Audit Review Period:		

Issue(s) of non-compliance:	**Auditors:** **Select All that Apply**	**Issue**
		Provision of services to Medicaid participants during an appeal
		Provision of services following an approved appeal

Scope:	**Provision of services to Medicaid participants during an appeal:** • All appeals during the audit review period. **Provision of services following an approved appeal:** • All approved and partially denied appeals during the audit review period.	

Instructions:	**General:** • 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. **Provision of services to Medicaid participants during an appeal:** • Review each appeal to determine if the participant requested to continue the service during the appeal. • If the participant was enrolled in Medicaid, answer all of the remaining questions. If the participant was not enrolled in Medicaid, answer NA to all of the remaining questions. **Provision of services following an approved appeal:** • Review each approved and partially denied appeal and respond to the questions in the Participant Impact 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)

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	Enrollment Type (Medicare only, Medicaid only, Dual Eligible, Private Pay)	Date Appeal Received MM/DD/YYYY	Description of the Appeal/ Specific Issue	Appeal Disposition Enter approved if all of the appealed services were approved as requested. Enter partially denied if the appealed services were not fully approved as requested and/or the appeal reviewer approved modified or alternative services. Enter denied if the appealed services were fully denied.

Section 2 - This information is to be completed if the Impact Analysis is being requested for: Provision of services to Medicaid participants during an appeal						
Was the participant enrolled in Medicaid? This includes participants who are Medicaid only and dual eligible. (Yes/No) If the auditor did not select Provision of services to Medicaid participants during an appeal on the instructions tab the PO may enter NA in all columns in Section 2. If the answer to this question is No enter NA in all remaining columns in Section 2.	Was the appeal related to a termination or reduction in services that were currently being furnished to the participant? (Yes/No)	Did the participant request to continue the service during the appeal process? (Yes/No) Enter NA if the appeal was not related to a termination or reduction in services that were currently being furnished to the participant.	Was the service continued during the appeal process? (Yes/No) Enter NA if the appeal was not related to a termination or reduction in services that were currently being furnished to the participant OR if the participant did not request to continue the service during the appeal.	If the participant requested to continue the service and the service was not continued, please enter the date the service was terminated. MM/DD/YYYY Enter NA if the participant did not request to continue the service.	If the service was terminated and the service was approved by the third-party reviewer, enter the date that the service resumed. MM/DD/YYYY Enter NA if the service was denied by the third-party or the service was never terminated.	If the participant requested to continue the service and the service was not continued, were there any negative participant outcomes? (Yes/No)

Section 3 - This information is to be completed if the Impact Analysis is being requested for: Provision of services following an approved appeal (enter all appeals that were approved at any level of the appeal (e.g., third party reviewer, Medicaid State Fair Hearings, IRE, etc.)

Did the PO provide approved services, as expeditiously as the participant's condition required, following a favorable appeal? (Yes/No) Enter NA if the appeal was fully denied. If the auditor did not select Provision of services following an approved appeal on the instructions tab, the PO may enter NA in all columns in Section 3. If the answer to this question is Yes or NA, enter NA in all remaining columns in Section 3.	Date the appeal decision was rendered by any appeal entity (e.g., third party reviewer, IRE, State fair hearings, etc.). MM/DD/YYYY	Entity that approved or partially denied the appeal. (Third Party Reviewer, IRE, State Fair Hearings, etc.)	If partially denied, what was the approved portion of the service? Enter NA if the appeal was approved in full.	If the service was approved or partially denied by either the third-party, Medicaid, or Medicare reviewer, enter the date that the approved service was provided or resumed. MM/DD/YYYY Enter "Not Provided" if the approved service was not provided or if there is no evidence the approved service was provided.

Section 4 - General Information: This information is to be completed for all Impact Analyses		
If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to provide the item or service, or to provide the item or service as expeditiously as the participant's condition required? (Yes/No) Enter NA if there were no negative outcomes	If the participant experienced any negative outcomes, please describe the negative outcomes. Enter NA if there were no negative outcomes.	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.