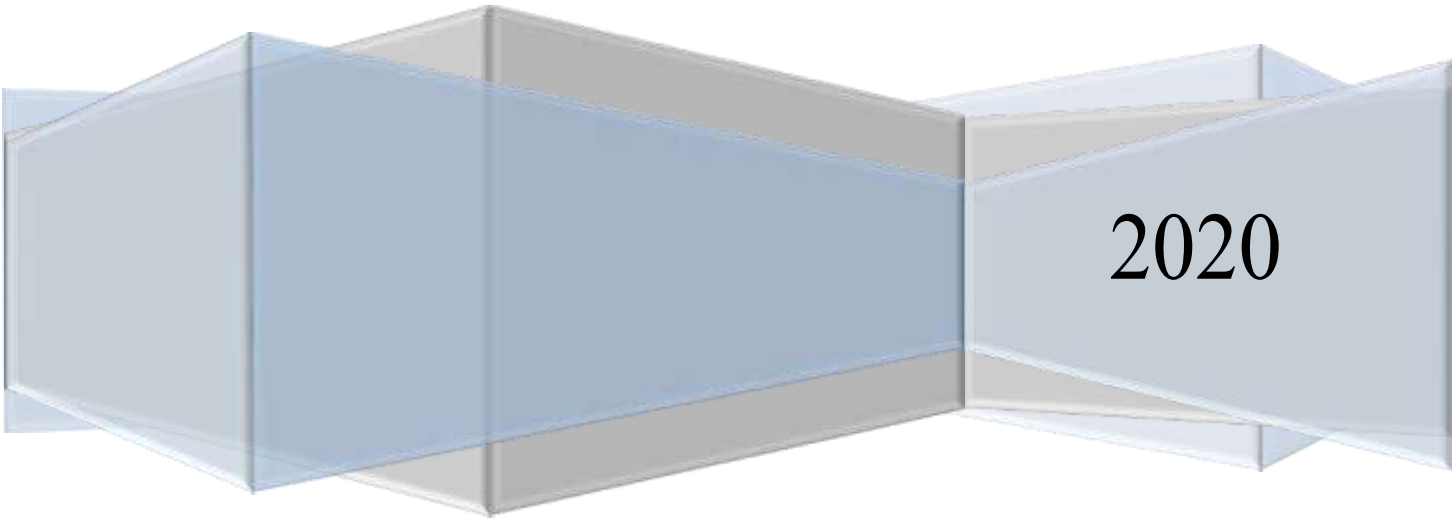
Medicare-Medicaid Plan (MMP) Service Authorization Requests, Appeals and Grievances (SARAG) Program Area

Audit Process and Data Request



Contents

Audit Purpose and General Guidelines

1. **Purpose:** To evaluate performance in the three areas outlined in this protocol related to MMP service authorization requests, provider payment requests, appeals and grievances. This will include the assessment of medical, behavioral health, substance use, and long term services and supports (LTSS) services. The Centers for Medicare & Medicaid Services (CMS), or its contractor, will perform its audit activities using these instructions (unless otherwise noted).

2. **Review Period:** The review period will be the 3 month period preceding, and including, the date of the audit engagement letter. For example, if the MMP receives the audit engagement letter on July 5, 2020, then the audit review period would be April 5, 2020- July 5, 2020. CMS reserves the right to expand the review period to ensure sufficient universe size.

3. **Audit Process and Data Request document layout**: This document has been generalized to apply to MMPs in multiple states. Auditors will evaluate MMPs in accordance with state-specific compliance standards and terminology set forth in the three-way contract between the MMP, State, and CMS, heretofore referred to as the contract. Where the contracts across states use varied terminology to label similar concepts, this document will reference unified terms applicable to all MMPs and provide definitions of those terms to ensure clarity.

4. **Responding to Documentation Requests:** The MMP 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.

5. **MMP Disclosed Issues**: MMPs 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.

   MMPs 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 engagement letter. The MMP's Contract Management Team (CMT) Medicare representative, otherwise referred to as Account Manager, will review the summary to validate that "disclosed" issues were known to CMS prior to receipt of the audit engagement letter. These are the "disclosed" issues that are reported to the CMT in the region that includes the state where the MMP is issued.

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

6. **Impact Analysis (IA):** An impact analysis must be submitted as requested by CMS. The impact analysis must identify all members subjected to or impacted by the issue of non- compliance. MMPs 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 members across all contracts audited.

7. **Calculation of Score:** CMS will determine if each condition cited is an Observation (0 points), Corrective Action Required (CAR) (1 point), or an ICAR (2 points). Invalid Data Submission (IDS) conditions will be cited when a MMP 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 SARAG 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 scores and audit scores.

8. **Informing MMP of Results:** CMS will provide daily updates regarding conditions discovered that audit 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. Also, MMPs will receive a draft audit report which they may formally comment on and then a final report will be issued after consideration of MMP comments on the draft.

MMP-SARAG Terminology

1. **Definitions**: Throughout this document, some terms have been standardized such that they may be applied to MMPs operating under any demonstration contract. For the purposes of ease of readability and conciseness, the following definitions apply to the below terms included in this document:
   - Service Authorization Request: A request for the provision of a covered service submitted by the MMP member/authorized representative. This may also include a service request submitted by a Service Coordinator or Care Coordinator on behalf of the member.
   - Plan Level Appeal: An appeal to the MMP for the provision of a covered service submitted by the MMP member/authorized representative after the MMP has initially denied the authorization or continuation of the service in whole or part.
   - State Fair Hearing: A state based appeal process external to the MMP that reviews MMP member/ authorized representative appeals for Medicaid services for which the MMP has denied or reduced coverage or payment. For NY MMPs, the State Fair Hearing refers to the appeals process overseen by the Integrated Administrative Hearings Office (IAHO), which reviews member/ authorized representative appeals for both Medicare and Medicaid services.
   - Grievance: A complaint from the MMP member/authorized representative related to any aspect of the MMP's or MMP providers' operations other than a Service Authorization Request or appeal.
   - Long-term services and supports: Long-term services and supports (LTSS) means services and supports provided to members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of meeting the member's daily needs and supporting the ability of the member to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. Examples of LTSS include: services assisting with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation.

     - MMPs must identify LTSS services as such in their universe submissions. LTSS related service authorization requests, appeals, and grievances that are not identified in the universe may necessitate resubmission of the universe to ensure appropriate categorization of Type of Service. See the Appendix for additional information on universe submission requirements.

For the audit, the MMP will be evaluated in accordance with the terminology definitions set forth in the contract between the MMP, State, and CMS.

Universe Preparation & Submission

1. **Responding to Universe Requests:** SARAG universes include requests by MMP members, their providers, and their authorized representatives for covered services, and/or payment for such services. Additionally, SARAG universes should include prescription drugs processed under Medicare Part B, but will exclude all other prescription drugs. The total number of universes that the MMP will submit for the SARAG program area depends on the applicable contract. Appendix A of this document includes each SARAG universe record layout, which specifies the data content and format of each universe required, whether the universe would not apply to MMPs in particular demonstrations, and other criteria.

   The MMP 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. MMPs 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 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 MMP fails to provide accurate and timely universe submissions twice, CMS will document this as an observation in the audit report. After the third failed attempt, or when the MMP determines after fewer attempts that they are unable to provide an accurate universe within the timeframe specified during the audit, the MMP will be cited an 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 MMP has deficiencies related to timeliness, clinical decision making and grievances in the area of SARAG. The MMP will provide universes of all of its service authorization requests (standard and expedited), all plan level appeals (standard and expedited), requests for provider payment, all external appeals cases that required effectuation (i.e., State Fair Hearings, Independent Review Entity (IRE) or IAHO, Administrative Law Judge (ALJ), Medicare Appeals Council (MAC) overturns), as well as all standard and expedited grievances.

   Instructions for what should be included in each universe are listed above the record layout tables in Appendix A. For each respective universe, the MMP should include all cases that match the description for that universe. The universes of sponsors with multiple MMP contracts should include all MMP contracts as identified in the audit engagement letter (e.g., all standard service authorization requests for all MMP contracts 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 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: MMP Standard Service Authorization Requests (MSSAR)
   - Table 2: MMP Expedited Service Authorization Requests (MESAR)
   - Table 3: MMP Provider Requests for Payment (M_Claims)
   - Table 4: MMP Standard Plan Level Appeals (MSPLA)

- Table 5: MMP Expedited Plan Level Appeals (MEPLA)
- Table 6: MMP State Fair Hearings Decisions Requiring Effectuation (M_SFHEFF)
- Table 7: MMP IRE Cases Requiring Effectuation (M_IREEFF)
- Table 8: MMP IRE Payment Cases Requiring Effectuation (M_IREClaimsEFF)
- Table 9: MMP ALJ and MAC Cases Requiring Effectuation (M_ALJMACEFF)
- Table 10: MMP Standard Grievances (MGRV_S)
- Table 11: MMP Expedited Grievances (MGRV_E)

3. **Submit Universes to CMS:** MMPs 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 1-11. If a sponsor has multiple MMPs, the sponsor should submit its SARAG universes in whole and not separately for each MMP contract. If the sponsor does not have any cases responsive to a particular universe request (e.g., if there were no MMP ALJ and MAC Cases Requiring Effectuation 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:** Timeliness compliance standards will align with contract requirements. CMS will run the tests indicated below on each universe except for Tables 3 and 6. While a sponsor with multiple MMPs will submit its universes in whole and not separately for each contract, timeliness tests will assess each contract separately. For each individual MMP's effectuation tests, auditors will determine percentage of timely cases from the MMP's approvals (favorable cases) or overturns. For notification timeliness tests, auditors will determine the percentage of timely cases for an individual MMP based on the timeliness of approvals and denials notification.

MMP-SARAG Timeliness Tests Table

TABLE #	RECORD LAYOUT	UNIVERSE	TIMELINESS TEST
1	MSSAR	MMP Standard Service Authorization Requests	Notification
2	MESAR	MMP Expedited Service Authorization Requests	Notification
3	M_Claims	Timeliness will not be assessed for Table 3 of the MMP universes.	
4	MSPLA	MMP Standard Plan Level Appeals	Effectuation
			Notification
5	MEPLA	MMP Expedited Plan Level Appeals	Effectuation
			Notification
6	M_SFHEFF	Timeliness will not be assessed for Table 3 of the MMP universes.	
7	M_IREEFF	MMP IRE Cases Requiring Effectuation (Medicare services only)	Effectuation
8	M_IREClaimsEFF	MMP IRE Payment Cases Requiring Effectuation (Medicare services only)	Effectuation
9	M_ALJMACEFF	MMP ALJ and MAC Cases Requiring Effectuation (Medicare services only)	Effectuation
10	MGRV_S	MMP Standard Grievances	Notification
11	MGRV_E	MMP Expedited Grievances	Notification

Audit Elements

I. Timeliness – Service Authorization Requests, Appeals and Grievances (TSARAG) (Performed via webinar prior to the entrance conference, results communicated to MMP during live portion of the audit)

1. **Select Sample Cases:** CMS will randomly select 5 cases from record layouts 1 through 11 for a total of 55 cases.[1]

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

   2.1. For service authorization requests, provider payment requests, or plan level appeals:
   - Original service authorization, provider payment request, or plan level appeal. Letters, emails or documentation confirming the MMP'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, member or member's authorized representative.
   - Documentation of effectuation including approval in service authorization requests/ appeals systems and evidence of effectuation in the MMP's claims adjudication system, clearly showing date and time override was entered.
   - Documentation showing approval notification to the member and/or their representative and physician/provider, as applicable.
     - If written decision letter was given, 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 claims payment records.
   - Documentation showing denial notification to the member and/or their representative and provider/physician, if applicable:
     - If written decision letter was given, 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 MMP's decision to process an expedited request under the standard timeframe, including any pertinent medical documentation, and any associated notices provided to the member and the requesting provider/physician.
   - If a plan level appeals case involving a Medicare benefit was upheld, include the following:
     - Documentation showing when the MMP auto-forwarded the request to the IRE. (Not applicable to NY MMPs)
     - NY MMPs only: Documentation showing the MMP auto-forwarded the request to the IAHO. NOTE: This applies to both Medicare and Medicaid services.

[1] Tables 7 and 8 are not applicable to NY MMPs. Therefore, the TSARAG review for NY MMPs will include 35 cases.

2.2. State Fair Hearings, IRE, ALJ or MAC Overturns

- Copy of overturn notice from the State Fair Hearing Entity, IRE, ALJ, or MAC, including date/time stamp of receipt by the MMP.
- Documentation of effectuation, including evidence of effectuation in MMP claims system clearly showing date/time the override was entered.
- Copy of 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. <u>Apply Compliance Standards</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 SARAG requirements not being met.

3.1. Universe Accuracy Standard: CMS will test 9 universes by confirming the data through the 5 selected cases (45 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 data accuracy for that universe. MMPs will be expected to produce the new universe prior to the live portion of the audit per CMS instructions. If the MMP 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 MMP's systems consistent with the universe submission?

3.2. Calculate Universe Timeliness: The CMS Audit Team will then calculate timeliness in accordance with the timeliness requirements applicable to each MMP contract and as specified in the MMP-SARAG Timeliness Tests Table. Some universes will have two types of timeliness tests performed: one for effectuation of approvals, and one for request notification. Other universes may only have one or no timeliness test performed. **Record Layouts 3 and 6 will not be included in the SARAG timeliness calculation.**

Each timeliness test calculation is initially determined at the contract level and based on the contract's number of late cases divided by the contract's total number of cases applicable for that test in each universe. For instance, to calculate timeliness for notification of standard service authorization request decisions for a particular contract, all of the contract's standard service authorization requests with untimely notifications will be divided by the contract's total number of approvals and denials in the universe. Once the percentage of late cases is determined for the contract, CMS will calculate the percentage of timely cases (100% - % late cases) and apply the compliance threshold for that test. If the sponsor has multiple MMP contracts, timeliness is calculated separately for each contract and compliance thresholds are assigned at the contract level.

CMS has determined 3 timeliness thresholds that apply to every test in each universe. For sponsors with one MMP contract, if the MMP falls at or above the first threshold, it will generally not be cited a condition. An MMP contract that falls within the second threshold will generally be cited for a corrective action required (CAR) for unmet timeliness requirements. An MMP that falls below the third threshold may be cited an immediate corrective action (ICAR)

for unmet timeliness requirements. For sponsors with multiple MMP contracts, individual MMP contract performance determines the final timeliness threshold for a particular test. If one or more of the sponsor's MMP contracts performs at the second or third timeliness threshold for a test, the worst performing contract will generally determine the final timeliness threshold for the test.

MMPs will not be allowed to resubmit universes after auditors have shared timeliness test results with the MMP.

3.2.1. Does the MMP meet all timelines requirements in accordance with the contract,, Medicare and Medicaid regulations, and as described in the MMP-SARAG Timeliness Tests Table above?

4. **Inform MMP of Results:** CMS will inform the MMP of the results of its analysis for each of the 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 SARA Processing Requirements

1. **Select Sample Cases:** CMS will select a targeted sample of 36 cases total that appear clinically significant from service authorization requests, payment requests, plan level appeals, State Fair Hearing overturns, and IRE/ALJ/MAC overturns record layouts (Appendix A, Tables 1 through 9). CMS will ensure, to the extent possible, that the sample set is representative of various medical, behavioral health, substance use, and LTSS cases. CMS will generally select samples as follows:

   - 10 service authorization requests (denied[2]), standard and expedited
   - 10 plan level appeals (denied[2]), standard and expedited
   - 2 provider payment requests (2 denied[2])
   - 10 IRE/ ALJ/ MAC/ State Fair Hearing overturns[3]; and
   - 4 plan level appeal approvals (standard and expedited)

   For sponsors with multiple MMP contracts, CMS may sample cases from any of the MMP contracts and will select a total sample of 36 cases. CMS reserves the authority to substitute samples in order to ensure the complete review of the Appropriateness of Clinical Decision-Making element.

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

   2.1. For service authorization requests, payment requests, or plan level appeals:
   - Original service authorization, payment, or plan level appeal request.
   - Integrated Notice of Action, if the appeal was filed in relation to an Adverse Benefit Determination.
   - Letters, emails or documentation confirming the MMP'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 benefit requested from the provider/physician/ Service Coordinator or the member.
   - Notices, letters, call logs or other documentation showing the MMP requested additional information (if applicable) from the requesting provider/physician/ Service Coordinator, 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/ Service Coordinator.
   - All supplemental information submitted by the requesting provider/physician/ Service Coordinator or member.
     - 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.

[2] For audit purposes, partially favorable decisions are treated as denials.

[3] The IRE and ALJ are not part of the NY MMP appeal process. If the NY MMP does not have 5 MAC overturns, CMS will select up to 5 additional State Fair Hearings overturns, or 5 additional plan level appeals if there are not enough State Fair Hearing overturns to reach the total 36 cases sampled for this element.

- Documentation of case review steps including name and title of final reviewer; rationale for denial; any reference to CMS guidance, Federal Regulations, State Regulations, the contract, clinical criteria, peer reviewed literature (where allowed), and MMP documents (e.g., EOC); or any other documentation used when considering the request.
- Documentation of effectuation including approval in service authorizations/plan level appeals and evidence of effectuation in MMP's claims adjudication system.
- Documentation regarding any determinations of member eligibility for aid pending appeal.
- Documentation of continued provision of service in the event that the member is due aid pending appeal.
- Documentation showing approval notification to the member and/or their representative and physician/provider, as applicable.
    - If written notification was given, 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 issued to the provider.
- Documentation showing denial notification to the member 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 MMP's decision to process an expedited request under the standard timeframe, including any pertinent medical documentation, and any associated notices provided to the member and the requesting provider/physician.
- For cases involving Medicare services where the MMP upheld its adverse decision or was untimely in its decision, include the following:
    - Documentation showing the MMP auto-forwarded the request to the IRE. (Not applicable to NY MMPs.)
      NY MMPs only: Documentation showing the MMP auto-forwarded the request to the IAHO. NOTE: This applies to both Medicare and Medicaid services.

2.2. For State Fair Hearings, IRE, ALJ or MAC Overturns:

- Copy of overturn notice from the State Fair Hearing, IRE, ALJ, or MAC.
- Documentation of effectuation, including evidence of effectuation in MMP claims system.
- Documentation of continued provision of the service in the event that the member is due aid pending appeal and determinations of member eligibility for aid pending appeal. (Applicable to plan level appeals, State Fair Hearing appeals, and for certain IRE auto-forward cases if required in the contract.)
- Copy of effectuation notice to IRE (IRE overturn only).
- Screen print of all claims for the requested service after approval date
    - If denied, explanation why the benefit 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 SARAG requirements not being met.

3.1. Clinical Appropriateness/Approvals:

3.1.1. Was appropriate notification (i.e., correct notice and approval language

understandable for the member) provided to the member (or representative) and provider/physician, if applicable?

3.1.2. If a representative received the response, was an appointment of representative (AOR), or other conforming instrument, on file?

3.1.3. Did the MMP appropriately consider clinical information and comply with CMS coverage requirements?

3.1.4. Did the MMP 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 MMP effectuate the request in its system?

3.1.6. If the member qualified for aid pending appeal during the plan level appeal, did the member receive the appropriate services?

3.2. Clinical Appropriateness/Denials:

3.2.1 Was appropriate notification provided to the member (or representative) and provider/physician, if applicable? (e.g., the notification includes correct notice and denial language understandable to the member, and if applicable, appeal rights for non-contract providers, the right to request a State Fair Hearing for denied Medicaid services; the right to continue to receive services pending a plan level appeal decision, IRE, or State Fair Hearing decision, how to request the continuation of benefits)

3.2.2. If a representative received the response, was an appointment of representative (AOR), or other conforming instrument, on file?

3.2.3. Did the MMP make reasonable and diligent efforts to obtain all medical records and other pertinent documentation within the required timeframes?

3.2.4. Was the service authorization request reviewed by the appropriate personnel?

3.2.5. Was the plan level appeal reviewed by the appropriate personnel?

3.2.6. When making a determination, did the MMP appropriately consider clinical information and comply with CMS coverage requirements?

3.2.7. For cases involving Medicare services where the MMP upheld its adverse decision or was untimely in its decision, did the MMP forward the case to the IRE properly and within the required timeframe? (For NY MMPs- Did the NY MMP forward cases involving upheld adverse decisions or untimely decisions to the IAHO?)

3.2.8. If care or services were provided by a contract provider or for covered services, was the member held harmless from balance billing?

3.2.9. If the member qualified for aid pending appeal during the plan level appeal, did the member receive the appropriate services?

3.3. State Fair Hearings, **IRE, ALJ or MAC Overturns:** If a reviewer determines the State Fair Hearing, IRE, ALJ or MAC reversal was in error, and aid pending appeal (if applicable) was appropriately rendered, the case will pass. For all other State Fair Hearing, IRE, ALJ and MAC cases, apply the following compliance criteria:

3.3.1. Did the State Fair Hearing Office, 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?

3.3.3. If the member qualified for aid pending appeal during the external appeal review, did the member receive the appropriate services?

4. **Sample Case Results:** CMS will test each of the 36 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 10 and 11). If the MMP does not have enough expedited grievances, the auditors will sample additional cases from the standard grievance universe. For sponsors with multiple MMP contracts, CMS may select the 20 sample cases from any of the MMP contracts.

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 MMP will need access to the following documents or audio files during the live webinar and CMS may request the MMP 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.
   - 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 member.
   - Documentation of all supplemental information submitted by member 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 MMP took to resolve the issue and a description of the final resolution. Documentation showing the steps the MMP took to resolve the issue may include, but is not limited to, appropriate correspondence with other departments within the organization; referral to the MMP's fraud, waste, and abuse department; and outreach to providers.
   - Documentation showing the MMP's investigation, follow-up steps, and description of the final grievance outcome. Include all notices, letters, and member communications.
   - Documentation showing resolution notification to the member and/or their representative:
     - If written decision letter sent, copy of 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 stamp.
   - For quality of care grievances processed internally: 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 SARAG requirements not being met.

   3.1. Was the grievance 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.

Appendix

Appendix—Service Authorization Requests, Appeals, and Grievances (SARAG) Record Layout

The universes for the Service Authorization Requests, Appeals, and Grievances (SARAG) 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 Service Authorization Requests (MSSAR) Record Layout

- Include all standard service authorization requests for Medicare and Medicaid services, whether approvals or denials, submitted by MMP members/member representatives.
- Exclude payment and reimbursement requests, dismissals, reopenings, withdrawn requests, all requests processed as expedited service authorization requests. Also, exclude concurrent review for inpatient hospital and Skilled Nursing Facility (SNF) services, post-service reviews, and notifications of admissions. Submit cases based on the date the MMP'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 service authorization request involves 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 service authorization request.

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member ID	CHAR Always Required	20	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.

Column ID	Field Name	Field Type	Field Length	Description
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 MMP 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 service authorization request was made by a contract provider (CP), non-contract provider (NCP), member (M), member's representative (MR), or Service Coordinator/Care Coordinator (SC) 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 member 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	Type of service	CHAR Always Required	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
L	Issue description	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 service request was denied.

Column ID	Field Name	Field Type	Field Length	Description
M	Was the 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 a standard timeframe.
N	Was a timeframe extension taken?	CHAR Always Required	2	Yes (Y)/No (N)/ Not Applicable (NA) indicator of whether the MMP extended the timeframe to make the service authorization decision.
O	If an extension was taken, did the MMP 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 MMP notified the member of the delay. Answer NA if no extension was taken.
P	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. MMPs 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 MMP decision	CHAR Always Required	10	Date of the MMP decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). MMPs 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 member	CHAR Always Required	10	Date oral notification provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no oral notification.
T	Date written notification provided to member	CHAR Always Required	10	Date written notification provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification.
U	Date service authorization entered/effectuated in the MMP's system	CHAR Always Required	10	Date service authorization entered in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials. Date service authorization/approval entered in the MMP's system.

Column ID	Field Name	Field Type	Field Length	Description
V	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. 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 service authorization request (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 2: Expedited Service Authorization Requests (MESAR) Record Layout

- Include all requests from MMP members/representatives processed as expedited service authorization requests for Medicare and Medicaid services, whether approvals or denials.
- Exclude payment and reimbursement requests, dismissals, reopenings, withdrawn requests, all requests processed as standard service authorization requests. Also, exclude concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions.
- Submit cases based on the date the MMP'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 service authorization request addresses 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 service authorization request.

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 MMP 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.

Column ID	Field Name	Field Type	Field Length	Description
G	Who made the request?	CHAR Always Required	3	Indicate whether the service authorization request was made by a contract provider (CP), non- contract provider (NCP), member (M) or member's representative (MR), Service Coordinator/ Care Coordinator (SC). 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). Note- If the request was received as a standard service authorization request, but later expedited, enter the date of the request to expedite the service authorization request.
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 service authorization request, but later expedited, enter the time of the request to expedite the service authorization.
K	Diagnosis	CHAR Always Required	100	Provide the member 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	Type of service	CHAR Always Required	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services.. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
M	Issue description	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 service request was denied.

Column ID	Field Name	Field Type	Field Length	Description
N	Was a timeframe extension taken?	CHAR Always Required	2	Yes (Y)/No (N)/ Not Applicable (NA) indicator of whether the MMP extended the timeframe to make the service authorization decision.
O	If an extension was taken, did the MMP 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 MMP notified the member of the delay. Answer NA if no extension was taken.
P	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. MMPs 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 MMP decision	CHAR Always Required	10	Date of the MMP decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). MMPs should answer NA for untimely cases that are still open.
R	Time of MMP decision	CHAR Always Required	8	Time of the MMP decision (e.g., approved, denied). Submit in HH:MM:SS military time format (e.g., 23:59:59). MMPs should answer NA for untimely cases that are still open.
S	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.
T	Date oral notification provided to member	CHAR Always Required	10	Date oral notification provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no oral notification.
U	Time oral notification provided to member	CHAR Always Required	8	Time oral notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no oral notification.
V	Date written notification provided to member	CHAR Always Required	10	Date written notification provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided.
W	Time written notification provided to member	CHAR Always Required	8	Time written notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no written notification was provided.

Column ID	Field Name	Field Type	Field Length	Description
X	Date service authorization entered/effectuated in the MMP's system	CHAR Always Required	10	Date service authorization/approval was entered in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials.
Y	Time service authorization entered/effectuated in the MMP's system	CHAR Always Required	8	Time service authorization/approval entered in the MMP's system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA for denials. Note – This is the point at which the member could obtain the service.
Z	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.
AA	AOR receipt time	CHAR Always Required	8	Time the Appointment of Representative (AOR) form or other appropriate documentation received by MMP. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no AOR form was required.
AB	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 service authorization request (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 3: MMP Provider Payment Requests (M_Claims) Record Layout

- Include all requests to the MMP processed as both contract and non-contract provider denied claims and paid claims from non-contract providers only.
- 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 members who are not enrolled on the date of service, claims denied due to recoupment of payment. Submit provider payment requests (claims) based on the date the claim 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 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	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 MMP 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 provider (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 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 member 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	Type of service	CHAR Always Required	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
L	Issue description	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.
M	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. MMPs 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.
N	Date the claim was paid or denied	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.
O	Was interest paid on the claim?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether interest was paid on the claim.
P	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.
Q	Date written notification provided to member	CHAR Always Required	10	Date written notification provided to member. Submit in CCYY/MM/DD format (e.g., 2015/01/01). 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 member.

Column ID	Field Name	Field Type	Field Length	Description
R	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., 2015/01/01). Answer NA if no written notification was provided.
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 claim (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 4: MMP Standard Plan Level Appeals (MSPLA) Record Layout

- Include all requests from MMP members/representatives processed as standard plan level (internal) appeals.
- Exclude appeals initiated through external organizations (e.g., hospital discharge appeals to the Quality Improvement Organization- QIO), and payment and reimbursement requests, concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions. Exclude all requests processed as expedited plan level appeals, dismissals, reopenings and withdrawn plan level appeals requests.
- Submit cases based on the date the MMP'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	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 MMP 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 plan level appeal was made by a contract provider (CP), non-contract provider (NCP), member (M), or member's representative (MR), or Service Coordinator/ Care Coordinator (SC). 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).
J	Diagnosis	CHAR Always Required	100	Provide the member 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	Type of service	CHAR Always Required	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
L	Issue description	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 service request was denied.
M	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 received as expedited but was downgraded and processed under the standard timeframe (e.g., based on the MMP deciding that the expedited plan level appeal was unnecessary).
N	Request for expedited timeframe	CHAR Always Requested	3	If an expedited timeframe was requested, indicate who requested the expedited plan level appeal timeframe: contract provider (CP), non-contract provider (NCP), member (M), member's representative (MR), Service Coordinator/ Care Coordinator (SC), or the MMP/ sponsor (S). Answer NA if no expedited timeframe was requested. Answer MR if a contract provider submitted an expedited plan level appeal as the member's representative.
O	Was a timeframe extension taken?	CHAR Always Required	2	Yes (Y)/No (N)/ Not Applicable (NA) indicator of whether the MMP extended the timeframe to make the appeal decision.
P	If an extension was taken, did the MMP 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 MMP notified the member of the delay. Answer NA if no extension was taken.

Column ID	Field Name	Field Type	Field Length	Description
Q	Request Disposition	CHAR Always Required	50	Status of the request. Valid values are: approved, denied, denied with IRE/IAHO auto forward, or IRE/IAHO auto-forward due to untimely decision. MMPs 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.
R	Date of MMP decision	CHAR Always Required	10	Date of the MMP decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). MMPs should answer NA for untimely cases that are still open.
S	Was the initial service authorization request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the initial service authorization request was denied for lack of medical necessity. Answer No (N) if the initial service authorization request was denied because it was untimely.
T	Date written notification provided to member/provider	CHAR Always Required	10	Date written notification provided to member, or if applicable the non-contract provider. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided.
U	Date service authorization entered/effectuated in the MMP's system	CHAR Always Required	10	Date authorization/approval entered in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials and IRE/IAHO auto-forwards.
V	Date forwarded to IRE/IAHO if denied or untimely	CHAR Always Required	10	Date the MMP forwarded request to the IRE/IAHO if request for Medicare service was denied or processed untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if approved or not forwarded to IRE/IAHO. NY MMPs only: For this field, include the date the MMP forwarded the request to the IAHO if the request for the service was denied or processed untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if approved or not forwarded to IAHO.
W	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. 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
X	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the plan level appeal (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.
Y	Does the request appeal a Notice of Action (NOA) decision?	CHAR Always Required	3	Yes (Y) or No (N) indicator depending on whether the member filed an appeal to continue a benefit that the MMP advised would be terminated or reduced per a Notice of Action (NOA).
Z	Should have/ Did the member qualify for continuation of the benefit under appeal during the plan level appeal process?	CHAR Always Required	2	Yes (Y) or No (N) indicator depending on whether the member should have or did qualify for continuation of the benefit under appeal during the plan level appeal process. Answer NA if the member did not appeal a request for a benefit previously authorized.
AA	Were the benefits under appeal provided to the member during the plan level appeal process?	CHAR Always Required	2	Yes (Y), No (N), or NA indicator depending on whether the member continued to receive the benefit under appeal during the plan level appeal process. Answer NA if the member did not qualify to continue receiving the benefit under appeal during the appeal process or if the member did not appeal a request for a benefit previously authorized.

Table 5: MMP Expedited Plan Level Appeals (MEPLA) Record Layout

- Include all requests from MMP members/representatives processed as expedited plan level appeals.
- Exclude appeals initiated through external organizations (e.g., hospital discharge appeals to the Quality Improvement Organization- QIO) and payment and reimbursement requests.
- Exclude all requests processed as standard plan level appeals, dismissals, reopenings and withdrawn plan level appeal requests. Also, exclude concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions. Submit cases based on the date the MMP'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	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 MMP 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 plan level appeal request was made by a contract provider (CP), non-contract provider (NCP), member (M) or, member's representative (MR), or Service Coordinator/ Care Coordinator (SC). 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).
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).
K	Diagnosis	CHAR Always Required	100	Provide the member 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	Type of service	CHAR Always Required	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
M	Issue description	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 service request was denied.
N	Request for expedited timeframe	CHAR Always Requested	3	If an expedited timeframe was requested, indicate who requested the expedited plan level appeal timeframe: contract provider (CP), non-contract provider (NCP), member (M), member's representative (MR) or MMP/sponsor(S) or Service Coordinator/ Care Coordinator (SC). Answer NA if no expedited timeframe was requested. Answer MR if a contract provider submitted the expedited plan level appeal request on behalf of a member.
O	Was a timeframe extension taken?	CHAR Always Required	2	Yes (Y)/No (N)/ Not Applicable (NA) indicator of whether the MMP extended the timeframe to make the service authorization decision.
P	If an extension was taken, did the MMP notify the member of the reason(s) for the	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the MMP notified the member of the delay. Answer NA if no extension was taken.

Column ID	Field Name	Field Type	Field Length	Description
Q	Request Disposition	CHAR Always Required	50	Status of the request. Valid values are: approved, denied, denied with IRE/IAHO auto forward, or IRE/IAHO auto-forward due to untimely decision. MMPs 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.
R	Date of MMP decision	CHAR Always Required	10	Date of the MMP decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). MMPs should answer NA for untimely cases that are still open.
S	Time of MMP decision	CHAR Always Required	8	Time of the MMP decision (e.g., approved or denied). Submit in HH:MM:SS military time format (e.g., 23:59:59). MMPs should answer NA for untimely cases that are still open.
T	Was the initial service authorization request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the initial service authorization request was denied for lack of medical necessity. Answer No (N) if the initial service request was denied because it was untimely.
U	Date oral notification provided to member	CHAR Always Required	10	Date oral notification provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no oral notification was provided.
V	Time oral notification provided to member	CHAR Always Required	8	Time oral notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no oral notification was provided.
W	Date written notification provided to member	CHAR Always Required	10	Date written notification provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided.
X	Time written notification provided to member	CHAR Always Required	8	Time written notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no written notification was provided.
Y	Date service authorization entered/effectuated in the MMP's system	CHAR Always Required	10	Date authorization/approval entered/effectuated in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials and IRE/IAHO auto-forwards.

Column ID	Field Name	Field Type	Field Length	Description
Z	Time service authorization entered/effectuated in the MMP's system	CHAR Always Required	8	Time authorization/approval entered/effectuated in the MMP's system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA for denials and IRE/IAHO auto-forwards.
AA	Date forwarded to IRE/IAHO if denied or untimely	CHAR Always Required	10	Date the MMP forwarded request to the IRE/IAHO if request denied or untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if the request was approved. NY MMPs only: For this field, include the date the MMP forwarded the request to the IAHO if the request for the service was denied or processed untimely. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if approved or not forwarded to IAHO.
AB	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.
AC	AOR receipt time	CHAR Always Required	8	Time the Appointment of Representative (AOR) form or other appropriate documentation received by MMP. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no AOR form was required.
AD	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 plan level appeal (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.
AE	Does the request appeal a Notice of Action (NOA) decision?	CHAR Always Required	3	Yes (Y), No (N), or NA indicator depending on whether the member filed an appeal to continue a benefit that the MMP advised would be terminated or reduced per a Notice of Action (NOA).
AF	Should have/ Did the member qualify for continuation of the benefit under appeal during the plan level appeal process?	CHAR Always Required	2	Yes (Y), No (N), or NA indicator depending on whether the member should have or did qualify for continuation of the benefit under appeal during the plan level appeal process. Answer NA if the member did not appeal a request for a benefit previously authorized.

Column ID	Field Name	Field Type	Field Length	Description
AG	Were the benefits under appeal provided to the member during the appeal process?	CHAR Always Required	2	Yes (Y), No (N), or NA indicator depending on whether the member continued to receive the benefit under appeal during the plan level appeal process. Answer NA if the member did not qualify to continue receiving the benefit under appeal during the appeal process or if the member did not appeal a request for a benefit previously authorized.

Table 6: State Fair Hearing Decisions Requiring Effectuation (M_SFHEFF) Record Layout

- Include all requests from MMP members/representatives processed as cases overturned by the State Fair Hearing Entity, including standard and expedited cases (i.e., a favorable decision was rendered by the State Fair Hearing entity).
- Exclude all requests processed as requests for payment and as unfavorable requests where the State Fair Hearing Entity upheld the denial. Also, exclude concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions
- Submit cases based on the date of receipt of the State Fair Hearing Entity 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	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 MMP 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 member 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.

Column ID	Field Name	Field Type	Field Length	Description
H	Type of service	CHAR Always Required	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
I	Issue description	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 service request was denied.
J	Request for expedited timeframe	CHAR Always Requested	1	Indicate whether the plan level appeal was processed under the expedited (E) timeframe or standard (S) timeframe.
K	Date of receipt of State Fair Hearing decision	CHAR Always Required	10	Date the MMP received the State Fair Hearing overturn decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
L	Date service authorization entered/effectuated in the MMP's system	CHAR Always Required	10	Date the State Fair Hearing determination was effectuated in the MMP's system. 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.
N	Should have/ Did the member qualify for continuation of the benefit under appeal during the external appeal process?	CHAR Always Required	2	Yes (Y) or No (N) indicator depending on whether the member should have or did qualify for continuation of the benefit under appeal during the external appeal process. Answer NA if the member did not appeal a request for a benefit previously authorized.
O	Were the benefits under appeal provided to the member during the external appeal process?	CHAR Always Required	2	Yes (Y), No (N), or NA indicator depending on whether the member continued to receive the benefit under appeal during the external appeal process. Answer NA if the member did not qualify to continue receiving the benefit under appeal during the appeal process or if the member did not appeal a request for a benefit previously authorized.

Table 7: MMP IRE Cases Requiring Effectuation (M_IREEFF) Record Layout

- This record layout will not apply to New York MMPs. MMPs should omit Table 7 from their universe submissions if they only operate a New York MMP.
- Include all requests from MMP members/representatives processed as 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 requests for payment and unfavorable requests where the IRE upheld the denial, concurrent review for inpatient hospital and SNF services, post-service reviews, 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	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 MMP 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 member 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.

Column ID	Field Name	Field Type	Field Length	Description
H	Issue description and type of service	CHAR Always Required	2000	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	2	Indicate whether the request was processed under the expedited (E) timeframe or standard (S) timeframe. Default to standard (S) if there is no distinction between expedited or standard timeframes for IRE effectuation per the contract.
J	Date of receipt of IRE decision	CHAR Always Required	10	Date the MMP received the IRE overturn decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
K	Time of receipt for IRE decision	CHAR Always Required	8	Provide the time the MMP received the IRE overturn decision. Submit in HH:MM:SS military time format (e.g., 23:59:59).
L	Date service authorization entered/effectuated in the MMP's system	CHAR Always Required	10	Date the service authorization was effectuated in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
M	Time service authorization entered/effectuated in the MMP's system	CHAR Always Required	8	Time effectuated in the MMP's system. Submit in HH:MM:SS military time format (e.g., 23:59:59).
N	Date service provided	CHAR Always Required	10	Date the member received the service. Submit in CCYY/MM/DD format (e.g., 2020/01/01). If the member did not receive the service, answer NA.
O	Date written notification provided to IRE	CHAR Always Required	10	Date written notification of MMP's effectuation sent to the IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01). If no written notification was provided to the IRE, answer NA.
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 8: MMP IRE Payment Cases Requiring Effectuation (M_IREClaimsEFF) Record Layout

- This universe is not applicable to New York MMPs. MMPs should omit Table 8 from their universe submissions if they only operate a New York MMP.
- Include all requests to the MMP overturned by the IRE that were processed as non-contract provider payment requests (i.e., a favorable decision was rendered by the IRE).
- Exclude all requests processed as member reimbursements, dismissals and unfavorable requests where the IRE upheld the denial Also, exclude concurrent review for inpatient hospital and SNF services, post-service reviews, 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	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 MMP 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 member 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	2000	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 MMP received the IRE overturn decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
K	Date service authorization entered/effectuated in the MMP's system	CHAR Always Required	10	Date the IRE overturn decision was effectuated in the MMP'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 MMP'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 9: MMP ALJ and MAC Cases Requiring Effectuation (M_ALJMACEFF) Record Layout

- Include all requests to the MMP processed as overturned by the ALJ or MAC, including standard and expedited cases, both service authorizations and payment (i.e., a favorable decision was rendered by the ALJ or MAC). The New York MMP appeals process does not involve the ALJ. New York MMPs would only submit MAC cases for this universe.
- Exclude all requests processed as dismissals and unfavorable requests where the ALJ or MAC upheld the denial.
- 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	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 MMP 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 member 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	2000	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 request was processed under the expedited (E) timeframe or standard (S) timeframe. Answer NA for payment requests. Default to standard (S) if there is no distinction between expedited or standard timeframes for IRE case effectuation per the 3- way contract.
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 service authorization request.
K	Date of receipt of ALJ/MAC decision	CHAR Always Required	10	Date the MMP received the ALJ/MAC overturn decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
L	Did the MMP appeal ALJ decision to MAC?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the MMP appealed the ALJ decision to the MAC.
M	Date written notification provided to member	CHAR Always Required	10	If MMP appealed the ALJ's decision to the MAC, provide the date written notification provided to member. 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 MMP's system	CHAR Always Required	10	Date the ALJ/MAC overturn decision was effectuated in the MMP'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 MMP's effectuation sent to ALJ/MAC. 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 10: MMP Standard Grievances (MGRV_S) Record Layout

- Include all requests from MMP members/representatives processed as internal standard grievances.
- Exclude all requests processed as expedited grievances, dismissals, withdrawn grievances, and external grievances (i.e., 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	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 contract provider (CP), non-contract provider (NCP), member (M), member's representative (MR), or Service Coordinator/ Care Coordinator (SC).
G	Date Grievance/Complaint was Received	CHAR Always Required	10	Date the grievance/complaint was received from the member 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	40	Describe how the grievance/complaint was received from the member or authorized representative (e.g., Written, In Person, Phone Call to customer service, etc.)

Column ID	Field Name	Field Type	Field Length	Description
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, Service Authorization and Plan Level Appeals process (which can also be categorized as Organization Determination and Redetermination Process Grievances), Quality of Care, Grievances Related to "CMS" Issues, and Other. List all that apply.
J	Issue Description	CHAR Always Required	1,800	Provide a description of the grievance/ complaint issue.
K	Identify whether the issue involved any of the following types of services: behavioral health, substance use, long term services and supports.	CHAR Always Required	4	Indicate "BH" for behavioral health, "SU" for substance use, and "LTSS" for long term supports and services. Answer "NA" if none of the above services apply to the issue(s).
L	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the MMP extended the timeframe to respond to the grievance/complaint.
M	If an extension was taken, did the MMP notify the member of the reason(s) for the delay?	CHAR Always Required	2	Yes (Y)/No (N)/ Not Applicable (NA) indicator of whether the MMP notified the member of the delay. Answer NA if an extension was not taken.
N	If the extension was taken because the MMP needed more information, did the notice include how	CHAR Always Required	2	Yes (Y)/No (N)/ Not Applicable (NA) indicator of whether the MMP notified the member of how the extension of the timeframe was in the interest of the member. Answer NA if an extension was not taken.
O	Date oral notification of resolution provided to member	CHAR Always Required	10	Date oral notification of resolution provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no oral notification was provided to the member.
P	Date written notification of resolution provided to member	CHAR Always Required	10	Date written notification of resolution provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided to the member.
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 MMP. 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
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 11: MMP Expedited Grievances (MGRV_E) Record Layout

- Include all requests processed from MMP members/representatives as internal expedited grievances.
- Exclude all requests processed as standard grievances, dismissals, withdrawn grievances, and external grievances (i.e., 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	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member 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 contract provider (CP), non-contract provider (NCP), member (M), member's representative (MR), or Service Coordinator/ Care Coordinator (SC)
G	Date Grievance/Complaint was Received	CHAR Always Required	10	Date the grievance/complaint was received from the member 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 member 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	40	Describe how the grievance/complaint was received from the member or authorized representative (Written, In Person, Phone Call to Customer Services, etc.)

Column ID	Field 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 member because the plan declined to process a case on the expedited timeframe (ETD) or whether it was submitted due to the member'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	Identify whether the issue involved any of the following types of services: behavioral health, substance use, long term services and supports.	CHAR Always Required	4	Indicate "BH" for behavioral health, "SU" for substance use, and "LTSS" for long term supports and services. Answer "NA" if none of the above services apply to the issue(s).
M	Date oral notification of resolution provided to member	CHAR Always Required	10	Date oral notification of resolution provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no oral notification provided to member.
N	Time oral notification of resolution provided to member	CHAR Always Required	8	Time oral notification of resolution provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no oral notification provided to member.
O	Date written notification of resolution provided to member	CHAR Always Required	10	Date written notification of resolution provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided to member.
P	Time written notification of resolution provided to member	CHAR Always Required	8	Time written notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no written notification was provided to member.
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 MMP. 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
S	AOR receipt time	CHAR Always Required	8	Time the Appointment of Representative (AOR) Form or other appropriate documentation received by MMP. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no AOR form was required.
T	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.