

<b>Audit Review Period:</b>	
<b>Issue of non-compliance:</b>	Identifying and processing requests as service determination requests
<b>Scope:</b>	<ul style="list-style-type: none"> <li>• The scope of this Impact Analysis is no more than 50% of the participants enrolled during the audit review period who were not included in the provision of services sample selection.</li> <li>• The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab.</li> </ul>
<b>Instructions:</b>	<ul style="list-style-type: none"> <li>• Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab.</li> <li>• Review the selected medical records to determine if the participant, the participant's representative, or caregiver requested to initiate a service, modify an existing service (including to increase, reduce, eliminate, or otherwise change a service), or continue coverage of a service that the PACE organization is recommending be discontinued or reduced.</li> <li>• Respond to the questions in the Participant Impact tab.</li> <li>• The review timeframe is the audit review period. Errors noted before or after the audit review period should not be included.</li> <li>• After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab.</li> </ul>
<b>Impact Analysis Due Date:</b>	

<p><b>Brief Description Of Issue</b> (Completed By The CMS Audit Lead)</p>	<p><b>Type of Issue Identified</b> (Completed By The CMS Audit Lead)  (Applies to condition <u>1P.02 Only</u>. For all other conditions enter N/A)</p>	<p><b>Detailed Description of the Issue</b>  (Explain what happened)</p>
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<b>Date Identified (MM/DD/YY) (Completed By The CMS Audit Lead)</b>	<b>Brief Description Of Issue (Completed By The CMS Audit Lead)</b>	<b>Condition Language (Completed By The CMS Audit Lead)</b>
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<b>Root Cause Analysis for the Issue (Explain why it happened)</b>	<b>Methodology - Describe the process that was undertaken to determine the # of individuals (e.g. participants) impacted</b>	<b># of Individuals Impacted</b>	<b>Action Taken to Resolve System/ Operational Issues</b>
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<b>Date System/ Operational Remediation Initiated (MM/DD/YY)</b>	<b>Date System/ Operational Remediation Completed (MM/DD/YY)</b>	<b>Actions Taken to Resolve Negatively Impacted Individuals Including Outreach Description and Status</b>	<b>Date Individual Outreach and Remediation Initiated (MM/DD/YY)</b>	<b>Date Individual Outreach and Remediation Completed (MM/DD/YY)</b>
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Section 1 - Instructions: Information in this section will be completed by the audit team.					
Participant First Name	Participant Last Name	Medicare Beneficiary Identifier	Participant ID	Date of Enrollment MM/DD/YYYY	Date of Disenrollment MM/DD/YYYY Enter NA if the participant is still enrolled.

Section 2 - Instructions: The PO must respond to the questions in this section for every participant.				
<p>Did the participant, their representative, or caregiver request to initiate, modify, or continue a particular item or service during the audit review period?</p> <p>(Yes/No)</p> <p>If No, please enter NA in <u>all</u> remaining columns.</p>	<p>Describe the item or service the participant, their representative, or caregiver requested to initiate, modify, or continue.</p> <p>Enter <u>each</u> request in a <u>new row</u>.</p> <p><u>Please note</u>: Impact analyses will be <u>returned</u> for correction if each request is not listed in a <u>new row</u>.</p>	<p>Enter the date the participant, their representative, or caregiver requested to initiate, modify, or continue the item or service.</p> <p>MM/DD/YYYY</p>	<p>Is there documentation that the request was processed as a service determination request?</p> <p>(Yes/No)</p> <p>If the response is NO, enter <u>NA</u> in all columns in <u>section 3</u>.</p>	<p>Was the request included in the SDR Universe submitted to CMS?</p> <p>(Yes/No)</p> <p>If the response is Yes, enter NA in <u>all</u> remaining columns.</p>

Section 3 - Instructions: If the request was processed as a service determination request, respond to the questions in Section 3.			
<p>Was the request approved, denied, partially denied, or withdrawn?</p> <p>(Approved/Denied/Partially Denied/Withdrawn)</p> <p>If the participant did not have a request OR if the request was <u>not</u> processed as a service determination request, enter <u>NA</u> in all columns in Section 3.</p>	<p>Date the participant, designated representative, or caregiver was notified of the IDT's decision.</p> <p>If written and oral notification were provided on different dates, enter the earliest date of notification.</p> <p>MM/DD/YYYY</p> <p>Enter NA if notification was not provided.</p>	<p>If the request was approved or partially denied enter the date the IDT approved services were provided.</p> <p>MM/DD/YYYY</p> <p>Enter NA if the request was fully denied or withdrawn.</p> <p>Enter "Not Provided" if the IDT approved services were not provided.</p>	<p>If the request was approved or partially denied and the IDT approved services were not provided, please explain why they were not provided.</p> <p>Enter NA if the IDT approved services were provided or if the request was fully denied or withdrawn.</p>

**Section 4 - Instructions: If the request was not processed as a service determination request, respond to the questions in Section 4.**

<p>If the requested service was <u>not</u> processed as a service determination request, was it processed/decided under a different process?</p> <p>(Yes/No)</p> <p>If the participant did not have a request OR if the request <u>was</u> processed as a service determination request, enter <u>NA</u> in all columns in Section 4.</p>	<p>Was the requested service provided in full (as requested)?</p> <p>(Yes/No)</p>	<p>Date the requested service was provided in full.</p> <p>MM/DD/YYYY</p> <p>(Enter NA if the requested service was not provided in full/as requested)</p>
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Section 5 - Instructions: The PO must respond to the questions in this section for every participant.		
<p>Were there any negative participant outcomes as a result of not processing the request as an SDR?</p> <p>(Yes/No)</p>	<p>If yes, describe the negative outcomes.</p> <p>Enter NA if the participant did not experience negative outcomes.</p>	<p>Optional: Please note, you do not have to complete this column.</p> <p>If there are any mitigating factors that you would like CMS to consider related to a specific service determination request, please enter the information in this column.</p>