Audit Review Period:	

Issue(s) of non-compliance:	Provision of services following an approved service determination request

Scope:	• All service determination requests that were approved or partially denied during the audit review period.

Instructions:	• The review timeframe is the audit review period. Errors noted prior to the audit review period should not be included. • Review each service determination request that was approved or partially denied during the audit review period and respond to the questions in the Participant Impact tab. • After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab.

Impact Analysis Due Date:	

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 1P.02 Only. For all other conditions enter N/A)	Detailed Description of the Issue (Explain what happened)

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)

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

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	Date Service Determination Request Brought to the full IDT	Description of the Request	Request Disposition
				MM/DD/YYYY	MM/DD/YYYY Enter NA if the participant is still enrolled.	MM/DD/YYYY		Enter approved if all of the requested services were approved as requested. Enter partially denied if the requested services were not fully approved as requested and/or the PO provided modified or alternative services to the participant.

Date oral/written notification of the decision was provided to the participant, designated representative, or caregiver. If oral and written notification were provided, enter the earliest date. MM/DD/YYYY Enter NA if notification was not rendered.	If the request was partially denied, enter the services approved by the IDT. Enter NA if approved in full.	Date the service was provided to the participant. MM/DD/YYYY Enter NA if the service was not provided.	Was the approved service provided as expeditiously as the participant's condition required? (Yes/No)

If the participant experienced any negative outcomes, please describe the negative outcomes. Enter NA if there were no negative outcomes.	If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to provide the item or service, or to provide the item or service as expeditiously as the participant's condition required? (Yes/No) 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 appeal, please enter the information in this column.