QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Region 1

CT – MA – ME – NH – RI – VT

January 1 – October 31, 2023

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

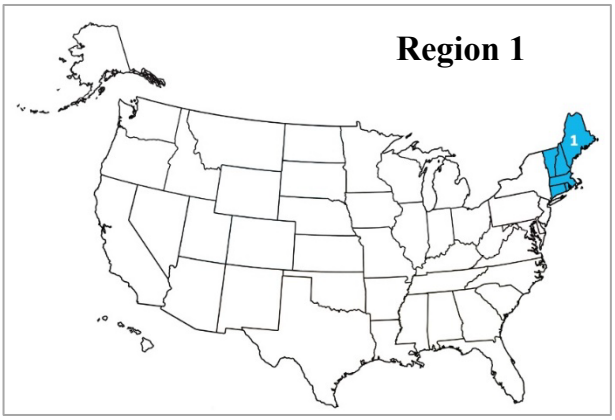
Kepro®

BFCC-QIO 12TH SOW ANNUAL MEDICAL REVIEW SERVICES REVIEW REPORT REPORTING YEAR 2023

REGION 1

TABLE OF CONTENTS

INTRODUCTION:



Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 1. Region 1 covers Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The QIO program is an integral part of the United States Department of Health & Human Services' National Quality Strategy and CMS Quality Strategy. In this report, you will find data that reflect Kepro's work during this reporting period. 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 offers 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. Providing these services protects the rights of Medicare beneficiaries, and the Medicare Trust Fund.

ANNUAL REPORT BODY:

1) TOTAL NUMBER OF REVIEWS

The data below reflect the total number of medical record reviews completed for Region 1. The BFCC-QIO has review authority for several 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)	194	2.19%
Quality of Care Review (All Other Selection Reasons)	90	1.02%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	22	0.25%
Notice of Non-coverage (BIPA)	661	7.46%
Notice of Non-coverage (Grijalva)	6,757	76.27%
Notice of Non-coverage (Hospital Discharge)	1,129	12.74%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	3	0.03%
EMTALA 5-Day	3	0.03%
EMTALA 60-Day	0	0.00%
Total	**8,859**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	21,841	26.18%
2. U071 – COVID-19	9,134	10.95%
3. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	9,016	10.81%
4. I110 – Hypertensive Heart Disease with Heart Failure	8,457	10.14%
5. N179 – Acute Kidney Failure, Unspecified	7,456	8.94%
6. J189 – Pneumonia, Unspecified Organism	7,393	8.86%
7. N390 – Urinary Tract Infection, Site Not Specified	5,856	7.02%
8. I214 – Non-ST-Elevation (NSTEMI) Myocardial Infarction	5,700	6.83%
9. J690 – Pneumonitis Due to Inhalation of Food and Vomit	4,912	5.89%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	3,668	4.40%
Total	**83,433**	**100.00%**

3) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	127	14.24%
1: Distinct Psychiatric Facility	11	1.23%
2: Distinct Rehabilitation Facility	9	1.01%
3: Distinct Skilled Nursing Facility	632	70.85%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.11%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based RHC	1	0.11%
C: Free Standing Ambulatory Surgery Center	2	0.22%
G: End Stage Renal Disease Unit	2	0.22%
H: Home Health Agency	36	4.04%
N: Critical Access Hospital	22	2.47%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	10	1.12%
R: Hospice	29	3.25%
S: Psychiatric Unit of an Inpatient Facility	4	0.45%
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	4	0.45%
Z: Swing Bed Designation for Critical Access Hospitals	2	0.22%
Other	0	0.00%
Total	**892**	**100.00%**

4) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

The below data reflect the category of Quality of Care concerns identified during medical record reviews along with the corresponding outcomes.

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. It can also be 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 designated 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.

4.A. QUALITY OF CARE CONCERNS CONFIRMED

The below data reflect the total number of confirmed concerns.

Quality of Care ("C" Category) QRD 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	38	4	10.53%
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)]	110	10	9.09%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	39	3	7.69%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	5	2	40.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	4	2	50.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	2	66.67%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	5	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	1	50.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	9	1	11.11%
C11: Apparently did not demonstrate that the patient was ready for discharge	13	1	7.69%
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%
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)	26	3	11.54%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	2	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	22	3	13.64%
Total	**284**	**35**	**12.32%**

4.B. 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 designated 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**
29	82.86%
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	3
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	1
Provider-Continuity of Care – Improvement needed in coordination across disciplines	3
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	2
Provider-Continuity of Care – Improvement needed in staff assessment completion/reporting	1
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	5
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

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 medication errors	2
Provider-Staff and Medical Staff - Improvement needed in ensuring competence/continuing education of provider staff	1

5) DISCHARGE/SERVICE TERMINATIONS

The data below reflect the discharge location of beneficiaries linked to discharge/service termination reviews for Request for BFCC-QIO Concurrence and Weichardt Reviews completed in Region 1. 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, 2023****, to* ***October 31, 2023****.*

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self-care (routine discharge)	16	15.38%
02: Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03: Discharged/transferred to skilled nursing facility (SNF)	42	40.38%
04: Discharged/transferred to intermediate care facility (ICF)	2	1.92%
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	39	37.50%
07: Left against medical advice or discontinued care	1	0.96%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	2	1.92%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	0	0.00%
40: Expired at home (hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or free-standing hospice)	0	0.00%
42: Expired – Place unknown (hospice claims only)	0	0.00%
43: Discharged/transferred to a federal hospital	0	0.00%
50: Hospice – Home	0	0.00%
51: Hospice – Medical facility	0	0.00%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	0	0.00%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	2	1.92%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
63: Discharged/transferred to a long-term care hospital	0	0.00%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66: Discharged/transferred to a critical access hospital	0	0.00%
70: Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%
Other	0	0.00%
Total	**104**	**100.00%**

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

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

Appeal Review by Notification Type	Number of Reviews	Peer Reviewer Disagreed with Discharge (%)	Peer Reviewer Agreed with Discharge (%)
Notice of Non-coverage FFS Preadmission/Admission – (Admission and Preadmission/HINN 1)	22	9.09%	90.91%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	3	0.00%	100.00%
MA Appeal Review (CORF, HHA, SNF, *Value-Based Insurance Design (VBID) Model Hospice Benefit Component) – (Grijalva)	6,743	37.68%	62.32%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	658	34.04%	65.96%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	568	6.87%	93.13%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	556	5.76%	94.24%
Total	**8,550**	**33.19%**	**66.81%**

*On January 1, 2021, CMS began testing the inclusion of the Part A Hospice Benefit within the MA benefits package through the Hospice Benefit Component of the VBID Model.

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. These 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. These 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 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.

		CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	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®	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	ACC Acute Myocardial Infarction Guidelines; CMS' Acute Myocardial Infarction indicators (AMI 2-10)	ACC's guidelines for the management of patients with an acute myocardial infarction 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.
	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) UpToDate®	IHI developed sepsis indicators and guidelines for the identification and treatment of sepsis. Adherence to such guidelines has improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Adverse Drug Events	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events 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	Determination Guidelines; JIMMO settlement language and guidelines,

		settlement language and guidelines, InterQual®, and CMS' Two Midnight Rule Benchmark criteria	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 versus 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	788	94.83%
Rural	43	5.17%
Unknown	0	0.00%
Total	**831**	**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	68	98.55%
Rural	1	1.45%
Unknown	0	0.00%
Total	**69**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro's Outreach Specialist (OS) partnered with the Massachusetts Senior Medicare Patrol (MA SMP) and attended the MA SMP Statewide Advisory Committee meeting, which aims to educate all Medicare and Medicaid beneficiaries on the importance of being engaged healthcare consumers. Kepro's OS shares all updated information and resources with the MA SMP, which reaches about 10,000 Medicare beneficiaries.

Kepro's OS strengthened the relationship with the Long-Term Care (LTC) Ombudsman program in Massachusetts and regularly shares all updates and new information with the program's directors. Kepro's OS communicates with the Massachusetts Health and Hospital Association and the New Hampshire Hospital Association, providing them with updates and revised materials.

10) Immediate Advocacy Cases

The data below reflect the number of beneficiary complaints resolved using 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 before proceeding.

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
598	568	94.98%

11) Example/Success Story

After a stay at a rehabilitation facility in Massachusetts, the beneficiary's representative needed to make plans for discharge. The representative was concerned that there were no discharge plans in place. His mother had dementia, so he had to assist with the planning. The representative was having difficulty communicating with the facility staff, so he requested an intervention by Kepro by using the Immediate Advocacy service.

Kepro's Clinical Care Coordinator (CCC) was able to contact the social worker at the facility. The social worker explained that the rehabilitation portion was ending, and the beneficiary needed custodial care. She explained that the family was working with an attorney to get the beneficiary's finances to possibly keep her at the facility for long-term care. The CCC then contacted the representative to update him on his mother's status. The representative stated that the family filed the Medicaid papers and sent them to the facility. The CCC suggested following up again with the social worker if he had any more questions. He was appreciative of the information from Kepro.

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	60,679
Total Number of Calls Answered	59,862
Total Number of Abandoned Calls	664
Average Length of Call Wait Times	00:00:10
Number of Calls Transferred by 1-800-Medicare	212

CONCLUSION:

Kepro's outcomes and findings for the reporting period 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.

APPENDIX

KEPRO BFCC-QIO REGION 1 – STATE OF CONNECTICUT

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	56	1.44%
Quality of Care Review (All Other Selection Reasons)	33	0.85%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.05%
Notice of Non-coverage (BIPA)	289	7.44%
Notice of Non-coverage (Grijalva)	3,280	84.41%
Notice of Non-coverage (Hospital Discharge)	224	5.76%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	2	0.05%
EMTALA 60-Day	0	0.00%
Total	**3,886**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	5,222	30.97%
2. N179 – Acute Kidney Failure, Unspecified	1,735	10.29%
3. I110 – Hypertensive Heart Disease with Heart Failure	1,728	10.25%
4. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	1,726	10.24%
5. U071 – COVID-19	1,641	9.73%
6. J189 – Pneumonia, Unspecified Organism	1,214	7.20%
7. N390 – Urinary Tract Infection, Site Not Specified	1,153	6.84%
8. J690 – Pneumonitis due to Inhalation of Food and Vomit	938	5.56%
9. I214 – NSTEMI Myocardial Infarction	833	4.94%
10. J9601 – Acute Respiratory Failure with Hypoxia	673	3.99%
Total	**16,863**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	3,509	60.97%
Male	2,246	39.03%
Unknown	0	0.00%
Total	**5,755**	**100.00%**
Race		
Asian	51	0.89%
Black	621	10.79%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Hispanic	58	1.01%
North American Native	4	0.07%
Other	57	0.99%
Unknown	86	1.49%
White	4,878	84.76%
Total	**5,755**	**100.00%**
Age		
Under 65	427	7.42%
65-70	675	11.73%
71-80	1,769	30.74%
81-90	1,974	34.30%
91+	910	15.81%
Total	**5,755**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	31	12.55%
1: Distinct Psychiatric Facility	1	0.40%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	189	76.52%
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 RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	1	0.40%
H: Home Health Agency	15	6.07%
N: Critical Access Hospital	0	0.00%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	0.40%
R: Hospice	6	2.43%
S: Psychiatric Unit of an Inpatient Facility	2	0.81%
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	0.40%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**247**	**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. It can also be 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 designated 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) QRD 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	11	2	18.18%
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)]	33	4	12.12%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	17	1	5.88%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	1	100.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	2	66.67%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	2	2	100.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	4	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	4	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	5	0	0.00%
C17: Apparently did not order/follow evidence-based practices	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	5	0	0.00%
Total	**89**	**12**	**13.48%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
11	91.67%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
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	3
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	1
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	4
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)	2	0.05%
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)	3,275	86.53%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	287	7.58%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	122	3.22%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	99	2.62%
Total	**3,785**	**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	238	99.58%	94.83%
Rural	1	0.42%	5.17%
Unknown	0	0.00%	0.00%
Total	**239**	**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	20	100.00%	98.55%
Rural	0	0.00%	1.45%
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
152	143	94.08%

KEPRO BFCC-QIO REGION 1 – STATE OF MAINE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	5	0.74%
Quality of Care Review (All Other Selection Reasons)	3	0.44%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	6	0.88%
Notice of Non-coverage (BIPA)	16	2.36%
Notice of Non-coverage (Grijalva)	526	77.47%
Notice of Non-coverage (Hospital Discharge)	122	17.97%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.15%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**679**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,549	27.27%
2. I214 – NSTEMI Myocardial Infarction	643	11.32%
3. J189 – Pneumonia, Unspecified Organism	591	10.40%
4. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail And Stg 1-4/Unsp Chr Kdny	588	10.35%
5. U071 – COVID-19	528	9.30%
6. I110 – Hypertensive Heart Disease with Heart Failure	496	8.73%
7. N179 – Acute Kidney Failure, Unspecified	412	7.25%
8. N390 – Urinary Tract Infection, Site Not Specified	304	5.35%
9. J9601 – Acute Respiratory Failure with Hypoxia	290	5.11%
10. J690 – Pneumonitis due to Inhalation of Food and Vomit	279	4.91%
Total	**5,680**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	734	62.57%
Male	439	37.43%
Unknown	0	0.00%
Total	**1,173**	**100.00%**
Race		
Asian	3	0.26%
Black	15	1.28%
Hispanic	0	0.00%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	3	0.26%
Other	6	0.51%
Unknown	20	1.71%
White	1,126	95.99%
Total	**1,173**	**100.00%**
Age		
Under 65	110	9.38%
65-70	157	13.38%
71-80	409	34.87%
81-90	358	30.52%
91+	139	11.85%
Total	**1,173**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	15	16.30%
1: Distinct Psychiatric Facility	3	3.26%
2: Distinct Rehabilitation Facility	1	1.09%
3: Distinct Skilled Nursing Facility	61	66.30%
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 RHC	0	0.00%
9: Provider Based RHC	1	1.09%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	3	3.26%
N: Critical Access Hospital	6	6.52%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	2	2.17%
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	**92**	**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. It can also be 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 designated 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) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	2	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	1	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

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

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
0	**0.00%**
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
N/A	N/A

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	6	0.90%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	1	0.15%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	523	78.29%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	16	2.40%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	48	7.19%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	74	11.08%
Total	**668**	**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	59	68.60%	94.83%
Rural	27	31.40%	5.17%
Unknown	0	0.00%	0.00%
Total	**86**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	2	66.67%	98.55%
Rural	1	33.33%	1.45%
Unknown	0	0.00%	0.00%
Total	**3**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
33	31	93.94%

KEPRO BFCC-QIO REGION 1 – STATE OF MASSACHUSETTS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	119	5.69%
Quality of Care Review (All Other Selection Reasons)	31	1.48%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	10	0.48%
Notice of Non-coverage (BIPA)	265	12.68%
Notice of Non-coverage (Grijalva)	1,253	59.95%
Notice of Non-coverage (Hospital Discharge)	411	19.67%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.05%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**2,090**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	11,159	24.50%
2. U071 – COVID-19	5,410	11.88%
3. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	5,132	11.27%
4. I110 – Hypertensive Heart Disease with Heart Failure	4,497	9.87%
5. J189 – Pneumonia, Unspecified Organism	4,107	9.02%
6. N179 – Acute Kidney Failure, Unspecified	4,012	8.81%
7. N390 – Urinary Tract Infection, Site Not Specified	3,350	7.35%
8. J690 – Pneumonitis due to Inhalation of Food and Vomit	2,910	6.39%
9. I214 – NSTEMI Myocardial Infarction	2,796	6.14%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	2,178	4.78%
Total	**45,551**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,428	59.22%
Male	1,672	40.78%
Unknown	0	0.00%
Total	**4,100**	**100.00%**
Race		
Asian	37	0.90%
Black	210	5.12%
Hispanic	29	0.71%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	1	0.02%
Other	50	1.22%
Unknown	59	1.44%
White	3,714	90.59%
Total	**4,100**	**100.00%**
Age		
Under 65	325	7.93%
65-70	465	11.34%
71-80	1,275	31.10%
81-90	1,418	34.59%
91+	617	15.05%
Total	**4,100**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	52	14.94%
1: Distinct Psychiatric Facility	6	1.72%
2: Distinct Rehabilitation Facility	6	1.72%
3: Distinct Skilled Nursing Facility	244	70.11%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	12	3.45%
N: Critical Access Hospital	3	0.86%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	8	2.30%
R: Hospice	14	4.02%
S: Psychiatric Unit of an Inpatient Facility	2	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	0.29%
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. It can also be 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 designated 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) QRD 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	21	1	4.76%
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)]	64	5	7.81%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	16	2	12.50%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	1	25.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	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)	3	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	4	1	25.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	5	1	20.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
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%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	14	3	21.43%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	2	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	9	1	11.11%
Total	**150**	**19**	**12.67%**

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**
14	73.68%
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	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	1
Provider-Continuity of Care – Improvement needed in coordination across disciplines	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 carrying out plan of care	1
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 other safety of the environment in patient care area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	2

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	10	0.52%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	1	0.05%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	1,250	64.60%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	264	13.64%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	223	11.52%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	187	9.66%
Total	**1,935**	**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	312	100.00%	94.83%
Rural	0	0.00%	5.17%
Unknown	0	0.00%	0.00%
Total	**312**	**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	35	100.00%	98.55%
Rural	0	0.00%	1.45%
Unknown	0	0.00%	0.00%
Total	**35**	**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
291	275	94.50%

KEPRO BFCC-QIO REGION 1 – STATE OF NEW HAMPSHIRE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	13	1.99%
Quality of Care Review (All Other Selection Reasons)	5	0.76%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.15%
Notice of Non-coverage (BIPA)	34	5.20%
Notice of Non-coverage (Grijalva)	460	70.34%
Notice of Non-coverage (Hospital Discharge)	140	21.41%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	1	0.15%
EMTALA 60-Day	0	0.00%
Total	**654**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	2,253	26.10%
2. I110 – Hypertensive Heart Disease with Heart Failure	921	10.67%
3. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	887	10.28%
4. J189 – Pneumonia, Unspecified Organism	843	9.77%
5. U071 – COVID-19	809	9.37%
6. I214 – NSTEMI Myocardial Infarction	753	8.72%
7. N179 – Acute Kidney Failure, Unspecified	706	8.18%
8. N390 – Urinary Tract Infection, Site Not Specified	589	6.82%
9. I350 – Nonrheumatic Aortic (Valve) Stenosis	441	5.11%
10. J690 – Pneumonitis due to Inhalation of Food and Vomit	429	4.97%
Total	**8,631**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	705	59.34%
Male	483	40.66%
Unknown	0	0.00%
Total	**1,188**	**100.00%**
Race		
Asian	3	0.25%
Black	13	1.09%
Hispanic	3	0.25%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	2	0.17%
Other	11	0.93%
Unknown	13	1.09%
White	1,143	96.21%
Total	**1,188**	**100.00%**
Age		
Under 65	134	11.28%
65-70	171	14.39%
71-80	387	32.58%
81-90	372	31.31%
91+	124	10.44%
Total	**1,188**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	14	16.47%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	2	2.35%
3: Distinct Skilled Nursing Facility	51	60.00%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	1.18%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	2	2.35%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	2	2.35%
N: Critical Access Hospital	8	9.41%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	1.18%
R: Hospice	2	2.35%
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	2	2.35%
Other	0	0.00%
Total	**85**	**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. It can also be 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 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) QRD 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	4	1	25.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	8	1	12.50%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	2	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	2	0	0.00%
Total	**18**	**2**	**11.11%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
2	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	1
Provider-Continuity of Care – Improvement needed in staff assessment completion/reporting	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	0.16%
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)	459	72.40%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	34	5.36%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	80	12.62%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA hospital discharge)	60	9.46%
Total	**634**	**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	71	92.21%	94.83%
Rural	6	7.79%	5.17%
Unknown	0	0.00%	0.00%
Total	**77**	**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	6	100.00%	98.55%
Rural	0	0.00%	1.45%
Unknown	0	0.00%	0.00%
Total	**6**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
50	48	96.00%

KEPRO BFCC-QIO REGION 1 – STATE OF RHODE ISLAND

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	1	0.08%
Quality of Care Review (All Other Selection Reasons)	1	0.08%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.16%
Notice of Non-coverage (BIPA)	36	2.86%
Notice of Non-coverage (Grijalva)	1,046	83.15%
Notice of Non-coverage (Hospital Discharge)	171	13.59%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.08%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**1,258**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	843	22.25%
2. I110 – Hypertensive Heart Disease with Heart Failure	472	12.46%
3. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	427	11.27%
4. U071 – COVID-19	414	10.93%
5. I214 – NSTEMI Myocardial Infarction	333	8.79%
6. N179 – Acute Kidney Failure, Unspecified	316	8.34%
7. J189 – Pneumonia, Unspecified Organism	305	8.05%
8. J690 – Pneumonitis due to Inhalation of Food and Vomit	231	6.10%
9. N390 – Urinary Tract Infection, Site Not Specified	228	6.02%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	220	5.81%
Total	**3,789**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,078	60.84%
Male	694	39.16%
Unknown	0	0.00%
Total	**1,772**	**100.00%**
Race		
Asian	11	0.62%
Black	69	3.89%
Hispanic	19	1.07%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	0	0.00%
Other	25	1.41%
Unknown	22	1.24%
White	1,626	91.76%
Total	**1,772**	**100.00%**
Age		
Under 65	141	7.96%
65-70	232	13.09%
71-80	495	27.93%
81-90	647	36.51%
91+	257	14.50%
Total	**1,772**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	9	10.98%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	67	81.71%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	2	2.44%
N: Critical Access Hospital	0	0.00%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	3	3.66%
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	1.22%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**82**	**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. It can also be 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 designated 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) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	0	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	2	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

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

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
0	0.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
N/A	N/A

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	2	0.16%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	1	0.08%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	1,045	83.33%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	36	2.87%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	55	4.39%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	115	9.17%
Total	**1,254**	**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	80	100.00%	94.83%
Rural	0	0.00%	5.17%
Unknown	0	0.00%	0.00%
Total	**80**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	1	100.00%	98.55%
Rural	0	0.00%	1.45%
Unknown	0	0.00%	0.00%
Total	**1**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
57	56	98.25%

KEPRO BFCC-QIO REGION 1 – STATE OF VERMONT

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	0	0.00%
Quality of Care Review (All Other Selection Reasons)	17	5.82%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.34%
Notice of Non-coverage (BIPA)	21	7.19%
Notice of Non-coverage (Grijalva)	192	65.75%
Notice of Non-coverage (Hospital Discharge)	61	20.89%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**292**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	867	24.69%
2. I214 – NSTEMI Myocardial Infarction	395	11.25%
3. I110 – Hypertensive Heart Disease with Heart Failure	356	10.14%
4. U071 – COVID-19	343	9.77%
5. J189 – Pneumonia, Unspecified Organism	339	9.66%
6. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	294	8.37%
7. N179 – Acute Kidney Failure, Unspecified	286	8.15%
8. N390 – Urinary Tract Infection, Site Not Specified	237	6.75%
9. J9601 – Acute Respiratory Failure with Hypoxia	201	5.72%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	193	5.50%
Total	**3,511**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	293	57.91%
Male	213	42.09%
Unknown	0	0.00%
Total	**506**	**100.00%**
Race		
Asian	0	0.00%
Black	4	0.79%
Hispanic	2	0.40%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	1	0.20%
Other	1	0.20%
Unknown	9	1.78%
White	489	96.64%
Total	**506**	**100.00%**
Age		
Under 65	41	8.10%
65-70	76	15.02%
71-80	197	38.93%
81-90	139	27.47%
91+	53	10.47%
Total	**506**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	6	15.79%
1: Distinct Psychiatric Facility	1	2.63%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	20	52.63%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	1	2.63%
H: Home Health Agency	2	5.26%
N: Critical Access Hospital	5	13.16%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	2	5.26%
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	2.63%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**38**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative. It can also be 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 designated 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) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	2	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	3	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	1	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	3	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	6	2	33.33%
Total	**17**	**2**	**11.76%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
2	100.00%
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	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	0.36%
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)	191	69.71%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	21	7.66%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	40	14.60%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	21	7.66%
Total	**274**	**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	28	75.68%	94.83%
Rural	9	24.32%	5.17%
Unknown	0	0.00%	0.00%
Total	**37**	**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	4	100.00%	98.55%
Rural	0	0.00%	1.45%
Unknown	0	0.00%	0.00%
Total	**4**	**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
15	15	100.00%

Publication No R1-330-1/2024. This material was prepared by Kepro, a Medicare Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.