MMP-SARAG Audit Process and Data Request Protocol
Crosswalk of Significant Updates from 2018 to 2020
Updated language has been italicized in the 2020 Protocol Language column.

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1	Various sections throughout the protocol: Audit Purpose and General Guidelines Universe Preparation & Submission Section III. Grievances and Misclassification of Requests Table 12: MMP Call Log (MCL) Record Layout	All references to the MMP Call Logs Record Layout and Call Log samples.	Removed all MMP Call Log (MCL) Record Layout and sample references from the protocol, as the collection of the MCL universe is no longer needed. See Update No.15, for further details regarding Call Log changes to Section III Grievances and Misclassification of Requests.	NA
2	Audit Purpose and General Guidelines: Calculation of Score	NA	Added language that explains how SARAG program area audit performance affects the overall sponsor/ MMP audit score. The language is standard across each program Audit Process and Data Request protocol.	*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 MMP-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*

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				be included in the program area and audit scores.
3	MMP-SARAG Terminology	NA	Added definition of long-term services and supports (LTSS), as defined in 42 CFR § 438.2, and included examples of services that may be considered LTSS. Added language to remind MMPs that failing to identify LTSS cases in universe submissions could result in resubmission of the affected universe(s).	• *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.*

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4	Universe Preparation and Submission: Submit Universes to CMS	NA	Added language to confirm the actions an MMP must take regarding universe submission if the MMP does not have any cases in response to a universe request.	*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.*
5	Universe Preparation and Submission: 4. Timeliness Tests	CMS will run the tests indicated below on each universe except for Tables 3 and 6. For the effectuation tests, auditors will determine percentage of timely cases from the MMP's approvals (favorable cases). For the notification timeliness tests, auditors will determine the percentage of timely cases from a full universe of approvals and denials.	Clarified that, for sponsors with multiple MMP contracts, timeliness tests will assess the performance of each MMP contract separately before determining compliance.	*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*.

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6	Audit Elements: I. Timeliness: 2. Verify Universe Submission: 2.1	• Description of the service/benefit requested from the provider/physician, member or member's authorized representative. Notices, letters, call logs or other documentation showing the MMP requested additional information (if applicable) from the requesting provider/physician, including date, time, and type of communication. If the request was made via phone call, copy of the call log detailing what was communicated to the physician/provider. • All supplemental information submitted by the requesting provider/physician or member, including documentation showing when information was received by the MMP. o If information was received via fax/mail/email, copy of original request including date/time stamp of receipt. o If information was received via phone, copy of CSR notes and/or documentation of call including date/time stamp of call and call details. • Documentation of case review steps including name and title of final reviewer; rationale for denial; any reference to CMS guidance, Federal Regulations, clinical criteria, peer reviewed literature (where allowed), the contract, and MMP member documents (e.g., Evidence of Coverage (EOC)); or any other documentation used when considering the request.	Removed certain documents from the list of records the MMP may be required to produce during the Audit Team's verification of the dates and times provided in the SARAG universe submissions.	• Description of the service/benefit requested from the provider/physician, member or member's authorized representative. [REMOVED: *Notices, letters, call logs or other documentation showing the MMP requested additional information… If information was received via phone, copy of CSR notes and/or documentation of call including date/time stamp of call and call details.*] • 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.

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7	Audit Elements: I. Timeliness: 3. Apply Compliance Standards: 3.2. Calculate Universe Timeliness	**3.2. Calculate Universe Timeliness**: CMS or its contractor, when applicable, will then calculate the applicable timeliness tests as identified in the contract, and Medicare and Medicaid regulations and guidance. Some universes will have three types of timeliness tests performed: one for effectuation of approvals, one for IRE/IAHO auto-forwards, and one for notification of all requests. 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. For each timeliness test in the universe, the number of late cases will be divided by the total number of cases applicable for that test in each universe. For instance, for effectuation of standard service authorization requests, all approvals that were effectuated untimely will be divided by all approvals in the universe. Once the percentage of late cases is determined, CMS will calculate the percentage of timely cases (100% - % late cases) and apply the compliance threshold for that test. For sponsors with multiple MMP contracts, the timeliness calculations will be applied in accordance with the timeliness requirements applicable to the individual MMP contracts CMS has determined 3 timeliness thresholds that apply to every test in each universe. MMPs/sponsors that fall at or	Clarified that, for sponsors with multiple MMP contracts, timeliness tests will assess the performance of each MMP contract separately before determining compliance. Additionally, explained that MMPs will not be allowed to resubmit universes after auditors have shared timeliness test results with the MMP.	**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 above.* 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.

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		above the first threshold will generally not be cited a condition. MMPs that fall within the second threshold will generally be cited for a corrective action required (CAR) for unmet timeliness requirements. MMPs falling below the third threshold may be cited an immediate corrective action (ICAR) for unmet timeliness requirements.		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.*

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8	Audit Elements: I. Timeliness: 3. Apply Compliance Standards: 3.2. Calculate Universe Timeliness: 3.2.1.	3.2.1. Are the MMP's universes timely in accordance with the CMS compliance standards referenced in the contract and applicable Medicare and Medicaid regulations and guidance?	Clarified compliance standard 3.2.1. to reference the tests in the MMP-SARAG Timeliness Tests Table.	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?
9	Audit Elements: I. Timeliness: 3. Apply Compliance Standards: 3.1. Universe Accuracy Standard	3.1. **Universe Accuracy Standard:** CMS will test 11 universes by confirming the data through the 5 selected cases (55 total cases).	Reduced the total number of universes and cases that CMS will test when applying the Universe Accuracy Standard from 11 to 9 universes and 55 to 45 cases. Record Layouts 3 and 6 will not be included in the Universe Accuracy Standard review, but samples from these universes will be reviewed for compliance as per the evaluation criteria described in Section II. Appropriateness of Clinical Decision-Making & Compliance with SARA Processing Requirements.	3.1. **Universe Accuracy Standard:** CMS will test *9* universes by confirming the data through the *5* selected cases (*45* total cases).

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10	Audit Elements: II. Appropriateness of Clinical Decision-Making: Select Sample Cases	**Select Sample Cases**: CMS will select a targeted sample of 40 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 generally select samples as follows: • 10 service authorization requests (denied), standard and expedited • 10 plan level appeals (denied), standard and expedited • 2 provider payment requests (1 approved, 1 denied) • 5 IRE/ ALJ/ MAC overturns; and • 5 State Fair Hearings overturns • 4 service authorization request approvals (standard and expedited); and • 4 plan level appeal approvals (standard and expedited)	Updated the sample cases for Appropriateness of Clinical Decision-Making & Compliance with SARA Processing Requirements to remove service authorization approvals and sample two denied provider payment requests rather than one denial and one approval. A total of 36 samples will be reviewed for this element.	**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 generally select samples as follows: • 10 service authorization requests (denied), standard and expedited • 10 plan level appeals (denied), standard and expedited • 2 provider payment requests *(2 denied)* • *10 IRE/ ALJ/ MAC/ State Fair Hearing overturns;* and • 4 plan level appeal approvals (standard and expedited)

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11	Audit Elements: II. Appropriateness of Clinical Decision-Making: 2. Review Sample Case Documentation: 2.1 and 2.2.	2.1: NA 2.2: Documentation of continued provision of the service in the event that the member is due aid pending appeal.	Added that auditors may request that the MMP produce screenshots of documentation pertaining to a members' eligibility for aid pending appeal.	2.1: *Documentation regarding any determinations of member eligibility for aid pending appeal* 2.2: 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*.
12	Audit Elements: II. Appropriateness of Clinical Decision-Making: 3. Apply Compliance Standard: 3.2. Clinical Appropriateness/ Denials	3.2.8. Documentation showing the member was notified his or her case had been forwarded to the IRE for review, including a copy of the notification letter.	Removed this compliance standard from the protocol.	NA
13	Audit Elements: II. Appropriateness of Clinical Decision-Making: 3. Apply Compliance Standard: 3.2. Clinical Appropriateness/ Denials	3.2.10. Did the member get a clinically equivalent or alternate service, if applicable?	Removed this compliance standard from the protocol.	NA

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14	Audit Elements: II. Appropriateness of Clinical Decision-Making: 3. Apply Compliance Standard: 3.3. State Fair Hearings, IRE, ALJ, or MAC Overturns	**3.3. State Fair Hearings**, **IRE, ALJ or MAC Overturns:** If a reviewer determines the 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 IRE, ALJ or MAC receive additional information that would have changed the sponsor's decision to deny the case? 3.3.2. … 3.3.3. If the member qualified for aid pending appeal during the State Fair Hearing review, did the member receive the appropriate services?	Clarified the applicability of external appeals entities, particularly State Fair Hearings, in the review of 3.3. compliance standards.	**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. ... 3.3.3. If the member qualified for aid pending appeal during the *external appeal* review, did the member receive the appropriate services?
15	Audit Elements: III Grievances and Misclassification of Requests	**Select Sample Cases**: CMS will select a targeted sample of 10 total grievances: 7 from the standard grievances record layout and 3 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. CMS will also select a targeted sample of 10 calls from the MMP Call Log universe (Table 12). **Review Sample Case Documentation:** CMS will also review call logs to determine that incoming calls were	As mentioned in update number 1, all MMP Call Log (MCL) Record Layout and sample references from the protocol have been removed, as the MCL universe will not be collected or reviewed in 2020.	**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. **Review Sample Case Documentation:** Call Log language removed.

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		appropriately classified as either service authorizations, plan level appeals, or grievances. **2.2. For Call Logs:** • Initial call record: • Date and time call received • Copy of Customer Service Representative (CSR) notes and/or documentation of call details • Documentation explaining the call issue(s) • Call log audio files (recorded calls) • Documentation of how the call was processed, routed, or handled • If the call was classified as a grievance: • Copy of grievance case file • Copy of all notification sent to the member concerning the grievance • Documentation of resolution of issue • If the call was classified as a service authorization request or plan-level appeal: • Copy of service authorization or plan level appeal case file • Dates and times request was initiated • Documentation of case file notes • Any notification sent to the member of the resolution • If the call was classified as an inquiry: • Any follow-up done, if applicable. • Call notes, dates and times of the call 3.1. Was the grievance or call correctly classified, and, if not, was it transferred to the appropriate process?		**2.2. For Call Logs:** Call Log language removed. 3.1. Was the grievance [REMOVED: *or call*] correctly classified, and, if not, was it transferred to the appropriate process?

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16	Audit Elements: III Grievances and Misclassification of Requests: 2. Review Sample Case Documentation: 2.1. For Grievances	• Any documentation explaining the issue. • Where applicable, copy of all notices, letters, call logs, or other documentation showing when the MMP acknowledged receipt of the grievance to the member, and/or requested additional information from the member and/or their representative, including the date and time of the acknowledgement. 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.	Removed certain documents from the list of records the MMP may be required to produce during the Audit Team's review of grievances.	• Any documentation explaining the issue. [REMOVED: *Where applicable, copy of all notices, letters, call logs, or other documentation showing when the MMP acknowledged receipt …including the date and time of the acknowledgement.*] • 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.
17	Appendix : Tables 1-11: Cardholder ID	Field Name: Cardholder ID Field Description: Cardholder identifier used to identify the member. This is assigned by the plan.	As a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, starting January 1, 2020, all MMPs must use the Medicare Beneficiary Identifier (MBI). The MMPM Record Layout Column D now requires the Medicare Beneficiary Identifier (MBI) in lieu of the Cardholder ID.	Field Name: *Member ID* Field Description: *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.*

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18	Appendix Inclusion/ Exclusion criteria for Table Record Layouts 1, 2, and 4- 9	**Exclude**…If an MMP has already programmed its systems to include these requests in this universe, we will accept the universe submission. Note that requests for extensions of previously approved services have not been excluded.	Removed option for MMPs to include certain cases in universe submissions due to their system programming, as CMS excludes such cases from review.	NA
19	Appendix Table Record Layouts 1-11 Field Name: Level of service	Field Name: Level of service Field Description: Provide the level of service requested (e.g., inpatient/outpatient/ER/post stabilization care/ urgent care /point of sale transaction/ home healthcare).	Removed from all Tables in the protocol.	NA

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20	Appendix Table 1: Standard Service Authorization Requests (MSSAR) Record Layout Original Column ID N Request for expedited timeframe	Field Name: Request for expedited timeframe Description: If there was a request expedite the service authorization request after it was initially requested, indicate who made the subsequent request to expedite the request: 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 request was made after the service authorization was submitted.	Removed field.	NA
21	Appendix Table Record Layouts 1,2,4,5 Date of MMP decision Time of MMP Decision	Field Name: Date of the MMP decision. Description: Submit in CCYY/MM/DD format (e.g., 2018/01/01). MMPs should answer NA for untimely cases that are still open. Note – This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes. Field Name: Time of MMP decision (Tables 2 and 5 only) Description: 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.	Removed the note that accompanied the *Date of the MMP decision* and *Time of MMP decision* descriptions. Although the note remains accurate, CMS considers the note unnecessary for describing the proper population of the Field.	Field Name: Date of the MMP decision. Description: Submit in CCYY/MM/DD format (e.g., 20*20*/01/01). MMPs should answer NA for untimely cases that are still open. Field Name: Time of MMP decision (Tables 2 and 5 only) Description: 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.

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		Note – This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.		
22	Appendix Table Record Layouts 1-5 If denied for lack of medical necessity, was the review completed by a physician or other appropriate health care professional?	Field Name: If denied for lack of medical necessity, was the review completed by a physician or other appropriate health care professional? Description: Yes (Y)/No (N) indicator of review by a physician or other appropriate health care professional if request was denied for lack of medical necessity. Answer NA if the request was approved or not denied due to lack of medical necessity.	Removed field.	NA
23	Appendix Table Record Layouts 1,2,5,11 (Table 4 revision discussed in Update No.30) Date oral notification provided to member Time oral notification provided to member	Field Name: Date oral notification provided to member Description: Date oral notification provided to member. Submit in CCYY/MM/DD format (e.g., 2018/01/01). Answer NA if no oral notification. If good faith effort was made to contact the member, CMS recommends including the last good faith effort made within the notification timeframe. Field Name: Time oral notification provided to member (Tables 2 and 5 only)	CMS has removed all references to good faith efforts from the SARAG audit protocol. Please see section 10.5.4 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (issued February 2019) for more information on good faith efforts. In assessing good faith effort for CMS Program Audit timeliness purposes, CMS does not	Field Name: Date oral notification provided to member Description: Date oral notification provided to member. Submit in CCYY/MM/DD format (e.g., 20182020/01/01). Answer NA if no oral notification. Field Name: Time oral notification provided to member (Tables 2 and 5 only) Description: 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.

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		Description: 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. If good faith effort was made to contact the member, CMS recommends including the last good faith effort made within the notification timeframe.	deviate from the notification timeframes identified in the applicable three-way contract when assessing notification timeliness.	
24	Appendix Table Record Layouts 1-5, 7-11 Date written notification provided to member Date written notification provided to provider Date written notification provided to member/provider Date written notification provided to IRE Date written notification of resolution provided to member	Field Names: Date written notification provided to member (Tables 1,2,3,5,9) Date written notification provided to provider (Table 3) Date written notification provided to member/provider (Table 4) Date written notification provided to IRE (Tables 7,8,9) Date written notification of resolution provided to member (Tables 10,11) Description excerpt changed: "…The term "provided" means when the letter left the MMP's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the MMP's organization…"	CMS removed the following language from all of the applicable SARAG record layout fields, "The term "provided" means when the letter left the sponsor's establishment by US Mail, fax, or electronic communication." For more information on when a notification is considered delivered by a sponsoring organization, CMS suggests that MMPs review section 10.5.3 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance issued in February, 2019. In light of this information being included in the aforementioned guidance, CMS has removed the aforementioned language	NA

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			from all applicable SARAG Table Record Layouts.	
25	Appendix Record Layout Table 2: Expedited Service Authorization Requests (MESAR) Record Layout Original Column ID O Subsequent expedited request	Field Name: Subsequent expedited request Description: If a request to expedite the service authorization request was made after the request was received, indicate who made the subsequent request to expedite the request: 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 subsequent expedited timeframe was requested.	Removed field.	NA
26	Appendix Table 3: MMP Provider Payment Requests (M_Claims) Record Layout Exclusion criteria	• 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. Also, exclude concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions. If an MMP has already programmed its systems to include these requests in this universe we will accept the universe submission. Note that	Removed the following exclusion criteria for Table 3, as they are not applicable to the Table 3 Record Layout: "Also, exclude concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions. If an MMP has already programmed its systems to include these requests in this universe we will accept the universe submission. Note that requests for	• 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.

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		requests for extensions of previously approved services have not been excluded.	extensions of previously approved services have not been excluded."	
27	Appendix Table 4: MMP Standard Plan Level Appeals (MSPLA) Record Layout Original Column ID N Was request made under the expedited timeframe but processed by the plan under the standard timeframe?	Field Name: Was request made under the expedited timeframe but processed by the plan under the standard timeframe? Description: 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). Answer NA if the request was received as a standard request.	Removed response option "NA" as unnecessary, since the response "N" indicates the request was received as standard.	Field Name: Was request made under the expedited timeframe but processed by the plan under the standard timeframe? Description: 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).
28	Appendix Table Record Layouts 4,5 Was the request denied for lack of medical necessity?	Field Name: Was the request denied for lack of medical necessity? Description: Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the initial request was approved. Answer No if the request was denied because it was untimely.	Removed "Answer NA if the initial request was approved". Added language to indicate this field pertains to the initial service delivery request.	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.

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29	Appendix Table Record Layouts 4,5 If the request was denied for lack of medical necessity, was the plan level appeal completed by a physician other than the person involved in making the initial request?	Field Name: If the request was denied for lack of medical necessity, was the plan level appeal completed by a physician other than the person involved in making the initial request? Description: Yes (Y)/No (N) indicator of review by a different physician than the original reviewer. Answer NA if the request was not denied for lack of medical necessity or the request was not denied (i.e., approved, auto-forwarded, or dismissed).	Removed field.	NA
30	Appendix Table 4: MMP Standard Plan Level Appeals (MSPLA) Record Layout Original Column ID W Date oral notification provided to member	Field: Date oral notification provided to member Description: Date oral notification provided to member. Submit in CCYY/MM/DD format (e.g., 2018/01/01). Answer NA if no oral notification provided. If good faith effort was made to contact the member, CMS recommends including the last good faith effort made within the notification timeframe.	Removed field. Also see Update No 23.	NA

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31	Appendix Table Record Layouts 4,5,7,9,10 Date written notification provided to member/provider Date written notification provided to member Time written notification provided to member Date written notification provided to IRE Date written notification of resolution provided to member	Field Names: Date written notification provided to member/provider (Tables 4) Date written notification provided to member (Table 5,9) Time written notification provided to member (Table 5) Date written notification provided to IRE (Tables 7,9) Date written notification of resolution provided to member (Table 10) Description excerpt changed: "…If no proof of mailing is available, populate based on worst case scenario according to policies in place…"	Removed all references to "If no proof of mailing is available, populate based on worst case scenario according to policies in place" from the SARAG protocol. Although the note remains accurate, CMS considers the note unnecessary for describing the proper population of the Field and will align with the ODAG Audit Process and Data Request description for similar fields. Also see Update No 24.	NA

Update No.	Section in 2018 Protocol	2018 Protocol Language	Clarification or Change	2020 Protocol Language
32	Appendix Table Record Layouts 1,2,4-7 Date service authorization entered/effectuated in the MMP's system Time service authorization entered/effectuated in the MMP's system	Field Name: Date service authorization entered/effectuated in the MMP's system Description: Date authorization/approval entered in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2018/01/01). Answer NA for denials and IRE/IAHO auto-forwards. Note – This is the point at which the member could obtain the service. Field Name: Time service authorization entered/effectuated in the MMP's system Description: 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. (Tables 5 and 7 only) Note – This is the point at which the member could obtain the service.	Removed all references to "Note – This is the point at which the member could obtain the service" from the SARAG protocol. Although the note remains accurate, CMS considers the note unnecessary for describing the proper population of the Field and will align with the ODAG Audit Process and Data Request description for similar fields.	Field Name: Date service authorization entered/effectuated in the MMP's system Description: 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. Field Name: Time service authorization entered/effectuated in the MMP's system Description: 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. (Tables 5 and 7 only)

Update No.	Section in 2018 Protocol	2018 Protocol Language	Clarification or Change	2020 Protocol Language
33	Appendix Table Record Layouts 4,5 If request denied or untimely, date member notified request has been forwarded to IRE/IAHO	Field Name: If request denied or untimely, date member notified request has been forwarded to IRE/IAHO Description: Date member notified that request was forwarded to the IRE/IAHO if request for Medicare service was denied or processed untimely. Submit in CCYY/MM/DD format (e.g., 2018/01/01). Answer NA if approved or not forwarded to IRE/IAHO.	Removed field.	NA
34	Appendix Table 5: MMP Expedited Plan Level Appeals (MEPLA) Record Layout Original Column ID H Is this a Level 2 plan appeal?	Field Name: Is this a Level 2 plan appeal? Description: Yes (Y)/No (N) indicator of whether the appeal is a Level 2 appeal internal to the plan. Answer NA if Level 2 plan (internal) appeals do not apply to your organization.	Removed field.	NA

Update No.	Section in 2018 Protocol	2018 Protocol Language	Clarification or Change	2020 Protocol Language
35	Appendix Table 5: MMP Expedited Plan Level Appeals (MEPLA) Record Layout Original Column ID O Was request made under the standard timeframe but processed by the plan under the expedited timeframe?	Field Name: Was request made under the standard timeframe but processed by the plan under the expedited timeframe? Field Description: Yes (Y)/No (N) indicator of whether the request was received as standard but was upgraded and processed under the expedited timeframe. Answer NA if the case was received as an expedited request.	Removed field.	NA
36	Appendix Table 6: State Fair Hearing Decisions Requiring Effectuation (M_SFHEFF) Record Layout Inclusion criteria	•California MMPs' SFHEFF universe should be inclusive of Independent Medical Review (IMR) cases overturned by the Department of Managed Health Care (DMHC) in addition to State Fair Hearing overturns.	Removed "California MMPs' SFHEFF universe should be inclusive of Independent Medical Review (IMR) cases overturned by the Department of Managed Health Care (DMHC) in addition to State Fair Hearing overturns". MMPs should include State Fair Hearing overturns only.	NA

Update No.	Section in 2018 Protocol	2018 Protocol Language	Clarification or Change	2020 Protocol Language
37	Appendix Table Record Layouts 1,2 Date the request was received Time the request was received	Field Name: Date the request was received (Table 1) Field Description: Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2018/01/01). Note- This is the original receipt of the request by the MMP or delegated entity and not the date that the request became valid via an AOR. Field Name: Time the request was received (Table 2) Field Description: Provide the time the request was received by your organization. Submit in HH:MM:SS military time format (e.g., 23:59:59). Note- This is the original receipt of the request by the MMP or delegated entity and not the date that the request became valid via an AOR. Also- 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.	Removed "This is the original receipt of the request by the MMP or delegated entity and not the date that the request became valid via an AOR" from the SARAG protocol. Although the note remains accurate, CMS considers the note unnecessary for describing the proper population of the Field and will align with the ODAG Audit Process and Data Request description for similar fields.	Field Name: Date the request was received Description: Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Field Name: Time the request was received Description: 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.