2.2 Serious Reportable Adverse Events (SRAEs) (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Serious Reportable Adverse Events (SRAEs)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	

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1.e		Data file locations are referenced correctly.	**Review Results:**	
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*
2.a	RSC-1	The appropriate date range(s) for the reporting period(s) is captured. Organization reports data based on the required reporting period of 1/1 through 12/31.	**Review Results:**	
2.b	RSC-2	Data are assigned at the applicable level (e.g., plan benefit package or contract level). Organization properly assigns data to the applicable CMS contract.	**Review Results:**	
2.c	RSC-3	Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadline for reporting annual data to CMS by 5/31. [*Note to reviewer:* If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]	**Review Results:**	

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications			*
2.e		The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.	Data Element 3.1	**Review Results:**	
		Applicable Reporting Section Criteria:	Data Element 3.2	**Review Results:**	
	RSC-4	RSC-4: Organization accurately calculates the total number of surgeries, including the following criteria: RSC-4a: Includes all surgeries with dates of service that occur during the reporting period. If a date of service is not available, date of discharge is acceptable. [Data Element 3.1]			
		RSC-4b: Includes only surgeries that occur in an acute inpatient hospital setting. [Data Element 3.1]	Data Element 3.3	**Review Results:**	

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-5	RSC-5: Organization accurately calculates the total number of surgeries, including the following criteria: RSC-5a: Accurately maps SRAEs to the codes provided by CMS in Appendix 2 of the Part C Reporting Requirements Technical Specifications Document, Table 2. If available, plans may use "expanded ranges" codes to further specify the procedure or disease. [*Note to reviewer*: Organizations may map non-standard, homegrown codes, or events/conditions that are typically documented by hospital review personnel to the applicable SRAE. It is not necessary for an SRAE claim to contain every qualifier to be counted.] [Data Elements 3.2-3.5]			
			Data Element 3.4	**Review Results:**	
		RSC-5b: Includes all specified SRAEs that are confirmed during the reporting period. If a date of service is not available, date of discharge is acceptable. [Data Elements 3.2-3.5]			
			Data Element 3.5	**Review Results:**	
		RSC-5c: Includes only surgical SRAEs that occur in an acute inpatient hospital setting (i.e., during the hospital stay). [Data Elements 3.2-3.5]			
		RSC-5d: Excludes surgical SRAEs acquired after admission to Long Term Acute Care facilities. [Data Elements 3.2-3.5]			
			Data Element 3.6	**Review Results:**	

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5e: Includes SRAEs identified by paid claims as well as claims denied only due to being a non-reimbursable SRAE ("Never Events"). [Data Elements 3.2-3.5]	Data Element 3.7	**Review Results:**	
		RSC-5f: Excludes any patient admitted with an SRAE and/or hospital acquired condition (HAC) and only counts acute care in-patients who suffer an SRAE and/or HAC after admission, but during their hospital stay (if an SRAE is reported on a claim, the Present on Admission (POA) indicator must be "N" (no) for the SRAE/HAC to be counted as acquired during the hospital stay). [Data Elements 3.2-3.5]	Data Element 3.8	**Review Results:**	
		RSC-5g: Properly assigns each event to a single applicable SRAE data element unless multiple SRAEs occur during that single episode; if multiple events are associated with multiple procedures, organization appropriately reports each SRAE associated with all of those procedures. [Data Elements 3.2-3.5]	Data Element 3.9	**Review Results:**	

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5h: Properly sorts by each of the following events: Surgeries on wrong body part; Surgeries on wrong patient; Wrong surgical procedures on a patient; and Surgeries with post-operative death in normal health patient. [Data Elements 3.2-3.5] RSC-5i: Properly counts each unique event. [Data Elements 3.2-3.5]			
	RSC-6	RSC-6: Organization accurately calculates the number of HACs, including the following criteria: RSC-6a: Accurately maps HACs to the codes provided by CMS in Appendix 2 of the Part C Reporting Requirements Technical Specifications Document, Table 3 and Table 4. If available, plans may use "expanded ranges" codes to further specify the procedure or disease. [*Note to reviewer*: Organizations may map non-standard, homegrown codes, or events/conditions that are typically documented by hospital review personnel to the applicable SRAE. It is not necessary for an HAC claim to contain every qualifier to be counted.] [Data Elements 3.6–3.16]	Data Element 3.10	**Review Results:**	
		RSC-6b: Includes all specified HACs that are confirmed during the reporting period. If a date of service is not available, date of discharge is acceptable. The diagnosis code and procedure code may be on the same	Data Element 3.11	**Review Results:**	

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		claim or on different claims, and may or may not be on the same date of service. [Data Elements 3.6-3.16]			
		RSC-6c: For Data Elements 3.6-3.14, includes only HACs that occur in an acute inpatient hospital setting (i.e., during the hospital stay). [Data Elements 3.6-3.14]	Data Element 3.12	**Review Results:**	
		RSC-6d: For Data Elements 3.15 – 3.16, includes only those HACs that occur in an acute inpatient hospital setting and are diagnosed during the hospital stay. [Data Elements 3.15, 3.16]			
		RSC-6e: Excludes HACs acquired after admission to Long Term Acute Care facilities. [Data Elements 3.6-3.16]			
			Data Element 3.13	**Review Results:**	
		RSC-6f: Includes HACs identified by paid claims as well as claims denied only due to being a non-reimbursable HAC ("Never Events"). [Data Elements 3.6-3.16]	Data Element 3.14	**Review Results:**	

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-6g: Excludes any patient admitted with an SRAE and/or HAC and only counts acute care inpatients who suffer an SRAE and/or HAC *after* admission, but during their hospital stay (if an SRAE is reported on a claim the POA indicator must be "N" (no) for the SRAE/HAC to be counted as acquired during the hospital stay). [Data Elements 3.6-3.16]			
		RSC-6h: Properly assigns each HAC to a single applicable HAC data element unless multiple HACs occur during that single episode; if multiple HACs are associated with multiple procedures, organization appropriately reports each HAC associated with all of those procedures. [Data Elements 3.6-3.16]	Data Element 3.15	**Review Results:**	
		RSC-6i: Properly sorts by each of the following HACs: Foreign object retained after surgery; Air embolism events; Blood incompatibility events; Stage III & IV pressure ulcers; Fractures; Dislocations; Intracranial injuries; Crushing injuries; Burns; Vascular catheter-associated infections; and Catheter-associated UTIs. [Data Elements 3.6– 3.16]	Data Element 3.16	**Review Results:**	
		RSC-6j: Properly counts each unique event. [Data Elements 3.6– 3.16]			

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-7	RSC-7: Organization accurately calculates the number of HACs, including the following criteria: RSC-7a: Accurately maps HACs to the codes provided by CMS in Appendix 2 of the Part C Reporting Requirements Technical Specifications Document, Table 4. If available, plans may use "expanded ranges" codes to further specify the procedure or disease. [*Note to reviewer*: Organizations may map non-standard, homegrown codes, or events/conditions that are typically documented by hospital review personnel to the applicable SRAE. It is not necessary for an HAC claim to contain every qualifier to be counted.] [Data Elements 3.17–3.21]	Data Element 3.17	**Review Results:**	
			Data Element 3.18	**Review Results:**	
		RSC-7b: Includes all specified HACs that are confirmed during the reporting period. If a date of service is not available, date of discharge is acceptable. The diagnosis code and procedure code may be on the same claim or on different claims, and may or may not be on the same date of service. [Data Elements 3.17-3.21]			
		RSC-7c: Excludes HACs acquired after admission to Long Term Acute Care facilities. [Data Elements 3.17-3.21]	Data Element 3.19	**Review Results:**	

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		RSC-7d: For Data Element 3.17, includes only those HACs that occur in an acute inpatient hospital setting and are diagnosed during the hospital stay. [Data Element 3.17] RSC-7e: For Data Element 3.18, includes SSI diagnosis codes with a date of service that extends 30 days from discharge. Includes data for the CC/ MCC code found from hospital claims only (hospital claim with the procedure and/or subsequent hospital claim). [Data Elements 3.18]			
		RSC-7f: For Data Element 3.19, includes SSI diagnosis codes with a date of service that extends 365 days after discharge. Includes data for the CC/ MCC code found from hospital claims only (hospital claim with the procedure and/or subsequent hospital claim). [Data Elements 3.19] RSC-7g: For Data Element 3.20, includes SSI diagnosis codes with a date of service that extends 30 days after discharge. Includes data for the CC/ MCC code found from hospital claims only (hospital claim with the procedure and/or subsequent hospital claim). [Data Element 3.20]	Data Element 3.20	**Review Results:**	
		RSC-7h: Includes HACs identified by paid claims as well as claims denied only due to being a non-reimbursable HAC ("Never Events"). [Data Elements 3.17-3.21]	Data Element 3.21	**Review Results:**	

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-7i: For Data Elements 3.17 and 3.21, excludes any patient admitted with an SRAE and/or HAC and only counts acute care in-patients who suffer an SRAE and/or HAC *after* admission, but during their hospital stay (if an SRAE is reported on a claim, the POA indicator must be "N" for the SRAE/HAC to be counted as acquired during the hospital stay. [Data Elements 3.17– and 3.21]			
		RSC-7j: For Data Elements 3.18 – 3.20, includes any patient admitted with a SRAE and/ or HAC that resulted from a previous hospitalization and is readmitted, either as a result of that SRAE/HAC and/or for other reasons, in which the POA indicator is "Y". [Data Elements 3.18– 3.20]			
		RSC-7kj: Properly assigns each HAC to a single applicable HAC data element unless multiple HACs occur during that single episode; if multiple HACs are associated with multiple procedures, organization appropriately reports each HAC associated with all of those procedures. [Data Elements 3.17– 3.21]			

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		RSC-7lk: Properly sorts by each of the following HACs: Manifestations of poor glycemic control; SSI (mediastinitis) after CABG; SSI after certain orthopedic procedures; SSI following bariatric surgery for obesity; and DVT and pulmonary embolism following certain orthopedic procedures. [Data Elements 3.17– 3.21] RSC-7ml: Properly counts each unique event. [Data Elements 3.17– 3.21]			
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element 3.1	**Review Results:**	
			Data Element 3.2	**Review Results:**	

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			Data Element 3.3	**Review Results:**	
			Data Element 3.4	**Review Results:**	
			Data Element 3.5	**Review Results:**	
			Data Element 3.6	**Review Results:**	
			Data Element 3.7	**Review Results:**	
			Data Element 3.8	**Review Results:**	
			Data Element 3.9	**Review Results:**	
			Data Element 3.10	**Review Results:**	
			Data Element 3.11	**Review Results:**	
			Data Element 3.12	**Review Results:**	
			Data Element 3.13	**Review Results:**	

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			Data Element 3.14	**Review Results:**	
			Data Element 3.15	**Review Results:**	
			Data Element 3.16	**Review Results:**	
			Data Element 3.17	**Review Results:**	
			Data Element 3.18	**Review Results:**	
			Data Element 3.19	**Review Results:**	
			Data Element 3.20	**Review Results:**	
			Data Element 3.21	**Review Results:**	
3.b		All source, intermediate, and final stage data sets and other ouputs relied upon to enter data into CMS systems are archived.		**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Serious Reportable Adverse Events (SRAEs)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).	**Data Sources:** **Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).	**Data Sources:** **Review Results:**	
6		*If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):* Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.	**Data Sources:** **Review Results:**	
7		*If data collection and/or reporting for this reporting section is delegated to another entity:* Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/ downstream contractor.	**Data Sources:** **Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Serious Reportable Adverse Events (SRAEs)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Serious Reportable Adverse Events (SRAEs)**
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Instructions for each Standard or Sub-standard:
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1.e		Data file locations are referenced correctly.	**Review Results:**	
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Serious Reportable Adverse Events (SRAEs)**
Last Updated:	**MM/DD/YYYY**
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Name of Reviewer:	**Last name, First name**
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*
2.a	RSC-1	The appropriate date range(s) for the reporting period(s) is captured. Organization reports data based on the required reporting period of 1/1 through 12/31.	**Review Results:**	
2.b	RSC-2	Data are assigned at the applicable level (e.g., plan benefit package or contract level). Organization properly assigns data to the applicable CMS contract.	**Review Results:**	
2.c	RSC-3	Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadline for reporting annual data to CMS by 2/28. [*Note to reviewer:* If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Serious Reportable Adverse Events (SRAEs)**
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Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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Instructions for each Standard or Sub-standard:
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications			*
2.e		The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.	Data Element 3.1	**Review Results:**	
		Applicable Reporting Section Criteria:	Data Element 3.2	**Review Results:**	
	RSC-4	RSC-4: Organization accurately calculates the total number of surgeries, including the following criteria: RSC-4a: Includes all surgeries with dates of service that occur during the reporting period. If a date of service is not available, date of discharge is acceptable. [Data Element 3.1]			
		RSC-4b: Includes only surgeries that occur in an acute inpatient hospital setting. [Data Element 3.1]	Data Element 3.3	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

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Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-5	RSC-5: Organization accurately calculates the total number of surgeries, including the following criteria: RSC-5a: Accurately maps SRAEs to the codes provided by CMS in Appendix 1 of the Part C Reporting Requirements Technical Specifications Document, Table 2. If available, plans may use "expanded ranges" codes to further specify the procedure or disease. [*Note to reviewer*: Organizations may map non-standard, homegrown codes, or events/conditions that are typically documented by hospital review personnel to the applicable SRAE. It is not necessary for an SRAE claim to contain every qualifier to be counted.] [Data Elements 3.2-3.5]			
			Data Element 3.4	**Review Results:**	
		RSC-5b: Includes all specified SRAEs that are confirmed during the reporting period. If a date of service is not available, date of discharge is acceptable. [Data Elements 3.2-3.5]			
			Data Element 3.5	**Review Results:**	
		RSC-5c: Includes only surgical SRAEs that occur in an acute inpatient hospital setting (i.e., during the hospital stay). [Data Elements 3.2-3.5]			
		RSC-5d: Excludes surgical SRAEs acquired after admission to Long Term Acute Care facilities. [Data Elements 3.2-3.5]			
			Data Element 3.6	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

Organization Name:	
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Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5e: Includes SRAEs identified by paid claims as well as claims denied only due to being a non-reimbursable SRAE ("Never Events"). [Data Elements 3.2-3.5] RSC-5f: Excludes any patient admitted with an SRAE and/or hospital acquired condition (HAC) and only counts acute care in-patients who suffer an SRAE and/or HAC after admission, but during their hospital stay (if an SRAE is reported on a claim, the Present on Admission (POA) indicator must be "N" (no) for the SRAE/HAC to be counted as acquired during the hospital stay). [Data Elements 3.2-3.5] RSC-5g: Properly assigns each event to a single applicable SRAE data element unless multiple SRAEs occur during that single episode; if multiple events are associated with multiple procedures, organization appropriately reports each SRAE associated with all of those procedures. [Data Elements 3.2-3.5]	Data Element 3.7	**Review Results:**	
			Data Element 3.8	**Review Results:**	
			Data Element 3.9	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

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Name of Reviewer:	**Last name, First name**
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5h: Properly sorts by each of the following events: Surgeries on wrong body part; Surgeries on wrong patient; Wrong surgical procedures on a patient; and Surgeries with post-operative death in normal health patient. [Data Elements 3.2-3.5] RSC-5i: Properly counts each unique event. [Data Elements 3.2-3.5]			
	RSC-6	RSC-6: Organization accurately calculates the number of HACs, including the following criteria: RSC-6a: Accurately maps HACs to the codes provided by CMS in Appendix 1of the Part C Reporting Requirements Technical Specifications Document, Table 3 and Table 4. If available, plans may use "expanded ranges" codes to further specify the procedure or disease. [*Note to reviewer*: Organizations may map non-standard, homegrown codes, or events/conditions that are typically documented by hospital review personnel to the applicable SRAE. It is not necessary for an HAC claim to contain every qualifier to be counted.] [Data Elements 3.6–3.16]	Data Element 3.10	**Review Results:**	
			Data Element 3.11	**Review Results:**	
		RSC-6b: Includes all specified HACs that are confirmed during the reporting period. If a date of service is not available, date of discharge is acceptable. The diagnosis code and procedure code may be on the same			

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

Organization Name:	
Contract Number:	
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Name of Reviewer:	**Last name, First name**
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		claim or on different claims, and may or may not be on the same date of service. [Data Elements 3.6-3.16]			
		RSC-6c: For Data Elements 3.6-3.14, includes only HACs that occur in an acute inpatient hospital setting (i.e., during the hospital stay). [Data Elements 3.6-3.14]	Data Element 3.12	**Review Results:**	
		RSC-6d: For Data Elements 3.15 – 3.16, includes only those HACs that occur in an acute inpatient hospital setting and are diagnosed during the hospital stay. [Data Elements 3.15, 3.16]			
		RSC-6e: Excludes HACs acquired after admission to Long Term Acute Care facilities. [Data Elements 3.6-3.16]			
			Data Element 3.13	**Review Results:**	
		RSC-6f: Includes HACs identified by paid claims as well as claims denied only due to being a non-reimbursable HAC ("Never Events"). [Data Elements 3.6-3.16]	Data Element 3.14	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-6g: Excludes any patient admitted with an SRAE and/or HAC and only counts acute care inpatients who suffer an SRAE and/or HAC *after* admission, but during their hospital stay (if an SRAE is reported on a claim the POA indicator must be "N" (no) for the SRAE/HAC to be counted as acquired during the hospital stay). [Data Elements 3.6-3.16]			
			Data Element 3.15	**Review Results:**	
		RSC-6h: Properly assigns each HAC to a single applicable HAC data element unless multiple HACs occur during that single episode; if multiple HACs are associated with multiple procedures, organization appropriately reports each HAC associated with all of those procedures. [Data Elements 3.6-3.16]			
		RSC-6i: Properly sorts by each of the following HACs: Foreign object retained after surgery; Air embolism events; Blood incompatibility events; Stage III & IV pressure ulcers; Fractures; Dislocations; Intracranial injuries; Crushing injuries; Burns; Vascular catheter-associated infections; and Catheter-associated UTIs. [Data Elements 3.6– 3.16]	Data Element 3.16	**Review Results:**	
		RSC-6j: Properly counts each unique event. [Data Elements 3.6– 3.16]			

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-7	RSC-7: Organization accurately calculates the number of HACs, including the following criteria: RSC-7a: Accurately maps HACs to the codes provided by CMS in Appendix 1 of the Part C Reporting Requirements Technical Specifications Document, Table 4. If available, plans may use "expanded ranges" codes to further specify the procedure or disease. [*Note to reviewer*: Organizations may map non-standard, homegrown codes, or events/conditions that are typically documented by hospital review personnel to the applicable SRAE. It is not necessary for an HAC claim to contain every qualifier to be counted.] [Data Elements 3.17–3.21]	Data Element 3.17	**Review Results:**	
			Data Element 3.18	**Review Results:**	
		RSC-7b: Includes all specified HACs that are confirmed during the reporting period. If a date of service is not available, date of discharge is acceptable. The diagnosis code and procedure code may be on the same claim or on different claims, and may or may not be on the same date of service. [Data Elements 3.17-3.21]			
		RSC-7c: Excludes HACs acquired after admission to Long Term Acute Care facilities. [Data Elements 3.17-3.21]	Data Element 3.19	**Review Results:**	

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-7d: For Data Element 3.17, includes only those HACs that occur in an acute inpatient hospital setting and are diagnosed during the hospital stay. [Data Element 3.17] RSC-7e: For Data Element 3.18, includes SSI diagnosis codes with a date of service that extends 30 days from discharge. Includes data for the CC/ MCC code found from hospital claims only (hospital claim with the procedure and/or subsequent hospital claim). [Data Elements 3.18]			
		RSC-7f: For Data Element 3.19, includes SSI diagnosis codes with a date of service that extends 365 days after discharge. Includes data for the CC/ MCC code found from hospital claims only (hospital claim with the procedure and/or subsequent hospital claim). [Data Elements 3.19] RSC-7g: For Data Element 3.20, includes SSI diagnosis codes with a date of service that extends 30 days after discharge. Includes data for the CC/ MCC code found from hospital claims only (hospital claim with the procedure and/or subsequent hospital claim). [Data Element 3.20]	Data Element 3.20	**Review Results:**	
			Data Element 3.21	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-7h: Includes HACs identified by paid claims as well as claims denied only due to being a non-reimbursable HAC ("Never Events"). [Data Elements 3.17-3.21]		
		RSC-7i: For Data Elements 3.17 and 3.21, excludes any patient admitted with an SRAE and/or HAC and only counts acute care in-patients who suffer an SRAE and/or HAC *after* admission, but during their hospital stay (if an SRAE is reported on a claim, the POA indicator must be "N" for the SRAE/HAC to be counted as acquired during the hospital stay. [Data Elements 3.17–and 3.21]		
		RSC-7j: For Data Elements 3.18 – 3.20, includes any patient admitted with a SRAE and/ or HAC that resulted from a previous hospitalization and is readmitted, either as a result of that SRAE/HAC and/or for other reasons, in which the POA indicator is "Y". [Data Elements 3.18– 3.20]		
		RSC-7k: For Data Elements 3.18 – 3.20, includes HAC for which the procedure may be on a different claim and may have occurred in the year prior to the reporting period as long as the HAC diagnosis occurred during the reporting period (1/1 – 12/31). [Data Elements 3.18– 3.20]		

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-7lj: Properly assigns each HAC to a single applicable HAC data element unless multiple HACs occur during that single episode; if multiple HACs are associated with multiple procedures, organization appropriately reports each HAC associated with all of those procedures. [Data Elements 3.17– 3.21] RSC-7m: Properly sorts by each of the following HACs: Manifestations of poor glycemic control; SSI (mediastinitis) after CABG; SSI after certain orthopedic procedures; SSI following bariatric surgery for obesity; and DVT and pulmonary embolism following certain orthopedic procedures. [Data Elements 3.17– 3.21] RSC-7n: Properly counts each unique event. [Data Elements 3.17– 3.21]			
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element 3.1	**Review Results:**	
			Data Element 3.2	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

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1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
			Data Element 3.3	**Review Results:**	
			Data Element 3.4	**Review Results:**	
			Data Element 3.5	**Review Results:**	
			Data Element 3.6	**Review Results:**	
			Data Element 3.7	**Review Results:**	
			Data Element 3.8	**Review Results:**	
			Data Element 3.9	**Review Results:**	
			Data Element 3.10	**Review Results:**	
			Data Element 3.11	**Review Results:**	
			Data Element 3.12	**Review Results:**	
			Data Element 3.13	**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Serious Reportable Adverse Events (SRAEs)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
			Data Element 3.14	**Review Results:**	
			Data Element 3.15	**Review Results:**	
			Data Element 3.16	**Review Results:**	
			Data Element 3.17	**Review Results:**	
			Data Element 3.18	**Review Results:**	
			Data Element 3.19	**Review Results:**	
			Data Element 3.20	**Review Results:**	
			Data Element 3.21	**Review Results:**	
3.b		All source, intermediate, and final stage data sets and other ouputs relied upon to enter data into CMS systems are archived.		**Review Results:**	

2.2 Serious Reportable Adverse Events (SRAEs) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Serious Reportable Adverse Events (SRAEs)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).	**Data Sources:** **Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).	**Data Sources:** **Review Results:**	
6		*If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):* Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.	**Data Sources:** **Review Results:**	
7		*If data collection and/or reporting for this reporting section is delegated to another entity:* Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/ downstream contractor.	**Data Sources:** **Review Results:**	

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
Note to reviewer:	Aggregate all quarterly data submitted within the reporting year before applying the 90% threshold.			
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1.e		Data file locations are referenced correctly.	**Review Results:**	
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*
2.a		The appropriate date range(s) for the reporting period(s) is captured.	**Review Results:**	

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-1	Organization reports data based on the periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.		
2.b		Data are assigned at the applicable level (e.g., plan benefit package or contract level).	**Review Results:**	
	RSC-2	Organization properly assigns data to the applicable CMS contract.		
2.c		Appropriate deadlines are met for reporting data (e.g., quarterly).	**Review Results:**	
	RSC-3	Organization meets deadlines for reporting data to CMS by 2/28. [Note to reviewer: If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]		
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.	**Review Results:**	
	RSC-4	Organization properly defines the term "Organization Determinations" in accordance with 42 C.F.R Part 422, Subpart M and the Medicare Managed Care Manual Chapter 13, Section 10. This includes applying all relevant guidance properly when performing its calculations and categorizations.		
	RSC-98	Organization properly defines the term "Reconsideration" in accordance with 42 C.F.R. Part 422, Subpart M and the Medicare Managed Care Manual Chapter 13, Sections 10 and 70. This includes applying all relevant guidance properly when performing its calculations and categorizations.		

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.e		The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.	Data Element 6.1	**Review Results:**	
	RSC-5	Applicable Reporting Section Criteria: RSC-5: Organization accurately calculates the total number of organization determinations, including the following criteria:			
		RSC-5a: Includes all completed organization determinations (Part C only) with a date of member notification of the final decision that occurs during the reporting period, regardless of when the request for organization determination was received. [Data Elements 6.1 – 6.3]			
		RSC-5b: Includes adjudicated claims with a date of adjudication that occurs during the reporting period. [Data Elements 6.1 – 6.3]			
		RSC-5c: Includes all claims submitted for payment including those that pass through the adjudication system that may not require determination by the staff of the organization or its delegated entity.			

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		[Data Elements 6.1 – 6.3]	Data Element 6.2	**Review Results:**	
		RSC-5d: Includes decisions made on behalf of the organization by a delegated entity. [Data Elements 6.1 – 6.3]			
		RSC-5e: Includes organization determinations that are filed directly with the organization or its delegated entities (e.g., excludes all organization determinations that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity). If a member requests an organization determination directly with the organization and files an identical complaint via the CTM, the organization includes only the organization determination that was filed directly with the organization and excludes the identical CTM complaint. [Data Elements 6.1 – 6.3]			
		RSC-5f: Includes all methods of organization determination request receipt (e.g., telephone, letter, fax, in-person). [Data Elements 6.1 – 6.3]			
		RSC-5g: Includes all organization determinations regardless of who filed the request. [Data Elements 6.1 – 6.3]	Data Element 6.3	**Review Results:**	

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5h: Includes supplemental benefits (i.e., non- Medicare covered item or service) provided as a part of a plan's Medicare benefit package. [Data Elements 6.1 – 6.3]		
		RSC-5i: Excludes dismissals and withdrawals. [Data Elements 6.1 – 6.3]		
		RSC-5j: Excludes Independent Review Entity Decisions. [Data Elements 6.1 – 6.3]		
		RSC-5k: Excludes Quality Improvement Organization (QIO) reviews of a member's request to continue Medicare-covered services (e.g., a SNF stay). [Data Elements 6.1 – 6.3]		
		RSC-5l: Excludes duplicate payment requests concerning the same service or item. [Data Elements 6.1 – 6.3]		
		RSC-5m: Excludes payment requests returned to a provider/supplier in which a substantive decision (fully favorable, partially favorable or adverse) has not yet been made due to error (e.g., payment requests or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim). [Data Elements 6.1 – 6.3]		
	RSC-~~6~~5	RSC-6: Organization accurately calculates the number of fully favorable (e.g., approval of entire request resulting in full coverage of the item or service) organization determinations, including the following criteria:		

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-6a: Includes all fully favorable pre-service organization determinations for contract and non-contract providers/suppliers. [Data Element 6.1] RSC-6b: Includes all fully favorable payment (claim) organization determinations for contract and non-contract providers/suppliers. [Data Element 6.1] RSC-6c: For instances when a request for payment is submitted to an organization concerning an item or service, and the organization has already made a favorable organization determination (i.e., issued a fully favorable pre-service decision), includes the request for payment for the same item or service as another, separate, fully favorable organization determination. [Data Element 6.1] RSC-6d: 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, includes the decision to extend or continue coverage of the same item or service as another, separate, fully favorable organization determination. [Data Element 6.1]		

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-7	RSC-7: Organization accurately calculates the number of partially favorable (e.g., coverage denial of some items and coverage approval of some items in a claim that has multiple line items) organization determinations, including the following criteria: RSC-7a: Includes all partially favorable pre-service organization determination for contract and non-contract providers/suppliers. [Data Element 6.2] RSC-7b: Includes all partially favorable payment organization determinations for contract and non-contract providers/suppliers. [Data Element 6.2]		
	RSC-8	RSC-8: Organization accurately calculates the number of adverse (e.g., denial of entire request resulting in no coverage of the item or service) organization determinations, including the following criteria: RSC-8a: Includes all adverse pre-service organization determinations for contract and non-contract providers/suppliers. [Data Element 6.3] RSC-8b: Includes all adverse payment (claim) organization determinations that result in zero payment being made to contract and non-contract providers. [Data Element 6.3]		

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-10	RSC-10: Organization accurately calculates the total number of reconsiderations, including the following criteria: RSC-10a: Includes all completed reconsiderations (Part C only) with a date of member notification of the final decision that occurs during the reporting period, regardless of when the request for reconsideration was received. [Data Elements 6.4 – 6.6] RSC-10b: Includes decisions made on behalf of the organization by a delegated entity. [Data Elements 6.4 – 6.6] RSC-10c: Includes all methods of reconsideration request receipt (e.g., telephone, letter, fax, in-person). [Data Elements 6.4 – 6.6]	Data Element 6.4	**Review Results:**	
		RSC-10d: Includes all reconsiderations regardless of who filed the request. For example, if a non-contracted provider signs a waiver of liability and submits a reconsideration request, a plan is to report this reconsideration in the same manner it would report a member-filed reconsideration. [Data Elements 6.4 – 6.6] RSC-10e: Includes reconsiderations that are filed directly with the organization or its delegated entities (e.g., excludes all reconsiderations that are only forwarded to the organization from the CMS Complaint	Data Element 6.5	**Review Results:**	

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		Tracking Module (CTM) and not filed directly with the organization or delegated entity). If a member requests a reconsideration directly with the organization and files an identical complaint via the CTM, the organization includes only the reconsideration that was filed directly with the organization and excludes the identical CTM complaint. [Data Elements 6.4 – 6.6] RSC-10f: Includes supplemental benefits (i.e., non- Medicare covered item or service) provided as a part of a plan's Medicare benefit package. [Data Element 6.4-6.6] RSC-10g: Excludes dismissals or withdrawals. [Data Element 6.4-6.6] RSC-10h: Excludes Independent Review Entity Decisions. [Data Element 6.4-6.6] RSC-10i:Excludes QIO reviews of a member's request to continue Medicare-covered services (e.g., a SNF stay). [Data Elements 6.4-6.6] RSC-10j:Excludes duplicate payment requests concerning the same service or item. [Data Elements 6.4 – 6.6]		

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-10k: Excludes payment requests returned to a provider/supplier in which a substantive decision (Fully Favorable, Partially Favorable or Adverse) has not yet been made due to error – (e.g., payment requests or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim). [Data Elements 6.4 – 6.6]			
			Data Element 6.6	**Review Results:**	
	RSC-11	RSC-11: Organization accurately calculates the number of fully favorable (e.g., approval of entire request resulting in full coverage of the item or service) reconsiderations, including the following criteria:			
		RSC-11a: Includes all fully favorable pre-service reconsideration determinations for contract and non-contract providers/suppliers. [Data Element 6.4]			
		RSC-11b: Includes all fully favorable payment (claim) reconsideration determinations for contract and non-contract providers/suppliers. [Data Element 6.4]			
	RSC-12	RSC-12: Organization accurately calculates the number of partially favorable (e.g., coverage denial of some items and coverage approval of some items in a claim that has multiple line items) reconsiderations, including the following criteria:			

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-12a: Includes all partially favorable pre-service reconsideration determinations for contract and non-contract providers/suppliers. [Data Element 6.5] RSC-12b: Includes all partially favorable payment reconsideration determinations for contract and non-contract providers/suppliers. [Data Element 6.5]			
	RSC-13	RSC-13: Organization accurately calculates the number of adverse (e.g., denial of entire request resulting in no coverage of the item or service) reconsiderations, including the following criteria: RSC-13a: Includes all adverse pre-service reconsideration determinations for contract and non-contract providers/suppliers. [Data Element 6.6] RSC-13b: Includes all adverse payment (claim) reconsideration determinations that result in zero payment being made to contract and non-contract providers. [Data Element 6.6]			
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element 6.1	**Review Results:**	

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
			Data Element 6.2	**Review Results:**	
			Data Element 6.3	**Review Results:**	
			Data Element 6.4	**Review Results:**	
			Data Element 6.5	**Review Results:**	
			Data Element 6.6	**Review Results:**	
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.		**Review Results:**	
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).		**Data Sources:** **Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).		**Data Sources:** **Review Results:**	
6		*If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):* Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.		**Data Sources:** **Review Results:**	

2.5 Organization Determinations/Reconsiderations (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
7		*If data collection and/or reporting for this reporting section is delegated to another entity:* Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/ downstream contractor.	**Data Sources:** **Review Results:**	

2.4 Grievances (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
Note to reviewer: Aggregate all quarterly data before applying the threshold. Note to reviewer: Do not apply the 90% threshold to individual grievance categories; 100% correct records are required for individual grievance categories.				
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	

2.4 Grievances (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1.e		Data file locations are referenced correctly.	**Review Results:**	
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*
2.a		The appropriate date range(s) for the reporting period(s) is captured.	**Review Results:**	

2.4 Grievances (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-1	Organization reports data based on the periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.		
2.b		Data are assigned at the applicable level (e.g., plan benefit package or contract level).	**Review Results:**	
	RSC-2	Organization properly assigns data to the applicable CMS plan benefit package.		
2.c		Appropriate deadlines are met for reporting data (e.g., quarterly).	**Review Results:**	
	RSC-3	Organization meets deadlines for reporting data to CMS by 2/28. [Note to reviewer: If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]		
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.	**Review Results:**	
	RSC-4	Organization properly defines the term "Grievance" in accordance with 42 CFR §422.564 and the Medicare Managed Care Manual Chapter 13, Sections 10 and 20. This includes applying all relevant guidance properly when performing its calculations and categorizations. Requests for organization determinations or appeals are not improperly categorized as grievances.		
2.e		The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been — Data Element 5.1	**Review Results:**	

2.4 Grievances (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.			
			Data Element 5.2	**Review Results:**	
	RSC-5	Applicable Reporting Section Criteria: RSC-5: Organization accurately calculates the total number of grievances, including the following criteria:			
		RSC-5a: Includes all grievances that were completed (i.e., organization has notified member of its decision) during the reporting period, regardless of when the grievance was received. [Data Elements 5.1–5.10]	Data Element 5.3	**Review Results:**	
		RSC-5b: Includes all grievances reported by or on behalf of members who were previously eligible, regardless of whether the member was eligible on the date that the grievance was reported to the organization. [Data Elements 5.1-5.10]	Data Element 5.4	**Review Results:**	
		RSC-5c: If a grievance contains multiple issues filed under a single complaint, each issue is calculated as a separate grievance. [Data Elements 5.1–5.10]	Data Element 5.5	**Review Results:**	

2.4 Grievances (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5d: If a member files a grievance and then files a subsequent grievance on the same issue *prior* to the organization's decision or the deadline for decision notification (whichever is earlier), then the issue is counted as one grievance. [Data Elements 5.1–5.10]			
			Data Element 5.6	**Review Results:**	
		RSC-5e: If a member files a grievance and then files a subsequent grievance on the same issue *after* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as a separate grievance. [Data Elements 5.1–5.10]			
			Data Element 5.7	**Review Results:**	
		RSC-5f: Includes all methods of grievance receipt (e.g., telephone, letter, fax, in-person. [Data Elements 5.1– 5.10]			
		RSC-5g: Includes all grievances regardless of who filed the grievance (e.g., member or appointed representative). [Data Elements 5.1–5.10]	Data Element 5.8	**Review Results:**	
		RSC-5h: Includes only grievances that are filed directly with the organization (e.g., excludes all complaints that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization). If a member files the same complaint both directly with the organization and via the CTM, the organization includes only the grievance that was filed directly with the	Data Element 5.9	**Review Results:**	

2.4 Grievances (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		organization and excludes the identical CTM complaint. [Data Elements 5.1–5.10]			
			Data Element 5.10	**Review Results:**	
		RSC-5i: *For MA-PD contracts:* Includes only grievances that apply to the Part C benefit (If a clear distinction cannot be made for an MA-PD, cases are reported as Part C grievances). [Data Elements 5.1–5.10]			
	RSC- 6	RSC-6: Organization accurately calculates the number of grievances by category, including the following criteria:	Data Element 5.11	**Review Results:**	
		RSC-6a: Properly sorts the total number of grievances by grievance category: Fraud; Enrollment/Disenrollment; Benefit Package; Access; Marketing; Customer Service; Privacy Issues; Quality of Care; and Appeals. [Data Elements 5.1–5.10]	Data Element 5.12	**Review Results:**	
			Data Element 5.13	**Review Results:**	
		RSC-6b: Assigns all additional categories tracked by the organization that are not listed above as Other. [Data Elements 5.1–5.10]			
			Data Element 5.14	**Review Results:**	

2.4 Grievances (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

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1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-7	RSC-7: Organization accurately calculates the number of grievances for which it provided timely notification of the decision, including the following criteria:	Data Element 5.15	**Review Results:**	
		RSC-7a: Includes only grievances for which the member is notified of the decision according to the following timelines: [Data Elements 5.11-5.18]	Data Element 5.16	**Review Results:**	
		i. For standard grievances: no later than 30 days after receipt of grievance.	Data Element 5.17	**Review Results:**	
		ii. For standard grievances with an extension taken: no later than 44 days after receipt of grievance.			
		iii. For expedited grievances: no later than 24 hours after receipt of grievance.	Data Element 5.18	**Review Results:**	
		RSC-7b: Each number calculated is a subset of the total number of grievances received for the applicable category. [Data Elements 5.11-5.18]			
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a.		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element 5.1	**Review Results:**	
			Data Element 5.2	**Review Results:**	
			Data Element 5.3	**Review Results:**	

2.4 Grievances (Part C) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part C)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
			Data Element 5.4	**Review Results:**	
			Data Element 5.5	**Review Results:**	
			Data Element 5.6	**Review Results:**	
			Data Element 5.7	**Review Results:**	
			Data Element 5.8	**Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	
1.e		Data file locations are referenced correctly.	**Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
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2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*
2.a	RSC-1	The appropriate date range(s) for the reporting period(s) is captured. Organization reports data based on the required reporting period of 1/1 through 12/31.	**Review Results:**	
2.b		Data are assigned at the applicable level (e.g., plan benefit package or contract level).	**Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-2	Organization properly assigns data to the applicable CMS plan benefit package.		
2.c	RSC-3	Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadline for reporting annual data to CMS by 5/31. [Note to reviewer: If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]	**Review Results:**	
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.		*

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.e	RSC-4	The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.	Data Element 13.1	**Review Results:**	
		Applicable Reporting Section Criteria: RSC-4: Organization accurately calculates the number of new members who are eligible for an initial health risk assessment (HRA), including the following criteria:			
		RSC-4a: Includes all new members who enrolled during the measurement year and those members who may have enrolled as early as 90 days prior to the measurement year if no initial HRA had been performed prior to 1/1. [Data Element 13.1]	Data Element 13.2	**Review Results:**	
		RSC-4b: Excludes members with a documented initial HRA that occurred under the plan during the previous year. These members, and their HRAs, should be counted as new in the previous year. [Data Element 13.1]			

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
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2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-4c: Excludes members who received an initial HRA but were subsequently deemed ineligible because they were never enrolled in the plan. [Data Element 13.1]			
	RSC-5	RSC-5: Organization accurately calculates the number of members eligible for an annual health risk reassessment during the reporting period, including the following criteria:			
		RSC-5a: Includes members who remained continuously enrolled in the same plan for 365 days starting from the date of their last HRA. [Data Element 13.2]			
		RSC-5b: Excludes members who received a reassessment but were subsequently deemed ineligible because they were never enrolled in the plan. [Data Element 13.2]			
		RSC-5c: Excludes members who did not remain enrolled in their same health plan for at least 365 days after their last HRA. [Data Element 13.2]			

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-6	RSC-6: Organization accurately calculates the number of initial health risk assessments performed on new members, including the following criteria [*Note to reviewer*: CMS has not identified a standard tool that SNPs must use to complete initial and annual health risk assessments. The information will not be captured by designated CPT or ICD-9 Procedure codes. Reviewer should confirm that the SNP maintained documentation for each reported assessment.]:	Data Element 13.3	**Review Results:**	
		RSC-6a: Includes only initial HRAs performed on new members within 90 days of enrollment. [Data Element 13.3]			
		RSC-6b: Includes only HRAs that were performed between 1/1 and 12/31 of the measurement year even if the new member enrolled prior to the start of the measurement year. [Data Element 13.3]			
		RSC-6c: Counts only one HRA for members who have multiple HRAs within 90 days of enrollment. [Data Element 13.3]			
		RSC-6d: Excludes HRAs completed for members who were subsequently deemed ineligible because they were never enrolled in the plan. [Data Element 13.3]			

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-6: The number of initial assessments calculated for Data Element 13.3 is a subset of the number of new members calculated for Data Element 13.1. [Data Element 13.3]			
	RSC-7	RSC-7: Organization accurately calculates the number of annual health risk reassessments performed on members eligible for a reassessment, including the following criteria [*Note to reviewer*: CMS has not identified a standard tool that SNPs must use to complete initial and annual health risk assessments. The information will not be captured by designated CPT or ICD-9 Procedure codes. Reviewer should confirm that the SNP maintained documentation for each reported assessment.]:	Data Element 13.4	**Review Results:**	
		RSC-7a: Includes annual reassessments that were completed within 365 days of the member becoming eligible for a reassessment (i.e., within 365 days of their previous HRA). [Data Element 13.4]			
		RSC-7b: Includes only HRAs that were performed between 1/1 and 12/31 of the measurement year. [Data Element 13.4]			

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-7c: Counts only one HRA for members who have multiple reassessments within 365 days of becoming eligible for a reassessment. [Data Element 13.4]			
		RSC-7d: Excludes HRAs completed for members who were subsequently deemed ineligible because they were never enrolled in the plan. [Data Element 13.4]			
		RSC-7e: The number of annual reassessments calculated for Data Element 13.4 is a subset of the number of eligible members calculated for Data Element 13.2. [Data Element 13.4]			

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element 13.1	**Review Results:**	
			Data Element 13.2	**Review Results:**	
			Data Element 13.3	**Review Results:**	
			Data Element 13.4	**Review Results:**	
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.		**Review Results:**	
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).		**Data Sources:** **Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).		**Data Sources:** **Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2012 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
6		*If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):* Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.	**Data Sources:** **Review Results:**	
7		*If data collection and/or reporting for this reporting section is delegated to another entity:* Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/ downstream contractor.	**Data Sources:** **Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	
1.e		Data file locations are referenced correctly.	**Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
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2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*
2.a	RSC-1	The appropriate date range(s) for the reporting period(s) is captured. Organization reports data based on the required reporting period of 1/1 through 12/31.	**Review Results:**	
2.b		Data are assigned at the applicable level (e.g., plan benefit package or contract level).	**Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-2	Organization properly assigns data to the applicable CMS plan benefit package.		
2.c	RSC-3	Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadline for reporting annual data to CMS by 2/28 [Note to reviewer: If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]	**Review Results:**	
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.		*

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.e	RSC-4	The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. Applicable Reporting Section Criteria: RSC-4: Organization accurately calculates the number of new members who are eligible for an initial health risk assessment (HRA), including the following criteria:	Data Element 13.1	**Review Results:**	
		RSC-4a: Includes all new members who enrolled during the measurement year and those members who may have enrolled as early as 90 days prior to the measurement year if no initial HRA had been performed prior to 1/1. [Data Element 13.1]	Data Element 13.2	**Review Results:**	
		RSC-4b: Includes members who have enrolled in the plan after dis-enrolling from another plan (different sponsor or organization). [Data Element 13.1]			

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-4c: Includes members who dis-enrolled from and re-enrolled into the same plan if an initial HRA was not performed prior to dis-enrollment and calculates the member's eligibility date starting from the date of re-enrollment. [Data Element 13.1]		
		RSC-4d: Exlcudes members who dis-enrolled from and re-enrolled into the same plan if an intial HRA or reassessment was performed prior to dis-enrollment. [Data Element 13.1]		
		RSC-4e: Excludes members with a documented initial HRA that occurred under the plan during the previous year. These members, and their HRAs, should be counted as new in the previous year. [Data Element 13.1]		
		RSC-4f: Excludes members who received an initial HRA but were subsequently deemed ineligible because they were never enrolled in the plan. [Data Element 13.1]		
		RSC-4g: Excludes new members who dis-enrolled from the plan within 90 days of enrollment, if they did not receive an initial HRA prior to dis-enrolling. [Data Element 13.1]		

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-5	RSC-5: Organization accurately calculates the number of members eligible for an annual health risk reassessment during the reporting period, including the following criteria: RSC-5a: Includes members who were enrolled for more than 90 days in the same plan without receiving an initial HRA. [Data Element 13.2] RSC-5b: Includes members who remained continuously enrolled in the same plan for 365 days, starting from either the 91st day of enrollment if no initial HRA had been performed, or from the date of their previous HRA. [Data Element 13.2] RSC-5c: Includes members who received a reassessment during the measurement year within 365 days after their last HRA. [Data Element 13.2] RSC-5d: Includes members who dis-enrolled from and re-enrolled into the same plan if an intial HRA or reassessment was performed prior to dis-enrollment and calculates the member's reassessment eligibility date starting from the date of re-enrollment. [Data Element 13.2] RSC-5e: Excludes members who dis-enrolled from and re-enrolled into the same plan if an initial HRA was not performed prior to dis-enrollment. [Data Element 13.2]		

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5f: Excludes members who received a reassessment but were subsequently deemed ineligible because they were never enrolled in the plan. [Data Element 13.2] RSC-5g: Excludes members who did not remain enrolled in their same health plan for at least 365 days after their last HRA and did not receive a reassessment HRA. [Data Element 13.2]			
	RSC-6	RSC-6: Organization accurately calculates the number of initial health risk assessments performed on new members, including the following criteria [*Note to reviewer*: CMS has not identified a standard tool that SNPs must use to complete initial and annual health risk assessments. The information will not be captured by designated CPT or ICD-9 Procedure codes. Reviewer should confirm that the SNP maintained documentation for each reported assessment.]: RSC-6a: Includes only initial HRAs performed on new members within 90 days of enrollment/re-enrollment. [Data Element 13.3] RSC-6b: Includes only HRAs that were performed between 1/1 and 12/31 of the measurement year even if the new member enrolled prior to the start of the measurement year. [Data Element 13.3]	Data Element 13.3	**Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-6c: For members who dis-enrolled from and re-enrolled into the same plan, excludes any HRAs (initial or reassessment) performed during their previous enrollment [Data Element 13.3] RSC-6d: Counts only one HRA for members who have multiple HRAs within 90 days of enrollment. [Data Element 13.3] RSC-6e: Excludes HRAs completed for members who were subsequently deemed ineligible because they were never enrolled in the plan. [Data Element 13.3] RSC-6f The number of initial assessments calculated for Data Element 13.3 is a subset of the number of new members calculated for Data Element 13.1. [Data Element 13.3]			
	RSC-7	RSC-7: Organization accurately calculates the number of annual health risk reassessments performed on members eligible for a reassessment, including the following criteria [*Note to reviewer*: CMS has not identified a standard tool that SNPs must use to complete initial and annual health risk assessments. The information will not be captured by designated CPT or ICD-9 Procedure codes. Reviewer should confirm that the SNP maintained documentation for each reported assessment.]:	Data Element 13.4	**Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-7a: Includes annual HRA reassessments that were completed within 365 days of the member becoming eligible for a reassessment (i.e., within 365 days of their previous HRA, or within 365 days of their 91st day of enrollment (for new members who did not receive an initial HRA), or within 365 days of re-enrollment (for members who dis-enrolled from and re-enrolled into the same plan)). [Data Element 13.4]			
		RSC-7b: Includes only HRAs that were performed between 1/1 and 12/31 of the measurement year. [Data Element 13.4]			
		RSC-7c: Counts only one HRA for members who have multiple reassessments within 365 days of becoming eligible for a reassessment. [Data Element 13.4]			
		RSC-7d: Excludes HRAs completed for members who were subsequently deemed ineligible because they were never enrolled in the plan. [Data Element 13.4]			
		RSC-7e: The number of annual reassessments calculated for Data Element 13.4 is a subset of the number of eligible members calculated for Data Element 13.2. [Data Element 13.4]			

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element 13.1	**Review Results:**	
			Data Element 13.2	**Review Results:**	
			Data Element 13.3	**Review Results:**	
			Data Element 13.4	**Review Results:**	
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.		**Review Results:**	
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).		**Data Sources:** **Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).		**Data Sources:** **Review Results:**	

2.8 Special Needs Plans (SNPs) Care Management (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management**
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Name of Peer Reviewer:	**Last name, First name**

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
6		*If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):* Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.	**Data Sources:** **Review Results:**	
7		*If data collection and/or reporting for this reporting section is delegated to another entity:* Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/ downstream contractor.	**Data Sources:** **Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
Note to reviewer: If the Part D sponsor has no MTM members, then it is not required to report this data and data validation is not required for this reporting section.				
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	
1.e		Data file locations are referenced correctly.	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*
2.a	RSC-1	The appropriate date range(s) for the reporting period(s) is captured. Organization reports data based on the required reporting period of 1/1 through 12/31.	**Review Results:**	
2.b		Data are assigned at the applicable level (e.g., plan benefit package or contract level).	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-2	Organization properly assigns data to the applicable CMS contract.			
2.c		Appropriate deadlines are met for reporting data (e.g., quarterly).		**Review Results:**	
	RSC-3	Organization meets deadline for reporting annual data to CMS by 2/28. [Note to reviewer: If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]			
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.		**Review Results:**	
	RSC-4	Organization properly defines the MTM program services per CMS definitions, such as Comprehensive Medication Review (CMR) with written summary and Targeted Medication Review (TMR) in accordance with the annual MTM Program Guidance and Submission memo posted on the CMS MTM web page. This includes applying all relevant guidance properly when performing its calculations and categorizations.			
2.e		The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.	Data Element B	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-5	Applicable Reporting Section Criteria: RSC-5: Organization accurately identifies data on MTM program participation and uploads it into Gentran, including the following criteria:	Data Element C	**Review Results:**	
		RSC-5a: Properly identifies and includes members who either met the specified targeting criteria per CMS Part D requirements or other expanded plan-specific targeting criteria at any time during the reporting period. [Data Elements B-G, J-K]	Data Element D	**Review Results:**	
			Data Element E	**Review Results:**	
		RSC-5b: Includes the ingredient cost, dispensing fee, sales tax, and the vaccine administration fee (if applicable) when determining if the total annual cost of a member's covered Part D drugs is likely to equal or exceed the specified annual cost threshold for MTM program eligibility. [Data Elements B-G, J-K]			
		RSC-5c: Includes continuing MTM program members as well as members who were newly identified and auto-enrolled in the MTM program at any time during the reporting period. [Data Elements B-G, J-K]	Data Element F	**Review Results:**	
		RSC-5d: Includes and reports each targeted member once per contract year per contract file, based on the member's most current HICN. [Data Elements B-G, J-K]			

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5e: Excludes members deceased prior to their MTM eligibility date. [Data Elements B-G, J-K] RSC-5f: Excludes members who receive MTM services outside of the CMS-required MTM criteria defined by the plan. [Data Elements B-G, J-K]	Data Element G	**Review Results:**	
		RSC-5g: Properly identifies and includes members' date of MTM program enrollment (i.e., date they were automatically enrolled) that occurs within the reporting period. [Data Elements B-G, J-K] RSC-5h: For those members who met the specified targeting criteria per CMS Part D requirements, properly identifies the date the member met the specified targeting criteria. [Data Elements B-G, J-K] RSC-5i: Includes members who moved between contracts in each corresponding file uploaded to Gentran. Dates of enrollment, disenrollment elements, and other elements (e.g., TMR/CMR data) are specific to the activity that occurred for the member within each contract. [Data Elements B-G, J-K] RSC-5j: Counts each member who disenrolls from and re-enrolls in the same contract once. [Data Elements B-G, J-K]	Data Element H	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-6	Organization accurately identifies MTM eligible long-term care facility residents and uploads it into Gentran, including the following criteria: RSC-6a: Properly identifies and includes whether each member was a resident in a long-term care facility at any time s/he was enrolled in the MTM program during the reporting period or on the date the member opted-out of MTM program enrollment. [Data Element H]	Data Element I	**Review Results:**	
	RSC-7	Organization accurately identifies MTM eligible members who are cognitively impaired and uploads it into Gentran, including the following criteria: RSC-7a: Properly identifies and includes whether each member was cognitively impaired and reports this status as of the date of the CMR offer. [Data Element I]			
	RSC-8	RSC-8:Organization accurately identifies data on members who opted-out of enrollment in the MTM program and uploads it into Gentran, including the following criteria: RSC-8a: Properly identifies and includes members' date of MTM program opt-out that occurs within the reporting period, but prior to 12/31. [Data Elements L, M] RSC-8b: Properly identifies and includes the reason participant opted-out of the MTM program for every applicable member with an opt-out date completed (death, disenrollment, request by member, other	Data Element J	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		date completed (death, disenrollment, request by member, other reason). [Data Elements L, M]	Data Element K	**Review Results:**	
		RSC-8c: Excludes members who refuse or decline individual services without opting-out (disenrolling) from the MTM program. [Data Elements L, M]			
		RSC-8d: Excludes members who disenroll from and re-enroll in the same contract if the gap of MTM program enrollment is equal to 60 days or less. [Data Elements L, M]			
	RSC-9	RSC-9: Organization accurately identifies data on CMR offers and uploads it into Gentran, including the following criteria:	Data Element L	**Review Results:**	
		RSC-9a: Properly identifies and includes MTM program members who were offered a CMR per CMS Part D requirements during the reporting period. [Data Elements N, O]			
		RSC-9b: Properly identifies and includes members' date of initial offer of a CMR that occurs within the reporting period. [Data Elements N, O]			
	RSC-10	RSC-10 Organization accurately identifies data on CMR dates and uploads it into Gentran, including the following criteria:	Data Element M	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-10a: Properly identifies and includes the number of CMRs the member received, if applicable, with written summary in CMS standardized format. [Data Elements P - U]			
		RSC-10b Properly identifies and includes the date(s) (up to five) the member received a CMR, if applicable. The date occurs within the reporting period, is completed for every member with a "Y" entered for Field Name "Received annual ɛCMR with written summary in CMS standardized format," and if more than one comprehensive medication review occurred, includes the date of the first CMR. [Data Elements P - U]	Data Element N	**Review Results:**	
		RSC-10c: Properly identifies and includes the method of delivery for the initial CMR received by the member; if more than one CMR is received, the method of delivery for only the initial CMR is reported. The method of delivery must be reported as one of the following: Face-to-Face, Telephone, Telehealth Consultation, or Other. [Data Elements P - U]			
		RSC-10d: Properly identifies and includes the qualified provider who performed the initial CMR; if more than one CMR is received, the qualified provider for only the initial CMR is reported. The qualified provider must be reported as one of the following: Physician, Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Physician's Assistant, Local Pharmacist, LTC Consultant Pharmacist, Plan Sponsor Pharmacist, Plan Benefit Manager (PBM) _Pharmacist, MTM Vendor Local Pharmacist, MTM Vendor In-house Pharmacist, Hospital Pharmacist, Pharmacist – Other, or Other. [Data Elements P - U]			

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-10e: Properly identifies the recipient of the annual CMR; if more than one CMR is received, only the recipient of the initial CMR is reported. The recipient must be reported as one of the following: Beneficiary, Beneficiary's Prescriber, Caregiver, or Other Authorized Individual. [Data Elements P - U]			
	RSC-11	RSC-11: Organization accurately identifies data on MTM drug therapy problem recommendations and uploads it into Gentran, including the following criteria:	Data Element O	**Review Results:**	
		RSC-11a: Properly identifies and includes all targeted medication reviews within the reporting period for each applicable member. [Data Elements O – Q]			
		RSC-11b: Properly identifies and includes the number of drug therapy problem recommendations made to prescribers as a result of MTM services within the reporting period for each applicable member, regardless of the success or result of the recommendations and counts these recommendations based on the number of unique recommendations made to prescribers (e.g., the number is not equal to the total number of prescribers that received drug therapy problem recommendations from the organization). Organization does not count each individual drug therapy problem identified per prescriber recommendation (e.g., if the organization sent a prescriber a fax identifying 3 drug therapy problems for a member, this is reported as 1 recommendation). [Data Elements O – Q]	Data Element P	**Review Results:**	
			Data Element Q	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-11c: Properly identifies and includes the number of drug therapy problem resolutions made as a result of MTM program recommendations within the reporting period for each applicable member (includes, but is not limited to, initiate drug, change drug (such as product in different therapeutic class, dosage form, quantity, or interval), discontinue or substitute drug (such as discontinue drug, generic substitutions, or formulary substitution), and medication compliance/adherence . [*Note to reviewer:* If the resolution was observed in the calendar year after the current reporting period, but was the result of an MTM recommendation made within the current reporting period, the resolution may be reported for the current reporting period. However, this resolution cannot be reported again in the following reporting period.] [Data Elements V - X]			
			Data Element R	**Review Results:**	
			Data Element S	**Review Results:**	
			Data Element T	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
			Data Element U	**Review Results:**	
			Data Element V	**Review Results:**	
			Data Element W	**Review Results:**	
			Data Element X	**Review Results:**	
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element B	**Review Results:**	
			Data Element C	**Review Results:**	
			Data Element D	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
			Data Element E	**Review Results:**	
			Data Element F	**Review Results:**	
			Data Element G	**Review Results:**	
			Data Element H	**Review Results:**	
			Data Element I	**Review Results:**	
			Data Element J	**Review Results:**	
			Data Element K	**Review Results:**	
			Data Element L	**Review Results:**	
			Data Element M	**Review Results:**	
			Data Element N	**Review Results:**	
			Data Element O	**Review Results:**	
			Data Element P	**Review Results:**	
			Data Element Q	**Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
			Data Element R	**Review Results:**	
			Data Element S	**Review Results:**	
			Data Element T	**Review Results:**	
			Data Element U	**Review Results:**	
			Data Element V	**Review Results:**	
			Data Element W	**Review Results:**	
			Data Element X	**Review Results:**	
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.		**Review Results:**	
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).		**Data Sources:** **Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).		**Data Sources:** **Review Results:**	

3.2 Medication Therapy Management (MTM) Programs (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
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2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
6		*If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade)*: Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.	**Data Sources:** **Review Results:**	
7		*If data collection and/or reporting for this reporting section is delegated to another entity*: Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/ downstream contractor.	**Data Sources:** **Review Results:**	

3.3 Grievances (Part D) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
Note to reviewer: Aggregate all quarterly data before applying the threshold. Note to reviewer: Do not apply the 90% threshold to individual grievance categories; 100% correct records are required for individual grievance categories.				
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	

3.3 Grievances (Part D) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1.e		Data file locations are referenced correctly.	**Review Results:**	
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*

3.3 Grievances (Part D) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.a		The appropriate date range(s) for the reporting period(s) is captured.	**Review Results:**	
	RSC-1	Organization reports data based on the periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.		
2.b		Data are assigned at the applicable level (e.g., plan benefit package or contract level).	**Review Results:**	
	RSC-2	Organization properly assigns data to the applicable CMS plan benefit package.		
2.c		Appropriate deadlines are met for reporting data (e.g., quarterly).	**Review Results:**	
	RSC-3	Organization meets deadlines for reporting data to CMS by 2/28. [Note to reviewer: If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]		
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.	**Review Results:**	
	RSC-4	Organization properly defines the term "Grievance" in accordance with 42 CFR §423.564 and the Prescription Drug Benefit Manual Chapter 18, Sections 10 and 20. This includes applying all relevant guidance properly when performing its calculations and categorizations. Requests for coverage determinations, exceptions, or redeterminations are not categorized as grievances.		

3.3 Grievances (Part D) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.e		The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission.	Data Element A	**Review Results:**	
	RSC-5	RSC-5: Organization accurately calculates the total number of grievances, including the following criteria: RSC-5a: Includes all grievances with a date of decision that occurs during the reporting period, regardless of when the grievance was received or completed (i.e., organization notified member of its decision). [Data Elements A-J] RSC-5b: If a grievance contains multiple issues filed by a single complainant, each issue is calculated as a separate grievance. [Data Elements A-J]	Data Element B	**Review Results:**	
		RSC-5c: If a member files a grievance and then files a subsequent grievance on the same issue prior to the organization's decision or deadline for decision notification (whichever is earlier), then the issue	Data Element C	**Review Results:**	

3.3 Grievances (Part D) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		is counted as one grievance. [Data Elements A-J]			
		RSC-5d: If a member files a grievance and then files a subsequent grievance on the same issue after the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as a separate grievance. [Data Elements A-J]			
		RSC-5e: Includes all methods of grievance receipt (e.g., telephone, letter, fax, in-person). [Data Elements A-J]			
		RSC-5f: Includes all grievances regardless of who filed the grievance (e.g., member or appointed representative). [Data Elements A-J]	Data Element D	**Review Results:**	
		RSC-5g: Excludes complaints received only by 1-800 Medicare or recorded only in the CMS Complaint Tracking Module (CTM); however, complaints filed separately as grievances with the organization are included. [Data Elements A-J]			
		RSC-5h: Excludes withdrawn Part D grievances. [Data Elements A-J]			

3.3 Grievances (Part D) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5i: *For MA-PD contracts*: Includes only grievances that apply to the Part D benefit and were processed through the Part D grievance process. If a clear distinction cannot be made for an MA-PD, cases are calculated as Part C grievances. [Data Elements A-J].			
		RSC-5j: Counts grievances for the plan ID to which the member belongs at the time the grievance is resolved, regardless of where the grievance originated (e.g., if a grievance is resolved within the reporting period for a member that has disenrolled from a plan and enrolled in a new plan, then the member's new plan should report the grievance regardless of where the grievance originated, if they actually resolve the grievance.) [Data Elements A-J]	Data Element E	**Review Results:**	
	RSC-6	Organization accurately calculates the number of grievances by category, including the following criteria:	Data Element F	**Review Results:**	
		RSC-6a: Properly sorts the total number of grievances by grievance category: Enrollment/Plan Benefits/Pharmacy Access; Customer Service; CMS Issues (which includes grievances related to issues outside of the organization's direct control); and Coverage determinations/Exceptions/Appeals Process (which includes expedited grievances (e.g., untimely decisions) and any grievance	Data Element G	**Review Results:**	

3.3 Grievances (Part D) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		about the exceptions and appeals process). [Data Elements A, C, E, G, I]			
		RSC-6b: Assigns all additional categories tracked by organization that are not listed above as Other. [Data Elements A, C, E, G, I]			
	RSC-7	RSC-7: Organization accurately calculates the number of grievances which the Part D sponsor provided timely notification of the decision, including the following criteria:			
		RSC-7a: Includes only grievances for which the member is notified of decision according to the following timelines: i. For standard grievances: no later than 30 days after receipt of grievance. ii. For standard grievances with an extension taken: no later than 44 days after receipt of grievance. iii. For expedited grievances: no later than 24 hours after receipt of grievance. [Data Elements B, D, F, H, J]			
			Data Element H	**Review Results:**	
			Data Element I	**Review Results:**	
			Data Element J	**Review Results:**	
		RSC-7b: Each number calculated is a subset of the total number of grievances received for the applicable category. [Data Elements B, D, F, H, J]			

3.3 Grievances (Part D) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element A	**Review Results:**	
			Data Element B	**Review Results:**	
			Data Element C	**Review Results:**	
			Data Element D	**Review Results:**	
			Data Element E	**Review Results:**	
			Data Element F	**Review Results:**	
			Data Element G	**Review Results:**	
			Data Element H	**Review Results:**	
			Data Element I	**Review Results:**	
			Data Element J	**Review Results:**	

3.3 Grievances (Part D) (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.	**Review Results:**	
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).	**Data Sources:** **Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).	**Data Sources:** **Review Results:**	
6		*If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):* Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.	**Data Sources:** **Review Results:**	
7		*If data collection and/or reporting for this reporting section is delegated to another entity:* Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/ downstream contractor.	**Data Sources:** **Review Results:**	

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
Note to reviewer: Aggregate all quarterly data before applying the 90% threshold.				
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1.e		Data file locations are referenced correctly.	**Review Results:**	
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*
2.a		The appropriate date range(s) for the reporting period(s) is captured.	**Review Results:**	

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-1	Organization reports data based on the required reporting periods 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.		
2.b		Data are assigned at the applicable level (e.g., plan benefit package or contract level).	**Review Results:**	
	RSC-2	Organization properly assigns data to the applicable CMS contract.		
2.c		Appropriate deadlines are met for reporting data (e.g., quarterly).	**Review Results:**	
	RSC-3	Organization meets deadlines for reporting data to CMS by 2/28. [Note to reviewer: If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]		
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.	**Review Results:**	
	RSC-4	Organization properly determines whether a request is subject to the coverage determinations or the exceptions process in accordance with 42 CFR §423.566, §423.578, and the Prescription Drug Benefit Manual Chapter 18, Sections 10 and 30. This includes applying all relevant guidance properly when performing its calculations and categorizations for the above-mentioned regulations in addition to 42 CFR §423.568, §423.570, §423.572, §423.576 and the Prescription Drug Benefit Manual Chapter 18, Sections 40, 50, and 130.		

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.e	RSC-5	The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. Applicable Reporting Section Criteria: RSC-5: Organization accurately calculates the number of pharmacy transactions, including the following criteria:	Data Element A	**Review Results:**	
		RSC-5a: Includes pharmacy transactions for Part D drugs with a fill date (not batch date) that falls within the reporting period. [Data Element A] RSC-5b: Includes transactions with a final disposition of reversed. [Data Element A]	Data Element B	**Review Results:**	
		RSC-5c: Excludes pharmacy transactions for drugs assigned to an excluded drug category. [Data Element A] RSC-5d: If a prescription drug claim contains multiple transactions, each transaction is calculated as a separate pharmacy transaction. [Data Element A]	Data Element C	**Review Results:**	

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-6	RSC-6: Organization accurately calculates the number of pharmacy transactions rejected due to formulary restrictions, including the following criteria:			
		RSC-6a: Excludes rejections due to early refill requests. [Data Element B]	Data Element D	**Review Results:**	
		RSC-6b: If a prescription drug claim contains multiple rejections, each rejection is calculated as a separate pharmacy transaction. [Data Element B] RSC-6c: Number calculated for Data Element B is a subset of the number of pharmacy transactions calculated for Data Element A. [Data Element B]	Data Element E	**Review Results:**	

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-7	RSC-7: Organization accurately calculates the number of pharmacy transactions rejected due to prior authorization (PA) requirements, including the following criteria:			
		RSC-7a: Excludes rejections due to early refill requests. [Data Element C]	Data Element F	**Review Results:**	
		RSC-7b: If a prescription drug claim contains multiple rejections, each rejection is calculated as a separate pharmacy transaction. [Data Element C]			
		RSC-7c: Number calculated for Data Element D is a subset of the number of pharmacy transactions calculated for Data Element A. [Data Element C]			
	RSC-8	RSC-8: Organization accurately calculates the number of pharmacy transactions rejected due to step therapy requirements, including the following criteria:			
		RSC-8a: Excludes rejections due to early refill requests. [Data Element D]	Data Element G	**Review Results:**	
		RSC-8b: If a prescription drug claim contains multiple rejections, each rejection is calculated as a separate pharmacy transaction. [Data Element D]			
		RSC-8c: Number calculated for Data Element D is a subset of the number of pharmacy transactions calculated for Data Element A. [Data Element D]			

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-9	RSC-9: Organization accurately calculates the number of pharmacy transactions rejected due to quantity limits (QL) requirements, including the following criteria:			
		RSC-9a: Excludes rejections due to safety edits and early refill requests. [Data Element E]	Data Element H	**Review Results:**	
		RSC-9b: Includes all types of QL rejects, including but not limited to claim rejections due to quantity limits or time rejections (e.g., a claim is submitted for 20 tablets/10 days, but is only approved for 10 tablets/5 days). [Data Element E]			
		RSC-9c: If a prescription drug claim contains multiple rejections, each rejection is calculated as a separate pharmacy transaction. [Data Element E]			
		RSC-9d: Number calculated for Data Element E is a subset of the number of pharmacy transactions calculated for Data Element A. [Data Element E]	Data Element I	**Review Results:**	
	RSC-10	RSC-10: Organization accurately reports data on high cost edits, including the following criteria:			
		RSC-10a: Indiciates whether or not high cost edits for compounds were in place during the reporting period. [Data Elements F - K]			

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-10b: If high cost edits for compounds were in place during the reporting period, reports the cost threshold used. [Data Elements F - K]			
		RSC-10c: Indicates whether or not high cost edits for non-compounds were in place during the reporting period. [Data Elements F - K]	Data Element J	**Review Results:**	
		RSC-10d: If high cost edits for non-compounds were in place during the reporting period, reports the cost threshold used. [Data Elements F - K]			
		RSC-10e: Includes the number of claims rejected due to high cost edits for compounds. [Data Elements F - K]			
		RSC-10f: Includes the number of claims rejected due to high cost edits for non-compounds. [Data Elements F - K]			
		RSC-10g: If a prescription drug claim contains multiple rejections, each rejection is calculated as a separate pharmacy transaction. [Data Elements F - K]	Data Element K	**Review Results:**	
	RSC-11	RSC-11: Organization accurately calculates the number of coverage determinations and exceptions (Part D only), including the following criteria:			

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-11a: Includes all coverage determinations/exceptions with a date of decision that occurs during the reporting period, regardless of when the request for coverage determination or exception was received. [Data Elements L - CC]			
		RSC-11b: Includes all methods of receipt (e.g., telephone, letter, fax, in-person). [Data Elements L - CC]			
			Data Element L	**Review Results:**	
		RSC-11c: Includes all coverage determinations/exceptions regardless of who filed the request (e.g., member, appointed representative, or prescribing physician). [Data Elements L - CC]			
		RSC-11d: Includes coverage determinations/exceptions from delegated entities. [Data Elements L - CC]			
		RSC-11e: Includes both standard and expedited coverage determinations/exceptions. [Data Elements L - CC]			
		RSC-11f: Excludes requests for coverage determinations or exceptions that are withdrawn. [Data Elements L - CC]	Data Element M	**Review Results:**	

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-11g: Excludes coverage determinations/ exceptions regarding drugs assigned to an excluded drug category. [Data Elements L - CC]			
		RSC-11h: Excludes members who have UM requirements waived based on an exception decision made in a previous plan year or reporting period. [Data Elements L - CC]			
	RSC-12	RSC-12: Organization accurately calculates the total number of PA decisions made in the reporting period, including the following criteria:			
		RSC-12a. Includes all decisions made (both favorable and unfavorable) on whether a member has, or has not, satisfied a PA requirement. [Data Element L]			
		RSC-12b: Includes PA decisions that relate to Part B versus Part D coverage (drugs covered under Part B are considered denials under Part D). [Data Element L]	Data Element N	**Review Results:**	
		RSC-12c: Includes PA requests that were forwarded to the Independent Review Entity (IRE) because the organization failed to make a timely decision. [Data Element L]			
		RSC-12d: Includes PA requests that were approved (fully favorable) soon after the adjudication timeframes expired (i.e., within 24 hours) and were not auto-forwarded to the IRE. [Data Element L]			

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-12e: Excludes exception requests (i.e., requests for a decision where a member/ prescribing physician is seeking an exception to a PA requirement). [Data Element L]			
			Data Element O	**Review Results:**	
	RSC-13	RSC- 13: Organization accurately calculates the number of PA decisions for which it provided a timely notification of the decision, including the following criteria: RSC- 13a: Includes only PA determinations for which the member is notified of the decision according to the following timelines: [Data Element M] i. For standard coverage determinations: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request ii. For expedited coverage determinations: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the request			
		RSC-13b: Excludes favorable determinations in which the organization did not authorize or provide the benefit or payment under dispute according to the following timelines: [Data Element M]	Data Element P	**Review Results:**	

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Name of Reviewer:	**Last name, First name**
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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		i. For standard coverage determinations: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request ii. For expedited coverage determinations: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the request RSC-13c: Excludes PA requests that were forwarded to the IRE because the organization failed to make a timely decision. [Data Element M]			
		RSC-13d: Number calculated for timely PA decisions (Data Element M) is a subset of the number of PA decisions made (Data Element L). [Data Element M]	Data Element Q	**Review Results:**	
	RSC-14	RSC-14: Organization accurately calculates the number of PA decisions made that were favorable (PA requirements satisfied), including the following criteria: RSC-14a: Includes all favorable decisions on requests for PAs. [Data Element N] RSC-14b: Excludes decisions that are only partially favorable. [Data Element N]			

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-15	RSC-15: Organization accurately calculates the number of decisions for PA exceptions made in the reporting period, including the following criteria: RSC 14c: Excludes decisions made by the IRE. [Data Element N] RSC-14d: Number calculated for favorable PA decisions (Data Element N) is a subset of the number of PA decisions made (Data Element L). [Data Element N]	Data Element R	**Review Results:**	
		RSC-15a: Includes all decisions made (both favorable and unfavorable) where a member/prescribing physician is seeking an exception to a PA (e.g., a physician indicates that the member would suffer adverse effects if he or she were required to satisfy the PA requirement). [Data Element O] RSC-15b:Excludes PA requests (i.e., requests for a decision on whether a member has, or has not, satisfied a PA requirement). [Data Element O]	Data Element S	**Review Results:**	

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-15c: Includes PA exception requests that were forwarded to the Independent Review Entity (IRE) because the organization failed to make a timely decision. [Data Element O]			
		RSC-15d: Includes PA exception requests that were approved (fully favorable) soon after the adjudication timeframes expired (i.e., within 24 hours) and were not auto-forwarded to the IRE. [Data Element O]	Data Element T	**Review Results:**	
	RSC -16	RSC-16: Organization accurately calculates the number of PA exception decisions for which it provided a timely notification of the decision, including the following criteria:			
		RSC-16a: Includes only exception decisions for which the member (and the prescribing physician or other prescriber involved, as appropriate) is notified of the decision according to the following timelines: [Data Element P]			

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Name of Reviewer:	**Last name, First name**
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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement. ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement. RSC-16b: Excludes favorable exception decisions in which the organization did not authorize or provide the benefit or payment under dispute according to the following timelines: [Data Element P] i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement. ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement.	Data Element U	**Review Results:**	
		RSC-16c: Excludes exception requests that were forwarded to the IRE because the organization failed to make a timely decision. [Data Element P] RSC-16d: Number calculated for timely PA exception decisions (Data Element P) is a subset of the number of exception decisions made (Data Element O). [Data Element P]	Data Element V	**Review Results:**	

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2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-17	RSC-17: Organization accurately calculates the number of favorable PA exception decisions made, including the following criteria: RSC-17a: Includes all favorable decisions on requests for PA exceptions- [Data Element Q] RSC-17b: Excludes decisions that are only partially favorable. [Data Element Q] RSC-17c: Excludes decisions made by the IRE. [Data Element Q]			
		RSC-17d: Number calculated for favorable PA exception decisions (Data Element Q) is a subset of the number of UM exception decisions made (Data Element O). [Data Element Q]	Data Element W	**Review Results:**	
	RSC-18	RSC-18: Organization accurately calculates the number of decisions for exceptions to step therapy requirements made in the reporting period, including the following criteria: RSC-18a: Includes all decisions made (both favorable and unfavorable) where a member/prescribing physician is seeking an exception to a step therapy requirement (e.g., a physician indicates that the member would suffer adverse effects if he or she were required to satisfy the step therapy requirement). [Data Element R]			

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-18b: Includes exception requests to step therapy requirements that were forwarded to the Independent Review Entity (IRE) because the organization failed to make a timely decision. [Data Element R] RSC-18c: Includes exception requests to step therapy requirements that were approved (fully favorable) soon after the adjudication timeframes expired (i.e., within 24 hours) and were not auto-forwarded to the IRE. [Data Element R]			
	RSC-19	RSC-19: Organization accurately calculates the number of exception decisions made for step therapy requirements for which it provided a timely notification of the decision, including the following criteria: RSC-19a: Includes only exception decisions for which the member (and the prescribing physician or other prescriber involved, as appropriate) is notified of the decision according to the following timelines: [Data Element S] i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement. ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement.	Data Element X	**Review Results:**	

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-19b: Excludes favorable exception decisions in which the organization did not authorize or provide the benefit or payment under dispute according to the following timelines: [Data Element S]			
		i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement.	Data Element Y	**Review Results:**	
		ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement.			
		RSC-19c: Excludes exception requests that were forwarded to the IRE because the organization failed to make a timely decision. [Data Element S]			
		RSC-19d: Number calculated for timely exception decisions on step therapy requirements (Data Element S) is a subset of the number of exception decisions for step therapy requirements made (Data Element R). [Data Element S]			
	RSC-20	RSC-20: Organization accurately calculates the number of favorable exception decisions made for step therapy requirements, including the following criteria:			
		RSC-20a: Includes all favorable decisions on requests for exceptions to step therapy requirements. [Data Element T]			

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Instructions for each Standard or Sub-standard:
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2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-20b: Excludes decisions that are only partially favorable. [Data Element T]	Data Element Z	**Review Results:**	
		RSC-20c: Excludes decisions made by the IRE. [Data Element T]			
		RSC-20d: Number calculated for favorable exception decisions to step therapy requirements (Data Element T) is a subset of the number of exception decisions to step therapy requirements made (Data Element R). [Data Element T]			
	RSC-21	RSC-21: Organization accurately calculates the number of decisions for exceptions to quantity limits (QL) requirements made in the reporting period, including the following criteria:			
		RSC-21a: Includes all decisions made (both favorable and unfavorable) where a member/prescribing physician is seeking an exception to a step therapy requirement (e.g., a physician indicates that the member would suffer adverse effects if he or she were required to satisfy the QL requirement). [Data Element U]			
		RSC-21b: Includes exception requests to QL requirements that were forwarded to the Independent Review Entity (IRE) because the organization failed to make a timely decision. [Data Element U]			

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-21c: Includes exception requests to QL requirements that were approved (fully favorable) soon after the adjudication timeframes expired (i.e., within 24 hours) and were not auto-forwarded to the IRE. [Data Element U]	Data Element AA	**Review Results:**	
	RSC-22	RSC-22: Organization accurately calculates the number of exception decisions made for quantity limits (QL) requirements for which it provided a timely notification of the decision, including the following criteria: RSC-22a: Includes only exception decisions for which the member (and the prescribing physician or other prescriber involved, as appropriate) is notified of the decision according to the following timelines: [Data Element V] i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement. ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement. RSC-22b: Excludes favorable exception decisions in which the organization did not authorize or provide the benefit or payment under dispute according to the following timelines: [Data Element V]			
		i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement.	Data Element BB	**Review Results:**	

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement. RSC-22c: Excludes exception requests that were forwarded to the IRE because the organization failed to make a timely decision. [Data Element V] RSC-22d: Number calculated for timely exception decisions on QL requirements (Data Element V) is a subset of the number of exception decisions for QL requirements made (Data Element U). [Data Element V]			
	RSC-23	RSC-23: Organization accurately calculates the number of favorable exception decisions made for quantity limits (QL) requirements, including the following criteria: RSC-23a: Includes all favorable decisions on requests for exceptions to QL requirements. [Data Element W] RSC-23b: Excludes decisions that are only partially favorable. [Data Element W] RSC-23c: Excludes decisions made by the IRE. [Data Element W] RSC-23d: Number calculated for favorable exception decisions to QL requirements (Data Element W) is a subset of the number of exception decisions to QL requirements made (Data Element U). [Data Element W]	Data Element CC	**Review Results:**	
	RSC-24	RSC-24: Organization accurately calculates the number of decisions made in the reporting period on tier exceptions, including the following criteria.			

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Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-24a: Includes all decisions (both favorable and unfavorable) on whether to permit a member to obtain a non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. [Data Element ŧX]		
		RSC-24b: Includes tier exception requests that were forwarded to the Independent Review Entity (IRE) because the organization failed to make a timely decision. [Data Element ŧX]		
		RSC-24c: Includes tier exception requests that were approved (fully favorable) soon after the adjudication timeframes expired (i.e., within 24 hours) and were not auto-forwarded to the IRE. [Data Element X]		
	RSC-25	RSC-25: Organization accurately calculates the number of tier exception decisions for which it provided a timely notification of the decision, including the following criteria:		
		RSC-25a: Includes only exception decisions for which the member is notified of the decision according to the following timelines: [Data Element Y]		

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement. ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement. RSC-15b: Excludes favorable exception decisions in which the organization did not authorize or provide the benefit or payment under dispute according to the following timelines: [Data Element Y] i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement. ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement. RSC-15c: Excludes exceptions requests that were forwarded to the IRE because the organization failed to make a timely decision. [Data Element ƷY] RSC-15d: Number calculated for timely tier exception decisions (Data Element ƷY) is a subset of the number of exception decisions made (Data Element ƸX). [Data Element ƷY]		

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-26	RSC-26: Organization accurately calculates the number of favorable tier exception decisions made ~~that were approved~~, including the following criteria: RSC-26a: Includes all favorable decisions on requests for tier exceptions. [Data Element ~~KZ~~] RSC-26b: Excludes decisions that are only partially favorable. [Data Element ~~KZ~~] RSC-26c: Excludes decisions made by the IRE. [Data Element ~~KZ~~] RSC-26d: Number calculated for favorable tier exception decisions (Data Element ~~KZ~~) is a subset of the number of decisions made on tier exceptions (Data Element ~~IX~~). [Data Element ~~KZ~~]		
	RSC-27	RSC-27: Organization accurately calculates the number of decisions made in the reporting period on formulary exceptions, including the following criteria: RSC-27a: Includes all decisions (both favorable and unfavorable) on whether to permit a member to obtain a Part D drug that is not included on the formulary (i.e., includes only decisions made for non-formulary drugs. [Data Element AA]		

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-27b: Includes formulary exception requests that were forwarded to the Independent Review Entity (IRE) because the organization failed to make a timely decision. [Data Element AA]		
		RSC-27c: Includes formulary exception requests that were approved (fully favorable) soon after the adjudication timeframes expired (i.e., within 24 hours) and were not auto-forwarded to the IRE. [Data Element AA]		
	RSC-28	RSC-28: Organization accurately calculates the number of formulary exception decisions for which it provided a timely notification of the decision, including the following criteria:		
		RSC-28a: Includes only exception decisions for which the member is notified of the decision according to the following timelines: [Data Element BB]		
		i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement.		
		ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement.		
		RSC-28b: Excludes favorable exception decisions in which the organization did not authorize or provide the benefit or payment under dispute according to the following timelines: [Data Element BB]		

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		i. For standard exceptions: as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the physician's or other prescriber's supporting statement. ii. For expedited exceptions: as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the physician's or other prescriber's supporting statement. RSC-28c: Excludes exceptions requests that were forwarded to the IRE because the organization failed to make a timely decision. [Data Element BB] RSC-28d: Number calculated for timely exception decisions (Data Element BB) is a subset of the number of exception decisions made (Data Element AA). [Data Element BB]		
	RSC-29	Organization accurately calculates the number of favorable formulary exception decisions made that were approved, including the following criteria: RSC-29a: Includes all favorable decisions on requests for non-formulary medications. [Data Element CC] RSC-29b: Excludes decisions that are only partially favorable. [Data Element CC] RSC-29c: Excludes decisions made by the IRE. [Data Element CC]		

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-29d: Number calculated for favorable formulary exception decisions (Data Element CC) is a subset of the number of decisions made on formulary exceptions (Data Element AA). [Data Element CC]			
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element A	**Review Results:**	
			Data Element B	**Review Results:**	
			Data Element C	**Review Results:**	
			Data Element D	**Review Results:**	
			Data Element E	**Review Results:**	
			Data Element F	**Review Results:**	
			Data Element G	**Review Results:**	
			Data Element H	**Review Results:**	
			Data Element I	**Review Results:**	
			Data Element J	**Review Results:**	

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
			Data Element K	**Review Results:**	
			Data Element L	**Review Results:**	
			Data Element M	**Review Results:**	
			Data Element N	**Review Results:**	
			Data Element O	**Review Results:**	
			Data Element P	**Review Results:**	
			Data Element Q	**Review Results:**	
			Data Element R	**Review Results:**	
			Data Element S	**Review Results:**	
			Data Element T	**Review Results:**	
			Data Element U	**Review Results:**	
			Data Element V	**Review Results:**	
			Data Element W	**Review Results:**	

3.4 Coverage Determinations and Exceptions (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Coverage Determinations and Exceptions (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
			Data Element X	**Review Results:**	
			Data Element Y	**Review Results:**	
			Data Element Z	**Review Results:**	
			Data Element AA	**Review Results:**	
			Data Element BB	**Review Results:**	
			Data Element CC	**Review Results:**	
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.		**Review Results:**	

3.5 Redeterminations (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Redeterminations**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
Note to reviewer: Aggregate all quarterly data submitted within the reporting year before applying the 90% threshold.				
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	

3.5 Redeterminations (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Redeterminations**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
1.e		Data file locations are referenced correctly.	**Review Results:**	
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*

3.5 Redeterminations (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Redeterminations**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.a		The appropriate date range(s) for the reporting period(s) is captured.	**Review Results:**	
	RSC-1	Organization reports data based on the periods of 1/1 through 3/31, 4/1 through 6/30, 7/1 through 9/30, and 10/1 through 12/31.		
2.b		Data are assigned at the applicable level (e.g., plan benefit package or contract level).	**Review Results:**	
	RSC-2	Organization properly assigns data to the applicable CMS contract		
2.c		Appropriate deadlines are met for reporting data (e.g., quarterly).	**Review Results:**	
	RSC-3	Organization meets deadlines for reporting data to CMS by 2/28. [Note to reviewer: If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]		
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.	**Review Results:**	
	RSC-4	Organization properly defines the term "Redetermination" in accordance with Title 42, Part 423, Subpart M §423.560, §423.580, §423.582, §423.584, and §423.590 and the Prescription Drug Benefit Manual Chapter 18, Section 10, 70, and 130. This includes applying all relevant guidance properly when performing its calculations and categorizations.		

3.5 Redeterminations (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Redeterminations**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.e	RSC-5	The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. Applicable Reporting Section Criteria: RSC-5: Organization accurately calculates the total number of redeterminations (Part D only), including the following criteria: RSC-5a: Includes all redetermination decisions for Part D drugs with a date of final decision that occurs during the reporting period, regardless of when the request for redetermination was received or when the member was notified of the decision. [Data Element A]	Data Element A	**Review Results:**	
		RSC-5b: Includes all redetermination decisions, including fully favorable, partially favorable, and unfavorable decisions. [Data Element A]	Data Element B	**Review Results:**	

3.5 Redeterminations (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Redeterminations**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5c: Includes redetermination requests that were forwarded to the IRE because the organization failed to make a timely decision. [Data Element A]		
		RSC-5d: Includes both standard and expedited redeterminations. [Data Element A]		
		RSC-5e: Includes all methods of receipt (e.g., telephone, letter, fax, in-person). [Data Element A]		
		RSC-5f: Includes all redeterminations regardless of who filed the request (e.g., member, appointed representative, or prescribing physician). [Data Element A]		
		RSC-5g: Includes all redetermination decisions that relate to Part B versus Part D coverage (drugs covered under Part B are considered denials under Part D). [Data Element A]		
		RSC-5h: If a redetermination request contains multiple distinct disputes (i.e., multiple drugs), each dispute is calculated as a separate redetermination. [Data Element A]		
		RSC-5i: Excludes dismissals or withdrawals. [Data Element A]		

3.5 Redeterminations (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Redeterminations**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-5j: Excludes IRE decisions, as they are considered to be the second level of appeal. [Data Element A]			
		RSC-5k: Excludes redeterminations regarding excluded drugs. [Data Element A]	Data Element C	**Review Results:**	
		RSC-5l: Limits reporting to just the redetermination level. [Data Element A]			
	RSC-6	RSC-6: Organization accurately calculates the number of redeterminations for which the Part D sponsor provided timely notification of the decision, including the following criteria:			
		RSC-6a: Includes only redeterminations for which the member is notified of the decision according to the following timelines: i. For standard redeterminations: no later than 7 calendar days after receipt of the request. ii. For expedited redeterminations: no later than 72 hours after receipt of the request [Data Element B]			

3.5 Redeterminations (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Redeterminations**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-6b: Excludes approvals in which the sponsor did not authorize or provide the benefit or payment under dispute according to the following timelines:			
		i. For standard redeterminations: no later than 7 calendar days after receipt of the request. [Data element B]	Data Element D	**Review Results:**	
		ii. For expedited redeterminations: no later than 72 hours after receipt of the request. [Data Element B]			
		RSC-6c: Excludes redeterminations that were forwarded to the IRE because the organization failed to make a timely decision. [Data Element B]			
		RSC-6d: The number calculated for Data Element B is a subset of the total number of redeterminations calculated for Data Element A. [Data Element B]			
	RSC-7:	RSC-7: Organization accurately calculates the number of redeterminations by final decision, including the following criteria:			

3.5 Redeterminations (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Redeterminations**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
1) In the "Data Sources and Review Results:" column, enter the review results and/or data sources used for each standard or sub-standard.
2) In the "Findings" column, select "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or sub-standard has not been met, select "N." If any standard or sub-standard does not apply, select "N/A."

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-7a: Properly categorizes the total number of redeterminations by final decision: partially favorable (e.g., denial with a "part" that has been approved) and fully favorable (e.g., fully favorable decision reversing the original coverage determination). [Data Elements C, D] RSC-7b: Each number calculated for Data Elements C and D is a subset of the total number of redeterminations calculated for Data Element A. [Data Elements C, D] RSC-7c: Excludes redetermination decisions made by the IRE. [Data Elements C, D]			
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element A	**Review Results:**	
			Data Element B	**Review Results:**	
			Data Element C	**Review Results:**	
			Data Element D	**Review Results:**	

3.5 Redeterminations (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Redeterminations**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.	**Review Results:**	
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).	**Data Sources:** **Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).	**Data Sources:** **Review Results:**	
6		*If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):* Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.	**Data Sources:** **Review Results:**	
7		*If data collection and/or reporting for this reporting section is delegated to another entity:* Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/ downstream contractor.	**Data Sources:** **Review Results:**	

3.6 Long Term Care Utilization (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Long Term Care Utilization (Part D)**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
Note to reviewer: Employer-Direct PDPs, Employer-Direct PFFS, and any other contracts that have only 800 series plans are excluded from this reporting. For contracts with both non-800 series and 800-series plans, data for the 800-series plan(s) may be excluded.				
1		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) indicates that all source documents accurately capture required data fields and are properly documented.	**Data Sources:**	*
1.a		Source documents are properly secured so that source documents can be retrieved at any time to validate the information submitted to CMS via CMS systems.	**Review Results:**	
1.b		Source documents create all required data fields for reporting requirements.	**Review Results:**	
1.c		Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors, use correct fields, have appropriate data selection, etc.).	**Review Results:**	
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient_ID, rather than Field1 and maintain the same field name across data sets).	**Review Results:**	
1.e		Data file locations are referenced correctly.	**Review Results:**	
1.f		If used, macros are properly documented.	**Review Results:**	
1.g		Source documents are clearly and adequately documented.	**Review Results:**	
1.h		Titles and footnotes on reports and tables are accurate.	**Review Results:**	
1.i		Version control of source documents is appropriately applied.	**Review Results:**	
2		A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flows) and census or sample data, whichever is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.	**Data Sources:**	*

3.6 Long Term Care Utilization (for 2013 reported data)

Organization Name:	
Contract Number:	
Reporting Section:	**Long Term Care Utilization (Part D)**
Last Updated:	**MM/DD/YYYY**
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Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
2.a	RSC-1	The appropriate date range(s) for the reporting period(s) is captured. Organization reports data based on the required reporting periods of 1/1 through 6/30 and 7/1 through 12/31.		**Review Results:**	
2.b	RSC-2	Data are assigned at the applicable level (e.g., plan benefit package or contract level). Organization properly assigns data to the applicable CMS contract.		**Review Results:**	
2.c	RSC-3	Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadlines for reporting biannual data to CMS by 8/31 and 2/28. [Note to reviewer: If the organization has, for any reason, re-submitted its data to CMS for this reporting section, the reviewer should verify that the organization's original data submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-submits data for any reason and if the re-submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for the rest of the reporting section criteria for this reporting section.]		**Review Results:**	
2.d		Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.			*
2.e	RSC-4	The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified; all calculations (e.g., derived data fields) are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming code, saved queries, analysis plans); version control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to data submission. Applicable Reporting Section Criteria: RSC-4: Organization accurately calculates the number of network LTC pharmacies in the service area, including the following criteria:	Data Element A	**Review Results:**	

3.6 Long Term Care Utilization (for 2013 reported data)

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Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Instructions for each Standard or Sub-standard:
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-4a: Includes the number of contracted LTC pharmacies at the state level for PDPs and RPPOs, and at the contract level for MA-PDs. [Data Element A] RSC-4b: Includes any LTC pharmacy that is active in the network network (i.e., contracted with the Part D organization) for one (1) or more days in the reporting period. [Data Element A] RSC-4c: Includes LTC pharmacies that do not have utilization. [Data Element A]			
	RSC-5	RSC-5: Organization accurately calculates the number of network retail pharmacies in the service area, including: RSC-5a: Includes the number of contracted retail pharmacies at the state level for PDPs and RPPOs, and at the contract level for MA-PDs. [Data Element B] RSC-5b: Includes any retail pharmacy that is active in the network (i.e., contracted with the Part D organization) for one (1) or more days in the reporting period. [Data Element B] RSC-5c: Includes retail pharmacies that do not have utilization.	Data Element B	**Review Results:**	
	RSC-6	[Data Element B] RSC-6: Organization accurately calculates the total number of distinct members in LTC facilities for whom Part D drugs have been provided,			

3.6 Long Term Care Utilization (for 2013 reported data)

Organization Name:	
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Reporting Section:	**Long Term Care Utilization (Part D)**
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Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		including the following criteria: RSC-6a: Includes the number of members at the state level for PDPs and RPPOs, and at the contract level for MA-PDs. [Data Element C] RSC-6b: Counts each member only once in each reporting period. [Data Element C] RSC-6c: Includes only members with covered Part D drug claims at network pharmacies with dates of service within the reporting period. [Data Element C] RSC-6d: Includes only members who resided in a long-term care facility on the date of service for that Part D drug at the time the Part D claim for that member was processed. [*Note to reviewer*: Claims with patient residence code 03 or the LTI report may be used to identify applicable members.] [Data Element C]			
			Data Element C	**Review Results:**	
		RSC-6e: Includes all covered members regardless if the LTC pharmacy is located in the service area. [Data Element C]			
	RSC-7	RSC-7: Organization accurately identifies the data below for each network LTC pharmacy in the service area and uploads it into the HPMS submission tool: RSC-7a: PDPs, RPPOs, and MA-PDs report ~~for the entire service area~~ at the contract level. [Data Element D: a-d]			

3.6 Long Term Care Utilization (for 2013 reported data)

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		RSC-7b: LTC pharmacy name, LTC pharmacy NPI, contract entity name of LTC pharmacy, chain code of LTC pharmacy ("Not Available" is specified in the chain code field if the pharmacy chain code is unknown or does not exist.) [Data Element D: a-d]		
		RSC-7c: Includes all LTC pharmacies that were active in the network (i.e., contracted with the Part D organization) for one or more days in the reporting period. [Data Element D: a-d]		
		RSC-7d: Includes LTC pharmacies holding a license for the state(s) in the sponsor's service area, including those without a physical location/address in the service area. [Data Element D: a-d]		
		RSC-7e: Includes LTC pharmacies that do not have utilization (zeroes are entered for number and cost of prescriptions). [Data Element D: a-d]		
		RSC-7f: Number calculated for Data Element D is a subset of the total number of network LTC pharmacies calculated for Data Element A. [Data Element D: a-d]		
	RSC-8	RSC-8: Organization accurately calculates the number of 31-day equivalent prescriptions dispensed for each network LTC pharmacy in the service area and uploads it into the HPMS submission tool, including the following criteria:		
		RSC-8a: PDPs, RPPOs, and MA-PDs report for the entire service area. [Data Element D: e-f]		
		RSC-8b: Sums days supply of all covered Part D prescriptions dispensed		

3.6 Long Term Care Utilization (for 2013 reported data)

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		and divides this by 31 days. [Data Element D: e-f]			
		RSC-8c: Performs the calculations separately for formulary prescriptions and non-formulary prescriptions. [Data Element D: e-f]			
		RSC-8d: Includes only covered Part D prescriptions dispensed with a fill date (not batch date) that falls within the reporting period. [Data Element D: e-f]	Data Element D	**Review Results:**	
		RSC-8e: Includes LTC pharmacies holding a license for the state(s) in the sponsor's service area, including those without a physical location/address in the service area. [Data Element D: e-f]			
		RSC-8f: Includes LTC pharmacies that do not have utilization (zeroes are entered for number and cost of prescriptions). [Data Element D: e-f]			
		RSC-8g: Includes any pharmacy that services a LTC facility; claims with patient residence code 03 may be used to identify LTC pharmacies.			
		RSC-8h: Number calculated for Data Element D is a subset of the total number of network LTC pharmacies calculated for Data Element A. [Data Element D: e-f]			
	RSC-9	RSC-9: Organization accurately calculates prescription costs for each network LTC pharmacy in the service area and uploads it into the HPMS submission tool, including the following criteria:			
		RSC-9a: PDPs, RPPOs, and MA-PDs report for the entire service area. [Data Element D: g-h]			

3.6 Long Term Care Utilization (for 2013 reported data)

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		[Data Element D: g-h]		
		RSC-9b: Prescription cost is the sum of the ingredient cost, dispensing fee, sales tax and vaccine administration fee. [Data Element D: g-h]		
		RSC-9c: Ingredient cost reflects Sponsor's negotiated price. [Data Element D: g-h]		
		RSC-9d: Performs the calculations separately for formulary prescriptions and non-formulary prescriptions. [Data Element D: g-h]		
		RSC-9e: Includes only covered Part D prescriptions dispensed with a fill date (not batch date) that falls within the reporting period. [Data Element D: g-h]		
		RSC-9f: Includes LTC pharmacies holding a license for the state(s) in the sponsor's service area, including those without a physical location/address in the service area. [Data Element D: g-h]		
		RSC-9g: Includes LTC pharmacies that do not have utilization (zeroes are entered for number and cost of prescriptions). [Data Element D: g-h]		
		RSC-9h: Includes any pharmacy that services a LTC facility; claims with patient residence code 03 may be used to identify LTC pharmacies.		
		RSC-9i: Number calculated for Data Element D is a subset of the total number of network LTC pharmacies calculated for Data Element A. [Data Element D: g-h]		

3.6 Long Term Care Utilization (for 2013 reported data)

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Name of Reviewer:	**Last name, First name**
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
	RSC-10	RSC-10: Organization accurately calculates the number of 30-day equivalent prescriptions dispensed for each network retail pharmacy in the service area, including the following criteria:			
		RSC-10a: PDPs and RPPOs report at the state level; MA-PDs report at the contract level. [Data Element E: a-b]			
		RSC-10b: Sums days supply of all covered Part D prescriptions dispensed and divides this by 30 days. [Data Element E: a-b]	Data Element E a	**Review Results:**	
		RSC-10c: Performs the calculations separately for formulary prescriptions and non-formulary prescriptions. [Data Element E: a-b]			
		RSC-10d: Includes only covered Part D prescriptions dispensed with a fill date (not batch date) that falls within the reporting period. [Data Element E: a-b]	Data Element E b	**Review Results:**	
		RSC-10e: Includes all retail pharmacies that were active in the network (i.e., contracted with the Part D organization) for one or more days in the reporting period. [Data Element E: a-b]			
		RSC-10f: Number calculated for Data Element is a subset of the total number of retail pharmacies calculated for Data Element B. [Data Element E: a-b]			
	RSC-11	RSC-11: Organization accurately calculates prescription costs for all network retail pharmacies in the service area, including the following criteria:			
		RSC-11a: PDPs and RPPOs report at the state level; MA-PDs report at the	Data Element E c	**Review Results:**	

3.6 Long Term Care Utilization (for 2013 reported data)

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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description		Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		contract level. [Data Element E: c-d] RSC-11b: Prescription cost is the sum of the ingredient cost, dispensing fee, sales tax and vaccine administration fee. [Data Element E: c-d] RSC-11c: Ingredient cost reflects Sponsor's negotiated price. [Data Element E: c-d] RSC-11d: Performs the calculations separately for formulary prescriptions and non-formulary prescriptions. [Data Element E: c-d] RSC-11e: Includes only covered Part D prescriptions dispensed with a fill date (not batch date) that falls within the reporting period. [Data Element E: c-d] RSC-11f: Includes all retail pharmacies that were active in the network (i.e., contracted with the Part D organization) for one or more days in the reporting period. [Data Element E: c-d] RSC-11g: Number calculated for Data Element is a subset of the total number of retail pharmacies calculated for Data Element B. [Data Element E: c-d]	Data Element E d	**Review Results:**	
3		Organization implements policies and procedures for data submission, including the following:		**Data Sources:**	*
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element A	**Review Results:**	
			Data Element B	**Review Results:**	
			Data Element C	**Review Results:**	
			Data Element D	**Review Results:**	
			Data Element E a	**Review Results:**	
			Data Element E b	**Review Results:**	
			Data Element E c	**Review Results:**	

3.6 Long Term Care Utilization (for 2013 reported data)

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Contract Number:	
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Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Sources and Review Results: Enter review results and/or data sources	Findings: Select "Y" "N" or "N/A" from Sections in White Only. Grey cells are marked *.
		Data Element E d	**Review Results:**	
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.	**Review Results:**	
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).	**Data Sources:** **Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).	**Data Sources:** **Review Results:**	
6		*If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade):* Organization provided documentation on the data system changes and, upon review, there were no issues that adversely impacted data reported.	**Data Sources:** **Review Results:**	
7		*If data collection and/or reporting for this reporting section is delegated to another entity:* Organization regularly monitors the quality and timeliness of the data collected and/or reported by the delegated entity or first tier/ downstream contractor.	**Data Sources:** **Review Results:**	