QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Region 6

AR – LA – NM – OK – TX

January 1 – October 31, 2023

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

REGION 6

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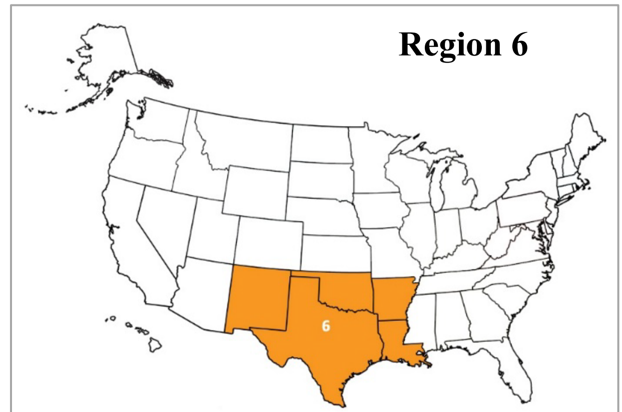
INTRODUCTION:



Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 6. Region 6 covers Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. The QIO program is an integral part of the United States Department of Health & Human Services' National Quality Strategy and CMS Quality Strategy. Within this report, you will find data that reflect the work completed by Kepro 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, which does not require a medical record review. By providing these services, the rights of Medicare beneficiaries are protected, as is 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 6.

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 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)	422	2.56%
Quality of Care Review (All Other Selection Reasons)	226	1.37%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	3	0.02%
Notice of Non-coverage (BIPA)	557	3.38%
Notice of Non-coverage (Grijalva)	12,737	77.35%
Notice of Non-coverage (Hospital Discharge)	2,440	14.82%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	2	0.01%
EMTALA 5-Day	78	0.47%
EMTALA 60-Day	1	0.01%
Total	**16,466**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	54,133	30.15%
2. N179 – Acute Kidney Failure, Unspecified	18,206	10.14%
3. J189 – Pneumonia, Unspecified Organism	16,548	9.22%
4. U071 – COVID-19	16,477	9.18%
5. I110 – Hypertensive Heart Disease with Heart Failure	16,024	8.92%
6. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	15,129	8.43%
7. N390 – Urinary Tract Infection, Site Not Specified	12,703	7.07%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
8. I214 – Non-ST Elevation (NSTEMI) Myocardial Infarction	11,788	6.56%
9. R5381 – Other Malaise	9,420	5.25%
10. I480 – Paroxysmal Atrial Fibrillation	9,141	5.09%
Total	**179,569**	**100.00%**

3) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	314	16.28%
1: Distinct Psychiatric Facility	25	1.30%
2: Distinct Rehabilitation Facility	93	4.82%
3: Distinct Skilled Nursing Facility	1,229	63.71%
5: Clinic	1	0.05%
6: Distinct Dialysis Center Facility	3	0.16%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based RHC	4	0.21%
C: Free Standing Ambulatory Surgery Center	5	0.26%
G: End Stage Renal Disease Unit	7	0.36%
H: Home Health Agency	63	3.27%
N: Critical Access Hospital	61	3.16%
O: Setting Does Not Fit Into Any Other Existing Setting Code	5	0.26%
Q: Long-Term Care Facility	65	3.37%
R: Hospice	49	2.54%
S: Psychiatric Unit of an Inpatient Facility	2	0.10%
T: Rehabilitation Unit of an Inpatient Facility	2	0.10%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.05%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**1,929**	**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. 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 quality of care 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	3	1	33.33%
C02: Apparently did not make appropriate diagnoses and/or assessments	57	9	15.79%
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)]	270	50	18.52%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	81	25	30.86%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	22	8	36.36%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	5	2	40.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	4	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	8	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	8	3	37.50%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	11	3	27.27%
C11: Apparently did not demonstrate that the patient was ready for discharge	38	8	21.05%
C12: Apparently did not provide appropriate personnel and/or resources	6	4	66.67%
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	6	2	33.33%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	48	24	50.00%
C17: Apparently did not order/follow evidence-based practices	6	2	33.33%
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	13	22.81%
Total	**648**	**161**	**24.85%**

4.B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

Kepro, in keeping with CMS' directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate 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**
134	83.23%
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	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	14
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	5
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	10
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	9
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner safety precautions	2
Provider-Continuity of Care – Improvement needed in case management/discharge planning	4
Provider-Continuity of Care – Improvement needed in coordination across disciplines	4
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	6
Provider-Continuity of Care – Improvement needed in other continuity of care area	2

Provider-Continuity of Care – Improvement needed in staff assessment completion/reporting	2
Provider-Other Administrative – Improvement needed in medical record documentation to support billing	1
Provider-Other Administrative – Improvement needed in other administrative area	2
Provider-Patient Care by Staff – Improvement needed in other patient care by staff area	2
Provider-Patient Care by Staff – Improvement needed in staff assessments	3
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	5
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	9
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	14
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	2
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	5
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	5
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	6
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	4
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	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 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, 2023**, to **October 31, 2023***

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self-care (routine discharge)	50	28.57%
02: Discharged/transferred to another short-term general hospital for inpatient care	2	1.14%
03: Discharged/transferred to skilled nursing facility (SNF)	48	27.43%
04: Discharged/transferred to intermediate care facility (ICF)	0	0.00%
05: Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06: Discharged/transferred to home under care of organized home health service organization	63	36.00%
07: Left against medical advice or discontinued care	0	0.00%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	0	0.00%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	0	0.00%
40: Expired at home (hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or free-standing hospice)	0	0.00%
42: Expired – place unknown (hospice claims only)	0	0.00%
43: Discharged/transferred to a federal hospital	0	0.00%
50: Hospice – home	2	1.14%
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	8	4.57%
63: Discharged/transferred to a long-term care hospital	1	0.57%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
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	1	0.57%
Total	**175**	**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)	3	100.00%	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	2	0.00%	100.00%
MA Appeal Review (CORF, HHA, SNF, *Value-Based Insurance Design (VBID) Model Hospice Benefit Component) – (Grijalva)	12,694	36.91%	63.09%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	555	42.70%	57.30%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs - (FFS hospital discharge)	1,062	9.13%	90.87%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs - (MA hospital discharge)	1,369	7.38%	92.62%
Total	**15,685**	**32.66%**	**67.34%**

*Beginning 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 Value-Based Insurance Design (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, 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 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	The Agency for Healthcare Research and Quality (AHRQ) remains an excellent online resource for the identification of standards of care and practice guidelines.

		website (www.WOCN.org) CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure) UpToDate®	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 Infarction Guidelines; CMS' Acute Myocardial Infarction indicators (AMI 2-10) UpToDate®	ACC's guidelines for the management of patients with acute myocardial infarction address aspects of care that, when followed, are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Urinary Tract Infection	HAI-CAUTI (f/k/a HAC-7)	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 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

Urban and Rural: In tables 8A and 8B, the number and percent are provided by rural versus 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	1,352	79.34%
Rural	352	20.66%
Unknown	0	0.00%
Total	**1,704**	**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	134	89.33%
Rural	16	10.67%
Unknown	0	0.00%
Total	**150**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro had the opportunity to present information at the Louisiana fraud prevention seminar. Kepro's Outreach Specialist (OS) shared information on how to file a discharge appeal, who to contact for help with Immediate Advocacy, and how to file a complaint for medical quality of care issues. Kepro's OS shared information with 115 Senior Medicare Patrol (SMP) staff and volunteers, helping potentially 900,000 beneficiaries in Louisiana.

Kepro's OS provided training to 142 Indian Health Services (IHS) staff members in New Mexico. This staff assists 132,000 Native Americans living on reservations in New Mexico or receiving IHS services. The

presentation included understanding how discharge appeals and beneficiary complaints are filed and how to access Immediate Advocacy services for beneficiaries in need of immediate help with medical assistance.

There were several guests from Region 6 on Kepro's podcast, Aging Health Matters. The Long-Term Care Ombudsman discussed their services, two guests from the QIN-QIOs shared how they work with Kepro on quality improvement, and a guest from the Oklahoma Department of Human Services spoke on caregiving.

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
1,376	1,305	94.84%

11) Example/Success Story

The beneficiary contacted Kepro with concerns about his bill at the skilled nursing facility in Texas. He paid them twice, yet they still sent him a new bill for almost $2,000. He had been there for only three weeks and had not had any success getting the concern resolved. He reached out to Kepro for assistance by using the Immediate Advocacy process.

Kepro's Clinical Care Coordinator (CCC) contacted the business office at the facility, and after looking into the matter, it was determined that the beneficiary did not owe any more money and was entitled to a refund. The business office would be mailing the beneficiary a check. The CCC then followed up with the beneficiary, who was very grateful for the assistance on his behalf.

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	75,762
Total Number of Calls Answered	74,138
Total Number of Abandoned Calls	1,348
Average Length of Call Wait Times	00:00:19
Number of Calls Transferred by 1-800-Medicare	491

Conclusion:

Kepro's outcomes and findings for this reporting period 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 6 – STATE OF ARKANSAS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	35	3.53%
Quality of Care Review (All Other Selection Reasons)	32	3.23%
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)	20	2.02%
Notice of Non-coverage (Grijalva)	792	79.92%
Notice of Non-coverage (Hospital Discharge)	110	11.10%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	2	0.20%
EMTALA 60-Day	0	0.00%
Total	**991**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	5,518	28.69%
2. N179 – Acute Kidney Failure, Unspecified	2,046	10.64%
3. J189 – Pneumonia, Unspecified Organism	1,950	10.14%
4. U071 – COVID-19	1,698	8.83%
5. I110 – Hypertensive Heart Disease with Heart Failure	1,654	8.60%
6. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	1,510	7.85%
7. I214 – NSTEMI Myocardial Infarction	1,374	7.15%
8. N390 – Urinary Tract Infection, Site Not Specified	1,333	6.93%
9. I480 – Paroxysmal Atrial Fibrillation	1,243	6.46%
10. R531 – Weakness	904	4.70%
Total	**19,230**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,118	62.15%
Male	681	37.85%
Unknown	0	0.00%
Total	**1,799**	**100.00%**
Race		
Asian	2	0.11%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Black	366	20.34%
Hispanic	7	0.39%
North American Native	15	0.83%
Other	4	0.22%
Unknown	8	0.44%
White	1,397	77.65%
Total	**1,799**	**100.00%**
Age		
Under 65	322	17.90%
65-70	310	17.23%
71-80	612	34.02%
81-90	447	24.85%
91+	108	6.00%
Total	**1,799**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	24	14.29%
1: Distinct Psychiatric Facility	1	0.60%
2: Distinct Rehabilitation Facility	8	4.76%
3: Distinct Skilled Nursing Facility	107	63.69%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.60%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	1	0.60%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	7	4.17%
N: Critical Access Hospital	8	4.76%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	7	4.17%
R: Hospice	3	1.79%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.60%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**168**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative. 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	5	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)]	34	2	5.88%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	2	1	50.00%
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	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	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	2	40.00%
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	5	3	60.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	5	2	40.00%
Total	**67**	**11**	**16.42%**

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**
10	90.91%
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 general treatment planning/administration	1
Provider-Other Administrative – Improvement needed in other administrative area	1
Provider-Patient Care by Staff – Improvement needed in staff assessments	2
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	1
Provider-Patient Rights – Improvement needed in other patient rights area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in other safety of the environment in patient care area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	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)	788	85.93%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	20	2.18%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	57	6.22%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	52	5.67%
Total	**917**	**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	122	82.43%	79.34%
Rural	26	17.57%	20.66%
Unknown	0	0.00%	0.00%
Total	**148**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	17	73.91%	89.33%
Rural	6	26.09%	10.67%
Unknown	0	0.00%	0.00%
Total	**23**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
60	52	86.67%

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)	21	1.96%
Quality of Care Review (All Other Selection Reasons)	9	0.84%
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)	21	1.96%
Notice of Non-coverage (Grijalva)	842	78.69%
Notice of Non-coverage (Hospital Discharge)	170	15.89%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	7	0.65%
EMTALA 60-Day	0	0.00%
Total	**1,070**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	6,378	27.67%
2. N179 – Acute Kidney Failure, Unspecified	2,476	10.74%
3. I110 – Hypertensive Heart Disease with Heart Failure	2,161	9.38%
4. N390 – Urinary Tract Infection, Site Not Specified	2,157	9.36%
5. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	2,121	9.20%
6. U071 – COVID-19	2,029	8.80%
7. J189 – Pneumonia, Unspecified Organism	2,026	8.79%
8. I214 – NSTEMI Myocardial Infarction	1,515	6.57%
9. R5381 – Other Malaise	1,106	4.80%
10. I480 – Paroxysmal Atrial Fibrillation	1,080	4.69%
Total	**23,049**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,113	60.89%
Male	715	39.11%
Unknown	0	0.00%
Total	**1,828**	**100.00%**
Race		
Asian	5	0.27%
Black	627	34.30%
Hispanic	3	0.16%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	2	0.11%
Other	5	0.27%
Unknown	14	0.77%
White	1,172	64.11%
Total	**1,828**	**100.00%**
Age		
Under 65	224	12.25%
65-70	329	18.00%
71-80	637	34.85%
81-90	479	26.20%
91+	159	8.70%
Total	**1,828**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	36	16.00%
1: Distinct Psychiatric Facility	4	1.78%
2: Distinct Rehabilitation Facility	10	4.44%
3: Distinct Skilled Nursing Facility	145	64.44%
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	0.44%
H: Home Health Agency	6	2.67%
N: Critical Access Hospital	7	3.11%
O: Setting Does Not Fit Into Any Other Existing Setting Code	1	0.44%
Q: Long-Term Care Facility	10	4.44%
R: Hospice	5	2.22%
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	**225**	**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)]	17	4	23.53%
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	1	1	100.00%
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	1	100.00%
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	4	0	0.00%
Total	**30**	**7**	**23.33%**

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**
6	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 medication management	4
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	841	81.49%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	21	2.03%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	72	6.98%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	98	9.50%
Total	**1,032**	**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%	79.34%
Rural	194	100.00%	20.66%
Unknown	0	0.00%	0.00%
Total	194	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%	89.33%
Rural	9	100.00%	10.67%
Unknown	0	0.00%	0.00%
Total	9	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
140	136	97.14%

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)	10	1.90%
Quality of Care Review (All Other Selection Reasons)	14	2.66%
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)	27	5.13%
Notice of Non-coverage (Grijalva)	370	70.34%
Notice of Non-coverage (Hospital Discharge)	94	17.87%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	11	2.09%
EMTALA 60-Day	0	0.00%
Total	**526**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	2,637	33.95%
2. U071 – COVID-19	969	12.47%
3. J189 – Pneumonia, Unspecified Organism	808	10.40%
4. I110 – Hypertensive Heart Disease with Heart Failure	648	8.34%
5. I214 – NSTEMI Myocardial Infarction	604	7.78%
6. N179 – Acute Kidney Failure, Unspecified	555	7.14%
7. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	442	5.69%
8. N390 – Urinary Tract Infection, Site Not Specified	426	5.48%
9. A4189 – Other Specified Sepsis	378	4.87%
10. J9601 – Acute Respiratory Failure with Hypoxia	301	3.87%
Total	**7,768**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	571	57.44%
Male	423	42.56%
Unknown	0	0.00%
Total	**994**	**100.00%**
Race		
Asian	10	1.01%
Black	25	2.52%
Hispanic	64	6.44%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	45	4.53%
Other	16	1.61%
Unknown	4	0.40%
White	830	83.50%
Total	**994**	**100.00%**
Age		
Under 65	122	12.27%
65-70	145	14.59%
71-80	356	35.81%
81-90	299	30.08%
91+	72	7.24%
Total	**994**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	19	22.62%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	4	4.76%
3: Distinct Skilled Nursing Facility	47	55.95%
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	0	0.00%
H: Home Health Agency	10	11.90%
N: Critical Access Hospital	1	1.19%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	2	2.38%
R: Hospice	1	1.19%
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	**84**	**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	2	2	100.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	12	3	25.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	2	66.67%
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	2	2	100.00%
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	2	40.00%
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	**24**	**11**	**45.83%**

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	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 medical record documentation that impacts patient care	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	1
Provider-Patient Care by Staff – Improvement needed in other patient care by staff area	2
Provider-Patient Care by Staff – Improvement needed in staff assessments	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	1
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	1

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)	369	75.31%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	27	5.51%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	38	7.76%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	56	11.43%
Total	**490**	**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	86.76%	79.34%
Rural	9	13.24%	20.66%
Unknown	0	0.00%	0.00%
Total	**68**	**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	10	100.00%	89.33%
Rural	0	0.00%	10.67%
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
81	76	93.83%

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)	38	2.89%
Quality of Care Review (All Other Selection Reasons)	17	1.29%
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)	48	3.65%
Notice of Non-coverage (Grijalva)	1,114	84.65%
Notice of Non-coverage (Hospital Discharge)	93	7.07%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	6	0.46%
EMTALA 60-Day	0	0.00%
Total	**1,316**	**100.00%**

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	6,165	27.17%
2. N179 – Acute Kidney Failure, Unspecified	2,653	11.69%
3. J189 – Pneumonia, Unspecified Organism	2,300	10.14%
4. I110 – Hypertensive Heart Disease with Heart Failure	1,944	8.57%
5. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	1,941	8.55%
6. U071 – COVID-19	1,848	8.14%
7. N390 – Urinary Tract Infection, Site Not Specified	1,822	8.03%
8. I214 – NSTEMI Myocardial Infarction	1,465	6.46%
9. J9601 – Acute Respiratory Failure with Hypoxia	1,319	5.81%
10. R5381 – Other Malaise	1,234	5.44%
Total	**22,691**	**100.00%**

3) Beneficiary Demographics Possible Data Source:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,450	63.37%
Male	838	36.63%
Unknown	0	0.00%
Total	**2,288**	**100.00%**
Race		
Asian	12	0.52%
Black	243	10.62%
Hispanic	13	0.57%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	125	5.46%
Other	13	0.57%
Unknown	13	0.57%
White	1,869	81.69%
Total	**2,288**	**100.00%**
Age		
Under 65	304	13.29%
65-70	396	17.31%
71-80	817	35.71%
81-90	613	26.79%
91+	158	6.91%
Total	**2,288**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	36	20.22%
1: Distinct Psychiatric Facility	2	1.12%
2: Distinct Rehabilitation Facility	5	2.81%
3: Distinct Skilled Nursing Facility	99	55.62%
5: Clinic	1	0.56%
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	0.56%
C: Free Standing Ambulatory Surgery Center	1	0.56%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	5	2.81%
N: Critical Access Hospital	19	10.67%
O: Setting Does Not Fit Into Any Other Existing Setting Code	1	0.56%
Q: Long-Term Care Facility	5	2.81%
R: Hospice	3	1.69%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**178**	**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	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	7	2	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)]	27	7	25.93%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	9	5	55.56%
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	2	1	50.00%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	1	100.00%

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)	3	3	100.00%
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	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	2	1	50.00%
Total	**55**	**21**	**38.18%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
20	95.24%
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 general treatment planning/administration	7
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 coordination across disciplines	3
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	2
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	5
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	1
Provider-Safety of the Environment in Patient Care – Improvement needed in other safety of the environment in patient care area	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)	1,111	88.74%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	48	3.83%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	49	3.91%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	44	3.51%
Total	**1,252**	**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	130	84.97%	79.34%
Rural	23	15.03%	20.66%
Unknown	0	0.00%	0.00%
Total	**153**	**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	15	93.75%	89.33%
Rural	1	6.25%	10.67%
Unknown	0	0.00%	0.00%
Total	**16**	**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
96	88	91.67%

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)	318	2.53%
Quality of Care Review (All Other Selection Reasons)	154	1.23%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	3	0.02%
Notice of Non-coverage (BIPA)	441	3.51%
Notice of Non-coverage (Grijalva)	9,619	76.57%
Notice of Non-coverage (Hospital Discharge)	1,973	15.70%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	2	0.02%
EMTALA 5-Day	52	0.41%
EMTALA 60-Day	1	0.01%
Total	**12,563**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	33,515	31.07%
2. N179 – Acute Kidney Failure, Unspecified	10,493	9.73%
3. U071 – COVID-19	9,949	9.22%
4. I110 – Hypertensive Heart Disease with Heart Failure	9,637	8.93%
5. J189 – Pneumonia, Unspecified Organism	9,480	8.79%
6. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	9,159	8.49%
7. N390 – Urinary Tract Infection, Site Not Specified	6,977	6.47%
8. I214 – NSTEMI Myocardial Infarction	6,853	6.35%
9. R5381 – Other Malaise	6,177	5.73%
10. I480 – Paroxysmal Atrial Fibrillation	5,617	5.21%
Total	**107,857**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	12,347	60.93%
Male	7,917	39.07%
Unknown	0	0.00%
Total	**20,264**	**100.00%**
Race		
Asian	274	1.35%
Black	3,598	17.76%
Hispanic	687	3.39%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	29	0.14%
Other	248	1.22%
Unknown	184	0.91%
White	15,244	75.23%
Total	**20,264**	**100.00%**
Age		
Under 65	2,099	10.36%
65-70	3,160	15.59%
71-80	7,169	35.38%
81-90	6,014	29.68%
91+	1,822	8.99%
Total	**20,264**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	199	15.62%
1: Distinct Psychiatric Facility	18	1.41%
2: Distinct Rehabilitation Facility	66	5.18%
3: Distinct Skilled Nursing Facility	831	65.23%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	2	0.16%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	2	0.16%
C: Free Standing Ambulatory Surgery Center	4	0.31%
G: End Stage Renal Disease Unit	6	0.47%
H: Home Health Agency	35	2.75%
N: Critical Access Hospital	26	2.04%
O: Setting Does Not Fit Into Any Other Existing Setting Code	3	0.24%
Q: Long-Term Care Facility	41	3.22%
R: Hospice	37	2.90%
S: Psychiatric Unit of an Inpatient Facility	2	0.16%
T: Rehabilitation Unit of an Inpatient Facility	2	0.16%
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	**1,274**	**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	2	1	50.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	39	4	10.26%
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)]	180	34	18.89%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	65	17	26.15%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	19	7	36.84%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	5	2	40.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	7	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	7	2	28.57%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	9	3	33.33%
C11: Apparently did not demonstrate that the patient was ready for discharge	29	5	17.24%
C12: Apparently did not provide appropriate personnel and/or resources	5	4	80.00%
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	5	1	20.00%

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)	34	16	47.06%
C17: Apparently did not order/follow evidence-based practices	6	2	33.33%
C18: Apparently did not provide medical record documentation that impacts patient care	9	3	33.33%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	46	10	21.74%
Total	**472**	**111**	**23.52%**

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**
87	78.38%
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	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	8
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner safety precautions	2

Provider-Continuity of Care – Improvement needed in case management/discharge planning	4
Provider-Continuity of Care – Improvement needed in coordination across disciplines	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	5
Provider-Continuity of Care – Improvement needed in other continuity of care area	2
Provider-Continuity of Care – Improvement needed in staff assessment completion/reporting	2
Provider-Other Administrative – Improvement needed in medical record documentation to support billing	1
Provider-Other Administrative – Improvement needed in other administrative area	1
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	4
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	6
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	2
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	4
Provider-Patient Rights – Improvement needed in other patient rights area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in other safety of the environment in patient care area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	5
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	1

Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of other operative and postoperative complications	1
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	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)	3	0.03%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	2	0.02%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	9,585	79.91%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	439	3.66%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	846	7.05%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	1,119	9.33%
Total	**11,994**	**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	1,041	91.24%	79.34%
Rural	100	8.76%	20.66%
Unknown	0	0.00%	0.00%
Total	**1,141**	**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	92	100.00%	89.33%
Rural	0	0.00%	10.67%
Unknown	0	0.00%	0.00%
Total	**92**	**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
999	953	95.40%

Publication No R6-332-1/2024. 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.