QIO Program
BFCC-QIO 12th SOW

Annual Medical Services Review Report

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

Region 8
CO – MT – ND – SD – UT - WY

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

Kepro™

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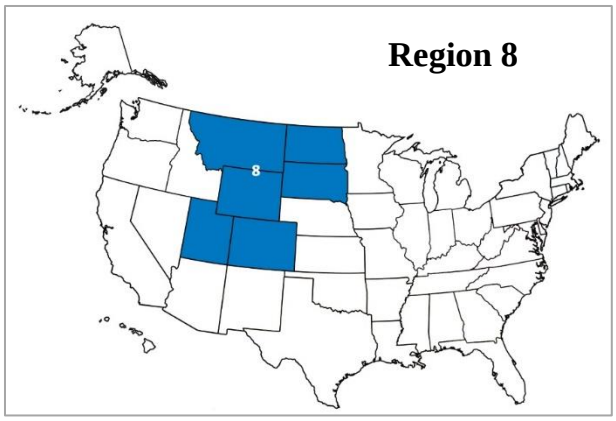
INTRODUCTION:



Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 8, which covers the following states: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. The 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 8.

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)	82	2.91%
Quality of Care Review (All Other Selection Reasons)	9	0.32%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	628	22.31%
Notice of Non-coverage (Grijalva)	1,721	61.14%
Notice of Non-coverage (Weichardt)	365	12.97%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	3	0.11%
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day	6	0.21%
EMTALA 60 Day	1	0.04%
Total	**2,815**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	15,892	27.90%
2. U071 - COVID-19	9,715	17.06%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	5,301	9.31%
4. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	4,558	8.00%
5. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	4,523	7.94%
6. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	4,496	7.89%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
7. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	3,941	6.92%
8. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	2,877	5.05%
9. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	2,868	5.04%
10. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	2,789	4.90%
Total	**56,960**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	78	19.02%
1: Distinct Psychiatric Facility	1	0.24%
2: Distinct Rehabilitation Facility	11	2.68%
3: Distinct Skilled Nursing Facility	252	61.46%
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	14	3.41%
N: Critical Access Hospital	14	3.41%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	8	1.95%
R: Hospice	32	7.80%
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	**410**	**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.**lity 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	1	100.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	29	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)]	43	2	4.65%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	30	3	10.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	13	4	30.77%
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	4	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	7	1	14.29%
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	20	8	40.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	13	4	30.77%
C12: Apparently did not provide appropriate personnel and/or resources	2	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)	18	7	38.89%
C17: Apparently did not order/follow evidence-based practices	2	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	1	1	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	12	3	25.00%
Total	**199**	**34**	**17.09%**

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**
31	91.18%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	2
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 provision of patient education, ensuring stability for discharge and providing discharge planning	2
Provider-Continuity of Care - Improvement needed in case management/discharge planning	4
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	2
Provider-Patient Care by Staff - Improvement needed in other patient care by staff area	1
Provider-Patient Care by Staff - Improvement needed in staff care planning	1
Provider-Patient Care by Staff - Improvement needed in staff following provider established care protocols	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	5
Provider-Safety of the Environment in Patient Care - Improvement needed in other safety of the environment in patient care area	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	2

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 8. 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)	3	13.04%
02: Discharged/transferred to another short-term general hospital for inpatient care	1	4.35%
03: Discharged/transferred to skilled nursing facility (SNF)	8	34.78%
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	8	34.78%
07: Left against medical advice or discontinued care	0	0.00%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	0	0.00%
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	1	4.35%
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	1	4.35%
63: Discharged/transferred to a long-term care hospital	1	4.35%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%
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	0	0.00%
Other	0	0.00%
Total	**23**	**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)	0	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	3	33.33%	66.67%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	1,319	35.10%	64.90%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	552	20.47%	79.53%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	175	4.00%	96.00%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (MA Weichardt)	113	9.73%	90.27%
Total	**2,162**	**27.52%**	**72.48%**

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	284	75.94%
Rural	90	24.06%
Unknown	0	0.00%
Total	**374**	**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	35	74.47%
Rural	12	25.53%
Unknown	0	0.00%
Total	**47**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Collaborations continue to strengthen with Long-Term Care (LTC) Ombudsman throughout Region 8. LTC Ombudsman work diligently to resolve problems related to the health, safety, welfare, and rights of Medicare beneficiaries, a strong alignment to the work performed by BFCC-QIOs and therefore an extremely valuable partnership. Collaborations took place with LTC Ombudsman at the South Dakota Department of Social Services, the Wyoming Department of Health, the Area Agency on Aging of Northwest Colorado, amongst other LTC Ombudsman programs throughout the six-state region. Kepro's outreach staff gave virtual presentations throughout the year and shared information about the services offered to Medicare beneficiaries as well as tools and resources to use with beneficiaries they encounter through their daily work. LTC Ombudsman throughout Region 8 have found value in Kepro's advocacy resources and use them to guide Medicare beneficiaries and representatives needing medical record review or Immediate Advocacy assistance from Kepro. Region 8 collaborations potentially reached more than 600,000 beneficiaries in 2020.

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
144	90	62.50%

11) EXAMPLE/SUCCESS STORY

A Medicare beneficiary contacted Kepro and discussed concerns that she had not received her Velcro compression leg wraps and needed assistance with working with the assigned home health agency. The Immediate Advocacy process and limitations were discussed by the Clinical Care Coordinator (CCC), including an option of either a 3-way call or the CCC would advocate on her behalf. The beneficiary was agreeable to Immediate Advocacy, provided permission to disclose her identity, and requested that the CCC call the home health agency to advocate on her behalf.

The CCC spoke with the Director of Nursing (DON) for the home health agency who was agreeable to participate in an Immediate Advocacy effort. The CCC discussed the beneficiary's concerns about not having received the leg wraps. The DON informed the CCC that the wraps were been ordered and would be brought to the beneficiary's home as soon as they arrive at their office. The CCC thanked the DON for the information.

The beneficiary was contacted and given the information provided by the DON. The CCC asked the beneficiary to contact her with any other concerns that she may have.

12) BENEFICIARY HELPLINE STATISTICS

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	8,658
Total Number of Calls Answered	7,229
Total Number of Abandoned Calls	974
Average Length of Call Wait Times	00:03:56 (236 Secs)
Number of Calls Transferred by 1-800-Medicare	81

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 8 – STATE OF COLORADO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	48	3.68%
Quality of Care Review (All Other Selection Reasons)	6	0.46%
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)	304	18.92%
Notice of Non-coverage (Grijalva)	1,079	67.14%
Notice of Non-coverage (Weichardt)	170	10.58%
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	**1,607**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	6,252	32.96%
2. U071 - COVID-19	2,483	13.09%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	1,531	8.07%
4. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	1,435	7.56%
5. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	1,395	7.35%
6. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	1,343	7.08%
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	1,314	6.93%
8. A4189 - OTHER SPECIFIED SEPSIS	1,215	6.40%
9. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	1,037	5.47%
10. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	966	5.09%
Total	**18,971**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	602	61.62%
Male	375	38.38%
Unknown	0	0.00%
Total	**977**	**100.00%**
Race		

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Asian	10	1.02%
Black	45	4.61%
Hispanic	9	0.92%
North American Native	3	0.31%
Other	6	0.61%
Unknown	9	0.92%
White	895	91.61%
Total	**977**	**100.00%**
Age		
Under 65	96	9.83%
65-70	141	14.43%
71-80	328	33.57%
81-90	297	30.40%
91+	115	11.77%
Total	**977**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	37	20.67%
1: Distinct Psychiatric Facility	1	0.56%
2: Distinct Rehabilitation Facility	5	2.79%
3: Distinct Skilled Nursing Facility	110	61.45%
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	5	2.79%
N: Critical Access Hospital	4	2.23%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	3	1.68%
R: Hospice	14	7.82%
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	**179**	**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	1	100.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	17	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)]	22	1	4.55%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	20	3	15.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	8	3	37.50%
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	3	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	5	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	12	4	33.33%
C11: Apparently did not demonstrate that the patient was ready for discharge	6	3	50.00%
C12: Apparently did not provide appropriate personnel and/or resources	2	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	0	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)	13	5	38.46%
C17: Apparently did not order/follow evidence-based practices	0	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	9	2	22.22%
Total	**119**	**22**	**18.49%**

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**
20	90.91%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	2
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	2
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 other patient care by staff area	1
Provider-Patient Care by Staff - Improvement needed in staff care planning	1
Provider-Patient Care by Staff - Improvement needed in staff following provider established care protocols	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	3
Provider-Safety of the Environment in Patient Care - Improvement needed in other safety of the environment in patient care area	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	2

Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	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)	805	66.75%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	269	22.31%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	68	5.64%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	64	5.31%
Total	**1,206**	**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	149	92.55%	75.94%
Rural	12	7.45%	24.06%
Unknown	0	0.00%	0.00%
Total	**161**	**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	22	81.48%	74.47%
Rural	5	18.52%	25.53%
Unknown	0	0.00%	0.00%
Total	**27**	**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
86	52	60.47%

KEPRO BFCC-QIO REGION 8 – STATE OF MONTANA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	10	4.55%
Quality of Care Review (All Other Selection Reasons)	0	0.00%
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)	78	35.45%
Notice of Non-coverage (Grijalva)	114	51.82%
Notice of Non-coverage (Weichardt)	18	8.18%
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	**220**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	2,110	27.12%
2. U071 - COVID-19	1,482	19.05%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	752	9.66%
4. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	692	8.89%
5. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	546	7.02%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	526	6.76%
7. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	500	6.43%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	438	5.63%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	432	5.55%
10. A4189 - OTHER SPECIFIED SEPSIS	303	3.89%
Total	**7,781**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	89	62.24%
Male	54	37.76%
Unknown	0	0.00%
Total	**143**	**100.00%**
Race		
Asian	1	0.70%
Black	3	2.10%
Hispanic	0	0.00%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	3	2.10%
Other	0	0.00%
Unknown	0	0.00%
White	136	95.10%
Total	**143**	**100.00%**
Age		
Under 65	16	11.19%
65-70	19	13.29%
71-80	40	27.97%
81-90	46	32.17%
91+	22	15.38%
Total	**143**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	7	18.42%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	2	5.26%
3: Distinct Skilled Nursing Facility	20	52.63%
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	2	5.26%
N: Critical Access Hospital	4	10.53%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	3	7.89%
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	**38**	**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	2	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)]	6	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	0	0.00%
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	1	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	1	100.00%
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	1	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	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	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	2	0	0.00%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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	0	0	0.00%
Total	**22**	**1**	**4.55%**

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**
0	**0.00%**
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
N/A	N/A

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)	91	50.84%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	75	41.90%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	6	3.35%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	7	3.91%
Total	**179**	**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	14	42.42%	75.94%
Rural	19	57.58%	24.06%
Unknown	0	0.00%	0.00%
Total	**33**	**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	2	40.00%	74.47%
Rural	3	60.00%	25.53%
Unknown	0	0.00%	0.00%
Total	**5**	**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
16	8	50.00%

KEPRO BFCC-QIO REGION 8 – STATE OF NORTH DAKOTA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	7	3.48%
Quality of Care Review (All Other Selection Reasons)	0	0.00%
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)	110	54.73%
Notice of Non-coverage (Grijalva)	59	29.35%
Notice of Non-coverage (Weichardt)	18	8.96%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	2	1.00%
EMTALA 5 Day	5	2.49%
EMTALA 60 Day	0	0.00%
Total	**201**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	1,730	22.05%
2. U071 - COVID-19	1,691	21.55%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	804	10.25%
4. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	797	10.16%
5. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	777	9.90%
6. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	572	7.29%
7. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	459	5.85%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	374	4.77%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	334	4.26%
10. I639 - CEREBRAL INFARCTION, UNSPECIFIED	308	3.93%
Total	**7,846**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	75	59.52%
Male	51	40.48%
Unknown	0	0.00%
Total	**126**	**100.00%**
Race		
Asian	0	0.00%
Black	0	0.00%
Hispanic	0	0.00%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	1	0.79%
Other	0	0.00%
Unknown	1	0.79%
White	124	98.41%
Total	**126**	**100.00%**
Age		
Under 65	6	4.76%
65-70	8	6.35%
71-80	35	27.78%
81-90	47	37.30%
91+	30	23.81%
Total	**126**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	7	18.42%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	2.63%
3: Distinct Skilled Nursing Facility	26	68.42%
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	0	0.00%
N: Critical Access Hospital	2	5.26%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	5.26%
R: Hospice	0	0.00%
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	**38**	**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	1	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)]	3	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	1	100.00%
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	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	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	1	1	100.00%
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	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	0	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)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	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	0	0	0.00%
Total	**11**	**2**	**18.18%**

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**
2	100%
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 monitoring of patient response/changes and adjusting treatment	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	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)	2	1.33%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	38	25.33%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	93	62.00%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	12	8.00%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	5	3.33%
Total	**150**	**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	22	62.86%	75.94%
Rural	13	37.14%	24.06%
Unknown	0	0.00%	0.00%
Total	**35**	**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	2	66.67%	74.47%
Rural	1	33.33%	25.53%
Unknown	0	0.00%	0.00%
Total	**3**	**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
7	5	71.43%

KEPRO BFCC-QIO REGION 8 – STATE OF SOUTH DAKOTA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	1	0.68%
Quality of Care Review (All Other Selection Reasons)	1	0.68%
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)	32	21.77%
Notice of Non-coverage (Grijalva)	55	37.41%
Notice of Non-coverage (Weichardt)	57	38.78%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.68%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**147**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. U071 - COVID-19	1,973	22.16%
2. A419 - SEPSIS, UNSPECIFIED ORGANISM	1,689	18.97%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	907	10.19%
4. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	780	8.76%
5. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	727	8.17%
6. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	649	7.29%
7. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	610	6.85%
8. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	576	6.47%
9. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	552	6.20%
10. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	439	4.93%
Total	**8,902**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	61	67.78%
Male	29	32.22%
Unknown	0	0.00%
Total	**90**	**100.00%**
Race		
Asian	0	0.00%
Black	1	1.11%
Hispanic	1	1.11%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	1	1.11%
Other	0	0.00%
Unknown	0	0.00%
White	87	96.67%
Total	**90**	**100.00%**
Age		
Under 65	7	7.78%
65-70	13	14.44%
71-80	22	24.44%
81-90	35	38.89%
91+	13	14.44%
Total	**90**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	6	17.65%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	22	64.71%
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	0	0.00%
N: Critical Access Hospital	3	8.82%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	1	2.94%
R: Hospice	2	5.88%
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	**34**	**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	0	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)]	0	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	1	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	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	0	0	0.00%
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	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	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	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	0	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)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	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	2	0	0.00%
Total	**3**	**0**	**0.00%**

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**
0	0.00%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
N/A	N/A

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)	1	0.86%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	41	35.34%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	27	23.28%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	36	31.03%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	11	9.48%
Total	**116**	**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	18	58.06%	75.94%
Rural	13	41.94%	24.06%
Unknown	0	0.00%	0.00%
Total	**31**	**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	0	0.00%	74.47%
Rural	2	100.00%	25.53%
Unknown	0	0.00%	0.00%
Total	**2**	**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
8	6	75.00%

KEPRO BFCC-QIO REGION 8 – STATE OF UTAH

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	16	2.68%
Quality of Care Review (All Other Selection Reasons)	2	0.33%
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)	96	16.05%
Notice of Non-coverage (Grijalva)	403	67.39%
Notice of Non-coverage (Weichardt)	79	13.21%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	1	0.17%
EMTALA 60 Day	1	0.17%
Total	**598**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	3,318	32.00%
2. U071 - COVID-19	1,255	12.10%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	961	9.27%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	923	8.90%
5. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	798	7.70%
6. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	728	7.02%
7. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	671	6.47%
8. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	583	5.62%
9. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	574	5.54%
10. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	559	5.39%
Total	**10,370**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	226	60.75%
Male	146	39.25%
Unknown	0	0.00%
Total	**372**	**100.00%**
Race		
Asian	1	0.27%
Black	7	1.88%
Hispanic	5	1.34%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	2	0.54%
Other	8	2.15%
Unknown	4	1.08%
White	345	92.74%
Total	**372**	**100.00%**
Age		
Under 65	61	16.40%
65-70	62	16.67%
71-80	123	33.06%
81-90	107	28.76%
91+	19	5.11%
Total	**372**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	16	15.24%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	2	1.90%
3: Distinct Skilled Nursing Facility	67	63.81%
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	6.67%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	1.90%
R: Hospice	11	10.48%
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	**105**	**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	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)]	12	1	8.33%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	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	0	0	0.00%
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	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	6	3	50.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	5	1	20.00%
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%

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)	3	2	66.67%
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	1	1	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	1	1	100.00%
Total	**44**	**9**	**20.45%**

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**
9	100%
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 medical record documentation that impacts patient care	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	2
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 other continuity of care area	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	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)	339	70.63%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	81	16.88%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	35	7.29%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	25	5.21%
Total	**480**	**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	75	75.76%	75.94%
Rural	24	24.24%	24.06%
Unknown	0	0.00%	0.00%
Total	**99**	**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	9	90.00%	74.47%
Rural	1	10.00%	25.53%
Unknown	0	0.00%	0.00%
Total	**10**	**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
25	17	68.00%

KEPRO BFCC-QIO REGION 8 – STATE OF WYOMING

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	0	0.00%
Quality of Care Review (All Other Selection Reasons)	0	0.00%
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)	8	20.00%
Notice of Non-coverage (Grijalva)	10	25.00%
Notice of Non-coverage (Weichardt)	22	55.00%
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	**40**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. U071 - COVID-19	831	20.46%
2. A419 - SEPSIS, UNSPECIFIED ORGANISM	793	19.52%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	534	13.15%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	321	7.90%
5. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	312	7.68%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	298	7.34%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	282	6.94%
8. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	277	6.82%
9. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	250	6.15%
10. R531 - WEAKNESS	164	4.04%
Total	**4,062**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	12	44.44%
Male	15	55.56%
Unknown	0	0.00%
Total	**27**	**100.00%**
Race		
Asian	0	0.00%
Black	0	0.00%
Hispanic	1	3.70%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	1	3.70%
Other	0	0.00%
Unknown	0	0.00%
White	25	92.59%
Total	**27**	**100.00%**
Age		
Under 65	4	14.81%
65-70	4	14.81%
71-80	5	18.52%
81-90	12	44.44%
91+	2	7.41%
Total	**27**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	5	31.25%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	6.25%
3: Distinct Skilled Nursing Facility	7	43.75%
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	0	0.00%
N: Critical Access Hospital	1	6.25%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	2	12.50%
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	**16**	**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	0	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)]	0	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	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	0	0	0.00%
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	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	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	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	0	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)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	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	0	0	0.00%
Total	**0**	**0**	**None**

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**
0	0.00%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
N/A	N/A

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)	5	16.13%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	7	22.58%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	18	58.06%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	1	3.23%
Total	**31**	**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	6	40.00%	75.94%
Rural	9	60.00%	24.06%
Unknown	0	0.00%	0.00%
Total	**15**	**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	0	None	74.47%
Rural	0	None	25.53%
Unknown	0	None	0.00%
Total	**0**	**None**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
2	2	100.00%

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