Audit Review Period:	

Issue of non-compliance:	Identifying and processing requests as service determination requests

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. • 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 to determine if the participant or participant's representative requested to initiate a service, modify an existing service (including to increase, reduce, eliminate, or otherwise change a service), or continue coverage of a service that the PACE organization is recommending be discontinued or reduced. • Respond to the questions in the Participant Impact tab. • The review timeframe is the audit review period. Errors noted before or after 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.

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)

Instructions: Information in this section will be completed by the audit team.					
Participant First Name	**Participant Last Name**	**Medicare Beneficiary Identifier**	**Participant ID**	**Date of Enrollment** **MM/DD/YYYY**	**Date of Disenrollment** **MM/DD/YYYY**

Instructions: The PO must respond to the questions in this section for every participant. Enter NA in columns H-K if the participant did not submit a request during the audit review period.				
Did the participant, their representative, or caregiver request to initiate, modify, or continue a particular item or service during the audit review period? (Yes/No) If No, please enter NA in columns H through U.	Enter the date the participant, their representative, or caregiver requested to initiate, modify, or continue a particular item or service. MM/DD/YYYY	Describe the request.	Is there documentation that the request was processed as a service determination request? (Yes/No) If the response is NO, enter NA in columns L-O.	Was the request included in the SDR Universe submitted to CMS? (Yes/No) If the response is Yes, enter NA in columns L through U.

Instructions: If the request was processed as a service determination request, respond to the questions in columns L-O. If the participant did not have a request or if the request was not processed as a service determination request, enter NA in columns L-O.			
Was the request approved, denied, or partially denied? (Approved/Denied/Partially Denied)	Date the participant, designated representative, or caregiver was notified of the IDT's decision. If written and oral notification were provided on different dates, enter the earliest date of notification. MM/DD/YYYY	If the request was approved or partially denied enter the date the IDT approved services were provided. MM/DD/YYYY Enter NA if the request was fully denied. Enter "Not Provided" if the IDT approved services were not provided.	If the request was approved or partially denied and the IDT approved services were not provided, please explain why they were not provided. Enter NA if the IDT approved services were provided or if the request was fully denied.

Instructions: If the request was not processed as a service determination request, respond to the questions in columns P-R. If the participant did not have a request or if the request was processed as a service determination request, enter NA in columns P-R.		
If the requested was not processed as a service determination request, was it processed/decided under a different process? (Yes/No)	Was the requested service provided in full (as requested)? (Yes/No)	Date the requested service was provided in full. MM/DD/YYY (Enter NA if the requested service was not provided in full/as requested)

Instructions: The PO must respond to the questions in columns S-T. Column U is optional and may be completed at the PO's discretion.		
Were there any negative participant outcomes as a result of not processing the request as an SDR? (Yes/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 service determination request, please enter the information in this column.