QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Contract Year 4

(January 1 - December 31, 2022)

Region 4

AL – FL – GA – KY – MS – NC – SC – TN

Quality Improvement Organizations

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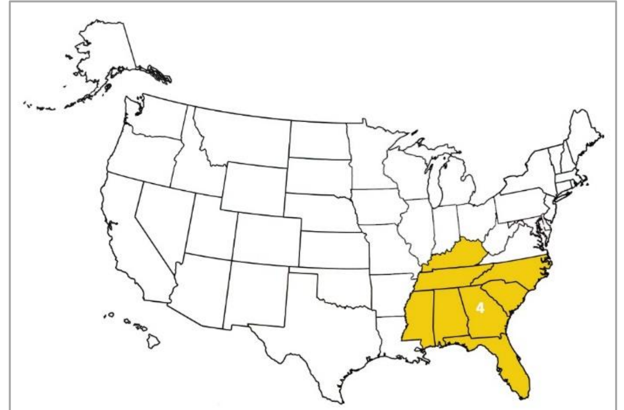
INTRODUCTION:



Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 4, which covers Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. The QIO program is an integral part of the U.S. Department of Health and Human Services National Quality Strategy and CMS Quality Strategy. Within this report, you will find data that reflects the work completed by Kepro during the fourth 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, necessary, and 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 that 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 BODY:

1) TOTAL NUMBER OF REVIEWS

The data below reflects the total number of medical record reviews completed for Region 4.

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 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 when a request is made for an 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 the patient requests it, an appropriate transfer should be implemented.

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	640	0.81%
Quality of Care Review (All Other Selection Reasons)	728	0.93%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	53	0.07%
Notice of Non-coverage (BIPA)	5,512	7.02%
Notice of Non-coverage (Grijalva)	56,992	72.56%
Notice of Non-coverage (Weichardt)	14,081	17.93%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	214	0.27%
EMTALA 5-Day	249	0.32%
EMTALA 60-Day	77	0.10%
Total	**78,546**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	119,065	26.21%
2. U071 – COVID-19	73,002	16.07%
3. N179 – Acute Kidney Failure, Unspecified	41,153	9.06%
4. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	39,581	8.71%
5. I110 – Hypertensive Heart Disease with Heart Failure	39,374	8.67%
6. J189 – Pneumonia, Unspecified Organism	36,861	8.11%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
7. N390 – Urinary Tract Infection, Site Not Specified	30,051	6.62%
8. I214 – Non-ST Elevation Myocardial Infarction	29,747	6.55%
9. A4189 – Other Specified Sepsis	22,790	5.02%
10. I480 – Paroxysmal Atrial Fibrillation	22,643	4.98%
Total	**454,267**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	622	17.38%
1: Distinct Psychiatric Facility	39	1.09%
2: Distinct Rehabilitation Facility	87	2.43%
3: Distinct Skilled Nursing Facility	2,247	62.78%
5: Clinic	5	0.14%
6: Distinct Dialysis Center Facility	3	0.08%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	6	0.17%
9: Provider Based Rural Health Clinic (RHC)	7	0.20%
C: Freestanding Ambulatory Surgery Center	10	0.28%
G: End-Stage Renal Disease Unit	7	0.20%
H: Home Health Agency	184	5.14%
N: Critical Access Hospital	74	2.07%
O: Setting does not fit into any other existing setting code	11	0.31%
Q: Long-Term Care Facility	71	1.98%
R: Hospice	187	5.22%
S: Psychiatric Unit of an Inpatient Facility	4	0.11%
T: Rehabilitation Unit of an Inpatient Facility	5	0.14%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.03%
Y: Federally Qualified Health Centers	9	0.25%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**3,579**	**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 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 Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that 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 retains them and works directly with the healthcare provider and/or practitioner.

4A. 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	15	5	33.33%
C02: Apparently did not make appropriate diagnoses and/or assessments	234	89	38.03%
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)]	1,069	166	15.53%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	593	172	29.01%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	49	11	22.45%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	32	15	46.88%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	47	31	65.96%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	51	6	11.76%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	8	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	73	26	35.62%
C11: Apparently did not demonstrate that the patient was ready for discharge	105	24	22.86%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	13	1	7.69%
C14: Apparently specialty consultation process was not completed in a timely manner	7	1	14.29%
C15: Apparently did not effectively coordinate across disciplines	10	3	30.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	134	62	46.27%
C17: Apparently did not order/follow evidence-based practices	16	7	43.75%
C18: Apparently did not provide medical record documentation that impacts patient care	74	66	89.19%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	201	26	12.94%
Total	**2,732**	**711**	**26.02%**

4B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns that 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**
505	71.03%
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 opioid management	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	9
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner determining medical necessity of procedures/surgery	14
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	112
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	35
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	23
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	37
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering necessary laboratory and imaging tests	9
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering of/coordination with/completion of practitioner specialty consultation	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	5

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**
505	71.03%
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 test/procedure/surgery technique	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner use of evidence-based practices	3
Practitioner-Patient Care by Practitioner – Improvement needed to prevent practitioner treatment delays	6
Provider-Clinical Topics – Improvement needed in evidence-based practices for heart failure	6
Provider-Continuity of Care – Improvement needed in case management/discharge planning	18
Provider-Continuity of Care – Improvement needed in coordination across disciplines	3
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	9
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	23
Provider-Continuity of Care – Improvement needed in other continuity of care area	6
Provider-Continuity of Care – Improvement needed in practitioner specialty consultant assessment completion/reporting	2
Provider-Continuity of Care – Improvement needed in staff assessment completion/reporting	2
Provider-Other Administrative – Improvement needed in other administrative area	1
Provider-Patient Care by Staff – Improvement needed in other patient care by staff area	8
Provider-Patient Care by Staff – Improvement needed in staff assessments	3
Provider-Patient Care by Staff – Improvement needed in staff care planning	16
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	14
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	15
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	18
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	7
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	11

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**
505	71.03%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Patient Rights – Improvement needed in other patient rights area	18
Provider-Safety of the Environment in Patient Care – Improvement needed in other safety of the environment in patient care area	5
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of complications due to equipment unavailability/failure/misuse/unmaintained	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	18
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of elopement/suicide	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	9
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	22
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of other adverse events leading to death or permanent loss of function	2
Provider-Staff and Medical Staff – Improvement needed in ensuring competence/continuing education of provider staff	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 4. 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.

*Note: Data contained in this table represent discharge/service termination reviews from **January 1, 2022** to **December 31, 2022**.*

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self-care (routine discharge)	314	21.46%
02: Discharged/transferred to another short-term general hospital for inpatient care	14	0.96%
03: Discharged/transferred to skilled nursing facility (SNF)	520	35.54%
04: Discharged/transferred to intermediate care facility (ICF)	16	1.09%
05: Discharged/transferred to another type of institution (including distinct parts)	0	0.00%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
06: Discharged/transferred to home under care of organized home health service organization	459	31.37%
07: Left against medical advice or discontinued care	3	0.21%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	9	0.62%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	1	0.07%
40: Expired at home (Hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or freestanding 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	24	1.64%
51: Hospice - medical facility	21	1.44%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	3	0.21%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	61	4.17%
63: Discharged/transferred to a long-term care hospital	9	0.62%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	3	0.21%
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	3	0.21%
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	2	0.14%
Other	1	0.07%
Total	**1,463**	**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)	53	37.74%	62.26%

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	214	33.64%	66.36%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	56,860	44.41%	55.59%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	5,509	33.29%	66.71%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	7,318	8.23%	91.77%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	6,745	6.60%	93.40%
Total	**76,699**	**36.80%**	**63.20%**

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 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)	CMS' guidelines for the management of patients with Community Acquired Pneumonia 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®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
			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)	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®	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)	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' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	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 and serious medical errors.
		UpToDate®	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

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
			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 and 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,

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
			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 and 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 and 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 and 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 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 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	2,927	89.81%
Rural	331	10.16%
Unknown	1	0.03%
Total	**3,259**	**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	410	94.04%
Rural	26	5.96%
Unknown	0	0.00%
Total	**436**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro has formed strong relationships with the vice president of the Association for Home & Hospice Care of North Carolina as well as the South Carolina Home Care & Hospice Association. The groups partner to offer home health, hospice, palliative care, and personal care services to 130-plus member hospitals, health systems, and affiliated post-acute providers. These stakeholders regularly share updates from Kepro, including a bimonthly webinar invitation, with their hospice community via their newsletter. A Kepro outreach specialist regularly speaks with the vice president to discuss issues within the hospice community and any Kepro updates.

Kepro has also cultivated strong relationships with South Carolina's State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP), which are part of its Department on Aging. Kepro has presented at several of their quarterly coordinator's meetings, which are held for all state coordinators and volunteer counselors. SHIP and SMP have appeared on two episodes – on open enrollment and Medicare Advantage plans – for Kepro's "Aging Health Matters" podcast. SHIP and SMP also conducted several outreach sessions last year, reaching approximately 80,000 and 50,000 beneficiaries, respectively.

10) Immediate Advocacy Cases

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 it before proceeding.

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
4,267	4,001	93.77%

11) Example/Success Story

The beneficiary's mother/representative stated the physician informed her that: the beneficiary's urine was dark and appeared to have feces in it; the catheter did not look right; imaging needed to be done; and intravenous antibiotics should be started. She stated imaging was not done and antibiotics not started before the facility discharged the beneficiary in an unsafe manner. She added the physician signed the beneficiary into hospice services without her consent and when she questioned this, she was told, "People do it all the time."

The customer representative reviewed the concerns with Kepro's Quality department. The department stated it would investigate the concerns, reach out to the beneficiary's care team and clinicians, and follow up with the beneficiary's mother and customer representative.

The customer representative called the beneficiary's representative to follow up. She stated she talked with the Quality department and was satisfied with the outcome.

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	192,545
Total Number of Calls Answered	184,877
Total Number of Abandoned Calls	6,637
Average Length of Call Wait Times	00:01:18
Number of Calls Transferred by 1-800-Medicare	256

Conclusion:

Kepro's outcomes and findings for Contract Year 4 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. The Public Health Emergency continued to present unique challenges throughout the year, but Kepro was able to adapt to the circumstances and assist Medicare beneficiaries, their families, and healthcare providers and practitioners.

APPENDIX

KEPRO BFCC-QIO REGION 4 – STATE OF ALABAMA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	32	0.72%
Quality of Care Review (All Other Selection Reasons)	50	1.13%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	178	4.03%
Notice of Non-coverage (Grijalva)	3,509	79.37%
Notice of Non-coverage (Weichardt)	619	14.00%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	6	0.14%
EMTALA 5-Day	9	0.20%
EMTALA 60-Day	18	0.41%
Total	**4,421**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	6,305	22.36%
2. U071 – COVID-19	5,101	18.09%
3. J189 – Pneumonia, Unspecified Organism	2,655	9.42%
4. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	2,419	8.58%
5. I110 – Hypertensive Heart Disease with Heart Failure	2,413	8.56%
6. N179 – Acute Kidney Failure, Unspecified	2,354	8.35%
7. N390 – Urinary Tract Infection, Site Not Specified	2,299	8.15%
8. I214 – Non-ST Elevation Myocardial Infarction	1,867	6.62%
9. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	1,413	5.01%
10. I480 – Paroxysmal Atrial Fibrillation	1,368	4.85%
Total	**28,194**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,360	63.58%
Male	1,352	36.42%
Unknown	0	0.00%
Total	**3,712**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	7	0.19%
Black	1,136	30.60%
Hispanic	10	0.27%
North American Native	1	0.03%
Other	8	0.22%
Unknown	22	0.59%
White	2,528	68.10%
Total	**3,712**	**100.00%**
Age		
Under 65	484	13.04%
65-70	643	17.32%
71-80	1,353	36.45%
81-90	975	26.27%
91+	257	6.92%
Total	**3,712**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	49	17.38%
1: Distinct Psychiatric Facility	2	0.71%
2: Distinct Rehabilitation Facility	8	2.84%
3: Distinct Skilled Nursing Facility	180	63.83%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	2	0.71%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	1	0.35%
9: Provider Based Rural Health Clinic (RHC)	1	0.35%
C: Freestanding Ambulatory Surgery Center	1	0.35%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	13	4.61%
N: Critical Access Hospital	3	1.06%
O: Setting does not fit into any other existing setting code	1	0.35%
Q: Long-Term Care Facility	5	1.77%
R: Hospice	15	5.32%
S: Psychiatric Unit of an Inpatient Facility	1	0.35%
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	**282**	**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 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 Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that 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 retains them and works directly with the healthcare provider and/or practitioner.

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	9	1	11.11%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	60	7	11.67%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	5	1	20.00%
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	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	12	11	91.67%
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	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	3	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	2	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%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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)	7	3	42.86%
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	15	14	93.33%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	13	0	0.00%
Total	**132**	**37**	**28.03%**

5B. 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**
31	83.78%
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 determining medical necessity of procedures/surgery	12
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering necessary laboratory and imaging tests	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner test/procedure/surgery technique	2
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	3
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of elopement/suicide	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)	6	0.14%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	3,505	81.36%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	178	4.13%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	335	7.78%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	284	6.59%
Total	4,308	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	230	87.45%	89.81%
Rural	33	12.55%	10.16%
Unknown	0	0.00%	0.03%
Total	**263**	**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	25	100.00%	94.04%
Rural	0	0.00%	5.96%
Unknown	0	0.00%	0.00%
Total	**25**	**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
121	109	90.08%

KEPRO BFCC-QIO REGION 4 – STATE OF FLORIDA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	260	0.99%
Quality of Care Review (All Other Selection Reasons)	332	1.27%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.00%
Notice of Non-coverage (BIPA)	2,362	9.03%
Notice of Non-coverage (Grijalva)	14,926	57.08%
Notice of Non-coverage (Weichardt)	8,225	31.45%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	8	0.03%
EMTALA 5-Day	25	0.10%
EMTALA 60-Day	11	0.04%
Total	**26,150**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	41,470	26.39%
2. U071 – COVID-19	23,628	15.04%
3. N179 – Acute Kidney Failure, Unspecified	13,948	8.88%
4. I110 – Hypertensive Heart Disease with Heart Failure	13,830	8.80%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	12,954	8.24%
6. N390 – Urinary Tract Infection, Site Not Specified	11,866	7.55%
7. J189 – Pneumonia, Unspecified Organism	11,813	7.52%
8. I214 – Non-ST Elevation Myocardial Infarction	10,555	6.72%
9. I480 – Paroxysmal Atrial Fibrillation	8,730	5.56%
10. A4189 – Other Specified Sepsis	8,320	5.30%
Total	**157,114**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	14,506	59.86%
Male	9,728	40.14%
Unknown	0	0.00%
Total	**24,234**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	176	0.73%
Black	3,093	12.76%
Hispanic	800	3.30%
North American Native	36	0.15%
Other	242	1.00%
Unknown	312	1.29%
White	19,575	80.77%
Total	**24,234**	**100.00%**
Age		
Under 65	2,765	11.41%
65-70	3,461	14.28%
71-80	7,677	31.68%
81-90	7,635	31.51%
91+	2,696	11.12%
Total	**24,234**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	188	18.29%
1: Distinct Psychiatric Facility	14	1.36%
2: Distinct Rehabilitation Facility	36	3.50%
3: Distinct Skilled Nursing Facility	644	62.65%
5: Clinic	4	0.39%
6: Distinct Dialysis Center Facility	1	0.10%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	1	0.10%
9: Provider Based Rural Health Clinic (RHC)	1	0.10%
C: Freestanding Ambulatory Surgery Center	5	0.49%
G: End-Stage Renal Disease Unit	4	0.39%
H: Home Health Agency	56	5.45%
N: Critical Access Hospital	5	0.49%
O: Setting does not fit into any other existing setting code	6	0.58%
Q: Long-Term Care Facility	21	2.04%
R: Hospice	40	3.89%
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	1	0.10%
Y: Federally Qualified Health Centers	1	0.10%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**1,028**	**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 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 Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that 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 retains them and works directly with the healthcare provider and/or practitioner.

5A. 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	9	2	22.22%
C02: Apparently did not make appropriate diagnoses and/or assessments	105	45	42.86%
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)])	463	82	17.71%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	282	109	38.65%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	19	3	15.79%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	18	12	66.67%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	29	20	68.97%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	19	3	15.79%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	4	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	26	10	38.46%
C11: Apparently did not demonstrate that the patient was ready for discharge	35	9	25.71%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	8	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	4	1	25.00%
C15: Apparently did not effectively coordinate across disciplines	4	2	50.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	48	24	50.00%
C17: Apparently did not order/follow evidence-based practices	8	2	25.00%
C18: Apparently did not provide medical record documentation that impacts patient care	40	38	95.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	90	17	18.89%
Total	**1,211**	**379**	**31.30%**

5B. 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**
206	54.35%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner determining medical necessity of procedures/surgery	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	57
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	10
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	13
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	7
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 ordering of/coordination with/completion of practitioner specialty consultation	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	2

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**
206	54.35%
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 to prevent practitioner treatment delays	4
Provider-Continuity of Care – Improvement needed in case management/discharge planning	6
Provider-Continuity of Care – Improvement needed in coordination across disciplines	1
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	8
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	10
Provider-Continuity of Care – Improvement needed in other continuity of care area	4
Provider-Continuity of Care – Improvement needed in practitioner specialty consultant assessment completion/reporting	2
Provider-Patient Care by Staff – Improvement needed in other patient care by staff area	3
Provider-Patient Care by Staff – Improvement needed in staff assessments	2
Provider-Patient Care by Staff – Improvement needed in staff care planning	5
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	9
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	7
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	8
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	4
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	10
Provider-Patient Rights – Improvement needed in other patient rights area	6
Provider-Safety of the Environment in Patient Care – Improvement needed in other safety of the environment in patient care area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	6
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of elopement/suicide	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	5

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**
206	54.35%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	8

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	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	8	0.03%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	14,888	58.44%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	2,362	9.27%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	4,229	16.60%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	3,988	15.65%
Total	**25,476**	**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	878	96.91%	89.81%
Rural	28	3.09%	10.16%
Unknown	0	0.00%	0.03%
Total	**906**	**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	158	99.37%	94.04%
Rural	1	0.63%	5.96%
Unknown	0	0.00%	0.00%
Total	**159**	**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
2,353	2,245	95.41%

KEPRO BFCC-QIO REGION 4 – STATE OF GEORGIA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	123	1.49%
Quality of Care Review (All Other Selection Reasons)	108	1.31%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	16	0.19%
Notice of Non-coverage (BIPA)	497	6.03%
Notice of Non-coverage (Grijalva)	5,407	65.57%
Notice of Non-coverage (Weichardt)	1,854	22.48%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	186	2.26%
EMTALA 5-Day	42	0.51%
EMTALA 60-Day	13	0.16%
Total	**8,246**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	14,300	25.95%
2. U071 – COVID-19	9,208	16.71%
3. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	5,263	9.55%
4. I110 – Hypertensive Heart Disease with Heart Failure	4,954	8.99%
5. N179 – Acute Kidney Failure, Unspecified	4,914	8.92%
6. J189 – Pneumonia, Unspecified Organism	4,285	7.78%
7. I214 – Non-ST Elevation Myocardial Infarction	3,430	6.22%
8. N390 – Urinary Tract Infection, Site Not Specified	3,162	5.74%
9. A4189 – Other Specified Sepsis	2,820	5.12%
10. I480 – Paroxysmal Atrial Fibrillation	2,769	5.02%
Total	**55,105**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	4,296	61.40%
Male	2,701	38.60%
Unknown	0	0.00%
Total	**6,997**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	47	0.67%
Black	2,535	36.23%
Hispanic	32	0.46%
North American Native	5	0.07%
Other	44	0.63%
Unknown	62	0.89%
White	4,272	61.05%
Total	**6,997**	**100.00%**
Age		
Under 65	893	12.76%
65-70	1,148	16.41%
71-80	2,503	35.77%
81-90	1,955	27.94%
91+	498	7.12%
Total	**6,997**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	87	18.83%
1: Distinct Psychiatric Facility	5	1.08%
2: Distinct Rehabilitation Facility	8	1.73%
3: Distinct Skilled Nursing Facility	257	55.63%
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)	2	0.43%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	1	0.22%
H: Home Health Agency	23	4.98%
N: Critical Access Hospital	20	4.33%
O: Setting does not fit into any other existing setting code	1	0.22%
Q: Long-Term Care Facility	13	2.81%
R: Hospice	42	9.09%
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	3	0.65%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**462**	**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 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 Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that 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 retains them and works directly with the healthcare provider and/or practitioner.

5A. 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	28	9	32.14%
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)])	182	16	8.79%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	37	2	5.41%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	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)	11	2	18.18%
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	19	9	47.37%
C11: Apparently did not demonstrate that the patient was ready for discharge	19	4	21.05%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	1	100.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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	1	100.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	26	13	50.00%
C17: Apparently did not order/follow evidence-based practices	2	2	100.00%
C18: Apparently did not provide medical record documentation that impacts patient care	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	23	0	0.00%
Total	**356**	**60**	**16.85%**

5B. 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**
54	90.00%
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 diagnosis and evaluation of patients	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	2
Provider-Clinical Topics – Improvement needed in evidence-based practices for heart failure	4
Provider-Continuity of Care – Improvement needed in case management/discharge planning	4
Provider-Continuity of Care – Improvement needed in coordination across disciplines	2
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	1
Provider-Continuity of Care – Improvement needed in other continuity of care area	1

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**
54	90.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Continuity of Care – Improvement needed in staff assessment completion/reporting	1
Provider-Patient Care by Staff – Improvement needed in other patient care by staff area	4
Provider-Patient Care by Staff – Improvement needed in staff care planning	4
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 other patient rights area	4
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 complications due to equipment unavailability/failure/misuse/unmaintained	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	6
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	3
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of other adverse events leading to death or permanent loss of function	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)	16	0.20%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	186	2.34%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	5,396	67.94%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	496	6.25%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	902	11.36%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	946	11.91%
Total	**7,942**	**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	374	88.00%	89.81%
Rural	51	12.00%	10.16%
Unknown	0	0.00%	0.03%
Total	**425**	**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	54	93.10%	94.04%
Rural	4	6.90%	5.96%
Unknown	0	0.00%	0.00%
Total	**58**	**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
490	448	91.43%

KEPRO BFCC-QIO REGION 4 – STATE OF KENTUCKY

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	36	0.57%
Quality of Care Review (All Other Selection Reasons)	39	0.62%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	32	0.51%
Notice of Non-coverage (BIPA)	405	6.46%
Notice of Non-coverage (Grijalva)	5,403	86.14%
Notice of Non-coverage (Weichardt)	348	5.55%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	3	0.05%
EMTALA 5-Day	6	0.10%
EMTALA 60-Day	0	0.00%
Total	**6,272**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	8,535	25.93%
2. U071 – COVID-19	5,836	17.73%
3. J189 – Pneumonia, Unspecified Organism	3,405	10.34%
4. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	2,849	8.66%
5. N179 – Acute Kidney Failure, Unspecified	2,757	8.38%
6. I110 – Hypertensive Heart Disease with Heart Failure	2,495	7.58%
7. I214 – Non-ST Elevation Myocardial Infarction	2,272	6.90%
8. N390 – Urinary Tract Infection, Site Not Specified	1,812	5.50%
9. R5381 – Other Malaise	1,482	4.50%
10. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	1,474	4.48%
Total	**32,917**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,926	62.84%
Male	1,730	37.16%
Unknown	0	0.00%
Total	**4,656**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	7	0.15%
Black	465	9.99%
Hispanic	3	0.06%
North American Native	4	0.09%
Other	15	0.32%
Unknown	18	0.39%
White	4,144	89.00%
Total	**4,656**	**100.00%**
Age		
Under 65	440	9.45%
65-70	652	14.00%
71-80	1,664	35.74%
81-90	1,435	30.82%
91+	465	9.99%
Total	**4,656**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	51	14.66%
1: Distinct Psychiatric Facility	4	1.15%
2: Distinct Rehabilitation Facility	9	2.59%
3: Distinct Skilled Nursing Facility	239	68.68%
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)	3	0.86%
9: Provider Based Rural Health Clinic (RHC)	2	0.57%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	8	2.30%
N: Critical Access Hospital	17	4.89%
O: Setting does not fit into any other existing setting code	1	0.29%
Q: Long-Term Care Facility	6	1.72%
R: Hospice	7	2.01%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.29%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**348**	**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 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 Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that 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 retains them and works directly with the healthcare provider and/or practitioner.

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	21	6	28.57%
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)])	53	6	11.32%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	50	11	22.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	5	1	20.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	4	1	25.00%
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	6	4	66.67%
C11: Apparently did not demonstrate that the patient was ready for discharge	4	1	25.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	3	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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)	6	3	50.00%
C17: Apparently did not order/follow evidence-based practices	4	2	50.00%
C18: Apparently did not provide medical record documentation that impacts patient care	5	4	80.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	14	0	0.00%
Total	**182**	**39**	**21.43%**

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**
38	97.44%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	14
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 use of evidence-based practices	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	1
Provider-Patient Care by Staff – Improvement needed in staff care planning	5
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	1

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**
38	97.44%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Patient Rights – Improvement needed in other patient rights area	3
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	1

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)	32	0.52%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	3	0.05%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	5,391	87.25%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	405	6.55%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	198	3.20%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	150	2.43%
Total	**6,179**	**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	237	72.92%	89.81%
Rural	88	27.08%	10.16%
Unknown	0	0.00%	0.03%
Total	**325**	**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	24	72.73%	94.04%
Rural	9	27.27%	5.96%
Unknown	0	0.00%	0.00%
Total	**33**	**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
146	134	91.78%

KEPRO BFCC-QIO REGION 4 – STATE OF MISSISSIPPI

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	24	1.65%
Quality of Care Review (All Other Selection Reasons)	28	1.93%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	91	6.27%
Notice of Non-coverage (Grijalva)	1,028	70.85%
Notice of Non-coverage (Weichardt)	259	17.85%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	12	0.83%
EMTALA 60-Day	9	0.62%
Total	**1,451**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	11,387	28.39%
2. U071 – COVID-19	5,755	14.35%
3. N179 – Acute Kidney Failure, Unspecified	3,945	9.83%
4. J189 – Pneumonia, Unspecified Organism	3,520	8.77%
5. I110 – Hypertensive Heart Disease with Heart Failure	3,212	8.01%
6. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	3,090	7.70%
7. N390 – Urinary Tract Infection, Site Not Specified	2,742	6.84%
8. A4189 – Other Specified Sepsis	2,552	6.36%
9. I214 – Non-ST Elevation Myocardial Infarction	2,322	5.79%
10. I639 – Cerebral Infarction, Unspecified	1,590	3.96%
Total	**40,115**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	716	59.27%
Male	492	40.73%
Unknown	0	0.00%
Total	**1,208**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	2	0.17%
Black	521	43.13%
Hispanic	2	0.17%
North American Native	1	0.08%
Other	7	0.58%
Unknown	4	0.33%
White	671	55.55%
Total	**1,208**	**100.00%**
Age		
Under 65	219	18.13%
65-70	221	18.29%
71-80	411	34.02%
81-90	288	23.84%
91+	69	5.71%
Total	**1,208**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	35	20.83%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	2	1.19%
3: Distinct Skilled Nursing Facility	90	53.57%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	1	0.60%
C: Freestanding Ambulatory Surgery Center	1	0.60%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	3	1.79%
N: Critical Access Hospital	12	7.14%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	1.19%
R: Hospice	21	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	1	0.60%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**168**	**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 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 Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that 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 retains them and works directly with the healthcare provider and/or practitioner.

5A. 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	10	5	50.00%
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)])	40	5	12.50%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	29	3	10.34%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	5	5	100.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	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	3	1	33.33%
C11: Apparently did not demonstrate that the patient was ready for discharge	8	2	25.00%
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%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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)	6	3	50.00%
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	2	2	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	15	0	0.00%
Total	**122**	**27**	**22.13%**

5B. 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**
23	85.19%
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 diagnosis and evaluation of patients	5
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	5
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	5
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	1

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**
23	85.19%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	1

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	1,023	74.51%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	91	6.63%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	168	12.24%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	91	6.63%
Total	**1,373**	**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	128	86.49%	89.81%
Rural	20	13.51%	10.16%
Unknown	0	0.00%	0.03%
Total	**148**	**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	95.65%	94.04%
Rural	1	4.35%	5.96%
Unknown	0	0.00%	0.00%
Total	**23**	**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
61	52	85.25%

KEPRO BFCC-QIO REGION 4 – STATE OF NORTH CAROLINA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	70	0.42%
Quality of Care Review (All Other Selection Reasons)	76	0.45%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.01%
Notice of Non-coverage (BIPA)	1,076	6.41%
Notice of Non-coverage (Grijalva)	14,198	84.58%
Notice of Non-coverage (Weichardt)	1,255	7.48%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	9	0.05%
EMTALA 5-Day	91	0.54%
EMTALA 60-Day	10	0.06%
Total	**16,787**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	12,948	24.57%
2. U071 – COVID-19	9,533	18.09%
3. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	5,208	9.88%
4. N179 – Acute Kidney Failure, Unspecified	4,582	8.70%
5. I110 – Hypertensive Heart Disease with Heart Failure	4,556	8.65%
6. J189 – Pneumonia, Unspecified Organism	4,178	7.93%
7. I214 – Non-ST Elevation Myocardial Infarction	3,562	6.76%
8. N390 – Urinary Tract Infection, Site Not Specified	3,230	6.13%
9. A4189 – Other Specified Sepsis	2,505	4.75%
10. I480 – Paroxysmal Atrial Fibrillation	2,387	4.53%
Total	**52,689**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	7,689	62.70%
Male	4,574	37.30%
Unknown	0	0.00%
Total	**12,263**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	34	0.28%
Black	3,163	25.79%
Hispanic	33	0.27%
North American Native	24	0.20%
Other	75	0.61%
Unknown	84	0.68%
White	8,850	72.17%
Total	**12,263**	**100.00%**
Age		
Under 65	1,295	10.56%
65-70	1,798	14.66%
71-80	4,182	34.10%
81-90	3,855	31.44%
91+	1,133	9.24%
Total	**12,263**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	84	14.56%
1: Distinct Psychiatric Facility	2	0.35%
2: Distinct Rehabilitation Facility	4	0.69%
3: Distinct Skilled Nursing Facility	395	68.46%
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: Freestanding Ambulatory Surgery Center	1	0.17%
G: End-Stage Renal Disease Unit	1	0.17%
H: Home Health Agency	36	6.24%
N: Critical Access Hospital	11	1.91%
O: Setting does not fit into any other existing setting code	2	0.35%
Q: Long-Term Care Facility	9	1.56%
R: Hospice	25	4.33%
S: Psychiatric Unit of an Inpatient Facility	1	0.17%
T: Rehabilitation Unit of an Inpatient Facility	5	0.87%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.17%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**577**	**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 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 Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that 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 retains them and works directly with the healthcare provider and/or practitioner.

5A. 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	3	2	66.67%
C02: Apparently did not make appropriate diagnoses and/or assessments	16	6	37.50%
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)])	107	26	24.30%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	60	25	41.67%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	8	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	2	66.67%
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)	6	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	8	1	12.50%
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	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	1	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)	23	8	34.78%
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	6	5	83.33%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	23	4	17.39%
Total	**279**	**81**	**29.03%**

5B. 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**
72	88.89%
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 opioid management	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	24
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	5
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering necessary laboratory and imaging tests	8
Practitioner-Patient Care by Practitioner – Improvement needed to prevent practitioner treatment delays	2
Provider-Continuity of Care – Improvement needed in case management/discharge planning	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	4
Provider-Continuity of Care – Improvement needed in other continuity of care area	1

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**
72	88.89%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Other Administrative – Improvement needed in other administrative 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 assessments	1
Provider-Patient Care by Staff – Improvement needed in staff care planning	2
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	3
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	3
Provider-Patient Rights – Improvement needed in other patient rights area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in other safety of the environment in patient care area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	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)	2	0.01%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	9	0.05%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	14,158	85.82%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	1,076	6.52%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	631	3.82%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	621	3.76%
Total	**16,497**	**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	492	90.94%	89.81%
Rural	48	8.87%	10.16%
Unknown	1	0.18%	0.03%
Total	**541**	**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	65	94.20%	94.04%
Rural	4	5.80%	5.96%
Unknown	0	0.00%	0.00%
Total	**69**	**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
432	403	93.29%

KEPRO BFCC-QIO REGION 4 – STATE OF SOUTH CAROLINA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	28	0.57%
Quality of Care Review (All Other Selection Reasons)	20	0.41%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.02%
Notice of Non-coverage (BIPA)	338	6.91%
Notice of Non-coverage (Grijalva)	3,839	78.54%
Notice of Non-coverage (Weichardt)	661	13.52%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	1	0.02%
EMTALA 60-Day	0	0.00%
Total	**4,888**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	8,227	24.96%
2. U071 – COVID-19	5,568	16.89%
3. N179 – Acute Kidney Failure, Unspecified	3,324	10.08%
4. I110 – Hypertensive Heart Disease with Heart Failure	3,089	9.37%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	2,952	8.96%
6. J189 – Pneumonia, Unspecified Organism	2,433	7.38%
7. I214 – Non-ST Elevation Myocardial Infarction	2,237	6.79%
8. I480 – Paroxysmal Atrial Fibrillation	1,783	5.41%
9. R5381 – Other Malaise	1,719	5.22%
10. N390 – Urinary Tract Infection, Site Not Specified	1,629	4.94%
Total	**32,961**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,498	61.08%
Male	1,592	38.92%
Unknown	0	0.00%
Total	**4,090**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	16	0.39%
Black	1,158	28.31%
Hispanic	13	0.32%
North American Native	2	0.05%
Other	11	0.27%
Unknown	19	0.46%
White	2,871	70.20%
Total	**4,090**	**100.00%**
Age		
Under 65	521	12.74%
65-70	630	15.40%
71-80	1,384	33.84%
81-90	1,239	30.29%
91+	316	7.73%
Total	**4,090**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	48	18.25%
1: Distinct Psychiatric Facility	2	0.76%
2: Distinct Rehabilitation Facility	9	3.42%
3: Distinct Skilled Nursing Facility	158	60.08%
5: Clinic	1	0.38%
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: Freestanding Ambulatory Surgery Center	1	0.38%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	19	7.22%
N: Critical Access Hospital	1	0.38%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	5	1.90%
R: Hospice	16	6.08%
S: Psychiatric Unit of an Inpatient Facility	2	0.76%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.38%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**263**	**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 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 Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that 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 retains them and works directly with the healthcare provider and/or practitioner.

5A. 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	12	2	16.67%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis that 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)])	40	6	15.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	16	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	1	50.00%
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)	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	2	1	50.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	8	2	25.00%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	2	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	3	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	7	2	28.57%
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	13	4	30.77%
Total	**108**	**18**	**16.67%**

5B. 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**
18	100.00%
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 diagnosis and evaluation of patients	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Provider-Clinical Topics – Improvement needed in evidence-based practices for heart failure	2
Provider-Continuity of Care – Improvement needed in case management/discharge planning	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	1
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	1
Provider-Patient Rights – Improvement needed in other patient rights area	2

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**
18	100.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
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)	1	0.02%
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)	3,832	79.34%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	336	6.96%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	419	8.67%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	242	5.01%
Total	**4,830**	**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	230	93.88%	89.81%
Rural	15	6.12%	10.16%
Unknown	0	0.00%	0.03%
Total	**245**	**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	18	75.00%	94.04%
Rural	6	25.00%	5.96%
Unknown	0	0.00%	0.00%
Total	**24**	**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
230	212	92.17%

KEPRO BFCC-QIO REGION 4 – STATE OF TENNESSEE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	67	0.65%
Quality of Care Review (All Other Selection Reasons)	75	0.73%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.01%
Notice of Non-coverage (BIPA)	565	5.47%
Notice of Non-coverage (Grijalva)	8,682	84.04%
Notice of Non-coverage (Weichardt)	860	8.32%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	2	0.02%
EMTALA 5-Day	63	0.61%
EMTALA 60-Day	16	0.15%
Total	**10,331**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	16,196	28.17%
2. U071 – COVID-19	8,480	14.75%
3. N179 – Acute Kidney Failure, Unspecified	5,394	9.38%
4. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	5,064	8.81%
5. I110 – Hypertensive Heart Disease with Heart Failure	4,988	8.67%
6. J189 – Pneumonia, Unspecified Organism	4,616	8.03%
7. I214 – Non-ST Elevation Myocardial Infarction	3,593	6.25%
8. N390 – Urinary Tract Infection, Site Not Specified	3,333	5.80%
9. A4189 – Other Specified Sepsis	2,993	5.21%
10. I480 – Paroxysmal Atrial Fibrillation	2,845	4.95%
Total	**57,502**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	4,962	63.27%
Male	2,881	36.73%
Unknown	0	0.00%
Total	**7,843**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	18	0.23%
Black	1,383	17.63%
Hispanic	17	0.22%
North American Native	7	0.09%
Other	20	0.26%
Unknown	44	0.56%
White	6,354	81.01%
Total	**7,843**	**100.00%**
Age		
Under 65	973	12.41%
65-70	1,173	14.96%
71-80	2,642	33.69%
81-90	2,393	30.51%
91+	662	8.44%
Total	**7,843**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	80	17.74%
1: Distinct Psychiatric Facility	10	2.22%
2: Distinct Rehabilitation Facility	11	2.44%
3: Distinct Skilled Nursing Facility	284	62.97%
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)	1	0.22%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	1	0.22%
G: End-Stage Renal Disease Unit	1	0.22%
H: Home Health Agency	26	5.76%
N: Critical Access Hospital	5	1.11%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	10	2.22%
R: Hospice	21	4.66%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.22%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**451**	**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 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 Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that 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 retains them and works directly with the healthcare provider and/or practitioner.

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	33	15	45.45%
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)]	124	18	14.52%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	114	21	18.42%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	5	1	20.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	2	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	8	1	12.50%
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	6	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	17	4	23.53%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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)	11	6	54.55%
C17: Apparently did not order/follow evidence-based practices	1	1	100.00%
C18: Apparently did not provide medical record documentation that impacts patient care	5	2	40.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	10	1	10.00%
Total	**342**	**70**	**20.47%**

5B. 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**
63	90.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	19
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	13
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner use of evidence-based practices	2
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	4
Provider-Continuity of Care – Improvement needed in staff assessment completion/reporting	1
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	2
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	2

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**
63	90.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	1
Provider-Patient Rights – Improvement needed in other patient rights area	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	7
Provider-Staff and Medical Staff – Improvement needed in ensuring competence/continuing education of provider staff	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	0.01%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	2	0.02%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	8,667	85.86%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	565	5.60%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	436	4.32%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	423	4.19%
Total	**10,094**	**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	358	88.18%	89.81%
Rural	48	11.82%	10.16%
Unknown	0	0.00%	0.03%
Total	**406**	**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	44	97.78%	94.04%
Rural	1	2.22%	5.96%
Unknown	0	0.00%	0.00%
Total	**45**	**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
434	398	91.71%

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