QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Contract Year 2

(January 1 - December 31, 2020)

Region 10

AK – ID – OR - WA

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Kepro™

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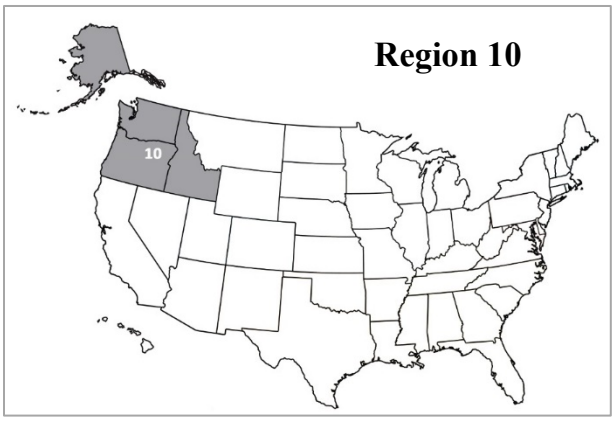
INTRODUCTION:

Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 10, which covers the following states: Alaska, Idaho, Oregon, and Washington. 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 10.

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)	92	2.19%
Quality of Care Review (All Other Selection Reasons)	4	0.10%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	2	0.05%
Notice of Non-coverage (BIPA)	829	19.75%
Notice of Non-coverage (Grijalva)	2,491	59.35%
Notice of Non-coverage (Weichardt)	775	18.47%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	4	0.10%
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**4,197**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	18,361	32.40%
2. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	6,085	10.74%
3. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	5,482	9.67%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	5,191	9.16%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	5,146	9.08%
6. U071 - COVID-19	4,571	8.07%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
7. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	3,949	6.97%
8. J9601 - ACUTE RESPIRATORY FAILURE WITH HYPOXIA	2,717	4.80%
9. A4151 - SEPSIS DUE TO ESCHERICHIA COLI ï¿½E. COLIï¿½	2,589	4.57%
10. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	2,572	4.54%
Total	**56,663**	**100.00%**

3) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	88	17.67%
1: Distinct Psychiatric Facility	6	1.20%
2: Distinct Rehabilitation Facility	6	1.20%
3: Distinct Skilled Nursing Facility	297	59.64%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.20%
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	33	6.63%
N: Critical Access Hospital	16	3.21%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	5	1.00%
R: Hospice	23	4.62%
S: Psychiatric Unit of an Inpatient Facility	2	0.40%
T: Rehabilitation Unit of an Inpatient Facility	4	0.80%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	3	0.60%
Y: Federally Qualified Health Centers	5	1.00%
Z: Swing Bed Designation for Critical Access Hospitals	9	1.81%
Other	0	0.00%
Total	**498**	**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 all 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	2	1	50.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	25	2	8.00%
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)]	52	6	11.54%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	30	4	13.33%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	7	1	14.29%
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	1	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	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	14	3	21.43%
C11: Apparently did not demonstrate that the patient was ready for discharge	12	2	16.67%
C12: Apparently did not provide appropriate personnel and/or resources	1	1	100.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	2	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)	11	3	27.27%
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	5	2	40.00%
Total	**168**	**26**	**15.48%**

4.B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

As previously reported, 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**
19	73.08%
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 monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner obtaining patient history and performing physical examination	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	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	2
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	4
Provider-Patient Care by Staff - Improvement needed in staff assessments	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	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	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of other operative and postoperative complications	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 10. 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)	34	51.52%
02: Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03: Discharged/transferred to skilled nursing facility (SNF)	14	21.21%
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	17	25.76%
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	1	1.52%
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	0	0.00%
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	0	0.00%
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	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	**66**	**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)	1	0.00%	100.00%
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)	1,912	32.53%	67.47%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	715	19.86%	80.14%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	359	3.62%	96.38%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (MA Weichardt)	259	8.49%	91.51%
Total	**3,249**	**24.62%**	**75.38%**

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

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

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	357	74.69%
Rural	113	23.64%
Unknown	8	1.67%
Total	**478**	**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	38	80.85%
Rural	9	19.15%
Unknown	0	0.00%
Total	**47**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro continues to develop strong relationships with the State Health Insurance Assistance Programs (SHIPs) in Region 10 to collectively offer information and guidance to Medicare beneficiaries throughout the four-state region. Each year, Medicare beneficiaries seek guidance and support from SHIP counselors during the open enrollment period. Kepro has worked with numerous SHIPs across the region to provide "Train the Trainer" presentations to educate SHIP counselors about BFCC-QIO services available to people with Medicare. This is a valuable partnership and a great way to get information in the hands of those who would benefit from BFCC-QIO resources and support. Over the past reporting year, this collaboration has potentially benefited more than 300,000 Medicare beneficiaries in Region 10.

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
175	117	66.86%

11) Example/Success Story

A Medicare beneficiary's representative contacted Kepro about the beneficiary's hospital care. The beneficiary was sent to the hospital with troubled breathing. She was being treated for congestive health failure and pneumonia and was on a temporary vent. The doctor was discussing removing it. The representative had questions regarding the plan of care and treatment. The representative felt that the fluid should be removed first before the vent was discontinued and wanted to speak to the doctor regarding his questions/concerns relating to care.

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 could advocate on the beneficiary's behalf. The representative was agreeable to Immediate Advocacy, provided permission to disclose his identity, and requested that the CCC call the hospital to advocate on on the beneficiary's behalf.

The CCC spoke with the hospital social worker who was agreeable to participating in Immediate Advocacy. The CCC shared the representative's concerns and was informed that she would receive follow-up regarding the steps taken to address them.

Then the CCC contacted the representative who was very appreciative of the steps that were taken on his behalf. The representative stated that he had a much better understanding of the situation due to the CCC discussing his concerns with the hospital social worker. The representative was able to speak to the doctor and learned that the fluid in the beneficiary's lungs had decreased, and a BiPap will continue to be used when the vent is shut off. The antibiotics had also been effective. The representative was very pleased with the services that were provided by Kepro.

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	15,848
Total Number of Calls Answered	12,743
Total Number of Abandoned Calls	2,080
Average Length of Call Wait Times	00:04:24 (264 Secs)
Number of Calls Transferred by 1-800-Medicare	99

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 10 – STATE OF ALASKA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	2	6.67%
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)	6	20.00%
Notice of Non-coverage (Grijalva)	2	6.67%
Notice of Non-coverage (Weichardt)	19	63.33%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	3.33%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**30**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	1,106	34.59%
2. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	333	10.42%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	275	8.60%
4. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	261	8.16%
5. U071 - COVID-19	255	7.98%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	242	7.57%
7. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	208	6.51%
8. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	196	6.13%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	163	5.10%
10. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	158	4.94%
Total	**3,197**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	12	60.00%
Male	8	40.00%
Unknown	0	0.00%
Total	**20**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	0	0.00%
Black	0	0.00%
Hispanic	0	0.00%
North American Native	2	10.00%
Other	0	0.00%
Unknown	1	5.00%
White	17	85.00%
Total	**20**	**100.00%**
Age		
Under 65	4	20.00%
65-70	2	10.00%
71-80	10	50.00%
81-90	3	15.00%
91+	1	5.00%
Total	**20**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	5	33.33%
1: Distinct Psychiatric Facility	1	6.67%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	4	26.67%
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	1	6.67%
N: Critical Access Hospital	1	6.67%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	0	0.00%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	6.67%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	6.67%
Y: Federally Qualified Health Centers	1	6.67%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**15**	**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)]	0	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	2	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	**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	4.76%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	1	4.76%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	4	19.05%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	14	66.67%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	1	4.76%
Total	**21**	**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	5	38.46%	74.69%
Rural	8	61.54%	23.64%
Unknown	0	0.00%	1.67%
Total	**13**	**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	1	100.00%	80.85%
Rural	0	0.00%	19.15%
Unknown	0	0.00%	0.00%
Total	**1**	**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
3	2	66.67%

KEPRO BFCC-QIO REGION 10 – STATE OF IDAHO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	13	4.51%
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)	64	22.22%
Notice of Non-coverage (Grijalva)	166	57.64%
Notice of Non-coverage (Weichardt)	44	15.28%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.35%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**288**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	2,449	30.89%
2. U071 - COVID-19	1,310	16.52%
3. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	653	8.24%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	651	8.21%
5. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	552	6.96%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	549	6.92%
7. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	536	6.76%
8. A4189 - OTHER SPECIFIED SEPSIS	499	6.29%
9. J9601 - ACUTE RESPIRATORY FAILURE WITH HYPOXIA	370	4.67%
10. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	359	4.53%
Total	**7,928**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	116	65.17%
Male	62	34.83%
Unknown	0	0.00%
Total	**178**	**100.00%**
Race		
Asian	0	0.00%
Black	2	1.12%
Hispanic	0	0.00%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	2	1.12%
Other	0	0.00%
Unknown	3	1.69%
White	171	96.07%
Total	**178**	**100.00%**
Age		
Under 65	19	10.67%
65-70	20	11.24%
71-80	57	32.02%
81-90	57	32.02%
91+	25	14.04%
Total	**178**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	8	12.31%
1: Distinct Psychiatric Facility	2	3.08%
2: Distinct Rehabilitation Facility	2	3.08%
3: Distinct Skilled Nursing Facility	37	56.92%
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	3.08%
N: Critical Access Hospital	4	6.15%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	3.08%
R: Hospice	5	7.69%
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	3	4.62%
Other	0	0.00%
Total	**65**	**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)]	7	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	2	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	1	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	0	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%

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)	1	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	**18**	**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)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	126	57.53%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	57	26.03%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	20	9.13%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	16	7.31%
Total	**219**	**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	29	46.03%	74.69%
Rural	31	49.21%	23.64%
Unknown	3	4.76%	1.67%
Total	**63**	**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	3	60.00%	80.85%
Rural	2	40.00%	19.15%
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
23	16	69.57%

KEPRO BFCC-QIO REGION 10 – STATE OF OREGON

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	38	3.41%
Quality of Care Review (All Other Selection Reasons)	1	0.09%
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)	184	16.50%
Notice of Non-coverage (Grijalva)	634	56.86%
Notice of Non-coverage (Weichardt)	257	23.05%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.09%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**1,115**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	4,482	31.74%
2. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	1,574	11.15%
3. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	1,441	10.21%
4. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	1,410	9.99%
5. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	1,369	9.70%
6. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	998	7.07%
7. U071 - COVID-19	775	5.49%
8. A4151 - SEPSIS DUE TO ESCHERICHIA COLI ï¿½E. COLIï¿½	711	5.04%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	699	4.95%
10. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	660	4.67%
Total	**14,119**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	427	57.39%
Male	317	42.61%
Unknown	0	0.00%
Total	**744**	**100.00%**
Race		
Asian	15	2.02%
Black	22	2.96%
Hispanic	2	0.27%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	16	2.15%
Other	10	1.34%
Unknown	7	0.94%
White	672	90.32%
Total	**744**	**100.00%**
Age		
Under 65	99	13.31%
65-70	121	16.26%
71-80	227	30.51%
81-90	221	29.70%
91+	76	10.22%
Total	**744**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	29	19.08%
1: Distinct Psychiatric Facility	1	0.66%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	91	59.87%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.66%
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	13	8.55%
N: Critical Access Hospital	7	4.61%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	1	0.66%
R: Hospice	7	4.61%
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	2	1.32%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**152**	**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	13	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)]	16	3	18.75%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	8	1	12.50%
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)	2	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	5	2	40.00%
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	1	100.00%
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)	2	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	1	50.00%
Total	**55**	**10**	**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**
8	80%
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
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	2
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	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)	1	0.12%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	482	56.64%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	163	19.15%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	106	12.46%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	99	11.63%
Total	**851**	**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	115	79.31%	74.69%
Rural	30	20.69%	23.64%
Unknown	0	0.00%	1.67%
Total	**145**	**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	12	85.71%	80.85%
Rural	2	14.29%	19.15%
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
50	30	60.00%

KEPRO BFCC-QIO REGION 10 – STATE OF WASHINGTON

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	39	1.41%
Quality of Care Review (All Other Selection Reasons)	3	0.11%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.07%
Notice of Non-coverage (BIPA)	575	20.80%
Notice of Non-coverage (Grijalva)	1,689	61.11%
Notice of Non-coverage (Weichardt)	455	16.46%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.04%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**2,764**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	10,324	32.22%
2. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	3,698	11.54%
3. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	3,086	9.63%
4. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	2,914	9.10%
5. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	2,896	9.04%
6. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	2,257	7.04%
7. U071 - COVID-19	2,231	6.96%
8. J9601 - ACUTE RESPIRATORY FAILURE WITH HYPOXIA	1,610	5.03%
9. I639 - CEREBRAL INFARCTION, UNSPECIFIED	1,561	4.87%
10. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	1,462	4.56%
Total	**32,039**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,033	60.80%
Male	666	39.20%
Unknown	0	0.00%
Total	**1,699**	**100.00%**
Race		
Asian	38	2.24%
Black	85	5.00%
Hispanic	13	0.77%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	13	0.77%
Other	37	2.18%
Unknown	15	0.88%
White	1,498	88.17%
Total	**1,699**	**100.00%**
Age		
Under 65	178	10.48%
65-70	273	16.07%
71-80	550	32.37%
81-90	508	29.90%
91+	190	11.18%
Total	**1,699**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	46	17.29%
1: Distinct Psychiatric Facility	2	0.75%
2: Distinct Rehabilitation Facility	4	1.50%
3: Distinct Skilled Nursing Facility	165	62.03%
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	17	6.39%
N: Critical Access Hospital	4	1.50%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	0.75%
R: Hospice	11	4.14%
S: Psychiatric Unit of an Inpatient Facility	2	0.75%
T: Rehabilitation Unit of an Inpatient Facility	3	1.13%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	2	0.75%
Y: Federally Qualified Health Centers	2	0.75%
Z: Swing Bed Designation for Critical Access Hospitals	6	2.26%
Other	0	0.00%
Total	**266**	**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	2	1	50.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	9	2	22.22%
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)]	29	3	10.34%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	17	3	17.65%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	1	25.00%
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	9	1	11.11%
C11: Apparently did not demonstrate that the patient was ready for discharge	7	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	2	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)	8	3	37.50%
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	3	1	33.33%
Total	**92**	**16**	**17.39%**

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	68.75%
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 monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner obtaining patient history and performing physical examination	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner use of evidence-based practices	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	2
Provider-Patient Care by Staff - Improvement needed in staff assessments	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	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 other operative and postoperative complications	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)	1	0.05%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.05%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	1,303	60.38%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	491	22.75%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	219	10.15%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	143	6.63%
Total	**2,158**	**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	208	80.93%	74.69%
Rural	44	17.12%	23.64%
Unknown	5	1.95%	1.67%
Total	**257**	**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%	80.85%
Rural	5	18.52%	19.15%
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
99	69	69.70%

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