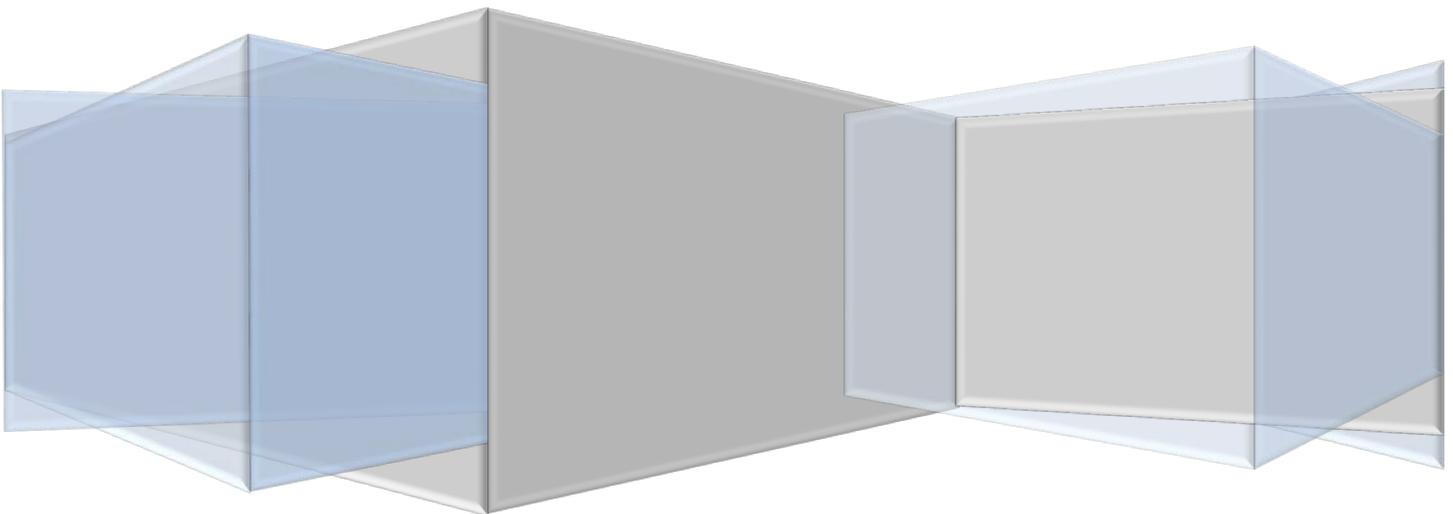




**Medicare-Medicaid Plan (MMP)  
Service Authorization Requests,  
Appeals, and Grievances (SARAG)**

**PROGRAM AUDIT PROTOCOL AND DATA  
REQUEST**



**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

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**Program Audit Protocol and Data Request  
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## **Program Audit Protocol**

### **Purpose**

To evaluate performance in the areas outlined in this Program Audit Protocol and Data Request related to Medicare-Medicaid Plan (MMP) service authorization requests, provider payment requests, appeals and grievances for medical, behavioral health, substance use disorder, and long-term services and supports (LTSS) services. The Centers for Medicare & Medicaid Services (CMS) performs its program audit activities in accordance with the MMP-SARAG Program Audit Protocol and Data Request and applying the compliance standards outlined in this Program Audit Protocol and the Program Audit Process Overview document. At a minimum, CMS will evaluate cases against the criteria listed below. CMS may review factors not specifically addressed below if it is determined that there are other related three-way contract requirements not being met.

### **Audit Elements Tested**

1. Timeliness
2. Processing of Coverage Requests
3. Classification of Requests

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## **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:

- **Grievance:** A complaint from the MMP enrollee/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 (LTSS):** services and supports provided to enrollees of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of meeting the enrollee's daily needs and supporting the ability of the enrollee 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.
- **Plan Level Appeal:** An appeal to the MMP for the provision of a covered service submitted by the MMP enrollee/authorized representative after the MMP has initially denied the authorization or continuation of the service in whole or part. The appeal universe would be inclusive of Medicare Part B drugs, but would exclude Medicaid drugs.
- **Service Authorization Request:** A request for the provision of a covered service submitted by the MMP enrollee/authorized representative. This may also include a service request submitted by a Service Coordinator or Care Coordinator on behalf of the enrollee. The service authorization request universe would be inclusive of Medicare Part B drugs, but would exclude Medicaid drugs.
- **State Fair Hearing:** A state based appeal process external to the MMP that reviews MMP enrollee/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 enrollee/ authorized representative appeals for both Medicare and Medicaid services.

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

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Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria
Not Applicable	Universe Integrity Testing	<p>Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)</p> <p>Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)</p> <p>Universe Table 3: MMP Provider Payment Requests and Appeals (M_PYMT)</p> <p>Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, SFH, ALJ, or MAC (M_EFF)</p> <p>Universe Table 5: MMP Standard and Expedited Grievances (M_GRV)</p>	<p>Select 10 cases from each universe, Tables 1 through 5, for a total of 50 cases.</p> <p>Prior to field work, CMS will schedule a webinar with the MMP to verify accuracy of data within the universe submissions, and to confirm effectuation of approved requests, for each of the sampled cases. Review all cases selected for universe integrity testing. The integrity of the universe will be questioned if data points specific to the sample case(s) are incomplete, do not match, or cannot be verified by viewing the Sponsoring organization's systems and/or other supporting documentation.</p> <p>Sample selections will be provided to the MMP approximately one hour prior to the scheduled webinar.</p>	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Timeliness	1.1	Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)	Conduct timeliness test at the universe level on standard service authorization requests to determine whether the MMP provided notification of the determination timely.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Timeliness	1.2	Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)	Conduct timeliness test at the universe level on standard service authorization requests for Part B drugs to determine whether the MMP provided notification of the determination no later than 72 hours after receipt of the request.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.568(b)

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<b>Audit Element</b>	<b>Compliance Standard</b>	<b>Data Request</b>	<b>Method of Evaluation</b>	<b>Criteria</b>
Timeliness	1.3	Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)	Conduct timeliness test at the universe level on expedited service authorization requests to determine whether the MMP provided notification of the timely.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Timeliness	1.4	Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)	Conduct timeliness test at the universe level on expedited service authorization requests for Part B drugs to determine whether the MMP provided notification of the determination no later than 24 hours after the MMP received the request.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.572(a) 42 CFR § 422.572(c)
Timeliness	1.5	Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)	Conduct timeliness test at the universe level on standard plan level appeals to determine whether the MMP provided notification of its determinations timely and forwarded its upheld decisions to the IRE timely.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Timeliness	1.6	Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)	Conduct timeliness test at the universe level on standard plan level appeals for Part B drugs to determine whether the MMP provided notification of its determinations and forwarded its upheld decision to the IRE no later than 7 calendar days after receipt of the request.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.590(c) 42 CFR § 422.590(d)
Timeliness	1.7	Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)	Conduct timeliness test at the universe level on expedited plan level appeals to determine whether the MMP provided notification of its decisions timely and forwarded its upheld decision to the IRE timely.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract

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<b>Audit Element</b>	<b>Compliance Standard</b>	<b>Data Request</b>	<b>Method of Evaluation</b>	<b>Criteria</b>
Timeliness	1.8	Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)	Conduct timeliness test at the universe level on expedited plan level appeals for Part B drugs to determine whether the MMP provided notification of its overturned decision no later than 72 hours after receipt of the request or forwarded its upheld decision to the IRE no later than 24 hours after affirmation of the determination or no later than 96 hours if the MMP failed to provide the enrollee with the results of its appeal within the required timeframe.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.590(e) 42 CFR § 422.590(g)
Timeliness	1.9	Universe Table 3: MMP Provider Payment Requests and Appeals (M_PYMT)	Conduct timeliness test at the universe level on provider payment appeals to determine whether the MMP paid overturned provider appeals claims from non-contracted providers or forwarded its upheld decision to the IRE no later than 60 calendar days after receipt of the request.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Timeliness	1.10	Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, SFH, ALJ, or MAC (M_EFF)	Conduct timeliness test at the universe level on pre-service IRE cases in which the MMP's determination was reversed in whole or in part by the IRE to determine whether the MMP effectuated the decision timely.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.618(b)
Timeliness	1.11	Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, SFH, ALJ, or MAC (M_EFF)	Conduct timeliness test at the universe level on standard Part B drug request IRE cases in which the MMP's determination was reversed in whole or in part by the IRE to determine whether the MMP authorized or provided the Part B drug under dispute within 72 hours after receipt of the notice reversing the determination.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.618(b)
Timeliness	1.12	Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, SFH, ALJ, or MAC (M_EFF)	Conduct timeliness test at the universe level on expedited Part B drug request IRE cases in which the MMP's determination was reversed in whole or in part by the IRE to determine whether the MMP authorized or provided the Part B drug under dispute within 24 hours after receipt of the notice reversing the determination.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.619(b)

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<b>Audit Element</b>	<b>Compliance Standard</b>	<b>Data Request</b>	<b>Method of Evaluation</b>	<b>Criteria</b>
Timeliness	1.13	Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, SFH, ALJ, or MAC (M_EFF)	Conduct timeliness test at the universe level on payment decisions reversed in whole or in part by the IRE to determine whether the MMP paid for the service no later than 30 calendar days after receipt of the notice reversing the determination.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.618(b)
Timeliness	1.14	Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, SFH, ALJ, or MAC (M_EFF)	Conduct timeliness test at the universe level on standard and expedited decisions overturned by an ALJ or the MAC to determine whether the MMP authorized or provided the service under dispute no later than 60 calendar days after receipt of the notice of determination reversal.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.618(c) 42 CFR § 422.619(c)
Timeliness	1.15	Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, SFH, ALJ, or MAC (M_EFF)	Conduct timeliness test at the universe level on standard and expedited Part B drug request decisions overturned by an ALJ or the MAC to determine whether the MMP authorized or provided the Part B drug under dispute no later than 72 hours for standard requests or 24 hours for expedited requests after receipt of the notice of determination reversal.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract  42 CFR § 422.619(c)
Timeliness	1.16	Universe Table 5: MMP Standard and Expedited Grievances (M_GRV)	Conduct timeliness test at the universe level on standard grievances to determine whether the MMP responded to the enrollee's grievance timely.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Timeliness	1.17	Universe Table 5: MMP Standard and Expedited Grievances (M_GRV)	Conduct timeliness test at the universe level on expedited grievances to determine whether the MMP responded to the enrollee's grievance timely.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract

**Program Audit Protocol and Data Request**  
**MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria
Processing of Coverage Requests	2.1	<p>Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)</p> <p>Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)</p> <p>Universe Table 3: MMP Provider Payment Requests and Appeals (M_PYMT)</p>	<p>Select 30 denied requests from tables 1-3. The number of cases per record layout will vary.</p> <p>Ensure sample set represents behavioral health, substance use disorder, LTSS, and various medical services (e.g., ER services, outpatient hospital, inpatient hospital, urgent care, etc.) where possible.</p> <p>For each denial case, review case file documentation for proper notification of the denial decision.</p> <p>If the enrollee identified a representative, review case file to determine if notification was sent to the enrollee’s representative.</p> <p>If a provider requested the coverage, review case file to determine if notification of decision was also sent to provider.</p> <p>Sample selections will be provided to the MMP approximately one hour prior to the scheduled webinar.</p>	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Processing of Coverage Requests	2.2	<p>Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)</p> <p>Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)</p> <p>Universe Table 3: MMP Provider Payment Requests and Appeals (M_PYMT)</p>	For the sampled cases, review case file documentation to ensure a physician or other appropriate health care professional with sufficient medical and other expertise reviewed the determination.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract

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Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria
Processing of Coverage Requests	2.3	Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)  Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)  Universe Table 3: MMP Provider Payment Requests and Appeals (M_PYMT)	For each sampled denial case, review case file documentation for clinical accuracy.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Processing of Coverage Requests	2.4	Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)  Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)	For each sampled case, review case file for documentation to ensure an extension was appropriate.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Processing of Coverage Requests	2.5	Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)  Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)	For each case sampled, review case file documentation for proper downgrade from an expedited determination request to a standard determination and for proper notification to the enrollee that explains that the MMP will process the request using standard determination timeframe, informs the enrollee of the right to file an expedited grievance, informs the enrollee of the right to resubmit a request for an expedited determination with any physician's support, and provides instructions about the grievance process and timeframes.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Processing of Coverage Requests	2.6	Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)  Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)	For each sampled case, review case file to determine if the MMP applied step therapy only to new administrations of Part B drugs using at least a 365-day look back period.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract

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Audit Element	Compliance Standard	Data Request	Method of Evaluation	Criteria
Processing of Coverage Requests	2.7	Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)  Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, SFH, ALJ, or MAC (M_EFF)	For each sampled case, review case file to determine if the MMP provided aid pending appeal when required.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract
Classification of Requests	3.1	Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M_SAR)  Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M_PLA)  Universe Table 3: MMP Provider Payment Requests and Appeals (M_PYMT)	Select 10 dismissed requests from Tables 1-3.  Review case file documentation to determine if the request was appropriately dismissed or whether it should have been treated as a coverage request or grievance.  Sample selections will be provided to the MMP approximately one hour prior to the scheduled webinar.	42 CFR § 422.566  42 CFR § 422.578  42 CFR § 422.582  42 CFR § 422.584  42 CFR § 422.590  42 CFR § 423.564
Classification of Requests	3.2	Universe Table 5: MMP Standard and Expedited Grievances (M_GRV)	Select 20 grievance sample cases from Table 5.  Sample both verbal and written grievances.  Target samples that appear to: relate to quality of care; involve multiple issues and do not appear in the service authorization request and plan level appeals universes; and appear to be misclassified requests.  Review case file documentation to determine if proper notification (i.e., written or verbal) was provided. If the MMP extended the deadline, review case file for documentation stating how the delay is in the interest of the enrollee. Also, review case file for written notification to the enrollee of the reason(s) for the delay.  If the enrollee identified a representative, review case file to determine if notification was sent to the enrollee's representative.	Applicable demonstration three-way contract, including Medicare and Medicaid regulations referenced in the contract

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**Program Audit Data Request**

**Audit Engagement and Universe Submission Phase**

**Universe Submissions**

MMPs must submit universe tables 1 - 5, comprehensive of all MMP contracts identified in the audit engagement letter, in either Microsoft Excel (.xlsx) file format with a header row or Text (.txt) file format without a header row. Characters are required in all requested fields, unless otherwise specified, and data must be limited to the request specified in each record layout. MMPs must provide accurate and timely universe submissions within 15 business days of the audit engagement letter date. Submissions that do not strictly adhere to the record layout specifications will be rejected. Sponsoring organizations may however enter the time within universes instead of ‘None’ if the time is not required per the field description.

**Universe Requests**

1. Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M\_SAR) Record Layout
2. Universe Table 2: MMP Standard and Expedited Pre-service Plan Level Appeals (M\_PLA) Record Layout
3. Universe Table 3: MMP Provider Payment Requests and Appeals (M\_PYMT) Record Layout
4. Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, IAHO, SFH, ALJ, or MAC (M\_EFF) Record Layout
5. Universe Table 5: MMP Standard and Expedited Grievances (M\_GRV) Record Layout

Universe Record Layout	Scope of Universe Request*
Table 1 Table 2 Table 3 Table 4 Table 5	Submit the 12-week period preceding, and including, the date of the audit engagement letter.

\* CMS reserves the right to expand the review period to ensure sufficient universe size.

Please use the guidance below for the following record layout:

**Universe Table 1: MMP Standard and Expedited Service Authorization Requests (M\_SAR) Record Layout**

- Include all service authorization requests the MMP approved, denied or dismissed during the universe request period. The date of the MMP’s determination (Column ID P) must fall within the universe request period.
- Include all pre-service initial requests for Part B drugs.
- If a service authorization request includes 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

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request.

- o Enter any request denied in whole or in part as denied.
- Enter all fields for a single request in the same time zone. For example, if the MMP has systems in EST and CST, all data in a single line item must be in the same time zone.
- Exclude all requests processed as appeals, payments, reopenings, and withdrawals.
  - o Exclude all concurrent reviews for inpatient hospital services and inpatient SNF services, and notifications of admissions.

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee 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	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	<p>Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the MMP to provide administrative or health care services to an enrollee under the MMP program) that processed the request.</p> <p>Enter None if the MMP processed the request.</p>
G	Authorization or Claim Number	CHAR Always Required	40	<p>Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number.</p> <p>Enter None if there is no authorization, claim or other tracking number available.</p>
H	Date the request was received	CHAR Always Required	10	<p>Enter the date the request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01).</p> <p>If a standard request was upgraded to expedited, enter the date the request was upgraded.</p>

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
I	Time the request was received	CHAR Always Required	8	<p>For all expedited requests and standard Part B drug requests, enter the time the request was received. Submit in HH:MM:SS military time format (e.g., 23:59:59).</p> <p>If a standard request was upgraded to expedited, enter the time the request was upgraded.</p> <p>Enter None for standard service requests and dismissed requests.</p>
J	Part B Drug Request	CHAR Always Required	1	<p>Enter:</p> <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
K	AOR/Equivalent notice Receipt Date	CHAR Always Required	10	<p>Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in CCYY/MM/DD format (e.g., 2020/01/01).</p> <p>Enter None if no AOR or equivalent written notice was received or required.</p>
IL	AOR/Equivalent notice Receipt Time	CHAR Always Required	8	<p>For all expedited requests and standard Part B drug requests, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in HH:MM:SS format (e.g., 23:59:59).</p> <p>Enter None for standard service requests, dismissed requests, or if no AOR or equivalent written notice was received or required.</p>

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
M	Request Determination	CHAR Always Required	9	Enter: <ul style="list-style-type: none"> <li>• Approved</li> <li>• Denied</li> <li>• Dismissed</li> </ul>
N	Was the request processed as Standard or Expedited?	CHAR Always Required	1	Enter the manner by which the request was processed: <ul style="list-style-type: none"> <li>• S for Standard</li> <li>• E for Expedited</li> </ul>
O	Was a timeframe extension taken?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
P	Date of Determination	CHAR Always Required	10	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). For dismissed requests, enter the date the MMP dismissed the request.
Q	Time of Determination	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard and dismissed requests.
R	Date oral notification provided to enrollee	CHAR Always Required	10	Enter the date oral notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if no oral notification was provided.

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
S	Time oral notification provided to enrollee	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time oral notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard service requests, dismissed requests, or if no oral notification was provided.
T	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification of determination was provided to enrollee. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if no written notification was provided.
U	Time written notification provided to enrollee	CHAR Always Required	8	For all expedited requests and standard Part B drug requests, enter the time written notification of determination was provided to enrollee. Do not enter the time a letter was generated or printed. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard service requests, dismissed requests, or if no written notification was provided.

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
V	Who made the request?	CHAR Always Required	3	Enter who made the request: <ul style="list-style-type: none"> <li>• E for enrollee</li> <li>• ER for enrollee's representative or purported representative</li> <li>• CP for requests by a contract provider/ facility</li> <li>• NCP for requests by a non-contract provider/ facility</li> </ul>
W	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service or item requested and why it was requested (if known). If describing behavioral health services, long-term services and supports (LTSS), or substance use disorder services, include the terms behavioral health, LTSS, and substance use disorder service in the description, as applicable. For denials, also provide an explanation of why the pre-service request was denied.  For dismissed requests, provide the reason for dismissal.
X	Was an expedited request made but processed as standard?	CHAR Always Required	4	Enter: <ul style="list-style-type: none"> <li>• Y for Yes if an expedited request was received but downgraded to standard</li> <li>• None for all other requests (e.g. the request was received as expedited and processed as expedited, the request was received as standard)</li> </ul>
Y	Was the request denied for lack of medical necessity?	CHAR Always Required	4	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• None if the request was approved or dismissed.</li> </ul>

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

Please use the guidance below for the following record layout:

**Universe Table 2: MMP Standard and Expedited Plan Level Appeals (M PLA) Record Layout**

- Include all pre-service plan level appeals the MMP approved, denied, or auto-forwarded to the IRE/IAHO or dismissed during the universe request period. The date of the MMP’s determination (Column ID P) must fall within the universe request period.
- Include all pre-service plan level appeals for Part B drugs.
- If a pre-service plan level appeal includes more than one service, include all of the request’s line items in a single row and enter multiple line items as a single appeal. Enter any appeal denied in whole or in part as denied.
- Enter all fields for a single appeal in the same time zone. For example, if the MMP has systems in EST and CST, all data in a single line item must be in a single time zone.
- Exclude all requests processed as service authorization requests, payment requests, reopenings, and withdrawals.
- Exclude all requests for concurrent reviews for inpatient hospital and inpatient SNF services, and notifications of admissions.

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee 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	Enter the contract number (e.g., H1234).

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the MMP to provide administrative or health care services to an enrollee under the MMP program) that processed the request.  Enter None if the MMP processed the request.
G	Authorization or Claim Number	CHAR Always Required	40	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number.  Enter None if there is no authorization, claim or other tracking number available.
H	Date the request was received	CHAR Always Required	10	Enter the date the request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  If a standard request was upgraded to expedited, enter the date the request was upgraded.  If the MMP obtained information establishing good cause after the 60-day filing timeframe, enter the date the MMP received the information establishing good cause.

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
I	Time the request was received	CHAR Always Required	8	<p>For all expedited requests, enter the time the request was received. Submit in HH:MM:SS military time format (e.g., 23:59:59).</p> <p>If a standard request was upgraded to expedited, enter the time the request was upgraded.</p> <p>If the MMP obtained information establishing good cause after the 60-day filing timeframe, enter the time the MMP received the information establishing good cause.</p> <p>Enter None for standard and dismissed requests.</p>
J	Part B Drug Request	CHAR Always Required	1	<p>Enter:</p> <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
K	AOR/Equivalent Notice Receipt Date	CHAR Always Required	10	<p>Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in CCYY/MM/DD format (e.g., 2020/01/01).</p> <p>Enter None if no AOR or equivalent written notice was received or required.</p>

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
L	AOR/Equivalent Notice Receipt Time	CHAR Always Required	8	For all expedited requests, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in HH:MM:SS format (e.g., 23:59:59).  Enter None for standard requests or if no AOR or equivalent written notice was received or required.
M	Request Determination	CHAR Always Required	9	Enter: <ul style="list-style-type: none"> <li>• Approved</li> <li>• Denied</li> <li>• Dismissed</li> </ul>
N	Was the request processed as Standard or Expedited?	CHAR Always Required	1	Enter the manner by which the request was processed: <ul style="list-style-type: none"> <li>• S for Standard</li> <li>• E for Expedited</li> </ul>
O	Was a timeframe extension taken?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
P	Date of Determination	CHAR Always Required	10	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  For dismissed requests enter the date the MMP dismissed the request.
Q	Time of Determination	CHAR Always Required	8	For all expedited requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard and dismissed requests.

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
R	Date oral notification provided to enrollee	CHAR Always Required	10	Enter the date oral notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None for dismissed requests or if no oral notification was provided.
S	Time oral notification provided to enrollee	CHAR Always Required	8	For all expedited requests, enter the time oral notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard requests, dismissed requests or if no oral notification was provided.
T	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification was provided to enrollee. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if no written notification was provided.
U	Time written notification provided to enrollee	CHAR Always Required	8	For all expedited requests, enter the time written notification was provided to enrollee. Do not enter the time a letter is generated or printed. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard requests, dismissed requests, or if no written notification was provided.

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
V	Date appeal effectuated in the system	CHAR Always Required	10	Enter the date the appeal was effectuated in the system. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if the appeal was denied or dismissed.
W	Time appeal effectuated in the system	CHAR Always Required	8	For all expedited requests, enter the time the appeal was effectuated in the system. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard cases, dismissed cases, or if the request was denied.
X	Date forwarded to IRE/IAHO	CHAR Always Required	10	Enter the date the request was forwarded to the IRE/IAHO. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if the enrollee was notified of the approved appeal, or if the request was not forwarded to the IRE/IAHO.
Y	Time forwarded to IRE/IAHO	CHAR Always Required	8	For all expedited requests, enter the time the request was forwarded to the IRE/IAHO. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None if the enrollee was notified of the approved appeal, if the request was not forwarded to the IRE/IAHO, or for standard requests.

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
Z	Who made the request?	CHAR Always Required	3	Enter who made the request: <ul style="list-style-type: none"> <li>• E for enrollee</li> <li>• ER for enrollee's representative or purported representative</li> <li>• CP for requests by a contract provider/ facility</li> <li>• NCP for requests by a non-contract provider/ facility</li> </ul>
AA	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service or item requested and why it was requested (if known). If describing behavioral health services, long-term services and supports (LTSS), or substance use disorder services, include the terms behavioral health, LTSS, and substance use disorder service in the description, as applicable. For denials, also provide an explanation of why the pre-service request was denied.  For dismissed requests, provide the reason for dismissal.
AB	Was an expedited request made but processed as standard?	CHAR Always Required	4	Enter: <ul style="list-style-type: none"> <li>• Y for Yes if an expedited request was received but downgraded to standard</li> <li>• None for all other cases (e.g. the request was received as expedited and processed as expedited, the request was received as standard, or the request was dismissed.)</li> </ul>

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
AC	Was the initial service authorization request denied for lack of medical necessity?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA for Not Applicable</li> </ul>
AD	Did the enrollee request to continue services pending an appeal resolution for a previously approved service that was being terminated or modified?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
AE	Were the services under appeal provided to the enrollee during the plan level appeal process?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA for Not Applicable if the service under appeal was not a previously approved service that was being appealed due to the termination or modification of the service.</li> </ul>
AF	Is the requested service a Medicaid-only service?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>

Please use the guidance below for the following record layout:

**Universe Table 3: MMP Provider Payment Requests and Appeals (M PYMT) Record Layout**

- Include all claims and payment appeals the MMP approved, denied, or dismissed from non-contract providers, and non-contract pharmacies during the universe request period.
- Submit provider payment requests (claims) based on the date the claim was paid (Column N) or notification of the denial to the provider (if provider submitted the claim - Column P). Submit payment appeals based on the date the overturned appeal was paid or, for upheld payment appeals, submit based on the date the case was forwarded to the IRE. Submit dismissed requests based on the date of the decision to dismiss (Column M).
- Submit claims based on the date the claim was paid (Column N) or notification of the denial to the provider (Column P).
- Include all claims for Part B drugs if applicable.
- If a claim includes more than one service, include all of the claim's line items in a single row and enter the multiple line items as a claim.
  - o Enter any request denied in whole or in part as denied.
- Enter all fields for a single case in the same time zone. For example, if the MMP has systems in EST and CST, all data in a single line item must be in a single time zone.

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

- Exclude all provider payment requests processed as:
  - o duplicate claims,
  - o payment adjustments,
  - o reopenings,
  - o withdrawals, and
  - o retrospective reviews.
- Exclude any provider payment requests that were denied due to:
  - o invalid billing codes,
  - o eligibility (i.e., enrollees who were not enrolled on the date of service, providers not accepting assignment), or
  - o recoupment of payment, including pending determination of other primary insurance such as automobile, worker’s compensation, etc.

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee 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	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the MMP to provide administrative or health care services to an enrollee under the MMP program) that processed the request.  Enter None if the MMP processed the request.
G	Authorization or Claim Number	CHAR Always Required	40	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number.  Enter None if there is no authorization, claim or other tracking number available.
H	Date the request was received	CHAR Always Required	10	Enter the date the payment request was received. If the MMP obtained information establishing good cause after the 60-day filing timeframe, enter the date the MMP received the information establishing good cause.  Submit in CCYY/MM/DD format (e.g., 2020/01/01).
I	Waiver of Liability (WOL) Receipt Date	CHAR Always Required	10	Enter the date the WOL form was received for non-contracted provider payment appeals. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None for claims, or if a WOL was never received.

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
J	Was it a clean claim?	CHAR Always Required	4	Enter: <ul style="list-style-type: none"> <li>• Y for clean claim</li> <li>• N for unclean claim</li> <li>• None for payment appeals</li> </ul>
K	Was the request processed as a claim or an appeal?	CHAR Always Required	6	Enter the manner by which the request was processed: <ul style="list-style-type: none"> <li>• Claim</li> <li>• Appeal</li> </ul>
L	Request Determination	CHAR Always Required	9	Enter: <ul style="list-style-type: none"> <li>• Approved</li> <li>• Denied</li> <li>• Dismissed</li> </ul>
M	Date of Determination	CHAR Always Required	10	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). This is the date the determination was entered in the system and may be the same as the date claim was paid.  For dismissed requests, enter the date the MMP dismissed the request.
N	Date claim/ payment appeal was paid	CHAR Always Required	10	Enter the date the claim was paid. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if payment was not provided, if the request was denied, or if the request was dismissed.
O	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if no written notification was provided.

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
P	Date written notification provided to provider	CHAR Always Required	10	Enter the date written notification was provided to provider. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if no written notification was provided.
Q	Date forwarded to IRE	CHAR Always Required	10	Enter the date the payment appeal was forwarded to the IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None for claims, or if the payment appeal was approved, dismissed, or not forwarded to the IRE.
R	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service or item requested and why it was requested (if known). If describing behavioral health services, long-term services and supports (LTSS), or substance use disorder services, include the terms behavioral health, LTSS, and substance use disorder service in the description, as applicable. For denials, also provide an explanation of why the claim or payment appeal was denied.  For dismissed requests, please provide the reason for dismissal.
S	Was the initial claim denied for lack of medical necessity?	CHAR Always Required	4	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• None if the request was approved or dismissed.</li> </ul>

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

Column ID	Field Name	Field Type	Field Length	Description
T	Is the requested service a Medicaid-only service?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>

Please use the guidance below for the following record layout:

**Universe Table 4: MMP Effectuations of Overturned Decisions by IRE, SFH, ALJ, or MAC (M EFF) Record Layout**

- Include all plan level appeals fully or partially overturned by the IRE, SFH, ALJ, or MAC requiring an effectuation as pre-service or post-service (payment) that were received from the IRE, SFH, ALJ, or MAC during the universe request period. The date of the MMP's receipt of the overturn decision (Column ID J) must fall within the universe request period.
- For the purposes of the Table 4 Record Layout, SFH is inclusive of the IAHO.
- Exclude any cases that were dismissed or upheld by the IRE, SFH, ALJ, or MAC.

Column ID	Field Name	Field Type	Field Length	Description
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.
C	Enrollee 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	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).

**Program Audit Protocol and Data Request  
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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	<p>Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the MMP to provide administrative or health care services to an enrollee under the MMP program) that processed the request.</p> <p>Enter None if the MMP processed the request.</p>
G	Authorization or Claim Number	CHAR Always Required	40	<p>Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number.</p> <p>Enter None if there is no authorization, claim or other tracking number available.</p>
H	Type of appeal case	CHAR Always Required	9	<p>Enter the type of appeal case submitted to IRE/SFH/ALJ/MAC:</p> <ul style="list-style-type: none"> <li>• Standard</li> <li>• Expedited</li> <li>• Payment</li> </ul> <p>For pre-service cases, enter Standard or Expedited. Default to Standard for pre-service cases if the three-way contract has one effectuation timeframe for the applicable external appeals entity's overturns.</p> <p>For post-service cases, enter Payment.</p>

**Program Audit Protocol and Data Request  
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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
I	Review Entity	CHAR Always Required	3	Enter the entity that overturned the decision: <ul style="list-style-type: none"> <li>• IRE</li> <li>• SFH (including the IAHO)</li> <li>• ALJ</li> <li>• MAC</li> </ul>
J	Date the overturned decision was received	CHAR Always Required	10	Enter the date the overturned decision was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
K	Time the overturned decision was received	CHAR Always Required	8	For expedited requests and Part B drug requests, enter the time the overturned decision was received. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None if not an expedited or Part B drug request.
L	Part B Drug Request	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
M	Date overturned decision or payment effectuated in the system	CHAR Always Required	10	Enter the date overturned decision effectuated in the system. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if the overturned decision was not effectuated.
N	Time overturned decision or payment effectuated in the system	CHAR Always Required	8	For expedited requests and Part B drug requests, enter the time the overturned decision was effectuated in the system. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard pre-service requests and payment appeals, or if the overturned decision was not effectuated.

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
O	Did the enrollee request to continue services pending an appeal resolution for a previously approved service that was being terminated or modified?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
P	Were the services under appeal provided to the enrollee during the external appeal process?	CHAR Always Required	2	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> <li>• NA for Not Applicable if the service under appeal was not a previously approved service that was being appealed due to the termination or modification of the service.</li> </ul>

Please use the guidance below for the following record layout:

**Universe Table 5: MMP Standard and Expedited Grievances (M GRV) Record Layout**

- Include all MMP grievances the MMP responded to during the universe request period. The date of the MMP’s notification (Column ID Q or S) must fall within the universe request period.
- Grievances with multiple issues must be entered as a single line item, unless the Sponsoring organization issued separate notifications.
- Exclude all grievances that were withdrawn and dismissed during the universe request period.
- Exclude complaints filed only within the Complaints Tracking Module (CTM) in HPMS. If a complaint was processed both within the CTM and was also received as a grievance, exclude the CTM complaint but include the grievance as processed by the MMP.

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
A	Enrollee First Name	CHAR Always Required	50	Enter the first name of the enrollee.
B	Enrollee Last Name	CHAR Always Required	50	Enter the last name of the enrollee.

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
C	Enrollee 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	Enter the contract number (e.g., H1234).
E	Plan Benefit Package (PBP)	CHAR Always Required	3	Enter the PBP (e.g., 001).
F	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the MMP to provide administrative or health care services to an enrollee under the MMP program) that processed the grievance.  Enter None if the MMP processed the grievance.
G	Date the grievance was received	CHAR Always Required	10	Enter the date the grievance was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01).

**Program Audit Protocol and Data Request  
MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
H	Time the grievance was received	CHAR Always Required	8	Enter the time the grievance was received. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard cases.
I	AOR/Equivalent notice Receipt Date	CHAR Always Required	10	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if no AOR or equivalent written notice was received or required.
J	AOR/Equivalent notice Receipt Time	CHAR Always Required	8	For expedited grievances, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in HH:MM:SS format (e.g., 23:59:59).  Enter None for standard grievances, or if an AOR or equivalent written notice was not received or required.
K	How was the grievance received?	CHAR Always Required	7	Enter the method of receipt of the grievance: <ul style="list-style-type: none"> <li>• Oral</li> <li>• Written</li> </ul>
L	Was the grievance processed as Standard or Expedited?	CHAR Always Required	1	Enter how the grievance was processed: <ul style="list-style-type: none"> <li>• S for Standard</li> <li>• E for Expedited</li> </ul>
M	Category of the issue	CHAR Always Required	50	Enter the category of the grievance as assigned by the MMP. Enter based on the MMP's internal labeling system.

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
N	Grievance Description	CHAR Always Required	2,000	Enter a description of the grievance.
O	Was this processed as a quality of care grievance?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
P	Was a timeframe extension taken?	CHAR Always Required	1	Enter: <ul style="list-style-type: none"> <li>• Y for Yes</li> <li>• N for No</li> </ul>
Q	Date oral notification provided to enrollee	CHAR Always Required	10	Enter the date oral notification was provided to the enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if no oral notification was provided.
R	Time oral notification provided to enrollee	CHAR Always Required	8	Enter the time oral notification was provided to the enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard grievances, or if no oral notification was provided.
S	Date written notification provided to enrollee	CHAR Always Required	10	Enter the date written notification was provided to enrollee. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01).  Enter None if a written notification was not provided.
T	Time written notification provided to enrollee	CHAR Always Required	8	Enter the time written notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59).  Enter None for standard cases, or if written notification was not provided.

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<b>Column ID</b>	<b>Field Name</b>	<b>Field Type</b>	<b>Field Length</b>	<b>Description</b>
U	Who made the request?	CHAR Always Required	2	Enter who made the request: <ul style="list-style-type: none"> <li>• E for enrollee</li> <li>• ER for enrollee’s representative or purported representative</li> </ul>

## **Audit Field Work Phase**

### **Supporting Documentation Submissions**

Each case will be evaluated to determine whether the MMP is compliant with its three-way contract requirements. To facilitate this review, the MMP must have access to, and the ability to save and upload screenshots of, supporting documentation and data relevant for a particular case, including, but not limited to:

- Original pre-service request or payment (i.e., claim) request or appeal:
  - o If request was received via fax/mail/email, copy of original request including date/time stamp of receipt.
  - o 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.
  - o If a request was received via a chat feature that is available on the MMP’s website, copy of the transcript.
  - o If request was received from a representative or NCP (appeals), copy of the AOR or equivalent written notice/WOL received.
- Letters, emails or documentation confirming the MMP’s receipt of the request:
  - o If request was received via fax/mail/email, copy of original request.
  - o If request was received via phone, copy of CSR notes and/or documentation of call.
- Description of the service requested from the provider/physician or the enrollee.
- Notices, letters, call logs or other documentation showing the MMP requested additional information (if applicable) from the requesting provider/physician, 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.
- All supplemental information submitted by the requesting provider/physician or enrollee.
  - o If information was received via fax/mail/email, copy of original request.
  - o If information was received via phone, copy of CSR notes and/or documentation of call.
- Documentation of case review steps including name and title of final reviewer; clinical criteria that supports rationale for denial; any reference to the three-way contract, CMS guidance, Federal Regulations, 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 authorization request/appeal systems and evidence of effectuation in MMP’s claims adjudication system.
- Documentation showing approval notification to the enrollee and/or their representative and physician/provider, as applicable.

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- o Copy of the written decision letter;
- o If oral notification was given, copy of CSR notes and/or documentation of call.
- Records indicating that payments were made/issued such as EFT records.
- Documentation showing denial notification to the enrollee and/or their representative and provider/physician, if applicable:
  - o Copy of written decision letter;
  - o If oral notification was given, copy of CSR notes and/or documentation of call.
- Documentation showing appeal denial notification to the enrollee and/or their representative and provider/physician, if applicable:
  - o Copy of written decision letter;
  - o 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 enrollee and the requesting provider/physician.
- If applicable, providing timely notification of dismissed requests to enrollees or another party, and informing enrollees and other parties about the right to request IRE/IAHO review of the dismissed request.
- ANOC/EOC to support application of Step Therapy to Part B drugs.
- For appeals, all documentation outlined for both the original determination and the appeal.
- If appealed case was not determined wholly in the enrollee's favor or untimely, include the following:
  - o Documentation showing the MMP auto-forwarded the request to the IRE for Medicare and Medicare-Medicaid overlap services.
  - o NY MMPs only: Documentation showing the MMP auto-forwarded the request to the IAHO.  
NOTE: This applies to both Medicare and Medicaid services.
- Copy of overturn notice from SFH/IRE/ALJ/MAC.
- Copy of effectuation notice sent to IRE.
- Documentation of continued provision of the service in the event that the enrollee is due aid pending appeal and determinations of enrollee eligibility for aid pending appeal. (Applicable to plan level appeals, State Fair Hearing appeals, and to certain IRE auto-forward cases if required in the contract.)
- Initial Complaint and any other supplemental documentation explaining the issue:
  - o If complaint was received via fax/mail/email, copy of original complaint including date/time stamp of receipt;
  - o If complaint was received via phone, copy of CSR notes and/or documentation of call including date/time of call and call details.
- Where applicable, copy of all notices, letters, call logs, or other documentation showing when the MMP acknowledged receipt of the grievance to the enrollee, and/or requested additional information from the enrollee 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 enrollee.
- Documentation of all supplemental information submitted by enrollee and/or their representative:
  - o If information was received via fax/mail/email, copy of documentation provided 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 of call and call details.

## **Program Audit Protocol and Data Request MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

- 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 enrollee communications.
- Documentation showing resolution notification to the enrollee and/or their representative:
  - o Copy of the written decision letter sent and documentation of date/time letter was printed and mailed.
  - o If oral notification was given, copy of CSR notes and/or documentation of call including date/time stamp.
- Documentation that supports a MMPs record layout population (e.g. mailroom policies).

MMPs are expected to submit supporting documentation within two business days of the request.

### **Root Cause Analysis Submissions**

MMPs may be required to provide a root cause analysis using the Root Cause Template provided by CMS. MMPs have two business days from the date of the request to respond.

### **Impact Analysis Submissions**

When non-compliance with contract requirements is identified on audit, MMPs must submit each requested impact analysis, comprehensive of all MMP contracts identified in the audit engagement letter, in either Microsoft Excel (.xlsx) file format with a header row or Text (.txt) file format without a header row using one of the universe record layouts above, as specified by CMS. The MMP must include all requests impacted by the issue of non-compliance during the impact analysis request period. MMPs must provide accurate and timely impact analysis submissions within 10 business days of the request. Submissions that do not strictly adhere to the record layout specifications will be rejected.

**Verification of Information Collected:** CMS may conduct integrity tests to validate the accuracy of all universes, impact analyses, and other related documentation submitted in furtherance of the audit. If data integrity issues are noted, MMPs may be required to resubmit their data.