Audit Review Period:	

Issue of non-compliance:	Provision of services

Scope:	• 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.

Instructions:	• 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 (e.g., medical record documentation) to determine if any necessary services were not provided as authorized by the IDT or provided without IDT authorization. POs should consider any documentation and/or evidence that shows provision of services including the medical record, invoices, outside specialist notes, etc. • 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. • 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. • 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 MM/DD/YYYY	Date of Disenrollment MM/DD/YYYY Enter NA if the participant is still enrolled.

Were all services (other than medications, home care, and wound care) provided as authorized by the IDT during the audit review period? 'Authorized,' means the service was determined necessary by the IDT or an IDT member, approved by IDT, ordered by a PACE PCP, or care planned. Enter Yes if all services (other than medications, home care, and wound care) were provided as authorized by the IDT. If Yes, enter NA in all remaining columns. Enter No if any service was: • not provided, • partially provided, • delayed, or • provided without IDT authorization. Enter each service that was not provided, partially provided, delayed, or provided without IDT authorization in a new row. Please note: Impact analyses will be returned for correction if each service is not listed in a new row.	Describe the service that was not provided, partially provided, delayed, or provided without IDT authorization. Enter each service that was not provided, partially provided, delayed, or provided without IDT authorization in a new row.

Was the service: • determined necessary by the IDT or an IDT member, • approved by IDT, • ordered by a PCP, or • care planned? If another scenario applies, please enter a brief description.	Was the service: • not provided, • partially provided, • delayed, or • provided without IDT authorization? Note: Partially provided means a service that was provided in-part but not as authorized (ordered, approved, care planned, etc.) by the IDT.	In what setting was or should the service have been provided? (PACE Center, SNF, ALF, Home, etc.)	Did an error occur as a result of a failure to effectively coordinate care with a sub-acute facility such as a skilled nursing facility, nursing facility, assisted living facility, board and care facility, etc.? (Yes/No)

Enter the date the service should have been provided to the participant. If the service was a recurring service, such as physical therapy, enter the date the services should have started. MM/DD/YYYY	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.	If the service was partially provided, describe the service provided to the participant.

Describe why the service was not provided, partially provided, delayed, or provided without IDT authorization.	Did the participant experience negative outcomes, in some part, as a result of the failure to provide the service as determined necessary, approved, ordered, or care planned by the IDT or a member of the IDT or because the service was provided without IDT authorization? (Enter Yes or No)	If yes, describe the negative outcomes. Enter NA if the participant did not experience 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.