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| Audit Review Period: | |
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| Issue of non-compliance: | Home care services |
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| Scope: | <ul style="list-style-type: none">• 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.• The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab. |
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| Instructions: | <ul style="list-style-type: none">• Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab.• Review the selected medical records to determine if home care services were provided as approved, ordered, and/or care planned during the audit review period.• The review timeframe is the audit review period. Issues noted before or after the audit review period should not be included.• Respond to the questions in the Participant Impact tab for all participants.• After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab. |
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| Impact Analysis Due Date: | |
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| Tracking ID Number | Brief Description Of Issue (Completed By The CMS Audit Lead) | Type of Issue Identified (Completed By The CMS Audit Lead) (Applies to condition <u>1P.02 Only</u> . For all other conditions enter N/A) | Detailed Description of the Issue (Explain what happened) |
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| Date Identified (MM/DD/YY) (Completed By The CMS Audit Lead) | Brief Description Of Issue (Completed By The CMS Audit Lead) | Condition Language (Completed By The CMS Audit Lead) |
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| Root Cause Analysis for the Issue (Explain why it happened) | Methodology - Describe the process that was undertaken to determine the # of individuals (e.g. participants) impacted | # of Individuals Impacted | Action Taken to Resolve System/ Operational Issues |
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| Date System/ Operational Remediation Initiated (MM/DD/YY) | Date System/ Operational Remediation Completed (MM/DD/YY) | Actions Taken to Resolve Negatively Impacted Individuals Including Outreach Description and Status | Date Individual Outreach and Remediation Initiated (MM/DD/YY) | Date Individual Outreach and Remediation Completed (MM/DD/YY) |
|--|--|---|--|--|
|--|--|---|--|--|

| Participant First Name | Participant Last Name | Medicare Beneficiary Identifier | Participant ID | Date of Enrollment | Date of Disenrollment |
|------------------------|-----------------------|---------------------------------|----------------|--------------------|--|
| | | | | MM/DD/YYYY | MM/DD/YYYY Enter NA if the participant is still enrolled. |

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| <p>During the audit review period was home care approved, ordered, authorized or care planned by the IDT?</p> <p><u>Enter Yes</u> if the participant received or should have received home care during the audit review period.</p> <p><u>Enter No</u> if home care services were not approved, ordered, authorized or care planned by the IDT.</p> <p>If the answer to this question is <u>No</u> enter NA in all remaining columns.</p> | <p>Were home care services <u>provided</u> as approved, ordered, authorized, or care planned by the IDT?</p> <p>(Yes/No)</p> <p>If the answer to this question is <u>Yes</u> enter NA in all remaining columns.</p> | <p>Enter the number of days home care services <u>were not provided</u> as approved, ordered, authorized or care planned by the IDT during the audit review period.</p> |
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| <p>Enter the number of days home care services <u>should have been</u> provided as approved, ordered, authorized or care planned by the IDT during the audit review period.</p> | <p>Identify the types of services the participant <u>should have received</u> when home care was not provided.</p> <p>For example: assistance with bathing, assistance with dressing, meal preparation, skilled wound care, medication administration, assistance with transfers, etc.</p> | <p>If the participant experienced negative outcomes, did they occur, in some part, as a result of the failure to provide IDT approved, ordered, authorized or care planned home care?</p> <p>(Yes/No)</p> |
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If Yes, please describe the negative outcomes.

Enter NA if there were no negative outcomes.

Optional: Please note, you do not have to complete this column.

If there are any mitigating factors that you would like CMS to consider related to a specific participant, please enter the information in this column.