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| **Audit Review Period:** | |

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| **Issue of non-compliance:** | Restriction of Services |

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| **Scope:** | • The scope of this Impact Analysis is limited to 50% of the participants enrolled during the audit review period who were not included in the provision of services sample selection.<br><br>• The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab. |

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| **Instructions:** | • Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab.<br><br>• Review the selected medical records to determine if any limitations were applied to Medicare or Medicaid benefits.<br><br>• Respond to the questions in the Participant Impact tab.<br><br>• The review timeframe is the audit review period. Errors noted before or after the audit review period should not be included.<br><br>• 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:** | |

| Brief Description Of Issue<br>(Completed By The CMS Audit Lead) | Detailed Description of the Issue<br>(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<br>(Explain why it happened) | Methodology - Describe the process that was undertaken to determine the # of individuals (e.g. participants) impacted | # of Individuals Impacted |
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| 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) |
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| Participant First Name | Participant Last Name | Medicare Beneficiary Identifier | Participant ID | Date of Enrollment<br><br>MM/DD/YYYY | Date of Disenrollment<br><br>MM/DD/YYYY<br><br>Enter NA if the participant is still enrolled. |
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| During the audit review period, were any limitations applied to the amount, duration, or scope of Medicare or Medicaid benefits that were:<br>• determined necessary by the IDT or an IDT member;<br>• approved by IDT;<br>• included in the participant's care plan; or<br>• ordered by a PCP?<br><br>(Yes/No)<br><br>These limitation may include but are not limited to, Home Care, DME, Medications, Dental Services, Hearing Services, Nursing Facility stays/placement, ER use, etc.<br><br>If No, the PO may enter NA in columns H through S. | Date the service was:<br><br>• determined necessary by the IDT or an IDT member;<br>• approved by IDT;<br>• included in the participant's care plan; or<br>• ordered by a PCP.<br><br>MM/DD/YYYY<br><br>Each limitation must be described on a new line. |
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| Was the service:<br><br>• determined necessary by the IDT or an IDT member;<br>• approved by IDT;<br>• included in the participant's care plan; or<br>• ordered by a PCP<br><br>If another scenario applies, please enter a brief description. | Describe the service that was:<br><br>• determined necessary by the IDT or an IDT member;<br>• approved by IDT;<br>• included in the participant's care plan; or<br>• ordered by a PCP?<br><br>(Example: Glasses, home care, hearing aids, etc.) |
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| Describe the limitation that was applied.<br><br>(Examples: Glasses only provided once a year, or home care is not provided overnight, etc.) | Describe why the limitation was applied. | Who applied the limitation (or determined that the limitation should apply)? |
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| What date was the determination to limit the service rendered.<br><br>MM/DD/YYYY | Did the participant ever receive the service without limitation (per the original request or determination)?<br><br>(Yes/No) | If yes, date the participant received the service without limitations (as determined necessary, approved, care planned or ordered).<br><br>MM/DD/YYYY<br><br>Enter NA if there was a limitation applied. | Were there any negative participant outcomes?<br><br>(Yes/No) |
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| If yes, describe the negative outcomes.<br><br>Enter NA if the participant did not experience negative outcomes. | Optional: Please note, you do not have to complete this column.<br><br>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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