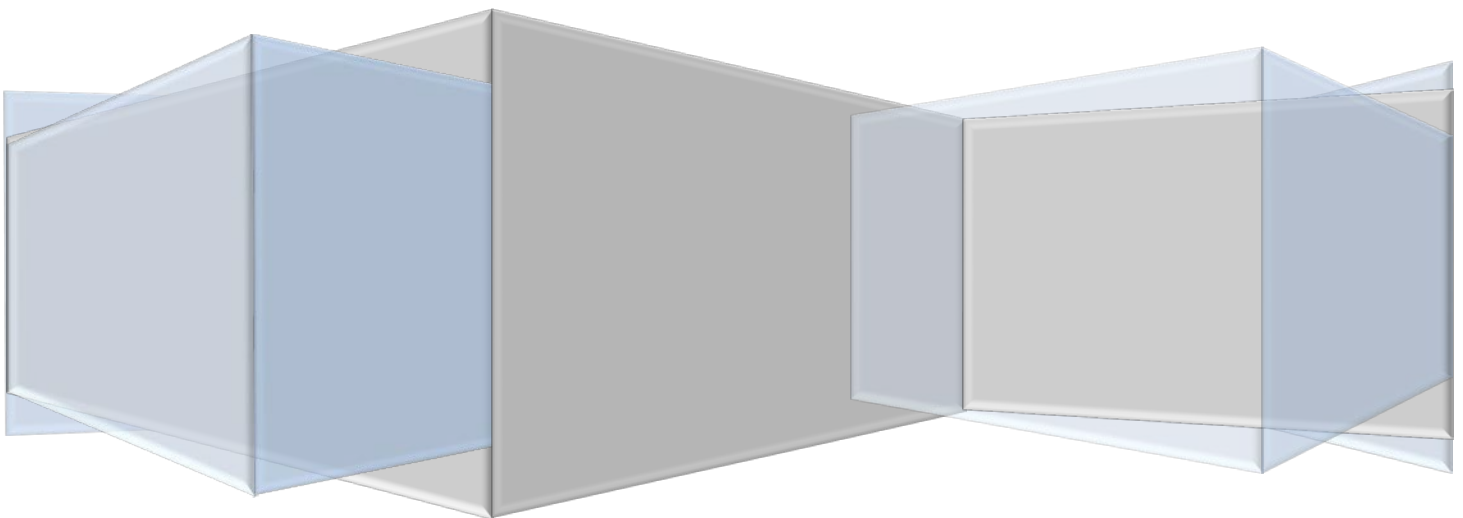




Medicare Part C Utilization Management (UM)

Annual Data Submission



**Annual Data Submission
Medicare Part C Utilization Management (UM)**

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Annual Data Submission

Purpose

To collect and analyze data related to Medicare Part C utilization management (UM) requirements. The Centers for Medicare and Medicaid Services (CMS) will collect and analyze the information in this data submission on an annual basis from all Medicare Advantage (MA) organizations (MAO) that offer the Medicare Part C benefit. In addition to analyzing the information across all MAOs, CMS will utilize the submitted data to implement effective oversight strategies.

Universe Submissions

MAOs submit the following universe in Tab Delimited Text File (txt) format with a header row. Each parent organization will identify the impacted contracts when submitting universe files to the Health Plan Management System (HPMS).

Descriptions and guidance for what must be included in each universe data field are outlined in the record layout below. Characters are required in all requested fields, unless otherwise specified, and data must be limited to the request specified in each field.

MAOs must provide an accurate and timely universe submission by February 28 of each calendar year. Submissions that do not strictly adhere to the record layout specifications will be rejected.

CMS may validate universe submissions and request resubmissions if errors are noted.

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Please use the guidance below for the following record layout:

Utilization Management Annual Submission (UMAS) Record Layout

Scope

Enter all internal coverage criteria:

- Applicable to Medicare Part C services, including Medicare Part B drugs, **that require prior authorization by the MAO and any first tier, downstream, and related entity (FDR) during the calendar year.**
- Use the following definition of "service" when populating the record layout:
 - “Services means medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital, CAH, or SNF facilities.” (42 C.F.R. 400.202)

Exclude:

- Internal coverage criteria used exclusively for concurrent reviews, retrospective reviews, payment reviews, or other organization determinations/ redeterminations that are not pre-service determinations
- Medicare Part B step therapy policies

Specific Requirements

- If the internal coverage criteria applicable to a service varies by service area, enter each unique internal coverage criteria policy for the service in a separate row.
- Enter information in each field (i.e., no blank fields).
- Enter information in the specific formatting requested (when applicable).
- Enter “NA” if a column or field does not apply.
- For all fields with multiple responses/entries (e.g., multiple jurisdictions, FDRs, etc.) use commas to separate each entry (e.g., FDR1, FDR2, FDR3, etc.).
- Do NOT use commas as part of criteria, service, FDR, organization, or vendor names.
- Reference the Utilization Management Annual Submission (UMAS) Record Layout with Examples document for more examples of how to populate the UMAS Record Layout.

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Column ID	Field Name	Description
A	Criteria Name or Identifier	<p>Enter the unique name, number, or other identifier for each policy or document containing internal coverage criteria for all Medicare Part C services subject to prior authorization.</p> <p>Each unique criteria name or identifier must be entered into a separate row.</p>
B	Service Name	<p>Enter the name of each Medicare Part C service subject to prior authorization and associated with the applicable internal coverage criteria policy or document identified in Column A.</p> <p>If this internal coverage criteria policy or document covers multiple services, include all applicable services using a comma-separated list.</p>
C	Medicare Administrative Contractor (MAC) Jurisdictions	<p>Enter all MAC jurisdictions where the internal coverage criteria policy or document is applicable. When entering the jurisdiction, enter “J-” and the jurisdiction code. For example, J-5.</p> <p>MAC jurisdiction codes are available at: https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs</p> <p>If the internal coverage criteria policy or document is applicable in multiple MAC jurisdictions, enter all applicable MAC jurisdictions using a comma-separated list.</p> <p>Enter ALL if this specific internal coverage criteria policy or document applies in all MAC jurisdictions in which the MAO operates.</p>

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Column ID	Field Name	Description
D	FDR	<p>Identify all entities (including your organization and any applicable FDRs) that utilize this specific internal coverage criteria policy or document to determine if prior authorization requirements have been satisfied for this service.</p> <p>Enter ALL if all entities utilize this specific internal coverage criteria policy or document.</p> <p>If <u>some but not all</u> entities utilize this internal coverage criteria policy or document, the organization may report the information in <u>one</u> of the following ways (whichever is easiest for your organization):</p> <ul style="list-style-type: none"> • Enter all applicable entities that <u>use</u> this internal coverage criteria policy or document, OR • Enter, “All excluding” and all applicable entities that <u>do not use</u> this specific internal coverage criteria policy or document. <p>When entering multiple entities use a comma-separated list.</p> <p>Examples:</p> <ul style="list-style-type: none"> • ALL • FDR 1, FDR 2, FDR 3 • All excluding FDR 4, FDR 5
E	Organization or Vendor	<p>Enter the name(s) of any entity (your organization, entity and/or any vendors) that developed, assisted with developing, or is/are responsible for updating this specific internal coverage criteria policy or document. Use a comma-separated list for multiple entries (e.g., MCG).</p>

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is OMB 0938-1488 (Expires 09/30/2028). This information collection will allow CMS to perform oversight of Medicare Part C utilization management (UM) requirements. The time required to complete this information collection is estimated at 15 hours per response, including the time to gather, compile, and report the data to CMS. This information collection is mandatory per CMS’s authority under Section 1857(d) of the Social Security Act and implementing regulations at 42 CFR § 422.503 and § 422.504, which state that CMS must oversee a Medicare Advantage (MA) organization’s continued compliance with MA program requirements. Additionally, per § 422.516(a), MA organizations are required to compile and report to CMS information related to the utilization of services, and other matters as CMS may require. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4- 26-05, Baltimore, Maryland 21244-1850.