Grievances (Part C) 2019

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part C) 2019**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description
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.
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.

1.b		Source documents create all required data fields for reporting requirements.
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.).
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).
1.e		Data file locations are referenced correctly.

1.f		If used, macros are properly documented.
1.g		Source documents are clearly and adequately documented.
1.h		Titles and footnotes on reports and tables are accurate.
1.i		Version control of source documents is appropriately applied.

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.
2.a	RSC-1	The appropriate date range(s) for the reporting period(s) is captured. 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	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.
2.c	RSC-3	Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadlines for reporting data to CMS by 2/3/2020. *[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	RSC-4	Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications. Organization properly defines the term “Grievance” in accordance with 42 CFR §422.564 and the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Manual. This includes applying all relevant guidance properly when performing its calculations.
	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. [Data Elements A-E] RSC-5: Organization data passes data integrity checks listed below:
	2.e	RSC-5.a	RSC-5.a: Total grievances in Data Element B does not exceed Data Element A.
	2.e	RSC-5.b	RSC-5.b: Total grievances in which timely notification was given is Data Element D does not exceed Data Element B.

2.e	RSC-5.c	RSC-5.c: Number of expedited grievances (Data Element C) does not exceed total grievances (Data Element A).
2.e	RSC-5.d	RSC-5.d: Number of expedited grievances in which timely notification was given (Data Element D) does not exceed total expedited grievances (Data Element C).
2.e	RSC-5.e	RSC-5.e: Number of dismissed grievances (Data Element E) is excluded from the total.
2.e	RSC-5.f	RSC-5.f: If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS (Data Elements A-E).

2.e	RSC-6	Organization accurately calculates the total number of grievances, including the following criteria:
2.e	RSC-6.a	RSC-6.a: 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.
2.e	RSC-6.a	
2.e	RSC-6.a	

2.e	RSC-6.a	
2.e	RSC-6.a	
2.e	RSC-6.b	RSC-6.b: 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.
2.e	RSC-6.b	

2.e	RSC-6.b	
2.e	RSC-6.b	
2.e	RSC-6.b	
2.e	RSC-6.c	RSC-6.c: If a grievance contains multiple issues filed by a single complainant, each issue is calculated as a separate grievance.

2.e	RSC-6.c	
2.e	RSC-6.c	
2.e	RSC-6.c	
2.e	RSC-6.c	

2.e	RSC-6.d	RSC-6.d: 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.
2.e	RSC-6.d	
2.e	RSC-6.d	
2.e	RSC-6.d	

2.e	RSC-6.d	
2.e	RSC-6.e	RSC-6.e: 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.
2.e	RSC-6.e	
2.e	RSC-6.e	

2.e	RSC-6.e	
2.e	RSC-6.e	
2.e	RSC-6.f	RSC-6.f: Includes all methods of grievance receipt (e.g., telephone, letter, fax, and in-person).
2.e	RSC-6.f	

2.e	RSC-6.f	
2.e	RSC-6.f	
2.e	RSC-6.f	
2.e	RSC-6.g	RSC-6.g: Includes all grievances regardless of who filed the grievance (e.g., member or appointed representative).

2.e	RSC-6.g	
2.e	RSC-6.g	
2.e	RSC-6.g	
2.e	RSC-6.g	

2.e	RSC-6.h	RSC-6.h: 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 organization and excludes the identical CTM complaint.
2.e	RSC-6.h	
2.e	RSC-6.h	
2.e	RSC-6.h	

2.e	RSC-6.h	
2.e	RSC-6.h	
2.e	RSC-6.i	RSC-6.i: 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).
2.e	RSC-6.i	

2.e	RSC-6.i	
2.e	RSC-6.i	
2.e	RSC-6.i	
2.e	RSC-6.i	

2.e	RSC-6.j	Excludes withdrawn grievances.
2.e	RSC-6.j	
2.e	RSC-6.j	
2.e	RSC-6.j	

2.e	RSC-6.j	
2.e	RSC-6.j	
2.e	RSC-7	Organization accurately calculates the number of grievances by category for which it provided timely notification of the decision, including the following criteria: RSC-7.a: Includes only grievances for which the member is notified of decision according to the following timelines:
2.e	RSC-7.ai	RSC-7.a.i. For standard grievances: no later than 30 days after receipt of grievance.

2.e	RSC-7.aii	RSC-7.aii: For standard grievances with an extension taken: no later than 44 days after receipt of grievance.
2.e	RSC-7.aiii	RSC-7.aiii: For expedited grievances: no later than 24 hours after receipt of grievance.
3		Organization implements policies and procedures for data submission, including the following:
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.

3.a		
3.a		
3.a		
3.a		

3.b		All sources, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, and claims adjustments).
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
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.

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.

	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) Enter "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, enter "N". If any standard or sub-standard does not apply, enter "N/A". 3) For standards 1c, 1d, 1e, 1g, 1h, and 2e, enter 'Findings' as follows based on the five-point scale: Select "1" if plan data has more than 20% error, select "2" if plan data has between 15.1% - 20.0% error, select "3" if plan data has between 10.1% - 15.0% error, select "4" if plan data has between 5.1% - 10.0% error, select "5" if plan data has less than or equal to a 5% error. Enter "N/A" if standard does not apply.

Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
	Data Sources:	*
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Data Sources:	*
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Data Sources:	*
Data Element B	**Review Results:**	
Data Element D	**Review Results:**	

Data Element C	**Review Results:**	
Data Element D	**Review Results:**	
Data Element E	**Review Results:**	
Data Elements A-E	**Review Results:**	

	Data Sources:	*
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 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 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 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 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 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 A	**Review Results:**	

Data Element B	**Review Results:**	
Data Element C	**Review Results:**	
Data Element D	**Review Results:**	
Data Element E	**Review Results:**	

	Data Sources:	*
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 Sources:	*
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 Sources:	*
Data Element A	**Review Results:**	
Data Element B	**Review Results:**	
Data Element C	**Review Results:**	

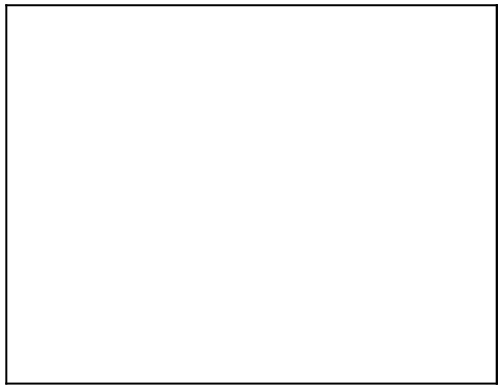
Data Element D	**Review Results:**	
Data Element E	**Review Results:**	
	Data Sources:	*
Data Element B	**Review Results:**	

Data Element B	**Review Results:**	
Data Element B	**Review Results:**	
	Data Sources:	*
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:**	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	



Organization Determinations/Reconsiderations (Part C) 2019

Organization Name:	
Contract Number:	
Reporting Section:	**Organization Determinations/Reconsiderations (Part C) 2019**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description
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.
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.

1.b		Source documents create all required data fields for reporting requirements.
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.).
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).
1.e		Data file locations are referenced correctly.

1.f		If used, macros are properly documented.
1.g		Source documents are clearly and adequately documented.
1.h		Titles and footnotes on reports and tables are accurate.
1.i		Version control of source documents is appropriately applied.

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.
2.a	RSC-1	The appropriate date range(s) for the reporting period(s) is captured. 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	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.
2.c	RSC-3	Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadlines for reporting data to CMS by 02/24/2020. *[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	RSC-4	Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications. Organization properly defines the term “Organization Determinations” in accordance with 42 C.F.R. Part 422, Subpart M, and the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Manual. This includes applying all relevant guidance properly when performing its calculations and categorizations. Organization properly defines the term “Reconsideration” in accordance with 42 C.F.R. Part 422, Subpart M, and the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Manual. This includes applying all relevant guidance properly when performing its calculations and categorizations.
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 have 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. RSC-5: Organization data passes data integrity checks listed below:
2.e	RSC-5.a	RSC-5.a: The total number of organization determinations (Subsection #1, Data Element A) is equal to sum of organization determinations by outcome (Subsection #2, Data Elements A-L).
2.e	RSC-5.b	RSC-5.b: The total number of reconsiderations (Subsection#3, Data Element A) is equal to sum of reconsiderations by outcome (Subsection #4, Data Elements A-L).

2.e	RSC-5.c	RSC-5.c: The total number of reopened decisions (Subsection #5, Data Element A) is equal to the number of records reported in the data file with a disposition of reopened.
2.e	RSC-5.d	RSC-5.d: The date each case was reopened (Subsection #5, Data Element K) is after the date of its original disposition (Subsection #5, Data Element F).
2.e	RSC-5.e	RSC-5.e: The date of disposition for each reopening (Subsection #5, Data Element N) is after the date of the original disposition (Subsection #5, Data Element F).
2.e	RSC-5.f	RSC-5.f: The date of disposition for each reopening (Subsection #5, Data Element N) is after the date the case was reopened (Subsection #5, Data Element K).

2.e	RSC-5.g	RSC-5.g: The date of disposition for each reopening (Subsection #5, Data Element N) is within the reporting quarter.
2.e	RSC-5.h	RSC-5.h: Verify that there is a valid value submitted for date of original disposition as MM/DD/YYYY format (Subsection #5, Data Element F).
2.e	RSC-5.i	RSC-5.i: Verify that there is a valid value submitted for case level (Organization Determination or Reconsideration) (Subsection #5, Data Element E).
2.e	RSC-5.j	RSC-5.j: Verify that there is a valid value submitted for reopening disposition (Fully Favorable; Partially Favorable; Adverse or Pending (Subsection #5, Data Element O).

2.e	RSC-5.k	RSC-5k: If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS.
2.e	RSC-6	RSC-6: Organization accurately calculates the total number of organization determinations, including the following criteria:
2.e	RSC-6.a	RSC-6.a: Includes all completed organization determinations (Part C only) for services requested by an enrollee/representative, a provider on behalf of the enrollee, or a non-contract provider, and all organization determinations for claims submitted by enrollee/representative or non-contract provider 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.
2.e	RSC-6.a	

2.e	RSC-6.a	
2.e	RSC-6.a	
2.e	RSC-6.a	
2.e	RSC-6.a	

2.e	RSC-6.a	
2.e	RSC-6.a	
2.e	RSC-6.a	
2.e	RSC-6.b	RSC-6.b: Includes adjudicated claims with a date of adjudication that occurs during the reporting period.

2.e	RSC-6.b	
2.e	RSC-6.b	
2.e	RSC-6.b	
2.e	RSC-6.b	

2.e	RSC-6.b	
2.e	RSC-6.b	
2.e	RSC-6.b	
2.e	RSC-6.b	

2.e	RSC-6.c	RSC-6.c: 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.e	RSC-6.c	
2.e	RSC-6.c	
2.e	RSC-6.c	

2.e	RSC-6.c	
2.e	RSC-6.c	
2.e	RSC-6.c	
2.e	RSC-6.c	

2.e	RSC-6.c	
2.e	RSC-6.d	RSC-6.d: Includes decisions made on behalf of the organization by a delegated entity.
2.e	RSC-6.d	
2.e	RSC-6.d	

2.e	RSC-6.d	
2.e	RSC-6.d	
2.e	RSC-6.d	
2.e	RSC-6.d	

2.e	RSC-6.d	
2.e	RSC-6.d	
2.e	RSC-6.e	RSC-6.e: Includes organization determinations that are filed directly with the organization or its delegated entities for services requested by an enrollee/representative, or a provider on behalf of the enrollee, or non-contract provider, and claims submitted either by an enrollee/representative or non-contract provider. 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.
2.e	RSC-6.e	

2.e	RSC-6.e	
2.e	RSC-6.e	
2.e	RSC-6.e	
2.e	RSC-6.e	

2.e	RSC-6.e	
2.e	RSC-6.e	
2.e	RSC-6.e	
2.e	RSC-6.f	RSC-6.f: Includes all methods of organization determination request receipt (e.g., telephone, letter, fax, in-person).

2.e	RSC-6.f	
2.e	RSC-6.f	
2.e	RSC-6.f	
2.e	RSC-6.f	

2.e	RSC-6.f	
2.e	RSC-6.f	
2.e	RSC-6.f	
2.e	RSC-6.f	

2.e	RSC-6.g	RSC-6.g: Includes all organization determinations for services requested by an enrollee/representative, or provider on behalf of the enrollee, or a non-contract provider, and claims submitted by either enrollee/representative or non-contract provider.
2.e	RSC-6.g	
2.e	RSC-6.g	
2.e	RSC-6.g	

2.e	RSC-6.g	
2.e	RSC-6.g	
2.e	RSC-6.g	
2.e	RSC-6.g	

2.e	RSC-6.g	
2.e	RSC-6.h	RSC-6.h: Includes supplemental benefits (i.e., non- Medicare covered item or service) provided as a part of a plan's Medicare benefit package.
2.e	RSC-6.h	
2.e	RSC-6.h	

2.e	RSC-6.h	
2.e	RSC-6.h	
2.e	RSC-6.h	
2.e	RSC-6.h	

2.e	RSC-6.h	
2.e	RSC-6.h	
2.e	RSC-6.i	RSC-6.i: Excludes dismissals and withdrawals.
2.e	RSC-6.i	

2.e	RSC-6.i	
2.e	RSC-6.i	
2.e	RSC-6.i	
2.e	RSC-6.i	

2.e	RSC-6.i	
2.e	RSC-6.i	
2.e	RSC-6.i	
2.e	RSC-6.j	RSC-6.j: Excludes Independent Review Entity Decisions.

2.e	RSC-6.j	
2.e	RSC-6.j	
2.e	RSC-6.j	
2.e	RSC-6.j	

2.e	RSC-6.j	
2.e	RSC-6.j	
2.e	RSC-6.j	
2.e	RSC-6.j	

2.e	RSC-6.k	RSC-6.k: Excludes Quality Improvement Organization (QIO) reviews of a member's request to continue Medicare-covered services (e.g., a SNF stay).
2.e	RSC-6.k	
2.e	RSC-6.k	
2.e	RSC-6.k	

2.e	RSC-6.k	
2.e	RSC-6.k	
2.e	RSC-6.k	
2.e	RSC-6.k	

2.e	RSC-6.k	
2.e	RSC-6.l	RSC-6.l: Excludes duplicate payment requests concerning the same service or item.
2.e	RSC-6.l	
2.e	RSC-6.l	

2.e	RSC-6.l	
2.e	RSC-6.l	
2.e	RSC-6.l	
2.e	RSC-6.l	

2.e	RSC-6.l	
2.e	RSC-6.l	
2.e	RSC-6.m	RSC-6.m: Excludes payment requests returned to an enrollee/representative or non-contract provider 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).
2.e	RSC-6.m	

2.e	RSC-6.m	
2.e	RSC-6.m	
2.e	RSC-6.m	
2.e	RSC-6.m	

2.e	RSC-6.m	
2.e	RSC-6.m	
2.e	RSC-6.m	
2.e	RSC-7	Organization accurately calculates the number of organization determinations, including the following criteria:

2.e	RSC-7.a	RSC-7.a: Includes all service organization determinations requested by enrollee/representative, provider on behalf of enrollee, or non-contract provider.
2.e	RSC-7.a	
2.e	RSC-7.b	RSC-7.b: Includes all payment (claim) organization determinations submitted by enrollee/representative or non-contract provider .
2.e	RSC-7.b	

2.e	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 criteria below. All non-adverse organization determinations must be either partially or fully favorable organization determinations.
2.e	RSC-8.a	RSC-8.a: Includes all adverse service organization determinations requested by enrollee/representative, a provider on behalf of the enrollee, or non-contract provider.
2.e	RSC-8.a	
2.e	RSC-8.b	RSC-8.b: Includes all adverse payment (claim) organization determinations submitted by enrollee/representative or non-contract provider that result in zero payment.

2.e	RSC-8.b	
2.e	RSC-9	RSC-9: Organization accurately calculates “Withdrawn Organization Determination” according to the following criteria:
2.e	RSC-9.a	RSC-9.a: Includes an organization determination that is withdrawn upon the enrollee’s request, the enrollee representative's request, or the enrollee provider's request but excludes appeals that the organization forwards to the IRE for dismissal.
2.e	RSC-10	Organization accurately calculates “Organization Determinations - Dismissals” according to the following criteria:

2.e	RSC-10.a	RSC-10.a: Includes dismissals that were processed in accordance with the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Manual.
2.e	RSC-11	Organization accurately calculates the total number of reconsiderations, including the following criteria:
2.e	RSC-11.a	RSC-11.a: Includes all completed reconsiderations (Part C only) both for services requested by an enrollee/representative, or provider on behalf of the enrollee, or non-contract provider, and claims submitted either by enrollee/representative or non-contract provider 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.
2.e	RSC-11.a	

2.e	RSC-11.a	
2.e	RSC-11.a	
2.e	RSC-11.a	
2.e	RSC-11.a	

2.e	RSC-11.a	
2.e	RSC-11.a	
2.e	RSC-11.a	
2.e	RSC-11.b	RSC-11.b: Includes decisions made on behalf of the organization by a delegated entity.

2.e	RSC-11.b	
2.e	RSC-11.b	
2.e	RSC-11.b	
2.e	RSC-11.b	

2.e	RSC-11.b	
2.e	RSC-11.b	
2.e	RSC-11.b	
2.e	RSC-11.b	

2.e	RSC-11.c	RSC-11.c: Includes all methods of reconsideration request receipt (e.g., telephone, letter, fax, and in-person).
2.e	RSC-11.c	
2.e	RSC-11.c	
2.e	RSC-11.c	

2.e	RSC-11.c	
2.e	RSC-11.c	
2.e	RSC-11.c	
2.e	RSC-11.c	

2.e	RSC-11.c	
2.e	RSC-11.d	RSC-11.d: Includes all reconsiderations for services requested by an enrollee/representative, or provider on behalf of the enrollee, or non-contract provider, and claims submitted either by enrollee/representative or non-contract provider.
2.e	RSC-11.d	
2.e	RSC-11.d	

2.e	RSC-11.d	
2.e	RSC-11.d	
2.e	RSC-11.d	
2.e	RSC-11.d	

2.e	RSC-11.d	
2.e	RSC-11.d	
2.e	RSC-11.e	RSC-11.e: Includes reconsiderations that are filed directly with the organization or its delegated entities for services requested by an enrollee/representative, or provider on behalf of the enrollee, or non-contract provider, and claims submitted either by enrollee/representative or non-contract provider. 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.
2.e	RSC-11.e	

2.e	RSC-11.e	
2.e	RSC-11.e	
2.e	RSC-11.e	
2.e	RSC-11.e	

2.e	RSC-11.e	
2.e	RSC-11.e	
2.e	RSC-11.e	
2.e	RSC-11.f	RSC-11.f: Includes supplemental benefits (i.e., non- Medicare covered item or service) provided as a part of a plan's Medicare benefit package.

2.e	RSC-11.f	
2.e	RSC-11.f	
2.e	RSC-11.f	
2.e	RSC-11.f	

2.e	RSC-11.f	
2.e	RSC-11.f	
2.e	RSC-11.f	
2.e	RSC-11.f	

2.e	RSC-11.g	RSC-11.g: Excludes dismissals and withdrawals.
2.e	RSC-11.g	
2.e	RSC-11.g	
2.e	RSC-11.g	

2.e	RSC-11.g	
2.e	RSC-11.g	
2.e	RSC-11.g	
2.e	RSC-11.g	

2.e	RSC-11.g	
2.e	RSC-11.h	RSC-11.h: Excludes Independent Review Entity Decisions.
2.e	RSC-11.h	
2.e	RSC-11.h	

2.e	RSC-11.h	
2.e	RSC-11.h	
2.e	RSC-11.h	
2.e	RSC-11.h	

2.e	RSC-11.h	
2.e	RSC-11.h	
2.e	RSC-11.i	RSC-11.i: Excludes QIO reviews of a member's request to continue Medicare-covered services (e.g., a SNF stay).
2.e	RSC-11.i	

2.e	RSC-11.i	
2.e	RSC-11.i	
2.e	RSC-11.i	
2.e	RSC-11.i	

2.e	RSC-11.i	
2.e	RSC-11.i	
2.e	RSC-11.i	
2.e	RSC-11.j	RSC-11.j: Excludes duplicate payment requests concerning the same service or item.

2.e	RSC-11.j	
2.e	RSC-11.j	
2.e	RSC-11.j	
2.e	RSC-11.j	

2.e	RSC-11.j	
2.e	RSC-11.j	
2.e	RSC-11.j	
2.e	RSC-11.j	

2.e	RSC-11.k	RSC-11.k: Excludes payment requests returned to an enrollee/representative or non-contract provider 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).
2.e	RSC-11.k	
2.e	RSC-11.k	
2.e	RSC-11.k	

2.e	RSC-11.k	
2.e	RSC-11.k	
2.e	RSC-11.k	
2.e	RSC-11.k	

2.e	RSC-11.k	
2.e	RSC-12	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 criteria below. All non-adverse organization reconsiderations must be either partially or fully favorable organization determinations:
2.e	RSC-12.a	RSC-12.a: Includes all adverse service reconsideration determinations requested by enrollee/representative, or provider on behalf of the enrollee, or non-contract provider.
2.e	RSC-12.a	

2.e	RSC-12.b	RSC-12.b: Includes all adverse payment (claim) reconsideration determinations submitted by enrollee/representative or non-contract provider that result in zero payment being made.
2.e	RSC-12.b	
2.e	RSC-12.c	RSC-12.c: For instances when a reconsideration request for payment is submitted to an organization concerning an item or service, and the organization has already made an adverse service reconsideration determination, includes the reconsideration request for payment for the same item or service as another, separate, adverse reconsideration determination.
2.e	RSC-12.c	

2.e	RSC-12.c	
2.e	RSC-12.c	
2.e	RSC-13	Organization accurately calculates “Withdrawn Reconsiderations” according to the following criteria:
2.e	RSC-13.a	RSC-13.a: Includes a Reconsideration that is withdrawn upon the enrollee’s request, the enrollee representative's request, or the enrollee provider's request.

2.e	RSC-14	Organization accurately calculates “Reconsiderations Dismissals” according to the following criteria:
2.e	RSC-14.a	RSC-14.a: Includes reconsiderations dismissals that were processed in accordance with the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Manual.
2.e	RSC-15	Organization accurately calculates the total number of reopened decisions according to the following criteria:
2.e	RSC-15.a	RSC-15.a: Includes a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

2.e	RSC-16	The organization accurately reports the following information for each reopened case.
2.e	RSC-16.a	RSC-16.a: Contract Number
2.e	RSC-16.b	RSC-16.b: Date of original disposition
2.e	RSC-16.c	RSC-16.c: Original disposition (Fully Favorable; Partially Favorable; or Adverse)

2.e	RSC-16.d	RSC-16.d: Case Level (Organization Determination or Reconsideration)
2.e	RSC-16.e	RSC-16.e: Date case was reopened
2.e	RSC-16.f	RSC-16.f: Reason (s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
2.e	RSC-16.g	RSC-16.g: Date of reopening disposition (revised decision)

2.e	RSC-16.h	RSC-16.h: Reopening disposition (Fully Favorable; Partially Favorable, Adverse, or Pending)
3		Organization implements policies and procedures for data submission, including the following:
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.
3.a		

3.a		
3.a		
3.a		
3.a		

3.a		
3.a		
3.a		
3.a		

3.a		
3.a		
3.a		
3.a		

3.a		
3.a		
3.a		
3.a		

3.a		
3.a		
3.a		
3.a		

3.a		
3.a		
3.a		
3.a		

3.a		
3.a		
3.a		
3.a		

3.a		
3.a		
3.a		
3.a		

3.a		
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).

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.
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.

	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) Enter "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, enter "N". If any standard or sub-standard does not apply, enter "N/A". 3) For standards 1c, 1d, 1e, 1g, 1h, and 2e, enter 'Findings' as follows based on the five-point scale: Select "1" if plan data has more than 20% error, select "2" if plan data has between 15.1% - 20.0% error, select "3" if plan data has between 10.1% - 15.0% error, select "4" if plan data has between 5.1% - 10.0% error, select "5" if plan data has less than or equal to a 5% error. Enter "N/A" if standard does not apply.

Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
	Data Sources:	*
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Data Sources:	*
	Review Results:	
	Review Results:	
	Review Results:	

	Data Sources:	*
	Data Sources:	*
Subsection #1, Data Element A, Subsection #2, Data Elements A-L	**Review Results:**	
Subsection #3, Data Element A, Subsection #4, Data Elements A-L	**Review Results:**	

Subsection #5, Data Element A	**Review Results:**	
Subsection #5, Data Element K	**Review Results:**	
Subsection #5, Data Element N	**Review Results:**	
Subsection #5, Data Element N	**Review Results:**	

Subsection #5, Data Element N	**Review Results:**	
Subsection #5, Data Element F	**Review Results:**	
Subsection #5, Data Element E	**Review Results:**	
Subsection #5, Data Element O	**Review Results:**	

Subsection #1, Data Elements A-G, Subsection #2, Data Elements A-L, Subsection #3, Data Elements A-G, Subsection #4, Data Elements A-L, Subsection #5, Data Elements A, E, F, G, N, and O	**Review Results:**	
	Data Sources:	*
Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	

Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	

Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	
Subsection #1, Data Element A	**Review Results:**	

Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	

Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	

Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	

Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	

Subsection #2, Data Element L	**Review Results:**	
Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	

Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	

Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	
Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	

Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	

Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	
Subsection #1, Data Element A	**Review Results:**	

Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	

Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	

Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	

Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	

Subsection #2, Data Element L	**Review Results:**	
Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	

Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	

Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	
Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	

Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	

Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	
Subsection #1, Data Element A	**Review Results:**	

Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	

Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	

Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	

Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	

Subsection #2, Data Element L	**Review Results:**	
Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	

Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	

Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	
Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	

Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	

Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	
Subsection #2, Data Element L	**Review Results:**	
	Data Sources:	*

Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element G	**Review Results:**	

	Data Sources:	*
Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	
Subsection #2 Data Element K	**Review Results:**	

Subsection #2 Data Element L	**Review Results:**	
	Data Sources:	*
Subsection #1, Data Element B	**Review Results:**	
	Data Sources:	*

Subsection #1, Data Element C	**Review Results:**	
	Data Sources:	*
Subsection #3, Data Element A	**Review Results:**	
Subsection #3, Data Element D	**Review Results:**	

Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	
Subsection #3, Data Element G	**Review Results:**	
Subsection #4, Data Element I	**Review Results:**	

Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	
Subsection #3, Data Elements A	**Review Results:**	

Subsection #3, Data Element D	**Review Results:**	
Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	
Subsection #3, Data Element G	**Review Results:**	

Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	

Subsection #3, Data Elements A	**Review Results:**	
Subsection #3, Data Element D	**Review Results:**	
Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	

Subsection #3, Data Element G	**Review Results:**	
Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	

Subsection #4, Data Element L	**Review Results:**	
Subsection #3, Data Element A	**Review Results:**	
Subsection #3, Data Element D	**Review Results:**	
Subsection #3, Data Element E	**Review Results:**	

Subsection #3, Data Element F	**Review Results:**	
Subsection #3, Data Element G	**Review Results:**	
Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	

Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	
Subsection #3, Data Element A	**Review Results:**	
Subsection #3, Data Element D	**Review Results:**	

Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	
Subsection #3, Data Element G	**Review Results:**	
Subsection #4, Data Element I	**Review Results:**	

Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	
Subsection #3, Data Element A	**Review Results:**	

Subsection #3, Data Element D	**Review Results:**	
Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	
Subsection #3, Data Element G	**Review Results:**	

Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	

Subsection #3, Data Element A	**Review Results:**	
Subsection #3, Data Element D	**Review Results:**	
Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	

Subsection #3, Data Element G	**Review Results:**	
Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	

Subsection #4, Data Element L	**Review Results:**	
Subsection #3, Data Element A	**Review Results:**	
Subsection #3, Data Element D	**Review Results:**	
Subsection #3, Data Element E	**Review Results:**	

Subsection #3, Data Element F	**Review Results:**	
Subsection #3, Data Element G	**Review Results:**	
Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	

Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	
Subsection #3, Data Element A	**Review Results:**	
Subsection #3, Data Element D	**Review Results:**	

Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	
Subsection #3, Data Element G	**Review Results:**	
Subsection #4, Data Element I	**Review Results:**	

Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	
Subsection #3, Data Element A	**Review Results:**	

Subsection #3, Data Element D	**Review Results:**	
Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	
Subsection #3, Data Element G	**Review Results:**	

Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	

Subsection #3, Data Element A	**Review Results:**	
Subsection #3, Data Element D	**Review Results:**	
Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	

Subsection #3, Data Element G	**Review Results:**	
Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	

Subsection #4, Data Element L	**Review Results:**	
	Data Sources:	*
Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	

Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	
Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	

Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	
	Data Sources:	*
Subsection #3, Data Element B	**Review Results:**	

	Data Sources:	*
Subsection #3, Data Element C	**Review Results:**	
	Data Sources:	*
Subsection #5, Data Element A	**Review Results:**	

	Data Sources:	*
Subsection #5, Data Element B	**Review Results:**	
Subsection #5, Data Element F	**Review Results:**	
Subsection #5, Data Element G	**Review Results:**	

Subsection #5, Data Element E	**Review Results:**	
Subsection #5, Data Element K	**Review Results:**	
Subsection #5, Data Element L	**Review Results:**	
Subsection #5, Data Element N	**Review Results:**	

Subsection #5, Data Element O	**Review Results:**	
	Data Sources:	*
Subsection #1, Data Element A	**Review Results:**	
Subsection #1, Data Element B	**Review Results:**	

Subsection #1, Data Element C	**Review Results:**	
Subsection #1, Data Element D	**Review Results:**	
Subsection #1, Data Element E	**Review Results:**	
Subsection #1, Data Element F	**Review Results:**	

Subsection #1, Data Element G	**Review Results:**	
Subsection #2, Data Element I	**Review Results:**	
Subsection #2, Data Element J	**Review Results:**	
Subsection #2, Data Element K	**Review Results:**	

Subsection #2, Data Element L	**Review Results:**	
Subsection #3, Data Element A	**Review Results:**	
Subsection #3, Data Element B	**Review Results:**	
Subsection #3, Data Element C	**Review Results:**	

Subsection #3, Data Element D	**Review Results:**	
Subsection #3, Data Element E	**Review Results:**	
Subsection #3, Data Element F	**Review Results:**	
Subsection #3, Data Element G	**Review Results:**	

Subsection #4, Data Element I	**Review Results:**	
Subsection #4, Data Element J	**Review Results:**	
Subsection #4, Data Element K	**Review Results:**	
Subsection #4, Data Element L	**Review Results:**	

Subsection #5, Data Element A	**Review Results:**	
Subsection #5, Data Element B	**Review Results:**	
Subsection #5, Data Element E	**Review Results:**	
Subsection #5, Data Element F	**Review Results:**	

Subsection #5, Data Element G	**Review Results:**	
Subsection #5, Data Element H	**Review Results:**	
Subsection #5, Data Element I	**Review Results:**	
Subsection #5, Data Element J	**Review Results:**	

Subsection #5, Data Element K	**Review Results:**	
Subsection #5, Data Element L	**Review Results:**	
Subsection #5, Data Element M	**Review Results:**	
Subsection #5, Data Element N	**Review Results:**	

Subsection #5, Data Element O	**Review Results:**	
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Review Results:	

Special Needs Plans (SNPs) Care Management 2019

Organization Name:	
Contract Number:	
Reporting Section:	**Special Needs Plans (SNPs) Care Management 2019**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description
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.
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.

1.b		Source documents create all required data fields for reporting requirements.
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.).
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).
1.e		Data file locations are referenced correctly.

1.f		If used, macros are properly documented.
1.g		Source documents are clearly and adequately documented.
1.h		Titles and footnotes on reports and tables are accurate.
1.i		Version control of source documents is appropriately applied.

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.
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.
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 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 2/24/2020. *[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.
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:
2.e	RSC-4.a	RSC-4.a: Includes all new members who enrolled during the measurement year. Includes those members who have an effective enrollment date that falls within the measurement year, and are continuously enrolled for at least 90 days during the measurement year. These members will be considered eligible for an initial HRA for the year in which the effective enrollment date falls.
2.e	RSC-4.b	RSC-4.b: Includes members who have an effective enrollment date that falls within the measurement year, are continuously enrolled for fewer than 90 days, and complete an initial HRA.

2.e	RSC-4.c	RSC-4.c:Includes members who have an effective enrollment date that falls in the previous measurement year, but a 90-day deadline for initial HRA completion that falls in this measurement year, if no initial HRA was completed in the previous measurement year.
2.e	RSC-4.d	RSC-4.d: Includes members who have enrolled in the plan after dis- enrolling from another plan (different sponsor or organization).
2.e	RSC-4.e	RSC-4.e: 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.
2.e	RSC-4.f	RSC-4.f: Excludes continuously enrolled 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.

2.e	RSC-4.g	RSC-4.g: Excludes members who received an initial HRA but were subsequently deemed ineligible because they were never enrolled in the plan.
2.e	RSC-4.h	RSC-4.h: Excludes members who disenroll from the plan prior to the effective enrollment date or within the first 90 days after the effective enrollment date, if an initial HRA was not completed prior to disenrolling.
2.e	RSC-4.i	RSC-4.i Excludes enrollees who receive an initial or reassessment HRA and remain continuously enrolled under a MAO whose contract was part of a consolidation of merger under the same legal entity during the member's continuous enrollment, where the consolidated SNP is still under the same Model of Care (MOC) as the enrollee's previous SNP.
2.e	RSC-5	RSC-5: Organization data passes data integrity checks listed below:

2.e	RSC-5.a	RSC-5.a: The number of initial HRAs performed on new enrollees (Data Element C) does not exceed the number of new enrollees (Data Element A).
2.e	RSC-5.b	RSC-5.b: The number of annual re-assessments performed (Data Element F) does not exceed number of enrollees eligible for annual HRA (Data Element B).
2.e	RSC-5.c	RSC-5.c: Number of initial HRAs refusals (Data Element D) does not exceed number of new enrollees (Data Element A).
2.e	RSC-5.d	RSC-5.d: Number of annual reassessment refusals (Data Element G) does not exceed the number of enrollees eligible for an annual reassessment HRA (Data Element B).

2.e	RSC-5.e	RSC-5.e: Number of initial HRAs where SNP is unable to reach enrollees (Data Element E) does not exceed number of new enrollees (Data Element A).
2.e	RSC-5.f	RSC-5.f: Number of annual reassessments where SNP is unable to reach enrollee (Data Element H) does not exceed number of enrollees eligible for annual HRA (Data Element B).
2.e	RSC-5.g	RSC-5.g: If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS.
2.e	RSC-6	RSC-6: Organization accurately calculates the number of members eligible for an annual health risk reassessment during the reporting period, including the following criteria:

2.e	RSC-6.a	RSC-6.a: Includes members who remained continuously enrolled in the same plan for 365 days, starting from the initial day of enrollment if no initial HRA had been performed, or from the date of their previous HRA.
2.e	RSC-6.b	RSC-6.b: Includes members who received a reassessment during the measurement year within 365 days after their last HRA.
2.e	RSC-6.c	RSC-6c: Includes new enrollees who missed both the deadline to complete an initial HRA and the deadline to complete a reassessment HRA, and are enrolled for all 365 days of the measurement year.
2.e	RSC-6.d	RSC-6.d: Includes new enrollees who missed an initial HRA, but completed a reassessment HRA by the 365-day deadline (even if the enrollee was covered for fewer than 365 days).

2.e	RSC-6.e	RSC-6.e: Includes members who dis-enrolled from and re-enrolled into the same plan if an initial HRA was performed within 90 days of re-enrollment and the member has continuously enrolled in the same plan for up to 365 days since the initial HRA.
2.e	RSC-6.f	RSC-6.f: Includes members who dis-enrolled from and re-enrolled into the same plan if an initial HRA or reassessment was not performed within 90 days of re-enrollment. The enrollee becomes eligible for a reassessment HRA the day after the 90-day initial period expires.
2.e	RSC-6.g	RSC-6.g: Excludes enrollees for whom the initial HRA was completed within the current measurement year.
2.e	RSC-6.h	RSC-6.h: Excludes new enrollees who miss the deadline to complete an initial HRA, and have not yet completed their reassessment HRA, but whose 365-day reassessment deadline is not until the following calendar year.

2.e	RSC-6.i	RSC-6.i. Excludes members who received a reassessment but were subsequently deemed ineligible because they were never enrolled in the plan.
2.e	RSC-6.j	RSC-6.j: Excludes members who were not continuously enrolled in their same health plan for 365 days after their last HRA and did not receive a reassessment HRA.
2.e	RSC-7	RSC-7: 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-10 Procedure codes. Reviewer should confirm that the SNP maintained documentation for each reported assessment.]
2.e	RSC-7.a	RSC-7.a: Includes only initial HRAs performed on new members within 90 days before or after the effective date of enrollment/re-enrollment.

2.e	RSC-7.b	RSC-7.b: The initial HRA is counted in the year that the effective date of enrollment occurred. For members who dis-enrolled from and re-enrolled into the same plan, excludes any HRAs (initial or reassessment) performed during their previous enrollment unless the re-enrollment occurred the day after the disenrollment.
2.e	RSC-7.c	RSC-7.c: : For members who dis-enrolled from and re-enrolled into the same plan, includes HRAs (initial or reassessment) performed during their previous enrollment if the HRAs are not more than 365 days old.
2.e	RSC-7.d	RSC-7.d: Counts only one HRA for members who have multiple HRAs within 90 days before or after the effective date of enrollment.
2.e	RSC-7.e	RSC-7.e: Excludes HRAs completed for members who were subsequently deemed ineligible because they were never enrolled in the plan.

2.e	RSC-8	RSC-8 Organization accurately calculates the number of initial health risk assessments refusals, including the following criteria:
2.e	RSC-8.a	RSC-8.a: Includes only initial HRAs that were not performed within 90 days before or after the effective date of enrollment/re-enrollment due to enrollee refusal.
2.e	RSC-8.b	RSC-8.b:Includes only initial HRA refusals for which the SNP has documentation of enrollee refusal.
2.e	RSC-9	RSC-9: Organization accurately calculates the number of initial health risk assessments not performed due to SNP not being able to reach the enrollee, including the following criteria:

2.e	RSC-9.a	RSC-9.a: Includes only initial HRAs not performed for which the SNP has documentation showing that enrollee did not respond to the SNP's attempts to reach him/her. Documentation must show that the SNP made at least 3 phone calls and sent a follow-up letter in its attempts to reach the enrollee.
2.e	RSC-9.b	RSC-9.b: Includes only those initial HRAs not performed where the SNP made an attempt to reach the enrollee at least within 90 days after the effective enrollment date.
2.e	RSC-10	RSC-10: 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-10 Procedure codes. Reviewer should confirm that the SNP maintained documentation for each reported assessment.]
2.e	RSC-10.a	RSC-10.a: Includes annual HRA reassessments that were completed within 365 days of the member becoming eligible for a reassessment.

2.e	RSC-10.b	RSC-10.b: Includes annual HRA reassessments within 365 days of the member's initial date of enrollment if the member did not receive an initial HRA within 90 days before or after the effective date of enrollment.
2.e	RSC-10.c	RSC-10.c: Includes only HRAs that were performed between 1/1 and 12/31 of the measurement year.
2.e	RSC-10.d	RSC-10.d: Counts only one HRA for members who have multiple reassessments within 365 days of becoming eligible for a reassessment.
2.e	RSC-10.e	RSC-10.e: Excludes HRAs completed for members who were subsequently deemed ineligible because they were never enrolled in the plan.

2.e	RSC-11	Organization accurately calculates the number of annual health risk reassessments not performed on members eligible for a reassessment due to enrollee refusal.
2.e	RSC-11.a	RSC-11.a: Only includes annual reassessments not performed due to enrollee refusal.
2.e	RSC-11.b	RSC-11.b: Includes only annual reassessments refusals for which the SNP has documentation of enrollee refusal.
2.e	RSC-12	Organization accurately calculates the number of annual health risk reassessments not performed on members eligible for a reassessment due to SNP not being able to reach enrollee.

2.e	RSC-12.a	RSC-12.a: Only includes annual reassessments not performed for which the SNP has documentation showing that the enrollee did not respond to the plan's attempts to reach him/her. Documentation must show that the SNP made at least 3 phone calls and sent a follow-up letter in its attempts to reach the enrollee.
3		Organization implements policies and procedures for data submission, including the following:
3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.
3.a		

3.a		
3.a		
3.a		
3.a		

3.a		
3.a		
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, claims adjustments).

5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
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.
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.

	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) Enter "Y" if the requirements for the standard or sub-standard have been completely met. If any requirement for the standard or substandard has not been met, enter "N". If any standard or sub-standard does not apply, enter "N/A". 3) For standards 1c, 1d, 1e, 1g, 1h, and 2e, enter 'Findings' as follows based on the five-point scale: Select "1" if plan data has more than 20% error, select "2" if plan data has between 15.1% - 20.0% error, select "3" if plan data has between 10.1% - 15.0% error, select "4" if plan data has between 5.1% - 10.0% error, select "5" if plan data has less than or equal to a 5% error. Enter "N/A" if standard does not apply.

Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
	Data Sources:	*
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Data Sources:	*
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Data Sources:	*
Data Element A	**Review Results:**	
Data Element A	**Review Results:**	

Data Element A	**Review Results:**	
Data Element A	**Review Results:**	
Data Element A	**Review Results:**	
Data Element A	**Review Results:**	

Data Element A	**Review Results:**	
Data Element A	**Review Results:**	
Data Element A	**Review Results:**	
	Data Sources:	*

Data Element C	**Review Results:**	
Data Element F	**Review Results:**	
Data Element D	**Review Results:**	
Data Element G	**Review Results:**	

Data Element E	**Review Results:**	
Data Element H	**Review Results:**	
Data Elements A-H	**Review Results:**	
	Data Sources:	*

Data Element B	**Review Results:**	
Data Element B	**Review Results:**	
Data Element B	**Review Results:**	
Data Element B	**Review Results:**	

Data Element B	**Review Results:**	
Data Element B	**Review Results:**	
Data Element B	**Review Results:**	
Data Element B	**Review Results:**	

Data Element B	**Review Results:**	
Data Element B	**Review Results:**	
	Data Sources:	*
Data Element C	**Review Results:**	

Data Element C	**Review Results:**	
Data Element C	**Review Results:**	
Data Element C	**Review Results:**	
Data Element C	**Review Results:**	

	Data Sources:	*
Data Element D	**Review Results:**	
Data Element D	**Review Results:**	
	Data Sources:	*

Data Element E	**Review Results:**	
Data Element E	**Review Results:**	
	Data Sources:	*
Data Element F	**Review Results:**	

Data Element F	**Review Results:**	
Data Element F	**Review Results:**	
Data Element F	**Review Results:**	
Data Element F	**Review Results:**	

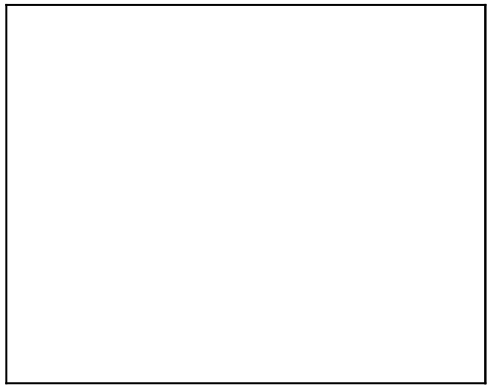
	Data Sources:	*
Data Element G	**Review Results:**	
Data Element G	**Review Results:**	
	Data Sources:	*

Data Element H	**Review Results:**	
	Data Sources:	*
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:**	
	Review Results:	
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	



Grievances (Part D) 2019

Organization Name:	
Contract Number:	
Reporting Section:	**Grievances (Part D) 2019**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description
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.
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.

1.b		Source documents create all required data fields for reporting requirements.
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.).
1.d		All data fields have meaningful, consistent labels (e.g., label field for patient ID as PatientID, rather than Field1 and maintain the same field name across data sets).
1.e		Data file locations are referenced correctly.

1.f		If used, macros are properly documented.
1.g		Source documents are clearly and adequately documented.
1.h		Titles and footnotes on reports and tables are accurate.
1.i		Version control of source documents is appropriately applied.

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.
2.a	RSC-1	The appropriate date range(s) for the reporting period(s) is captured. 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	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.
2.c	RSC-3	Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadlines for reporting data to CMS by 2/3/2020. *[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 resubmits 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	RSC-4	Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications. Organization properly defines the term “Grievance” in accordance with 42 CFR §422.564 and the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Manual. This includes applying all relevant guidance properly when performing its calculations.
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. [Data Elements A-E] RSC-5: Organization data passes data integrity checks listed below:
2.e	RSC-5.a	RSC-5.a Total grievances in Data Element B does not exceed Data Element A.
2.e	RSC-5.b	RSC-5.b: Total grievances in which timely notification was given (Data Element D) does not exceed Data Element B.

2.e	RSC-5.c	RSC-5.c: Number of expedited grievances (Data Element C) does not exceed total grievances (Data Element A).
2.e	RSC-5.d	RSC-5.d: Number of expedited grievances in which timely notification was given (Data Element D) does not exceed total expedited grievances (Data Element C).
2.e	RSC-5.e	RSC-5.e: Number of dismissed grievances (Data Element E) is excluded from the total.
2.e	RSC-5.f	RSC-5.f: If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS.

2.e	RSC-6	RSC-6: Organization accurately calculates and uploads into HPMS the total number of grievances, including the following criteria:
2.e	RSC-6.a	RSC-6.a: 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.
2.e	RSC-6.a	
2.e	RSC-6.a	

2.e	RSC-6.a	
2.e	RSC-6.a	
2.e	RSC-6.b	RSC-6.b: If a grievance contains multiple issues filed by a single complainant, each issue is calculated as a separate grievance.
2.e	RSC-6.b	

2.e	RSC-6.b	
2.e	RSC-6.b	
2.e	RSC-6.b	
2.e	RSC-6.c	RSC-6.c: 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 is counted as one grievance.

2.e	RSC-6.c	
2.e	RSC-6.c	
2.e	RSC-6.c	
2.e	RSC-6.c	

2.e	RSC-6.d	RSC-6.d: 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.
2.e	RSC-6.d	
2.e	RSC-6.d	
2.e	RSC-6.d	

2.e	RSC-6.d	
2.e	RSC-6.e	RSC-6.e: Includes all methods of grievance receipt (e.g., telephone, letter, fax, and in person).
2.e	RSC-6.e	
2.e	RSC-6.e	

2.e	RSC-6.e	
2.e	RSC-6.e	
2.e	RSC-6.f	RSC-6.f: Includes all grievances regardless of who filed the grievance (e.g., member or appointed representative).
2.e	RSC-6.f	

2.e	RSC-6.f	
2.e	RSC-6.f	
2.e	RSC-6.f	
2.e	RSC-6.g	RSC-6.g: 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.

2.e	RSC-6.g	
2.e	RSC-6.g	
2.e	RSC-6.g	
2.e	RSC-6.g	

2.e	RSC-6.h	RSC-6.h: Excludes withdrawn Part D grievances.
2.e	RSC-6.h	
2.e	RSC-6.h	
2.e	RSC-6.h	

2.e	RSC-6.h	
2.e	RSC-6.h	
2.e	RSC-6.i	RSC-6.i: *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.
2.e	RSC-6.i	

2.e	RSC-6.i	
2.e	RSC-6.i	
2.e	RSC-6.i	
2.e	RSC-6.i	

2.e	RSC-6.j	RSC-6.j: Counts grievances for the contract to which the member belongs at the time the grievance was filed, even if the beneficiary enrolled in a new contract before the grievance is resolved (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 previous plan is still responsible for investigating, resolving and reporting the grievance).
2.e	RSC-6.j	
2.e	RSC-6.j	
2.e	RSC-6.j	

2.e	RSC-6.j	
2.e	RSC-6.j	
2.e	RSC-7	Organization accurately calculates the number of grievances which the Part D sponsor provided timely notification of the decision, including the following criteria:
2.e	RSC-7.a	RSC-7.a: Includes only grievances for which the member is notified of decision according to the following timelines:

2.e	RSC-7.ai	RSC-7.a.i. For standard grievances: no later than 30 days after receipt of grievance.
2.e	RSC-7.aii	RSC-7.aii: For standard grievances with an extension taken: no later than 44 days after receipt of grievance.
2.e	RSC-7.aiii	RSC-7.aiii: For expedited grievances: no later than 24 hours after receipt of grievance.
3		Organization implements policies and procedures for data submission, including the following:

3.a		Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.
3.a		
3.a		
3.a		

3.a		
3.b		All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.
4		Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, and claims adjustments).
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).

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.
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.

	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) Enter "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, enter "N". If any standard or sub-standard does not apply, enter "N/A". 3) For standards 1c, 1d, 1e, 1g, 1h, and 2e, enter 'Findings' as follows based on the five-point scale: Select "1" if plan data has more than 20% error, select "2" if plan data has between 15.1% - 20.0% error, select "3" if plan data has between 10.1% - 15.0% error, select "4" if plan data has between 5.1% - 10.0% error, select "5" if plan data has less than or equal to a 5% error. Enter "N/A" if standard does not apply.

Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
	Data Sources:	*
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Data Sources:	*
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Data Sources:	*
Data Element B	**Review Results:**	
Data Element D	**Review Results:**	

Data Element C	**Review Results:**	
Data Element D	**Review Results:**	
Data Element E	**Review Results:**	
Data Elements A-E	**Review Results:**	

	Data Sources:	*
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 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 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 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 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 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 A	**Review Results:**	

Data Element B	**Review Results:**	
Data Element C	**Review Results:**	
Data Element D	**Review Results:**	
Data Element E	**Review Results:**	

	Data Sources:	*
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 Sources:	*
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 Sources:	*
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 Sources:	*
	Data Sources:	*

Data Element B	**Review Results:**	
Data Element B	**Review Results:**	
Data Element B	**Review Results:**	
	Data Sources:	*

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:**	
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Review Results:	

Coverage Determinat

Organization Name:	
Contract Number:	
Reporting Section:	
Last Updated:	
Date of Site Visit:	
Name of Reviewer:	
Name of Peer Reviewer:	

Standard/ Sub-standard ID	Reporting Section Criteria ID
1	
1.a	

1.b	
1.c	
1.d	
1.e	

1.f	
1.g	
1.h	
1.i	

2	
2.a	RSC-1
2.b	RSC-2
2.c	RSC-3

2.d	RSC-4
2.e	RSC-5
2.e	RSC-5.a
2.e	RSC-5.b

2.e	RSC-5.c
2.e	RSC-5.d
2.e	RSC-5.e
2.e	RSC-5.f

2.e	RSC-5.g
2.e	RSC-5.h
2.e	RSC-5.i
2.e	RSC-6

2.e	RSC-6.a
2.e	RSC-6.b
2.e	RSC-6.c
2.e	RSC-6.d

2.e	RSC-6.e
2.e	RSC-6.f
2.e	RSC-6.g
2.e	RSC-6.h

2.e	RSC-6.i
2.e	RSC-6.j
2.e	RSC-6.k
2.e	RSC-6.l

2.e	RSC-6.m
2.e	RSC-6.n
2.e	RSC-6.o
2.e	RSC-6.p

2.e	RSC-7
2.e	RSC-7.a
2.e	RSC-7.b
2.e	RSC-7.c

2.e	RSC-7.d
2.e	RSC-7.e
2.e	RSC-7.f
2.e	RSC-7.g

2.e	RSC-7.h
2.e	RSC-8
2.e	RSC-8.a
2.e	RSC-8.a

2.e	RSC-8.a
2.e	RSC-8.b
2.e	RSC-8.b
2.e	RSC-8.b

2.e	RSC-9
2.e	RSC-9.a
2.e	RSC-9.a
2.e	RSC-9.b

2.e	RSC-9.b
2.e	RSC-10
2.e	RSC-10.a
2.e	RSC-10.b

2.e	RSC-10.c
2.e	RSC-10.d
2.e	RSC-10.e
2.e	RSC-10.f

2.e	RSC-10.g
2.e	RSC-10.h
2.e	RSC-10.i
2.e	RSC-10.j

2.e	RSC-10.k
2.e	RSC-10.l
2.e	RSC-10.m
2.e	RSC-10.n

2.e	RSC-11
2.e	RSC-11.a
2.e	RSC-11.b
2.e	RSC-12

2.e	RSC-12.a
2.e	RSC-12.a
2.e	RSC-12.b
2.e	RSC-12.b

2.e	RSC-12.c
2.e	RSC-12.c
2.e	RSC-13
2.e	RSC-13.a

2.e	RSC-14
2.e	RSC-14.a
2.e	RSC-14.b
2.e	RSC-14.c

2.e	RSC-14.d
2.e	RSC-14.e
2.e	RSC-14.f
2.e	RSC-14.g

2.e	RSC-14.h
2.e	RSC-14.i
2.e	RSC-14.j
2.e	RSC-14.k

2.e	RSC-14.l
3	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.b	

4	
5	
6	
7	

Coverage Determinations and Redeterminations (Part D) 2019
MM/DD/YYYY
Last name, First name
Last name, First name

Standard/Sub-standard Description	Data Element
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.	
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.	

Source documents create all required data fields for reporting requirements.	
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.).	
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).	
Data file locations are referenced correctly.	

If used, macros are properly documented.	
Source documents are clearly and adequately documented.	
Titles and footnotes on reports and tables are accurate.	
Version control of source documents is appropriately applied.	

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.	
The appropriate date range(s) for the reporting period(s) is captured. 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.	
Data are assigned at the applicable level (e.g., plan benefit package or contract level). Organization properly assigns data to the applicable CMS contract.	
Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadlines for reporting data to CMS by 2/24/2020 *[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.]*	

Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications. Organization properly defines the term “Coverage Determinations” in accordance with 42 C.F.R. Part 423, Subpart M, and the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Manual. This includes applying all relevant guidance properly when performing its calculations and categorizations. Organization properly defines the term “Redetermination” in accordance with 42 C.F.R. Part 423, Subpart M, and the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Manual. This includes applying all relevant guidance properly when performing its calculations and categorizations.	
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. Organization data passes data integrity checks listed below: [Note: Data Elements 1.A - 1.R relate to Coverage Determinations, Data Elements 2.A – 2.F relate to Redeterminations, and Data Elements 3.A and 3.B.1 – 3.B.12 relate to Re-openings]	
RSC-5.a: Number of coverage determinations decisions by outcome (Data Elements (1.D + 1.E + 1.F) + (1.H + 1.I + 1.J) + (1.L + 1.M + 1.N) + (1.P + 1.Q + 1.R)) does not exceed the total number of processed coverage determinations that include exceptions (Data Element 1.A).	Data Elements (1.D+1.E+1.F) + (1.H+1.I+1.J) + (1.L+1.M+1.N) + (1.P+1.Q+1.R)
RSC-5.b: Number of exception decisions made in the reporting period (Data Elements (1.H + 1.I + 1.J) + (1.L + 1.M + 1.N) + (1.P + 1.Q + 1.R)) does not exceed the total number of processed coverage determination decisions that include exceptions (Data Element 1.A).	Data Elements (1.H+1.I+1.J) + (1.L+1.M+1.N) + (1.P+1.Q+1.R)

RSC-5.c: Number of redeterminations by outcome (Data Elements (2.D + 2.E + 2.F)) is equal to total number of redeterminations (Data Element 2.A).	Data Elements 2.D +2.E. + 2.F
RSC-5.d: Total number of reopened (revised) decisions (Data Element 3.A) is equal to the number of records reported in data file.	Data Element 3.A
RSC-5.e: Verify that the date of each reopening disposition (Data Element 3.B.11) is in the reporting quarter.	Data Element 3.B.11
RSC-5.f: Verify that the date of disposition for each reopening (Data Element 3.B.11) is equal to or later than the date of original dispostion Data Element 3.B.5).	Data Element 3.B.11

RSC-5.g: Verify that the date of each reopening disposition (Data Element 3.B.11) is equal to or later than the date the case was reopened (Data Element 3.B.9).	Data Element 3.B.11
RSC-5.h: Verify that the date each case was reopened (Data Element 3.B.9) is after the date of original disposition (Data Element 3.B.5).	Data Element 3.B.9
RSC-5.i: If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS.	Data Elements 1.A–1.R, 2.A–2.F, 3.A–3.B.9
RSC-6: Organization accurately calculates the number of coverage determinations (Part D only) decisions made in the reporting period, including the following criteria:	

RSC-6.a: Includes all coverage determinations (fully favorable, partially favorable, and adverse),including exceptions with a date of decision that occurs during the reporting period, regardless of when the request for coverage determination was received. [Note: Exception requests include tiering exceptions, formulary exceptions, and UM exceptions, such as prior authorization, step therapy, quantity limits, etc.]	Data Element 1.A
RSC-6.b: Includes hard morphine milligram equivalent dose (MME) edit coverage determinations.	Data Element 1.A
RSC-6.c: Includes opioid naïve days supply edit coverage determinations.	Data Element 1.A
RSC-6.d: Includes hospice-related coverage determinations.	Data Element 1.A

RSC-6.e: Includes all methods of receipt (e.g., telephone, letter, fax, in-person).	Data Element 1.A
RSC-6.f: Includes all coverage determinations (including exceptions) regardless of who filed the request (e.g., member, appointed representative, or prescribing physician).	Data Element 1.A
RSC-6.g: Includes coverage determinations (including exceptions) from delegated entities. [Note: Delegated entities are contractors to Part D sponsors]	Data Element 1.A
RSC-6.h: Includes both standard and expedited coverage determinations (including exceptions).	Data Element 1.A

RSC-6.i: Excludes requests for coverage determinations (including exceptions) that are withdrawn or dismissed.	Data Element 1.A
RSC-6.j: Includes each distinct dispute (i.e., multiple drugs) contained in one coverage determination request as a separate coverage determination request.	Data Element 1.A
RSC-6.k: Includes adverse coverage determination cases that were forwarded to the Independent Review Entity (IRE) because the organization made an untimely decision.	Data Element 1.A
RSC-6.l: Includes all coverage determination decisions that relate to Part B versus Part D coverage (drugs covered under Part B are considered adverse decisions under Part D). i. Point of Sale (POS) claims adjudications (e.g., a rejected claim for a drug indicating a B vs. D prior authorization (PA) is required) are not included unless the plan subsequently processed a coverage determination.	Data Element 1.A

RSC-6.m: Includes Direct Member Reimbursements (DMRs) part of the total number of exceptions if the plan processed the request under the tiering or formulary exceptions process. Verify that all DMRs regardless of request disposition type that were processed under the tiering or formulary exception process should be included in the count of the total number of coverage determination decisions made in the reporting period.	Data Elements 1.G, 1.K, 1.O
RSC-6.n: Excludes coverage determinations (including exceptions) regarding drugs assigned to an excluded drug category.	Data Element 1.A
RSC-6.o: Excludes members who have Utilization Management (UM) requirements waived based on an exception decision made in a previous plan year or reporting period.	Data Element 1.A
RSC-6.p: Confirm that a coverage determination was denied for lack of medical necessity based on review by a physician or other appropriate health care professional.	Data Element 1.A

RSC-7: Organization accurately calculates the total number of UM, Formulary, and Tier exceptions decisions made in the reporting period, including the following criteria:	
RSC-7.a. Includes all decisions made (fully favorable, partially favorable, and adverse) with a date of decision that occurs during the reporting period, regardless of when the exception decision was received.	Data Elements 1.G, 1.K, 1.O
RSC-7.b: Includes all methods of receipt (e.g., telephone, letter, fax, in person).	Data Elements 1.G, 1.K, 1.O
RSC-7.c: Includes exception requests that were forwarded to the Independent Review Entity (IRE) because the organization failed to make a timely decision.	Data Elements 1.G, 1.K, 1.O

RSC-7.d: Includes requests for exceptions from delegated entities.	Data Elements 1.G, 1.K, 1.O
RSC-7.e: Includes both standard and expedited exceptions.	Data Elements 1.G, 1.K, 1.O
RSC-7.f: Excludes requests for exemptions that are withdrawn or dismissed.	Data Elements 1.G, 1.K, 1.O
RSC-7.g: Excludes requests for exceptions regarding drugs assigned to an excluded drug category.	Data Elements 1.G, 1.K, 1.O

RSC-7.h: Excludes members who have UM requirements waived based on an exception decision made in a previous plan year or reporting period.	Data Elements 1.G, 1.K, 1.O
RSC-8: Organization accurately calculates the number of coverage determinations decisions made by final decision, including the following criteria:	
RSC-8.a: Properly categorizes the number of coverage determinations (excluding exceptions) by final decision: fully favorable, partially favorable, or adverse. Verify that all cases included in the count for the total number of processed coverage determinations made in the reporting period are identified as one of the accepted disposition types.	Data Element 1.D
RSC-8.a: Properly categorizes the number of coverage determinations (excluding exceptions) by final decision: fully favorable, partially favorable, or adverse. Verify that all cases included in the count for the total number of processed coverage determinations made in the reporting period are identified as one of the accepted disposition types.	Data Element 1.E

RSC-8.a: Properly categorizes the number of coverage determinations (excluding exceptions) by final decision: fully favorable, partially favorable, or adverse. Verify that all cases included in the count for the total number of processed coverage determinations made in the reporting period are identified as one of the accepted disposition types.	Data Element 1.F
RSC-8.b: Includes untimely coverage determinations decisions, regardless if they were auto-forwarded to the IRE.	Data Element 1.D
RSC-8.b: Includes untimely coverage determinations decisions, regardless if they were auto-forwarded to the IRE.	Data Element 1.E
RSC-8.b: Includes untimely coverage determinations decisions, regardless if they were auto-forwarded to the IRE.	Data Element 1.F

RSC-9: Organization accurately calculates the number of coverage determinations that were withdrawn or dismissed, including the following criteria:	
RSC-9.a: Includes all withdrawals and dismissals on requests for coverage determinations (including exceptions). This includes expedited coverage determinations and exceptions that were withdrawn or dismissed for any reason.	Data Element 1.B
RSC-9.a: Includes all withdrawals and dismissals on requests for coverage determinations (including exceptions). This includes expedited coverage determinations and exceptions that were withdrawn or dismissed for any reason.	Data Element 1.C
RSC-9.b: Includes dismissals that are made where the procedural requirements for a valid request are not met within the stipulated timeframe. The plan should issue a dismissal only when the required documentation was not received within a reasonable amount of time.	Data Element 1.B

RSC-9.b: Includes dismissals that are made where the procedural requirements for a valid request are not met within the stipulated timeframe. The plan should issue a dismissal only when the required documentation was not received within a reasonable amount of time.	Data Element 1.C
RSC-10: Organization accurately calculates the total number of redeterminations (Part D only), including the following criteria:	
RSC-10.a: Includes all redetermination final 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 2.A
RSC-10.b: Includes all redetermination decisions, including fully favorable, partially favorable, and adverse decisions.	Data Element 2.A

RSC-10.c: Includes redetermination requests that were forwarded to the IRE because the organization failed to make a timely decision.	Data Element 2.A
RSC-10.d: Includes both standard and expedited redeterminations.	Data Element 2.A
RSC-10.e: Includes beneficiary-specific Point of Sale (POS) edit, prescriber or pharmacy coverage limitation appeals (at-risk determination appeals) made under a drug management program redeterminations.	Data Element 2.A
RSC-10.f: Includes all methods of receipt (e.g., telephone, letter, fax, in-person).	Data Element 2.A

RSC-10.g: Includes all redeterminations regardless of who filed the request (e.g., member, appointed representative, or prescribing physician).	Data Element 2.A
RSC-10.h: Includes Direct Member Reimbursements (DMRs) part of the total number of redeterminations if the plan processed the request under the tiering or formulary exceptions process. Reference the Medicare Part C and Part D Reporting Requirements Data Validation Procedure Manual.	Data Element 2.A
RSC-10.i: Includes all redetermination decisions that relate to Part B versus Part D coverage (drugs covered under Part B are considered adverse decisions under Part D). a. Point of Sale (POS) claims adjudications (e.g., a rejected claim for a drug indicating a B vs. D PA is required) are not included unless the plan subsequently processed a redetermination.	Data Element 2.A
RSC-10.j: Includes each distinct dispute contained in one redetermination request (i.e., multiple drugs), as a separate redetermination request.	Data Element 2.A

RSC-10.k: Excludes dismissals and withdrawals.	Data Element 2.A
RSC-10.l: Excludes IRE decisions, as they are considered to be the second level of appeal.	Data Element 2.A
RSC-10.m: Excludes redeterminations regarding excluded drugs.	Data Element 2.A
RSC-10.n: Limits reporting to just the redetermination level.	Data Element 2.A

RSC-11: Organization accurately calculates the number of redeterminations by final decision, including the following criteria:	
RSC-11.a: Properly categorizes the total number of redeterminations by final decision, including the following criteria: fully favorable (e.g., fully favorable decision reversing the original coverage determination), partially favorable (e.g., denial with a “part” that has been approved), and adverse (e.g., the original coverage determination decision was upheld).	Data Elements 2.D–2.F
RSC-11.b: Excludes redetermination decisions made by the IRE.	Data Elements 2.D–2.F
RSC-12: Organization accurately calculates the number of redeterminations that were withdrawn or dismissed, including the following criteria:	

RSC-12.a: Includes all withdrawals and dismissals on requests for redeterminations.	Data Element 2.B
RSC-12.a: Includes all withdrawals and dismissals on requests for redeterminations.	Data Element 2.C
RSC-12.b: Includes dismissals that are made when the procedural requirements for a valid request are not met within the stipulated timeframe. The plan should issue a dismissal only when the required documentation has not been received within a reasonable amount of time.	Data Element 2.B
RSC-12.b: Includes dismissals that are made when the procedural requirements for a valid request are not met within the stipulated timeframe. The plan should issue a dismissal only when the required documentation has not been received within a reasonable amount of time.	Data Element 2.C

RSC-12.c: Each number calculated for requests for redeterminations that were withdrawn (Data Element 2.B) and requests for redeterminations that were dismissed (Data Element 2.C) is a subset of the number of redeterminations decisions made (Data Element 2.A).	Data Element 2.B
RSC-12.c: Each number calculated for requests for redeterminations that were withdrawn (Data Element 2.B) and requests for redeterminations that were dismissed (Data Element 2.C) is a subset of the number of redeterminations decisions made (Data Element 2.A).	Data Element 2.C
Organization accurately calculates the total number of reopened decisions according to the following criteria:	
RSC-13.a: Includes a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.	Data Element 3.A

Organization accurately reports the following information for each reopened case.	
RSC-14.a: Contract Number	Data Element 3.B.1
RSC-14.b: Plan ID	Data Element 3.B.2
RSC-14.c: Case ID	Data Element 3.B.3

RSC-14.d: Case level (Coverage Determination or Redetermination)	Data Element 3.B.4
RSC-14.e: Date of original disposition	Data Element 3.B.5
RSC-14.f: Original disposition (Fully Favorable; Partially Favorable; or Adverse)	Data Element 3.B.6
RSC-14.g: Was case processed under expedited timeframe (Y/N)	Data Element 3.B.7

RSC-14.h: Case type (Pre-Service; Payment)	Data Element 3.B.8
RSC-14.i: Date case was reopened	Data Element 3.B.9
RSC-14.j: Reason (s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)	Data Element 3.B.10
RSC-14.k: Date of reopening disposition (revised decision)	Data Element 3.B.11

RSC-14.l Reopening disposition (Fully Favorable; Partially Favorable; Adverse, or Pending)	Data Element 3.B.12
Organization implements policies and procedures for data submission, including the following:	
Data elements are accurately entered/uploaded into CMS systems and entries match corresponding source documents.	Data Element 1.A
	Data Element 1.B

	Data Element 1.C
	Data Element 1.D
	Data Element 1.E
	Data Element 1.F

	Data Element 1.G
	Data Element 1.H
	Data Element 1.I
	Data Element 1.J

	Data Element 1.K
	Data Element 1.L
	Data Element 1.M
	Data Element 1.N

	Data Element 1.O
	Data Element 1.P
	Data Element 1.Q
	Data Element 1.R

	Data Element 2.A
	Data Element 2.B
	Data Element 2.C
	Data Element 2.D

	Data Element 2.E
	Data Element 2.F
	Data Element 3.A
	Data Element 3.B.1

	Data Element 3.B.2
	Data Element 3.B.3
	Data Element 3.B.4
	Data Element 3.B.5

	Data Element 3.B.6
	Data Element 3.B.7
	Data Element 3.B.8
	Data Element 3.B.9

	Data Element 3.B.10
	Data Element 3.B.11
	Data Element 3.B.12
All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.	

Organization implements policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pharmacy status, and claims adjustments).	
Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).	
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.	
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.	

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) Enter "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, enter "N". If any standard or sub-standard does not apply, enter "N/A".
3) For standards 1c, 1d, 1e, 1g, 1h, and 2e, enter 'Findings' as follows based on the five-point scale: Select "1" if plan data has more than 20% error, select "2" if plan data has between 15.1% - 20.0% error, select "3" if plan data has between 10.1% - 15.0% error, select "4" if plan data has between 5.1% - 10.0% error, select "5" if plan data has less than or equal to a 5% error. Enter "N/A" if standard does not apply.

Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
Data Sources:	*
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Data Sources:	*
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Data Sources:	*
Review Results:	
Review Results:	

Review Results:		
Review Results:		
Review Results:		
Review Results:		

Review Results:		
Review Results:		
Review Results:		
Data Sources:	*	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Data Sources:	*
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Data Sources:	*
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Data Sources:	*
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Data Sources:	*
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Data Sources:	*
Review Results:	
Review Results:	
Data Sources:	*

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Data Sources:	*
Review Results:	

Data Sources:	*
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Data Sources:	*
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Review Results:	
Review Results:	
Review Results:	
Review Results:	

Improving Drug Utiliza

Organization Name:
Contract Number:
Reporting Section:
Last Updated:
Date of Site Visit:
Name of Reviewer:
Name of Peer Reviewer:

Standard/ Sub-standard ID	Reporting Section Criteria ID
1	
1.a	

1.b	
1.c	
1.d	
1.e	

1.f	
1.g	
1.h	
1.i	

2	
2.a	RSC-1
2.b	RSC-2
2.c	RSC-3

2.d	RSC-4
2.e	RSC-5

2.e	RSC-5.a
2.e	RSC-5.ai
2.e	RSC-5.aii
2.e	RSC-5.aiii

2.e	RSC-5.aiv
2.e	RSC-5.b
2.e	RSC-5.bi
2.e	RSC-5.bii

2.e	RSC-5.biii
2.e	RSC-5.biv
2.e	RSC-5.bv
2.e	RSC-5.c

2.e	RSC-5.d
2.e	RSC-5.di
2.e	RSC-5.dii
2.e	RSC-5.diii

2.e	RSC-5.div
2.e	RSC-5.dv
2.e	RSC-5.e
2.e	RSC-6

2.e	RSC-6.a
2.e	RSC-6.ai
2.e	RSC-6.ai
2.e	RSC-6.aii

2.e	RSC-6.aii
2.e	RSC-6.aiii
2.e	RSC-6.aiii
2.e	RSC-6.aiv

2.e	RSC-6.aiv
2.e	RSC-6.b
2.e	RSC-6.bi
2.e	RSC-6.bi

2.e	RSC-6.bii
2.e	RSC-6.bii
2.e	RSC-6.biii
2.e	RSC-6.biii

2.e	RSC-6.biv
2.e	RSC-6.biv
2.e	RSC-6.c
2.e	RSC-6.ci

2.e	RSC-6.ci
2.e	RSC-6.cii
2.e	RSC-6.cii
2.e	RSC-6.ciii

2.e	RSC-6.ciii
2.e	RSC-6.civ
2.e	RSC-6.civ
2.e	RSC-7

2.e	RSC-7.a
2.e	RSC-7.ai
2.e	RSC-7.ai
2.e	RSC-7.b

2.e	RSC-7.bi
2.e	RSC-7.bi
2.e	RSC-8
2.e	RSC-8.a

2.e	RSC-8.ai
2.e	RSC-8.aii
2.e	RSC-8.aiii
2.e	RSC-8.b

2.e	RSC-8.bi
2.e	RSC-8.bii
2.e	RSC-8.biii
2.e	RSC-9

2.e	RSC-9.a
2.e	RSC-9.ai
2.e	RSC-9.b
2.e	RSC-9.bi

2.e	RSC-10
2.e	RSC-10.a
2.e	RSC-10.ai
2.e	RSC-10.b

2.e	RSC-10.bi
3	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.a	

3.a	
3.a	
3.a	
3.b	

4	
5	
6	
7	

Improving Drug Utilization Review Controls (Part D) 2019
MM/DD/YYYY
Last name, First name
Last name, First name

Standard/Sub-standard Description
A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flo accurately capture required data fields and are properly documented.
Source documents and output are properly secured so that source documents can be retrieved at any time to validate the information su

Source documents create all required data fields for reporting requirements.
Source documents are error-free (e.g., programming code and spreadsheet formulas have no messages or warnings indicating errors).
All data fields have meaningful, consistent labels (e.g., label field for patient ID as Patient ID, rather than Field1 and maintain the same fiel
Data file locations are referenced correctly

If used, macros are properly documented.
Source documents are clearly and adequately documented.
Titles and footnotes on reports and tables are accurate.
Version control of source documents is appropriately applied.

A review of source documents (e.g., programming code, spreadsheet formulas, analysis plans, saved data queries, file layouts, process flo is applicable, indicates that data elements for each reporting section are accurately identified, processed, and calculated.
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 3/31, 1/1 through 6/30, 1/1 through 9/30, 1/1 through 1
Data are assigned at the applicable level (e.g., plan benefit package or contract level). Organization properly assigns data to the applicable CMS contract and plan.
Appropriate deadlines are met for reporting data (e.g., quarterly). Organization meets deadline for reporting annual data to CMS by 02/24/2020. *[Note to reviewer: If the organization has, for any reason, re- submitted its data to CMS for this reporting section, the reviewer should verif submissions met the CMS deadline in order to have a finding of "yes" for this reporting section criterion. However, if the organization re-su submission was completed by 3/31 of the data validation year, the reviewer should use the organization's corrected data submission(s) for this reporting section.]*

Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications.

Organization complies with drug utilization management (DUM) requirements of 42 C.F.R §423.153 et seq. to prevent overutilization of op
according to guidelines specified by CMS. This includes but is not limited to:

a. Applying all relevant guidance to properly establish and implement a care coordination formulary-level cumulative opioid morphine m
of sale (POS) edit, an opioid naïve days supply POS edit, and if applicable, a hard formulary-level cumulative opioid MME threshold POS ed

b. Organization provides documentation that its care coordination safety POS edit, an opioid naïve days supply POS edit, and if applicable
MME threshold POS edit were properly tested and validated prior to its implementation date.

c. For care coordination and safety edit,

i. Properly reports the care coordination safety edit formulary-level cumulative opioid MME threshold, provider count, and pharmacy c
2019 care coordination safety edit formulary-level cumulative opioid MME threshold submission to CMS via HPMS.

d. For the hard MME edit,

i. Properly reports the hard MME safety edit formulary-level cumulative opioid MME threshold, provider count, and pharmacy count c
MME safety edit formulary-level cumulative opioid MME threshold submission to CMS via HPMS.

e. For the opioid naive days supply safety edit,

i. Properly reports that the opioid naïve days supply safety edit look-back period reported matches the CY 2019 look-back period subm

The number of expected counts (e.g., number of members, claims, grievances, procedures) are verified; ranges of data fields are verified;
are verified; missing data has been properly addressed; reporting output matches corresponding source documents (e.g., programming co
control of reported data elements is appropriately applied; QA checks/thresholds are applied to detect outlier or erroneous data prior to c

RSC-5: Organization data passes data integrity checks listed below:

RSC-5.a: For the care coordination safety edit, the following is true:
RSC-5.ai: The number of claims rejected due to care coordination safety edits, and the number of unique beneficiaries rejected due to car reported (Data Elements C, E ≠ blank).
RSC-5.aii: The number of care coordination safety edit claim rejections overridden by the pharmacist at the pharmacy (Data Element D) is claims rejected due to the care coordination safety edit (Data Element C).
RSC-5.aiii: The number of unique beneficiaries with at least one care coordination safety edit claim rejection overridden by the pharmacist value less than or equal to the number of unique beneficiaries with at least one claim rejected due to the care coordination safety edit (Da

RSC-5.aiv: The number of unique beneficiaries with at least one care coordination safety edit claim rejection overridden by the pharmacist claim successfully processed at POS (Data Element G) is a value less than or equal to the number of unique beneficiaries with at least one safety edit (Data Element E).
RSC-5.b: If the organization had a hard MME safety edit (Data Element H =Yes), the following is true:
RSC-5.bi: The number of unique beneficiaries with at least one hard MME safety edit claim rejection that also had an opioid claim successf a favorable coverage determination or appeal, such as a pharmacist communication and/or plan override (Data Element N) is a value less beneficiaries with at least one claim rejected due to the hard MME safety edit (Data Element M).
RSC-5.bii: The number of unique beneficiaries with at least one hard MME safety edit claim rejection that also had a coverage determinati safety edit rejections (Data Element O) is less than or equal to the number of unique beneficiaries with at least one claim rejected due to t

RSC-5.biii: The number of unique beneficiaries with at least one hard MME safety edit claim rejection with a coverage determination or ap rejections that had a favorable (either full or partial) coverage determination or appeal (Data Element P) is a value less than or eqaual to t least one claim rejected due to the hard MME safety edit (Data Element M).
RSC-5.biv: The number of unique beneficiaries with at least one hard MME safety edit claim rejection that also had an opioid claim succes to the hard MME safety edit through favorable (either full or partial) coverage determination or appeal (Data Element Q) is a value less th beneficiaries with at least one claim rejected due to the hard MME safety edit (Data Element M).
RSC-5.bv: The cumulative MME threshold, the number of claims rejected due to hard MME safety edits, and the number of unique benefi to the hard MME safety edit must be reported (Data Elements I, L, M, ≠ blank).
RSC-5.c: If the organization does not have hard MME safety POS edits (Data Element H =No), Data Elements I, J, K, L, M, N, O, P and Q shou

RSC-5.d: For the opioid naïve days supply safety edit, the following is true:
RSC-5.di: The look-back period used to identify an initial opioid prescription fill for the treatment of acute pain, the number of claims rejec edit, and the number of unique beneficiaries with at least one claim rejected due to the naïve days supply safety edit must be reported (D
RSC-5.dii: The number of unique beneficiaries with at least one opioid naïve days supply safety edit claim rejection that also had an opioid than through a favorable coverage determination or appeal, such as a pharmacist communication and/or plan override (Data Element U) i of unique beneficiaries with at least one claim rejected due to the opioid naïve days supply safety edit (Data Element T).
RSC-5.diii: The number of unique beneficiaries with at least one opioid naïve days supply safety edit claim rejection that also had a coverag opioid drug subject to the edit (Data Element V) is a value less than or equal to the number of unique beneficiaries with at least one claim safety edit (Data Element T).

RSC-5.div: The number of unique beneficiaries with at least one opioid naïve days supply safety edit claim rejection that also had a coverag opioid drug subject to the edit that had favorable (either full or partial) coverage determination or appeal (Data Element W) is a value less beneficiaries with at least one claim rejected due to the opioid naïve days supply safety edit (Data Element T).
RSC-5.dv: The number of unique beneficiaries with at least one opioid naïve days supply safety edit claim rejection that also had a claim su subject to the opioid naïve days supply safety edit through a favorable (either full or partial) coverage determination or appeal (Data Elem number of unique beneficiaries with at least one claim rejected due to the opioid naïve days supply safety edit (Data Element T).
RSC-5.e: If the organization received a CMS outlier/data integrity notice based on their care coordination safety edit/hard MME safety edi cumulative opioid MME threshold and based on their opioid naïve days supply safety edit look-back period validate whether or not an inte resubmission through HPMS.
RSC-6: Organization can accurately identify and create a Part D data set of POS claim rejects related to its care coordination safety edit, ha days supply safety edit and correctly calculate and report counts to CMS via HPMS, including the following criteria:

RSC-6.a: Properly identifies and counts the number of POS rejects triggered and unique beneficiaries related to the care coordination safe pharmacy criterion.
RSC-6.ai: Includes pharmacy transactions for Part D opioid drugs with a fill date (not batch date) that falls within the reporting period.
RSC-6.ai: Includes pharmacy transactions for Part D opioid drugs with a fill date (not batch date) that falls within the reporting period.
RSC-6.aii: The rejected opioid claim due to the care coordination safety edit is not associated with an early refill rejection transaction.

RSC-6.aii: The rejected opioid claim due to the care coordination safety edit is not associated with an early refill rejection transaction.
RSC-6.aiii: Rejected opioid claims are counted at the unique plan, beneficiary, prescriber, pharmacy, drug (strength and dosage form), qua level opioid MME POS edit.
RSC-6.aiii: Rejected opioid claims are counted at the unique plan, beneficiary, prescriber, pharmacy, drug (strength and dosage form), qua level opioid MME POS edit.
RSC-6.aiv: Properly counts the number of unique beneficiaries by plan that triggered the care coordination safety edit and if applicable, a

RSC-6.aiv: Properly counts the number of unique beneficiaries by plan that triggered the care coordination safety edit and if applicable, a
RSC-6.b: Properly identifies and counts the number of POS rejects triggered and unique beneficiaries related to the established hard MME provider and pharmacy criterion.
RSC-6.bi: Includes pharmacy transactions for Part D opioid drugs with a fill date (not batch date) that falls within the reporting period.
RSC-6.bi: Includes pharmacy transactions for Part D opioid drugs with a fill date (not batch date) that falls within the reporting period.

RSC-6.bii: The rejected opioid claim due to the hard MME safety edit is not associated with an early refill rejection transaction.
RSC-6.bii: The rejected opioid claim due to the hard MME safety edit is not associated with an early refill rejection transaction.
RSC-6.biii: Rejected opioid claims are counted at the unique plan, beneficiary, prescriber, pharmacy, drug (strength and dosage form), qua level opioid MME POS edit.
RSC-6.biii: Rejected opioid claims are counted at the unique plan, beneficiary, prescriber, pharmacy, drug (strength and dosage form), qua level opioid MME POS edit.

RSC-6.biv: Properly counts the number of unique beneficiaries by plan that triggered the established hard MME safety edit threshold and criterion.
RSC-6.biv: Properly counts the number of unique beneficiaries by plan that triggered the established hard MME safety edit threshold and criterion.
RSC-6.c: Properly identifies and counts the number of POS rejects triggered and unique beneficiaries related to the opioid naïve days supp
RSC-6.ci: Includes pharmacy transactions for Part D opioid drugs with a fill date (not batch date) that falls within the reporting period.

RSC-6.ci: Includes pharmacy transactions for Part D opioid drugs with a fill date (not batch date) that falls within the reporting period.
RSC-6.cii: The rejected opioid claim due to opioid naïve days supply safety edit is not associated with an early refill rejection transaction.
RSC-6.cii: The rejected opioid claim due to opioid naïve days supply safety edit is not associated with an early refill rejection transaction.
RSC-6.ciii:Rejected opioid claims are counted at the unique plan, beneficiary, prescriber, pharmacy, drug (strength and dosage form), and

RSC-6.ciii:Rejected opioid claims are counted at the unique plan, beneficiary, prescriber, pharmacy, drug (strength and dosage form), and
RSC-6.civ: Properly counts the number of unique beneficiaries by plan that triggered the opioid naïve days supply safety edit.
RSC-6.civ: Properly counts the number of unique beneficiaries by plan that triggered the opioid naïve days supply safety edit.
RSC-7: From the data set of POS rejects (RSC 6a) related to the care coordination safety edit the organization accurately identifies and cou claims and correctly uploads the counts into HPMS, including the following criteria:

RSC-7.a: Properly identifies and counts the number of pharmacist overridden care coordination safety edit POS rejected claims.
RSC-7.ai: If a prescription drug claim contains multiple POS rejections, each rejection is considered as a separate pharmacy transaction and
RSC-7.ai: If a prescription drug claim contains multiple POS rejections, each rejection is considered as a separate pharmacy transaction and
RSC-7.b: Properly identifies and counts the number of unique beneficiaries per plan with at least one claim rejection due to its care coordi overridden care coordination safety POS edit rejected claim.

RSC-7.bi: If a prescription drug claim contains multiple POS rejections, each rejection is considered as a separate pharmacy transaction and
RSC-7.bi: If a prescription drug claim contains multiple POS rejections, each rejection is considered as a separate pharmacy transaction and
RSC-8: The organization accurately identifies claims leading to a coverage determination or appeal request and correctly uploads the coun criteria:
RSC-8.a: From the data set (RSC6b) of POS rejects related to the hard MME safety edits,

RSC-8.ai: If a prescription drug claim contains multiple POS rejections, each rejection is considered as a separate pharmacy transaction.
RSC-8.aii: Includes all methods of coverage determination or appeal receipt (e.g., telephone, letter, fax, in-person).
RSC-8.aiii: Includes all coverage determination or appeal requests.
RSC-8.b: From the data set (RSC6c) of POS rejects related to the opioid naïve days supply safety edits,

RSC-8.bi: If a prescription drug claim contains multiple POS rejections, each rejection is considered as a separate pharmacy transaction.
RSC-8.bii: Includes all methods of coverage determination or appeal receipt (e.g., telephone, letter, fax, in-person).
RSC-8.biii: Includes all coverage determination or appeal requests.
RSC-9: The organization accurately identifies the number of unique beneficiaries with at least one hard MME safety edit claim rejection an safety edit claim rejection that also had a claim successfully processed at POS for an opioid drug subject to the hard MME safety/opioid na through a favorable coverage determination or plan override. Correctly uploads the count, if the data set of POS rejects includes the comp the following criteria:

RSC-9.a: From the subset of POS rejects (RSC 6b) related to the hard MME safety POS edits,
RSC-9.ai: The beneficiary's opioid claim is also included in Data Element M.
RSC-9.b: From the subset of POS rejects (RSC 6c) related to the opioid naïve days supply safety POS edits,
RSC-9.bi: The beneficiary's opioid claim is also included in Data Element T.

RSC-10: The organization accurately identifies the number of unique beneficiaries with at least one hard MME safety edit claim rejection a supply safety edit claim rejection that also had a claim successfully processed at POS other than through a favorable coverage determinati communication and/or plan override. Correctly uploads the count, if the data set of POS rejects includes the complete reporting period, in
RSC-10.a: From the subset of POS rejects (RSC 6b) related to the hard MME safety POS edits,
RSC-10.ai:The beneficiary's opioid claim is also included in Data Element M.
RSC-10.b: From the subset of POS rejects (RSC 6c) related to the opioid naïve days supply safety POS edits,

RSC-10.bi:The beneficiary's opioid claim is also included in Data Element T.
Organization implements policies and procedures for data submission, including the following:
Data elements are accurately entered / uploaded into the HPMS tool and entries match corresponding source documents.

All source, intermediate, and final stage data sets and other outputs relied upon to enter data into CMS systems are archived.

Organization implements appropriate policies and procedures for periodic data system updates (e.g., changes in enrollment, provider/pha
Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).
If organization's data systems underwent any changes during the reporting period (e.g., as a result of a merger, acquisition, or upgrade): C the data system changes and, upon review, there were no issues that adversely impacted data reported.
If data collection and/or reporting for this reporting section is delegated to another entity: Organization regularly monitors the quality and reported by the delegated entity or first tier/ downstream contractor.

	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) Enter "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, enter "N". If any standard or sub-standard does not apply, enter "N/A". 3) For standards 1c, 1d, 1e, 1g, 1h, and 2e, enter 'Findings' as follows based on the five-point scale: Select "1" if plan data has more than 20% error, select "2" if plan data has between 15.1% - 20.0% error, select "3" if plan data has between 10.1% - 15.0% error, select "4" if plan data has between 5.1% - 10.0% error, select "5" if plan data has less than or equal to a 5% error. Enter "N/A" if standard does not apply.

Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
	Data sources:	*
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

	Data sources:	*
	Review Results:	
	Review Results:	
	Review Results:	

	Review Results:		
	Data Sources:	*	

	Data Sources:	*
Data Element C, E	**Review Results:**	
Data Elements: D	**Review Results:**	
Data Element F	**Review Results:**	

Data Element G	**Review Results:**	
	Data Sources:	*
Data Element N	**Review Results:**	
Data Element O	**Review Results:**	

Data Element P	**Review Results:**	
Data Element Q	**Review Results:**	
Data Elements: I, L, M	**Review Results:**	
Data Elements: I, J, K, L, M, N, O, P, Q	**Review Results:**	

	Data Sources:	*
Data Element R, S, T	**Review Results:**	
Data Elements: U	**Review Results:**	
Data Element V	**Review Results:**	

Data Element W	**Review Results:**	
Data Element X	**Review Results:**	
Data Elements A-G, I-Q, R-X	**Review Results:**	
	Data Sources:	*

	Data Sources:	*
Data Element C	**Review Results:**	
Data Element E	**Review Results:**	
Data Element C	**Review Results:**	

Data Element E	**Review Results:**	
Data Element C	**Review Results:**	
Data Element E	**Review Results:**	
Data Element C	**Review Results:**	

Data Element E	**Review Results:**	
	Data Sources:	*
Data Element L	**Review Results:**	
Data Element M	**Review Results:**	

Data Element L	**Review Results:**	
Data Element M	**Review Results:**	
Data Element L	**Review Results:**	
Data Element M	**Review Results:**	

Data Element L	**Review Results:**	
Data Element M	**Review Results:**	
	Data Sources:	*
Data Element S	**Review Results:**	

Data Element T	**Review Results:**	
Data Element S	**Review Results:**	
Data Element T	**Review Results:**	
Data Element S	**Review Results:**	

Data Element T	**Review Results:**	
Data Element S	**Review Results:**	
Data Element T	**Review Results:**	
	Data Sources:	*

	Data Sources:	*
Data Element D	**Review Results:**	
Data Element F	**Review Results:**	
	Data Sources:	*

Data Element D	**Review Results:**	
Data Element F	**Review Results:**	
	Data Sources:	*
	Data Sources:	*

Data Element O	**Review Results:**	
Data Element O	**Review Results:**	
Data Element O	**Review Results:**	
	Data Sources:	*

Data Elements V	**Review Results:**	
Data Elements V	**Review Results:**	
Data Elements V	**Review Results:**	
	Data Sources:	*

	Data Sources:	*
Data Element P	**Review Results:**	
	Data Sources:	*
Data Element W	**Review Results:**	

	Data Sources:	*
	Data Sources:	*
Data Element N	**Review Results:**	
	Data Sources:	*

Data Element U	**Review Results:**	
	Data Sources:	*
Data Element Zero Enrollment	**Review Results:**	
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:**	
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:**	
Data Element X	**Review Results:**	
	Review Results:	

	Review Results:	
	Review Results:	
	Review Results:	
	Review Results:	

Medication Therapy Management (MTM) Programs (Part D) 2019

Organization Name:	
Contract Number:	
Reporting Section:	**Medication Therapy Management (MTM) Programs (Part D) 2019**
Last Updated:	**MM/DD/YYYY**
Date of Site Visit:	
Name of Reviewer:	**Last name, First name**
Name of Peer Reviewer:	**Last name, First name**

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) Enter "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, enter "N". If any standard or sub-standard does not apply, enter "N/A".
3) For standards 1c, 1d, 1e, 1g, 1h, and 2e, enter 'Findings' as follows based on the five-point scale: Select "1" if plan data has more than 20% error, select "2" if plan data has between 15.1% - 20.0% error, select "3" if plan data has between 10.1% - 15.0% error, select "4" if plan data has between 5.1% - 10.0% error, select "5" if plan data has less than or equal to a 5% error. Enter "N/A" if standard does not apply.

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.

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
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:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
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	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 2/24/2020. *[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:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.d	RSC-4	Terms used are properly defined per CMS regulations, guidance and Reporting Requirements Technical Specifications. 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.		**Review Results:**	
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. RSC-5: Organization data passes data integrity checks listed below:		**Data Sources:**	*
2.e	RSC-5.a	RSC-5.a: Date of MTM program enrollment (Data Element I) is within the reporting period (between 1/1/2019 and 12/31/2019).	Data Element I	**Review Results:**	
2.e	RSC-5.b	RSC-5.b: One record is entered for each unique beneficiary i.e. only one record exists for a unique HICN (or MBI) or RRB number.	Data Element B	**Review Results:**	
2.e	RSC-5.c	RSC-5.c: Only reports beneficiaries enrolled in the contract during the reporting period, i.e. HICN (or MBI) or RRB Number (Data Element B) maps to a beneficiary enrolled at any point during the reporting year for the given Contract Number (Data Element A).	Data Element B	**Review Results:**	
2.e	RSC-5.d	RSC-5.d: CMR received date (Data Element R) is within the beneficiary's MTM enrollment period.	Data Element R	**Review Results:**	
2.e	RSC-5.e	RSC - 5.e: If the beneficiary was identified as cognitively impaired at time of CMS offer or delivery (Data Element G = Yes), the beneficiary should have been offered a CMR (Data Element M = Yes).	Data Element M	**Review Results:**	
2.e	RSC-5.f	RSC-5.f: If beneficiary was offered or received a CMR (Data Element M = Yes or Data Element P = Yes), the contract should report if beneficiary was cognitively impaired at time of CMR offer or delivery (Data Element G ≠ missing).	Data Element G	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-5.g	RSC-5.g: If the beneficiary was offered or received a CMR (Data Element M = Yes or Data Element P = Yes), the contract should report if beneficiary was in a long term care facility at time of CMR offer or delivery (Data Element H≠ missing).	Data Element H	**Review Results:**	
2.e	RSC-5.h	RSC-5.h: If beneficiary met the specified targeting criteria per CMS-Part D Requirements (Data Element F = Yes), then the contract should report the date the beneficiary met the specified targeting criteria (Data Element J ≠ missing).	Data Element J	**Review Results:**	
2.e	RSC-5.i	RSC-5.i: If beneficiary did not meet the specified targeting criteria per CMS-Part D Requirements (Data Element F = No), then the field for 'date meets the specified targeting criteria' (Data Element J) should be missing.	Data Element J	**Review Results:**	
2.e	RSC-5.j	RSC-5.j: If contract reports beneficiaries that were not eligible according to CMS-Part D Requirements (Data Element F = No), then Contract's MTM program submission information should indicate that contract uses expanded eligibility (Targeting Criteria for Eligibility in the MTMP ≠ Only enrollees who meet the specified targeting criteria per CMS requirements).	Data Element F	**Review Results:**	
2.e	RSC-5.k	RSC-5.k: If beneficiary opted out (Data Element K ≠ missing) then contract should provide an opt-out reason (Data Element L should not be missing).	Data Element L	**Review Results:**	
2.e	RSC-5.l	RSC-5.l: If the beneficiary did not opt-out (Data Element K = missing), the field for opt-out reason should be missing (Data Element L = missing).	Data Element L	**Review Results:**	
2.e	RSC-5.m	RSC-5.m: Date of MTM program opt-out (Data Element K) should not be before the date of MTM program enrollment (Data Element I).	Data Element K	**Review Results:**	
2.e	RSC-5.n	RSC-5.n: Date of (initial) CMR offer (Data Element N) should either be between the beneficiary's MTM enrollment date (Data Element I) and 12/31/2019 or the beneficiary's opt out date (Data Element K).	Data Element N	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-5.o	RSC-5.o: If a CMR was offered (Data Element M = Yes), there is also a reported offer date (Data Element N ≠ missing).	Data Element N	**Review Results:**	
2.e	RSC-5.p	RSC-5.p: If a CMR was not offered (Data Element M = No), there is no reported offer date (Data Element N = missing).	Data Element N	**Review Results:**	
2.e	RSC-5.q	RSC-5.q: If a CMR was received (Data Element P = Yes), there is a reported date of initial CMR (Data Element Q ≠ missing).	Data Element Q	**Review Results:**	
2.e	RSC-5.r	RSC-5.r: If a CMR was received (Data Element P = Yes), there is a reported delivery date(s) (Data Element R ≠ missing)	Data Element R	**Review Results:**	
2.e	RSC-5.s	RSC-5.s: If a CMR was not received (Data Element P = No), there are no reported delivery date(s) (Data Element R = missing) unless the CMR summary was returned via mail, then the reported delivery date should be the date that the written summary was sent (Data Element R ≠ missing).	Data Element R	**Review Results:**	
2.e	RSC-5.t	RSC-5.t: If records indicate that beneficiary received CMR (Data Element P = Yes), then indicator for CMR offered (Data element M ≠ No).	Data Element M	**Review Results:**	
2.e	RSC-5.u	RSC-5.u: CMR offer date (Data Element N) is before the CMR received date (Data Element R).	Data Element N	**Review Results:**	
2.e	RSC-5.v	RSC-5.v: If a CMR was offered (Data Element M), there is a reported recipient of initial offer (Data Element O ≠ missing).	Data Element O	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-5.w	RSC-5.w: If a CMR was received (Data Element P = Yes), there is a reported method of delivery (Data Element S ≠ missing).	Data Element S	**Review Results:**	
2.e	RSC-5.x	RSC-5.x: If a CMR was not received (Data Element P = No), there is no reported method of CMR delivery (Data Element S = missing).	Data Element S	**Review Results:**	
2.e	RSC-5.y	RSC-5.y: If a CMR was received (Data Element P = Yes), there is a reported provider who performed the CMR (Data Element T ≠ missing).	Data Element T	**Review Results:**	
2.e	RSC-5.z	RSC-5.z: If a CMR was not received (Data Element P = No), there is no reported provider who performed the CMR (Data Element T = missing).	Data Element T	**Review Results:**	
2.e	RSC-5.aa	RSC-5.aa: If a CMR was received (Data Element P = Yes), there is reported recipient of CMR (Data Element U ≠ missing).	Data Element U	**Review Results:**	
2.e	RSC-5.bb	RSC-5.bb: If a CMR was not received (Data Element P = No), there is no reported recipient of CMR (Data Element U = missing).	Data Element U	**Review Results:**	
2.e	RSC-5.cc	RSC-5.cc: Properly identifies and includes members' date of first TMR (Data Element W) if the number of targeted medication reviews (Data Element V) >0.	Data Element W	**Review Results:**	
2.e	RSC-5.dd	RSC-5.dd: If the organization received a CMS outlier/data integrity notice validate whether or not an internal procedure change was warranted or resubmission through HPMS.	Data Elements A-U	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-6	RSC-6: Organization accurately identifies data on MTM program participation and uploads it into HPMS, including the following criteria:		**Data Sources:**	*
2.e	RSC-6.a	RSC-6.a: 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 Element B	**Review Results:**	
2.e	RSC-6.a		Data Element C	**Review Results:**	
2.e	RSC-6.a		Data Element D	**Review Results:**	
2.e	RSC-6.a		Data Element E	**Review Results:**	
2.e	RSC-6.a		Data Element F	**Review Results:**	
2.e	RSC-6.a		Data Element G	**Review Results:**	
2.e	RSC-6.a		Data Element H	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-6.a		Data Element I	**Review Results:**	
2.e	RSC-6.a		Data Element J	**Review Results:**	
2.e	RSC-6.b	RSC-6.b: 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 Element F	**Review Results:**	
2.e	RSC-6.c	RSC-6.c: 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 Element B	**Review Results:**	
2.e	RSC-6.c		Data Element C	**Review Results:**	
2.e	RSC-6.c		Data Element D	**Review Results:**	
2.e	RSC-6.c		Data Element E	**Review Results:**	
2.e	RSC-6.c		Data Element F	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-6.c		Data Element G	**Review Results:**	
2.e	RSC-6.c		Data Element H	**Review Results:**	
2.e	RSC-6.c		Data Element I	**Review Results:**	
2.e	RSC-6.c		Data Element J	**Review Results:**	
2.e	RSC-6.d	RSC-6.d: Includes and reports each targeted member, reported once per contract year per contract file, based on the member's most current HICN (or MBI).	Data Element B	**Review Results:**	
2.e	RSC-6.d		Data Element C	**Review Results:**	
2.e	RSC-6.d		Data Element D	**Review Results:**	
2.e	RSC-6.d		Data Element E	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-6.d		Data Element F	**Review Results:**	
2.e	RSC-6.d		Data Element G	**Review Results:**	
2.e	RSC-6.d		Data Element H	**Review Results:**	
2.e	RSC-6.d		Data Element I	**Review Results:**	
2.e	RSC-6.d		Data Element J	**Review Results:**	
2.e	RSC-6.e	RSC-6.e: Excludes members deceased prior to their MTM eligibility date.	Data Element B	**Review Results:**	
2.e	RSC-6.e		Data Element C	**Review Results:**	
2.e	RSC-6.e		Data Element D	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-6.e		Data Element E	**Review Results:**	
2.e	RSC-6.e		Data Element F	**Review Results:**	
2.e	RSC-6.e		Data Element G	**Review Results:**	
2.e	RSC-6.e		Data Element H	**Review Results:**	
2.e	RSC-6.e		Data Element I	**Review Results:**	
2.e	RSC-6.e		Data Element J	**Review Results:**	
2.e	RSC-6.f	RSC-6.f: Includes members who receive MTM services based on plan-specific MTM criteria defined by the plan.	Data Element B	**Review Results:**	
2.e	RSC-6.f		Data Element C	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-6.f		Data Element D	**Review Results:**	
2.e	RSC-6.f		Data Element E	**Review Results:**	
2.e	RSC-6.f		Data Element F	**Review Results:**	
2.e	RSC-6.f		Data Element G	**Review Results:**	
2.e	RSC-6.f		Data Element H	**Review Results:**	
2.e	RSC-6.f		Data Element I	**Review Results:**	
2.e	RSC-6.f		Data Element J	**Review Results:**	
2.e	RSC-6.g	RSC-6.g: Properly identifies and includes members' date of MTM program enrollment (i.e., date they were automatically enrolled) that occurs within the reporting period.	Data Element I	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-6.h	RSC-6.h: 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 Element J	**Review Results:**	
2.e	RSC-6.i	RSC-6.i: Includes members who moved between contracts in each corresponding file uploaded to HPMS. 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 Element B	**Review Results:**	
2.e	RSC-6.i		Data Element C	**Review Results:**	
2.e	RSC-6.i		Data Element D	**Review Results:**	
2.e	RSC-6.i		Data Element E	**Review Results:**	
2.e	RSC-6.i		Data Element F	**Review Results:**	
2.e	RSC-6.i		Data Element G	**Review Results:**	
2.e	RSC-6.i		Data Element H	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-6.i		Data Element I	**Review Results:**	
2.e	RSC-6.i		Data Element J	**Review Results:**	
2.e	RSC-6.j	RSC-6.j: Counts each member who disenrolls from and re-enrolls in the same contract once.	Data Element B	**Review Results:**	
2.e	RSC-6.j		Data Element C	**Review Results:**	
2.e	RSC-6.j		Data Element D	**Review Results:**	
2.e	RSC-6.j		Data Element E	**Review Results:**	
2.e	RSC-6.j		Data Element F	**Review Results:**	
2.e	RSC-6.j		Data Element G	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-6.j		Data Element H	**Review Results:**	
2.e	RSC-6.j		Data Element I	**Review Results:**	
2.e	RSC-6.j		Data Element J	**Review Results:**	
2.e	RSC-7	Organization accurately identifies MTM eligible who are cognitively impaired at the time of CMR offer or delivery of CMR and uploads it into HPMS, including the following criteria:		**Data Sources:**	*
2.e	RSC-7.a	RSC-7.a: Properly identifies and includes whether each member was cognitively impaired and reports this status as of the date of the CMR offer or delivery of CMR.	Data Element G	**Review Results:**	
2.e	RSC-8	RSC-8: Organization accurately identifies data on members who opted-out of enrollment in the MTM program and uploads it into HPMS, including the following criteria:		**Data Sources:**	*
2.e	RSC-8.a	RSC-8.a: Properly identifies and includes members' date of MTM program opt-out that occurs within the reporting period, but prior to 12/31.	Data Element K	**Review Results:**	
2.e	RSC-8.b	RSC-8.b: 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 reason).	Data Element L	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-8.c	RSC-8.c: Excludes members who refuse or decline individual services without opting-out (disenrolling) from the MTM program.	Data Element K	**Review Results:**	
2.e	RSC-8.c		Data Element L	**Review Results:**	
2.e	RSC-8.d	RSC-8.d: Excludes members who disenroll from and re-enroll in the same contract regardless of the duration of the gap of MTM program enrollment	Data Element K	**Review Results:**	
2.e	RSC-8.d		Data Element L	**Review Results:**	
2.e	RSC-9	RSC-9: Organization accurately identifies data on CMR offers and uploads it into HPMS, including the following criteria:		**Data Sources:**	*
2.e	RSC-9.a	RSC-9.a: Properly identifies and includes MTM program members who were offered a CMR per CMS Part D requirements during the reporting period.	Data Element M	**Review Results:**	
2.e	RSC-9.b	RSC-9.b: Properly identifies and includes members' date of initial offer of a CMR that occurs within the reporting period.	Data Element N	**Review Results:**	
2.e	RSC-10	RSC-10 Organization accurately identifies data on CMR dates and uploads it into HPMS, including the following criteria:		**Data Sources:**	*

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-10.a	RSC-10.a: Properly identifies and includes the date the member received the initial CMR, if applicable. The date occurs within the reporting period, is completed for every member with a "Y" entered for Field Name "Received annual CMR with written summary in CMS standardized format," and if more than one comprehensive medication review occurred, includes the date of the first CMR.	Data Element R	**Review Results:**	
2.e	RSC-10.b	RSC-10.b: 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 Element S	**Review Results:**	
2.e	RSC-10.c	RSC-10.c: 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, Supervised Pharmacy Intern, or Other. Required if received annual CMR.	Data Element T	**Review Results:**	
2.e	RSC-10.d	RSC-10.d: 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 of the CMR interaction must be reported, not the recipient of the CMR documentation. The recipient must be reported as one of the following: Beneficiary, Beneficiary's Prescriber, Caregiver, or Other Authorized Individual.	Data Element U	**Review Results:**	
2.e	RSC-11	RSC-11: Organization accurately identifies data on MTM drug therapy problem recommendations and uploads it into HPMS, including the following criteria:		**Data Sources:**	*
2.e	RSC-11.a	RSC-11.a: Properly identifies and includes all targeted medication reviews within the reporting period for each applicable member.	Data Element V	**Review Results:**	
2.e	RSC-11.b	RSC-11.b: Properly identifies and includes the number of drug therapy problem recommendations made to beneficiary's prescriber(s) 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 counts 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 3 recommendations).	Data Element X	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
2.e	RSC-11.c	RSC-11.c: Properly identifies and includes the number of drug therapy problem resolutions resulting from recommendations made to beneficiary's prescriber(s) as a result of MTM program services within the reporting period for each applicable member. For reporting purposes, a resolution is defined as a change or variation from the beneficiary's previous drug therapy. Examples include, but are not limited to Initiate drug, Change drug (such as product in different therapeutic class, dose, dosage form, quantity, or interval), Discontinue or substitute drug (such as discontinue drug, generic substitution, 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 Element Y	**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:**	
3.a			Data Element B	**Review Results:**	
3.a			Data Element C	**Review Results:**	
3.a			Data Element D	**Review Results:**	
3.a			Data Element E	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
3.a			Data Element F	**Review Results:**	
3.a			Data Element G	**Review Results:**	
3.a			Data Element H	**Review Results:**	
3.a			Data Element I	**Review Results:**	
3.a			Data Element J	**Review Results:**	
3.a			Data Element K	**Review Results:**	
3.a			Data Element L	**Review Results:**	
3.a			Data Element M	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
3.a			Data Element N	**Review Results:**	
3.a			Data Element O	**Review Results:**	
3.a			Data Element P	**Review Results:**	
3.a			Data Element Q	**Review Results:**	
3.a			Data Element R	**Review Results:**	
3.a			Data Element S	**Review Results:**	
3.a			Data Element T	**Review Results:**	
3.a			Data Element U	**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
3.a			Data Element V	**Review Results:**	
3.a			Data Element W	**Review Results:**	
3.a			Data Element X	**Review Results:**	
3.a			Data Element Y	**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, and claims adjustments).		**Review Results:**	
5		Organization implements policies and procedures for archiving and restoring data in each data system (e.g., disaster recovery plan).		**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.		**Review Results:**	

Standard/ Sub-standard ID	Reporting Section Criteria ID	Standard/Sub-standard Description	Data Element	Data Sources and Review Results: Enter review results and/or data sources	Enter 'Findings' using the applicable choice in the appropriate cells. Cells marked with an '*' should not be edited.
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.		**Review Results:**	