

<b>Audit Review Period:</b>		
<b>Issue(s) of non-compliance:</b>	<b>Auditors:</b> <b>Select All that Apply</b>	<b>Issue</b>
		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
<b>Scope:</b>	<p><b>Provision of services following an approved service determination request:</b></p> <ul style="list-style-type: none"> <li>• All service determination requests that were approved or partially denied during the audit review period.</li> </ul> <p><b>Provision of services to Medicaid participants during an appeal:</b></p> <ul style="list-style-type: none"> <li>• All appeals during the audit review period.</li> </ul> <p><b>Provision of services following an approved appeal:</b></p> <ul style="list-style-type: none"> <li>• All approved and partially denied appeals during the audit review period.</li> </ul>	
<b>Instructions:</b>	<p><b>General:</b></p> <ul style="list-style-type: none"> <li>• The review timeframe is the audit review period. Errors noted prior to the audit review period should not be included.</li> <li>• After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab.</li> </ul> <p><b>Provision of services following an approved service determination request:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul> <p><b>Provision of services to Medicaid participants during an appeal:</b></p> <ul style="list-style-type: none"> <li>• Review each appeal to determine if the participant requested to continue the service during the appeal.</li> <li>• 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.</li> </ul> <p><b>Provision of services following an approved appeal:</b></p> <ul style="list-style-type: none"> <li>• Review each approved and partially denied appeal and respond to the questions in the Participant Impact tab.</li> </ul>	
<b>Impact Analysis Due Date:</b>		

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

**Detailed Description of the Issue**  
(Explain what happened)

<b>Date Identified (MM/DD/YY) (Completed By The CMS Audit Lead)</b>	<b>Brief Description Of Issue (Completed By The CMS Audit Lead)</b>
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<p><b>Condition Language</b> (Completed By The CMS Audit Lead)</p>	<p><b>Root Cause Analysis for the Issue</b> (Explain why it happened)</p>
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<b>Methodology - Describe the process that was undertaken to determine the # of individuals (e.g. participants) impacted</b>	<b># of Individuals Impacted</b>	<b>Action Taken to Resolve System/ Operational Issues</b>	<b>Date System/ Operational Remediation Initiated (MM/DD/YY)</b>	<b>Date System/ Operational Remediation Completed (MM/DD/YY)</b>
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<b>Actions Taken to Resolve Negatively Impacted Individuals Including Outreach Description and Status</b>	<b>Date Individual Outreach and Remediation Initiated (MM/DD/YY)</b>	<b>Date Individual Outreach and Remediation Completed (MM/DD/YY)</b>
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This information is to be completed if the impact analysis is being requested for <u>provision of services to be used in a program or periodic direct service demonstration request</u> .						
<p>Was the service demonstration request received by DC?</p> <p>MM/00/0000</p> <p>If the auditor did not select Provision of services following an approved service demonstration request on the instructions tab the DC may enter NA in columns 1-6.</p>	<p>Date and written notification of the decision was provided to the participant, designated representative, or caregiver, if any, and written notification were provided, enter the notified date.</p> <p>MM/00/0000</p> <p>Enter NA if notification was not rendered.</p>	<p>If the request was partially denied, enter the services approved by the DC.</p> <p>Enter NA if approved in full.</p>	<p>Was this service <u>available</u> to approved by the DTT?</p> <p>(Yes/No)</p>	<p>Date the service was provided to the participant.</p> <p>MM/00/0000</p> <p>Enter NA if the service was not provided.</p>	<p>What evidence/documentation does the DC have that demonstrates the service was provided?</p> <p>Enter NA if the service was not provided to the participant.</p>	<p>Did the participant experience any negative outcomes between the date the service was approved and the date that the service was provided?</p> <p>(Yes/No)</p>

This information is to be completed if the Impact Analysis is being requested for: <u>Continuation of services to Medicaid participants during an appeal</u>							
<p>Was the participant enrolled in Medicaid? This includes participants who are Medicaid only and dual eligible. [Yes/No]</p> <p>If the auditor did not select Provision of services to Medicaid participants during an appeal on the transaction with the PC they enter NA in column G.1. If the answer to this question is No enter NA in column B.1.</p>	<p>Was the appeal received by the PC? MM/DD/YYYY</p>	<p>Was the appeal denied by a termination or reduction in services that were currently being furnished to the participant? [Yes/No]</p>	<p>Did the participant request to continue the service during the appeal process? [Yes/No]</p>	<p>Was the service continued during the appeal process? [Yes/No]</p>	<p>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.</p>	<p>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 resumed.</p>	<p>What evidence or documentation does the PC have to show the service was provided? Enter NA if the service was not provided.</p> <p>If the participant requested to continue the service and the service was not continued, were there any negative participant outcomes? [Yes/No]</p>

This information is to be completed if the request Analysis is being requested for: <u>Provision of services/Invoices or approved appeal under all appeals that were assigned at any point of the appeal by a third party reviewer. Medical Data For Hearings, 09_09_2</u>							
<p>Was the appeal was received by OIG?</p> <p>MM/DD/YYYY</p> <p>If the auditor did not select Provision of services following an approved appeal on the instructions with the PC case enter NA in column 2.4G.</p>	<p>Description of the item/service being appealed</p>	<p>Was the appeal decision was reviewed by any appeal entity (e.g., third party reviewer, MS, State Fair hearings, etc.)</p> <p>MM/DD/YYYY</p>	<p>Entity that approved or partially denied the appeal</p> <p>(Third Party Reviewer, MS, State Fair Hearings, etc.)</p>	<p>If partially denied, what was the approved portion of the service?</p> <p>Enter NA if the appeal was approved in full.</p>	<p>If the service was approved or partially denied by either the third party, Medicaid, or Medicare review, enter the date that the approved service was provided or received.</p> <p>MM/DD/YYYY</p> <p>Enter "Not Provided" if the approved service was not provided in if there is no evidence the approved service was provided.</p>	<p>What evidence or documentation does the PO have to demonstrate that the approved service was provided?</p> <p>Enter NA if the approved service was not provided.</p>	<p>Did the participant experience any significant confusion between the date the service was approved and the date that the service was provided?</p> <p>(Yes/No)</p>

General Information: This information is to be completed for all Impact Analyses		
<p>If the participant experienced any negative outcomes, please describe the negative outcomes. Enter N/A if there were no negative outcomes.</p>	<p>If the participant experienced negative outcomes, did they occur, in some part, as a result of the failure to provide the loan or service? (Yes/No) Enter N/A if there were no negative outcomes.</p>	<p>Optional: Reason why you do not have to complete this column. If there are any mitigating factors that you would like OMB to consider related to a specific appeal, please enter the information in this column.</p>