

**Instructions:**

- Enter responses to each question in the Utilization Management (UM) Supplemental Questions tab of this document.
- Responses must reflect practices, policies, and procedures in place during the data collection period. The data collection period begins January 1 of the calendar year your organization received your audit engagement letter through the date of your audit engagement letter. For example, an audit engagement letter is issued on April 4, 2026. The audit review period for this audit is January 1, 2026 through April 4, 2026.

**Due Date:** This document must be completed and submitted to HPMS within 5 business days following the issuance of the audit engagement letter.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is OMB 0938-New. This information collection will allow CMS to conduct a comprehensive review of Sponsoring organizations' compliance with Medicare Part C utilization management (UM) requirements. The time required to complete this information collection is estimated at 410 hours per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory per CMS's authority under Section 1857(d) of the Social Security Act and implementing regulations at 42 CFR § 422.503 and § 422.504, which state that CMS must oversee a Medicare Advantage (MA) organization's continued compliance with the requirements for a MA organization. Additionally, per § 422.516(a), MA organizations are required to compile and report to CMS information related to the utilization of services, and other matters as CMS may require. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Questions on Public Availability of Internal Coverage Criteria		
Question #	Question	Response
1	Can members, non-members, and providers all access internal coverage criteria through your organization's website?  If no, please explain who cannot access the criteria via this method.	
2	Would members, non-members, and providers access the same link for internal coverage criteria or are there separate links based on who is accessing the criteria?  If separate links, please provide each link.	
3	Describe steps members, non-members, and providers have to take to access internal coverage criteria. This includes any navigation steps (accessing different websites) and includes any required information that has to be submitted such as names, phone numbers, etc.  If there are different processes based on who is accessing the criteria (i.e., providers or beneficiaries), please describe each process separately.	
4	Can members, non-members, and providers clearly identify which services the organization has internal coverage criteria for, and which services do not have internal coverage criteria? Please explain.	
Questions on Utilization Management Committee		
Question #	Question	Response
5	How often does your Utilization Management (UM) committee meet to discuss prior authorization and utilization management practices?	
6	Has your UM committee reviewed and approved each and every internal coverage criteria document/guideline/tool that is currently being utilized by your organization?	
7	Please explain how your UM committee documents their review and approval of individual UM internal coverage criteria documents?	
Question on First Tier, Downstream, and Related Entities (FDRs)		
Question #	Question	Response
8	Identify all FDRs that process coverage or payment decisions for the organization, including but not limited to processing organization determinations, redeterminations, concurrent reviews, retrospective reviews, etc. For each FDR listed, include what type of coverage and/or payment review the FDR does on behalf of the organization and the applicable item, service, or Part B drug.	