Audit Review Period:	

Issue of non-compliance:	Categorizing Appeals

Scope:	• Review all denied and partially denied service determination requests during the audit review period.

Instructions:	• Review the medical record for each participant who had a service determination request denial or partial denial to determine if the participant requested an appeal. • Respond to the questions in the Participant Impact Tab. • After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab.

Impact Analysis Due Date:	

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 1P.02 Only. 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)

Participant First Name	Participant Last Name

Medicare Beneficiary Identifier	Participant ID

SDR Disposition

(Denied, Partially Denied)

Service/Item being Appealed

Did the participant request to appeal (challenge) a denied service determination request during the audit review period?

(Yes/No)

If the answer to this question is No enter NA all remaining columns.

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.

If the appeal was reviewed by a third-party reviewer, what was the disposition of the appealed service?

(Approved, Denied, Partially Denied, Withdrawn)

Enter NA if the request for an appeal was not reviewed by the third-party.

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.

If an internal appeal was 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 an external (Medicare or Medicaid) appeal, was the 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.**