

<b>Audit Review Period:</b>		
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<b>Issue of non-compliance:</b>	Provision of services
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<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>	
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<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 (e.g., medical record documentation) to determine if any necessary services were not provided. POs should consider any documentation and/or evidence that shows provision of services including the medical record, invoices, outside specialist notes, etc.</li><li>• A 'service' means all Medicare-covered services, all Medicaid-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status, including items and drugs.</li><li>• Respond to the questions in the participant impact tab. If a participant was not impacted by the condition (i.e., they received all services in a timely manner), the PO should enter No in column G and then NA in all additional blue fields.</li></ul> <p>After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab.</p>	
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<b>Impact Analysis Due Date:</b>		
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**Brief Description Of Issue**  
**(Completed By The CMS Audit Lead)**

**Detailed Description of the Issue**  
**(Explain what happened)**

<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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**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**

<b># of Individuals Impacted</b>	<b>Action Taken to Resolve System/ Operational Issues</b>	<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>
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<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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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.



<p>During the audit review period, were any services:</p> <ul style="list-style-type: none"> <li>• determined necessary by the IDT or an IDT member;</li> <li>• approved by IDT;</li> <li>• ordered by a PCP; or</li> <li>• care planned;</li> </ul> <p><u>NOT</u> provided, partially provided, or delayed?</p> <p>Enter <u>Yes</u> if the services were not provided, partially provided, or delayed.</p> <p>Enter <u>No</u> if all services were provided as ordered, care planned, approved, etc., in a timely manner.</p> <p>If No, enter NA in columns H through R.</p> <p>(Each service or item that was delayed or not provided must be entered on a new line.)</p>	<p>Was the service:</p> <ul style="list-style-type: none"> <li>• determined necessary by the IDT or an IDT member;</li> <li>• approved by IDT;</li> <li>• ordered by a PCP or physician extender; or</li> <li>• care planned?</li> </ul> <p>If another scenario applies, please enter a brief description.</p>	<p>Was the service <u>delayed, not provided, or partially provided</u>?</p> <p>(Enter delayed, not provided, or partially provided)</p> <p>Note: Partially provided means a service that was provided in-part but not as authorized (ordered, approved, care planned, etc.) by the IDT.</p>
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<p>Describe the service that was delayed, not provided, or partially provided. (Each service or item that was delayed, not provided, or partially provided must be entered on a new line.)</p>	<p>Enter the date the service should have been provided to the participant. If the service was a recurring service, such as home care, enter the date the services should have started. MM/DD/YYYY</p>	<p>If the service was delayed, enter the date the service was provided to the participant. MM/DD/YYYY Enter Not Provided if the service was never provided. Enter NA if the service was not delayed.</p>

If the service was partially provided, describe the service <u>provided</u> to the participant.	In what setting was or should the service have been provided? (PACE Center, SNF, ALF, Home, etc.)	Describe why the service was delayed, not provided, or partially provided.

<p>Did a delay or failure to provide a service occur due to ineffective communication with or oversight of a contracted provider? (Yes/No)</p>	<p>Did the participant experience negative outcomes, in some part, as a result of the failure to provide the service in a timely manner? (Enter Yes or No)</p>	<p>If yes, describe the negative outcomes. Enter NA if the participant did not experience negative outcomes.</p>
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**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.**

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