QIO Program
BFCC-QIO 12th SOW

Annual Medical Services Review Report

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

Region 8
CO – MT – ND – SD – UT - WY

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

Kepro™

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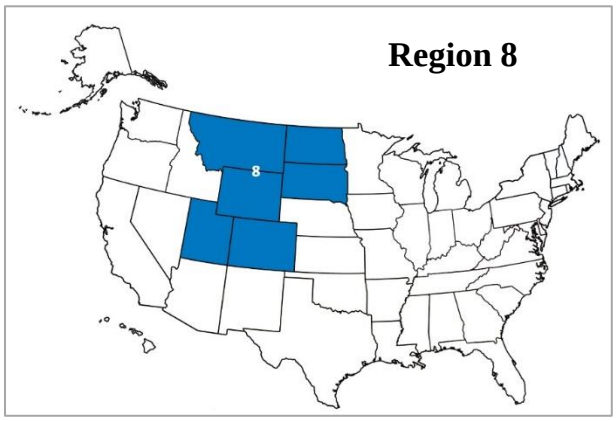
INTRODUCTION:



Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 8, which covers the following states: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. The QIO program is an integral part of the U.S. Department of Health and Human Services National Quality Strategy and CMS Quality Strategy. Within this report, you will find data that reflects the work completed by Kepro during the fourth year of its BFCC-QIO contract. The first section of this report contains regional data followed by an Appendix with state-specific data.

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

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

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

ANNUAL REPORT BODY:

1) TOTAL NUMBER OF REVIEWS

The data below reflects the total number of medical record reviews completed for Region 8.

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 EMTALA violations – In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for an examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability or the patient requests it, an appropriate transfer should be implemented.

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	79	1.38%
Quality of Care Review (All Other Selection Reasons)	94	1.64%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	2	0.03%
Notice of Non-coverage (BIPA)	653	11.42%
Notice of Non-coverage (Grijalva)	4,225	73.92%
Notice of Non-coverage (Weichardt)	607	10.62%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	6	0.10%
EMTALA 5-Day	50	0.87%
EMTALA 60-Day	0	0.00%
Total	**5,716**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	15,515	26.44%
2. U071 – COVID-19	11,713	19.96%
3. J189 – Pneumonia, Unspecified Organism	4,872	8.30%
4. I214 – Non-St Elevation Myocardial Infarction	4,549	7.75%
5. N179 – Acute Kidney Failure, Unspecified	4,525	7.71%
6. I110 – Hypertensive Heart Disease with Heart Failure	4,477	7.63%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
7. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	4,453	7.59%
8. N390 – Urinary Tract Infection, Site Not Specified	3,126	5.33%
9. A4189 – Other Specified Sepsis	2,858	4.87%
10. I480 – Paroxysmal Atrial Fibrillation	2,585	4.41%
Total	**58,673**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	95	16.81%
1: Distinct Psychiatric Facility	7	1.24%
2: Distinct Rehabilitation Facility	12	2.12%
3: Distinct Skilled Nursing Facility	332	58.76%
5: Clinic	1	0.18%
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	0.18%
9: Provider Based Rural Health Clinic (RHC)	1	0.18%
C: Freestanding Ambulatory Surgery Center	4	0.71%
G: End-Stage Renal Disease Unit	2	0.35%
H: Home Health Agency	26	4.60%
N: Critical Access Hospital	36	6.37%
O: Setting does not fit into any other existing setting code	2	0.35%
Q: Long-Term Care Facility	9	1.59%
R: Hospice	32	5.66%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	0.18%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.18%
Y: Federally Qualified Health Centers	2	0.35%
Z: Swing Bed Designation for Critical Access Hospitals	1	0.18%
Other	0	0.00%
Total	**565**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

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

4.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	7	1	14.29%
C02: Apparently did not make appropriate diagnoses and/or assessments	25	8	32.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis that 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])	133	26	19.55%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	24	4	16.67%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	6	4	66.67%
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	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	3	2	66.67%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	10	3	30.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	9	3	33.33%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	10	2	20.00%
C17: Apparently did not order/follow evidence-based practices	3	1	33.33%
C18: Apparently did not provide medical record documentation that impacts patient care	3	3	100.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	29	1	3.45%
Total	**272**	**58**	**21.32%**

4B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

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

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QOC Concerns Referred for QII**
50	86.21%
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	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	15
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 monitoring of patient response/changes and adjusting treatment	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	2
Provider-Clinical Topics – Improvement needed in evidence-based practices for heart failure	1
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-Patient Care by Staff – Improvement needed in staff assessments	3
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	1

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QOC Concerns Referred for QII**
50	86.21%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	1
Provider-Patient Rights – Improvement needed in other patient rights area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	1
Provider-Staff and Medical Staff – Improvement needed in other staff and medical staff area	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 8. Please note that the discharge location data for the completed appeals reported may be incomplete because of the inability to link them from the claims data.

*Note: Data contained in this table represent discharge/service termination reviews from **January 1, 2022**, to **December 31, 2022**.*

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self-care (routine discharge)	18	28.12%
02: Discharged/transferred to another short-term general hospital for inpatient Care	1	1.56%
03: Discharged/transferred to skilled nursing facility (SNF)	28	43.75%
04: Discharged/transferred to intermediate care facility (ICF)	0	0.00%
05: Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06: Discharged/transferred to home under care of organized home health service organization	12	18.75%
07: Left against medical advice or discontinued care	0	0.00%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	0	0.00%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	0	0.00%
40: Expired at home (Hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or freestanding Hospice)	0	0.00%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
42: Expired – place unknown (Hospice claims only)	0	0.00%
43: Discharged/transferred to a federal hospital	0	0.00%
50: Hospice - home	1	1.56%
51: Hospice - medical facility	0	0.00%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	0	0.00%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	2	3.12%
63: Discharged/transferred to a long-term care hospital	1	1.56%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66: Discharged/transferred to a critical access hospital	0	0.00%
70: Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%
Other	1	1.56%
Total	**64**	**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)	2	50.00%	50.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/ HINN 10)	6	50.00%	50.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	4,210	35.42%	64.58%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	653	28.94%	71.06%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	359	9.47%	90.53%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	246	6.10%	93.90%
Total	**5,476**	**31.65%**	**68.35%**

7) EVIDENCE USED IN DECISION-MAKING

The table that follows describes the most common types of evidence or standards of care used to support Kepro Review Analysts' assessments, which aid in formatting questions raised to the Peer Reviewer for his/her clinical decisions for medical necessity/utilization review and appeals. For the Quality of Care reviews, Kepro has provided one to three of the most highly utilized types of evidence/standards of care to support Kepro Review Analysts' assessments, which aid in formatting questions raised to the Peer Reviewer for his/her clinical decisions. A brief statement of the rationale for selecting the specific evidence or standards of care is also included.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
Quality of Care	Pneumonia	CMS' Pneumonia indicators (PN 2-7)	CMS' guidelines for the management of patients with Community Acquired Pneumonia address basic aspects of preventive care and treatment. The guidelines emphasize the importance of vaccination as well as the need for appropriate and timely antimicrobial therapy. Adherence to guidelines is associated with improved patient outcomes.
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Heart Failure	American College of Cardiology (ACC); CMS' Heart Failure indicators (HF 1-3)	ACC's guidelines for the management of patients with heart failure address aspects of care that when followed are associated with improved patient outcomes.
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Pressure Ulcers	AHRQ website; Wound, Ostomy & Continence Nursing website (www.WOCN.org)	The Agency for Healthcare Research and Quality (AHRQ) remains an excellent online resource for the identification of standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
		CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' Patient Safety Indicators (PSI) are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Acute Myocardial Infarction	American College of Cardiology (ACC) Acute Myocardial Infarction Guidelines; CMS' Acute Myocardial Infarction indicators (AMI 2-10)	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®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Urinary Tract Infection	HAI-CAUTI (f/k/a HAC-7)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
	Sepsis	Institute for Healthcare Improvement (IHI) UpToDate®	IHI developed sepsis indicators and guidelines for the identification and treatment of sepsis. Adherence to such guidelines has improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Adverse Drug Events	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
	Falls	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
	Patient Trauma	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events 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 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 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	432	86.92%
Rural	65	13.08%
Unknown	0	0.00%
Total	**497**	**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	37	74.00%
Rural	13	26.00%
Unknown	0	0.00%
Total	**50**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro not only offers training, but participation and assistance on advisory boards in several states. Montana Senior Medicare Patrol (SMP) serves about 240,000 Medicare beneficiaries. It requested a Kepro representative for its advisory board to help members understand Medicare programs and receive information that would help it make decisions about programs and training. In addition, a SMP staff member in Montana contacted a Kepro outreach representative regarding using the company's Immediate Advocacy program for a beneficiary it was assisting. Working with the Region 8 office of CMS and the six state SMP programs in the region, Kepro provided education to all staffers and volunteers.

10) Immediate Advocacy Cases

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

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

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

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
333	299	89.79%

11) Example/Success Story

The beneficiary's representative stated a discharge appeal was filed. The facility cited her not doing well with therapy for the discharge. The beneficiary's representative was concerned a lack of adequate pain control caused the problem with therapy, adding the nurses provided inconsistent information about when to administer pain medications (specific times/intervals or as-needed). The beneficiary's representative also was concerned the call bell was not in reach, preventing her from requesting pain medication.

The customer representative reviewed the concerns with the facility's director of nursing, who stated the nurse practitioner will see the beneficiary and determine if the pain medication should be changed from as-needed to scheduled, and the dose increased. The director of nursing also personally assured: the call bell will be within reach; the certified nursing assistant will be educated about the importance of it being within reach; and the nurses will be educated about the inconsistent information given to the beneficiary's representative. From there, the director of nursing will follow up with the case manager about home services if the discharge appeal is lost.

The customer representative spoke with the director of nursing, who reported following up with the beneficiary's representative. The beneficiary won the discharge appeal and will stay longer. The director of nursing stated the pain medication schedule and dose were changed and the beneficiary will be encouraged to participate in physical therapy. In addition, the director of nursing reported the social worker spoke with the beneficiary representative about discharge planning. The beneficiary and representative chose home hospice.

The customer representative spoke to the beneficiary's representative, who stated, "I am thankful that you were able to help."

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	14,840
Total Number of Calls Answered	14,078
Total Number of Abandoned Calls	562
Average Length of Call Wait Times	00:01:33
Number of Calls Transferred by 1-800-Medicare	26

CONCLUSION:

Kepro's outcomes and findings for Contract Year 4 of this CMS contract outline the daily work performed during the pursuit of care improvements provided to the individual Medicare beneficiary. These reviews provide solid data that can be extrapolated to improve the quality of provider care throughout the system based upon these individual's experiences as a part of the overall system. The Public Health Emergency continued to present unique challenges throughout the year, but Kepro was able to adapt to the circumstances and assist Medicare beneficiaries, their families, and healthcare providers and practitioners.

APPENDIX

KEPRO BFCC-QIO REGION 8 – STATE OF COLORADO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	61	1.68%
Quality of Care Review (All Other Selection Reasons)	45	1.24%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	269	7.41%
Notice of Non-coverage (Grijalva)	2,925	80.58%
Notice of Non-coverage (Weichardt)	286	7.88%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	44	1.21%
EMTALA 60-Day	0	0.00%
Total	**3,630**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	6,162	29.60%
2. U071 – COVID-19	4,099	19.69%
3. I110 – Hypertensive Heart Disease with Heart Failure	1,690	8.12%
4. N179 – Acute Kidney Failure, Unspecified	1,576	7.57%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	1,440	6.92%
6. I214 – Non-ST Elevation Myocardial Infarction	1,354	6.50%
7. A4189 – Other Specified Sepsis	1,317	6.33%
8. J189 – Pneumonia, Unspecified Organism	1,241	5.96%
9. I480 – Paroxysmal Atrial Fibrillation	1,041	5.00%
10. N390 – Urinary Tract Infection, Site Not Specified	896	4.30%
Total	**20,816**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,982	61.02%
Male	1,266	38.98%
Unknown	0	0.00%
Total	**3,248**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	17	0.52%
Black	154	4.74%
Hispanic	70	2.16%
North American Native	10	0.31%
Other	42	1.29%
Unknown	31	0.95%
White	2,924	90.02%
Total	**3,248**	**100.00%**
Age		
Under 65	246	7.57%
65-70	416	12.81%
71-80	1,105	34.02%
81-90	1,105	34.02%
91+	376	11.58%
Total	**3,248**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	41	16.53%
1: Distinct Psychiatric Facility	2	0.81%
2: Distinct Rehabilitation Facility	6	2.42%
3: Distinct Skilled Nursing Facility	152	61.29%
5: Clinic	1	0.40%
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	0.40%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	3	1.21%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	11	4.44%
N: Critical Access Hospital	5	2.02%
O: Setting does not fit into any other existing setting code	2	0.81%
Q: Long-Term Care Facility	6	2.42%
R: Hospice	16	6.45%
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	1	0.40%
Y: Federally Qualified Health Centers	1	0.40%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**248**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

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

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	5	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	14	3	21.43%
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])	83	13	15.66%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	17	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	6	4	66.67%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	3	2	66.67%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	8	2	25.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	5	1	20.00%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	3	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	3	0	0.00%
Total	**154**	**25**	**16.23%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QOC Concerns Referred for QII**
23	92.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	11
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 monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Provider-Clinical Topics – Improvement needed in evidence-based practices for heart failure	1
Provider-Staff and Medical Staff – Improvement needed in other staff and medical staff area	1

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	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)	2,914	84.03%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	269	7.76%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	135	3.89%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	150	4.33%
Total	**3,468**	**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	207	94.52%	86.92%
Rural	12	5.48%	13.08%
Unknown	0	0.00%	0.00%
Total	**219**	**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	95.65%	74.00%
Rural	1	4.35%	26.00%
Unknown	0	0.00%	0.00%
Total	**23**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
209	183	87.56%

KEPRO BFCC-QIO REGION 8 – STATE OF MONTANA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	2	0.56%
Quality of Care Review (All Other Selection Reasons)	13	3.61%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.28%
Notice of Non-coverage (BIPA)	67	18.61%
Notice of Non-coverage (Grijalva)	249	69.17%
Notice of Non-coverage (Weichardt)	26	7.22%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.28%
EMTALA 5-Day	1	0.28%
EMTALA 60-Day	0	0.00%
Total	**360**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,643	24.11%
2. U071 – COVID-19	1,421	20.85%
3. I214 – Non-ST Elevation Myocardial Infarction	635	9.32%
4. J189 – Pneumonia, Unspecified Organism	618	9.07%
5. I110 – Hypertensive Heart Disease with Heart Failure	517	7.59%
6. N179 – Acute Kidney Failure, Unspecified	466	6.84%
7. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	455	6.68%
8. N390 – Urinary Tract Infection, Site Not Specified	425	6.24%
9. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	335	4.92%
10. I480 – Paroxysmal Atrial Fibrillation	299	4.39%
Total	**6,814**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	192	62.14%
Male	117	37.86%
Unknown	0	0.00%
Total	**309**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	1	0.32%
Black	1	0.32%
Hispanic	1	0.32%
North American Native	14	4.53%
Other	3	0.97%
Unknown	0	0.00%
White	289	93.53%
Total	**309**	**100.00%**
Age		
Under 65	30	9.71%
65-70	42	13.59%
71-80	91	29.45%
81-90	102	33.01%
91+	44	14.24%
Total	**309**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	10	15.87%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	1.59%
3: Distinct Skilled Nursing Facility	28	44.44%
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)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	1	1.59%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	3	4.76%
N: Critical Access Hospital	15	23.81%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	3	4.76%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	1.59%
Z: Swing Bed Designation for Critical Access Hospitals	1	1.59%
Other	0	0.00%
Total	**63**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

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

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	1	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis that prompted this episode of care (excludes laboratory and/or imaging [see C06 or C09], procedures [see C07 or C08] and consultations [see C13 and C14])	8	2	25.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	1	100.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	2	1	50.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	4	1	25.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	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	7	0	0.00%
Total	**23**	**5**	**21.74%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QOC Concerns Referred for QII**
3	60.00%
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-Patient Care by Staff – Improvement needed in staff care planning	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)	1	0.29%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	1	0.29%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	248	72.30%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	67	19.53%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	23	6.71%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	3	0.87%
Total	**343**	**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	36	66.67%	86.92%
Rural	18	33.33%	13.08%
Unknown	0	0.00%	0.00%
Total	**54**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	4	57.14%	74.00%
Rural	3	42.86%	26.00%
Unknown	0	0.00%	0.00%
Total	**7**	**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
27	25	92.59%

KEPRO BFCC-QIO REGION 8 – STATE OF NORTH DAKOTA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	5	1.84%
Quality of Care Review (All Other Selection Reasons)	7	2.57%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.37%
Notice of Non-coverage (BIPA)	117	43.01%
Notice of Non-coverage (Grijalva)	104	38.24%
Notice of Non-coverage (Weichardt)	29	10.66%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	5	1.84%
EMTALA 5-Day	4	1.47%
EMTALA 60-Day	0	0.00%
Total	**272**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,795	22.76%
2. U071 – COVID-19	1,348	17.10%
3. J189 – Pneumonia, Unspecified Organism	856	10.86%
4. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	838	10.63%
5. I214 – Non-ST Elevation Myocardial Infarction	772	9.79%
6. N179 – Acute Kidney Failure, Unspecified	616	7.81%
7. I110 – Hypertensive Heart Disease with Heart Failure	551	6.99%
8. N390 – Urinary Tract Infection, Site Not Specified	392	4.97%
9. R531 – Weakness	362	4.59%
10. I480 – Paroxysmal Atrial Fibrillation	355	4.50%
Total	**7,885**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	159	60.46%
Male	104	39.54%
Unknown	0	0.00%
Total	**263**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	1	0.38%
Black	4	1.52%
Hispanic	0	0.00%
North American Native	11	4.18%
Other	0	0.00%
Unknown	1	0.38%
White	246	93.54%
Total	**263**	**100.00%**
Age		
Under 65	26	9.89%
65-70	28	10.65%
71-80	63	23.95%
81-90	98	37.26%
91+	48	18.25%
Total	**263**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	7	13.46%
1: Distinct Psychiatric Facility	1	1.92%
2: Distinct Rehabilitation Facility	1	1.92%
3: Distinct Skilled Nursing Facility	34	65.38%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	1	1.92%
H: Home Health Agency	0	0.00%
N: Critical Access Hospital	5	9.62%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	2	3.85%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	1.92%
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	**52**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

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

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	1	100.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	3	2	66.67%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis that prompted this episode of care (excludes laboratory and/or imaging [see C06 or C09], procedures [see C07 or C08] and consultations [see C13 and C14])	9	3	33.33%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	2	66.67%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	1	100.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	3	1	33.33%
Total	**21**	**10**	**47.62%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QOC Concerns Referred for QII**
9	90.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	1
Provider-Patient Care by Staff – Improvement needed in staff assessments	3
Provider-Patient Rights – Improvement needed in other patient rights area	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	2

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	1	0.39%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	5	1.95%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	104	40.62%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	117	45.70%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	22	8.59%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	7	2.73%
Total	**256**	**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	37	80.43%	86.92%
Rural	9	19.57%	13.08%
Unknown	0	0.00%	0.00%
Total	**46**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	2	66.67%	74.00%
Rural	1	33.33%	26.00%
Unknown	0	0.00%	0.00%
Total	**3**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
19	18	94.74%

KEPRO BFCC-QIO REGION 8 – STATE OF SOUTH DAKOTA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	0	0.00%
Quality of Care Review (All Other Selection Reasons)	11	4.47%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	37	15.04%
Notice of Non-coverage (Grijalva)	119	48.37%
Notice of Non-coverage (Weichardt)	79	32.11%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**246**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,668	20.81%
2. U071 – COVID-19	1,486	18.54%
3. J189 – Pneumonia, Unspecified Organism	799	9.97%
4. I214 – Non-ST Elevation Myocardial Infarction	726	9.06%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	697	8.69%
6. N179 – Acute Kidney Failure, Unspecified	649	8.10%
7. I110 – Hypertensive Heart Disease with Heart Failure	612	7.63%
8. N390 – Urinary Tract Infection, Site Not Specified	528	6.59%
9. M1711 – Unilateral Primary Osteoarthritis, Right Knee	434	5.41%
10. M1712 – Unilateral Primary Osteoarthritis, Left Knee	418	5.21%
Total	**8,017**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	142	58.92%
Male	99	41.08%
Unknown	0	0.00%
Total	**241**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	3	1.24%
Black	3	1.24%
Hispanic	2	0.83%
North American Native	6	2.49%
Other	0	0.00%
Unknown	1	0.41%
White	226	93.78%
Total	**241**	**100.00%**
Age		
Under 65	20	8.30%
65-70	28	11.62%
71-80	69	28.63%
81-90	95	39.42%
91+	29	12.03%
Total	**241**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	11	19.64%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	1.79%
3: Distinct Skilled Nursing Facility	33	58.93%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	1	1.79%
G: End-Stage Renal Disease Unit	1	1.79%
H: Home Health Agency	3	5.36%
N: Critical Access Hospital	6	10.71%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	0	0.00%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**56**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

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

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	2	1	50.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis that 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	5	50.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	1	1	100.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	3	3	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	7	0	0.00%
Total	**23**	**10**	**43.48%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QOC Concerns Referred for QII**
10	100.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	2
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 monitoring of patient response/changes and adjusting treatment	2
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)	0	0.00%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
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)	119	50.64%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	37	15.74%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	62	26.38%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	17	7.23%
Total	**235**	**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	40	83.33%	86.92%
Rural	8	16.67%	13.08%
Unknown	0	0.00%	0.00%
Total	48	100.00%	100.00%

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	1	20.00%	74.00%
Rural	4	80.00%	26.00%
Unknown	0	0.00%	0.00%
Total	**5**	**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
21	21	100.00%

KEPRO BFCC-QIO REGION 8 – STATE OF UTAH

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	5	0.44%
Quality of Care Review (All Other Selection Reasons)	11	0.97%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	154	13.59%
Notice of Non-coverage (Grijalva)	803	70.87%
Notice of Non-coverage (Weichardt)	160	14.12%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**1,133**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	3,440	30.07%
2. U071 – COVID-19	2,306	20.16%
3. N179 – Acute Kidney Failure, Unspecified	898	7.85%
4. I214 – Non-ST Elevation Myocardial Infarction	839	7.33%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	758	6.63%
6. J189 – Pneumonia, Unspecified Organism	748	6.54%
7. A4189 – Other Specified Sepsis	716	6.26%
8. I110 – Hypertensive Heart Disease with Heart Failure	705	6.16%
9. N390 – Urinary Tract Infection, Site Not Specified	574	5.02%
10. I480 – Paroxysmal Atrial Fibrillation	457	3.99%
Total	**11,441**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	602	58.33%
Male	430	41.67%
Unknown	0	0.00%
Total	**1,032**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	9	0.87%
Black	9	0.87%
Hispanic	17	1.65%
North American Native	6	0.58%
Other	12	1.16%
Unknown	5	0.48%
White	974	94.38%
Total	**1,032**	**100.00%**
Age		
Under 65	136	13.18%
65-70	155	15.02%
71-80	368	35.66%
81-90	291	28.20%
91+	82	7.95%
Total	**1,032**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	21	16.80%
1: Distinct Psychiatric Facility	3	2.40%
2: Distinct Rehabilitation Facility	2	1.60%
3: Distinct Skilled Nursing Facility	75	60.00%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	9	7.20%
N: Critical Access Hospital	1	0.80%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	3	2.40%
R: Hospice	11	8.80%
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	**125**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

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

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	1	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis that prompted this episode of care (excludes laboratory and/or imaging [see C06 or C09], procedures see [C07 or C08] and consultations [see C13 and C14])	12	2	16.67%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	1	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for Discharge	1	1	100.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	0	0.00%
C17: Apparently did not order/follow evidence-based practices	2	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	0	0.00%
Total	**24**	**3**	**12.50%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QOC Concerns Referred for QII**
3	100.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	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)	800	71.88%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	154	13.84%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	90	8.09%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	69	6.20%
Total	**1,113**	**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	100	86.96%	86.92%
Rural	15	13.04%	13.08%
Unknown	0	0.00%	0.00%
Total	**115**	**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	83.33%	74.00%
Rural	1	16.67%	26.00%
Unknown	0	0.00%	0.00%
Total	**6**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
47	44	93.62%

KEPRO BFCC-QIO REGION 8 – STATE OF WYOMING

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	6	8.00%
Quality of Care Review (All Other Selection Reasons)	7	9.33%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	9	12.00%
Notice of Non-coverage (Grijalva)	25	33.33%
Notice of Non-coverage (Weichardt)	27	36.00%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	1	1.33%
EMTALA 60-Day	0	0.00%
Total	**75**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. U071 – COVID-19	1,069	23.35%
2. A419 – Sepsis, Unspecified Organism	846	18.48%
3. J189 – Pneumonia, Unspecified Organism	617	13.47%
4. I110 – Hypertensive Heart Disease with Heart Failure	415	9.06%
5. N179 – Acute Kidney Failure, Unspecified	324	7.08%
6. N390 – Urinary Tract Infection, Site Not Specified	313	6.84%
7. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	281	6.14%
8. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	260	5.68%
9. I214 – Non-ST Elevation Myocardial Infarction	248	5.42%
10. R531 – Weakness	206	4.50%
Total	**4,579**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	42	58.33%
Male	30	41.67%
Unknown	0	0.00%
Total	**72**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	0	0.00%
Black	0	0.00%
Hispanic	2	2.78%
North American Native	0	0.00%
Other	0	0.00%
Unknown	1	1.39%
White	69	95.83%
Total	**72**	**100.00%**
Age		
Under 65	5	6.94%
65-70	13	18.06%
71-80	24	33.33%
81-90	25	34.72%
91+	5	6.94%
Total	**72**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	5	23.81%
1: Distinct Psychiatric Facility	1	4.76%
2: Distinct Rehabilitation Facility	1	4.76%
3: Distinct Skilled Nursing Facility	10	47.62%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	0	0.00%
N: Critical Access Hospital	4	19.05%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	0	0.00%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**21**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

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

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	4	2	50.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis that 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	1	9.09%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	2	1	50.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	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	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	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	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	6	0	0.00%
Total	**27**	**5**	**18.52%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QOC Concerns Referred for QII**
2	40.00%
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 medical record documentation that impacts patient care	1
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	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)	25	40.98%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	9	14.75%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	27	44.26%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	0	0.00%
Total	**61**	**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	12	80.00%	86.92%
Rural	3	20.00%	13.08%
Unknown	0	0.00%	0.00%
Total	**15**	**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	3	50.00%	74.00%
Rural	3	50.00%	26.00%
Unknown	0	0.00%	0.00%
Total	**6**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
10	8	80.00%

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