

<b>Audit Review Period:</b>	
<b>Issue of non-compliance:</b>	Identifying and processing requests as service determination requests
<b>Scope:</b>	<ul style="list-style-type: none"> <li>• The scope of this Impact Analysis is no more than 50% of the participants enrolled during the audit review period who were not included in the provision of services sample selection.</li> <li>• The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab.</li> </ul>
<b>Instructions:</b>	<ul style="list-style-type: none"> <li>• Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab.</li> <li>• Review the selected medical records to determine if the participant, the participant's representative, or caregiver 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.</li> <li>• Respond to the questions in the Participant Impact tab.</li> <li>• The review timeframe is the audit review period. Errors noted before or after 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>
<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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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)
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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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Section 1 - 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	Date of Disenrollment
				MM/DD/YYYY	MM/DD/YYYY
					Enter NA if the participant is still enrolled.

Section 2 - Instructions: The PO must respond to the questions in this section for every participant.				
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 <u>all</u> remaining columns.	Describe the item or service the participant, their representative, or caregiver requested to initiate, modify, or continue.  Enter <u>each</u> request in a <u>new row</u> .  <u>Please note:</u> Impact analyses will be <u>returned</u> for correction if each request is not listed in a <u>new row</u> .	Enter the date the participant, their representative, or caregiver requested to initiate, modify, or continue the item or service.  MM/DD/YYYY	Is there documentation that the request was processed as a service determination request?  (Yes/No)  If the response is NO, enter <u>NA</u> in all columns in <u>section 3</u> .	Was the request included in the SDR Universe submitted to CMS?  (Yes/No)  If the response is Yes, enter NA in <u>all</u> remaining columns.

Section 3 - Instructions: If the request was processed as a service determination request, respond to the questions in Section 3.			
Was the request approved, denied, partially denied, or withdrawn?	Date the participant, designated representative, or caregiver was notified of the IDT's decision.	If the request was approved or partially denied enter the date the IDT approved services were provided.	If the request was approved or partially denied and the IDT approved services were not provided, please explain why they were not provided.
(Approved/Denied/Partially Denied/Withdrawn)	If written and oral notification were provided on different dates, enter the earliest date of notification.	MM/DD/YYYY	Enter NA if the IDT approved services were provided or if the request was fully denied or withdrawn.
If the participant did not have a request OR if the request was <u>not</u> processed as a service determination request, enter <u>NA</u> in all columns in Section 3.	MM/DD/YYYY	Enter NA if the request was fully denied or withdrawn.	
	Enter NA if notification was not provided.	Enter "Not Provided" if the IDT approved services were not provided.	



Section 4 - Instructions: If the request was not processed as a service determination request, respond to the questions in Section 4.		
<p>If the requested service was <u>not</u> processed as a service determination request, was it processed/decided under a different process?</p> <p>(Yes/No)</p> <p>If the participant did not have a request OR if the request <u>was</u> processed as a service determination request, enter <u>NA</u> in all columns in Section 4.</p>	<p>Was the requested service provided in full (as requested)?</p> <p>(Yes/No)</p>	<p>Date the requested service was provided in full.</p> <p>MM/DD/YYYY</p> <p>(Enter NA if the requested service was not provided in full/as requested)</p>

Section 5 - Instructions: The PO must respond to the questions in this section for every participant.		
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.