QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Region 4

AL – FL – GA – KY – MS – NC – SC – TN

January 1 – October 31, 2023

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

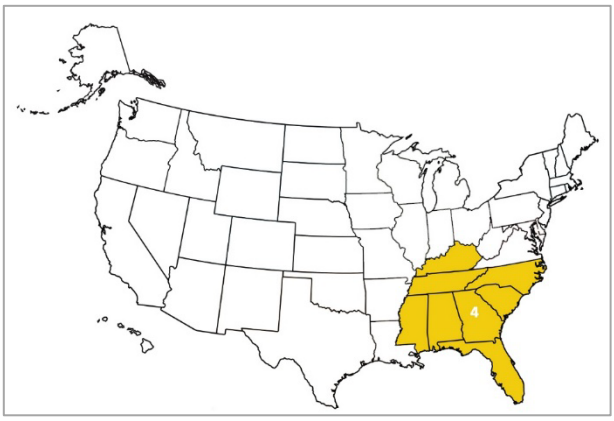
Kepro®

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

REGION 4

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 4. Region 4 covers Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. 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 well as 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 4.

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)	1,080	2.45%
Quality of Care Review (All Other Selection Reasons)	913	2.07%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	5	0.01%
Notice of Non-coverage (BIPA)	1,223	2.77%
Notice of Non-coverage (Grijalva)	33,971	76.92%
Notice of Non-coverage (Hospital Discharge)	6,525	14.77%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	12	0.03%
EMTALA 5-Day	316	0.72%
EMTALA 60-Day	121	0.27%
Total	**44,166**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	100,846	29.43%
2. N179 – Acute Kidney Failure, Unspecified	33,172	9.68%
3. U071 – COVID-19	32,507	9.49%
4. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	31,888	9.31%
5. I110 – Hypertensive Heart Disease with Heart Failure	31,821	9.29%
6. J189 – Pneumonia, Unspecified Organism	30,971	9.04%
7. N390 – Urinary Tract Infection, Site Not Specified	24,467	7.14%
8. I214 – Non-ST Elevation (NSTEMI) Myocardial Infarction	23,150	6.76%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
9. I480 – Paroxysmal Atrial Fibrillation	20,276	5.92%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	13,595	3.97%
Total	**342,693**	**100.00%**

3) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	560	17.47%
1: Distinct Psychiatric Facility	26	0.81%
2: Distinct Rehabilitation Facility	81	2.53%
3: Distinct Skilled Nursing Facility	2,107	65.72%
5: Clinic	1	0.03%
6: Distinct Dialysis Center Facility	1	0.03%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	4	0.12%
9: Provider Based RHC	7	0.22%
C: Free Standing Ambulatory Surgery Center	3	0.09%
G: End Stage Renal Disease Unit	6	0.19%
H: Home Health Agency	159	4.96%
N: Critical Access Hospital	69	2.15%
O: Setting Does Not Fit Into Any Other Existing Setting Code	11	0.34%
Q: Long-Term Care Facility	53	1.65%
R: Hospice	99	3.09%
S: Psychiatric Unit of an Inpatient Facility	7	0.22%
T: Rehabilitation Unit of an Inpatient Facility	3	0.09%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	9	0.28%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**3,206**	**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. It can also be referred to the BFCC-QIO from another agency, such as the Office of Medicare Ombudsmen or Congress.

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

to health care or related to documentation, Kepro retains them and works directly with the healthcare provider and/or practitioner.

4.A. QUALITY OF CARE CONCERNS CONFIRMED

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	21	6	28.57%
C02: Apparently did not make appropriate diagnoses and/or assessments	160	27	16.88%
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)]	653	103	15.77%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	277	102	36.82%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	42	9	21.43%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	16	8	50.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	104	83	79.81%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	48	6	12.50%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	18	5	27.78%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	58	15	25.86%
C11: Apparently did not demonstrate that the patient was ready for discharge	79	13	16.46%
C12: Apparently did not provide appropriate personnel and/or resources	3	0	0.00%
C13: Apparently did not order appropriate specialty consultation	11	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	6	1	16.67%
C15: Apparently did not effectively coordinate across disciplines	6	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	160	79	49.38%
C17: Apparently did not order/follow evidence-based practices	79	9	11.39%
C18: Apparently did not provide medical record documentation that impacts patient care	44	36	81.82%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	208	80	38.46%
Total	**1,993**	**582**	**29.20%**

4.B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

Kepro, in keeping with CMS' directions, has referred all confirmed quality of care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the designated QIN-QIO for follow-up.

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**
329	56.53%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in other patient care by practitioner area	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	9
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner determining medical necessity of procedures/surgery	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	46
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	27
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	24
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	11
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	10
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner obtaining patient history and performing physical examination	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering necessary laboratory and imaging tests	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering of/coordination with/completion of practitioner specialty consultation	1

Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	10
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner test/procedure/surgery technique	7
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner use of evidence-based practices	2
Practitioner-Patient Care by Practitioner – Improvement needed to prevent practitioner treatment delays	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	9
Provider-Continuity of Care – Improvement needed in coordination across disciplines	3
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	7
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	16
Provider-Continuity of Care – Improvement needed in practitioner specialty consultant assessment completion/reporting	5
Provider-Other Administrative – Improvement needed in medical record documentation to support billing	2
Provider-Other Administrative – Improvement needed in other administrative area	3
Provider-Patient Care by Staff –Improvement needed in other patient care by staff area	9
Provider-Patient Care by Staff – Improvement needed in staff assessments	13
Provider-Patient Care by Staff – Improvement needed in staff care planning	4
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	18
Provider-Patient Care by Staff - Improvement needed in staff following provider established care protocols	14

Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	22
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	4
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	13
Provider-Safety of the Environment in Patient Care – Improvement needed in other safety of the environment in patient care area	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	9
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	7
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	9
Provider-Staff and Medical Staff – Improvement needed in having adequate provider staff human resources	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 4. Please note that the discharge location data for the completed appeals reported may be incomplete because of the inability to link them from the claims data.

*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)	122	22.43%
02: Discharged/transferred to another short-term general hospital for inpatient care	6	1.10%
03: Discharged/transferred to skilled nursing facility (SNF)	152	27.94%
04: Discharged/transferred to intermediate care facility (ICF)	5	0.92%
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	198	36.40%
07: Left against medical advice or discontinued care	3	0.55%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	2	0.37%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	1	0.18%
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	15	2.76%
51: Hospice – Medical facility	6	1.10%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	1	0.18%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	28	5.15%
63: Discharged/transferred to a long-term care hospital	4	0.74%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	1	0.18%
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	544	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)	5	20.00%	80.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	12	8.33%	91.67%
MA Appeal Review (CORF, HHA, SNF, *Value-Based Insurance Design (VBID) Model Hospice Benefit Component) – (Grijalva)	33,871	40.11%	59.89%

Appeal Review by Notification Type	Number of Reviews	Peer Reviewer Disagreed with Discharge (%)	Peer Reviewer Agreed with Discharge (%)
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	1,209	37.97%	62.03%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	2,539	6.03%	93.97%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	3,961	6.13%	93.87%
Total	**41,597**	**34.72%**	**65.28%**

*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 Value-Based Insurance Design (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. These 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 utilized types of evidence/ standards of care to support Kepro Review Analysts' assessments. These 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	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.

		Infarction indicators (AMI 2-10) 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) UpToDate®	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Sepsis	Institute for Healthcare Improvement (IHI) UpToDate®	IHI developed sepsis indicators and guidelines for the identification and treatment of sepsis. Adherence to such guidelines has improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Adverse Drug Events	CMS' Hospital Acquired Conditions & Patient Safety Indicators	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed

		(PSI-03 & PSI-90 Composite Measure)	the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
	Falls	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
	Patient Trauma	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
	Surgical Complications	Surgical complications	Kepro's Generic Quality Screening Tool
Appeals		National Coverage Determination 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.

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

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	2,584	90.38%
Rural	275	9.62%
Unknown	0	0.00%
Total	**2,859**	**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	324	97.30%
Rural	9	2.70%
Unknown	0	0.00%
Total	**333**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

In efforts to promote health equity, Kepro's Outreach Specialist (OS) has cultivated a partnership with the Florida Department of Elder Affairs. The Florida Department of Elder Affairs provides direct services to the Medicare population through community-based efforts in partnership with the state's eleven Area Agencies on Aging and local service providers.

Kepro's OS has worked closely with the Director of Elder Protection of the Florida Department of Elder Affairs' Serving Health Insurance Needs of Elders (SHINE) program. SHINE is part of the national State Health Insurance Assistance Program (SHIP). The SHINE program provides free health insurance information and assistance to Medicare beneficiaries, their families, and caregivers to make informed healthcare choices. Kepro's OS has worked with the SHINE bilingual outreach program, to share resources and provide outreach to the Hispanic community across the state of Florida. Kepro's OS has presented on Kepro's services and provided a newsletter insert in both English and Spanish.

This year, there were roughly 300 SHINE volunteers that reached approximately 30,000 Medicare beneficiaries.

Kepro has also maintained a strong relationship with the South Carolina State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP) programs at the South Carolina Department on Aging. Kepro's OS presented at several of their Quarterly Coordinator meetings and continues to share all new resources and updates. The South Carolina SHIP program reaches approximately 80,000 beneficiaries. The SC SHIP/SMP has also participated in several podcast episodes for Kepro's Aging Health Matters podcast.

10) Immediate Advocacy Cases

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

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
4,241	4,100	96.68%

11) Example/Success Story

The beneficiary's representative was concerned about care from the home health agency in Georgia. The beneficiary had a stroke, and, as a complication, severe hand contractures. He had a wound developing in his closed hand and had new wounds on his feet, as well as ulcers on his legs. The home health nurse wrote that the representative was able to do the leg dressing, so the insurance would not cover any further visits.

The representative stated that she was able to do the leg dressing, but she could not treat the hand wound and did not know what to do for his feet. The representative had not been able to get any more visits from the home health agency approved, so she requested an intervention by Kepro, using the Immediate Advocacy service.

Kepro's Clinical Care Coordinator (CCC) reached out to the provider and was told that there was no Letter of Medical Necessity for any future visits. The representative will need to contact the primary care physician for new orders for the areas that need to be treated and the Letter of Medical Necessity. The CCC then followed up with the representative and she stated, "You have taken a huge weight off of my shoulders." She will be reaching out to the primary care physician for assistance to get the home health services back in place.

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	197,485
Total Number of Calls Answered	194,492
Total Number of Abandoned Calls	2,451
Average Length of Call Wait Times	00:00:12
Number of Calls Transferred by 1-800-Medicare	1,062

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 4 – STATE OF ALABAMA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	67	2.84%
Quality of Care Review (All Other Selection Reasons)	36	1.53%
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)	30	1.27%
Notice of Non-coverage (Grijalva)	1,854	78.56%
Notice of Non-coverage (Hospital Discharge)	327	13.86%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.04%
EMTALA 5 Day	38	1.61%
EMTALA 60 Day	7	0.30%
Total	**2,360**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	6,029	25.61%
2. U071 – COVID-19	2,432	10.33%
3. J189 – Pneumonia, Unspecified Organism	2,354	10.00%
4. I110 – Hypertensive Heart Disease with Heart Failure	2,223	9.44%
5. N179 – Acute Kidney Failure, Unspecified	2,124	9.02%
6. N390 – Urinary Tract Infection, Site Not Specified	2,124	9.02%
7. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	2,112	8.97%
8. I214 – NSTEMI Myocardial Infarction	1,527	6.49%
9. I480 – Paroxysmal Atrial Fibrillation	1,378	5.85%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	1,242	5.28%
Total	**23,545**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,398	61.03%
Male	1,531	38.97%
Unknown	0	0.00%
Total	**3,929**	**100.00%**
Race		

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Asian	8	0.20%
Black	1,271	32.35%
Hispanic	4	0.10%
North American Native	1	0.03%
Other	8	0.20%
Unknown	22	0.56%
White	2,615	66.56%
Total	**3,929**	**100.00%**
Age		
Under 65	519	13.21%
65-70	690	17.56%
71-80	1,395	35.51%
81-90	1,008	25.66%
91+	317	8.07%
Total	**3,929**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	47	18.80%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	9	3.60%
3: Distinct Skilled Nursing Facility	170	68.00%
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	14	5.60%
N: Critical Access Hospital	2	0.80%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	3	1.20%
R: Hospice	3	1.20%
S: Psychiatric Unit of an Inpatient Facility	2	0.80%
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	**250**	**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. 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	3	1	33.33%
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)]	45	7	15.56%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	6	2	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	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	4	3	75.00%
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	3	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	3	2	66.67%
C11: Apparently did not demonstrate that the patient was ready for discharge	7	2	28.57%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	9	5	55.56%
C17: Apparently did not order/follow evidence-based practices	4	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	6	1	16.67%
Total	**103**	**23**	**22.33%**

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**
17	73.91%
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 diagnosis and evaluation of patients	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	1
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	7
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	3
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	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

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)	1	0.05%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	1,851	83.83%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	29	1.31%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	141	6.39%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	186	8.42%
Total	**2,208**	**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	201	88.94%	90.38%
Rural	25	11.06%	9.62%
Unknown	0	0.00%	0.00%
Total	**226**	**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	23	95.83%	97.30%
Rural	1	4.17%	2.70%
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
162	154	95.06%

KEPRO BFCC-QIO REGION 4 – STATE OF FLORIDA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	490	3.54%
Quality of Care Review (All Other Selection Reasons)	328	2.37%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.01%
Notice of Non-coverage (BIPA)	541	3.90%
Notice of Non-coverage (Grijalva)	8,712	62.86%
Notice of Non-coverage (Hospital Discharge)	3,755	27.09%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	29	0.21%
EMTALA 60-Day	4	0.03%
Total	**13,860**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	37,266	29.79%
2. U071 – COVID-19	11,898	9.51%
3. N179 – Acute Kidney Failure, Unspecified	11,636	9.30%
4. I110 – Hypertensive Heart Disease with Heart Failure	11,499	9.19%
5. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	11,001	8.79%
6. J189 – Pneumonia, Unspecified Organism	10,480	8.38%
7. N390 – Urinary Tract Infection, Site Not Specified	10,034	8.02%
8. I214 – NSTEMI Myocardial Infarction	8,324	6.65%
9. I480 – Paroxysmal Atrial Fibrillation	8,070	6.45%
10. A4189 – Other Specified Sepsis	4,877	3.90%
Total	**125,085**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	15,229	59.99%
Male	10,157	40.01%
Unknown	0	0.00%
Total	**25,386**	**100.00%**
Race		
Asian	184	0.72%
Black	3,354	13.21%
Hispanic	832	3.28%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	19	0.07%
Other	277	1.09%
Unknown	331	1.30%
White	20,389	80.32%
Total	**25,386**	**100.00%**
Age		
Under 65	2,655	10.46%
65-70	3,696	14.56%
71-80	8,431	33.21%
81-90	7,872	31.01%
91+	2,732	10.76%
Total	**25,386**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	181	19.23%
1: Distinct Psychiatric Facility	10	1.06%
2: Distinct Rehabilitation Facility	30	3.19%
3: Distinct Skilled Nursing Facility	606	64.40%
5: Clinic	1	0.11%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	1	0.11%
9: Provider Based RHC	1	0.11%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	5	0.53%
H: Home Health Agency	50	5.31%
N: Critical Access Hospital	2	0.21%
O: Setting Does Not Fit Into Any Other Existing Setting Code	4	0.43%
Q: Long-Term Care Facility	20	2.13%
R: Hospice	29	3.08%
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	0.11%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**941**	**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. 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	12	3	25.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	76	16	21.05%
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)]	272	34	12.50%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	124	48	38.71%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	21	5	23.81%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	8	4	50.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	27	24	88.89%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	16	2	12.50%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	8	2	25.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	31	5	16.13%
C11: Apparently did not demonstrate that the patient was ready for discharge	27	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	2	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	5	1	20.00%
C15: Apparently did not effectively coordinate across disciplines	2	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	63	27	42.86%
C17: Apparently did not order/follow evidence-based practices	29	3	10.34%
C18: Apparently did not provide medical record documentation that impacts patient care	19	15	78.95%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	74	26	35.14%
Total	**818**	**215**	**26.28%**

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**
129	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 other patient care by practitioner area	2
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	34
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	8
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	17
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medication management	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering necessary laboratory and imaging tests	2

Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner test/procedure/surgery technique	3
Practitioner-Patient Care by Practitioner – Improvement needed to prevent practitioner treatment delays	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	5
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	4
Provider-Other Administrative – Improvement needed in medical record documentation to support billing	1
Provider-Other Administrative – Improvement needed in other administrative area	2
Provider-Patient Care by Staff – Improvement needed in other patient care by staff area	4
Provider-Patient Care by Staff – Improvement needed in staff assessments	7
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	2
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	7
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	1
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	6
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	3
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	4
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	6

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	1	0.01%
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)	8,674	67.00%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	533	4.12%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	1,494	11.54%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	2,244	17.33%
Total	**12,946**	**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	800	97.32%	90.38%
Rural	22	2.68%	9.62%
Unknown	0	0.00%	0.00%
Total	**822**	**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	121	100.00%	97.30%
Rural	0	0.00%	2.70%
Unknown	0	0.00%	0.00%
Total	**121**	**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
2,419	2,355	97.35%

KEPRO BFCC-QIO REGION 4 – STATE OF GEORGIA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	120	2.57%
Quality of Care Review (All Other Selection Reasons)	81	1.73%
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)	105	2.25%
Notice of Non-coverage (Grijalva)	3,423	73.25%
Notice of Non-coverage (Hospital Discharge)	901	19.28%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	4	0.09%
EMTALA 5-Day	36	0.77%
EMTALA 60-Day	3	0.06%
Total	**4,673**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	12,745	29.17%
2. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	4,538	10.38%
3. N179 – Acute Kidney Failure, Unspecified	4,350	9.95%
4. U071 – COVID-19	4,226	9.67%
5. I110 – Hypertensive Heart Disease with Heart Failure	4,191	9.59%
6. J189 – Pneumonia, Unspecified Organism	3,794	8.68%
7. I214 – STEMI Myocardial Infarction	2,907	6.65%
8. N390 – Urinary Tract Infection, Site Not Specified	2,625	6.01%
9. I480 – Paroxysmal Atrial Fibrillation	2,507	5.74%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	1,816	4.16%
Total	**43,699**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	4,700	61.06%
Male	2,997	38.94%
Unknown	0	0.00%
Total	**7,697**	**100.00%**
Race		
Asian	58	0.75%
Black	2,726	35.42%
Hispanic	26	0.34%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	5	0.06%
Other	35	0.45%
Unknown	68	0.88%
White	4,779	62.09%
Total	**7,697**	**100.00%**
Age		
Under 65	934	12.13%
65-70	1,246	16.19%
71-80	2,860	37.16%
81-90	2,120	27.54%
91+	537	6.98%
Total	**7,697**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	80	19.00%
1: Distinct Psychiatric Facility	3	0.71%
2: Distinct Rehabilitation Facility	8	1.90%
3: Distinct Skilled Nursing Facility	241	57.24%
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 RHC	0	0.00%
9: Provider Based RHC	1	0.24%
C: Free Standing Ambulatory Surgery Center	1	0.24%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	21	4.99%
N: Critical Access Hospital	22	5.23%
O: Setting Does Not Fit Into Any Other Existing Setting Code	1	0.24%
Q: Long-Term Care Facility	10	2.38%
R: Hospice	30	7.13%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	0.24%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	2	0.48%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**421**	**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. 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	1	100.00%
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)]	69	14	20.29%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	21	7	33.33%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	11	2	18.18%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	2	66.67%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	11	9	81.82%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	6	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	2	1	50.00%
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	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	18	11	61.11%
C17: Apparently did not order/follow evidence-based practices	1	1	100.00%
C18: Apparently did not provide medical record documentation that impacts patient care	12	12	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	28	12	42.86%
Total	**201**	**74**	**36.82%**

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**
45	60.81%
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 medical record documentation that impacts patient care	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	4
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner obtaining patient history and performing physical examination	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner test/procedure/surgery technique	1
Provider-Continuity of Care - Improvement needed in coordination across disciplines	2

Provider-Continuity of Care - Improvement needed in diagnostic service completion/result reporting/result receipt	4
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	5
Provider-Continuity of Care - Improvement needed in practitioner specialty consultant assessment completion/reporting	5
Provider-Patient Care by Staff - Improvement needed in staff assessments	1
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	1
Provider-Patient Care by Staff - Improvement needed in staff following provider established care protocols	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	7
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	2
Provider-Staff and Medical Staff - Improvement needed in having adequate provider staff human resources	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)	4	0.09%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	3,417	77.22%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	105	2.37%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	323	7.30%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	576	13.02%
Total	**4,425**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	320	86.49%	90.38%
Rural	50	13.51%	9.62%
Unknown	0	0.00%	0.00%
Total	**370**	**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%	97.30%
Rural	0	0.00%	2.70%
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
435	416	95.63%

KEPRO BFCC-QIO REGION 4 – STATE OF KENTUCKY

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	28	0.76%
Quality of Care Review (All Other Selection Reasons)	75	2.03%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.05%
Notice of Non-coverage (BIPA)	111	3.00%
Notice of Non-coverage (Grijalva)	3,322	89.91%
Notice of Non-coverage (Hospital Discharge)	147	3.98%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	9	0.24%
EMTALA 60-Day	1	0.03%
Total	**3,695**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	7,907	30.85%
2. J189 – Pneumonia, Unspecified Organism	2,767	10.79%
3. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	2,393	9.34%
4. N179 – Acute Kidney Failure, Unspecified	2,353	9.18%
5. U071 – COVID-19	2,162	8.43%
6. I110 – Hypertensive Heart Disease with Heart Failure	2,102	8.20%
7. I214 – NSTEMI Myocardial Infarction	1,916	7.47%
8. N390 – Urinary Tract Infection, Site Not Specified	1,680	6.55%
9. R5381 – Other Malaise	1,186	4.63%
10. I480 – Paroxysmal Atrial Fibrillation	1,167	4.55%
Total	**25,633**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	3,275	62.99%
Male	1,924	37.01%
Unknown	0	0.00%
Total	**5,199**	**100.00%**
Race		
Asian	10	0.19%
Black	532	10.23%
Hispanic	5	0.10%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	3	0.06%
Other	16	0.31%
Unknown	39	0.75%
White	4,594	88.36%
Total	**5,199**	**100.00%**
Age		
Under 65	555	10.68%
65-70	767	14.75%
71-80	1,762	33.89%
81-90	1,660	31.93%
91+	455	8.75%
Total	**5,199**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	37	12.42%
1: Distinct Psychiatric Facility	3	1.01%
2: Distinct Rehabilitation Facility	7	2.35%
3: Distinct Skilled Nursing Facility	220	73.83%
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	1	0.34%
9: Provider Based RHC	2	0.67%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	4	1.34%
N: Critical Access Hospital	15	5.03%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	3	1.01%
R: Hospice	5	1.68%
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	0.34%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**298**	**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. 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	6	1	16.67%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08), and consultations (see C13 and C14)]	26	3	11.54%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	13	8	61.54%
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	17	12	70.59%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	4	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	1	100.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	5	3	60.00%
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	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	1	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	13	10	76.92%
C17: Apparently did not order/follow evidence-based practices	2	1	50.00%
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	10	1	10.00%
Total	**103**	**40**	**38.83%**

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**
18	45.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner acting on laboratory and imaging test results	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner determining medical necessity of procedures/surgery	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	4
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner ordering of/coordination with/completion of practitioner specialty consultation	1
Provider-Patient Care by Staff - Improvement needed in staff assessments	2
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	1

Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	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)	2	0.06%
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)	3,315	92.78%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	110	3.08%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	55	1.54%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	91	2.55%
Total	**3,573**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	207	75.82%	90.38%
Rural	66	24.18%	9.62%
Unknown	0	0.00%	0.00%
Total	**273**	**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	14	82.35%	97.30%
Rural	3	17.65%	2.70%
Unknown	0	0.00%	0.00%
Total	**17**	**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
114	110	96.49%

KEPRO BFCC-QIO REGION 4 – STATE OF MISSISSIPPI

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	30	4.02%
Quality of Care Review (All Other Selection Reasons)	41	5.49%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.27%
Notice of Non-coverage (BIPA)	22	2.95%
Notice of Non-coverage (Grijalva)	511	68.41%
Notice of Non-coverage (Hospital Discharge)	110	14.73%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	24	3.21%
EMTALA 60-Day	7	0.94%
Total	**747**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	5,989	28.44%
2. U071 – COVID-19	2,369	11.25%
3. N179 – Acute Kidney Failure, Unspecified	2,252	10.69%
4. J189 – Pneumonia, Unspecified Organism	2,226	10.57%
5. N390 – Urinary Tract Infection, Site Not Specified	1,876	8.91%
6. I110 – Hypertensive Heart Disease with Heart Failure	1,815	8.62%
7. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	1,534	7.28%
8. I214 – NSTEMI Myocardial Infarction	1,111	5.28%
9. I480 – Paroxysmal Atrial Fibrillation	1,042	4.95%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	845	4.01%
Total	**21,059**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	749	58.20%
Male	538	41.80%
Unknown	0	0.00%
Total	**1,287**	**100.00%**
Race		
Asian	4	0.31%
Black	530	41.18%
Hispanic	2	0.16%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	1	0.08%
Other	1	0.08%
Unknown	1	0.08%
White	748	58.12%
Total	**1,287**	**100.00%**
Age		
Under 65	231	17.95%
65-70	249	19.35%
71-80	445	34.58%
81-90	291	22.61%
91+	71	5.52%
Total	**1,287**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	29	21.17%
1: Distinct Psychiatric Facility	1	0.73%
2: Distinct Rehabilitation Facility	2	1.46%
3: Distinct Skilled Nursing Facility	81	59.12%
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	1	0.73%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	3	2.19%
N: Critical Access Hospital	8	5.84%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	5	3.65%
R: Hospice	5	3.65%
S: Psychiatric Unit of an Inpatient Facility	1	0.73%
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	0.73%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**137**	**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. 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	14	1	7.14%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	21	3	14.29%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	4	2	50.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	1	100.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	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	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	6	4	66.67%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	5	1	20.00%
C17: Apparently did not order/follow evidence-based practices	2	2	100.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	14	1	7.14%
Total	**71**	**15**	**21.13%**

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent of Confirmed QOC Concerns Referred for QII**
15	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	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner use of evidence-based practices	1
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	1
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	4
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	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)	2	0.31%
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)	509	79.16%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	22	3.42%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	52	8.09%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	58	9.02%
Total	**643**	**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	97	82.91%	90.38%
Rural	20	17.09%	9.62%
Unknown	0	0.00%	0.00%
Total	**117**	**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%	97.30%
Rural	2	8.33%	2.70%
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
88	85	96.59%

KEPRO BFCC-QIO REGION 4 – STATE OF NORTH CAROLINA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	105	0.99%
Quality of Care Review (All Other Selection Reasons)	122	1.15%
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)	235	2.21%
Notice of Non-coverage (Grijalva)	9,473	88.97%
Notice of Non-coverage (Hospital Discharge)	560	5.26%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	7	0.07%
EMTALA 5 Day	89	0.84%
EMTALA 60 Day	56	0.53%
Total	**10,647**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	12,064	28.24%
2. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail And Stg 1-4/Unsp Chr Kdny	4,558	10.67%
3. U071 – Covid-19	4,235	9.91%
4. I110 – Hypertensive Heart Disease With Heart Failure	4,141	9.69%
5. J189 – Pneumonia, Unspecified Organism	4,108	9.62%
6. N179 – Acute Kidney Failure, Unspecified	3,896	9.12%
7. I214 – Non-St Elevation (Nstemi) Myocardial Infarction	3,016	7.06%
8. N390 – Urinary Tract Infection, Site Not Specified	2,468	5.78%
9. I480 – Paroxysmal Atrial Fibrillation	2,338	5.47%
10. J441 – Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	1,894	4.43%
Total	**42,718**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	8,196	62.14%
Male	4,994	37.86%
Unknown	0	0.00%
Total	**13,190**	**100.00%**
Race		
Asian	45	0.34%
Black	3,505	26.57%
Hispanic	33	0.25%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	33	0.25%
Other	93	0.71%
Unknown	114	0.86%
White	9,367	71.02%
Total	**13,190**	**100.00%**
Age		
Under 65	1,368	10.37%
65-70	1,943	14.73%
71-80	4,694	35.59%
81-90	4,051	30.71%
91+	1,134	8.60%
Total	**13,190**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	72	13.26%
1: Distinct Psychiatric Facility	1	0.18%
2: Distinct Rehabilitation Facility	3	0.55%
3: Distinct Skilled Nursing Facility	392	72.19%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.18%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	2	0.37%
C: Free Standing Ambulatory Surgery Center	1	0.18%
G: End Stage Renal Disease Unit	1	0.18%
H: Home Health Agency	36	6.63%
N: Critical Access Hospital	11	2.03%
O: Setting Does Not Fit Into Any Other Existing Setting Code	5	0.92%
Q: Long-Term Care Facility	4	0.74%
R: Hospice	11	2.03%
S: Psychiatric Unit of an Inpatient Facility	1	0.18%
T: Rehabilitation Unit of an Inpatient Facility	2	0.37%
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	543	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. 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	3	1	33.33%
C02: Apparently did not make appropriate diagnoses and/or assessments	12	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)]	76	16	21.05%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	20	7	35.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	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	17	16	94.12%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	5	1	20.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	4	1	25.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	12	5	41.67%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	21	11	52.38%
C17: Apparently did not order/follow evidence-based practices	17	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	2	1	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	32	16	50.00%
Total	**227**	**75**	**33.04%**

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**
27	36.00%
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	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	4
Provider-Continuity of Care – Improvement needed in coordination across disciplines	1
Provider-Patient Care by Staff – Improvement needed in staff assessments	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
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	1

Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	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)	7	0.07%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	9,441	92.22%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	233	2.28%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	184	1.80%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	372	3.63%
Total	**10,237**	**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	463	92.23%	90.38%
Rural	39	7.77%	9.62%
Unknown	0	0.00%	0.00%
Total	**502**	**100.00%**	**100.00%**

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	42	100.00%	97.30%
Rural	0	0.00%	2.70%
Unknown	0	0.00%	0.00%
Total	**42**	**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
436	427	97.94%

KEPRO BFCC-QIO REGION 4 – STATE OF SOUTH CAROLINA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	109	4.21%
Quality of Care Review (All Other Selection Reasons)	62	2.39%
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)	74	2.85%
Notice of Non-coverage (Grijalva)	2,010	77.55%
Notice of Non-coverage (Hospital Discharge)	317	12.23%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	13	0.50%
EMTALA 60-Day	7	0.27%
Total	**2,592**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	7,431	27.85%
2. N179 – Acute Kidney Failure, Unspecified	2,987	11.19%
3. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	2,669	10.00%
4. I110 – Hypertensive Heart Disease with Heart Failure	2,595	9.73%
5. U071 – COVID-19	2,513	9.42%
6. J189 – Pneumonia, Unspecified Organism	2,068	7.75%
7. I214 – NSTEMI Myocardial Infarction	1,913	7.17%
8. I480 – Paroxysmal Atrial Fibrillation	1,712	6.42%
9. R5381 – Other Malaise	1,416	5.31%
10. N390 – Urinary Tract Infection, Site Not Specified	1,378	5.16%
Total	**26,682**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,623	60.93%
Male	1,682	39.07%
Unknown	0	0.00%
Total	**4,305**	**100.00%**
Race		
Asian	12	0.28%
Black	1,256	29.18%
Hispanic	10	0.23%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	5	0.12%
Other	16	0.37%
Unknown	26	0.60%
White	2,980	69.22%
Total	**4,305**	**100.00%**
Age		
Under 65	504	11.71%
65-70	720	16.72%
71-80	1,544	35.87%
81-90	1,196	27.78%
91+	341	7.92%
Total	**4,305**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	47	20.35%
1: Distinct Psychiatric Facility	4	1.73%
2: Distinct Rehabilitation Facility	9	3.90%
3: Distinct Skilled Nursing Facility	136	58.87%
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	2	0.87%
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	15	6.49%
N: Critical Access Hospital	2	0.87%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	3	1.30%
R: Hospice	9	3.90%
S: Psychiatric Unit of an Inpatient Facility	2	0.87%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	2	0.87%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**231**	**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. 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	15	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)]	59	7	11.86%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	22	7	31.82%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	1	50.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	1	33.33%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	1	33.33%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	12	2	16.67%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	1	100.00%
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	12	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	17	4	23.53%
C17: Apparently did not order/follow evidence-based practices	4	1	25.00%
C18: Apparently did not provide medical record documentation that impacts patient care	4	2	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	10	4	40.00%
Total	**171**	**32**	**18.71%**

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**
28	87.50%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	4
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	3
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner test/procedure/surgery technique	3
Provider-Continuity of Care – Improvement needed in diagnostic service completion/result reporting/result receipt	3
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	2
Provider-Other Administrative – Improvement needed in medical record documentation to support billing	1

Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	5
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	1
Provider-Safety of the Environment in Patient Care – Improvement needed in other safety of the environment in patient care area	1

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	2,007	83.73%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	74	3.09%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	131	5.47%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	185	7.72%
Total	**2,397**	**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	194	96.04%	90.38%
Rural	8	3.96%	9.62%
Unknown	0	0.00%	0.00%
Total	**202**	**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	28	96.55%	97.30%
Rural	1	3.45%	2.70%
Unknown	0	0.00%	0.00%
Total	**29**	**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
229	215	93.89%

KEPRO BFCC-QIO REGION 4 – STATE OF TENNESSEE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	131	2.34%
Quality of Care Review (All Other Selection Reasons)	168	3.00%
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)	105	1.88%
Notice of Non-coverage (Grijalva)	4,666	83.44%
Notice of Non-coverage (Hospital Discharge)	408	7.30%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	78	1.39%
EMTALA 60-Day	36	0.64%
Total	**5,592**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	11,621	32.31%
2. N179 – Acute Kidney Failure, Unspecified	3,606	10.03%
3. I110 – Hypertensive Heart Disease with Heart Failure	3,373	9.38%
4. I130 – Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/Unsp Chr Kdny	3,222	8.96%
5. J189 – Pneumonia, Unspecified Organism	3,214	8.94%
6. U071 – COVID-19	2,693	7.49%
7. I214 – NSTEMI Myocardial Infarction	2,513	6.99%
8. N390 – Urinary Tract Infection, Site Not Specified	2,304	6.41%
9. I480 – Paroxysmal Atrial Fibrillation	2,080	5.78%
10. J9601 – Acute Respiratory Failure with Hypoxia	1,338	3.72%
Total	**35,964**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE:

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	5,091	63.59%
Male	2,915	36.41%
Unknown	0	0.00%
Total	**8,006**	**100.00%**
Race		
Asian	17	0.21%
Black	1,441	18.00%
Hispanic	19	0.24%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	5	0.06%
Other	26	0.32%
Unknown	51	0.64%
White	6,447	80.53%
Total	**8,006**	**100.00%**
Age		
Under 65	970	12.12%
65-70	1,313	16.40%
71-80	2,723	34.01%
81-90	2,351	29.37%
91+	649	8.11%
Total	**8,006**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	67	17.40%
1: Distinct Psychiatric Facility	4	1.04%
2: Distinct Rehabilitation Facility	13	3.38%
3: Distinct Skilled Nursing Facility	261	67.79%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	1	0.26%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	16	4.16%
N: Critical Access Hospital	7	1.82%
O: Setting Does Not Fit Into Any Other Existing Setting Code	1	0.26%
Q: Long-Term Care Facility	5	1.30%
R: Hospice	7	1.82%
S: Psychiatric Unit of an Inpatient Facility	1	0.26%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	2	0.52%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**385**	**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. 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	23	9	39.13%
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)]	85	19	22.35%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	67	21	31.34%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	1	50.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	25	18	72.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	4	1	25.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	1	50.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	5	2	40.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	5	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	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	14	10	71.43%
C17: Apparently did not order/follow evidence-based practices	20	1	5.00%
C18: Apparently did not provide medical record documentation that impacts patient care	7	6	85.71%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	34	19	55.88%
Total	**299**	**108**	**36.12%**

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**
50	46.30%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in other patient care by practitioner area	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	6
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	6
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering necessary laboratory and imaging tests	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner use of evidence-based practices	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	4

Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	5
Provider-Other Administrative – Improvement needed in other administrative area	1
Provider-Patient Care by Staff – Improvement needed in other patient care by staff area	5
Provider-Patient Care by Staff – Improvement needed in staff assessments	1
Provider-Patient Care by Staff – Improvement needed in staff following provider established care protocols	3
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	3
Provider-Patient Care by Staff – Improvement needed in staff provision of patient education	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)	4,657	90.11%
FFS Expedited Appeal (CORF, HHA, hospice, SNF) – (BIPA)	103	1.99%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS hospital discharge)	159	3.08%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA hospital discharge)	249	4.82%
Total	**5,168**	**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	302	87.03%	90.38%
Rural	45	12.97%	9.62%
Unknown	0	0.00%	0.00%
Total	**347**	**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	36	94.74%	97.30%
Rural	2	5.26%	2.70%
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
358	338	94.41%

Publication No R4-331-1/2024. This material was prepared by Kepro, a Medicare Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.