QIO Program
BFCC-QIO 12th SOW

Annual Medical Services Review Report

Contract Year 2
(January 1 - December 31, 2020)

Region 6
AR – LA – NM – OK – TX

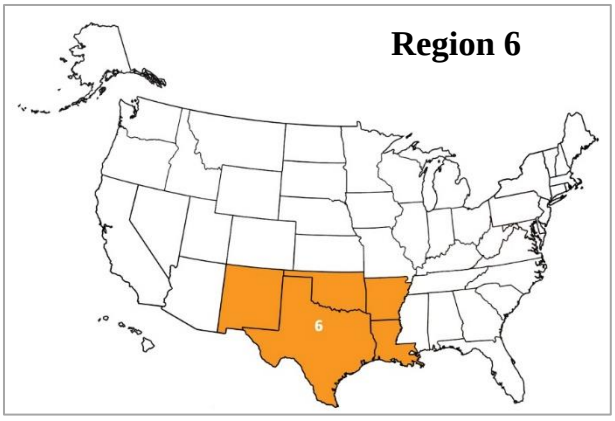
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Kepro™

TABLE OF CONTENTS

INTRODUCTION:

Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 6, which covers the following states: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. The Quality Improvement Organization (QIO) Program is an integral part of the U.S. Department of Health and Human Services National Quality Strategy and the CMS Quality Strategy. Within this report, you will find data which reflects the work Kepro has completed within the second year of its BFCC-QIO contract. The first section of this report contains regional data followed by an Appendix with state-specific data.



The QIO Program is all about improving the quality, safety, and value of the care the Medicare beneficiary receives through the Medicare program. CMS identifies the core functions of the QIO Program as:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

BFCC-QIOs, such as Kepro, review complaints about the quality of medical care. They also provide an appeal process for Medicare beneficiaries when a healthcare provider wants to discontinue services or discharge the beneficiary from the hospital. Kepro provides a service called Immediate Advocacy for beneficiaries who want to quickly resolve a Medicare situation with a provider, which does not require a medical record review. By providing these services, the rights of Medicare beneficiaries are protected while also protecting the Medicare Trust Fund.

ANNUAL REPORT:

1) TOTAL NUMBER OF REVIEWS

The data below reflects the total number of medical record reviews completed for Region 6.

The BFCC-QIO has review authority for a number of different situations. These include:

- Beneficiaries or their appointed representatives who have concerns related to the quality of provided healthcare services by either a facility or physician.
- Beneficiaries or their representatives who are appealing a pending hospital discharge or the discontinuation of skilled services such as physical therapy.
- Potential Emergency Medical Treatment & Labor Act (EMTALA) violations – In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	321	1.94%
Quality of Care Review (All Other Selection Reasons)	78	0.47%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	3	0.02%
Notice of Non-coverage (BIPA)	2,220	13.39%
Notice of Non-coverage (Grijalva)	10,861	65.53%
Notice of Non-coverage (Weichardt)	3,032	18.29%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	10	0.06%
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day	50	0.30%
EMTALA 60 Day	0	0.00%
Total	**16,575**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	73,114	28.05%
2. U071 - COVID-19	39,089	15.00%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	23,649	9.07%
4. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	22,365	8.58%
5. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	21,747	8.34%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	20,137	7.73%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	17,823	6.84%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	17,227	6.61%
9. A4189 - OTHER SPECIFIED SEPSIS	13,251	5.08%
10. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	12,231	4.69%
Total	**260,633**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	293	15.55%
1: Distinct Psychiatric Facility	23	1.22%
2: Distinct Rehabilitation Facility	94	4.99%
3: Distinct Skilled Nursing Facility	1,149	60.99%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	3	0.16%
C: Free Standing Ambulatory Surgery Center	4	0.21%
G: End Stage Renal Disease Unit	8	0.42%
H: Home Health Agency	88	4.67%
N: Critical Access Hospital	34	1.80%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	80	4.25%
R: Hospice	94	4.99%
S: Psychiatric Unit of an Inpatient Facility	4	0.21%
T: Rehabilitation Unit of an Inpatient Facility	4	0.21%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.05%
Y: Federally Qualified Health Centers	3	0.16%
Z: Swing Bed Designation for Critical Access Hospitals	2	0.11%
Other	0	0.00%
Total	**1,884**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation

Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health-care provider and/or practitioner.

4.A. QUALITY OF CARE CONCERNS CONFIRMED

The below data reflects the total number of confirmed quality of care concerns.

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	6	1	16.67%
C02: Apparently did not make appropriate diagnoses and/or assessments	97	13	13.40%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	250	37	14.80%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	137	29	21.17%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	38	12	31.58%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	6	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	13	1	7.69%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	21	2	9.52%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	13	3	23.08%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	34	4	11.76%
C11: Apparently did not demonstrate that the patient was ready for discharge	59	10	16.95%
C12: Apparently did not provide appropriate personnel and/or resources	4	0	0.00%
C13: Apparently did not order appropriate specialty consultation	16	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	3	1	33.33%
C15: Apparently did not effectively coordinate across disciplines	6	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	99	23	23.23%
C17: Apparently did not order/follow evidence-based practices	13	5	38.46%
C18: Apparently did not provide medical record documentation that impacts patient care	28	17	60.71%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	83	12	14.46%
Total	**926**	**170**	**18.36%**

4.B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up.

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
110	64.71%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	4
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner determining medical necessity of procedures/surgery	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	14
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	8
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner obtaining patient history and performing physical examination	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	6
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner safety precautions	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner use of evidence-based practices	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	6
Provider-Continuity of Care - Improvement needed in coordination across disciplines	3
Provider-Continuity of Care - Improvement needed in diagnostic service completion/result reporting/result receipt	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	10
Provider-Continuity of Care - Improvement needed in other continuity of care area	2

Provider-Continuity of Care - Improvement needed in staff assessment completion/reporting	1
Provider-Other Administrative - Improvement needed in use of care protocols/evidenced based care	1
Provider-Patient Care by Staff - Improvement needed in staff assessments	3
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	5
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	10
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	9
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of blood transfusion errors	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of complications due to equipment unavailability/failure/misuse/unmaintained	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	3
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	4
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of other operative and postoperative complications	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of wrong site/procedure/person surgery	1

5) DISCHARGE/SERVICE TERMINATIONS

The data below reflects the discharge location of beneficiaries linked to discharge/service termination reviews for Request for BFCC-QIO Concurrence and Weichardt Reviews completed in Region 6. Please note that the discharge location data for the completed appeals reported may be incomplete because of the inability to link them from the claims data.

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self care (routine discharge)	44	24.44%
02: Discharged/transferred to another short-term general hospital for inpatient care	3	1.67%
03: Discharged/transferred to skilled nursing facility (SNF)	51	28.33%
04: Discharged/transferred to intermediate care facility (ICF)	0	0.00%
05: Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06: Discharged/transferred to home under care of organized home health service organization	66	36.67%
07: Left against medical advice or discontinued care	1	0.56%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	1	0.56%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	0	0.00%
40: Expired at home (Hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or free standing Hospice)	0	0.00%
42: Expired – place unknown (Hospice claims only)	0	0.00%
43: Discharged/transferred to a federal hospital	0	0.00%
50: Hospice - home	7	3.89%
51: Hospice - medical facility	0	0.00%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	0	0.00%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	5	2.78%
63: Discharged/transferred to a long-term care hospital	0	0.00%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	1	0.56%
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66: Discharged/transferred to a critical access hospital	0	0.00%
70: Discharged/transferred to another type of health care institution not defined elsewhere in code list	1	0.56%
Other	0	0.00%
Total	**180**	**100.00%**

6) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

The data below reflect the number of appeal reviews and the percentage of reviews, for each outcome, in which the physician reviewer either agreed or disagreed with the hospital discharge or discontinuation of skilled services decision.

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
Notice of Non-coverage FFS Preadmission/Admission - (Admission and Preadmission/HINN 1)	2	50.00%	50.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	6	16.67%	83.33%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	8,240	35.08%	64.92%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	1,904	24.84%	75.16%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	1,528	9.69%	90.31%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (MA Weichardt)	923	7.04%	92.96%
Total	**12,603**	**28.40%**	**71.60%**

7) Evidence Used in Decision-Making

The table that follows describes the most common types of evidence or standards of care used to support Kepro Review Analysts' assessments, which aid in formatting questions raised to the Peer Reviewer for his/her clinical decisions for medical necessity/utilization review and appeals.

For the Quality of Care reviews, Kepro has provided one to three of the most highly utilized types of evidence/standards of care to support Kepro Review Analysts' assessments, which aid in formatting questions raised to the Peer Reviewer for his/her clinical decisions. A brief statement of the rationale for selecting the specific evidence or standards of care is also included.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	CMS' Pneumonia indicators (PN 2-7) UpToDate®	CMS' guidelines for the management of patients with Community Acquired Pneumonia (CAP) address basic aspects of preventive care and treatment. The guidelines emphasize the importance of vaccination as well as the need for appropriate and timely antimicrobial therapy. Adherence to guidelines is

			associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Heart Failure	American College of Cardiology (ACC); CMS' Heart Failure indicators (HF 1-3) UpToDate®	ACC's guidelines for the management of patients with heart failure address aspects of care that when followed are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Pressure Ulcers	AHRQ website; Wound, Ostomy & Continence Nursing website (www.WOCN.org) CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure) UpToDate®	The Agency for Healthcare Research and Quality (AHRQ) remains an excellent online resource for the identification of standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers. CMS' Patient Safety Indicators (PSI) are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice

			medicine and is the only resource of its kind associated with improved outcomes.
	Acute Myocardial Infarction	American College of Cardiology (ACC) Acute Myocardial Infarction Guidelines; CMS' Acute Myocardial Infarction indicators (AMI 2-10) UpToDate®	ACC's guidelines for the management of patients with acute myocardial infarction address aspects of care that when followed are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Urinary Tract Infection	HAI-CAUTI (f/k/a HAC-7) UpToDate®	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Sepsis	Institute for Healthcare Improvement (IHI) UpToDate®	IHI developed sepsis indicators and guidelines for the identification and treatment of sepsis. Adherence to such guidelines has improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its

			kind associated with improved outcomes.
	Adverse Drug Events	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors.
	Falls	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors.
	Patient Trauma	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors.
	Surgical Complications	Surgical complications	Kepro's Generic Quality Screening Tool
Appeals		National Coverage Determination Guidelines; JIMMO settlement language and guidelines, InterQual®, and CMS' Two Midnight Rule Benchmark criteria	Determination Guidelines; JIMMO settlement language and guidelines, InterQual®, and CMS' Two Midnight Rule Benchmark criteria Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). National coverage determinations (NCDs) are made through an evidence-based process.

8) Reviews by Geographic Area

In tables 8A-B, Kepro has provided the count and percent by rural vs. urban geographical locations for Health Service Providers (HSPs) associated with a completed BFCC-QIO review.

Table 8A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	1,372	79.49%
Rural	347	20.10%
Unknown	7	0.41%
Total	**1,726**	**100.00%**

Table 8B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	155	86.59%
Rural	24	13.41%
Unknown	0	0.00%
Total	**179**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro has worked continuously with state SHIP offices in Region 6, most recently collaborating with the Oklahoma SHIP and the Centers for Medicare & Medicaid Services (CMS) Regional Office in presenting at the Virtual Training Program to over 100 stakeholders and providers in the state. Additionally, Kepro has worked with SHIP offices throughout Region 6 to provide resources and education to over 300 Benefits Counselors regarding COVID-19 updates, the flu vaccine, and the development of Kepro's resource webpage for 24-hour access to important information. Kepro also continues to work closely with state Senior Medicare Patrol (SMP) offices, to deliver critical information to Medicare beneficiaries through quarterly update calls and being a referral source for Medicare rights related to Part A services. Lastly, as many trainings have taken place virtually, Kepro sustained a close collaborative relationship with the CMS Regional Office, often working with staff on appeal referrals, questions related to Kepro's services, and as a presenter on various trainings hosted by the Regional Office. Outreach collaborations in Region 6 potentially reached more than 500,000 Medicare beneficiaries across the region.

10) Immediate Advocacy Cases

The data below reflects the number of beneficiary complaints resolved through the use of Immediate Advocacy.

Based on the nature of the concern(s) raised by the beneficiary, Kepro staff members may recommend the use of Immediate Advocacy. Immediate Advocacy is an informal process used to quickly resolve an oral or verbal complaint. In this process, Kepro makes immediate/direct contact with a provider and/or practitioner for the beneficiary. The Kepro staff member will summarize what Immediate Advocacy involves for the beneficiary and obtain the beneficiary's oral consent to participate in Immediate Advocacy before proceeding.

During Contract Year 2 and due to the impact of COVID-19, Kepro has made a strategic plan to highly encourage Medicare beneficiaries and/or family members to take advantage of the advocacy benefits. As a

result, a high percentage of beneficiary-initiated quality of care complaints are being resolved through the use of Immediate Advocacy.

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
772	604	78.24%

11) EXAMPLE/SUCCESS STORY

A Medicare beneficiary contacted Kepro and voiced concerns with the temperature of the room during a hospital stay. The beneficiary had made multiple requests for a room change but had not received any assistance. The IA process and limitations were discussed by the clinical reviewer (CR), including an option of either a 3-way call or a CR could advocate on her behalf. The beneficiary was agreeable to the IA, provided permission to disclose her identity, and requested that the CR call the hospital to advocate on her behalf.

The CR was able to speak to the Director of Patient Services within the hospital who agreed to participate in the IA effort. The Director was made aware of the beneficiary's concerns. It was determined that the reverse thermostat in the room was causing cold temperatures. Maintenance was contacted and quickly addressed the issue with the temperature in the room.

The beneficiary expressed gratitude for the CR's assistance and stated that her room was warm again.

12) BENEFICIARY HELPLINE STATISTICS

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	52,435
Total Number of Calls Answered	44,156
Total Number of Abandoned Calls	6,026
Average Length of Call Wait Times	00:03:48 (228 Secs)
Number of Calls Transferred by 1-800-Medicare	367

CONCLUSION:

Kepro's outcomes and findings for year two of this CMS contract outline the daily work performed during the pursuit of care improvements provided to the individual Medicare beneficiary. These reviews provide solid data that can be extrapolated to improve the quality of provider care throughout the system based upon these individual's experiences as a part of the overall system. COVID-19 presented unique challenges throughout year, but Kepro was able to adapt to the circumstances and assist Medicare beneficiaries, their families, and healthcare providers and practitioners as they coped with the pandemic.

APPENDIX

KEPRO BFCC-QIO REGION 6 – STATE OF ARKANSAS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	29	4.22%
Quality of Care Review (All Other Selection Reasons)	5	0.73%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	91	13.25%
Notice of Non-coverage (Grijalva)	395	57.50%
Notice of Non-coverage (Weichardt)	167	24.31%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**687**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	6,937	25.57%
2. U071 - COVID-19	3,407	12.56%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	2,775	10.23%
4. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	2,566	9.46%
5. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	2,301	8.48%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	2,295	8.46%
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	2,042	7.53%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	1,883	6.94%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	1,636	6.03%
10. I480 - PAROXYSMAL ATRIAL FIBRILLATION	1,292	4.76%
Total	**27,134**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	240	59.26%
Male	165	40.74%
Unknown	0	0.00%
Total	**405**	**100.00%**
Race		

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Asian	1	0.25%
Black	76	18.77%
Hispanic	2	0.49%
North American Native	2	0.49%
Other	2	0.49%
Unknown	1	0.25%
White	321	79.26%
Total	**405**	**100.00%**
Age		
Under 65	85	20.99%
65-70	81	20.00%
71-80	120	29.63%
81-90	96	23.70%
91+	23	5.68%
Total	**405**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	23	14.94%
1: Distinct Psychiatric Facility	1	0.65%
2: Distinct Rehabilitation Facility	7	4.55%
3: Distinct Skilled Nursing Facility	100	64.94%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	4	2.60%
N: Critical Access Hospital	4	2.60%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	4	2.60%
R: Hospice	10	6.49%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	1	0.65%
Other	0	0.00%
Total	**154**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health-care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	9	1	11.11%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	16	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	15	4	26.67%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	3	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	1	50.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	4	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	5	0	0.00%
C17: Apparently did not order/follow evidence-based practices	2	2	100.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	5	0	0.00%
Total	**69**	**8**	**11.59%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
3	37.5%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner use of evidence-based practices	1

6) BENEFICIARY APPEALS OF PROVIDER DISCHARGE/SERVICE TERMINATIONS AND DENIALS OF HOSPITAL ADMISSIONS OUTCOMES BY NOTIFICATION TYPE

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	295	57.39%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	75	14.59%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	106	20.62%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	38	7.39%
Total	**514**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	83	57.64%	79.49%
Rural	60	41.67%	20.10%
Unknown	1	0.69%	0.41%
Total	**144**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	8	57.14%	86.59%
Rural	6	42.86%	13.41%
Unknown	0	0.00%	0.00%
Total	**14**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
42	28	66.67%

KEPRO BFCC-QIO REGION 6 – STATE OF LOUISIANA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	27	2.17%
Quality of Care Review (All Other Selection Reasons)	3	0.24%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	64	5.14%
Notice of Non-coverage (Grijalva)	889	71.35%
Notice of Non-coverage (Weichardt)	259	20.79%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	4	0.32%
EMTALA 60 Day	0	0.00%
Total	**1,246**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	9,442	24.48%
2. U071 - COVID-19	7,047	18.27%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	3,747	9.72%
4. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	3,266	8.47%
5. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	3,221	8.35%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	2,967	7.69%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	2,805	7.27%
8. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	2,316	6.01%
9. A4189 - OTHER SPECIFIED SEPSIS	1,904	4.94%
10. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	1,849	4.79%
Total	**38,564**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	477	61.47%
Male	299	38.53%
Unknown	0	0.00%
Total	**776**	**100.00%**
Race		
Asian	2	0.26%
Black	237	30.54%
Hispanic	2	0.26%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	0	0.00%
Other	5	0.64%
Unknown	5	0.64%
White	525	67.65%
Total	**776**	**100.00%**
Age		
Under 65	121	15.59%
65-70	121	15.59%
71-80	257	33.12%
81-90	206	26.55%
91+	71	9.15%
Total	**776**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	40	18.60%
1: Distinct Psychiatric Facility	2	0.93%
2: Distinct Rehabilitation Facility	10	4.65%
3: Distinct Skilled Nursing Facility	130	60.47%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	7	3.26%
N: Critical Access Hospital	7	3.26%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	7	3.26%
R: Hospice	10	4.65%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	0.47%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.47%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**215**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health-care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	7	1	14.29%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	17	3	17.65%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	9	3	33.33%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	2	1	50.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	3	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	5	3	60.00%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	4	1	25.00%
Total	**57**	**12**	**21.05%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
11	91.67%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	2
Provider-Continuity of Care - Improvement needed in staff assessment completion/reporting	1
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	1

6) BENEFICIARY APPEALS OF PROVIDER DISCHARGE/SERVICE TERMINATIONS AND DENIALS OF HOSPITAL ADMISSIONS OUTCOMES BY NOTIFICATION TYPE

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	747	74.33%

FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	54	5.37%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	105	10.45%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	99	9.85%
Total	**1,005**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	160	80.81%	79.49%
Rural	37	18.69%	20.10%
Unknown	1	0.51%	0.41%
Total	**198**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	10	66.67%	86.59%
Rural	5	33.33%	13.41%
Unknown	0	0.00%	0.00%
Total	**15**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
60	47	78.33%

KEPRO BFCC-QIO REGION 6 – STATE OF NEW MEXICO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	24	5.11%
Quality of Care Review (All Other Selection Reasons)	7	1.49%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	92	19.57%
Notice of Non-coverage (Grijalva)	264	56.17%
Notice of Non-coverage (Weichardt)	73	15.53%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	10	2.13%
EMTALA 60 Day	0	0.00%
Total	**470**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	3,138	30.53%
2. U071 - COVID-19	1,646	16.01%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	945	9.19%
4. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	818	7.96%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	795	7.73%
6. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	680	6.62%
7. A4189 - OTHER SPECIFIED SEPSIS	616	5.99%
8. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	609	5.92%
9. J9601 - ACUTE RESPIRATORY FAILURE WITH HYPOXIA	516	5.02%
10. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	516	5.02%
Total	**10,279**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	170	60.07%
Male	113	39.93%
Unknown	0	0.00%
Total	**283**	**100.00%**
Race		
Asian	0	0.00%
Black	8	2.83%
Hispanic	20	7.07%
North American Native	12	4.24%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Other	3	1.06%
Unknown	2	0.71%
White	238	84.10%
Total	**283**	**100.00%**
Age		
Under 65	41	14.49%
65-70	43	15.19%
71-80	90	31.80%
81-90	91	32.16%
91+	18	6.36%
Total	**283**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	16	20.78%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	4	5.19%
3: Distinct Skilled Nursing Facility	39	50.65%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	9	11.69%
N: Critical Access Hospital	1	1.30%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	1	1.30%
R: Hospice	6	7.79%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	1.30%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**77**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health-care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	5	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	20	2	10.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	6	2	33.33%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	2	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	7	1	14.29%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	4	1	25.00%
C17: Apparently did not order/follow evidence-based practices	1	1	100.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C99: Other quality concern not elsewhere classified	8	1	12.50%
Total	**61**	**8**	**13.11%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
7	87.5%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	3
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	1

6) BENEFICIARY APPEALS OF PROVIDER DISCHARGE/SERVICE TERMINATIONS AND DENIALS OF HOSPITAL ADMISSIONS OUTCOMES BY NOTIFICATION TYPE

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	199	59.76%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	75	22.52%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	30	9.01%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	29	8.71%
Total	**333**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	50	71.43%	79.49%
Rural	20	28.57%	20.10%
Unknown	0	0.00%	0.41%
Total	**70**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	7	58.33%	86.59%
Rural	5	41.67%	13.41%
Unknown	0	0.00%	0.00%
Total	**12**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
29	17	58.62%

KEPRO BFCC-QIO REGION 6 – STATE OF OKLAHOMA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	28	4.22%
Quality of Care Review (All Other Selection Reasons)	4	0.60%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	106	15.96%
Notice of Non-coverage (Grijalva)	409	61.60%
Notice of Non-coverage (Weichardt)	113	17.02%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	4	0.60%
EMTALA 60 Day	0	0.00%
Total	**664**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	9,784	27.56%
2. U071 - COVID-19	4,724	13.31%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	3,742	10.54%
4. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	3,272	9.22%
5. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	2,865	8.07%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	2,466	6.95%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	2,295	6.46%
8. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	2,246	6.33%
9. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	2,083	5.87%
10. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	2,024	5.70%
Total	**35,501**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	278	66.35%
Male	141	33.65%
Unknown	0	0.00%
Total	**419**	**100.00%**
Race		
Asian	2	0.48%
Black	62	14.80%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Hispanic	4	0.95%
North American Native	15	3.58%
Other	2	0.48%
Unknown	2	0.48%
White	332	79.24%
Total	**419**	**100.00%**
Age		
Under 65	70	16.71%
65-70	79	18.85%
71-80	137	32.70%
81-90	97	23.15%
91+	36	8.59%
Total	**419**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	29	23.02%
1: Distinct Psychiatric Facility	3	2.38%
2: Distinct Rehabilitation Facility	4	3.17%
3: Distinct Skilled Nursing Facility	63	50.00%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	1	0.79%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	6	4.76%
N: Critical Access Hospital	7	5.56%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	6	4.76%
R: Hospice	7	5.56%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**126**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health-care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	4	1	25.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	23	4	17.39%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	19	2	10.53%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	6	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	2	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	3	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	1	50.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	5	1	20.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	4	2	50.00%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	2	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	9	1	11.11%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	2	1	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	7	3	42.86%
Total	**91**	**16**	**17.58%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
15	93.75%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	1
Provider-Continuity of Care - Improvement needed in coordination across disciplines	1
Provider-Continuity of Care - Improvement needed in diagnostic service completion/result reporting/result receipt	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	1
Provider-Continuity of Care - Improvement needed in other continuity of care area	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	3
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	2

6) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	310	63.92%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	86	17.73%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	70	14.43%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	19	3.92%
Total	**485**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	81	77.14%	79.49%
Rural	24	22.86%	20.10%
Unknown	0	0.00%	0.41%
Total	**105**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	17	80.95%	86.59%
Rural	4	19.05%	13.41%
Unknown	0	0.00%	0.00%
Total	**21**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
59	47	79.66%

KEPRO BFCC-QIO REGION 6 – STATE OF TEXAS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	213	1.58%
Quality of Care Review (All Other Selection Reasons)	59	0.44%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	3	0.02%
Notice of Non-coverage (BIPA)	1,867	13.82%
Notice of Non-coverage (Grijalva)	8,903	65.92%
Notice of Non-coverage (Weichardt)	2,418	17.90%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	10	0.07%
EMTALA 5 Day	32	0.24%
EMTALA 60 Day	0	0.00%
Total	**13,505**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	43,813	29.16%
2. U071 - COVID-19	22,265	14.82%
3. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	12,751	8.49%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	12,705	8.45%
5. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	12,316	8.20%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	11,614	7.73%
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	10,401	6.92%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	9,728	6.47%
9. A4189 - OTHER SPECIFIED SEPSIS	8,356	5.56%
10. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	6,322	4.21%
Total	**150,271**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	4,839	61.24%
Male	3,063	38.76%
Unknown	0	0.00%
Total	**7,902**	**100.00%**
Race		
Asian	72	0.91%
Black	1,264	16.00%
Hispanic	299	3.78%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	12	0.15%
Other	86	1.09%
Unknown	48	0.61%
White	6,121	77.46%
Total	**7,902**	**100.00%**
Age		
Under 65	1,033	13.07%
65-70	1,192	15.08%
71-80	2,636	33.36%
81-90	2,344	29.66%
91+	697	8.82%
Total	**7,902**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	185	14.10%
1: Distinct Psychiatric Facility	17	1.30%
2: Distinct Rehabilitation Facility	69	5.26%
3: Distinct Skilled Nursing Facility	817	62.27%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	2	0.15%
C: Free Standing Ambulatory Surgery Center	4	0.30%
G: End Stage Renal Disease Unit	8	0.61%
H: Home Health Agency	62	4.73%
N: Critical Access Hospital	15	1.14%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	62	4.73%
R: Hospice	61	4.65%
S: Psychiatric Unit of an Inpatient Facility	4	0.30%
T: Rehabilitation Unit of an Inpatient Facility	3	0.23%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.08%
Y: Federally Qualified Health Centers	1	0.08%
Z: Swing Bed Designation for Critical Access Hospitals	1	0.08%
Other	0	0.00%
Total	**1,312**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health-care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	4	1	25.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	72	10	13.89%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	174	28	16.09%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	88	18	20.45%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	24	12	50.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	9	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	13	2	15.38%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	7	1	14.29%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	22	3	13.64%
C11: Apparently did not demonstrate that the patient was ready for discharge	44	7	15.91%
C12: Apparently did not provide appropriate personnel and/or resources	2	0	0.00%
C13: Apparently did not order appropriate specialty consultation	14	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	3	1	33.33%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	76	18	23.68%
C17: Apparently did not order/follow evidence-based practices	8	2	25.00%
C18: Apparently did not provide medical record documentation that impacts patient care	26	16	61.54%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	59	7	11.86%
Total	**648**	**126**	**19.44%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
74	58.73%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner determining medical necessity of procedures/surgery	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	13
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	5
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner obtaining patient history and performing physical examination	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	4
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner safety precautions	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	4
Provider-Continuity of Care - Improvement needed in coordination across disciplines	2
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	7

Provider-Continuity of Care - Improvement needed in other continuity of care area	1
Provider-Other Administrative - Improvement needed in use of care protocols/evidenced based care	1
Provider-Patient Care by Staff - Improvement needed in staff assessments	3
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	4
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	5
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	3
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of blood transfusion errors	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of complications due to equipment unavailability/failure/misuse/unmaintained	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of other operative and postoperative complications	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of wrong site/procedure/person surgery	1

6) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	2	0.02%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	6	0.06%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	6,689	65.16%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	1,614	15.72%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	1,217	11.85%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	738	7.19%
Total	**10,266**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	998	82.55%	79.49%
Rural	206	17.04%	20.10%
Unknown	5	0.41%	0.41%
Total	**1,209**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	113	96.58%	86.59%
Rural	4	3.42%	13.41%
Unknown	0	0.00%	0.00%
Total	**117**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
582	465	79.90%

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