

Audit Review Period:		
Issue(s) of non-compliance:	Auditors: Select All that Apply	Issue:
		Appeals Reviewers
		Presenting Evidence During Appeals
		Denial Notice Includes the Specific Reason
		Medicaid and Medicare Appeal Rights
Scope:	<p>Appeal Reviewers:</p> <ul style="list-style-type: none"> Review all of the appeals processed during the audit review period. <p>Presenting Evidence During Appeals:</p> <ul style="list-style-type: none"> Review all of the appeals processed during the audit review period. <p>Denial Notice Includes the Specific Reason</p> <ul style="list-style-type: none"> Review all of the denied or partially denied appeals processed during the audit review period. <p>Medicaid and Medicare Appeal Rights</p> <ul style="list-style-type: none"> Review all of the denied or partially denied appeals processed during the audit review period. 	
Instructions:	<p>General:</p> <ul style="list-style-type: none"> After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab. <p>Appeal Reviewers:</p> <ul style="list-style-type: none"> Review all of the appeals processed during the audit review period and respond to the questions in the Participant Impact tab. <p>Presenting Evidence During Appeals:</p> <ul style="list-style-type: none"> Review all of the appeals processed during the audit review period and respond to the questions in the Participant Impact tab. <p>Denial Notice Includes the Specific Reason</p> <ul style="list-style-type: none"> 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. <p>Medicaid and Medicare Appeal Rights</p> <ul style="list-style-type: none"> 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:		

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 780 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)
-----------------------	---	---	--

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)
---	---	--	---	---

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 Appeal Received	Description of the Appeal/ Specific Issue	Request Disposition (Approved, Denied, Partially Denied, Withdrawn)

Date of Written Notification

MM/DD/YYYY

Enter NA if written notification was not provided or not documented.

Section 2 - 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 all columns in Section 2.	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.	If approved or partially denied, what date did the participant receive the service? Enter NA if the appeal was denied.

Section 3 - 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 all columns in Section 3.	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 <u>in writing</u> ? (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.
---	--	--	---

Section 4 - This information is to be completed 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 OR if the appeal was approved, the PO may enter NA in all columns in Section 4.	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.

Section 5 - 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 OR if the appeal was approved, the PO may enter NA in all columns in Section 5.	For denials, did the PO provide written notification to the participant/participant representative informing them of their appeal rights under Medicare, Medicaid, or both (if applicable)? (Yes/No)	Did the participant/participant representative request to pursue their appeal rights under Medicare or Medicaid? (Yes/No)	Did the PO provide assistance to the participant/participant representative in choosing which appeal rights to pursue? (Yes/No) Enter NA if the participant/participant representative chose not to pursue additional appeals.

<div>Did the PO forward the appeal to the appropriate external entity?</div> <div>(Yes/No)</div> <div>Enter NA if the participant/participant representative chose not to pursue additional appeals.</div>	<div>Enter the date the appeal was forwarded to Medicare or Medicaid.</div> <div>MM/DD/YYYY</div> <div>Enter NA if the participant/participant representative chose not to pursue additional appeals.</div>
--	---

Section 6 - General Information: This information is to be completed for all Impact Analyses			
<p>If an internal appeal was denied or partially denied by the independent third-party reviewer, did the participant/representative request a Medicare/Medicaid appeal?</p> <p>Enter NA if the appeal was approved by the independent third-party reviewer</p>	<p>If the participant requested an external (Medicare or Medicaid) appeal, was the appeal approved or denied?</p> <p>Enter NA if the appeal was approved or if the participant did not request an additional appeal.</p>	<p>What was the date of the external Medicare/Medicaid decision?</p> <p>MM/DD/YYYY</p> <p>Enter NA if the appeal was approved or if the participant chose not to pursue additional appeal.</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>