Audit Review Period:		

Issue of non-compliance:	Provision of services

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 (e.g., medical record documentation) to determine if any necessary services were not provided. 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:		

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)

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.

During the audit review period, were any services: • determined necessary by the IDT or an IDT member; • approved by IDT; • ordered by a PCP; or • care planned; NOT provided, partially provided, or delayed? Enter Yes if the services were not provided, partially provided, or delayed. Enter No if all services were provided as ordered, care planned, approved, etc., in a timely manner. If No, enter NA in columns H through R. (Each service or item that was delayed or not provided must be entered on a new line.)	Was the service: • determined necessary by the IDT or an IDT member; • approved by IDT; • ordered by a PCP or physician extender; or • care planned? If another scenario applies, please enter a brief description.	Was the service delayed, not provided, or partially provided? (Enter delayed, not provided, or partially provided) Note: Partially provided means a service that was provided in-part but not as authorized (ordered, approved, care planned, etc.) by the IDT.

Describe the service that was delayed, not provided, or partially provided. (Each service or item that was delayed, not provided, or partially provided must be entered on a new line.)	Enter the date the service should have been provided to the participant. If the service was a recurring service, such as home care, 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.	In what setting was or should the service have been provided? (PACE Center, SNF, ALF, Home, etc.)	Describe why the service was delayed, not provided, or partially provided.

Did a delay or failure to provide a service occur due to ineffective communication with or oversight of a contracted provider? (Yes/No)	Did the participant experience negative outcomes, in some part, as a result of the failure to provide the service in a timely manner? (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.