60-day Package	Revised/New in 30-day Package	Reason for Change
		Previously, there were elements that only applied to either a coverage request or a payment request and this could have been confusing to report. This change was also in response to comments related to whether the reporting applies to both pre-service and payment requests. By separating each section this clarifies the expectation for reporting of both pre-service/coverage and payment requests.
There were two reporting sections with no subsections- Initial Determinations and Appeals	There are now two subsections for each reporting section - Initial Determinations (coverage decisions), Initial Determinations (payment), Reconsiderations (coverage decisions), Reconsiderations (payment)	
	Revised Reporting Elements for Initial Determinations (coverage decisions): Organization Determination Number Contract Number Plan Benefit Package (PBP) Enrollee MBI Requesting Party Provider NPI Item/Service/Part B Drug Code Item/Service/Part B Drug Description Diagnosis Codes Was prior authorization required? Was this a concurrent review decision? Processing Priority Was expedited processing requested? Date Request Received Date of Decision Notification Disposition Dismissal Rationale (if applicable) Decision Rationale Reviewer Qualifications Were internal plan coverage criteria applied? Did a third-party vendor participate, in any capacity, in the determination’s review or decision-making?	Based on comments and upon further review, there have been several revisions to the elements. We have reworded/rephrased some elements to improve clarity and the addition of new elements in each reporting section will allow CMS to broaden the scope of review for each case. Many commenters requested clarification around what is a "voluntary pre-service request". As a result, we revised this element to avoid confusion and will gather the information needed by asking if prior-authorization was required. We have also added "reviewer qualification" at the initial determination level based on several comments received.
Reporting Elements for all Initial Determination Requests: OD Number Contract number and PBP Parent organization Provider NPI Enrollee MBI Requested service codes (CPT/HCPCS) Name of service associated with CPT/HCPCS Submitted diagnosis codes (e.g., ICD-10, HIPPS codes) Processing priority (standard or expedited)		

Service location (Zip)
Date of service
Provider status (contracted or non-contracted)
Approved or denied
Date request received
Date of decision
Decision rationale
Were internal plan criteria applied?
Was PA requested?
If element R is yes, provide OD number for PA (claims only)
If element R is yes, was PA request required?
If element R is yes, was a voluntary pre-service request received?
Place of service, if applicable https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

Reporting Elements for Reconsiderations:

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

Revised Reporting Elements for Initial Determinations (payment):

Organization Determination Number
Contract Number
Plan Benefit Package (PBP)
Enrollee MBI
Requesting Party
Item/Service/Part B Drug Code
Item/Service/Part B Drug Description
Diagnosis Codes
Service Location
Place of Service
Date of Service
Provider NPI
Date Claim Received
Date of Decision
Date Claim was Paid
Was it a clean claim?
Disposition
Dismissal Rationale (if applicable)
Decision Rationale
Reviewer Qualifications
Were internal plan coverage criteria applied?
Was prior approval (e.g., a prior authorization or voluntary pre-service request) requested?
If element V is yes, provide the organization determination number for associated prior approval request
If element V is yes, was prior authorization a required condition for coverage?
Did a third-party vendor participate, in any capacity, in the determination’s review or decision-making?

Revised Elements for Reconsiderations (coverage decisions):

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