

<b>Audit Review Period:</b>	
<b>Issue(s) of non-compliance:</b>	Provision of services following an approved service determination request
<b>Scope:</b>	<ul style="list-style-type: none"> <li>• All service determination requests that were approved or partially denied during the audit review period.</li> </ul>
<b>Instructions:</b>	<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>• 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> <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>
<b>Impact Analysis Due Date:</b>	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1327. This information collection will allow CMS to conduct comprehensive reviews of PACE organizations to ensure compliance with regulatory requirements. The time required to complete this information collection is estimated at 671 per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory per CMS's authority under Section 1894 and 1934 of the Social Security Act and implementing regulations at 42 CFR § 460.190 and 460.194, which state that CMS, in conjunction with the State Administering Agency (SAA), audit PACE organizations (POs) annually for the first 3 contract years (during the trial period), and then on an ongoing basis following the trial period. Additionally, per § 460.200(a) PACE organizations are required to collect data, maintain records, and submit reports as required by CMS and the State administering agency. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Tracking ID Number	Brief Description Of Issue (Completed By The CMS Audit Lead)	Type of Issue Identified (Completed By The CMS Audit Lead)  (Applies to condition <u>1P.02 Only</u> . For all other conditions enter N/A)	Detailed Description of the Issue  (Explain what happened)
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<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>	<b>Condition Language (Completed By The CMS Audit Lead)</b>
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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
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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	Date of Disenrollment	Date Service Determination Request Brought to the full IDT	Description of the Request	Request Disposition	Date oral/written notification of the decision was provided to the participant, designated representative, or caregiver.
				MM/DD/YYYY	MM/DD/YYYY Enter NA if the participant is still enrolled.	MM/DD/YYYY		Enter approved if all of the requested services were approved as requested.  Enter partially denied if the requested services were not fully approved as requested and/or the IDT provided modified or alternative services to the participant.	MM/DD/YYYY Enter NA if notification was not rendered.

<div>If the request was partially denied, enter the services approved by the IDT.  Enter NA if approved in full.</div>	<div>Date the service was provided to the participant. MM/DD/YYYY  Enter NA if the service was not provided.</div>	<div>Was the approved service provided as expeditiously as the participant's condition required?  (Yes/No)</div>

<p>If the participant experienced any negative outcomes, please describe the negative outcomes.</p> <p>Enter NA if there were no negative outcomes.</p>	<p>If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to provide the item or service, or to provide the item or service as expeditiously as the participant's condition required?</p> <p>(Yes/No)</p> <p>Enter NA if there were no negative outcomes</p>	<p>Optional: Please note, you do not have to complete this column.</p> <p>If there are any mitigating factors that you would like CMS to consider related to a specific appeal, please enter the information in this column.</p>
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