Audit Review Period:		

Issue(s) of non-compliance:	**Auditors:** **Select All that Apply**	**Issue**
		Categorizing Appeals
		Appeals Reviewers
		Presenting Evidence During Appeals
		Denial Notice Includes the Specific Reason
		Medicaid and Medicare Appeal Rights

Scope:	**Categorizing Appeals:** • Review all denied service determination requests during the audit review period. **Appeal Reviewers:** • Review all of the appeals processed during the audit review period. **Presenting Evidence During Appeals:** • Review all of the appeals processed during the audit review period. **Denial Notice Includes the Specific Reason** • Review all of the denied or partially denied appeals processed during the audit review period. **Medicaid and Medicare Appeal Rights** • Review all of the denied or partially denied appeals processed during the audit review period.	

Instructions:	**General:** • After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab. **Categorizing Appeals:** • Review the medical record for each participant who had a service determination request denial to determine if the participant requested an appeal. • Respond to the questions in the Participant Impact Tab. **Appeal Reviewers:** • Review all of the appeals processed during the audit review period and respond to the questions in the Participant Impact tab. **Presenting Evidence During Appeals:** • Review all of the appeals processed during the audit review period and respond to the questions in the Participant Impact tab. **Denial Notice Includes the Specific Reason** • Review all of the denied or partially denied appeals processed during the audit review period and respond to the questions in the Participant Impact tab. **Medicaid and Medicare Appeal Rights** • Review all of the denied or partially denied appeals processed during the audit review period and respond to the questions in the Participant Impact 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)

General Information: This information is to be completed for all Impact Analyses						
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.	Service/Item being Appealed

This information is to be completed if the Impact Analysis is being requested for: Categorizing Appeals							
Did the participant request to appeal (challenge) a denied service determination request during the audit review period? (Yes/No) If the auditor did not select Categorizing Appeals on the instructions tab the PO may enter NA in columns H-O. If the answer to this question is No enter NA in columns I-O.	Date the request for the appeal was received. MM/DD/YYYY	Was the request for an appeal reviewed by a third-party reviewer? (Yes/No)	Was the request to appeal (challenge) ever resolved? (Was a decision ever rendered?) (Yes/No)	If the request to appeal (challenge) was resolved, date of resolution/decision. MM/DD/YYYY Enter NA if the appeal was not resolved.	Was the participant ever provided the disputed service? (Yes/No)	If the participant was provided the service, what was the date that service was provided? MM/DD/YYYY Enter NA if the service was not provided.	What evidence is there to demonstrate that the service was received? Enter NA if the service was not provided.

This information is to be completed if the Impact Analysis is being requested for: Appeals Reviewers					
Were any of the appeal reviewers involved in the initial decision to deny the service determination request? (Yes/No) If the auditor did not select Appeals Reviewers on the instructions tab the PO may enter NA in columns P-U. If the answer to this question is No enter NA in columns Q-U.	Do any of the appeal reviewers have a stake in the outcome of the appeal? (Yes/No)	Were any of the appeal reviewers appropriately credentialed in the field(s) or discipline(s) related to the appeal? (Yes/No)	Enter the credentials, discipline, or licensure of each of the 3rd-party reviewers involved in the review of the appeal.	Was the appeal approved, denied or partially denied? Enter Approved or Denied or Partially Denied.	If approved or partially denied, what date did the participant receive the service? Enter NA if the appeal was denied.

This information is to be completed if the Impact Analysis is being requested for: Presenting Evidence During Appeals

Did the PO provide written notification to the participant/participant representative that included the participant/participant representative's right to present evidence related to the dispute in person? (Yes/No) If the auditor did not select Presenting Evidence During Appeals on the instructions tab the PO may enter NA in columns V-AC.	Did the PO provide written notification to the participant/participant representative that included the participant/participant representative's right to present evidence related to the dispute in writing? (Yes/No)	Enter the date written notification was provided to the participant/participant representative. MM/DD/YYYY Enter NA if the participant/participant representative did not receive written notification.	Did any parties involved in the appeal request to present evidence related to the dispute in person? (Yes/No)	Did the any parties involved in the appeal request to present evidence related to the dispute in writing? (Yes/No)	Were all parties involved in the appeal given an opportunity to present evidence related to the dispute in person? (Yes/No) Enter NA if the participant/representative did not request to present information in person.	Were all parties involved in the appeal given an opportunity to present evidence related to the dispute in writing? (Yes/No) Enter NA if the participant/representative did not request to present information in writing.	Enter the date the parties involved in the appeal were notified of the appeal decision. MM/DD/YYYY Enter NA if there was no response to the appeal.

This information is to be comoleted if the Impact Analysis is being requested for: Denial Notice Includes the Specific Reason

For denied and partially denied appeals, did the participant receive written notification of the denial? (Yes/No) If the auditor did not select Denial Notice Includes the Specific Reason on the instructions tab the PO may enter NA in columns AD-AF.	Did the written notice of the denial include the specific reason for the denial, and explain the reason the service would not improve or maintain the participant's overall health status? (Yes/No)	Please provide the reason for the denial, as stated in the appeal letter.

This information is to be completed if the Impact Analysis is being requested for: Medicaid and Medicare Appeal Rights

Enter the date the parties involved in the appeal were notified of the appeal decision to deny or partially deny. MM/DD/YYYY If the auditor did not select Medicaid and Medicare Appeal Rights on the instructions tab the PO may enter NA in columns AG-AL. Enter NA if approved.	For denials, did the PO provide written notification to the participant/participant representative informing them of their appeal rights under Medicare and Medicaid? (Yes/No) Enter NA if the service being appealed was approved.	Did the participant/participant representative request to pursue their appeal rights under Medicare and Medicaid? (Yes/No) Enter NA if the service being appealed was approved.	Did the PO provide assistance to the participant/participant representative in choosing which appeal rights to pursue? (Yes/No) Enter NA if the service being appealed was approved or if the participant/participant representative chose not to pursue additional appeals.	Did the PO forward the appeal to the appropriate external entity? (Yes/No) Enter NA if the service being appealed was approved or if the participant/participant representative chose not to pursue additional appeals.	Enter the date the appeal was forwarded to Medicare, Medicaid, or Both. MM/DD/YYYY Enter NA if the service being appealed was approved or if the participant/participant representative chose not to pursue additional appeals.

General Information: This information is to be completed for all Impact Analyses			
If denied or partially denied by the independent third party reviewer, did the participant/representative request a Medicare/Medicaid appeal? Enter NA if the appeal was approved by the independent third party reviewer.	If the participant requested another appeal, was the external (Medicare or Medicaid) appeal approved or denied? Enter NA if the appeal was approved or if the participant did not request an additional appeal.	What was the date of the external Medicare/Medicaid decision? MM/DD/YYYY Enter NA if the appeal was approved or if the participant chose not to pursue additional appeal.	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 appeal, please enter the information in this column.