QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Region 10

AK – ID – OR – WA

January 1 – October 31, 2023

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

REGION 10

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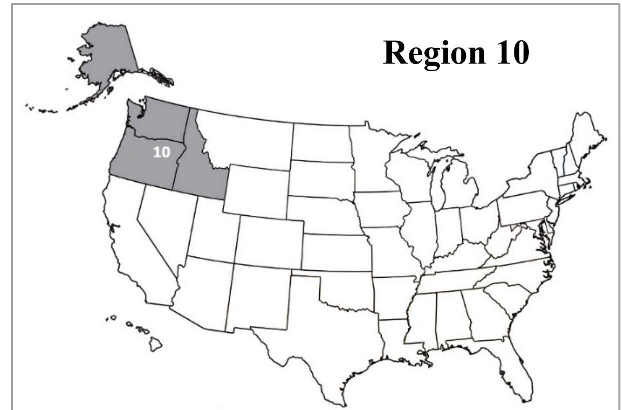
INTRODUCTION:

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

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)	132	2.94%
Quality of Care Review (All Other Selection Reasons)	57	1.27%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	3	0.07%
Notice of Non-coverage (BIPA)	213	4.74%
Notice of Non-coverage (Grijalva)	3,463	77.06%
Notice of Non-coverage (Hospital Discharge)	580	12.91%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	8	0.18%
EMTALA 5-Day	38	0.85%
EMTALA 60-Day	0	0.00%
Total	**4,494**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	15,790	32.06%
2. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	4,904	9.96%
3. I110 – Hypertensive Heart Disease with Heart Failure	4,825	9.80%
4. U071 – COVID-19	4,589	9.32%
5. N179 – Acute Kidney Failure, Unspecified	4,556	9.25%
6. I214 – Non-ST Elevation (NSTEMI) Myocardial Infarction	4,240	8.61%
7. J189 – Pneumonia, Unspecified Organism	3,543	7.19%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
8. J9601 – Acute Respiratory Failure with Hypoxia	2,400	4.87%
9. I480 – Paroxysmal Atrial Fibrillation	2,212	4.49%
10. I350 – Nonrheumatic Aortic (Valve) Stenosis	2,193	4.45%
Total	**49,252**	**100.00%**

3) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	93	18.13%
1: Distinct Psychiatric Facility	9	1.75%
2: Distinct Rehabilitation Facility	3	0.58%
3: Distinct Skilled Nursing Facility	317	61.79%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	1	0.19%
9: Provider RHC	1	0.19%
C: Free Standing Ambulatory Surgery Center	1	0.19%
G: End Stage Renal Disease Unit	2	0.39%
H: Home Health Agency	32	6.24%
N: Critical Access Hospital	26	5.07%
O: Setting does not fit into any other existing setting code	2	0.39%
Q: Long-Term Care Facility	5	0.97%
R: Hospice	14	2.73%
S: Psychiatric Unit of an Inpatient Facility	1	0.19%
T: Rehabilitation Unit of an Inpatient Facility	3	0.58%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.19%
Z: Swing Bed Designation for Critical Access Hospitals	2	0.39%
Other	0	0.00%
Total	**513**	**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 outcome.

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 all 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	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	25	5	20.00%
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)]	60	7	11.67%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	20	6	30.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	2	50.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	5	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	5	1	20.00%
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	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	9	2	22.22%
C11: Apparently did not demonstrate that the patient was ready for discharge	15	1	6.67%
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	3	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	10	2	20.00%
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	4	1	25.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	24	7	29.17%
Total	**189**	**34**	**17.99%**

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 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**
31	91.18%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner–- Improvement needed in other patient care by practitioner area	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner determining medical necessity of procedures/surgery	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	2
Provider-Continuity of Care – Improvement needed in case management/discharge planning	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	8

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	4
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	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 10. Please note that the discharge location data for the completed appeals reported may be incomplete because of the inability to link them from the claims data.

*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)	31	53.45%
02: Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03: Discharged/transferred to skilled nursing facility (SNF)	9	15.52%
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	14	24.14%
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)	1	1.72%
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	3.45%

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	1	1.72%
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	**58**	**100.00%**

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

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	33.33%	66.67%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	8	25.00%	75.00%
MA Appeal Review (CORF, HHA, SNF, *Value-Based Insurance Design (VBID) Model Hospice Benefit Component) – (Grijalva)	3,456	34.38%	65.62%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	212	33.96%	66.04%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs - (FFS hospital discharge)	233	8.58%	91.42%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	345	7.25%	92.75%
Total	**4,257**	**30.73%**	**69.27%**

*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 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 or serious medical errors. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Acute Myocardial Infarction	American College of Cardiology (ACC) Acute Myocardial Infarction Guidelines; CMS' Acute Myocardial Infarction indicators (AMI 2-10) UpToDate®	ACC's guidelines for the management of patients with acute myocardial infarction address aspects of care that, when followed, are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Urinary Tract Infection	HAI-CAUTI (f/k/a HAC-7)	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 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	Determination Guidelines; JIMMO settlement language and guidelines,

		Guidelines; JIMMO 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 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	428	94.48%
Rural	25	5.52%
Unknown	0	0.00%
Total	**453**	**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	35	92.11%
Rural	3	7.89%
Unknown	0	0.00%
Total	**38**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro's Outreach Specialist closely worked with CMS Regional Office 10 to disseminate information regarding Kepro's services to the Latino population in the states of Washington and Oregon. Kepro translated an informational poster, website resources, and a newsletter insert into Spanish to share with the Yakima Farm Worker Clinics. This included 40 clinics in 18 communities across Washington and Oregon, serving more than 180,000 patients. Kepro was able to potentially reach 93,500 Latino at-risk beneficiaries in Washington and Oregon.

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
410	393	95.85%

11) Example/Success Story

The beneficiary's representative was concerned about the discharge from a skilled nursing facility in Oregon. She wanted to know her options and did not feel that there was good communication with the facility. She requested assistance from Kepro by using the Immediate Advocacy process to try to get a better grasp on the situation.

Kepro's Clinical Care Coordinator (CCC) contacted the facility's social worker. The CCC explained the situation and was told the staff was waiting to hear from the assisted living facility (ALF) that the representative had requested. The social worker followed up later with the CCC to let her know that the beneficiary had been accepted at the ALF. The CCC then contacted the representative who was very happy with the outcome.

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	23,228
Total Number of Calls Answered	22,520
Total Number of Abandoned Calls	280
Average Length of Call Wait Times	00:00:15
Number of Calls Transferred by 1-800-Medicare	181

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 10 – STATE OF ALASKA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	3	11.54%
Quality of Care Review (All Other Selection Reasons)	2	7.69%
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)	2	7.69%
Notice of Non-coverage (Grijalva)	3	11.54%
Notice of Non-coverage (Hospital Discharge)	15	57.69%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	1	3.85%
EMTALA 60-Day	0	0.00%
Total	**26**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,157	34.57%
2. U071 – COVID-19	323	9.65%
3. N179 – Acute Kidney Failure, Unspecified	318	9.50%
4. I110 – Hypertensive Heart Disease with Heart Failure	292	8.72%
5. J189 – Pneumonia, Unspecified Organism	286	8.54%
6. I214 – NSTEMI Myocardial Infarction	265	7.92%
7. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	259	7.74%
8. A4151 – Sepsis Due to Escherichia Coli [E. Coli]	163	4.87%
9. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	152	4.54%
10. J9601 – Acute Respiratory Failure with Hypoxia	132	3.94%
Total	**3,347**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	44	58.67%
Male	31	41.33%
Unknown	0	0.00%
Total	**75**	**100.00%**
Race		
Asian	1	1.33%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Black	6	8.00%
Hispanic	1	1.33%
North American Native	6	8.00%
Other	2	2.67%
Unknown	0	0.00%
White	59	78.67%
Total	**75**	**100.00%**
Age		
Under 65	10	13.33%
65-70	12	16.00%
71-80	29	38.67%
81-90	19	25.33%
91+	5	6.67%
Total	**75**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	7	70.00%
1: Distinct Psychiatric Facility	1	10.00%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	1	10.00%
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	0	0.00%
N: Critical Access Hospital	1	10.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	0	0.00%
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	**10**	**100.00%**

5) 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 outcome.

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)]	1	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	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%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	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	1	0	0.00%
Total	**5**	**0**	**0.00%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

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

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	3	15.00%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	2	10.00%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	14	70.00%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	1	5.00%
Total	**20**	**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%	94.48%
Rural	6	100.00%	5.52%
Unknown	0	0.00%	0.00%
Total	**6**	**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%	92.11%
Rural	2	100.00%	7.89%
Unknown	0	0.00%	0.00%
Total	**2**	**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
10	10	100.00%

KEPRO BFCC-QIO REGION 10 – STATE OF IDAHO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	11	2.74%
Quality of Care Review (All Other Selection Reasons)	9	2.24%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.25%
Notice of Non-coverage (BIPA)	20	4.98%
Notice of Non-coverage (Grijalva)	312	77.61%
Notice of Non-coverage (Hospital Discharge)	42	10.45%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	7	1.74%
EMTALA 60-Day	0	0.00%
Total	**402**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	2,124	32.06%
2. I214 – NSTEMI Myocardial Infarction	640	9.66%
3. U071 – COVID-19	601	9.07%
4. N179 – Acute Kidney Failure, Unspecified	599	9.04%
5. I110 – Hypertensive Heart Disease with Heart Failure	578	8.72%
6. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	541	8.16%
7. J189 – Pneumonia, Unspecified Organism	485	7.32%
8. J9601 – Acute Respiratory Failure with Hypoxia	396	5.98%
9. I480 – Paroxysmal Atrial Fibrillation	383	5.78%
10. J9621 – Acute and Chronic Respiratory Failure with Hypoxia	279	4.21%
Total	**6,626**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	454	58.88%
Male	317	41.12%
Unknown	0	0.00%
Total	**771**	**100.00%**
Race		
Asian	3	0.39%
Black	8	1.04%
Hispanic	11	1.43%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	3	0.39%
Other	5	0.65%
Unknown	8	1.04%
White	733	95.07%
Total	**771**	**100.00%**
Age		
Under 65	66	8.56%
65-70	105	13.62%
71-80	278	36.06%
81-90	238	30.87%
91+	84	10.89%
Total	**771**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	10	13.16%
1: Distinct Psychiatric Facility	2	2.63%
2: Distinct Rehabilitation Facility	1	1.32%
3: Distinct Skilled Nursing Facility	48	63.16%
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	6	7.89%
N: Critical Access Hospital	4	5.26%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	2.63%
R: Hospice	2	2.63%
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	1.32%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**76**	**100.00%**

5) 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 outcome.

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	1	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	9	1	11.11%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	2	100.00%
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	2	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%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	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	1	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	1	1	100.00%
Total	**20**	**5**	**25.00%**

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**
3	60.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	1

6) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admission 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	0.27%
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)	311	83.16%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	20	5.35%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	20	5.35%

MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	22	5.88%
Total	**374**	**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	58	87.88%	94.48%
Rural	8	12.12%	5.52%
Unknown	0	0.00%	0.00%
Total	**66**	**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%	92.11%
Rural	0	0.00%	7.89%
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
33	32	96.97%

KEPRO BFCC-QIO REGION 10 – STATE OF OREGON

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	49	4.31%
Quality of Care Review (All Other Selection Reasons)	18	1.58%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.09%
Notice of Non-coverage (BIPA)	39	3.43%
Notice of Non-coverage (Grijalva)	806	70.83%
Notice of Non-coverage (Hospital Discharge)	208	18.28%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	7	0.62%
EMTALA 5-Day	10	0.88%
EMTALA 60-Day	0	0.00%
Total	**1,138**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	4,114	31.59%
2. I110 – Hypertensive Heart Disease with Heart Failure	1,360	10.44%
3. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	1,334	10.24%
4. U071 – COVID-19	1,261	9.68%
5. N179 – Acute Kidney Failure, Unspecified	1,176	9.03%
6. I214 – NSTEMI Myocardial Infarction	1,096	8.41%
7. J189 – Pneumonia, Unspecified Organism	867	6.66%
8. J9601 – Acute Respiratory Failure with Hypoxia	656	5.04%
9. A4151 – Sepsis Due to E. Coli	592	4.55%
10. I350 – Nonrheumatic Aortic (Valve) Stenosis	569	4.37%
Total	**13,025**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,322	61.78%
Male	818	38.22%
Unknown	0	0.00%
Total	**2,140**	**100.00%**
Race		
Asian	15	0.70%
Black	41	1.92%
Hispanic	7	0.33%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	13	0.61%
Other	33	1.54%
Unknown	31	1.45%
White	2,000	93.46%
Total	**2,140**	**100.00%**
Age		
Under 65	188	8.79%
65-70	287	13.41%
71-80	812	37.94%
81-90	626	29.25%
91+	227	10.61%
Total	**2,140**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	31	20.13%
1: Distinct Psychiatric Facility	2	1.30%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	93	60.39%
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	1	0.65%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	2	1.30%
H: Home Health Agency	12	7.79%
N: Critical Access Hospital	5	3.25%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	1	0.65%
R: Hospice	6	3.90%
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	1	0.65%
Other	0	0.00%
Total	**154**	**100.00%**

5) 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 outcome.

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	12	3	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)]	21	3	14.29%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	4	2	50.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	4	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)	2	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	5	2	40.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	6	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	2	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	3	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	**67**	**12**	**17.91%**

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**
12	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	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	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 Admission 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	0.09%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	7	0.66%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	801	75.85%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) - (BIPA)	39	3.69%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	66	6.25%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	142	13.45%
Total	**1,056**	**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	129	97.73%	94.48%
Rural	3	2.27%	5.52%
Unknown	0	0.00%	0.00%
Total	**132**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	12	100.00%	92.11%
Rural	0	0.00%	7.89%
Unknown	0	0.00%	0.00%
Total	**12**	**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
154	149	96.75%

KEPRO BFCC-QIO REGION 10 – STATE OF WASHINGTON

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	69	2.36%
Quality of Care Review (All Other Selection Reasons)	28	0.96%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.03%
Notice of Non-coverage (BIPA)	152	5.19%
Notice of Non-coverage (Grijalva)	2,342	79.99%
Notice of Non-coverage (Hospital Discharge)	315	10.76%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.03%
EMTALA 5-Day	20	0.68%
EMTALA 60-Day	0	0.00%
Total	**2,928**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	8,425	31.73%
2. I130 - Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	2,781	10.47%
3. I110 – Hypertensive Heart Disease with Heart Failure	2,601	9.80%
4. N179 – Acute Kidney Failure, Unspecified	2,468	9.30%
5. U071 – COVID-19	2,406	9.06%
6. I214 – NSTEMI Myocardial Infarction	2,254	8.49%
7. J189 – Pneumonia, Unspecified Organism	1,907	7.18%
8. I350 – Nonrheumatic Aortic (Valve) Stenosis	1,286	4.84%
9. J9601 – Acute Respiratory Failure with Hypoxia	1,218	4.59%
10. I480 – Paroxysmal Atrial Fibrillation	1,203	4.53%
Total	**26,549**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,996	59.52%
Male	2,038	40.48%
Unknown	0	0.00%
Total	**5,034**	**100.00%**
Race		
Asian	134	2.66%
Black	265	5.26%
Hispanic	45	0.89%
North American Native	56	1.11%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Other	99	1.97%
Unknown	79	1.57%
White	4,356	86.53%
Total	**5,034**	**100.00%**
Age		
Under 65	490	9.73%
65-70	777	15.44%
71-80	1,762	35.00%
81-90	1,528	30.35%
91+	477	9.48%
Total	**5,034**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	45	16.48%
1: Distinct Psychiatric Facility	4	1.47%
2: Distinct Rehabilitation Facility	2	0.73%
3: Distinct Skilled Nursing Facility	175	64.10%
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	0.37%
C: Free Standing Ambulatory Surgery Center	1	0.37%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	14	5.13%
N: Critical Access Hospital	16	5.86%
O: Setting does not fit into any other existing setting code	2	0.73%
Q: Long-Term Care Facility	2	0.73%
R: Hospice	6	2.20%
S: Psychiatric Unit of an Inpatient Facility	1	0.37%
T: Rehabilitation Unit of an Inpatient Facility	3	1.10%
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	1	0.37%
Other	0	0.00%
Total	**273**	**100.00%**

5) 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 outcome.

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	12	2	16.67%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	29	3	10.34%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	12	4	33.33%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	4	1	25.00%
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	2	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	8	1	12.50%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	5	1	20.00%
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	3	1	33.33%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	16	4	25.00%
Total	**97**	**17**	**17.53%**

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**
16	94.12%
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 other patient care by practitioner area	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner determining medical necessity of procedures/surgery	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	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	6
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	3

6) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admission 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	0.04%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	1	0.04%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	2,341	83.40%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	151	5.38%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	133	4.74%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	180	6.41%
Total	**2,807**	**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	241	96.79%	94.48%
Rural	8	3.21%	5.52%
Unknown	0	0.00%	0.00%
Total	**249**	**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	94.44%	92.11%
Rural	1	5.56%	7.89%
Unknown	0	0.00%	0.00%
Total	**18**	**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
213	202	94.84%

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