Public Comments for ICR 202505-0938-016

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Comments Received :

If the initial request is received after the service is completed, but before a claim is submitted, is the data to be collected under Subsection 1- Initial Determinations (coverage decisions) or Subsection 2 Initial Determinations (payment)?

This new report is duplicative of the required reporting under Part C annual reporting, is there a way to streamline so it can be just one submission for one report instead of two separate reports?

How should fields be populated when they don't apply? Blank, NA, None? (i.e. Supplemental benefits such as fitness and weight loss benefits claims would not have CPT/HCPCS and ICD10 codes).

Non-Contracted Provider Appeals – if no waiver of liability is received, would the rationale be invalid request or not party to the appeal?

For supplemental benefits such as fitness reimbursements, how should the start and end dates be populated in the payments section? Should it be the same date for the start and end field?

For Element X in Subsection 1.B Payment Decisions, was this meant to be in reference to Element W rather than Element V? It would make more sense if there was a Prior Approval requested in Element W then the OD Number would be populated into Element X.

CMS should delay the implementation of this reporting til 2027 to give plans sufficient time to implement updates to coding in reporting systems and applications in order to meet the large amount of data required for this report.