Audit Review Period:		

Issue(s) of non-compliance:	**Auditors:** **Select All that Apply**	**Issue**
		Oral and/or written service determination request denial rationale
		Oral and/or written service determination request denial appeal notification
		IDT decision making
		Service determination request review by IDT members

Scope:	**Oral and/or written service determination request denial notification did not include the specific reasons for the denial in understandable language:** • All service determination requests that were denied or partially denied during the audit review period. Please include denied and partially denied service determination requests only. **Oral and/or written service determination request denial notification did not include appeal information:** • All service determination requests that were denied or partially denied during the audit review period. Please include denied and partially denied service determination requests only. **The IDT did not consider all relevant information when rendering a service determination request decision** • All service delivery determination requests that were denied or partially denied during the audit review period. Please include denied and partially denied service determination requests only. **The service determination request was not reviewed by the complete IDT:** • All service determination requests processed during the audit review period that were not immediately approved by a member of the interdisciplinary team, in full, at the time the request was made.	

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. **Oral and/or written service determination request denial notifications did not include the specific reasons for the denial in understandable language:** • Review each service determination request denial and partial denial to determine if: o Oral and written notification of the denial/partial denial were provided; and o Oral and written notification of the denial/partial denial included the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the participant's overall health status, taking into account the participant's medical, physical, emotional, and social needs, and the results of the reassessment(s) in understandable language. ~~and~~ • Respond to the questions in the Participant Impact tab. **Oral and/or written service determination request denial notifications did not include appeal information:** • Review each service determination request denial to determine if oral and written notification of the denial included appeal rights and respond to the questions in the Participant Impact tab. • Review each service determination request denial and partial denial to determine if: o Oral and written notification of the denial/partial denial were provided; and o Oral and written notification of the denial/partial denial included appeal rights. • 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 completed for all Impact Analyses								
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	Date Request Received by IDT MM/DD/YYYY	Request Disposition Valid entries include: Approved, Denied, Partially Denied, or Withdrawn.

This information is to be completed if the Impact Analysis is being requested for: Oral and/or written service determination request denial rationale			
Is there documentation or evidence that the participant received oral notification of the denial/partial denial? (Yes/No) If the auditor did not select Oral and/or written service determination request denial rationale on the instructions tab the PO may enter NA in columns J-M.	Did documentation of the oral notification state the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the participant's overall health status, taking into account the participant's medical, physical, emotional, and social needs, and the results of the reassessment(s) in understandable language? (Yes/No) If the participant did not receive oral notification please respond - NA	Is there documentation or evidence that the participant received written notification of the denial/partial denial? (Yes/No)	Did documentation of the written notification state the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the participant's overall health status, taking into account the participant's medical, physical, emotional, and social needs, and the results of the reassessment(s) in understandable language? (Yes/No) If the participant did not receive written notification please respond - NA

This information is to be completed if the Impact Analysis is being requested for: Oral and/or written service determination request denial appeal notification			
Is there documentation or evidence that the participant received oral notification of the denial/partial denial? (Yes/No) If the auditor did not select Oral and/or written service determination request denial appeal notification on the instructions tab the PO may enter NA in columns N-Q.	Did documentation of the oral notification include the participant's right to appeal the denial/partial denial? (Yes/No) If the participant did not receive oral notification please respond - NA	Is there documentation or evidence that the participant received written notification of the denial? (Yes/No)	Did documentation of the written notification include the participant's right to appeal the denial/partial denial and information describing both the standard and expedited appeals processes? (Yes/No) If the participant did not receive written notification please respond - NA

This information is to be completed if the Impact Analysis is being requested for: IDT decision making		
Is there documentation that the IDT considered the results of the reassessment when rendering a service determination request decision? (Yes/No) If the auditor did not select IDT Decision Making on the instructions tab the PO may enter NA in columns R- T.	Is there documentation that the IDT considered the participants medical, physical, emotional and social needs when rendering a service determination request decision? (Yes/No)	Is there documentation that the IDT considered clinical practice guidelines and standards of care when rendering a service determination request decision, if applicable? (Yes/No) Enter NA if there are no clinical practice guidelines and/or standards of care applicable to the requested service.

This information is to be completed if the Impact Analysis is being requested for: Service determination request review by IDT members					
Is there documentation that, at some point during the processing of the service determination request, the request was reviewed by the full IDT? (Yes/No) In order to answer Yes, the organization must have documentation or evidence that all 11 disciplines reviewed the request between the request being made (participant indicating a need) and the decision being rendered (approving or denying the request). If the auditor did not select Service delivery request review by IDT members on the instructions tab the PO may enter NA in columns U-Z.	Which IDT members were NOT involved in the review of the service determination request? Enter NA if the service determination request was reviewed by all 11 IDT disciplines.	Was the service determination request approved, denied or partially denied?	For approvals and partial denials, did the participant receive the approved service(s)? (Yes/No) Enter NA is the service determination request was fully denied.	If the participant received the service(s), what was the date received? MM/DD/YYYY Enter NA is the service determination request was fully denied.	What documentation or evidence is there to show the participant received the item(s) or service(s)? Enter NA is the service determination request was denied.

General Information: This information is to be completed for all Impact Analyses
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 service determination request, please enter the information in this column.