Audit Review Period:		

Issue(s) of non-compliance:	**Auditors:** **Select All that Apply**	**Issue**
		Provision of services following an approved service determination request
		Provision of services to Medicaid participants during an appeal
		Provision of services following an approved appeal

Scope:	**Provision of services following an approved service determination request:** • All service determination requests that were approved or partially denied during the audit review period. **Provision of services to Medicaid participants during an appeal:** • All appeals during the audit review period. **Provision of services following an approved appeal:** • All approved and partially denied appeals during the audit review period.	

Instructions:	**General:** • The review timeframe is the audit review period. Errors noted prior to the audit review period should not be included. • After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab. **Provision of services following an approved service determination request:** • 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. **Provision of services to Medicaid participants during an appeal:** • Review each appeal to determine if the participant requested to continue the service during the appeal. • If the participant was enrolled in Medicaid, answer all of the remaining questions. If the participant was not enrolled in Medicaid, answer NA to all of the remaining questions. **Provision of services following an approved appeal:** • Review each approved and partially denied appeal and respond to the questions in the Participant Impact tab.	

Impact Analysis Due Date:		

Brief Description Of Issue (Completed By The CMS Audit Lead)	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)

General Information: This information is to be considered for all Innovair Audience								
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.	**Service/Item Requested**	**Request Type** Enter SDR if the request was processed as a service determination request. Enter appeal if the request was processed as an appeal. Note to Audtion: Only include this column if the impact analysis will include both SDR and appeal data. If the impact analysis includes only SDR data or only appeal data, remove this column.	**Request Disposition** 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. Enter denied if the requested services were fully denied.

This information is to be considered if the issuer Analyst is being requested for: Provision of services following an approved or partially denied service determination request						
Date the service determination request was received by IDT. MM/DD/YYYY If the auditor did not select Provision of services following an approved service determination request on the instructions tab the PO may enter NA in ~~this~~ columns J-P.	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 is notification was not rendered.	If the request was partially denied, enter the services approved by the IDT. Enter NA if approved in full.	Was the service provided as approved by the IDT? (Yes/No)	Date the service was provided to the participant. MM/DD/YYYY Enter NA if the service was not provided.	What evidence/documentation does the PO have that demonstrates the service was provided? Enter NA if the service was not provided to the participant.	Did the participant experience any negative outcomes between the date the service was approved and the date that the service was provided? (Yes/No)

This information is to be completed if the issuer includes in home-supported for: Provision of services to Medicaid participants during an appeal

Was the participant enrolled in Medicaid? This includes participants who are Medicaid only and dual-eligible. (Yes/No) If the auditor did not select Provision of services to Medicaid participants during an appeal on the instructions tab the PO may enter NA in columns Q-T. If the answer to this question is No enter NA in columns R-T.	Date the appeal was received by the PO. MM/DD/YYYY	Was the appeal related to a termination or reduction in services that were currently being furnished to the participant? (Yes/No)	Did the participant request to continue the service during the appeal process? (Yes/No)	Was the service continued during the appeal process? (Yes/No)	If the participant requested to continue the service and the service was not continued, please enter the date the service was terminated. MM/DD/YYYY Enter NA if the participant did not request to continue the service.	If the service was terminated and the service was approved by the third-party reviewer, enter the date that the service resumed. MM/DD/YYYY Enter NA if the service was denied by the third-party or the service was never terminated.	What evidence or documentation does the PO have to show the service was provided? Enter NA if the service was not provided.	If the participant requested to continue the service and the service was not continued, were there any negative participant outcomes? (Yes/No)

This information is to be completed if the instant Analysis is being requested for: Resolution of previous Follow-up on unmet need (enter all records that were unmet at any level of the appeal (i.e., third party reviewer, Medicaid State Fair Hearing, IRE, etc.)

Date the appeal was received by IDT. MM/DD/YYYY If the auditor did not select Provision of services following an approved appeal on the instructions tab the PO may enter NA in column Z-AG.	Description of the item/service being appealed.	Date the appeal decision was rendered by any appeal entity (e.g., third party reviewer, IRE, State fair hearings, etc.). MM/DD/YYYY	Entity that approved or partially denied the appeal. (Third Party Reviewer, IRE, State Fair Hearings, etc.)	If partially denied, what was the approved portion of the service? Enter NA if the appeal was approved in full.	If the service was approved or partially denied by either the third-party, Medicaid, or Medicare reviewer, enter the date that the approved service was provided or resumed. MM/DD/YYYY Enter "Not Provided" if the approved service was not provided or if there is no evidence the approved service was provided.	What evidence or documentation does the PO have to demonstrate that the approved service was provided? Enter NA if the approved service was not provided.	Did the participant experience any negative outcomes between the date the service was approved and the date that the service was provided? (Yes/No) Enter NA if the service was denied.

General Information: This information is to be considered for all Lesson Audience		
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 the failure to provide the item or service? (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.