that an investigation and appropriate follow up (including issuance of written notice) took place.

3. **Apply Compliance Standard:** At a minimum, CMS will evaluate cases against the following criteria. CMS may review factors not specifically addressed in these questions if it is determined that there are other related ODAG requirements not being met.

   3.1. Was the grievance or call correctly classified, and, if not, was it transferred to the appropriate process?

   3.2. For grievances, did the grievance notification appropriately address all issues raised in the complaint?

4. **Sample Case Results:** CMS will test each of the 20 cases. If CMS requirements are not met, conditions (findings) are cited. If CMS requirements are met, no conditions (findings) are cited.

   NOTE: Cases and conditions may have a one-to-one or a one-to-many relationship. For example, one case may have a single condition or multiple conditions of non-compliance.

IV. Dismissals

1. **Select Sample Cases:** CMS will select a targeted sample of 15 dismissals as follows:

   - 5 pre-service dismissals;
   - 5 payment dismissals; and
   - 5 grievances.

2. **Review Sample Case Documentation:** For each case, the sponsor must be able to access all relevant documentation during the webinar and provide screen shots of any applicable documentation, including, but not limited to:
   - The pre-service or payment (i.e., claim) organization determination request.
   - The pre-service or payment reconsideration request.
   - Letters, emails or documentation confirming the sponsor's receipt of the request.
   - Notices, letters, or other documentation showing the sponsor requested additional information and/or attempted to obtain the missing documentation (i.e., the Waiver of Liability (WOL) or Appointment of Representative (AOR), or other conforming instrument) from the requesting provider/physician or purported representative, including date, time and type of communication.
   - All supplemental information submitted by the requesting provider/physician or representative, including documentation showing when the information was received by the sponsor.
   - Written notice of dismissal.
     - If applicable, providing timely notification of dismissals to enrollees or another party, and informing enrollees and other parties about the right to request IRE review of the dismissal since sponsors will no longer automatically forward such reconsideration cases to the IRE for review.

3. **Apply Compliance Standard:** At a minimum, CMS will evaluate cases against the following criteria. CMS may review factors not specifically addressed in these questions if it is determined that there are other related ODAG requirements not being met.

   3.1. Did the sponsor make a reasonable effort to obtain the AOR (or other conforming instrument) or WOL and document those efforts in the case file?

   3.2. Did the sponsor send a written notice of the dismissal to the parties at their last known addresses within the applicable adjudication timeframe pursuant to the requirements of 42 CFR Part 422, Subpart M?

   3.3. Did the dismissal notice state the reason for the dismissal?

   3.4. Did the dismissal notice explain the right to request IRE review of the dismissal within 60 calendar days after receipt of the written notice of the sponsor's dismissal?

   3.5. If applicable, did the sponsor assemble and forward the case file to the IRE within 24 hours of receiving the IRE's case file request?

4. **Sample Case Results:** CMS will test each of the 15 cases. If CMS requirements are not met, conditions (findings) are cited. If CMS requirements are met, no conditions (findings) are cited.

   NOTE: Cases and conditions may have a one-to-one or a one-to-many relationship. For example, one case may have a single condition or multiple conditions of non-compliance.

Appendix

Appendix A—Organization Determinations, Appeals, and Grievances (ODAG) Record Layouts

The universes for the Part C Organization Determination, Appeals and Grievances (ODAG) program area must be submitted as a Microsoft Excel (.xlsx) file with a header row reflecting the field names or Text (.txt) file without a header row. Do not include additional information outside of what is dictated in the record layout. Submissions that do not strictly adhere to the record layout will be rejected.

Please use a comma (,) to separate multiple values within one field if there is more than one piece of information for a specific field. Please ensure that all cases in your universes are populated based on the time zone where the request was received.

If you do not have data for any of the fields identified below, please discuss that with your Auditor in Charge (AIC) prior to populating or submitting your universes.

Note: There is a maximum of 4,000 characters per record row and spaces count toward this 4,000 character limit. Therefore, should additional characters be needed for a variable, enter this information on the next record at the appropriate start position.

Table 1: Standard Pre-service Organization Determinations (SOD) Record Layout

- Include all requests processed as standard pre-service organization determinations, including all supplemental services, such as dental and vision, and include all approvals and denials.
- Exclude payment requests, dismissals, reopenings, withdrawn requests, all requests processed as expedited organization determinations, and all requests that do not require a prior authorization.
- Exclude requests for concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions.
- Submit cases based on the date the sponsor's decision was rendered, or should have been rendered (the date the request was initiated may fall outside of the review period).
- If a standard 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.

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.

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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the sponsor for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Who made the request?	CHAR Always Required	3	Indicate whether the pre-service request was made by a contract provider (CP), non-contract provider (NCP), beneficiary (B) or beneficiary's representative (BR). Note: the term "provider" encompasses physicians and facilities.
H	Provider Type	CHAR Always Required	3	Indicate whether the provider performing the service is a contract provider (CP) or non-contract provider (NCP).
I	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
J	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
K	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the pre-service request was denied.

Column ID	Field Name	Field Type	Field Length	Description
L	Was request made under the expedited timeframe but processed by the plan under the standard timeframe?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the request was made under an expedited timeframe but was processed under the standard timeframe.
M	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the sponsor extended the timeframe to make the organization determination.
N	If an extension was taken, did the sponsor notify the member of the reason(s) for the delay and of their right to file an expedited grievance?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the sponsor notified the beneficiary of the delay. Answer NA if no extension was taken.
O	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. Sponsors should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
P	Date of sponsor decision	CHAR Always Required	10	Date of the sponsor decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Sponsors should answer NA for untimely cases that are still open.
Q	Was the request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.
R	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). Answer NA if no oral notification.
S	Date written notification provided to enrollee	CHAR Always Required	10	Date written notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification.
T	Date service authorization entered/effectuated in the sponsor's system	CHAR Always Required	10	Date service authorization entered in the sponsor's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials.
U	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.

Column ID	Field Name	Field Type	Field Length	Description
V	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the standard pre-service organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 2: Expedited Pre-service Organization Determinations (EOD) Record Layout

- Include all requests processed as expedited pre-service organization determinations, including all supplemental services, such as dental and vision, and include all approvals and denials.
- Exclude payment requests, dismissals, reopenings, withdrawn requests, all requests processed as standard organization determinations, and all requests that do not require a prior authorization.
- Exclude requests for concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions.
- Submit cases based on the date the sponsor's decision was rendered, or should have been rendered (the date the request was initiated may fall outside of the review period).
- If an expedited 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.

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the sponsor for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Who made the request?	CHAR Always Required	3	Indicate whether the pre-service request was made by a contract provider (CP), non-contract provider (NCP), beneficiary (B) or beneficiary's representative (BR). Note: the term "provider" encompasses physicians and facilities.

Column ID	Field Name	Field Type	Field Length	Description
H	Provider Type	CHAR Always Required	3	Indicate whether the provider performing the service is a contract provider (CP) or non-contract provider (NCP).
I	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Note: If the request was received as a standard organization determination request, but later expedited, enter the date of the request to expedite the organization determination.
J	Time the request was received	CHAR Always Required	8	Provide the time the request was received by your organization. Submit in HH:MM:SS military time format (e.g., 23:59:59). Note: If the request was received as a standard organization determination request, but later expedited, enter the time of the request to expedite the organization determination.
K	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
L	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the expedited pre-service request was denied.
M	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the Sponsor extended the timeframe to make the organization determination.
N	If an extension was taken, did the sponsor notify the member of the reason(s) for the delay and of their right to file an expedited grievance?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the sponsor notified the beneficiary of the delay. Answer NA if no extension was taken.
O	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. Sponsors should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
P	Date of sponsor decision	CHAR Always Required	10	Date of the sponsor decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Sponsors should answer NA for untimely cases that are still open.

Column ID	Field Name	Field Type	Field Length	Description
Q	Time of sponsor decision	CHAR Always Required	8	Time of the sponsor decision (e.g., approved, denied). Submit in HH:MM:SS military time format (e.g., 23:59:59). Sponsors should answer NA for untimely cases that are still open.
R	Was the request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.
S	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). Answer NA if no oral notification.
T	Time oral notification provided to enrollee	CHAR Always Required	8	Time oral notification provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no oral notification.
U	Date written notification provided to enrollee	CHAR Always Required	10	Date written notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided.
V	Time written notification provided to enrollee	CHAR Always Required	8	Time written notification provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no written notification was provided.
W	Date service authorization entered/effectuated in the sponsor's system	CHAR Always Required	10	Date service authorization was entered in the sponsor's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials.
X	Time service authorization entered/effectuated in the sponsor's system	CHAR Always Required	8	Time service authorization entered in the sponsor's system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA for denials.
Y	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.
Z	AOR receipt time	CHAR Always Required	8	Time the Appointment of Representative (AOR) form or other appropriate documentation received by sponsor. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no AOR form was required.
AA	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the expedited organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 3: Requests for Payment Organization Determinations (Claims) Record Layout

- Include all requests processed as both contract and non-contract provider denied claims and only non-contract provider paid claims.
- Exclude all requests processed as direct member reimbursements, dismissals, duplicate claims and payment adjustments to claims, reopenings, claims denied for invalid billing codes, denied claims for beneficiaries who are not enrolled on the date of service, withdrawn requests and claims denied due to recoupment of payment.
- Submit payment organization determinations (claims) based on the date the claim was paid, or should have been paid, or the notification date of the denial, or the date the denial notification should have been sent (the date the request was initiated may fall outside of the review period).
- If a claim has more than one line item, include all of the claim's line items in a single row and enter the multiple line items as a single claim.

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated claim or payment request number assigned by the sponsor for this request. If a claim or payment request number is not available, please provide your internal tracking or case number. Answer NA if there is no claim, payment request or other tracking number available.
G	Provider Type	CHAR Always Required	3	Indicate whether the provider who performed the service is a contract (CP) or non-contract provider (NCP). Note: the term "provider" encompasses physicians and facilities.
H	Is this a clean claim?	CHAR Always Required	2	Yes/No indicator flag to indicate whether the claim is clean (Y) or unclean (N). Answer NA for untimely requests that are still open or if clean status has not yet been determined.

Column ID	Field Name	Field Type	Field Length	Description
I	Date the request was received	CHAR Always Required	10	Provide the date the payment request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
J	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
K	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the claim was denied.
L	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. Sponsors should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
M	Date the claim was paid	CHAR Always Required	10	Date the claim was paid. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer DENIED for claims that were denied. Answer NA for untimely cases that are still open.
N	Was interest paid on the claim?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether interest was paid on the claim.
O	Was the request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.
P	Date written notification provided to enrollee	CHAR Always Required	10	Date written notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer Pending if written notification has not yet been provided, but is anticipated to be provided in a forthcoming EOB or IDN notice. Answer NA if no written notification provided to the enrollee.
Q	Date written notification provided to provider	CHAR Always Required	10	Date written notification provided to the provider. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided.
R	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the claim (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 4: Direct Member Reimbursement (DMR) Requests Record Layout

- Include all requests processed as direct member reimbursements, including approvals, denials, partial approvals, reconsiderations and non-contract provider claim reconsiderations submitted by beneficiaries.
- Exclude all requests processed as contract and non-contract provider claims, reopenings and dismissals.
- Exclude requests for concurrent review for inpatient hospital and SNF services, post-service reviews, withdrawn requests, and notifications of admissions.
- Submit direct member reimbursement requests based on the date the reimbursement was issued, or should have been issued, or the notification date of the denial, or the date the denial notification should have been sent (the date the request was initiated may fall outside of the review period).
- If a reimbursement request has more than one line item, include all of the request's line items in a single row and enter the multiple line items as a single reimbursement request.

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated claim or payment request number assigned by the sponsor for this request. If a claim or payment request number is not available, please provide your internal tracking or case number. Answer NA if there is no claim, payment request or other tracking number available.
G	Person who made the request	CHAR Always Required	2	Indicate whether the payment request was made by a beneficiary (B) or beneficiary's representative (BR).
H	Provider Type	CHAR Always Required	3	Indicate whether the provider who performed the service is a contract provider (CP) or non-contract provider (NCP).

Column ID	Field Name	Field Type	Field Length	Description
I	Date the request was received	CHAR Always Required	10	Provide the date the reimbursement request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
J	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
K	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the direct member reimbursement request was denied.
L	Request Disposition	CHAR Always Required	41	Status of the request. Valid values are: approved, denied, denied with IRE auto forward or IRE auto-forward due to untimely decision. Sponsors should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
M	Date reimbursement paid	CHAR Always Required	10	Date the sponsor issued payment to the member or provider. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer DENIED for reimbursement requests that were denied. Sponsors should answer NA for untimely cases that are still open.
N	Was interest paid on the reimbursement request?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether interest was paid on the reimbursement request.
O	Date written notification provided to enrollee	CHAR Always Required	10	Date written notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer Pending if written notification has not yet been provided, but is anticipated to be provided in a forthcoming EOB notice. Answer Untimely if reimbursement request was not timely paid or denied.
P	Date forwarded to IRE if denied or untimely	CHAR Always Required	10	Date the sponsor forwarded request to the IRE if request denied or untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if approved, request was an organization determination or not forwarded to IRE.
Q	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.
R	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the direct member reimbursement request (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 5: Standard Pre-service Reconsiderations (SREC) Record Layout

- Include all requests processed as standard pre-service reconsiderations.
- Exclude all requests processed as expedited reconsiderations, dismissals, reopenings and withdrawn reconsideration requests.
- Exclude requests for concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions.
- Submit cases based on the date the sponsor's decision was rendered, or should have been rendered (the date the request was initiated may fall outside of the review period).

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the sponsor for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Who made the request?	CHAR Always Required	3	Indicate whether the reconsideration request was made by a contract provider (CP), non-contract provider (NCP), beneficiary (B) or beneficiary's representative (BR). Note: the term "provider" encompasses physicians and facilities.
H	Provider Type	CHAR Always Required	3	Indicate whether the provider performing the service is a contract provider (CP) or non-contract provider (NCP).
I	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).

Column ID	Field Name	Field Type	Field Length	Description
J	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
K	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the pre-service reconsideration was denied.
L	Was request made under the expedited timeframe but processed by the plan under the standard timeframe?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request made under an expedited timeframe was processed under the standard timeframe (e.g., based on the sponsor deciding that the expedited pre-service request was unnecessary). Answer NA if the request was received as a standard request.
M	Request for expedited timeframe	CHAR Always Requested	3	If an expedited timeframe was requested, indicate who requested the expedited reconsideration timeframe: non-contract provider (NCP), beneficiary (B) or beneficiary's representative (BR). Answer NA if no expedited timeframe was requested. Answer BR if a contract provider submitted an expedited reconsideration request as the enrollee's representative.
N	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the Sponsor extended the timeframe to make the determination.
O	If an extension was taken, did the sponsor notify the member of the reason(s) for the delay and of their right to file an expedited grievance?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the sponsor notified the beneficiary of the delay. Answer NA if no extension was taken.
P	Request Disposition	CHAR Always Required	41	Status of the request. Valid values are: approved, denied, denied with IRE auto forward or IRE auto-forward due to untimely decision. Sponsors should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
Q	Date of sponsor decision	CHAR Always Required	10	Date of the sponsor decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Sponsors should answer NA for untimely cases that are still open.
R	Was the organization determination denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the initial request was denied for lack of medical necessity. Answer No if the initial request was denied because it was untimely.

Column ID	Field Name	Field Type	Field Length	Description
S	Date written notification provided to enrollee/provider	CHAR Always Required	10	Date written notification provided to enrollee, if the decision was favorable, or if applicable, the non-contract provider. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Otherwise, answer NA if denied or no written notification was provided.
T	Date service authorization entered/effectuated in the sponsor's system	CHAR Always Required	10	Date authorization entered in the sponsor's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials and IRE auto-forwards.
U	Date forwarded to IRE if denied or untimely	CHAR Always Required	10	Date the sponsor forwarded request to the IRE if request denied or untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if approved or not forwarded to IRE.
V	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.
W	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the standard pre-service reconsideration (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 6: Expedited Pre-service Reconsiderations (EREC) Record Layout

- Include all requests processed as expedited pre-service reconsiderations.
- Exclude all requests processed as standard reconsiderations, dismissals, reopenings and withdrawn reconsideration requests.
- Exclude requests for concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions.
- Submit cases based on the date the sponsor's decision was rendered, or should have been rendered (the date the request was initiated may fall outside of the review period).

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the sponsor for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Who made the request?	CHAR Always Required	3	Indicate whether the reconsideration request was made by a contract provider (CP), non-contract provider (NCP), beneficiary (B) or beneficiary's representative (BR). Note: the term "provider" encompasses physicians and facilities.
H	Provider Type	CHAR Always Required	3	Indicate whether the provider performing the service is a contract provider (CP) or non-contract provider (NCP).

Column ID	Field Name	Field Type	Field Length	Description
I	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Note: If the request was received as a standard reconsideration request, but later expedited, enter the date of the request to expedite the reconsideration.
J	Time the request was received	CHAR Always Required	8	Provide the time the request was received by your organization. Submit in HH:MM:SS military time format (e.g., 23:59:59). Note: If the request was received as a standard reconsideration request, but later expedited, enter the time of the request to expedite the reconsideration.
K	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
L	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the expedited pre-service reconsideration was denied.
M	Request for expedited timeframe	CHAR Always Requested	3	If an expedited timeframe was requested, indicate who requested the expedited reconsideration timeframe: contract provider (CP), non-contract provider (NCP), beneficiary (B), beneficiary's representative (BR) or sponsor (S). Answer BR if a contract provider submitted the expedited reconsideration request on behalf of an enrollee.
N	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the Sponsor extended the timeframe to make the determination.
O	If an extension was taken, did the sponsor notify the member of the reason(s) for the delay and of their right to file an expedited grievance?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the sponsor notified the beneficiary of the delay. Answer NA if no extension was taken.
P	Request Disposition	CHAR Always Required	41	Status of the request. Valid values are: approved, denied, denied with IRE auto forward or IRE auto-forward due to untimely decision. Sponsors should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.

Column ID	Field Name	Field Type	Field Length	Description
Q	Date of sponsor decision	CHAR Always Required	10	Date of the sponsor decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Sponsors should answer NA for untimely cases that are still open.
R	Time of sponsor decision	CHAR Always Required	8	Time of the sponsor decision (e.g., approved or denied). Submit in HH:MM:SS military time format (e.g., 23:59:59). Sponsors should answer NA for untimely cases that are still open.
S	Was the organization determination denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the initial request was denied for lack of medical necessity. Answer No if the initial request was denied because it was untimely.
T	Date oral notification provided to enrollee	CHAR Always Required	10	Date oral notification provided to enrollee, if decision was favorable. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Otherwise, answer NA if no oral notification was provided.
U	Time oral notification provided to enrollee	CHAR Always Required	8	Time oral notification provided to enrollee, if decision was favorable. Submit in HH:MM:SS military time format (e.g., 23:59:59). Otherwise, answer NA if no oral notification was provided.
V	Date written notification provided to enrollee	CHAR Always Required	10	Date written notification provided to enrollee, if the decision was favorable. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Otherwise, answer NA if denied or no written notification was provided.
W	Time written notification provided to enrollee	CHAR Always Required	8	Time written notification provided to enrollee, if decision was favorable. Submit in HH:MM:SS military time format (e.g., 23:59:59). Otherwise, answer NA if denied or no written notification was provided.
X	Date service authorization entered/effectuated in the sponsor's system	CHAR Always Required	10	Date authorization entered/effectuated in the sponsor's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials and IRE auto-forwards.
Y	Time service authorization entered/effectuated in the sponsor's system	CHAR Always Required	8	Time authorization entered/effectuated in the sponsor's system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA for denials and IRE auto-forwards.
Z	Date forwarded to IRE if denied or untimely	CHAR Always Required	10	Date the sponsor forwarded request to the IRE if request denied or untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if the request was favorable or was not forwarded to the IRE.
AA	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.

Column ID	Field Name	Field Type	Field Length	Description
AB	AOR receipt time	CHAR Always Required	8	Time the Appointment of Representative (AOR) form or other appropriate documentation received by sponsor. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no AOR form was required.
AC	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the expedited pre-service reconsideration (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 7: Requests for Payment Reconsiderations (PREC) Record Layout

- Include all requests processed as payment reconsiderations from non-contract providers.
- Exclude all requests processed as direct member reimbursements and direct member reimbursement reconsideration requests, dismissals, reopenings, duplicate reconsideration requests and payment adjustments to reconsideration requests, reopenings, reconsideration requests denied for invalid billing codes, denied reconsideration requests for beneficiaries who are not enrolled on the date of service and reconsideration requests denied due to recoupment of payment.
- Exclude requests for concurrent review for inpatient hospital and SNF services, post-service reviews, withdrawn requests, and notifications of admissions.
- Submit payment reconsiderations based on the date the reconsideration was paid or denied, or should have been paid or denied (the date the request was initiated may fall outside of the review period).
- If a reconsideration request has more than one line item, include all of the request's line items in a single row and enter the multiple line items as a single request.

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated claim or payment request number assigned by the sponsor for this request. If a claim or payment request number is not available, please provide your internal tracking or case number. Answer NA if there is no claim, payment request or other tracking number available.
G	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).

Column ID	Field Name	Field Type	Field Length	Description
H	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
I	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the claim reconsideration was denied.
J	Request Disposition	CHAR Always Required	41	Status of the request. Valid values are: approved, denied, denied with IRE auto forward or IRE auto-forward due to untimely decision. Sponsors should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
K	Date the reconsideration request was paid	CHAR Always Required	10	Date the reconsideration request was paid. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Sponsors should answer NA for untimely cases that are still open.
L	Was interest paid on the reconsideration request?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether interest was paid on the reconsideration request.
M	Was the organization determination denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the initial request was denied for lack of medical necessity. Answer No if the request was denied because it was untimely.
N	Date written notification provided to provider	CHAR Always Required	10	Date notification provided to the provider. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided.
O	Date forwarded to IRE if denied or untimely	CHAR Always Required	10	Date the sponsor forwarded request to the IRE if request denied or untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if reconsideration was approved.
P	WOL Receipt date	CHAR Always Required	10	Date the Waiver of Liability (WOL) form received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no WOL form was required.
Q	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the payment reconsideration (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 8: Pre-service IRE Cases Requiring Effectuation (IREEFF) Record Layout

- Include all requests processed as pre-service cases overturned by the IRE, including standard and expedited cases (i.e., a favorable decision was rendered by the IRE).
- Exclude all requests processed as dismissals, requests for payment and unfavorable requests where the IRE upheld the denial.
- Exclude requests for concurrent review for inpatient hospital and SNF services, post-service reviews, withdrawn requests, and notifications of admissions.
- Submit cases based on the date of receipt of the IRE overturn decision (the date the request was initiated may fall outside of the review period).

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the sponsor for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
H	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the request was denied before going to the IRE.
I	Request for expedited timeframe	CHAR Always Requested	1	Indicate whether the pre-service request was processed under the expedited (E) timeframe or standard (S) timeframe.

Column ID	Field Name	Field Type	Field Length	Description
J	Date of receipt of IRE decision	CHAR Always Required	10	Date the sponsor received the IRE overturn decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
K	Time of receipt of IRE decision	CHAR Always Required	8	Provide the time the sponsor received the IRE overturn decision. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if the request was not expedited.
L	Date service authorization entered/effectuated in the sponsor's system	CHAR Always Required	10	Date the IRE determination was effectuated in the sponsor's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
M	Time service authorization entered/effectuated in the sponsor's system	CHAR Always Required	8	Time effectuated in the sponsor's system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if the request was not expedited.
N	Date written notification provided to IRE	CHAR Always Required	10	Date written notification of sponsor's effectuation sent to IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
O	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the effectuation (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 9: IRE Payment Cases Requiring Effectuation (IREClaimsEFF) Record Layout

- Include all requests overturned by the IRE that were processed as non-contract provider payment or direct member reimbursement requests (i.e., a favorable decision was rendered by the IRE).
- Exclude all requests processed as dismissals, pre-service requests and unfavorable requests where the IRE upheld the denial.
- Exclude requests for concurrent review for inpatient hospital and SNF services, post-service reviews, withdrawn requests, and notifications of admissions.
- Submit cases based on the date of receipt of the IRE overturn decision (the date the request was initiated may fall outside of the review period).

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated claim or payment request number assigned by the sponsor for this request. If a claim or payment request number is not available, please provide your internal tracking or case number. Answer NA if there is no claim, payment request or other tracking number available.
G	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
H	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the request was denied before going to the IRE.

Column ID	Field Name	Field Type	Field Length	Description
I	Was interest paid on the claim or reimbursement request?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether interest was paid on the claim or reimbursement request.
J	Date of receipt of IRE decision	CHAR Always Required	10	Date the sponsor received the IRE overturn decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
K	Date service authorization entered/effectuated in the sponsor's system	CHAR Always Required	10	Date the IRE overturn decision was effectuated in the sponsor's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
L	Date written notification provided to IRE	CHAR Always Required	10	Date written notification of sponsor's effectuation sent to IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
M	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the effectuation (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 10: All Part C ALJ and MAC Cases Requiring Effectuation (ALJMACEFF) Record Layout

- Include all requests processed as overturned by the ALJ or MAC, including standard and expedited cases, both pre-service and payment (i.e., a favorable decision was rendered by the ALJ or MAC).
- Exclude all requests processed as dismissals and unfavorable requests where the ALJ or MAC upheld the denial.
- Exclude requests for concurrent review for inpatient hospital and SNF services, post-service reviews, withdrawn requests, and notifications of admissions.
- Submit cases based on the date of receipt of the ALJ or MAC overturn decision (the date the request was initiated may fall outside of the review period).

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization, claim or payment request number assigned by the sponsor for this request. If an authorization, claim or payment request number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization, claim, payment request or other tracking number available.
G	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
H	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the request was denied before going to the ALJ/MAC.

Column ID	Field Name	Field Type	Field Length	Description
I	Request for expedited timeframe	CHAR Always Requested	2	Indicate whether the pre-service request was processed under the expedited (E) timeframe or standard (S) timeframe. Answer NA for payment requests.
J	Was interest paid on the claim or reimbursement request?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether interest was paid on the claim or reimbursement request. Answer NA if a pre-service request.
K	Date of receipt of ALJ/MAC decision	CHAR Always Required	10	Date the sponsor received the ALJ/MAC overturn decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
L	Did sponsor appeal ALJ decision to MAC?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the sponsor appealed the ALJ decision to the MAC.
M	Date written notification provided to enrollee	CHAR Always Required	10	If sponsor appealed the ALJ's decision to the MAC, provide the date written notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if the ALJ's decision was not appealed to the MAC.
N	Date service authorization entered/effectuated in the sponsor's system	CHAR Always Required	10	Date the ALJ/MAC overturn decision was effectuated in the sponsor's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
O	Date written notification provided to IRE	CHAR Always Required	10	Date written notification of sponsor's effectuation sent to IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
P	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the effectuation (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 11: Part C Oral & Written Standard Grievances (GRV_S) Record Layout

- Include all requests processed as standard oral and written grievances.
- Exclude all requests processed as expedited oral and written grievances, dismissals, withdrawn requests, and CTM complaints.
- Submit cases based on the date the resolution notification was issued or the date the resolution notification should have been issued (the date the grievance was received may fall outside of the review period).

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Person who made the request	CHAR Always Required	2	Indicate whether the grievance was submitted by a beneficiary (B) or a beneficiary's representative (BR).
G	Date Grievance/Complaint was Received	CHAR Always Required	10	Date the grievance/complaint was received from the beneficiary or their authorized representative. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
H	How was the grievance/complaint received?	CHAR Always Required	7	Describe how the grievance/complaint was first received from the beneficiary or authorized representative. Valid values include: Oral or Written.
I	Category of the grievance/complaint	CHAR Always Required	54	Category of the grievance/complaint. At a minimum categories must include each of the following: Enrollment/Disenrollment, Benefit Package, Access, Marketing, Customer Service, Organization Determination and Reconsideration Process, Quality of Care, Grievances Related to "CMS" Issues, and Other.
J	Grievance/complaint Description	CHAR Always Required	1,800	Provide a description of the grievance/complaint issue.

Column ID	Field Name	Field Type	Field Length	Description
K	Was this a quality of care grievance?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the grievance was a quality of care grievance.
L	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the Sponsor extended the timeframe to respond to the grievance/complaint.
M	If an extension was taken, did the sponsor notify the member of the reason(s) for the delay?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the sponsor notified the beneficiary of the delay. Answer NA if an extension was not taken.
N	If the extension was taken because the sponsor needed more information, did the notice include how the delay was in the best interest of the enrollee?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the sponsor notified the beneficiary of how the extension of the timeframe was in the interest of the beneficiary. Answer NA if an extension was not taken.
O	Date oral notification of resolution provided to enrollee	CHAR Always Required	10	Date oral notification of resolution provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no oral notification was provided to the enrollee.
P	Date written notification of resolution provided to enrollee	CHAR Always Required	10	Date written notification of resolution provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided to the enrollee.
Q	Resolution Description	CHAR Always Required	1,800	Provide a full description of the grievance resolution.
R	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.
S	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the grievance/complaint (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 12: Part C Oral & Written Expedited Grievances (GRV_E) Record Layout

- Include all requests processed as expedited oral and written grievances.
- Exclude all requests processed as standard oral and written grievances, dismissals, withdrawn requests, and CTM complaints.
- Submit cases based on the date the resolution notification was issued or the date the resolution notification should have been issued (the date the grievance was received may fall outside of the review period).

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Person who made the request	CHAR Always Required	2	Indicate whether the grievance was submitted by a beneficiary (B) or a beneficiary's representative (BR).
G	Date Grievance/Complaint was Received	CHAR Always Required	10	Date the grievance/complaint was received from the beneficiary or their authorized representative. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
H	Time Grievance/Complaint was Received	CHAR Always Required	8	Provide the time the grievance/complaint was received from the beneficiary or their authorized representative. Time is in HH:MM:SS military time format (e.g., 23:59:59).
I	How was the grievance/complaint received?	CHAR Always Required	7	Describe how the grievance/complaint was first received from the beneficiary or authorized representative. Valid values include: Oral or Written.

Column ID	Filed Name	Field Type	Field Length	Description
J	Category of the grievance/complaint	CHAR Always Required	3	Category of the grievance/complaint. Indicate whether the expedited grievance was submitted by the enrollee because the plan declined to process a case on the expedited timeframe (ETD) or whether it was submitted due to the enrollee's dissatisfaction with the plan taking a processing timeframe extension (PTE).
K	Grievance/complaint Description	CHAR Always Required	1,800	Provide a description of the grievance/complaint issue.
L	Date oral notification of resolution provided to enrollee	CHAR Always Required	10	Date oral notification of resolution provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no oral notification provided to enrollee.
M	Time oral notification of resolution provided to enrollee	CHAR Always Required	8	Time oral notification of resolution provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no oral notification provided to enrollee.
N	Date written notification of resolution provided to enrollee	CHAR Always Required	10	Date written notification of resolution provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided to enrollee.
O	Time written notification of resolution provided to enrollee	CHAR Always Required	8	Time written notification provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no written notification was provided to enrollee.
P	Resolution Description	CHAR Always Required	1,800	Provide a full description of the grievance resolution.
Q	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.
R	AOR receipt time	CHAR Always Required	8	Time the Appointment of Representative (AOR) Form or other appropriate documentation received by sponsor. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no AOR form was required.
S	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the grievance/complaint (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 13: Dismissals Record Layout

- Include all requests processed as sponsor dismissals.
- Submit cases based on the dismissal date (the date the request was initiated may fall outside of the review period), or based on the date the IRE requested information from the plan for a case that was appealed to the IRE after it was dismissed by the plan.

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
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	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the sponsor for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Who made the request?	CHAR Always Required	3	Indicate whether the request was made by a contract provider (CP), non-contract provider (NCP), beneficiary (B) or beneficiary's representative (BR).
H	Type of Request	CHAR Always Required	45	Identify the type of request that was dismissed. Valid values are: grievance, pre-service organization determination, pre-service reconsideration, non-contract provider claim, direct member reimbursement request, non-contract provider payment reconsideration, or DMR reconsideration.
I	Provider Type	CHAR Always Required	3	Indicate whether the provider who has or will be performing the service is a contract provider (CP) or non-contract provider (NCP). Answer NA for grievances that do not involve providers or if a request was dismissed before it was possible to determine whether the provider was contract or non-contract provider.
J	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).

Column ID	Field Name	Field Type	Field Length	Description
K	Description of the Issue	CHAR Always Required	300	Provide a description of the service requested, and why it was requested (if known).
L	Is this an expedited or standard request?	CHAR Always Required	1	Answer E if request was an expedited request or S if a request was a standard request.
M	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the sponsor extended the timeframe before dismissing the request.
N	Date the request was dismissed	CHAR Always Required	10	Provide the date the request was dismissed by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
O	Reason for Dismissal	CHAR Always Required	300	Provide a description of why the request was dismissed. Valid values include, but are not limited to: • No AOR form • No WOL • Untimely filing
P	Date written notification provided to enrollee/provider	CHAR Always Required	10	Provide the date the dismissal notice was sent to the enrollee or provider. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
Q	Appealed to IRE?	CHAR Always Required	1	Yes (Y) / No (N) indicator of whether the dismissal was appealed to the IRE.
R	Date forwarded to IRE	CHAR Always Required	10	Provide the date the case file was forwarded to the IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer "NA" if the case was not appealed to the IRE.
S	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the dismissal (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.