QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Contract Year 4

(January 1 - December 31, 2022)

Region 10

AK – ID – OR - WA

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

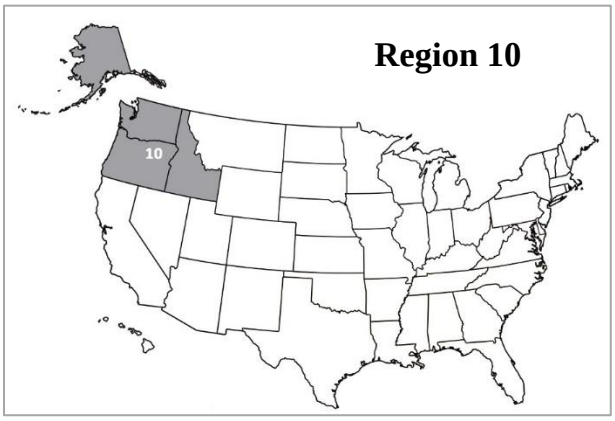
CENTERS FOR MEDICARE & MEDICAID SERVICES

Kepro™

TABLE OF CONTENTS

INTRODUCTION:

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

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)	66	0.81%
Quality of Care Review (All Other Selection Reasons)	77	0.94%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	1	0.01%
Notice of Non-coverage (BIPA)	1,002	12.28%
Notice of Non-coverage (Grijalva)	5,724	70.15%
Notice of Non-coverage (Weichardt)	1,285	15.75%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	5	0.06%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**8,160**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	15,678	27.73%
2. U071 – COVID-19	9,736	17.22%
3. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	5,576	9.86%
4. I110 – Hypertensive Heart Disease with Heart Failure	5,182	9.16%
5. I214 – Non-St Elevation Myocardial Infarction	4,995	8.83%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
6. N179 – Acute Kidney Failure, Unspecified	4,721	8.35%
7. J189 – Pneumonia, Unspecified Organism	3,464	6.13%
8. J9601 – Acute Respiratory Failure with Hypoxia	2,487	4.40%
9. A4189 – Other Specified Sepsis	2,394	4.23%
10. I350 – Non-rheumatic Aortic (Valve) Stenosis	2,315	4.09%
Total	**56,548**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	103	17.49%
1: Distinct Psychiatric Facility	5	0.85%
2: Distinct Rehabilitation Facility	4	0.68%
3: Distinct Skilled Nursing Facility	337	57.22%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	1	0.17%
9: Provider Based Rural Health Clinic (RHC)	2	0.34%
C: Freestanding Ambulatory Surgery Center	1	0.17%
G: End-Stage Renal Disease Unit	3	0.51%
H: Home Health Agency	46	7.81%
N: Critical Access Hospital	25	4.24%
O: Setting does not fit into any other existing setting code	3	0.51%
Q: Long-Term Care Facility	7	1.19%
R: Hospice	35	5.94%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	5	0.85%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.17%
Y: Federally Qualified Health Centers	1	0.17%
Z: Swing Bed Designation for Critical Access Hospitals	10	1.70%
Other	0	0.00%
Total	**589**	**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 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.

4A. QUALITY OF CARE CONCERNS CONFIRMED

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

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	16	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])	103	17	16.50%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	28	4	14.29%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	7	1	14.29%
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)	10	2	20.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	13	3	23.08%
C11: Apparently did not demonstrate that the patient was ready for discharge	17	2	11.76%
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%
C14: Apparently specialty consultation process was not completed in a timely manner	1	1	100.00%
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)	13	6	46.15%
C17: Apparently did not order/follow evidence-based practices	5	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C18: Apparently did not provide medical record documentation that impacts patient care	4	4	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	24	6	25.00%
Total	**247**	**46**	**18.62%**

4B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

As previously reported, 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**
35	76.09%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	7
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	4
Practitioner-Patient Care by Practitioner – Improvement needed to prevent practitioner treatment delays	1
Provider-Clinical Topics – Improvement needed in evidence-based practices for pneumonia	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	2
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	2
Provider-Continuity of Care – Improvement needed in practitioner specialty consultant assessment completion/reporting	3
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	3
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	2
Provider-Patient Rights – Improvement needed in other patient rights area	5
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of complications due to equipment unavailability/failure/misuse/unmaintained	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**
35	76.09%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	2

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 10. Please note that the discharge location data for the completed appeals reported may be incomplete because of the inability to link them from the claims data.

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

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self-care (routine discharge)	63	45.99%
02: Discharged/transferred to another short-term general hospital for inpatient care	1	0.73%
03: Discharged/transferred to skilled nursing facility (SNF)	20	14.60%
04: Discharged/transferred to intermediate care facility (ICF)	1	0.73%
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	40	29.20%
07: Left against medical advice or discontinued care	1	0.73%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	3	2.19%
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%
42: Expired – place unknown (hospice claims only)	0	0.00%
43: Discharged/transferred to a federal hospital	0	0.00%
50: Hospice – Home	8	5.84%
51: Hospice – Medical facility	0	0.00%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
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	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	0	0.00%
Total	**137**	**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)	1	0.00%	100.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/ HINN 10)	5	0.00%	100.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	5,711	38.36%	61.64%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	996	32.33%	67.67%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs - (FFS Weichardt)	697	6.89%	93.11%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	584	8.56%	91.44%
Total	**7,994**	**32.66%**	**67.34%**

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

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
			kind associated with improved outcomes.
	Pressure Ulcers	AHRQ website; Wound, Ostomy & Continence Nursing website (www.WOCN.org) CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure) UpToDate®	The Agency for Healthcare Research and Quality (AHRQ) remains an excellent online resource for the identification of standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers. CMS' Patient Safety Indicators (PSI) are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Acute Myocardial Infarction	American College of Cardiology (ACC) Acute Myocardial Infarction Guidelines; CMS' Acute Myocardial Infarction indicators (AMI 2-10) UpToDate®	ACC's guidelines for the management of patients with acute myocardial infarction address aspects of care that, when followed, are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
	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 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.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
	Patient Trauma	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
	Surgical Complications	Surgical complications	Kepro's Generic Quality Screening Tool
Appeals		National Coverage Determination Guidelines; JIMMO settlement language and guidelines, InterQual®, and CMS' Two Midnight Rule Benchmark criteria	Determination Guidelines; JIMMO settlement language and guidelines, InterQual®, and CMS' Two Midnight Rule Benchmark criteria Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). National Coverage Determinations are made through an evidence-based process.

8) Reviews by Geographic Area

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

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	512	91.92%
Rural	45	8.08%
Unknown	0	0.00%
Total	**557**	**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	58	95.08%
Rural	3	4.92%
Unknown	0	0.00%
Total	**61**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro works collaboratively with the Region 10 office in Seattle to provide information for providers, stakeholders, and over 2.5 million beneficiaries by offering regional and state level educational programs organized through our dedicated partners. Stakeholders, such as State Health Insurance Programs, Long-Term Care Ombudsman, and Senior Medical Patrol, benefit from training provided by sharing information with the 300,000 beneficiaries they encounter through their program offerings. On the state level, this regional office partnership encouraged Washington's Long-Term Care Ombudsman to invite our outreach specialist to train its state staff and volunteers, helping them better understand BFCC-QIO services and reach out to beneficiaries. This practice spread to others in the region. Kepro educated over 85 Long-Term Care Ombudsman staff and volunteers serving the northwest United States, allowing us to reach an estimated 115,000 Medicare recipients region wide.

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
362	329	90.88%

11) Example/Success Story

A beneficiary called the BFCC-QIO upset about her insurance company, Cigna, refusing her diabetic testing strips. She said she was having difficulty communicating with Cigna. The Care Coordinator explained how Immediate Advocacy works. The beneficiary consented to it, including giving permission to disclose her identity.

The care coordinator participated in a conference call with the beneficiary and Cigna. They were transferred to three representatives, spending a substantial amount of time on the line before obtaining assistance from the pharmacy department within Cigna. The provider completed a pre-authorization form for supplies through June

and told the beneficiary that because her testing strips are medically necessary, her primary care provider only had to call in a pre-authorization for a refill.

The beneficiary thanked Kepro and said no further assistance was needed at this time.

12) BENEFICIARY HELPLINE STATISTICS

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	21,748
Total Number of Calls Answered	20,596
Total Number of Abandoned Calls	789
Average Length of Call Wait Times	00:01:35
Number of Calls Transferred by 1-800-Medicare	36

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 10 – STATE OF ALASKA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	1	1.45%
Quality of Care Review (All Other Selection Reasons)	2	2.90%
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)	13	18.84%
Notice of Non-coverage (Grijalva)	11	15.94%
Notice of Non-coverage (Weichardt)	42	60.87%
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	**69**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,201	29.34%
2. U071 – COVID-19	854	20.86%
3. I214 – Non-ST Elevation Myocardial Infarction	339	8.28%
4. N179 – Acute Kidney Failure, Unspecified	317	7.74%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	289	7.06%
6. I110 – Hypertensive Heart Disease with Heart Failure	286	6.99%
7. J189 – Pneumonia, Unspecified Organism	263	6.42%
8. I639 – Cerebral Infarction, Unspecified	190	4.64%
9. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	183	4.47%
10. A4189 – Other Specified Sepsis	172	4.20%
Total	**4,094**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	53	62.35%
Male	32	37.65%
Unknown	0	0.00%
Total	**85**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	2	2.35%
Black	6	7.06%
Hispanic	1	1.18%
North American Native	6	7.06%
Other	2	2.35%
Unknown	2	2.35%
White	66	77.65%
Total	**85**	**100.00%**
Age		
Under 65	12	14.12%
65-70	11	12.94%
71-80	37	43.53%
81-90	17	20.00%
91+	8	9.41%
Total	**85**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	6	40.00%
1: Distinct Psychiatric Facility	1	6.67%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	5	33.33%
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	1	6.67%
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	13.33%
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	**15**	**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	0	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])	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)	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)	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	**3**	**1**	**33.33%**

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**
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 to prevent practitioner treatment delays	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)	11	16.67%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	13	19.70%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	40	60.61%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	2	3.03%
Total	**66**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	0	0.00%	91.92%
Rural	15	100.00%	8.08%
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	0	0.00%	95.08%
Rural	2	100.00%	4.92%
Unknown	0	0.00%	0.00%
Total	**2**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
8	7	87.50%

KEPRO BFCC-QIO REGION 10 – STATE OF IDAHO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	4	0.62%
Quality of Care Review (All Other Selection Reasons)	10	1.55%
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	9.60%
Notice of Non-coverage (Grijalva)	475	73.53%
Notice of Non-coverage (Weichardt)	95	14.71%
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	**646**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,927	26.85%
2. U071 – COVID-19	1,478	20.60%
3. I214 – Non-ST Elevation Myocardial Infarction	684	9.53%
4. N179 – Acute Kidney Failure, Unspecified	554	7.72%
5. I110 – Hypertensive Heart Disease with Heart Failure	511	7.12%
6. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	474	6.61%
7. J189 – Pneumonia, Unspecified Organism	442	6.16%
8. A4189 – Other Specified Sepsis	378	5.27%
9. I480 – Paroxysmal Atrial Fibrillation	369	5.14%
10. J9601 – Acute Respiratory Failure with Hypoxia	359	5.00%
Total	**7,176**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	340	58.42%
Male	242	41.58%
Unknown	0	0.00%
Total	**582**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	0	0.00%
Black	9	1.55%
Hispanic	6	1.03%
North American Native	6	1.03%
Other	5	0.86%
Unknown	2	0.34%
White	554	95.19%
Total	**582**	**100.00%**
Age		
Under 65	70	12.03%
65-70	94	16.15%
71-80	183	31.44%
81-90	184	31.62%
91+	51	8.76%
Total	**582**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	10	11.63%
1: Distinct Psychiatric Facility	2	2.33%
2: Distinct Rehabilitation Facility	2	2.33%
3: Distinct Skilled Nursing Facility	53	61.63%
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	8	9.30%
N: Critical Access Hospital	4	4.65%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	2.33%
R: Hospice	4	4.65%
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	1.16%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**86**	**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 which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	9	1	11.11%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	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	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)	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	1	1	100.00%
Total	**17**	**3**	**17.65%**

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	1
Provider-Patient Rights – Improvement needed in other patient rights area	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of complications due to equipment unavailability/failure/misuse/unmaintained	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)	474	75.36%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	60	9.54%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	45	7.15%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	50	7.95%
Total	**629**	**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	68	87.18%	91.92%
Rural	10	12.82%	8.08%
Unknown	0	0.00%	0.00%
Total	**78**	**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%	95.08%
Rural	1	16.67%	4.92%
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
30	27	90.00%

KEPRO BFCC-QIO REGION 10 – STATE OF OREGON

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	20	0.93%
Quality of Care Review (All Other Selection Reasons)	22	1.02%
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)	219	10.20%
Notice of Non-coverage (Grijalva)	1,431	66.62%
Notice of Non-coverage (Weichardt)	451	21.00%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	5	0.23%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**2,148**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	3,872	26.77%
2. U071 – COVID-19	2,577	17.82%
3. I110 – Hypertensive Heart Disease with Heart Failure	1,459	10.09%
4. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	1,446	10.00%
5. I214 – Non-ST Elevation Myocardial Infarction	1,256	8.68%
6. N179 – Acute Kidney Failure, Unspecified	1,208	8.35%
7. J189 – Pneumonia, Unspecified Organism	824	5.70%
8. I350 – Non-rheumatic Aortic (Valve) Stenosis	633	4.38%
9. J9601 – Acute Respiratory Failure with Hypoxia	613	4.24%
10. A4151 – Sepsis Due to Escherichia Coli	576	3.98%
Total	**14,464**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,197	60.33%
Male	787	39.67%
Unknown	0	0.00%
Total	**1,984**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	22	1.11%
Black	48	2.42%
Hispanic	11	0.55%
North American Native	13	0.66%
Other	26	1.31%
Unknown	31	1.56%
White	1,833	92.39%
Total	**1,984**	**100.00%**
Age		
Under 65	197	9.93%
65-70	293	14.77%
71-80	704	35.48%
81-90	576	29.03%
91+	214	10.79%
Total	**1,984**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	33	18.23%
1: Distinct Psychiatric Facility	1	0.55%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	95	52.49%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	1	0.55%
9: Provider Based Rural Health Clinic (RHC)	1	0.55%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	2	1.10%
H: Home Health Agency	19	10.50%
N: Critical Access Hospital	11	6.08%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	1.10%
R: Hospice	15	8.29%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	1	0.55%
Other	0	0.00%
Total	**181**	**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	2	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])	38	6	15.79%
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	3	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	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for Discharge	7	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)	2	1	50.00%
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	8	3	37.50%
Total	**67**	**11**	**16.42%**

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	90.91%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	5
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 carrying out plan of care	1
Provider-Patient Rights – Improvement needed in other patient rights area	3

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)	5	0.24%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	1,429	67.98%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	218	10.37%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	229	10.89%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	221	10.51%
Total	**2,102**	**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	168	98.82%	91.92%
Rural	2	1.18%	8.08%
Unknown	0	0.00%	0.00%
Total	**170**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	15	100.00%	95.08%
Rural	0	0.00%	4.92%
Unknown	0	0.00%	0.00%
Total	**15**	**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
131	121	92.37%

KEPRO BFCC-QIO REGION 10 – STATE OF WASHINGTON

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	41	0.77%
Quality of Care Review (All Other Selection Reasons)	43	0.81%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.02%
Notice of Non-coverage (BIPA)	708	13.37%
Notice of Non-coverage (Grijalva)	3,807	71.87%
Notice of Non-coverage (Weichardt)	697	13.16%
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	**5,297**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	8,702	27.87%
2. U071 – COVID-19	4,841	15.50%
3. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	3,388	10.85%
4. I110 – Hypertensive Heart Disease With Heart Failure	2,939	9.41%
5. I214 – Non-ST Elevation (NSTEMI) Myocardial Infarction	2,744	8.79%
6. N179 – Acute Kidney Failure, Unspecified	2,650	8.49%
7. J189 – Pneumonia, Unspecified Organism	1,938	6.21%
8. N390 – Urinary Tract Infection, Site Not Specified	1,352	4.33%
9. J9601 – Acute Respiratory Failure With Hypoxia	1,351	4.33%
10. I350 – Nonrheumatic Aortic (Valve) Stenosis	1,320	4.23%
Total	**31,225**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,798	60.92%
Male	1,795	39.08%
Unknown	0	0.00%
Total	**4,593**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	119	2.59%
Black	224	4.88%
Hispanic	31	0.67%
North American Native	46	1.00%
Other	76	1.65%
Unknown	65	1.42%
White	4,032	87.79%
Total	**4,593**	**100.00%**
Age		
Under 65	417	9.08%
65-70	689	15.00%
71-80	1,578	34.36%
81-90	1,389	30.24%
91+	520	11.32%
Total	**4,593**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	54	17.59%
1: Distinct Psychiatric Facility	1	0.33%
2: Distinct Rehabilitation Facility	2	0.65%
3: Distinct Skilled Nursing Facility	184	59.93%
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)	1	0.33%
C: Freestanding Ambulatory Surgery Center	1	0.33%
G: End-Stage Renal Disease Unit	1	0.33%
H: Home Health Agency	19	6.19%
N: Critical Access Hospital	9	2.93%
O: Setting does not fit into any other existing setting code	3	0.98%
Q: Long-Term Care Facility	3	0.98%
R: Hospice	14	4.56%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	5	1.63%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.33%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	9	2.93%
Other	0	0.00%
Total	**307**	**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	13	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)]	54	9	16.67%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	23	2	8.70%
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)	7	2	28.57%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	13	3	23.08%
C11: Apparently did not demonstrate that the patient was ready for discharge	9	2	22.22%
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) 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	1	1	100.00%
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)	8	5	62.50%
C17: Apparently did not order/follow evidence-based practices	3	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	4	4	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	15	2	13.33%
Total	**160**	**31**	**19.38%**

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**
21	67.74%
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
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	3
Provider-Clinical Topics – Improvement needed in evidence-based practices for pneumonia	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	2
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	2
Provider-Continuity of Care – Improvement needed in practitioner specialty consultant assessment completion/reporting	3
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	2
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	2
Provider-Patient Rights – Improvement needed in other patient rights area	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	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**
21	67.74%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	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	0.02%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	3,797	73.06%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	705	13.57%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	383	7.37%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	311	5.98%
Total	**5,197**	**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	276	93.88%	91.92%
Rural	18	6.12%	8.08%
Unknown	0	0.00%	0.00%
Total	**294**	**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	38	100.00%	95.08%
Rural	0	0.00%	4.92%
Unknown	0	0.00%	0.00%
Total	**38**	**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
193	174	90.16%

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