QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Contract Year 2

(January 1 - December 31, 2020)

Region 4

AL – FL – GA – KY – MS – NC – SC – TN

Quality Improvement Organizations

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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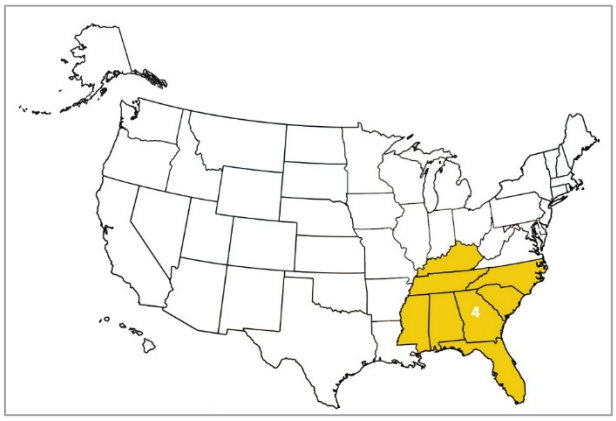
INTRODUCTION:



Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 4, which covers the following states: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. The Quality Improvement Organization (QIO) Program is an integral part of the U.S. Department of Health and Human Services National Quality Strategy and the CMS Quality Strategy. Within this report, you will find data which reflects the work completed by Kepro within the second year of its BFCC-QIO contract. The first section of this report contains regional data followed by an Appendix with state-specific data.

The QIO Program is all about improving the quality, safety, and value of the care the Medicare beneficiary receives through the Medicare program. CMS identifies the core functions of the QIO Program as:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

BFCC-QIOs, such as Kepro, review complaints about the quality of medical care. They also provide an appeal process for Medicare beneficiaries when a healthcare provider wants to discontinue services or discharge the beneficiary from the hospital. Kepro provides a service called Immediate Advocacy for beneficiaries who want to quickly resolve a Medicare situation with a provider, which does not require a medical record review. By providing these services, the rights of Medicare beneficiaries are protected while also protecting the Medicare Trust Fund.

ANNUAL REPORT:

1) TOTAL NUMBER OF REVIEWS

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

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

- Beneficiaries or their appointed representatives who have concerns related to the quality of provided healthcare services by either a facility or physician.
- Beneficiaries or their representatives who are appealing a pending hospital discharge or the discontinuation of skilled services such as physical therapy.
- Potential Emergency Medical Treatment & Labor Act (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 (MSE) when a request is made for 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 if the patient requests, an appropriate transfer should be implemented.

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	699	1.85%
Quality of Care Review (All Other Selection Reasons)	171	0.45%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	53	0.14%
Notice of Non-coverage (BIPA)	5,458	14.41%
Notice of Non-coverage (Grijalva)	22,604	59.67%
Notice of Non-coverage (Weichardt)	8,609	22.73%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	62	0.16%
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day	205	0.54%
EMTALA 60 Day	22	0.06%
Total	**37,883**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	126,233	26.81%
2. U071 - COVID-19	61,324	13.02%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	44,717	9.50%
4. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	43,806	9.30%
5. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	43,579	9.25%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	39,289	8.34%
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	32,918	6.99%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	32,886	6.98%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	26,383	5.60%
10. A4189 - OTHER SPECIFIED SEPSIS	19,759	4.20%
Total	**470,894**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	545	17.54%
1: Distinct Psychiatric Facility	37	1.19%
2: Distinct Rehabilitation Facility	70	2.25%
3: Distinct Skilled Nursing Facility	1,952	62.83%
5: Clinic	4	0.13%
6: Distinct Dialysis Center Facility	5	0.16%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	3	0.10%
9: Provider Based Rural Health Clinic (RHC)	3	0.10%
C: Free Standing Ambulatory Surgery Center	8	0.26%
G: End Stage Renal Disease Unit	10	0.32%
H: Home Health Agency	157	5.05%
N: Critical Access Hospital	40	1.29%
O: Setting does not fit into any other existing setting code	3	0.10%
Q: Long-Term Care Facility	71	2.29%
R: Hospice	182	5.86%
S: Psychiatric Unit of an Inpatient Facility	2	0.06%
T: Rehabilitation Unit of an Inpatient Facility	1	0.03%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	13	0.42%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	1	0.03%
Total	**3,107**	**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 either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

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

to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

4.A. QUALITY OF CARE CONCERNS CONFIRMED

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

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	13	2	15.38%
C02: Apparently did not make appropriate diagnoses and/or assessments	184	22	11.96%
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)]	618	122	19.74%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	339	106	31.27%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	104	20	19.23%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	76	60	78.95%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	23	4	17.39%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	51	5	9.80%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	25	4	16.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	121	27	22.31%
C11: Apparently did not demonstrate that the patient was ready for discharge	139	14	10.07%
C12: Apparently did not provide appropriate personnel and/or resources	14	11	78.57%
C13: Apparently did not order appropriate specialty consultation	17	2	11.76%
C14: Apparently specialty consultation process was not completed in a timely manner	6	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	8	2	25.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	162	54	33.33%
C17: Apparently did not order/follow evidence-based practices	33	19	57.58%
C18: Apparently did not provide medical record documentation that impacts patient care	88	83	94.32%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	186	27	14.52%
Total	**2,207**	**584**	**26.46%**

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 Quality Innovation Network QIO (QIN-QIO) for follow-up.

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
219	37.50%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	25
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner acting on laboratory and imaging test results	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	5
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	17
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	17
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	8
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	5
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner obtaining patient history and performing physical examination	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner ordering necessary laboratory and imaging tests	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner ordering of/coordination with/completion of practitioner specialty consultation	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	8
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner test/procedure/surgery technique	2
Practitioner-Patient Care by Practitioner - Improvement needed to prevent practitioner treatment delays	1
Provider-Clinical Topics - Improvement needed in evidence-based practices for immunizations	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	17
Provider-Continuity of Care - Improvement needed in coordination across disciplines	3

Provider-Continuity of Care - Improvement needed in diagnostic service completion/result reporting/result receipt	7
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	13
Provider-Continuity of Care - Improvement needed in other continuity of care area	4
Provider-Continuity of Care - Improvement needed in staff assessment completion/reporting	3
Provider-Other Administrative - Improvement needed in other administrative area	1
Provider-Other Administrative - Improvement needed in use of care protocols/evidenced based care	2
Provider-Patient Care by Staff - Improvement needed in staff assessments	3
Provider-Patient Care by Staff - Improvement needed in staff care planning	2
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	5
Provider-Patient Care by Staff - Improvement needed in staff following provider established care protocols	5
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	9
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	15
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	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of anesthesia complications	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	9
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of hospital acquired infections	3
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	16
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 medical staff credentialing to ensure competence	1

5) DISCHARGE/SERVICE TERMINATIONS

The data below reflects the discharge location of beneficiaries linked to discharge/service termination reviews for Request for BFCC-QIO Concurrence and Weichardt Reviews completed in Region 4. Please note that the discharge location data for the completed appeals reported may be incomplete because of the inability to link them from the claims data.

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self care (routine discharge)	154	24.29%
02: Discharged/transferred to another short-term general hospital for inpatient care	4	0.63%
03: Discharged/transferred to skilled nursing facility (SNF)	209	32.97%
04: Discharged/transferred to intermediate care facility (ICF)	5	0.79%
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	211	33.28%
07: Left against medical advice or discontinued care	5	0.79%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	2	0.32%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	2	0.32%
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	10	1.58%
51: Hospice - medical facility	4	0.63%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	2	0.32%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	20	3.15%
63: Discharged/transferred to a long-term care hospital	3	0.47%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	1	0.16%
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	2	0.32%
Total	**634**	**100.00%**

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

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

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
Notice of Non-coverage FFS Preadmission/Admission - (Admission and Preadmission/HINN 1)	44	47.73%	52.27%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	54	29.63%	70.37%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	16,997	37.58%	62.42%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	4,773	24.79%	75.21%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	4,148	5.98%	94.02%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (MA Weichardt)	2,858	6.40%	93.60%
Total	**28,874**	**27.84%**	**72.16%**

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) UpToDate®	CMS' guidelines for the management of patients with Community Acquired Pneumonia (CAP) 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® 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) UpToDate®	ACC's guidelines for the management of patients with heart failure address aspects of care that when followed are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Pressure Ulcers	AHRQ website; Wound, Ostomy & Continence Nursing website (www.WOCN.org) CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure) UpToDate®	The Agency for Healthcare Research and Quality (AHRQ) remains an excellent online resource for the identification of standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers. CMS' Patient Safety Indicators (PSI) are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events 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) UpToDate®	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events 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.
	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 or 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 or 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 or 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 (NCDs) are made through an evidence-based process.

8) Reviews by Geographic Area

In tables 8A-B, Kepro has provided the count and percent by rural vs. urban geographical locations for Health Service Providers (HSPs) associated with a completed BFCC-QIO review.

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

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	2,083	72.35%
Rural	789	27.41%
Unknown	7	0.24%
Total	**2,879**	**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	285	80.74%
Rural	68	19.26%
Unknown	0	0.00%
Total	**353**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro has maintained a collaborative relationship with the Atlanta Regional Centers for Medicare & Medicaid Services (CMS) office, sharing important BFCC-QIO updates and information, participating in annual meetings, and collaborating on joint conference calls. Kepro has also developed a collaborative partnership with the GeorgiaCares Program. GeorgiaCares is the State Health Insurance Assistance Program (SHIP) and SMP (Senior Medicare Patrol) project in Georgia. GeorgiaCares provides free services to Medicare beneficiaries and their caregivers, assisting them with making informed decisions about healthcare options. The staff and volunteer SHIP educators at GeorgiaCares have counseled over 56,000 people about Medicare-related issues. Each year at Medicare open enrollment, the Kepro Outreach Specialist in Georgia provides an educational presentation to Georgia staff, volunteers, and counselors. Regular trainings are also provided as requested to the GeorgiaCares team. This information has provided support to the GeorgiaCares staff in order to provide education and outreach to the 90,000 Medicare beneficiaries that they work with throughout the state. Kepro's Region 4 Outreach Specialist continues to share important announcements and updates, which are then shared with Georgia's Aging and Disability Network along with the GeorgiaCares staff. GeorgiaCares has also provided a testimony for Kepro, highlighting collaboration efforts and positive experiences with Kepro over the years.

10) Immediate Advocacy Cases

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

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
2,041	1,624	79.57%

11) EXAMPLE/SUCCESS STORY

A.) A Medicare beneficiary contacted Kepro and stated he had not received his oxygen delivery since his discharge from the hospital. The Immediate Advocacy (IA) process and limitations were discussed by the clinical reviewer (CR), including an option of either a 3-way call or the CR could advocate on the beneficiary's behalf. The beneficiary was agreeable to the IA process, provided permission to disclose his identity, and requested that the CR call the hospital to advocate on his behalf.

The CR left a message for the Case Manager requesting a call back. The Case Management Supervisor called the CR back and was agreeable to the IA process. They discussed the concern about the beneficiary not receiving oxygen since being discharged from the hospital. The Case Management Supervisor expressed appreciation for the call, as they were not aware that the beneficiary had not received his oxygen. The CR was informed that the assigned case manager would be reaching out to the durable medical equipment provider, as the provider was supposed to meet the beneficiary at home after discharge. The Case Management Supervisor stated that the beneficiary would be contacted as soon as the situation had been resolved.

The CR followed up with the beneficiary and learned that he had received the oxygen. The beneficiary thanked the CR for her efforts with the IA.

B.) A Medicare beneficiary reported being hospitalized due to an adverse reaction from a medication. During his stay, the hospital staff refused to speak with his family and his healthcare proxies, although he asked for them to be informed of his condition. He expressed concern about the unsatisfactory care from the staff, such as providing him with a blanket and leaving it out of his reach. He felt it was deliberately done to make him as uncomfortable as possible. The IA process and limitations were discussed by the clinical reviewer (CR), including an option of either a 3-way call or the CR could advocate on his behalf. The beneficiary was agreeable to the IA, provided permission to disclose his identity, and requested that the CR call the hospital to advocate on his behalf.

The CR contacted Risk Management for the hospital who agreed to participate in an IA. The beneficiary's concerns were discussed with the Risk Management staff. The Risk Management staff stated that she would report the beneficiary's concerns to the clinical staff and would follow up with the beneficiary. She stated that retraining/education would be provided to the staff to prevent this perception of care in the future.

The CR also received a call from the Director of Risk Management for the hospital. The CR reviewed the beneficiary's concerns with the Director, and the CR was informed that an investigation would begin and that the beneficiary would be contacted and offered an apology. The beneficiary was satisfied with the CR's IA efforts.

12) BENEFICIARY HELPLINE STATISTICS

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	119,880
Total Number of Calls Answered	103,272
Total Number of Abandoned Calls	12,920
Average Length of Call Wait Times	00:03:11 (191 Secs)
Number of Calls Transferred by 1-800-Medicare	925

CONCLUSION:

Kepro's outcomes and findings for year two of this CMS contract outline the daily work performed during the pursuit of care improvements provided to the individual Medicare beneficiary. These reviews provide solid data that can be extrapolated to improve the quality of provider care throughout the system based upon these individual's experiences as a part of the overall system. COVID-19 presented unique challenges throughout year, but Kepro was able to adapt to the circumstances and assist Medicare beneficiaries, their families, and healthcare providers and practitioners as they coped with the pandemic.

APPENDIX

KEPRO BFCC-QIO REGION 4 – STATE OF ALABAMA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	45	2.30%
Quality of Care Review (All Other Selection Reasons)	8	0.41%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.05%
Notice of Non-coverage (BIPA)	208	10.61%
Notice of Non-coverage (Grijalva)	1,342	68.47%
Notice of Non-coverage (Weichardt)	327	16.68%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	11	0.56%
EMTALA 5 Day	18	0.92%
EMTALA 60 Day	0	0.00%
Total	**1,960**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	7,902	22.36%
2. U071 - COVID-19	6,042	17.10%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	3,544	10.03%
4. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	3,057	8.65%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	2,837	8.03%
6. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	2,811	7.95%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	2,766	7.83%
8. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	2,439	6.90%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	2,380	6.73%
10. I639 - CEREBRAL INFARCTION, UNSPECIFIED	1,563	4.42%
Total	**35,341**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	708	61.19%
Male	449	38.81%
Unknown	0	0.00%
Total	**1,157**	**100.00%**
Race		

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Asian	1	0.09%
Black	340	29.39%
Hispanic	2	0.17%
North American Native	2	0.17%
Other	6	0.52%
Unknown	7	0.61%
White	799	69.06%
Total	**1,157**	**100.00%**
Age		
Under 65	178	15.38%
65-70	182	15.73%
71-80	382	33.02%
81-90	322	27.83%
91+	93	8.04%
Total	**1,157**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	44	17.25%
1: Distinct Psychiatric Facility	1	0.39%
2: Distinct Rehabilitation Facility	6	2.35%
3: Distinct Skilled Nursing Facility	151	59.22%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	15	5.88%
N: Critical Access Hospital	2	0.78%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	7	2.75%
R: Hospice	27	10.59%
S: Psychiatric Unit of an Inpatient Facility	2	0.78%
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	**255**	**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 either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	2	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	18	6	33.33%
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	3	8.82%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	14	3	21.43%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	15	2	13.33%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	5	1	20.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	3	1	33.33%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	8	2	25.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	8	2	25.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	8	0	0.00%
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	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%

Quality of Care ("C" Category) PRAF 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)	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	2	1	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	8	0	0.00%
Total	**139**	**23**	**16.55%**

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**
13	56.52%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner ordering necessary laboratory and imaging tests	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	1
Provider-Other Administrative - Improvement needed in use of care protocols/evidenced based care	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 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 decubiti or worsening of existing decubiti	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of hospital acquired infections	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)	9	0.60%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	1,048	70.01%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	179	11.96%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	149	9.95%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	112	7.48%
Total	**1,497**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	175	72.02%	72.35%
Rural	67	27.57%	27.41%
Unknown	1	0.41%	0.24%
Total	**243**	**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	77.27%	80.74%
Rural	5	22.73%	19.26%
Unknown	0	0.00%	0.00%
Total	**22**	**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
108	83	76.85%

KEPRO BFCC-QIO REGION 4 – STATE OF FLORIDA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	303	2.11%
Quality of Care Review (All Other Selection Reasons)	111	0.77%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	4	0.03%
Notice of Non-coverage (BIPA)	2,247	15.64%
Notice of Non-coverage (Grijalva)	6,730	46.83%
Notice of Non-coverage (Weichardt)	4,939	34.37%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.01%
EMTALA 5 Day	35	0.24%
EMTALA 60 Day	1	0.01%
Total	**14,371**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	44,010	27.53%
2. U071 - COVID-19	19,258	12.05%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	15,096	9.44%
4. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	14,599	9.13%
5. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	13,473	8.43%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	13,159	8.23%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	12,966	8.11%
8. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	11,510	7.20%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	8,627	5.40%
10. I480 - PAROXYSMAL ATRIAL FIBRILLATION	7,145	4.47%
Total	**159,843**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	5,341	58.63%
Male	3,768	41.37%
Unknown	0	0.00%
Total	**9,109**	**100.00%**
Race		
Asian	60	0.66%
Black	1,223	13.43%
Hispanic	319	3.50%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	7	0.08%
Other	93	1.02%
Unknown	80	0.88%
White	7,327	80.44%
Total	**9,109**	**100.00%**
Age		
Under 65	1,314	14.43%
65-70	1,238	13.59%
71-80	2,882	31.64%
81-90	2,709	29.74%
91+	966	10.60%
Total	**9,109**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	175	18.48%
1: Distinct Psychiatric Facility	17	1.80%
2: Distinct Rehabilitation Facility	27	2.85%
3: Distinct Skilled Nursing Facility	582	61.46%
5: Clinic	3	0.32%
6: Distinct Dialysis Center Facility	3	0.32%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	3	0.32%
G: End Stage Renal Disease Unit	5	0.53%
H: Home Health Agency	61	6.44%
N: Critical Access Hospital	2	0.21%
O: Setting does not fit into any other existing setting code	2	0.21%
Q: Long-Term Care Facility	21	2.22%
R: Hospice	39	4.12%
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	6	0.63%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	1	0.11%
Total	**947**	**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 either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health-care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	4	1	25.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	70	6	8.57%
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)]	322	88	27.33%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	190	80	42.11%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	44	12	27.27%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	62	54	87.10%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	12	2	16.67%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	21	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	8	1	12.50%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	47	11	23.40%
C11: Apparently did not demonstrate that the patient was ready for discharge	59	8	13.56%
C12: Apparently did not provide appropriate personnel and/or resources	9	9	100.00%
C13: Apparently did not order appropriate specialty consultation	7	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	4	1	25.00%

Quality of Care ("C" Category) PRAF 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)	86	36	41.86%
C17: Apparently did not order/follow evidence-based practices	18	15	83.33%
C18: Apparently did not provide medical record documentation that impacts patient care	75	72	96.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	114	11	9.65%
Total	**1,155**	**407**	**35.24%**

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**
97	23.83%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	12
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	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	9
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	9
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	4
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner ordering of/coordination with/completion of practitioner specialty consultation	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner test/procedure/surgery technique	1
Practitioner-Patient Care by Practitioner - Improvement needed to prevent practitioner treatment delays	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	10
Provider-Continuity of Care - Improvement needed in coordination across disciplines	2

Provider-Continuity of Care - Improvement needed in diagnostic service completion/result reporting/result receipt	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	5
Provider-Continuity of Care - Improvement needed in other continuity of care area	3
Provider-Continuity of Care - Improvement needed in staff assessment completion/reporting	2
Provider-Other Administrative - Improvement needed in other administrative area	1
Provider-Patient Care by Staff - Improvement needed in staff assessments	2
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	3
Provider-Patient Care by Staff - Improvement needed in staff 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	4
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	6
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of hospital acquired infections	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	8
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 medical staff credentialing to ensure competence	1

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	2	0.02%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.01%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	5,128	46.14%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	1,973	17.75%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	2,334	21.00%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	1,677	15.09%
Total	**11,115**	**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	797	91.82%	72.35%
Rural	66	7.60%	27.41%
Unknown	5	0.58%	0.24%
Total	**868**	**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	124	93.23%	80.74%
Rural	9	6.77%	19.26%
Unknown	0	0.00%	0.00%
Total	**133**	**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
993	820	82.58%

KEPRO BFCC-QIO REGION 4 – STATE OF GEORGIA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	94	2.39%
Quality of Care Review (All Other Selection Reasons)	15	0.38%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	8	0.20%
Notice of Non-coverage (BIPA)	586	14.88%
Notice of Non-coverage (Grijalva)	2,070	52.58%
Notice of Non-coverage (Weichardt)	1,116	28.35%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	28	0.71%
EMTALA 5 Day	20	0.51%
EMTALA 60 Day	0	0.00%
Total	**3,937**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	16,030	26.72%
2. U071 - COVID-19	9,140	15.23%
3. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	5,674	9.46%
4. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	5,410	9.02%
5. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	5,370	8.95%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	4,974	8.29%
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	3,808	6.35%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	3,425	5.71%
9. A4189 - OTHER SPECIFIED SEPSIS	3,106	5.18%
10. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	3,060	5.10%
Total	**59,997**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,512	62.32%
Male	914	37.68%
Unknown	0	0.00%
Total	**2,426**	**100.00%**
Race		
Asian	16	0.66%
Black	912	37.59%
Hispanic	13	0.54%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	0	0.00%
Other	9	0.37%
Unknown	25	1.03%
White	1,451	59.81%
Total	**2,426**	**100.00%**
Age		
Under 65	395	16.28%
65-70	383	15.79%
71-80	828	34.13%
81-90	650	26.79%
91+	170	7.01%
Total	**2,426**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	78	21.02%
1: Distinct Psychiatric Facility	5	1.35%
2: Distinct Rehabilitation Facility	6	1.62%
3: Distinct Skilled Nursing Facility	203	54.72%
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	0.27%
9: Provider Based Rural Health Clinic (RHC)	2	0.54%
C: Free Standing Ambulatory Surgery Center	2	0.54%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	12	3.23%
N: Critical Access Hospital	14	3.77%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	9	2.43%
R: Hospice	38	10.24%
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	0.27%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**371**	**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 either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	2	1	50.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	23	2	8.70%
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)]	93	10	10.75%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	28	5	17.86%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	11	2	18.18%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	2	66.67%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	2	1	50.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	6	3	50.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	3	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	10	1	10.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	23	2	8.70%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	3	1	33.33%
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) PRAF 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)	21	7	33.33%
C17: Apparently did not order/follow evidence-based practices	5	2	40.00%
C18: Apparently did not provide medical record documentation that impacts patient care	2	2	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	17	5	29.41%
Total	**252**	**46**	**18.25%**

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**
35	76.09%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	3
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 general treatment planning/administration	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner obtaining patient history and performing physical examination	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner test/procedure/surgery technique	1
Provider-Clinical Topics - Improvement needed in evidence-based practices for immunizations	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	2
Provider-Continuity of Care - Improvement needed in diagnostic service completion/result reporting/result receipt	2
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	2
Provider-Patient Care by Staff - Improvement needed in staff assessments	1

Provider-Patient Care by Staff - Improvement needed in staff care planning	1
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	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	1
Provider-Patient Rights - Improvement needed in other patient rights area	1
Provider-Safety of the Environment in Patient Care - Improvement needed in other safety of the environment in patient care area	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	4
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	1

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	5	0.17%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	33	1.12%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	1,492	50.70%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	498	16.92%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	571	19.40%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	344	11.69%
Total	**2,943**	**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	227	68.17%	72.35%
Rural	106	31.83%	27.41%
Unknown	0	0.00%	0.24%
Total	**333**	**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	42	84.00%	80.74%
Rural	8	16.00%	19.26%
Unknown	0	0.00%	0.00%
Total	**50**	**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
247	193	78.14%

KEPRO BFCC-QIO REGION 4 – STATE OF KENTUCKY

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	19	0.67%
Quality of Care Review (All Other Selection Reasons)	13	0.46%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	38	1.33%
Notice of Non-coverage (BIPA)	341	11.95%
Notice of Non-coverage (Grijalva)	2,129	74.62%
Notice of Non-coverage (Weichardt)	295	10.34%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	7	0.25%
EMTALA 5 Day	11	0.39%
EMTALA 60 Day	0	0.00%
Total	**2,853**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	9,220	29.19%
2. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	3,861	12.22%
3. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	3,168	10.03%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	3,147	9.96%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	2,641	8.36%
6. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	2,280	7.22%
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	2,260	7.15%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	1,930	6.11%
9. U071 - COVID-19	1,754	5.55%
10. J9621 - ACUTE AND CHRONIC RESPIRATORY FAILURE WITH HYPOXIA	1,329	4.21%
Total	**31,590**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,023	62.26%
Male	620	37.74%
Unknown	0	0.00%
Total	**1,643**	**100.00%**
Race		
Asian	0	0.00%
Black	177	10.77%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Hispanic	0	0.00%
North American Native	1	0.06%
Other	3	0.18%
Unknown	10	0.61%
White	1,452	88.37%
Total	**1,643**	**100.00%**
Age		
Under 65	169	10.29%
65-70	226	13.76%
71-80	588	35.79%
81-90	505	30.74%
91+	155	9.43%
Total	**1,643**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	39	13.49%
1: Distinct Psychiatric Facility	5	1.73%
2: Distinct Rehabilitation Facility	8	2.77%
3: Distinct Skilled Nursing Facility	210	72.66%
5: Clinic	1	0.35%
6: Distinct Dialysis Center Facility	1	0.35%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	1	0.35%
9: Provider Based Rural Health Clinic (RHC)	1	0.35%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	5	1.73%
N: Critical Access Hospital	6	2.08%
O: Setting does not fit into any other existing setting code	1	0.35%
Q: Long-Term Care Facility	7	2.42%
R: Hospice	4	1.38%
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	**289**	**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 either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	15	5	33.33%
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)]	11	3	27.27%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	5	1	20.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	1	50.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	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	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	14	5	35.71%
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	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	0	0.00%

Quality of Care ("C" Category) PRAF 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)	8	0	0.00%
C17: Apparently did not order/follow evidence-based practices	1	1	100.00%
C18: Apparently did not provide medical record documentation that impacts patient care	2	1	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	11	0	0.00%
Total	**78**	**17**	**21.79%**

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	58.82%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	6
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	2
Provider-Other Administrative - Improvement needed in use of care protocols/evidenced based care	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)	34	1.50%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	7	0.31%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	1,672	73.98%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	302	13.36%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	131	5.80%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	114	5.04%
Total	**2,260**	**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	140	52.24%	72.35%
Rural	128	47.76%	27.41%
Unknown	0	0.00%	0.24%
Total	**268**	**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	7	36.84%	80.74%
Rural	12	63.16%	19.26%
Unknown	0	0.00%	0.00%
Total	**19**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
87	70	80.46%

KEPRO BFCC-QIO REGION 4 – STATE OF MISSISSIPPI

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	15	2.03%
Quality of Care Review (All Other Selection Reasons)	3	0.41%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	67	9.07%
Notice of Non-coverage (Grijalva)	442	59.81%
Notice of Non-coverage (Weichardt)	211	28.55%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	1	0.14%
EMTALA 60 Day	0	0.00%
Total	**739**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	8,312	24.10%
2. U071 - COVID-19	6,204	17.99%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	3,713	10.77%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	3,143	9.11%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	2,605	7.55%
6. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	2,583	7.49%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	2,565	7.44%
8. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	1,976	5.73%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	1,769	5.13%
10. A4189 - OTHER SPECIFIED SEPSIS	1,617	4.69%
Total	**34,487**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	251	58.10%
Male	181	41.90%
Unknown	0	0.00%
Total	**432**	**100.00%**
Race		
Asian	0	0.00%
Black	181	41.90%
Hispanic	0	0.00%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	1	0.23%
Other	0	0.00%
Unknown	0	0.00%
White	250	57.87%
Total	**432**	**100.00%**
Age		
Under 65	81	18.75%
65-70	72	16.67%
71-80	147	34.03%
81-90	108	25.00%
91+	24	5.56%
Total	**432**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	27	20.93%
1: Distinct Psychiatric Facility	1	0.78%
2: Distinct Rehabilitation Facility	1	0.78%
3: Distinct Skilled Nursing Facility	73	56.59%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	6	4.65%
N: Critical Access Hospital	7	5.43%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	3	2.33%
R: Hospice	11	8.53%
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	**129**	**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 either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	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)]	10	1	10.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	8	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	1	50.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	1	100.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	5	1	20.00%
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	0	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	1	1	100.00%

Quality of Care ("C" Category) PRAF 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)	4	1	25.00%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	5	1	20.00%
Total	**48**	**7**	**14.58%**

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**
7	100%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Provider-Continuity of Care - Improvement needed in case management/discharge planning	1
Provider-Continuity of Care - Improvement needed in coordination across disciplines	1
Provider-Continuity of Care - Improvement needed in diagnostic service completion/result reporting/result receipt	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	2
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	1

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	1	0.18%
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)	324	58.59%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	51	9.22%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	130	23.51%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	47	8.50%
Total	**553**	**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	49	40.83%	72.35%
Rural	71	59.17%	27.41%
Unknown	0	0.00%	0.24%
Total	**120**	**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	5	41.67%	80.74%
Rural	7	58.33%	19.26%
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
45	33	73.33%

KEPRO BFCC-QIO REGION 4 – STATE OF NORTH CAROLINA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	92	1.34%
Quality of Care Review (All Other Selection Reasons)	17	0.25%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	1,070	15.59%
Notice of Non-coverage (Grijalva)	4,811	70.11%
Notice of Non-coverage (Weichardt)	820	11.95%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	52	0.76%
EMTALA 60 Day	0	0.00%
Total	**6,862**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	16,725	26.51%
2. U071 - COVID-19	6,849	10.86%
3. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	6,788	10.76%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	6,332	10.04%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	5,794	9.18%
6. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	5,652	8.96%
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	4,484	7.11%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	3,938	6.24%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	3,847	6.10%
10. I639 - CEREBRAL INFARCTION, UNSPECIFIED	2,674	4.24%
Total	**63,083**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,418	62.32%
Male	1,462	37.68%
Unknown	0	0.00%
Total	**3,880**	**100.00%**
Race		
Asian	13	0.34%
Black	981	25.28%
Hispanic	16	0.41%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	4	0.10%
Other	19	0.49%
Unknown	19	0.49%
White	2,828	72.89%
Total	**3,880**	**100.00%**
Age		
Under 65	457	11.78%
65-70	545	14.05%
71-80	1,302	33.56%
81-90	1,223	31.52%
91+	353	9.10%
Total	**3,880**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	78	15.35%
1: Distinct Psychiatric Facility	4	0.79%
2: Distinct Rehabilitation Facility	4	0.79%
3: Distinct Skilled Nursing Facility	353	69.49%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.20%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	1	0.20%
G: End Stage Renal Disease Unit	2	0.39%
H: Home Health Agency	23	4.53%
N: Critical Access Hospital	5	0.98%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	8	1.57%
R: Hospice	27	5.31%
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	2	0.39%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**508**	**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 either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	2	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	22	1	4.55%
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)]	62	6	9.68%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	48	11	22.92%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	12	1	8.33%
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	3	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	9	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	3	1	33.33%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	22	6	27.27%
C11: Apparently did not demonstrate that the patient was ready for discharge	20	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	2	1	50.00%
C13: Apparently did not order appropriate specialty consultation	3	1	33.33%
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) PRAF 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)	19	3	15.79%
C17: Apparently did not order/follow evidence-based practices	6	1	16.67%
C18: Apparently did not provide medical record documentation that impacts patient care	6	6	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	26	8	30.77%
Total	**266**	**46**	**17.29%**

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**
30	65.22%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Category Unspecified - Type Unspecified	4
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	3
Provider-Continuity of Care - Improvement needed in case management/discharge planning	2
Provider-Continuity of Care - Improvement needed in diagnostic service completion/result reporting/result receipt	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	1
Provider-Continuity of Care - Improvement needed in other continuity of care area	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	4
Provider-Patient Rights - Improvement needed in other patient rights area	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	6

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)	3,423	68.17%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	931	18.54%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	415	8.27%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	252	5.02%
Total	**5,021**	**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	320	65.57%	72.35%
Rural	168	34.43%	27.41%
Unknown	0	0.00%	0.24%
Total	**488**	**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	39	78.00%	80.74%
Rural	11	22.00%	19.26%
Unknown	0	0.00%	0.00%
Total	**50**	**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
208	149	71.63%

KEPRO BFCC-QIO REGION 4 – STATE OF SOUTH CAROLINA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	50	2.10%
Quality of Care Review (All Other Selection Reasons)	3	0.13%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	326	13.67%
Notice of Non-coverage (Grijalva)	1,614	67.70%
Notice of Non-coverage (Weichardt)	370	15.52%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	21	0.88%
EMTALA 60 Day	0	0.00%
Total	**2,384**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	8,969	25.29%
2. U071 - COVID-19	5,243	14.79%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	3,726	10.51%
4. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	3,258	9.19%
5. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	3,188	8.99%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	3,126	8.82%
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	2,554	7.20%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	1,904	5.37%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	1,773	5.00%
10. I639 - CEREBRAL INFARCTION, UNSPECIFIED	1,720	4.85%
Total	**35,461**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	860	59.47%
Male	586	40.53%
Unknown	0	0.00%
Total	**1,446**	**100.00%**
Race		
Asian	5	0.35%
Black	396	27.39%
Hispanic	3	0.21%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	2	0.14%
Other	5	0.35%
Unknown	8	0.55%
White	1,027	71.02%
Total	**1,446**	**100.00%**
Age		
Under 65	224	15.49%
65-70	205	14.18%
71-80	475	32.85%
81-90	431	29.81%
91+	111	7.68%
Total	**1,446**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	44	18.80%
1: Distinct Psychiatric Facility	2	0.85%
2: Distinct Rehabilitation Facility	7	2.99%
3: Distinct Skilled Nursing Facility	139	59.40%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	2	0.85%
H: Home Health Agency	8	3.42%
N: Critical Access Hospital	1	0.43%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	5	2.14%
R: Hospice	22	9.40%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	0.43%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	3	1.28%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**234**	**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 either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	9	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)]	31	4	12.90%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	19	3	15.79%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	8	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	1	100.00%
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)	5	1	20.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	7	1	14.29%
C11: Apparently did not demonstrate that the patient was ready for discharge	10	1	10.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	4	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

Quality of Care ("C" Category) PRAF 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)	4	1	25.00%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	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	**104**	**14**	**13.46%**

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	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 medical record documentation that impacts patient care	2
Provider-Continuity of Care - Improvement needed in case management/discharge planning	1
Provider-Continuity of Care - Improvement needed in diagnostic service completion/result reporting/result receipt	2
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	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-Patient Rights - Improvement needed in notice of noncoverage issuance	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)	1,169	66.69%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	284	16.20%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	187	10.67%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	113	6.45%
Total	**1,753**	**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	157	73.02%	72.35%
Rural	57	26.51%	27.41%
Unknown	1	0.47%	0.24%
Total	**215**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	22	78.57%	80.74%
Rural	6	21.43%	19.26%
Unknown	0	0.00%	0.00%
Total	**28**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
135	101	74.81%

KEPRO BFCC-QIO REGION 4 – STATE OF TENNESSEE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	81	1.70%
Quality of Care Review (All Other Selection Reasons)	1	0.02%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.04%
Notice of Non-coverage (BIPA)	613	12.86%
Notice of Non-coverage (Grijalva)	3,466	72.72%
Notice of Non-coverage (Weichardt)	530	11.12%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	5	0.10%
EMTALA 5 Day	47	0.99%
EMTALA 60 Day	21	0.44%
Total	**4,766**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	15,065	28.57%
2. U071 - COVID-19	6,834	12.96%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	5,092	9.66%
4. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	4,738	8.99%
5. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	4,679	8.87%
6. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	4,153	7.88%
7. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	3,887	7.37%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	3,392	6.43%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	2,647	5.02%
10. A4189 - OTHER SPECIFIED SEPSIS	2,236	4.24%
Total	**52,723**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,772	62.57%
Male	1,060	37.43%
Unknown	0	0.00%
Total	**2,832**	**100.00%**
Race		
Asian	8	0.28%
Black	488	17.23%
Hispanic	4	0.14%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	0	0.00%
Other	7	0.25%
Unknown	14	0.49%
White	2,311	81.60%
Total	**2,832**	**100.00%**
Age		
Under 65	410	14.48%
65-70	455	16.07%
71-80	959	33.86%
81-90	790	27.90%
91+	218	7.70%
Total	**2,832**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	60	16.04%
1: Distinct Psychiatric Facility	2	0.53%
2: Distinct Rehabilitation Facility	11	2.94%
3: Distinct Skilled Nursing Facility	241	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 Rural Health Clinic (RHC)	1	0.27%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	2	0.53%
G: End Stage Renal Disease Unit	1	0.27%
H: Home Health Agency	27	7.22%
N: Critical Access Hospital	3	0.80%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	11	2.94%
R: Hospice	14	3.74%
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	0.27%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**374**	**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 either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	2	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	22	2	9.09%
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)]	55	7	12.73%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	27	3	11.11%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	12	2	16.67%
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)	4	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	8	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	11	3	27.27%
C12: Apparently did not provide appropriate personnel and/or resources	2	1	50.00%
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	0	0.00%

Quality of Care ("C" Category) PRAF 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)	10	4	40.00%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	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	3	1	33.33%
Total	**165**	**24**	**14.55%**

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**
15	62.5%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner ordering necessary laboratory and imaging tests	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-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	1
Provider-Continuity of Care - Improvement needed in staff assessment completion/reporting	1
Provider-Patient Care by Staff - Improvement needed in staff care planning	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	1

Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of anesthesia complications	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	1

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	2	0.05%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	4	0.11%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	2,741	73.45%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	555	14.87%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	231	6.19%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	199	5.33%
Total	**3,732**	**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	218	63.37%	72.35%
Rural	126	36.63%	27.41%
Unknown	0	0.00%	0.24%
Total	**344**	**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	29	74.36%	80.74%
Rural	10	25.64%	19.26%
Unknown	0	0.00%	0.00%
Total	**39**	**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
218	175	80.28%

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