QIO Program
BFCC-QIO 12th SOW

Annual Medical Services Review Report

Contract Year 4
(January 1 - December 31, 2022)

Region 6
AR – LA – NM – OK – TX

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

Kepro™

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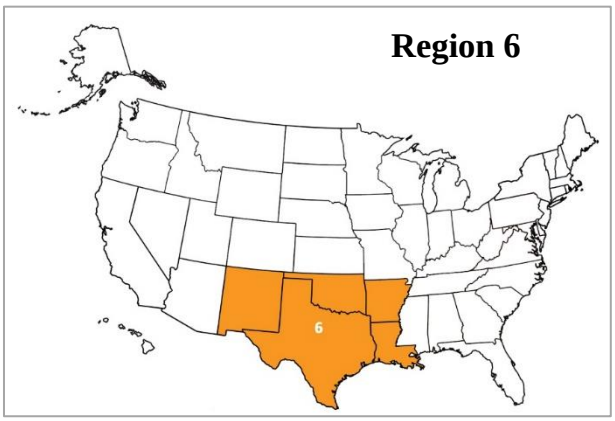
INTRODUCTION:

Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 6, which covers Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. 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, which does not require a medical record review. By providing these services, the rights of Medicare beneficiaries are protected while also protecting the Medicare Trust Fund.

ANNUAL REPORT BODY:

1) TOTAL NUMBER OF REVIEWS

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

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

- Beneficiaries or their appointed representatives who have concerns related to the quality of the 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)	307	0.98%
Quality of Care Review (All Other Selection Reasons)	319	1.01%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	28	0.09%
Notice of Non-coverage (BIPA)	2,723	8.65%
Notice of Non-coverage (Grijalva)	22,655	71.96%
Notice of Non-coverage (Weichardt)	5,347	16.98%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	15	0.05%
EMTALA 5-Day	86	0.27%
EMTALA 60-Day	3	0.01%
Total	**31,483**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	65,379	27.21%
2. U071 – COVID-19	39,883	16.60%
3. N179 – Acute Kidney Failure, Unspecified	22,161	9.22%
4. I110 – Hypertensive Heart Disease with Heart Failure	20,412	8.50%
5. J189 – Pneumonia, Unspecified Organism	19,484	8.11%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
6. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	19,439	8.09%
7. I214 – Non-ST Elevation Myocardial Infarction	16,062	6.68%
8. N390 – Urinary Tract Infection, Site Not Specified	15,388	6.40%
9. A4189 – Other Specified Sepsis	11,733	4.88%
10. I480 – Paroxysmal Atrial Fibrillation	10,329	4.30%
Total	**240,270**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	338	15.66%
1: Distinct Psychiatric Facility	24	1.11%
2: Distinct Rehabilitation Facility	104	4.82%
3: Distinct Skilled Nursing Facility	1,317	61.00%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.05%
7: Dialysis Center Unit of Inpatient Facility	1	0.05%
8: Independent Based Rural Health Clinic (RHC)	1	0.05%
9: Provider Based Rural Health Clinic (RHC)	7	0.32%
C: Freestanding Ambulatory Surgery Center	4	0.19%
G: End-Stage Renal Disease Unit	5	0.23%
H: Home Health Agency	78	3.61%
N: Critical Access Hospital	66	3.06%
O: Setting does not fit into any other existing setting code	6	0.28%
Q: Long-Term Care Facility	83	3.84%
R: Hospice	109	5.05%
S: Psychiatric Unit of an Inpatient Facility	2	0.09%
T: Rehabilitation Unit of an Inpatient Facility	4	0.19%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.05%
Y: Federally Qualified Health Centers	5	0.23%
Z: Swing Bed Designation for Critical Access Hospitals	3	0.14%
Other	0	0.00%
Total	**2,159**	**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 or 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

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

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	12	4	33.33%
C02: Apparently did not make appropriate diagnoses and/or assessments	142	49	34.51%
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)]	494	53	10.73%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	237	81	34.18%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	23	6	26.09%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	15	4	26.67%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	17	2	11.76%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	3	2	66.67%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	48	7	14.58%
C11: Apparently did not demonstrate that the patient was ready for discharge	45	10	22.22%
C12: Apparently did not provide appropriate personnel and/or resources	2	0	0.00%
C13: Apparently did not order appropriate specialty consultation	15	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	2	1	50.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C15: Apparently did not effectively coordinate across disciplines	7	1	14.29%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	55	18	32.73%
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	23	14	60.87%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	96	18	18.75%
Total	**1,247**	**272**	**21.81%**

4B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

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

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QOC Concerns Referred for QII**
233	85.66%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Clinical Topics – Improvement needed in evidence-based practices for SCIP	1
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 determining medical necessity of procedures/surgery	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	38
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	26
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	22
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	29
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	11
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner obtaining patient history and performing physical examination	3

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**
233	85.66%
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 ordering necessary laboratory and imaging tests	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	4
Provider-Clinical Topics – Improvement needed in evidence-based practices for heart failure	3
Provider-Continuity of Care – Improvement needed in capacity planning/management	3
Provider-Continuity of Care – Improvement needed in case management/discharge planning	7
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	6
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	14
Provider-Continuity of Care – Improvement needed in practitioner specialty consultant assessment completion/reporting	1
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	1
Provider-Patient Care by Staff – Improvement needed in staff assessments	9
Provider-Patient Care by Staff – Improvement needed in staff care planning	1
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	1
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	3
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	9
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	4

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**
233	85.66%
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 decubiti or worsening of existing decubiti	3
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	3
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of hospital acquired infections	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of other operative and postoperative complications	1
Provider-Staff and Medical Staff – Improvement needed in ensuring competence/continuing education of provider staff	1
Provider-Staff and Medical Staff – Improvement needed in other staff and medical staff area	2

5) DISCHARGE/SERVICE TERMINATIONS

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

*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)	155	29.47%
02: Discharged/transferred to another short-term general hospital for inpatient care	12	2.28%
03: Discharged/transferred to skilled nursing facility (SNF)	154	29.28%
04: Discharged/transferred to intermediate care facility (ICF)	5	0.95%
05: Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06: Discharged/transferred to home under care of organized home health service organization	160	30.42%
07: Left against medical advice or discontinued care	1	0.19%
09: Admitted as an inpatient to this hospital	0	0.00%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
20: Expired (or did not recover – Christian Science patient)	2	0.38%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	0	0.00%
40: Expired at home (hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or 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	6	1.14%
51: Hospice – medical facility	8	1.52%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	0	0.00%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	17	3.23%
63: Discharged/transferred to a long-term care hospital	4	0.76%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66: Discharged/transferred to a critical access hospital	1	0.19%
70: Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%
Other	1	0.19%
Total	**526**	**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)	28	57.14%	42.86%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	15	26.67%	73.33%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	22,594	39.08%	60.92%

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	2,718	37.49%	62.51%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	3,117	13.89%	86.11%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	2,225	9.35%	90.65%
Total	**30,697**	**34.23%**	**65.77%**

7) Evidence Used in Decision-Making

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

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

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	CMS' Pneumonia indicators (PN 2-7)	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 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.
	Heart Failure	American College of Cardiology (ACC); CMS' Heart Failure indicators (HF 1-3) UpToDate®	ACC's guidelines for the management of patients with heart failure address aspects of care that, when followed, are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Pressure Ulcers	AHRQ website; Wound, Ostomy & Continence Nursing website (www.WOCN.org) CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure) UpToDate®	The Agency for Healthcare Research and Quality (AHRQ) remains an excellent online resource for the identification of standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers. CMS' Patient Safety Indicators (PSI) are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events 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.
	Acute Myocardial Infarction	American College of Cardiology (ACC) Acute Myocardial	ACC's guidelines for the management of patients with acute myocardial infarction address aspects of care that, when

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
		Infarction Guidelines; CMS' Acute Myocardial Infarction indicators (AMI 2-10)	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.
	Urinary Tract Infection	HAI-CAUTI (f/k/a HAC-7)	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®	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)	IHI developed sepsis indicators and guidelines for the identification and treatment of sepsis. Adherence to such guidelines has 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

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
			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 (HSPs) associated with a completed BFCC-QIO review.

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

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	1,525	79.02%
Rural	405	20.98%
Unknown	0	0.00%
Total	**1,930**	**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	184	82.51%
Rural	39	17.49%
Unknown	0	0.00%
Total	**223**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

One rural health group receiving information via training by Kepro is Indian Health Services (IHS), which serves tribal communities in New Mexico, Oklahoma, and Texas. Kepro presented during the annual training of IHS workers offered by the Region 6 office of the Centers for Medicare & Medicaid Services. Kepro shared information about the services available to the roughly 5.5 million Medicare beneficiaries in the three states. Overall, 195 IHS workers received training they can share with co-workers and tribal members.

10) Immediate Advocacy Cases

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

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

During Contract Year 4, Kepro continues to highly encourage Medicare beneficiaries and/or family members to take advantage of Immediate Advocacy benefits. As a result, a high percentage of beneficiary-initiated quality of care complaints are being resolved through its use.

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
1,531	1,414	92.36%

11) Example/Success Story

The beneficiary's daughter stated she won a discharge appeal by default because Kepro did not receive the medical records in time. She added the facility did not receive a records request because Kepro sent it to the wrong fax number and the notes in the case summary were not read. She stated the beneficiary had made very little progress and now needed acute rehabilitation to regain the ability to walk. She also stated a physician had not examined the beneficiary and she was not satisfied with the old equipment being used or overall medical care. In addition, Humana provided inaccurate information about rehabilitation facilities and the coordinator of the desired facility told her Humana was not in-network.

The customer representative set up a three-way call with the facility's case manager and went over the concerns. The case manager stated the provider will follow up with the beneficiary's daughter to address the concerns, and she agreed to a conference with the case manager, rehabilitation coordinator, and Humana about the authorization issue. The case manager also will issue another Notice of Medicare Non-Coverage with a new last covered day, allowing for 48 hours' notice to file a discharge appeal. Finally, the case manager will have the therapy department follow up with the beneficiary's daughter about the concern regarding old equipment.

The customer representative called to follow up with the beneficiary's daughter, who stated she was very satisfied with the outcome.

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	75,959
Total Number of Calls Answered	72,698
Total Number of Abandoned Calls	2,855
Average Length of Call Wait Times	00:01:34
Number of Calls Transferred by 1-800-Medicare	131

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 individuals' 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 6 – STATE OF ARKANSAS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	23	1.66%
Quality of Care Review (All Other Selection Reasons)	23	1.66%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.07%
Notice of Non-coverage (BIPA)	56	4.03%
Notice of Non-coverage (Grijalva)	1,014	73.00%
Notice of Non-coverage (Weichardt)	269	19.37%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	3	0.22%
EMTALA 60-Day	0	0.00%
Total	**1,389**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	6,883	24.38%
2. U071 – COVID-19	4,577	16.21%
3. N179 – Acute Kidney Failure, Unspecified	2,865	10.15%
4. J189 – Pneumonia, Unspecified Organism	2,691	9.53%
5. I110 – Hypertensive Heart Disease with Heart Failure	2,424	8.58%
6. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	2,120	7.51%
7. I214 – Non-ST Elevation Myocardial Infarction	2,064	7.31%
8. N390 – Urinary Tract Infection, Site Not Specified	1,811	6.41%
9. I480 – Paroxysmal Atrial Fibrillation	1,612	5.71%
10. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	1,190	4.21%
Total	**28,237**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	771	60.05%
Male	513	39.95%
Unknown	0	0.00%
Total	**1,284**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	4	0.31%
Black	299	23.29%
Hispanic	3	0.23%
North American Native	8	0.62%
Other	3	0.23%
Unknown	8	0.62%
White	959	74.69%
Total	**1,284**	**100.00%**
Age		
Under 65	271	21.11%
65-70	240	18.69%
71-80	381	29.67%
81-90	322	25.08%
91+	70	5.45%
Total	**1,284**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	27	15.34%
1: Distinct Psychiatric Facility	2	1.14%
2: Distinct Rehabilitation Facility	8	4.55%
3: Distinct Skilled Nursing Facility	104	59.09%
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	0.57%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	8	4.55%
N: Critical Access Hospital	8	4.55%
O: Setting does not fit into any other existing setting code	1	0.57%
Q: Long-Term Care Facility	5	2.84%
R: Hospice	10	5.68%
S: Psychiatric Unit of an Inpatient Facility	1	0.57%
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	0.57%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%

Setting	Number of Providers	Percent of Providers
Other	0	0.00%
Total	**176**	**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.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	4	2	50.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	6	3	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	8	20.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	8	2	25.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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	2	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	5	2	40.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	4	1	25.00%
C17: Apparently did not order/follow evidence-based practices	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	4	1	25.00%
Total	**79**	**21**	**26.58%**

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	85.71%
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	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner obtaining patient history and performing physical examination	2
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	5
Provider-Continuity of Care – Improvement needed in staff assessment completion/reporting	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**
18	85.71%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	4
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)	1	0.07%
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)	1,011	75.67%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	56	4.19%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	202	15.12%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	66	4.94%
Total	**1,336**	**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	120	83.92%	79.02%
Rural	23	16.08%	20.98%
Unknown	0	0.00%	0.00%
Total	**143**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	17	85.00%	82.51%
Rural	3	15.00%	17.49%
Unknown	0	0.00%	0.00%
Total	**20**	**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
87	77	88.51%

KEPRO BFCC-QIO REGION 6 – STATE OF LOUISIANA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	40	2.02%
Quality of Care Review (All Other Selection Reasons)	37	1.87%
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)	78	3.94%
Notice of Non-coverage (Grijalva)	1,452	73.37%
Notice of Non-coverage (Weichardt)	357	18.04%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	3	0.15%
EMTALA 5-Day	10	0.51%
EMTALA 60-Day	2	0.10%
Total	**1,979**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	7,908	25.86%
2. U071 – COVID-19	4,837	15.82%
3. N179 – Acute Kidney Failure, Unspecified	2,994	9.79%
4. I110 – Hypertensive Heart Disease with Heart Failure	2,808	9.18%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	2,611	8.54%
6. J189 – Pneumonia, Unspecified Organism	2,508	8.20%
7. N390 – Urinary Tract Infection, Site Not Specified	2,374	7.76%
8. I214 – Non-ST Elevation Myocardial Infarction	2,036	6.66%
9. R5381 – Other Malaise	1,272	4.16%
10. J9601 – Acute Respiratory Failure with Hypoxia	1,230	4.02%
Total	**30,578**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,117	63.57%
Male	640	36.43%
Unknown	0	0.00%
Total	**1,757**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	4	0.23%
Black	577	32.84%
Hispanic	19	1.08%
North American Native	4	0.23%
Other	9	0.51%
Unknown	15	0.85%
White	1,129	64.26%
Total	**1,757**	**100.00%**
Age		
Under 65	224	12.75%
65-70	271	15.42%
71-80	602	34.26%
81-90	491	27.95%
91+	169	9.62%
Total	**1,757**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	47	17.80%
1: Distinct Psychiatric Facility	5	1.89%
2: Distinct Rehabilitation Facility	14	5.30%
3: Distinct Skilled Nursing Facility	151	57.20%
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	0.38%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	1	0.38%
H: Home Health Agency	3	1.14%
N: Critical Access Hospital	10	3.79%
O: Setting does not fit into any other existing setting code	1	0.38%
Q: Long-Term Care Facility	13	4.92%
R: Hospice	17	6.44%
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	0.38%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**264**	**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.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	2	1	50.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	26	11	42.31%
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	4	7.55%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	53	15	28.30%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	1	33.33%
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	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	5	2	40.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	9	2	22.22%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	2	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)	11	1	9.09%
C17: Apparently did not order/follow evidence-based practices	5	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	1	1	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	13	1	7.69%
Total	**189**	**40**	**21.16%**

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**
34	85.00%
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	10
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	2
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	9
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	4
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	2
Provider-Patient Care by Staff – Improvement needed in staff care planning	1
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	2
Provider-Staff and Medical Staff – Improvement needed in other staff and medical staff area	2

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	3	0.16%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	1,446	76.79%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	77	4.09%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	188	9.98%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	169	8.98%
Total	**1,883**	**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	0	0.00%	79.02%
Rural	234	100.00%	20.98%
Unknown	0	0.00%	0.00%
Total	**234**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	0	0.00%	82.51%
Rural	28	100.00%	17.49%
Unknown	0	0.00%	0.00%
Total	**28**	**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
137	123	89.78%

KEPRO BFCC-QIO REGION 6 – STATE OF NEW MEXICO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	21	2.16%
Quality of Care Review (All Other Selection Reasons)	28	2.88%
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)	132	13.57%
Notice of Non-coverage (Grijalva)	617	63.41%
Notice of Non-coverage (Weichardt)	173	17.78%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	2	0.21%
EMTALA 60-Day	0	0.00%
Total	**973**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	2,982	29.50%
2. U071 – COVID-19	2,066	20.44%
3. J189 – Pneumonia, Unspecified Organism	889	8.79%
4. I110 – Hypertensive Heart Disease with Heart Failure	823	8.14%
5. I214 – Non-ST Elevation Myocardial Infarction	724	7.16%
6. A4189 – Other Specified Sepsis	608	6.01%
7. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	583	5.77%
8. N179 – Acute Kidney Failure, Unspecified	557	5.51%
9. N390 – Urinary Tract Infection, Site Not Specified	464	4.59%
10. J9601 – Acute Respiratory Failure with Hypoxia	414	4.09%
Total	**10,110**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	535	55.67%
Male	426	44.33%
Unknown	0	0.00%
Total	**961**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	2	0.21%
Black	32	3.33%
Hispanic	58	6.04%
North American Native	38	3.95%
Other	18	1.87%
Unknown	9	0.94%
White	804	83.66%
Total	**961**	**100.00%**
Age		
Under 65	119	12.38%
65-70	186	19.35%
71-80	309	32.15%
81-90	262	27.26%
91+	85	8.84%
Total	**961**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	20	22.47%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	4	4.49%
3: Distinct Skilled Nursing Facility	47	52.81%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	7	7.87%
N: Critical Access Hospital	2	2.25%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	8	8.99%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	1.12%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**89**	**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 or 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	2	1	50.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	10	7	70.00%
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)])	34	4	11.76%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	35	23	65.71%
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	2	1	50.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	7	1	14.29%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

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)	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	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	12	1	8.33%
Total	**115**	**44**	**38.26%**

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**
41	93.18%
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	16
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	12
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	3
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	2
Provider-Patient Care by Staff – Improvement needed in staff assessments	1
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Safety of the Environment in Patient Care – Improvement needed in other safety of the environment in patient 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**
41	93.18%
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 hospital acquired infections	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	1

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	615	66.85%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	132	14.35%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	79	8.59%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	94	10.22%
Total	**920**	**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	64	84.21%	79.02%
Rural	12	15.79%	20.98%
Unknown	0	0.00%	0.00%
Total	**76**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	8	80.00%	82.51%
Rural	2	20.00%	17.49%
Unknown	0	0.00%	0.00%
Total	**10**	**100.00%**	**100.00%**

8) IMMEDIATE ADVOCACY CASES

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
86	79	91.86%

KEPRO BFCC-QIO REGION 6 – STATE OF OKLAHOMA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	31	1.33%
Quality of Care Review (All Other Selection Reasons)	32	1.37%
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)	179	7.66%
Notice of Non-coverage (Grijalva)	1,923	82.28%
Notice of Non-coverage (Weichardt)	168	7.19%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	4	0.17%
EMTALA 60-Day	0	0.00%
Total	**2,337**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	7,393	23.74%
2. U071 – COVID-19	5,380	17.28%
3. N179 – Acute Kidney Failure, Unspecified	3,278	10.53%
4. J189 – Pneumonia, Unspecified Organism	2,659	8.54%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	2,496	8.01%
6. I110 – Hypertensive Heart Disease with Heart Failure	2,479	7.96%
7. N390 – Urinary Tract Infection, Site Not Specified	2,211	7.10%
8. I214 – Non-ST Elevation Myocardial Infarction	2,025	6.50%
9. A4189 – Other Specified Sepsis	1,639	5.26%
10. J9601 – Acute Respiratory Failure with Hypoxia	1,583	5.08%
Total	**31,143**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,192	61.70%
Male	740	38.30%
Unknown	0	0.00%
Total	**1,932**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	9	0.47%
Black	231	11.96%
Hispanic	18	0.93%
North American Native	107	5.54%
Other	7	0.36%
Unknown	6	0.31%
White	1,554	80.43%
Total	**1,932**	**100.00%**
Age		
Under 65	243	12.58%
65-70	385	19.93%
71-80	640	33.13%
81-90	521	26.97%
91+	143	7.40%
Total	**1,932**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	35	19.23%
1: Distinct Psychiatric Facility	1	0.55%
2: Distinct Rehabilitation Facility	5	2.75%
3: Distinct Skilled Nursing Facility	101	55.49%
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	1.10%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	6	3.30%
N: Critical Access Hospital	15	8.24%
O: Setting does not fit into any other existing setting code	1	0.55%
Q: Long-Term Care Facility	7	3.85%
R: Hospice	9	4.95%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**182**	**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	14	4	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))]	35	6	17.14%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	26	12	46.15%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	1	33.33%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	1	33.33%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	2	100.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	1	100.00%
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	5	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%

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	1	100.00%
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)	4	2	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	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	10	4	40.00%
Total	**108**	**35**	**32.41%**

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**
23	65.71%
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 determining medical necessity of procedures/surgery	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	3
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 practitioner specialty consultant assessment completion/reporting	1
Provider-Patient Care by Staff – Improvement needed in staff assessments	1
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	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**
23	65.71%
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	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	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)	1,919	84.69%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	179	7.90%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	120	5.30%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	48	2.12%
Total	**2,266**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	139	87.97%	79.02%
Rural	19	12.03%	20.98%
Unknown	0	0.00%	0.00%
Total	**158**	**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	88.89%	82.51%
Rural	3	11.11%	17.49%
Unknown	0	0.00%	0.00%
Total	**27**	**100.00%**	**100.00%**

8) IMMEDIATE ADVOCACY CASES

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
106	96	90.57%

KEPRO BFCC-QIO REGION 6 – STATE OF TEXAS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	192	0.77%
Quality of Care Review (All Other Selection Reasons)	199	0.80%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	27	0.11%
Notice of Non-coverage (BIPA)	2,278	9.18%
Notice of Non-coverage (Grijalva)	17,649	71.15%
Notice of Non-coverage (Weichardt)	4,380	17.66%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	12	0.05%
EMTALA 5-Day	67	0.27%
EMTALA 60-Day	1	0.00%
Total	**24,805**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	40,327	28.31%
2. U071 – COVID-19	23,084	16.20%
3. N179 – Acute Kidney Failure, Unspecified	12,502	8.78%
4. I110 – Hypertensive Heart Disease with Heart Failure	11,918	8.37%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	11,678	8.20%
6. J189 – Pneumonia, Unspecified Organism	10,763	7.55%
7. I214 – Non-ST Elevation Myocardial Infarction	9,250	6.49%
8. N390 – Urinary Tract Infection, Site Not Specified	8,537	5.99%
9. A4189 – Other Specified Sepsis	7,612	5.34%
10. R5381 – Other Malaise	6,793	4.77%
Total	**142,464**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	12,482	61.26%
Male	7,894	38.74%
Unknown	0	0.00%
Total	**20,376**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	246	1.21%
Black	3,527	17.31%
Hispanic	707	3.47%
North American Native	35	0.17%
Other	233	1.14%
Unknown	156	0.77%
White	15,472	75.93%
Total	**20,376**	**100.00%**
Age		
Under 65	2,237	10.98%
65-70	3,165	15.53%
71-80	7,150	35.09%
81-90	5,985	29.37%
91+	1,839	9.03%
Total	**20,376**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	209	14.43%
1: Distinct Psychiatric Facility	16	1.10%
2: Distinct Rehabilitation Facility	73	5.04%
3: Distinct Skilled Nursing Facility	914	63.12%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.07%
7: Dialysis Center Unit of Inpatient Facility	1	0.07%
8: Independent Based Rural Health Clinic (RHC)	1	0.07%
9: Provider Based Rural Health Clinic (RHC)	3	0.21%
C: Freestanding Ambulatory Surgery Center	4	0.28%
G: End-Stage Renal Disease Unit	4	0.28%
H: Home Health Agency	54	3.73%
N: Critical Access Hospital	31	2.14%
O: Setting does not fit into any other existing setting code	3	0.21%
Q: Long-Term Care Facility	58	4.01%
R: Hospice	65	4.49%
S: Psychiatric Unit of an Inpatient Facility	1	0.07%
T: Rehabilitation Unit of an Inpatient Facility	4	0.28%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.07%
Y: Federally Qualified Health Centers	2	0.14%
Z: Swing Bed Designation for Critical Access Hospitals	3	0.21%
Other	0	0.00%
Total	**1,448**	**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	4	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	86	24	27.91%
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)])	332	31	9.34%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	115	29	25.22%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	16	4	25.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	6	1	16.67%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	12	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	1	100.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	31	3	9.68%
C11: Apparently did not demonstrate that the patient was ready for discharge	26	6	23.08%
C12: Apparently did not provide appropriate personnel and/or resources	2	0	0.00%
C13: Apparently did not order appropriate specialty consultation	11	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	6	1	16.67%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	29	12	41.38%
C17: Apparently did not order/follow evidence-based practices	3	2	66.67%
C18: Apparently did not provide medical record documentation that impacts patient care	15	7	46.67%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	57	11	19.30%
Total	**756**	**132**	**17.46%**

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**
117	88.64%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Clinical Topics – Improvement needed in evidence-based practices for SCIP	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner determining medical necessity of procedures/surgery	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	10
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	18
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	9
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	17
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	7
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner obtaining patient history and performing physical examination	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering necessary laboratory and imaging tests	3

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**
117	88.64%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	3
Provider-Clinical Topics – Improvement needed in evidence-based practices for heart failure	3
Provider-Continuity of Care – Improvement needed in capacity planning/management	3
Provider-Continuity of Care – Improvement needed in case management/discharge planning	3
Provider-Continuity of Care – Improvement needed in coordination across disciplines	1
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	7
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	7
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	1
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	3
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	3
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	3
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	3
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of other operative and postoperative complications	1
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)	27	0.11%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	12	0.05%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	17,603	72.46%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	2,274	9.36%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	2,528	10.41%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	1,848	7.61%
Total	**24,292**	**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	1,202	91.13%	79.02%
Rural	117	8.87%	20.98%
Unknown	0	0.00%	0.00%
Total	**1,319**	**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	135	97.83%	82.51%
Rural	3	2.17%	17.49%
Unknown	0	0.00%	0.00%
Total	**138**	**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
1,115	1,039	93.18%

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