DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: December 16, 2025

TO: All Medicare Advantage Organizations, Section 1876 Cost Plans, and Health Care Prepayment Plans

FROM: Gerard Mulcahy
Director, Medicare Enrollment and Appeals Group, Center for Medicare

SUBJECT: Service Level Data Collection for Initial Determinations and Appeals - Pilot Participation

On September 28, 2025, the Office of Management and Budget (OMB) approved a proposed data collection that CMS submitted through the Paperwork Reduction Act (PRA) process. The collection (CMS-10905, OMB:0938-1489) is called the Service Level Data Collection for Initial Determinations and Appeals[1] and collects data related to Medicare Advantage (MA) plan initial coverage decisions and plan processed appeals. This collection for MA complements the June 2025 roundtable meeting between HHS, CMS, and major health insurers in which health insurers pledged to streamline and improve the prior authorization process through six key reforms aimed at cutting red tape, accelerating care decisions, and enhancing transparency for patients and providers.[2] CMS is encouraged by plans' progress made to date executing on the pledges. The data collection will support continued momentum towards these goals.

Prior to implementing this required data collection across all MA plans, CMS intends to conduct a voluntary pilot, collecting the data from a select number of MA plans in 2026. Beginning the collection as a pilot will allow CMS to gather lessons learned and ensure efficient and accurate reporting of data upon launch of the full-scale collection. Pilot participants would have six months to prepare for the first data submission estimated in late 2026. After a few quarters of collecting data and making any adjustments as needed, CMS anticipates expanding the data collection to all plans in 2027. CMS is now soliciting MA plans interested in volunteering for the pilot.

Once pilot participants and CMS have determined readiness to start the industry wide data collection, all MA plans will report their data through HPMS in accordance with the Technical Specifications attached to this memo.[3] The experience and feedback of pilot plans will help CMS to shape the data collection effort moving forward.

Interested plans should submit an email to the Part C Appeals and Grievances resource portal by January 9, 2026: https://appeals.lmi.org. Any questions related to the pilot may also be sent to this mailbox.

[1] https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202505-0938-016
[2] https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html
[3] The Technical Specifications attached to this memo are subject to change as we work towards pilot implementation.

Appendix 1. Draft Service Level Data Collection for Initial Determinations and Appeals Technical Specifications

A. INTRODUCTION

These technical specifications supplement the Service Level Data Collection for Initial Determinations and Appeals (hereinafter referred to as Service Level Data Collection), and do not change, alter, or add to the data collection described above. The Service Level Data Collection is subject to OMB review and approval in compliance with the Paper Reduction Act of 1995, and its OMB control number is 0938-1489.

The technical specifications serve to further define data elements and provide information on how CMS will review and analyze the data. This technical guidance helps ensure that MA organizations have a common understanding of the data to be reported and assists in preparing and submitting datasets to help ensure a high level of accuracy in the data reported to CMS, thereby reducing the need to correct and resubmit data.

B. GENERAL INFORMATION

Plans will submit these data via HPMS.

The level of data reported

MA organizations must submit all required data at the contract number/PBP level, (e.g., plan 001 for contract H0000). This plan-level reporting is necessary to permit CMS to conduct appropriate oversight and monitoring of certain areas of the MA program.

Section	Subsections	Reporting Level	Submission Method
I. Initial Determinations	I.A. Coverage Decisions I.B. Payment Decisions	Plan	Upload
II. Reconsiderations	II.A. Coverage Decisions II.B. Payment Decisions	Plan	Upload

Submission of Data

- Compliance with these reporting requirements is a contractual obligation of all MA organizations. Compliance requires data be accurate and submitted in a timely manner. Data submissions are due by 11:59 p.m. Pacific Time on the date of the reporting deadline.
- Only data that reflect a good faith effort by an organization to provide accurate responses to the Service Level Data Collection will count as data submitted in a timely manner.
- CMS tracks resubmissions, including the number of resubmissions made after the deadline. CMS expects data to be accurate on the date of submission.
- CMS urges organizations to store revised data. Organizations must follow record

retention requirements, such as maintaining documentation supporting their reported data.

- Organizations should report their data based on their interpretation of the Service Level Data Collection and Technical Specifications and should be able to support their decisions. Plans may contact the mailbox at https://appeals.lmi.org with additional questions.
- Organizations are required to report complete quarters that precede non-renewal or termination of the plan (PBP) or contract.
    - For example: If H0000 terminates on May 31, of a given year, the organization is required to report quarter 1/1-3/31 for reporting period of that year. If H0000 non- renews on December 31, of a given year, the organization is required to report all quarters for reporting period of that year.

General Data Entry Rules

- HPMS will not allow the entry of greater than sign (>); less than sign (<); or semicolon (;); or decimals in any data entry field or uploaded file.
- Organizations must not submit "placeholder" data (e.g., submitting the value "99999" in reporting fields in HPMS).
- Fields that are numeric do not allow characters
- Where there are multiple options, a single selection must be made

Due Date Extension Requests

Generally, CMS does not grant extensions to reporting deadlines, as these will be established and published well in advance. It is our expectation that organizations do their best with the information provided in the most current versions of the technical specifications to prepare for data submission in a timely fashion. Any assumptions that organizations may make in order to submit data timely should be fully documented and defensible under audit. CMS will consider appropriate
"Resubmission Requests" through the HPMS Plan Reporting Module (PRM).

Once a reporting deadline has passed, CMS requires MA organizations to submit a formal request to resubmit any data. HPMS designates this request as a Request Resubmission. Approval for
resubmission requests will be for 7 days from the date of CMS review and approval of the request. Organizations should not submit resubmission requests until they have data available to submit.
Data is late if the submission is after the given reporting period deadline and may not be incorporated within CMS data analyses and reporting. HPMS will not allow the resubmission of data identical to the original data submission.

Correction of Previously Submitted Data / Resubmission Requests

If previously submitted data are incorrect, an organization should request the opportunity to

correct and resubmit data. Submission of inaccurate or incorrect data does not satisfy the obligation to report that data when the organization is aware or becomes aware of the inaccuracy. Corrections of previously submitted data are appropriate if due to an error made at the date of the original
submission, or as otherwise indicated by CMS. Once a reporting deadline has passed, organizations that need to correct data must submit a formal request to resubmit data via the PRM. A plan can only initiate a resubmission request after the original reporting deadline has expired. Organizations can access detailed instructions for resubmissions in the HPMS Plan Reporting Module User Guide in the Documentation section of the module.

Periodic Updates to the Technical Specifications

- If CMS revises these technical specifications to clarify accurate reporting for data element(s), plans must incorporate changes beginning the following reporting period from the publication date. For example, if CMS releases updated technical specifications in March of a certain year, plans must ensure their Q2 data of that year reflect the revised technical specifications.
- For questions specific to the Service Level Data Collection for Initial Determinations and Appeals, plans may contact the following mailbox: https://appeals.lmi.org. Please be aware immediate responses to individual questions may not always be possible due to volume of inquires received. CMS recommends plans first refer to the current Service Level Data Collection for Initial Determinations and Appeals or Technical Specifications for answers.
- For technical assistance relevant to file formats and uploads, please contact the HPMS help desk: 1-800-220-2028 or email: hpms@cms.hhs.gov.

Exclusions from Reporting

Excluded from this data collection are National PACE Plans and 1833 Cost Plans. Medicare-Medicaid Plans (MMPs) are also excluded from this reporting due to the transition of the Financial Alignment Initiative demonstrations to dual eligible special needs plan (D-SNP) models.

C. REPORTING SECTIONS

II. INITIAL DETERMINATIONS

This section requires file upload into HPMS at the plan-level. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	Report Frequency Level	Report Period	Due Date(s)
01 – Local CCP 02 – MSA 03 - RFB PFFS 04 - PFFS 06 – 1876 Cost 11 – Regional CCP 14 – Employer / Union Direct (ED)-PFFS 15 – RFB Local CCP 17 – ED Local CCP Organizations should include all 800 series plans.	4/Year Plan	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/25/XX (1/1-3/31) 8/31/XX (4/1-6/30) 11/30/XX (7/1-9/30) 2/22/XX (10/1-12/31)
Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.			

Data Element ID	Data Element Name	Data Element Description
Subsection #I.A.	**Coverage Decisions (made in the reporting period above)**	
A.	Organization Determination (OD) Number	Enter the plan's internal case number.
B.	Contract Number	Enter the contract number (e.g., H0000) of the organization in which the beneficiary is enrolled.
C.	Plan Benefit Package (PBP)	Enter the PBP (e.g., 001).

D.	Enrollee MBI	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee excluding hyphens or dashes.
E.	Requesting Party	Enter the party who made the request: • 01 - enrollee • 02 - enrollee's representative • 03 - contract provider • 04 - non-contract provider • 05 - plan
F.	Provider NPI	Enter requesting or ordering provider's NPI number.
G.	Was this a contracted provider referral?	Enter: • Y for Yes • N for No
H.	Item/Service/Part B Drug Code	Enter the CPT, HCPCS, or J code associated with the item/service/Part B drug.
I.	Item/Service/Part B Drug Description	Enter the name of the item/service/Part B drug if there's no associated code entered in element H.
J.	Diagnosis Codes	Enter the diagnosis code(s) submitted with the request (e.g., ICD-10, HIPPS codes) as a comma separated list.
K.	Was prior authorization required?	Enter: • Y for Yes • N for No
L.	Processing Priority	Enter how the request was processed: • S for Standard • E for Expedited
M.	Was expedited processing requested?	Enter: • Y for Yes • N for No
N.	Date Request Received	Enter the date and time the request was received. Submit in YYYY-MM-DD format (e.g., 2020-01-01).
O.	Date of Decision	Enter the date and time of the determination. This is the date and time all notification requirements were met. Submit in YYYY-MM-DD hh:mm:ss format.
P.	Disposition	Enter: • F for Fully favorable • P for Partially favorable • A for Adverse • D for Dismissal

Q.	Dismissal Rationale (if applicable)	For dismissals, enter the primary reason for the dismissal: • 01 - Requestor is not permitted to request the OD • 02 - Invalid request • 03 - Enrollee died while the request was pending • 04 - Withdrawn
R	Decision Rationale	For partially favorable and adverse decisions, enter the primary reason for the denial: • 01 - Cost Sharing/Benefit Limits • 02 - Coverage Excluded • 03 - Statutory Exclusion • 04 - (not applicable to this subsection) • 05 - Lack of Medical Necessity • 06 - (not applicable to this subsection) • 07 - Not Deemed Reasonable and Necessary • 08 - Not Urgent Out of Area • 09 - Requested Setting Not Approved • 10 - Procedural/Admin Denial (e.g., untimely filing, billing issue, invalid CPT/diagnosis code, etc.) • 11 - Step Therapy or UM Requirement Not Met
S.	Reviewer Qualifications	If the MA organization expected to issue a partially or fully adverse medical necessity decision based on the initial review of the request, provide the reviewer's qualifications (this includes requests that were approved, partially approved, or denied) Enter: • P for Physician • O for Other Appropriate Healthcare Professional
T.	Were internal plan coverage criteria applied?	Enter: • Y for Yes • N for No
U.	Did a third-party vendor participate, in any capacity, in the determination review or decision-making?	Enter: • Y for Yes • N for No

V.	For partially of fully favorable decisions, was the approved item, service or Part B drug different from what was requested?	Enter: • Y for Yes • N for No
W.	If element V is yes, provide the procedure code for the approved item, service, or Part B drug.	Enter the procedure code for the approved item, service, or Part B drug.
Subsection #I.B.	**Payment Decisions (made in the reporting period above)**	
A.	Organization Determination (OD) Number	Enter the plan's internal case number.
B.	Contract Number	Enter the contract number (e.g., H0000) of the organization in which the beneficiary is currently enrolled.
C.	Plan Benefit Package (PBP)	Enter the PBP (e.g., 001).
D.	Enrollee MBI	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee, excluding hyphens or dashes.
E.	Requesting Party	Enter the party who made the request: • 01 - enrollee • 02 - enrollee's representative • 03 - contract provider • 04 - non-contract provider
F.	Item/Service/Part B Drug Code	Enter the CPT, HCPCS, DRG or J code associated with the item/service/Part B drug
G.	Item/Service/Part B Drug Description	Enter the name of the item/service/Part B drug if there's no associated code entered in element F.
H.	Diagnosis Codes	Enter the diagnosis code submitted with the request (e.g., ICD-10, HIPPS codes) as a comma separated list.
I.	Service Location	Enter the zip code of the location where the item/service/Part B drug was provided.
J.	Place of Service	Enter the code for the place of service. https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets
K.	Start Date of Service	Enter the START date the service was rendered. Submit in YYYY-MM-DD format (e.g., 2020-01-01).

L.	End Date of Service	Enter the END date the service was rendered. Submit in YYYY-MM-DD format (e.g., 2020-01-05).
M.	Provider NPI	Enter service provider's NPI.
N.	Was this a contracted provider referral?	Enter: • Y for Yes • N for No
O.	Date Claim Received	Enter the date the claim was received. Submit in YYYY-MM-DD format (e.g., 2020-01-01).
P.	Date of Decision	Enter the date of the determination. Submit in YYYY-MM-DD format (e.g., 2020-01-01). This is the date that payment was made or notice of a denial was issued.
Q.	Was it a clean claim?	Enter: • Y for clean claim • N for unclean claim
R.	Disposition	Enter: • F for Fully favorable • P for Partially favorable • A for Adverse • D for Dismissal
S.	Dismissal Rationale (if applicable)	For dismissals, enter the primary reason for the dismissal: • 01 - Requestor is not permitted to request the OD • 02 - Invalid request • 03 - Enrollee died while the request was pending • 04 - Withdrawn

T.	Decision Rationale	For partially favorable and adverse decisions, enter the reason for the denial: • 01 - Cost Sharing/Benefit Limits • 02 - Coverage Excluded • 03 - Statutory Exclusion • 04 - No Prior Authorization • 05 - Lack of Medical Necessity • 06 - Not Deemed Emergency Care • 07 - Not Deemed Reasonable and Necessary • 08 - Not Urgent Out of Area • 09 - Requested Setting Not Approved • 10 - Procedural/Admin Denial (e.g., untimely filing, billing issue, invalid CPT/diagnosis code, etc.) • 11 - Step Therapy or UM Requirement Not Met
U.	Reviewer Qualifications	Enter: • P for Physician • O for Other Appropriate Healthcare Professional
V.	Were internal plan coverage criteria applied?	Enter: • Y for Yes • N for No
W.	Was prior approval (e.g., a prior authorization or voluntary pre-service request) requested?	Enter: • Y for Yes • N for No
X.	If element W is yes, provide the OD number for associated prior approval request.	Enter the plan's OD number for the prior approval request associated with the payment request.
Y.	If element W is yes, was prior authorization a required condition for coverage?	Enter: • Y for Yes • N for No
Z.	Did a third-party vendor participate, in any capacity, in the determination review or decision-making?	Enter: • Y for Yes • N for No

I. RECONSIDERATIONS

This section requires file upload into HPMS at the plan-level. Please refer to HPMS layouts and templates for more information.

Organization Types Required to Report	Report Frequency Level	Report Period	Due Date(s)
01 – Local CCP 02 – MSA 03 - RFB PFFS 04 - PFFS 06 – 1876 Cost 11 – Regional CCP 14 – Employer / Union Direct (ED)-PFFS 15 – RFB Local CCP 17 – ED Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this reporting section, regardless of organization type.	4/Year Plan	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/25/XX (1/1-3/31) 8/31/XX (4/1-6/30) 11/30/XX (7/1-9/30) 2/22/XX (10/1-12/31)

Subsection #II.A.	Coverage Decisions (made in the reporting period above)	
A.	Associated Organization Determination (OD) Number	Enter the plan's OD number associated with the appeal.
B.	Appeal Number	Enter the plan's appeal number.
C.	Contract Number	Enter the contract number (e.g., H0000) of the organization in which the beneficiary is currently enrollee.
D.	Plan Benefit Package (PBP)	Enter the PBP (e.g., 001).
E.	Enrollee MBI	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee, excluding hyphens or dashes.
F.	Was this a contracted provider referral?	Enter: • Y for Yes • N for No

G.	Date Request Received	Enter the date and time the request was received. Submit in YYYY-MM-DD format (e.g., 2020-01-01).
H.	Date of Decision	Enter the date and time of the determination. This is the date and time all notification requirements were met. Submit in YYYY-MM-DD hh:mm:ss format.
I	Processing Priority	Enter how the request was processed: • S for Standard • E for Expedited
J.	Was expedited processing requested?	Enter: • Y for Yes • N for No
K.	Is this an appeal of an OD dismissal?	Enter: • Y for Yes • N for No
L.	Disposition	Enter: • F for Fully favorable • P for Partially favorable • A for Adverse • D for Dismissal
M.	Dismissal Rationale (if applicable)	For dismissals, enter the reason for the dismissal: • 01 - Requestor is not a proper party to the OD • 02 - Invalid request • 03 - Untimely request • 04 - Enrollee died while the request was pending • 05 - Withdrawn

N.	Decision Rationale	For partially favorable and adverse decisions, enter the reason for the denial: • 01 - Cost Sharing/Benefit Limits • 02 - Coverage Excluded • 03 - Statutory Exclusion • 04 - No Prior Authorization • 05 - Lack of Medical Necessity • 06 - Not Deemed Emergency Care • 07 - Not Deemed Reasonable and Necessary • 08 - Not Urgent Out of Area • 09 - Requested Setting Not Approved • 10 - Procedural/Admin Denial (e.g., untimely filing, billing issue, invalid CPT/diagnosis code, etc.) • 11 - Step Therapy or UM Requirement Not Met
O.	Was the initial OD request denied for lack of medical necessity?	Enter: • Y for Yes • N for No
P.	Was the reconsideration request reviewed by a physician?	Enter: • Y for Yes • N for No
Q.	Did a third-party vendor participate, in any capacity, in the determination review or decision-making?	Enter: • Y for Yes • N for No
R.	For partially or fully favorable decisions, was the approved item, service or Part B drug different from what was requested?	Enter: • Y for Yes • N for No
S.	If element R was yes, provide the procedure code for the approved item, service, or Part B drug.	Enter the procedure code for the approved item, service, or Part B drug.
Subsection #II.B.	**Payment Decisions (made in the reporting period above)**	
A.	Associated Organization Determination (OD) Number	Enter the plan's OD number associated with the appeal.
B.	Appeal Number	Enter the plan's appeal number
C.	Contract Number	Enter the contract number (e.g., H0000) of the organization in which the beneficiary is currently enrolled.
D.	Plan Benefit Package (PBP)	Enter the PBP (e.g., 001).

E.	Enrollee MBI	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee, excluding hyphens or dashes.
F.	Was this a contracted provider referral?	Enter: • Y for Yes • N for No
G.	Date Request Received	Enter the date the request was received. Submit in YYYY-MM-DD format (e.g., 2020-01-01).
H.	Date of Decision	Enter the date of the determination. Submit in YYYY-MM-DD format (e.g., 2020-01-01). For claims payment enter the data of payment in YYYY-MM-DD format. This is the date that payment was made or notice of a denial was issued.
I.	Is this an appeal of an OD dismissal?	Enter: • Y for Yes • N for No
J.	Disposition	Enter: • F for Fully favorable • P for Partially favorable • A for Adverse • D for Dismissal
K.	Dismissal Rationale (if applicable)	For dismissals, enter the reason for the dismissal: • 01 - Requestor is not a proper party to the OD • 02 - Invalid request • 03 - Untimely request • 04 - Enrollee died while the request was pending • 05 - Withdrawn

L.	Decision Rationale	For partially favorable and adverse decisions, enter the reason for the denial: • 01 - Cost Sharing/Benefit Limits • 02 - Coverage Excluded • 03 - Statutory Exclusion • 04 - No Prior Authorization • 05 - Lack of Medical Necessity • 06 - Not Deemed Emergency Care • 07 - Not Deemed Reasonable and Necessary • 08 - Not Urgent Out of Area • 09 - Requested Setting Not Approved • 10 - Procedural/Admin Denial (e.g., untimely filing, billing issue, invalid CPT/diagnosis code, etc.) • 11 - Step Therapy or UM Requirement Not Met
M.	Was the initial OD request denied for lack of medical necessity?	Enter: • Y for Yes • N for No
N.	Was the reconsideration request reviewed by a physician?	Enter: • Y for Yes • N for No
O.	Did a third-party vendor participate, in any capacity, in the determination review or decision-making?	Enter: • Y for Yes • N for No

Edits and Validation Checks: Validation checks should be performed by each organization prior to data submission. For example, contracts should validate that the reconsideration 'date request received' field is later than or equal to the 'date of decision' field for the organization determination.

Notes:

- Organization determinations and reconsiderations should be included, if the request is consistent with the applicable regulations. For instances when the organization approves an initial request for an item or service (e.g., physical therapy services) and the organization approves a separate additional request to extend or continue coverage of the same item or service, include the decision to extend or continue coverage of the same item or service as another, separate, fully favorable organization determination.
- If an organization determination includes more than one service, include all the decision's multiple line items as separate entries. Each entry will have the same organization determination number.
- Requests submitted by staff of a physician's office on behalf of the physician (e.g.,

request is on said physician's letterhead) should also be reported as contract or non-contract provider, as appropriate.
- The provider's NPI must be reported on a service decision when the request is submitted by (or on behalf of) a provider or when an enrollee submits a service request and identifies a provider had ordered the requested item, service, or Part B drug or the enrollee requested to receive the item, service, or Part B drug from a specific provider.

Definitions for purposes of plan reporting:

- **Adverse Decision** for reporting purposes means an item, service, or Part B drug was denied in whole.
- **Clean Claim** as defined at 42 CFR §422.500(b), is a claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with 42 CFR §422.310(d)), or particular circumstance requiring special treatment that prevents timely payment and that otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare.
- **Fully Favorable** decision means an item, service, or Part B drug was covered in whole.
- **Internal Coverage Criteria** refers to an MA organization's established coverage criteria as defined in 42 CFR § 422.101(b)(6).
- **Organization Determination** is a plan's response to a request for coverage (payment or provision) of an item, service, or Part B drug, including auto-adjudicated claims, service authorizations which include prior-approvals (authorization that is issued prior to the services being rendered), concurrent authorization (further defined below), requests to continue previously authorized ongoing courses of treatment, and the reduction or discontinuation of covered provider or hospital services. It includes pre-service organization determination requests submitted by the enrollee, enrollee's representative, contract provider on behalf of the enrollee and requests from non-contract providers. This also includes claims payment requests from non-contract and contract providers.
- **Concurrent Authorization** is a coverage decision on an item, service, or Part B drug made by a plan contemporaneously to when an enrollee is receiving the item, service, or Part B drug at issue when there wasn't a prior authorization decision in advance.
- **Partially Favorable** decision means an item, service, or Part B drug was partially covered. For example, if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable. Also, if a pre-service request for 10 therapy services was processed, but only 5 were authorized, this would be considered partially favorable.
- **Prior Approval** refers to coverage decisions made before the provision of the item, service, or Part B drug at issue. This includes requests for items, services, or Part B drugs which are subject to a plan's prior authorization requirements (i.e., prior authorization requests) as well as requests for items, services, or Part B drugs that are not subject to a plan's prior authorization requirements (i.e., voluntary pre-service requests).

- **Reconsideration** is a plan's review of an adverse or partially favorable organization determination as defined in 42 CFR § 422.580.

Report:

- Completed organization determinations and reconsiderations (i.e., all required notification has occurred) during the reporting period, regardless of when the request was received. Plans are to report organization determinations or reconsiderations where a substantive decision has been made, as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M.
- A denial of a Medicare request for coverage (payment or provision) of an item or service as either partially favorable or adverse, regardless of whether Medicaid payment or provision ultimately is provided, in whole or in part, for that item or service. However, Dual Eligible Special Needs Plans (D-SNPs) that are applicable integrated plans as defined in 42 CFR § 422.561 should report a request for a Medicare item or service based on the outcome of applying both Medicare and Medicaid coverage criteria.
- Denials based on exhaustion of Medicare benefits.
- Organization determinations that involve hospital discharges and transfers to post-acute care settings.
- Include all requests for supplemental services that meet the criteria defined in 42 CFR § 422.100(c)(2).

Do Not Report:

- Independent Review Entity (IRE) decisions.
- Reopenings requested or completed by the IRE, Administrative Law Judge (ALJ), or Appeals Council.
- Duplicate payment requests concerning the same service or item.
- Payment requests returned to a provider/supplier in which a substantive decision (fully favorable, partially favorable or adverse) has not been made– e.g., payment requests or forms are incomplete or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).
- Part B drugs that are paid or denied at the pharmacy and point-of-sale Part B drug claim rejections are not reportable as organization determinations. If the plan subsequently processes an organization determination, this should be reported.
- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.
- A service only covered under the plan's Medicaid benefits and never covered by Medicare and not covered by the MA plan as a supplemental Medicare benefit (such as Medicaid home-and community-based long-term services and supports).
- Plan decisions regarding a request to vacate a dismissal.