

Audit Review Period:		
Issue(s) of non-compliance:	Auditors: Select All that Apply	Issue:
		Oral and/or written service determination request denial rationale
		Oral and/or written service determination request denial appeal notification
		IDT decision making
		Service determination request review by IDT members
Scope:	<p>Oral and/or written service determination request denial notification did not include the specific reasons for the denial in understandable language:</p> <ul style="list-style-type: none"> All service determination requests that were denied or partially denied during the audit review period. Please include denied and partially denied service determination requests only. <p>Oral and/or written service determination request denial notification did not include appeal information:</p> <ul style="list-style-type: none"> All service determination requests that were denied or partially denied during the audit review period. Please include denied and partially denied service determination requests only. <p>The IDT did not consider all relevant information when rendering a service determination request decision</p> <ul style="list-style-type: none"> All service determination requests that were <u>denied or partially denied</u> during the audit review period. Please include denied and partially denied service determination requests only. <p>The service determination request was not reviewed by the complete IDT:</p> <ul style="list-style-type: none"> All service determination requests processed during the audit review period that were not immediately approved by a member of the interdisciplinary team, in full, at the time the request was made. 	
Instructions:	<p>General:</p> <ul style="list-style-type: none"> The review timeframe is the audit review period. Errors noted prior to 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. <p>Oral and/or written service determination request denial notifications did not include the specific reasons for the denial in understandable language:</p> <ul style="list-style-type: none"> Review each service determination request denial and partial denial to determine if: <ul style="list-style-type: none"> Oral and written notification of the denial/partial denial were provided; and Oral and written notification of the denial/partial denial included the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the participant's overall health status, taking into account the participant's medical, physical, emotional, and social needs, and the results of the reassessment(s) in understandable language. Respond to the questions in the Participant Impact tab. <p>Oral and/or written service determination request denial notifications did not include appeal information:</p> <ul style="list-style-type: none"> Review each service determination request denial and partial denial to determine if: <ul style="list-style-type: none"> Oral and written notification of the denial/partial denial were provided; and Oral and written notification of the denial/partial denial included appeal rights. Respond to the questions in the Participant Impact tab. <p>The IDT did not consider all relevant information when rendering a service determination request decision:</p> <ul style="list-style-type: none"> Review each service determination request denial/partial denial to determine if: <ul style="list-style-type: none"> The IDT considered all relevant information, including but not limited to, the findings and results of any reassessments; and The participant's current medical, physical, emotional and social needs; and Current clinical practice guidelines and professional standards of care, if applicable. Respond to the questions in the Participant Impact tab. <p>The service determination request was not reviewed by the complete IDT:</p> <ul style="list-style-type: none"> Review each service determination request that was not approved by a member of the interdisciplinary team, in full, at the time the request was made to determine if the full interdisciplinary team reviewed and discussed each request. Respond to the questions in the Participant Impact tab. 	
Impact Analysis Due Date:		

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.

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 - General Information: This information is to be completed for all Impact Analyses								
Participant First Name	Participant Last Name	Medicare Beneficiary Identifier	Participant ID	Date Service Determination Request Made MM/DD/YYYY	Date Service Determination Request Brought to the full IDT MM/DD/YYYY	Description of the Request	Request Disposition Valid entries include: Approved, Denied, Partially Denied, or Withdrawn.	Immediate Approval (Yes/No)

Section 2 - This information is to be completed if the Impact Analysis is being requested for: Oral and/or written service determination request denial rationale			
<p>Is there documentation or evidence that the participant received <u>oral notification</u> of the denial/partial denial?</p> <p>(Yes/No)</p> <p>Enter NA if the SDR was approved.</p> <p>If the auditor did not select Oral and/or written service determination request denial rationale on the instructions tab the PO may enter NA in all columns in Section 2.</p> <p>If the response to this question is NA, enter NA in all remaining columns in Section 2.</p>	<p>Did documentation of the <u>oral notification</u> state the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the participant's overall health status, taking into account the participant's medical, physical, emotional, and social needs, and the results of the reassessment(s) in understandable language?</p> <p>(Yes/No)</p> <p>Enter NA if oral notification was not provided.</p>	<p>Is there documentation or evidence that the participant received <u>written notification</u> of the denial/partial denial?</p> <p>(Yes/No)</p>	<p>Did documentation of the <u>written notification</u> state the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the participant's overall health status, taking into account the participant's medical, physical, emotional, and social needs, and the results of the reassessment(s) in understandable language?</p> <p>(Yes/No)</p> <p>Enter NA if written notification was not provided.</p>

Section 3 -This information is to be completed if the Impact Analysis is being requested for: Oral and/or written service determination request denial appeal notification			
Is there documentation or evidence that the participant received <u>oral notification</u> of the denial/partial denial? (Yes/No) Enter NA if the SDR was approved. If the auditor did not select Oral and/or written service determination request denial appeal notification on the instructions tab the PO may enter NA in all columns in Section 3. If the response to this question is NA, enter NA in all remaining columns in Section 3.	Did documentation of the <u>oral notification</u> include the participant's right to appeal the denial/partial denial? (Yes/No) Enter NA if oral notification was not provided.	Is there documentation or evidence that the participant received <u>written notification</u> of the denial? (Yes/No)	Did documentation of the <u>written notification</u> include the participant's right to appeal the denial/partial denial and information describing both the standard and expedited appeals processes? (Yes/No) Enter NA if written notification was not provided.

Section 4 - This information is to be completed if the Impact Analysis is being requested for: IDT decision making		
<p>Is there documentation that the IDT considered the results of the reassessment when rendering a service determination request decision?</p> <p>(Yes/No)</p> <p>Enter NA if the SDR was approved.</p> <p>If the auditor did not select IDT decision making on the instructions tab the PO may enter NA in all columns in Section 4.</p> <p>If the response to this question is NA, enter NA in all remaining columns in Section 4.</p>	<p>Is there documentation that the IDT considered the participant's medical, physical, emotional and social needs when rendering a service determination request decision?</p> <p>(Yes/No)</p>	<p>Is there documentation that the IDT considered clinical practice guidelines and standards of care when rendering a service determination request decision, if applicable?</p> <p>(Yes/No)</p> <p>Enter NA if there are no clinical practice guidelines and/or standards of care applicable to the requested service.</p>

Section 5 - This information is to be completed if the Impact Analysis is being requested for: Service determination request review by IDT members				
<p>Is there documentation that, at some point during the processing of the service determination request, the request was reviewed by the full IDT?</p> <p>(Yes/No)</p> <p>In order to answer Yes, the organization must have documentation or evidence that all 11 disciplines reviewed the request between the request being made (participant indicating a need) and the decision being rendered (approving or denying the request).</p> <p>Enter NA if the SDR was immediately approved.</p> <p>If the auditor did not select Service determination request review by IDT members on the instructions tab the PO may enter NA in all columns in Section 5.</p> <p>If the response to this question is NA, enter NA in all remaining columns in Section 5.</p>	<p>Which IDT members were <u>NOT</u> involved in the review of the service determination request?</p> <p>Enter NA if the SDR was reviewed by all 11 IDT disciplines.</p>	<p>For approvals and partial denials, did the participant receive the approved service(s)?</p> <p>(Yes/No)</p> <p>Enter NA if the SDR was fully denied.</p>	<p>If the participant received the service(s), what was the date received?</p> <p>MM/DD/YYYY</p> <p>Enter if the SDR was fully denied.</p>	<p>What documentation or evidence is there to show the participant received the item(s) or service(s)?</p> <p>Enter NA if the SDR was fully denied.</p>

Section 6 - General Information: This information is to be completed for all Impact Analyses

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.