QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Region 8

CO – MT – ND – SD – UT - WY

January 1 – October 31, 2023

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Kepro®

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

REGION 8

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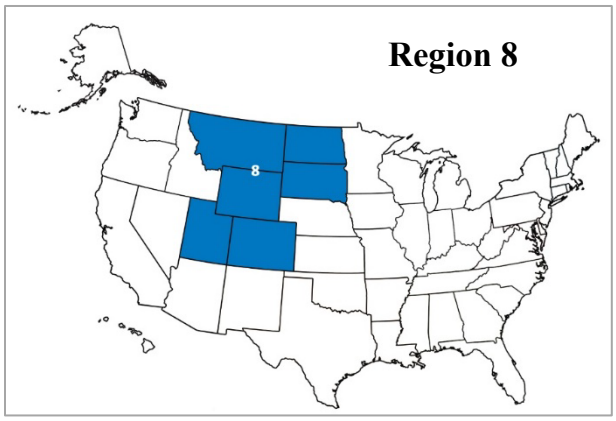
INTRODUCTION:

Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 8. Region 8 covers Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. The QIO program is an integral part of the United States Department of Health & Human Services' National Quality Strategy and CMS Quality Strategy. In this report, you will find data that reflect the work completed by Kepro during this reporting period. The first section of this report contains regional data followed by an appendix with state-specific data.



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

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

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

ANNUAL REPORT BODY:

1) TOTAL NUMBER OF REVIEWS

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

The BFCC-QIO has review authority for several different situations. These include:

- Beneficiaries or their appointed representatives who have concerns related to the quality of provided healthcare services by either a facility or physician.
- Beneficiaries or their representatives who are appealing a pending hospital discharge or the discontinuation of skilled services such as physical therapy.
- Potential EMTALA violations – In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for an examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability or the patient requests it, an appropriate transfer should be implemented.

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	132	4.16%
Quality of Care Review (All Other Selection Reasons)	61	1.92%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	1	0.03%
Notice of Non-coverage (BIPA)	145	4.57%
Notice of Non-coverage (Grijalva)	2,530	79.81%
Notice of Non-coverage (Hospital Discharge)	282	8.90%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	19	0.60%
EMTALA 60-Day	0	0.00%
Total	**3,170**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	14,740	31.50%
2. J189 – Pneumonia, Unspecified Organism	4,709	10.06%
3. U071 – COVID-19	4,565	9.76%
4. N179 – Acute Kidney Failure, Unspecified	4,090	8.74%
5. I110 – Hypertensive Heart Disease with Heart Failure	3,978	8.50%
6. I214 – Non-ST Elevation (NSTEMI) Myocardial Infarction	3,901	8.34%
7. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	3,882	8.30%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
8. N390 – Urinary Tract Infection, Site Not Specified	2,693	5.75%
9. I480 – Paroxysmal Atrial Fibrillation	2,335	4.99%
10. J9601 – Acute Respiratory Failure with Hypoxia	1,902	4.06%
Total	**46,795**	**100.00%**

3) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	82	17.63%
1: Distinct Psychiatric Facility	6	1.29%
2: Distinct Rehabilitation Facility	12	2.58%
3: Distinct Skilled Nursing Facility	294	63.23%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.22%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	12	2.58%
N: Critical Access Hospital	24	5.16%
O: Setting Does Not Fit Into Any Other Existing Setting Code	1	0.22%
Q: Long-Term Care Facility	9	1.94%
R: Hospice	22	4.73%
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	0.22%
Z: Swing Bed Designation for Critical Access Hospitals	1	0.22%
Other	0	0.00%
Total	**465**	**100.00%**

4) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

The below data reflect the category of quality of care concerns identified during medical record reviews along with the corresponding outcome.

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

Kepro, in keeping with CMS' directions, has referred all confirmed Quality of Care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the 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) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	34	7	20.59%
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)]	68	11	16.18%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	25	2	8.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	1	25.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	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)	5	2	40.00%
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	13	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	3	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	3	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	9	1	11.11%
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	10	3	30.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C99: Other quality concern not elsewhere classified	8	3	37.50%
Total	**193**	**31**	**16.06%**

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**
26	83.87%
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	7
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	1
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 to prevent practitioner treatment delays	2
Provider-Other Administrative – Improvement needed in other administrative area	2
Provider-Patient Care by Staff – Improvement needed in staff assessments	1
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	6
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2

5) DISCHARGE/SERVICE TERMINATIONS

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

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self-care (routine discharge)	7	28.00%
02: Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03: Discharged/transferred to skilled nursing facility (SNF)	7	28.00%
04: Discharged/transferred to intermediate care facility (ICF)	1	4.00%
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	7	28.00%
07: Left against medical advice or discontinued care	1	4.00%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	1	4.00%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	0	0.00%
40: Expired at home (hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or free-standing Hospice)	0	0.00%
42: Expired – Place unknown (hospice claims only)	0	0.00%
43: Discharged/transferred to a federal hospital	0	0.00%
50: Hospice – Home	0	0.00%
51: Hospice – Medical facility	0	0.00%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	0	0.00%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	0	0.00%
63: Discharged/transferred to a long-term care hospital	0	0.00%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	1	4.00%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66: Discharged/transferred to a critical access hospital	0	0.00%
70: Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%
Other	0	0.00%
Total	**25**	**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 peer reviewer either agreed or disagreed with the hospital discharge or discontinuation of skilled services decision.

Appeal Review by Notification Type	Number of Reviews	Peer Reviewer Disagreed with Discharge (%)	Peer Reviewer Agreed with Discharge (%)
Notice of Non-coverage FFS Preadmission/Admission - (Admission and Preadmission/HINN 1)	1	0.00%	100.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%	0.00%
MA Appeal Review (CORF, HHA, SNF, *Value-Based Insurance Design (VBID) Model Hospice Benefit Component) – (Grijalva)	2,523	33.33%	66.67%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	144	34.03%	65.97%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS hospital discharge)	120	10.00%	90.00%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (MA hospital discharge)	161	9.94%	90.06%
Total	**2,949**	**31.13%**	**68.87%**

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

7) Evidence Used in Decision-Making

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

Analysts' assessments, which aid in formatting questions raised to the peer reviewer for his/her clinical decisions. A brief statement of the rationale for selecting the specific evidence or standards of care is also included.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	CMS' Pneumonia indicators (PN 2-7)	CMS' guidelines for the management of patients with Community Acquired Pneumonia address basic aspects of preventive care and treatment. The guidelines emphasize the importance of vaccination as well as the need for appropriate and timely antimicrobial therapy. Adherence to guidelines is associated with improved patient outcomes.
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Heart Failure	American College of Cardiology (ACC); CMS' Heart Failure indicators (HF 1-3)	ACC's guidelines for the management of patients with heart failure address aspects of care that when followed are associated with improved patient outcomes.
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Pressure Ulcers	AHRQ website; Wound, Ostomy & Continence Nursing 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.
		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.
	Sepsis	Institute for Healthcare Improvement (IHI)	IHI developed sepsis indicators and guidelines for the identification and treatment of sepsis. Adherence to such guidelines has 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.
	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 and 8B, the number and percent are provided by rural versus urban geographical locations for Health Service Providers (HSPs) associated with a completed BFCC-QIO review (BFCC-QIO region data).

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

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	373	92.79%
Rural	29	7.21%
Unknown	0	0.00%
Total	**402**	**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	43	84.31%
Rural	8	15.69%
Unknown	0	0.00%
Total	**51**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro's Outreach Specialist (OS) educated the healthcare agencies in North and South Dakota on how and when to use Kepro's services. These agencies shared concerns about the skilled nursing facilities' understanding of the process of discharge from facilities and the use of the Notice of Medicare Non-Coverage (NOMNC). Kepro's OS presented about Kepro's services. These included discharge appeals and skilled service terminations, beneficiary complaints, and Immediate Advocacy. Detailed information was provided on how and when to use the NOMNC upon discharge from the skilled nursing facility.

Kepro's OS was able to train 192 facilities on the correct procedure for discharge. There was a guest from the Senior Medicare Patrol (SMP) in Region 8 on Kepro's podcast, Aging Health Matters, discussing Medicare fraud prevention.

10) Immediate Advocacy Cases

The data below reflect the number of beneficiary complaints resolved using Immediate Advocacy.

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

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

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
241	215	89.21%

11) Example/Success Story

The representative was concerned that the beneficiary did not receive appropriate therapy in a skilled nursing facility in Colorado. When the representative visited, the beneficiary was usually in a wheelchair in the hall. She never saw physical and speech therapies working with her mother. The representative felt that the beneficiary did not receive an appropriate evaluation prior to discharge. As a result, the representative requested assistance from Kepro by using the Immediate Advocacy process.

Kepro's Clinical Care Coordinator (CCC) contacted the social worker at the skilled nursing facility. The CCC explained the situation, and the social worker stated that the facility had a review process for concerns. The social worker will initiate a review, and the facility will contact the representative with the results. The CCC then followed up with the representative, who expressed understanding of the results and gratitude for the assistance.

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	15,280
Total Number of Calls Answered	14,964
Total Number of Abandoned Calls	162
Average Length of Call Wait Times	00:00:14
Number of Calls Transferred by 1-800-Medicare	122

CONCLUSION:

Kepro's outcomes and findings for this reporting period outline the daily work performed during the pursuit of care improvements provided to the individual Medicare beneficiary. These reviews provide solid data that can be extrapolated to improve the quality of provider care throughout the system based upon these individuals' experiences as a part of the overall system.

APPENDIX

KEPRO BFCC-QIO REGION 8 – STATE OF COLORADO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	70	3.44%
Quality of Care Review (All Other Selection Reasons)	18	0.88%
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)	62	3.05%
Notice of Non-coverage (Grijalva)	1,739	85.50%
Notice of Non-coverage (Hospital Discharge)	131	6.44%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	14	0.69%
EMTALA 60-Day	0	0.00%
Total	**2,034**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	5,262	34.68%
2. U071 – COVID-19	1,511	9.96%
3. N179 – Acute Kidney Failure, Unspecified	1,354	8.92%
4. I110 – Hypertensive Heart Disease with Heart Failure	1,340	8.83%
5. J189 – Pneumonia, Unspecified Organism	1,244	8.20%
6. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	1,125	7.41%
7. I214 – NSTEMI Myocardial Infarction	1,040	6.85%
8. I480 – Paroxysmal Atrial Fibrillation	970	6.39%
9. N390 – Urinary Tract Infection, Site Not Specified	684	4.51%
10. A4189 – Other Specified Sepsis	645	4.25%
Total	**15,175**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,108	60.73%
Male	1,363	39.27%
Unknown	0	0.00%
Total	**3,471**	**100.00%**
Race		
Asian	24	0.69%
Black	165	4.75%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Hispanic	58	1.67%
North American Native	5	0.14%
Other	51	1.47%
Unknown	34	0.98%
White	3,134	90.29%
Total	**3,471**	**100.00%**
Age		
Under 65	246	7.09%
65-70	473	13.63%
71-80	1,201	34.60%
81-90	1,130	32.56%
91+	421	12.13%
Total	**3,471**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	42	18.58%
1: Distinct Psychiatric Facility	3	1.33%
2: Distinct Rehabilitation Facility	7	3.10%
3: Distinct Skilled Nursing Facility	142	62.83%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	7	3.10%
N: Critical Access Hospital	5	2.21%
O: Setting Does Not Fit Into Any Other Existing Setting Code	1	0.44%
Q: Long-Term Care Facility	3	1.33%
R: Hospice	15	6.64%
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	0.44%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**226**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

The below data reflect the category of quality of care concerns identified during medical record reviews along with the corresponding outcome.

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

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

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	9	2	22.22%
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	7	20.59%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	15	1	6.67%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	1	33.33%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	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	4	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	6	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	2	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	2	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	6	1	16.67%
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	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	4	0	0.00%
Total	**88**	**12**	**13.64%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
11	91.67%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	2
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	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)	1,735	89.99%

FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	62	3.22%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	42	2.18%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	89	4.62%
Total	**1,928**	**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	191	96.46%	92.79%
Rural	7	3.54%	7.21%
Unknown	0	0.00%	0.00%
Total	**198**	**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	91.67%	84.31%
Rural	2	8.33%	15.69%
Unknown	0	0.00%	0.00%
Total	**24**	**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
151	135	89.40%

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)	6	3.30%
Quality of Care Review (All Other Selection Reasons)	10	5.49%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.55%
Notice of Non-coverage (BIPA)	8	4.40%
Notice of Non-coverage (Grijalva)	144	79.12%
Notice of Non-coverage (Hospital Discharge)	9	4.95%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	4	2.20%
EMTALA 60-Day	0	0.00%
Total	**182**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	2,473	35.26%
2. J189 – Pneumonia, Unspecified Organism	662	9.44%
3. U071 – COVID-19	639	9.11%
4. I214 – NSTEMI Myocardial Infarction	627	8.94%
5. I110 – Hypertensive Heart Disease with Heart Failure	569	8.11%
6. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	521	7.43%
7. N179 – Acute Kidney Failure, Unspecified	456	6.50%
8. N390 – Urinary Tract Infection, Site Not Specified	410	5.85%
9. A4189 – Other Specified Sepsis	360	5.13%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	297	4.23%
Total	**7,014**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	214	61.14%
Male	136	38.86%
Unknown	0	0.00%
Total	**350**	**100.00%**
Race		
Asian	1	0.29%
Black	3	0.86%
Hispanic	1	0.29%
North American Native	5	1.43%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Other	1	0.29%
Unknown	4	1.14%
White	335	95.71%
Total	**350**	**100.00%**
Age		
Under 65	30	8.57%
65-70	40	11.43%
71-80	116	33.14%
81-90	127	36.29%
91+	37	10.57%
Total	**350**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	7	17.95%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	2.56%
3: Distinct Skilled Nursing Facility	22	56.41%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	0	0.00%
N: Critical Access Hospital	7	17.95%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	2.56%
R: Hospice	1	2.56%
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	**39**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

The below data reflect the category of quality of care concerns identified during medical record reviews along with the corresponding outcome.

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

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

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	5	1	20.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	3	1	33.33%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	2	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	4	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	**16**	**2**	**12.50%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

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

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	1	0.62%
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)	144	88.89%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	8	4.94%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	5	3.09%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	4	2.47%
Total	**162**	**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	24	77.42%	92.79%
Rural	7	22.58%	7.21%
Unknown	0	0.00%	0.00%
Total	**31**	**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	66.67%	84.31%
Rural	2	33.33%	15.69%
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
15	13	86.67%

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)	10	7.35%
Quality of Care Review (All Other Selection Reasons)	5	3.68%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	27	19.85%
Notice of Non-coverage (Grijalva)	70	51.47%
Notice of Non-coverage (Hospital Discharge)	23	16.91%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	1	0.74%
EMTALA 60-Day	0	0.00%
Total	**136**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,535	25.46%
2. J189 – Pneumonia, Unspecified Organism	703	11.66%
3. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	683	11.33%
4. I214 – NSTEMI Myocardial Infarction	584	9.69%
5. N179 – Acute Kidney Failure, Unspecified	497	8.24%
6. I110 – Hypertensive Heart Disease with Heart Failure	491	8.15%
7. U071 – COVID-19	472	7.83%
8. R531 – Weakness	394	6.54%
9. N390 – Urinary Tract Infection, Site Not Specified	358	5.94%
10. I480 – Paroxysmal Atrial Fibrillation	311	5.16%
Total	**6,028**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	194	58.08%
Male	140	41.92%
Unknown	0	0.00%
Total	**334**	**100.00%**
Race		
Asian	0	0.00%
Black	6	1.80%
Hispanic	1	0.30%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	8	2.40%
Other	0	0.00%
Unknown	2	0.60%
White	317	94.91%
Total	**334**	**100.00%**
Age		
Under 65	22	6.59%
65-70	39	11.68%
71-80	100	29.94%
81-90	122	36.53%
91+	51	15.27%
Total	**334**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	10	25.00%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	2.50%
3: Distinct Skilled Nursing Facility	25	62.50%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	0	0.00%
N: Critical Access Hospital	3	7.50%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	1	2.50%
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	**40**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

The below data reflect the category of quality of care concerns identified during medical record reviews along with the corresponding outcome.

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

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

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	1	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	7	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	1	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	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)	2	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	2	2	100.00%
Total	**15**	**2**	**13.33%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
2	100.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner - Improvement needed to prevent practitioner treatment delays	2

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	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)	70	58.82%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	26	21.85%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	17	14.29%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	6	5.04%
Total	**119**	**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	29	85.29%	92.79%
Rural	5	14.71%	7.21%
Unknown	0	0.00%	0.00%
Total	**34**	**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	75.00%	84.31%
Rural	1	25.00%	15.69%
Unknown	0	0.00%	0.00%
Total	**4**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
13	12	92.31%

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)	22	14.01%
Quality of Care Review (All Other Selection Reasons)	10	6.37%
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)	3	1.91%
Notice of Non-coverage (Grijalva)	91	57.96%
Notice of Non-coverage (Hospital Discharge)	31	19.75%
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	**157**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,671	21.49%
2. J189 – Pneumonia, Unspecified Organism	934	12.01%
3. U071 – COVID-19	849	10.92%
4. I214 – NSTEMI Myocardial Infarction	761	9.79%
5. N179 – Acute Kidney Failure, Unspecified	725	9.32%
6. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	711	9.14%
7. I110 – Hypertensive Heart Disease with Heart Failure	596	7.66%
8. N390 – Urinary Tract Infection, Site Not Specified	560	7.20%
9. M1711 – Unilateral Primary Osteoarthritis, Right Knee	504	6.48%
10. M1712 – Unilateral Primary Osteoarthritis, Left Knee	465	5.98%
Total	**7,776**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	136	59.39%
Male	93	40.61%
Unknown	0	0.00%
Total	**229**	**100.00%**
Race		
Asian	0	0.00%
Black	8	3.49%
Hispanic	1	0.44%
North American Native	8	3.49%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Other	1	0.44%
Unknown	0	0.00%
White	211	92.14%
Total	**229**	**100.00%**
Age		
Under 65	25	10.92%
65-70	35	15.28%
71-80	72	31.44%
81-90	70	30.57%
91+	27	11.79%
Total	**229**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	7	16.67%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	2.38%
3: Distinct Skilled Nursing Facility	27	64.29%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	2	4.76%
N: Critical Access Hospital	4	9.52%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	2.38%
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	**42**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

The below data reflect the category of quality of care concerns identified during medical record reviews along with the corresponding outcome.

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

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

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	7	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)]	16	2	12.50%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	1	33.33%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	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)	3	2	66.67%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	1	0	0.00%
Total	**32**	**5**	**15.62%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
3	60.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	91	72.80%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	3	2.40%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	18	14.40%

MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	13	10.40%
Total	**125**	**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	33	91.67%	92.79%
Rural	3	8.33%	7.21%
Unknown	0	0.00%	0.00%
Total	**36**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	6	100.00%	84.31%
Rural	0	0.00%	15.69%
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
13	9	69.23%

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)	22	3.65%
Quality of Care Review (All Other Selection Reasons)	15	2.49%
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)	44	7.30%
Notice of Non-coverage (Grijalva)	455	75.46%
Notice of Non-coverage (Hospital Discharge)	67	11.11%
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	**603**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	2,937	35.51%
2. N179 – Acute Kidney Failure, Unspecified	789	9.54%
3. U071 – COVID-19	774	9.36%
4. I214 – NSTEMI Myocardial Infarction	736	8.90%
5. J189 – Pneumonia, Unspecified Organism	686	8.29%
6. I110 – Hypertensive Heart Disease with Heart Failure	641	7.75%
7. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	588	7.11%
8. N390 – Urinary Tract Infection, Site Not Specified	430	5.20%
9. I480 – Paroxysmal Atrial Fibrillation	358	4.33%
10. A4189 – Other Specified Sepsis	332	4.01%
Total	**8,271**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	770	62.91%
Male	454	37.09%
Unknown	0	0.00%
Total	**1,224**	**100.00%**
Race		
Asian	10	0.82%
Black	12	0.98%
Hispanic	24	1.96%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	9	0.74%
Other	13	1.06%
Unknown	10	0.82%
White	1,146	93.63%
Total	**1,224**	**100.00%**
Age		
Under 65	159	12.99%
65-70	202	16.50%
71-80	423	34.56%
81-90	364	29.74%
91+	76	6.21%
Total	**1,224**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	11	11.22%
1: Distinct Psychiatric Facility	3	3.06%
2: Distinct Rehabilitation Facility	1	1.02%
3: Distinct Skilled Nursing Facility	68	69.39%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	1.02%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	3	3.06%
N: Critical Access Hospital	2	2.04%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	4	4.08%
R: Hospice	5	5.10%
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	**98**	**100.00%**

5) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

The below data reflect the category of quality of care concerns identified during medical record reviews along with the corresponding outcome.

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

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

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	12	4	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)]	6	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	4	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	2	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	2	1	50.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	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	8	3	37.50%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	1	1	100.00%
Total	**37**	**9**	**24.32%**

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**
9	100.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	5
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	1
Provider-Other Administrative – Improvement needed in other administrative area	2
Provider-Patient Care by Staff – Improvement needed in staff assessments	1

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	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)	454	80.50%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	44	7.80%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	20	3.55%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	46	8.16%
Total	**564**	**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	82	94.25%	92.79%
Rural	5	5.75%	7.21%
Unknown	0	0.00%	0.00%
Total	**87**	**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	87.50%	84.31%
Rural	1	12.50%	15.69%
Unknown	0	0.00%	0.00%
Total	**8**	**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
42	40	95.24%

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)	2	3.45%
Quality of Care Review (All Other Selection Reasons)	3	5.17%
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)	1	1.72%
Notice of Non-coverage (Grijalva)	31	53.45%
Notice of Non-coverage (Hospital Discharge)	21	36.21%
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	**58**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	893	26.18%
2. J189 – Pneumonia, Unspecified Organism	487	14.28%
3. I110 – Hypertensive Heart Disease with Heart Failure	352	10.32%
4. U071 – COVID-19	324	9.50%
5. N179 – Acute Kidney Failure, Unspecified	271	7.94%
6. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	264	7.74%
7. N390 – Urinary Tract Infection, Site Not Specified	253	7.42%
8. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	236	6.92%
9. I214 – NSTEMI Myocardial Infarction	174	5.10%
10. R531 – Weakness	157	4.60%
Total	**3,411**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	64	62.14%
Male	39	37.86%
Unknown	0	0.00%
Total	**103**	**100.00%**
Race		
Asian	0	0.00%
Black	0	0.00%
Hispanic	1	0.97%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	3	2.91%
Other	1	0.97%
Unknown	0	0.00%
White	98	95.15%
Total	**103**	**100.00%**
Age		
Under 65	9	8.74%
65-70	22	21.36%
71-80	31	30.10%
81-90	30	29.13%
91+	11	10.68%
Total	**103**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	5	25.00%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	5.00%
3: Distinct Skilled Nursing Facility	10	50.00%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	0	0.00%
N: Critical Access Hospital	3	15.00%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	0	0.00%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	1	5.00%
Other	0	0.00%
Total	**20**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

The below data reflect the category of quality of care concerns identified during medical record reviews along with the corresponding outcome.

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

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

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	2	1	50.00%
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)	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	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
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	0	0	0.00%
Total	**5**	**1**	**20.00%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
1	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	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)	29	56.86%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	1	1.96%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	18	35.29%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	3	5.88%
Total	**51**	**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	14	87.50%	92.79%
Rural	2	12.50%	7.21%
Unknown	0	0.00%	0.00%
Total	**16**	**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	33.33%	84.31%
Rural	2	66.67%	15.69%
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
7	6	85.71%

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