Audit Review Period:	

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

Scope:	**Categorizing Appeals:** • Review all denied service delivery 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. **Medicaid and Medicare Appeal Rights** • Review all of the appeals processed during the audit review period.

Instructions:	**General:** • If there have been any changes to the Root Cause Analysis, since the original Root Cause Analysis was provided, please update the changes in the RCA tab**.** • After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the changes in the RCA tab. **Categorizing Appeals:** • Review the medical record for each participant who had a service delivery 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. **Medicaid and Medicare Appeal Rights** • Review all of the appeals processed during the audit review period and respond to the questions in the Participant Impact tab.

Impact Analysis Due Date:	

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)

Detailed Description of the Issue (Explain what happened) (Remaining fields to be Completed by PACE Organization)	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	Participant ID	Date of Enrollment MM/DD/YYYY	Date of Disenrollment 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 an appeal during the audit review period (or appeal/challenge a denied service delivery request)? (Yes/No) If the auditor did not select Categorizing Appeals on the instructions tab the PO may enter NA in fields G-O. If the answer to this question is No the PO may enter NA in fields H-O.	Date the request for the appeal was received. MM/DD/YYYY	Was the service/item being appealed originally processed as a service delivery request? (Yes/No)	Was the request for an appeal reviewed by a third-party reviewer? (Yes/No)	Was the request/appeal/challenge ever resolved? (Was a decision ever rendered?) (Yes/No)	If the appeal/request/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/item? (Yes/No)	If the participant was provided the item/service, what was the date that service was provided? MM/DD/YYYY Enter NA if the item/service was not provided.	What evidence is there to demonstrate that the service was received? Enter NA if the item/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 delivery request? (Yes/No) If the auditor did not select Appeals Reviewers on the instructions tab the PO may enter NA in fields P-W. If the answer to this question is No the PO may enter NA in fields Q-W.	Do any of the appeal reviewers have a stake in the outcome of 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 or denied? Enter Approved or Denied.	If approved, what date did the participant receive the service? Enter NA if the appeal was denied.	If denied, did the participant/representative request a Medicare/Medicaid appeal? Enter NA if the appeal was approved.	If the participant requested another appeal, was the external 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? Enter NA if the appeal was approved or if the participant chose not to pursue additional appeal.

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 fields X-AE.	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 the participant/participant representative request to present evidence related to the dispute in person? (Yes/No)	Did the participant/participant representative request to present evidence related to the dispute in writing? (Yes/No)	Was the participant/participant representative 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.	Was the participant/participant representative 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 PO responded to the appeal. MM/DD/YYYY Enter NA if there was no response to the appeal.

This information is to be completed if the Impact Analysis is being requested for: Medicaid and Medicare Appeal Rights							General Information: This information is to be completed for all Impact Analyses
Enter the date of the appeal decision. MM/DD/YYYY If the auditor did not select Medicaid and Medicare Appeal Rights on the instructions tab the PO may enter NA in fields AF-AL.	Was the service/item being appealed approved or denied by the third-party reviewer? Enter Approved or Denied.	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.	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.