AREA #1

BFCC-QIO 11TH SOW ANNUAL MEDICAL SERVICES REPORT

08/01/2018 - 03/15/2019

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

LIVANTA

From practical innovations to results.

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This material was prepared by Livanta LLC, the Medicare Quality Improvement Organization for BFCC Areas 1 and 5, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Heal The contents presented do not necessarily reflect CMS policy. 11-SOW-MD-2019-QIOBFCC-CP8.

Introduction

Livanta LLC is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Area #1, which includes the states of Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont, as well as Puerto Rico and the U.S. Virgin Islands.

The QIO Program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, is an integral part of the U.S. Department of Health and Human (HHS) Services' National Quality Strategy for providing better care and better health at lower cost. By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. CMS identifies the core functions of the QIO Program as:

Improving quality of care for beneficiaries;

Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and

Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Active Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

BFCC-QIOs improve healthcare services and protect beneficiaries through expeditious statutory review functions, including complaints and quality of care reviews for people with Medicare. The BFCC-QIO ensures consistency in the case review process while taking into consideration local factors and local needs for general quality of care, medical necessity, and readmissions.

This annual report provides data regarding case reviews that were completed on behalf of Medicare beneficiaries and their representatives, health care providers, and CMS for the date range of August 1, 2018 through March 15, 2019. Readers will find the overall Area #1 data in the first 12 sections of this report and state-specific data in the Appendix of the report. While this is the final annual report for the current BFCC-QIO contract (under the 11th Statement of Work), the QIO case review activities will continue without interruption in the 12th BFCC-QIO Statement of Work. This report underscores our commitment to transparency by providing key performance metrics from the fourth year of Livanta's work with Medicare beneficiaries. Livanta understands and respects beneficiaries' rights and concerns, and we are dedicated to protecting patients by reviewing appeals and quality complaints in an effective and efficient patient-centered manner. For more information on Livanta's performance metrics, please visit our online dashboard.

Livanta QIO Area #1 - Summary

1) Total Number of Reviews

Livanta completed reviews on behalf of Medicare beneficiaries receiving care in Area #1. This table breaks out the number of reviews by the different types of reviews we conducted.

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	3,684	9.15%
Coding Validation (Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	192	0.48%
Quality of Care Review (All Other Selection Reasons)	855	2.12%
Utilization/Medical Necessity (All Selection Reasons)	3,672	9.12%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	588	1.46%
Notice of Non-coverage (BIPA)	9,472	23.54%
Notice of Non-coverage (Grijalva)	15,664	38.92%
Notice of Non-coverage (Weichardt)	5,903	14.67%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	163	0.41%
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day	43	0.11%
EMTALA 60 Day	9	0.02%
Total	40,245	100.00%

2) Top 10 Principal Medical Diagnoses

This table provides information regarding the top 10 medical diagnoses for inpatient claims billed during the annual reporting period for Medicare patients in Area #1.

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	73,161	28.11%
2. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure and Stage 1-4/Unspecified Chronic Kidney	27,374	10.52%
3. N179 - Acute Kidney Failure, Unspecified	25,505	9.80%
4. I110 - Hypertensive Heart Disease with Heart Failure	24,485	9.41%
5. J189 - Pneumonia, Unspecified Organism	22,922	8.81%
6. N390 - Urinary Tract Infection, Site Not Specified	21,082	8.10%
7. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	20,111	7.73%
8. I214 - Non-ST Elevation (NSTEMI) Myocardial Infarction	19,179	7.37%
9. M1711 - Unilateral Primary Osteoarthritis, Right Knee	13,824	5.31%
10. M1712 - Unilateral Primary Osteoarthritis, Left Knee	12,658	4.86%
Total	260,301	100.00%

3) Provider Reviews Settings

This table provides information on the count and percent by setting for Health Service Providers (HSPs) associated with a completed BFCC-QIO review in Area #1.

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	503	16.37%
1: Distinct Psychiatric Facility	29	0.94%
2: Distinct Rehabilitation Facility	37	1.20%
3: Distinct Skilled Nursing Facility	2,075	67.52%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	2	0.07%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	4	0.13%
H: Home Health Agency	188	6.12%
N: Critical Access Hospital	30	0.98%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	29	0.94%
R: Hospice	147	4.78%
S: Psychiatric Unit of an Inpatient Facility	8	0.26%
T: Rehabilitation Unit of an Inpatient Facility	7	0.23%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	2	0.07%
Y: Federally Qualified Health Centers	7	0.23%
Z: Swing Bed Designation for Critical Access Hospitals	5	0.16%
Other	0	0.00%
Total	3,073	100.00%

4) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

This table provides the number of confirmed quality of care concerns as identified by Physician Reviewer Assessment Form (PRAF) category codes within the CMS case review systems. These quality of care concerns are confirmed by Livanta's independent physician reviewers as care that did not meet the professionally recognized standards of medical care. Confirmed quality of care concerns receive provider education and are referred as appropriate to the CMS designated Quality Innovation Network - Quality Improvement Organization (QIN-QIO) contractors who work with providers to make improvements in patient care.

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	11	4	36.36%
C02: Apparently did not make appropriate diagnoses and/or assessments	194	31	15.98%
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)]	1,165	104	8.93%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	53	3	5.66%
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	4	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	10	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	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	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	1	100.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	2	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	5	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	1,461	145	9.92%

This table provides the total number of quality of care concerns referred to the Quality Innovation Network QIOs (QIN-QIOs) and corresponding percentage of all quality of care concerns referred to the QIN-QIOs for the reporting period.

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	**Percent of Quality of Care Concerns Referred for QII**
53	37 %
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner diagnosis and evaluation of patients	5
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner general treatment planning/administration	32
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 of, coordination with or completion of practitioner specialty consultation	1
Provider – Patient Care by Staff: Improvement needed in staff assessments	3
Provider – Patient Care by Staff: Improvement needed in staff care planning	6
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 or adjust care	3
Provider – Safety of the Environment in Patient Care	1

5) Discharge/Service Terminations

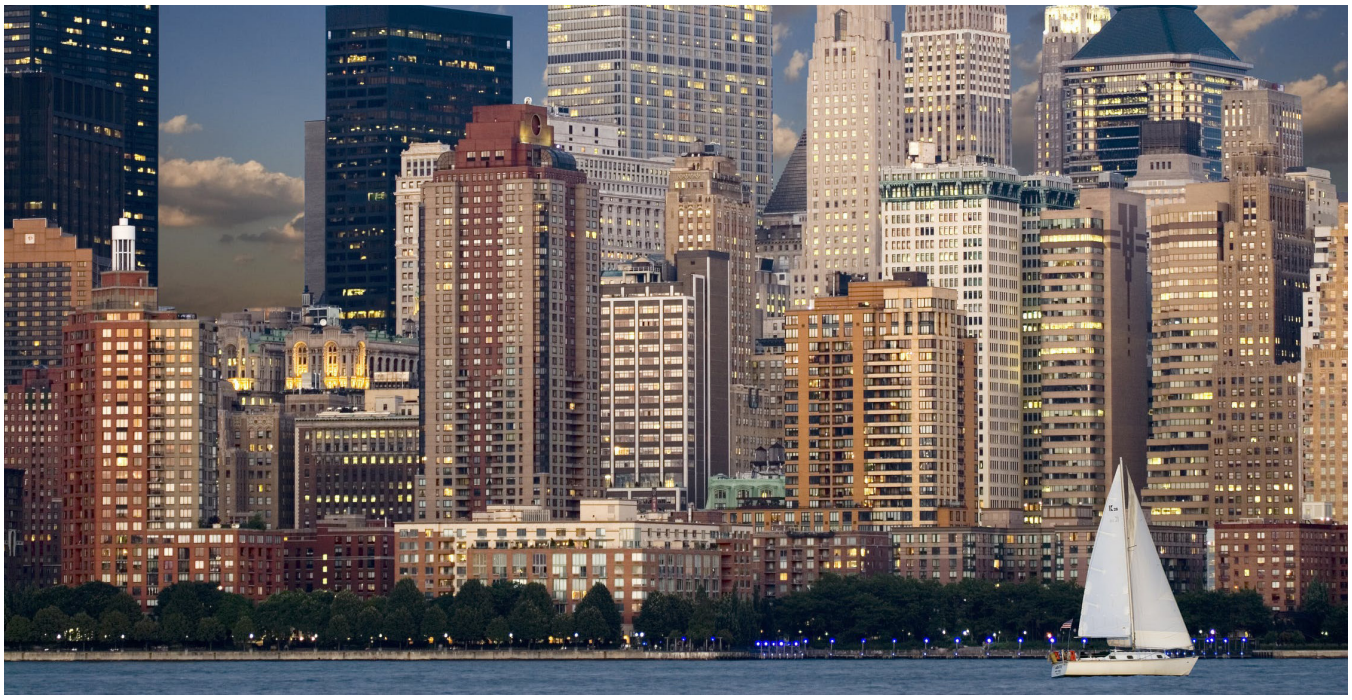
This table provides information regarding the discharge location of beneficiaries linked to appeals conducted by Livanta of provider-issued notices of Medicare non-coverage. Data contained in this table represents discharge/termination of service reviews from August 1, 2018 through December 15, 2018. A shortened timeframe is necessary to allow for maturity of claims data, which are the source of "Discharge Status" for these cases.

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self care (routine discharge)	5	29.41%
02: Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03: Discharged/transferred to skilled nursing facility (SNF)	8	47.06%
04: Discharged/transferred to intermediate care facility (ICF)	0	0.00%
05: Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06: Discharged/transferred to home under care of organized home health service organization	0	0.00%
07: Left against medical advice or discontinued care	0	0.00%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	0	0.00%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	0	0.00%
40: Expired at home (Hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or 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	1	5.88%
51: Hospice - medical facility	1	5.88%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	0	0.00%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	1	5.88%
63: Discharged/transferred to a long-term care hospital	0	0.00%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66: Discharged/transferred to a critical access hospital	0	0.00%
70: Discharged/transferred to another type of health care institution not defined elsewhere in code list	1	5.88%
Other	0	0.00%
Total	17	100.00%

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

This table provides the number of appeal reviews and the percentage of reviews, specifically for each outcome, in which Livanta's independent physician reviewer agreed or disagreed with the discharge.

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
Notice of Non-coverage FFS Preadmission/ Admission - (Admission and Preadmission/HINN 1)	587	28.28%	71.72%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	163	31.29%	68.71%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	15,664	14.72%	85.28%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	9,468	17.30%	82.70%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	4,171	10.07%	89.93%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (MA Weichardt)	1,727	10.54%	89.46%
Total	31,780	14.99%	85.01%



7) Evidence Used in Decision-Making

The following table describes one or more of the most common types of evidence or standards of care used to support Livanta's review coordinators and independent physician reviewer decisions for medical necessity/utilization review and appeals. Livanta uses evidence-based guidelines and medical literature to identify standards of care, where such standards exist. For quality of care reviews, we have provided several of the most highly utilized types of evidence/standards of care to support Livanta's review coordinator and independent physician reviewer decisions for the specific list of diagnostic categories provided in this table. A brief statement of the rationale for selecting the specific evidence or standards of care is included.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Percent of Total
Quality of Care	Pneumonia	Risk factors and prevention of hospital-acquired, ventilator-associated, and healthcare-associated pneumonia in adults. UpToDate (2018)	The following types of nosocomial (originating in a hospital) pneumonia have been defined: hospital-acquired pneumonia (HAP) is pneumonia that occurs 48 hours or more after admission and did not appear to be incubating at the time of admission; ventilator-associated pneumonia (VAP) is a type of HAP that develops more than 48 to 72 hours after endotracheal intubation; and healthcare-associated pneumonia (HCAP) includes any patient who was either hospitalized in an acute care hospital for two or more days within 90 days of the infection; or resided in a long term care facility; or received intravenous (IV) antimicrobial therapy, chemotherapy, or wound care within the 30 days prior to the current infection; or attends a hospital or hemodialysis clinic. Practices that are recommended for preventing VAP include avoiding intubation when possible, minimizing sedation, maintaining and improving physical conditioning, minimizing pooling of secretions above the endotracheal tube cuff, elevating the head of the bed, and maintaining ventilator circuits. Combining a core set of prevention measures into a bundle is a practical way to enhance care. The choice of the antibiotic treatment regimen for nosocomial pneumonia should be influenced by the patient's recent antibiotic therapy (if any), the resident flora in the hospital or intensive care unit, the presence of underlying diseases, available culture data interpreted with care, and whether the patient is at risk for multidrug-resistant pathogens.
Quality of Care	Heart Failure	Evaluation of the Patient with Suspected Heart Failure UpToDate (2018)	Heart failure (HF) is a common clinical syndrome caused by a variety of cardiac diseases. Symptoms of HF include those due to excess fluid accumulation (dyspnea, orthopnea, edema, pain from hepatic congestion, and abdominal distention from ascites) and those due to a reduction in cardiac output (fatigue, weakness) that is most pronounced with exertion. The initial evaluation of patients with symptoms or signs suggestive of HF includes clinical assessment (history and physical examination), an electrocardiogram, blood tests, and a chest radiograph. Management of HF includes management of contributing and associated conditions, lifestyle modification, drug therapy, device therapy as indicated, cardiac rehabilitation, and preventive care.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Percent of Total
Quality of Care	Pressure Ulcers	UpToDate: Clinical Staging and Management of Pressure Ulcers UpToDate (2018)	The treatment of pressure-induced skin and soft tissue injuries begins with a comprehensive assessment of the patient's general medical condition and evaluation of the wound. The development of an ulcer should underscore the need to review and intensify preventive measures. A standardized system should be used to document the initial presentation, plan appropriate treatment, and follow the healing progress of the wound. Close daily monitoring of the pressure injury, the dressing, the surrounding skin, any possible complications, and pain control should be documented. Adequate pain control should be provided. Particular attention should be paid to pain management during wound dressing and debridement. Nutritional status should be assessed, and any identified deficiencies should be corrected. Patients should be positioned and repositioned at least every two hours to relieve tissue pressure. The use of nonpowered support surfaces (e.g., foam mattresses or overlays) is recommended for most patients with pressure-induced skin and soft tissue injuries. Powered surfaces (e.g. air-fluidized beds) may be appropriate for select patients with large or multiple ulcers that preclude appropriate positioning. Most patients are successfully managed without surgery.
Quality of Care	Acute Myocardial Infarction	Overview of the Acute Management of ST Elevation Myocardial Infarction UpToDate (2018)	The first step in the management of the patient with an acute ST elevation myocardial infarction (STEMI) is prompt recognition, since the beneficial effects of therapy with reperfusion are greatest when performed soon after presentation. The diagnosis of STEMI can be confirmed by the electrocardiogram (EKG). Biomarkers may be normal early. An EKG should be obtained within 10 minutes of arrival, if it has not been obtained already by emergency medical service providers in the prehospital arena. Continuous cardiac monitoring, oxygen, intravenous access, blood pressure monitoring, and therapy should be started to relieve ischemic pain, stabilize hemodynamic status, and reduce ischemia while the patient is being assessed as a candidate for fibrinolysis or primary percutaneous coronary intervention.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Percent of Total
Quality of Care	Urinary Tract Infection	Acute Complicated Cystitis and Pyelonephritis UpToDate (2018)	A complicated urinary tract infection, whether localized to the lower or upper tract, is associated with an underlying condition that increases the risk of failing therapy. A urine culture and antimicrobial susceptibility testing (to determine which antibiotic will be effective against a specific bacteria) should be performed to guide treatment. Patients with persistent or recurrent symptoms within a few weeks of treatment for an acute complicated urinary tract infection should also have reevaluation for other conditions that might be causing their symptoms. In addition, patients with pyelonephritis (inflammation of the kidneys) should undergo radiographic imaging if they are severely ill, or have symptoms of or risk factors for complications of infection.
Quality of Care	Sepsis	UpToDate: Sepsis and the Systemic Inflammatory Response Syndrome: Definitions, Epidemiology, and Prognosis UpToDate (2018)	Sepsis is defined as the presence (probable or documented) of infection together with systemic manifestations of infection. Blood should be taken from two distinct venipuncture sites and from indwelling vascular access devices (intravenous catheters) and cultured aerobically (with free air) and anaerobically (without free air). Antibiotics should be administered within six hours of presentation, preferably after appropriate cultures have been obtained. Therapeutic priorities for patients with sepsis and septic shock include securing the airway, correcting hypoxemia (low blood oxygen), and administering fluids and antibiotics. The adequacy of perfusion (blood flow) should be assessed in patients with suspected severe sepsis and septic shock.
Quality of Care	Adverse Drug Event	Drug Prescribing for Older Adults UpToDate (2018)	The possibility of an adverse drug event (ADE) should always be borne in mind (considered) when evaluating an adult; any new symptom should be considered drug-related until proven otherwise. Clinicians must be alert to the use of herbal and dietary supplements by older patients, who may not volunteer this information and are prone to drug-drug interactions related to these supplements.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Percent of Total
Quality of Care	Falls	Falls: Prevention in Nursing Care Facilities and Hospital Settings UpToDate (2018)	A targeted history and physical examination can identify patients at risk for falling. In particular, a history of previous falls and a physical finding of lower-extremity weakness are important risk factors. Diagnostic testing may be indicated based upon the history and physical examination, including evaluation of postural stability (balance), gait (walk), and mobility.
Quality of Care	Patient Trauma	Initial Management of Trauma in Adults UpToDate (2018)	All trauma patients require a systematic approach to management in order to maximize outcomes and reduce the risk of undiscovered injuries. Optimal care requires effective and efficient communication and teamwork among clinicians. The primary evaluation should be organized according to the injuries that pose the most immediate threats to life. The primary survey consists of the following : • Airway assessment and protection (maintain cervical spine stabilization when appropriate); • Breathing and ventilation assessment (maintain adequate oxygenation); • Circulation assessment (control hemorrhage and maintain adequate end-organ perfusion); • Disability assessment (perform basic neurologic evaluation); and • Exposure, with environmental control (undress patient and search everywhere for possible injury, while preventing hypothermia). Problems are managed immediately in the order they are detected.
Quality of Care	Surgical Complications	Surgical- site complications/ infections UpToDate (2018)	Mechanical failure or failure of wound healing at the surgical site can lead to disruption (separation) of the closure thus leading to wound complications. Hematoma and seroma are collections of blood and serum respectively, and can cause the incision to separate, increasing the risk of wound infection. Risk factors for surgical site infection include smoking, diabetes, malnutrition, cancer, obesity, immunosuppression (a reduction of the activation or efficacy of the immune system), cardiovascular disease, prior incision, and irradiation at the surgical site.

Review Type	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Medical Necessity/ Utilization Review	MCG® and Interqual®	MCG® and InterQual® are standard, evidence-based criteria used to assess when and how individual patients progress through the continuum of care. Livanta also applies CMS's Two Midnight Rule, which states that inpatient admissions are generally appropriate if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.
Appeals	Medicare Benefit Policy Manual	According to the Medicare Benefit Policy Manual, Chapter 8, care in a skilled nursing facility (SNF) is covered if four factors are met. Physician reviewers apply those four requirements to each case reviewed. If ANY ONE of those four factors is not met, a stay in a SNF, even though it might include delivery of some skilled services, is not covered.
Appeals	Medicare Managed Care Guidelines, Chapter 13	Reconsideration Timing: "If the QIO upholds a Medicare health plan's decision to terminate services in whole or in part, the enrollee may request, no later than 60 days after notification that the QIO has upheld the decision, that the QIO reconsider its original decision."
Appeals	CMS Beneficiary Notices Initiative (BNI) website	Forms, model letter template language, and instructions for providers. "The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed."
Appeals	CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30: Financial Liability Protections	Instructions regarding hospital interactions with QIOs: "Before Medicare can pay for post-hospital extended care services, it must determine whether the beneficiary had a prior qualifying hospital stay of at least three consecutive calendar days."
Appeals	The Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7- Denials, Reconsiderations, & Appeals	This includes related instructions for the Quality Improvement Organization (QIO) processing of appeals.
Appeals	Local Coverage Determinations (LCDs)	These are coverage determinations for specific situations, and they are published by Medicare Administrative Contractors for cases within their own jurisdiction.

Appeals	Code of Federal Regulations	§422.622 Requesting immediate QIO review of the decision to discharge from the inpatient hospital: "Procedures the QIO must follow: (1) When the QIO receives the request for an expedited determination under paragraph (b)(1) of this section, it must immediately notify the hospital that a request for an expedited determination has been made. (2) The QIO determines whether the hospital delivered valid notice consistent with §405.1205(b)(3). (3) The QIO examines the medical and other records that pertain to the services in dispute. (4) The QIO must solicit the views of the beneficiary (or the beneficiary's representative) who requested the expedited determination. (5) The QIO must provide an opportunity for the hospital to explain why the discharge is appropriate."

8) Geographic Area

These tables provide information for Area #1 about the count and percentage by rural vs. urban geographical locations for Health Service Providers (HSPs) associated with a completed BFCC-QIO review. Table 8A provides data for Appeals, and Table 8B provides data for Quality of Care reviews.

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

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	2,626	88.93%
Rural	317	10.73%
Unknown	10	0.34%
Total	2,953	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	345	90.08%
Rural	36	9.40%
Unknown	2	0.52%
Total	383	100.00%

9) Outreach and Collaboration with Beneficiaries

Overview

The outreach and communication efforts of Livanta are designed to generate and maintain a regular flow of information to major stakeholders, educate customers, and create awareness of the role and purpose of the BFCC-QIO. Ensuring that relevant parties as well as beneficiaries and their caregivers have access and exposure to this information is vital to quality control, efficient use of resources, and a positive customer experience, as it increases situational understanding to all parties involved. The availability of information and education initiatives allows Livanta to establish clear expectations with customers and providers and to educate stakeholders on the roles and purposes of each player. Employing innovative and regularly used platforms of communication, Livanta provides pertinent information to stakeholders in an efficient and effective manner.

Beneficiaries and Families

To ensure that beneficiaries and their family members have access to the services of the BFCC-QIO, Livanta provides a toll-free HelpLine at 1-866-815-5440. The HelpLine is available locally from 9:00 am - 5:00 pm on weekdays and from 11:00 am - 3:00 pm on weekends and holidays. A 24-hour voicemail service is available, and all messages are time-stamped to ensure timeliness requirements are met. The HelpLine also maintains a TTY line at 1-866-868-2289 for use by the hearing impaired. In order to remove any potential language or cultural barriers to using the services of the BFCC-QIO, Livanta retains a translation firm to translate voice conversations in real-time into the language of choice for the beneficiary. Additionally, Livanta's Intake Center is bilingual, offering immediate Spanish language support for callers.

In order to engage stakeholders, beneficiaries, and caregivers better, the Livanta Communications Team has successfully launched and executed a successful multi-pronged approach to beneficiary and family communications. This effort is designed to familiarize beneficiaries and their families and caregivers with the services that Livanta provides as the BFCC-QIO as well as the QIO program itself. Specifically, Livanta hosted four beneficiary-focused symposia in New York and New Jersey to increase health literacy regarding quality of care and patient navigation in an underserved area.

Consistent social media outreach via Facebook, Twitter, and blogging allows Livanta to share information via storytelling. Storytelling is a very effective way of reaching an audience as it allows readers to empathize and evaluate their own circumstances through the anecdote that is being presented.

Partnerships and Collaborations

During the reporting period, the Livanta Communications Team engaged in an innovative and unique partnership with Senior Medicare Patrol agencies in Massachusetts and Nevada. These two agencies had a previously existing understanding and knowledge of Livanta and the BFCC-QIO Program through the Livanta Communications Team's previous direct on-site outreach visits over the last four years. What makes this relationship unique is both the approach to Quality of Care and the level of integration and collaboration between Livanta and the Senior Medicare Patrol. Although the charter of the Senior Medicare Patrol specifically delineates the role of their organizations as one of seeking out and exposing fraud in the Medicare system, the goal of the SMP is not mutually exclusive to Livanta's role as the BFCC-QIO to improve the quality of the healthcare delivery system through Quality of Care Reviews.

By directly engaging with and providing training to Senior Medicare Patrol in Massachusetts, the Livanta Team has become a regular part of the operations of this organization. Therefore, because of the level of collaboration and regular interaction, the Massachusetts SMP now refers cases to Livanta regularly. During a consultation with a beneficiary or representative, counselors at the SMP will now advise the client of their right to a quality of care review and make a direct referral if warranted. This relationship has allowed Livanta to review many cases in the state that would have otherwise gone unreported. This unique and innovative pilot program has yielded success and may be rolled out to other states in the next Statement of Work.

Below are stories where Livanta helped patients successfully resolve their issues regarding healthcare concerns.

Providers

After the successful conclusion of Livanta's unique and innovative series of Medicare rights symposia held in New York, NY, Philadelphia, PA, and Providence, RI in 2018, the Livanta Communications Team embarked on a major effort to engage the acute care provider networks in Area #1. As part of a

larger study completed by Livanta's Data Team in 2017-18, significant discrepancies were discovered regarding the delivery by hospitals of the Important Message from Medicare (IM). This document notifies beneficiaries of their upcoming discharge date and rights to appeal that date. Thus, it is a critical component of quality healthcare and safe care transitions and, most importantly, an effective guarantor of patient rights and beneficiary protection. If the IM is not delivered properly or neglected altogether, significant opportunities for patient harm may occur.

For the study, Livanta's Data Team sampled 1,750 medical records from Area #1. The records sampled were for recent Medicare inpatient stays. Using these records, Livanta audited for appropriate language, timeliness, and IM delivery. An analysis of the sampled records indicated that only 30% of reviewed records contained appropriate language, appropriate liability, and documentation of the IM being delivered. This represented a clear and immediate concern regarding patient safety and beneficiary rights. As a result of this study, the Livanta Communications Team developed an educational webinar for acute care hospital staff. The New Jersey Hospital Association participated in the pilot program due to a positive existing relationship developed over the last 4 years. In December 2018, the first training was attended by a majority of acute care hospitals in New Jersey. Livanta's positive and collaborative relationship with the New Jersey Hospital Association ensured that the training was well-received and widely attended. After this success, the team began to roll out this training to every hospital association in Area #1, including the US Virgin Islands (USVI), which does not currently have an active association. In that instance, the team collaborated with Health Services Advisory Group, the QIN-QIO for USVI, in order to achieve widespread participation. These successful ventures in collaboration with providers and provider groups represent a significant opportunity to protect beneficiary rights, promote patient safety, and put patients first.

10) Immediate Advocacy Reviews

Immediate Advocacy is an informal, voluntary process used by Livanta to resolve complaints quickly. This process begins when the beneficiary or his or her representative contacts Livanta and gives verbal consent to proceed with the complaint. Once consent is given, Livanta contacts the provider and/or practitioner on behalf of the Medicare patient. Immediate Advocacy is not appropriate when a patient wants to remain anonymous. Immediate Advocacy does not take the place of a clinical quality of care review, which includes an assessment of the patient's medical records.

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
877	671	76.51%

11) Examples/Success Stories

Example #1:

Ever since her cancer diagnosis, this 69-year-old beneficiary had struggled to remain positive and was very scared about her future. During a recent appointment, her oncologist told her he was changing her medication.

When she got home, she called her pharmacy, intending to ask about the difference between her old medications and the new ones. But since the oncologist had not called in the prescription, there was nothing to discuss. After several more calls, the pharmacist told her they had no record of a medication change. After numerous calls to her oncologist's office that were not returned, she called Livanta. She was extremely stressed.

Once she reviewed her concerns with the Livanta representative, she agreed to Immediate Advocacy. Livanta placed several calls to the oncologist's office before receiving a return call from the office nurse. The nurse explained that the new medication the doctor discussed is administered in the office via injection under observation. An additional appointment would be necessary to receive this medication.

The nurse then contacted the beneficiary and scheduled an appointment. The following week, she

received her injection. When she called Livanta to express her gratitude, she reported that she was back on track, focused, and prepared to keep moving forward.

Example #2:

Following a total left knee replacement, this 70-year old beneficiary started with physical therapy and occupational therapy through a home health agency (HHA) and then progress to outpatient therapy.

But her application for outpatient services was denied by the therapy facility. She was told that the therapy facility did not have documentation that home health services had terminated, and she was still considered to be under the care of the HHA.

She contacted Livanta to report that delayed notification of discontinued services affected her ability to obtain outpatient therapy. Through Immediate Advocacy, a Livanta representative contacted the HHA's clinical manager and was assured that all documentation regarding service termination had been sent to the outpatient therapy facility. The beneficiary was then contacted by Livanta to inform her that the clinical manager would contact the outpatient clinic to verify the date her services had ended.

The Livanta representative followed up with both the HHA agency and the outpatient therapy center to ensure that all information had been transmitted and received. As a result of Immediate Advocacy, the beneficiary was able to begin the next leg of her journey toward successful rehabilitation.

Example #3:

When this 70-year old beneficiary left the hospital, regular usage of a continuous positive airway pressure (CPAP) machine was necessary to assist with his respiratory function. Prior to discharge, the inhalation therapist had demonstrated how to use mask, insert the filter, and adjust the gauges to the correct liter rate of oxygen delivery. He was told the CPAP would ease his sleep apnea and reduce the strain it placed on his heart.

But when he returned home after his hospitalization, this necessary equipment had not been delivered. After several phone calls to the durable medical equipment (DME) vendor, he was told that his doctor had not sent the orders for this medical equipment. When he was unable to reach his doctor for clarification, the patient contacted Livanta.

The beneficiary agreed to Immediate Advocacy, and the Livanta representative contacted the physician's office for further information. The doctor reported that he had previously faxed DME orders to the vendor, but would re-send them and then contact the equipment company to confirm receipt of the order. During the representative's follow-up call with the beneficiary, he reported that the vendor had contacted him with the time and date that his CPAP would be delivered.

Through Immediate Advocacy, the beneficiary's concerns were resolved in a timely manner. By receiving his CPAP equipment quickly, he was able to avoid further medical complications.

12) Beneficiary Helpline Statistics

This table provides Livanta's Area #1 beneficiary HelpLine statistics for the period from August 1, 2018 through March 15, 2019.

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	107,857
Total Number of Calls Answered	63,158
Total Number of Abandoned Calls	2,086
Average Length of Call Wait Times	12 seconds
Number of Calls Transferred by 1-800-Medicare	140

Conclusion

As demonstrated in this report, Livanta provides significant value to Medicare beneficiaries, providers, and the Medicare program. Every day of the year, Livanta puts patients first and advocates on behalf of beneficiaries and families to ensure unfettered access to the rights guaranteed by Medicare. Leveraging our unique position, Livanta partners with providers to further guarantee beneficiaries are receiving both quality and medically necessary services and that providers are complying with Medicare regulations and requirements. Through innovative services, we offer patient support along the entire continuum of care – from initial symptom recognition to health maintenance.

- Beneficiary complaints and appeals provides beneficiaries with a caring advocate who can voice their expert perspective while also conveying the unique needs of beneficiaries, to healthcare providers. In addition, Livanta combines these concerns and nationally recognized standards of care to empower providers to improve future care for all beneficiaries.
- Immediate Advocacy reviews allow a rapid resolution to problems with concurrent care. For example, Immediate Advocacy can resolve logistical issues with care, such as access to expected supplies or equipment.
- Within Livanta's Quality of Care Program, when a quality of care concern is confirmed, educational feedback is delivered to the provider regarding how care can be improved in future cases. Moreover, where a systemic issue is identified, cases are referred to the state's local Quality Innovation Network Quality Improvement Organization (QIN-QIO). The QIN-QIO provides local technical assistance to the BFCC-QIO health care provider organization and addresses any underlying issues that may have led to the failure in care.
- Livanta protects beneficiary rights and the integrity of the Medicare Trust Fund through the handling of appeals, EMTALA cases, and utilization reviews, by ensuring that Medicare pays only for reasonable and medically necessary health care services, and that these services are provided in the most appropriate setting. By extension, this impacts the quality of care delivered. Any time a health care provider delivers care that is invasive but not medically necessary, there will be the risk of unnecessary harm to the patient.
- Education and empowerment through education and collaboration puts patients, families and advocates first. Through direct engagement of beneficiaries, families, advocates, providers, and critical stakeholders through its innovative and unique Quality Symposia Model, Livanta demonstrates its agility, innovative and entrepreneurial spirit, and deep commitment to putting patients first in all things. By empowering beneficiaries to take control of their health outcomes through education, Livanta can help to ensure that there are no barriers to access and that the disparities among vulnerable populations are reduced, positive health outcomes are achieved, and healthy communities are created. Through data driven educational initiatives along with broad based outreach to urban and rural areas alike, Livanta ensures that beneficiary protection is prioritized.

Livanta supports CMS's goal of ensuring that all Medicare beneficiaries receive quality care every time by ensuring that the medical care is paid by Medicare when it is medically necessary and meets the standards of care set by the medical community. The work that Livanta does to support beneficiaries and healthcare providers is essential to the Medicare program and puts patients first in all things.

Appendix

Livanta BFCC-QIO Area #1 – State of Connecticut

1) **Total Number of Reviews**

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	135	5.05%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	14	0.52%
Quality of Care Review (All Other Selection Reasons)	81	3.03%
Utilization/Medical Necessity (All Selection Reasons)	136	5.09%
Notice of Non-coverage (Admission and Preadmission/ HINN 1)	14	0.52%
Notice of Non-coverage (BIPA)	699	26.16%
Notice of Non-coverage (Grijalva)	1,260	47.16%
Notice of Non-coverage (Weichardt)	332	12.43%
Notice of Non-coverage (Request for QIO Concurrence/ HINN 10)	1	0.04%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	2,672	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	5,277	31.08%
2. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	1,796	10.58%
3. N179 - Acute Kidney Failure, Unspecified	1,736	10.23%
4. I110 - Hypertensive Heart Disease With Heart Failure	1,627	9.58%
5. N390 - Urinary Tract Infection, Uite Not Specified	1,406	8.28%
6. J189 - Pneumonia, Unspecified Organism	1,276	7.52%
7. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	1,046	6.16%
8. M1711 - Unilateral Primary Osteoarthritis, Right Knee	1,000	5.89%
9. I214 - Non-ST Elevation (Nstemi) Myocardial Infarction	930	5.48%
10. M1712 - Unilateral Primary Osteoarthritis, Left Knee	883	5.20%
Total	16,977	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,485	60.61%
Male	965	39.39%
Unknown	0	0.00%
Total	2,450	100.00%
Race		
Asian	17	0.69%
Black	228	9.31%
Hispanic	25	1.02%
North American Native	0	0.00%
Other	19	0.78%
Unknown	28	1.14%
White	2,133	87.06%
Total	2,450	100.00%
Age		
Under 65	241	9.84%
65-70	277	11.31%
71-80	705	28.78%
81-90	839	34.24%
91+	388	15.84%
Total	2,450	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	28	11.67%
1: Distinct Psychiatric Facility	2	0.83%
2: Distinct Rehabilitation Facility	1	0.42%
3: Distinct Skilled Nursing Facility	182	75.83%
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 Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	18	7.50%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	0.83%
R: Hospice	6	2.50%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.42%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	240	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	17	2	11.76%
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) and procedures (see C07 or C08) and consultations (see C13 and C14)	96	6	6.25%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	116	8	6.90%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	**Percent of Quality of Care Concerns Referred for QII**
1	7 %

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)	14	0.61%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.04%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	1,260	54.69%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	698	30.30%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	226	9.81%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	105	4.56%
Total	2,304	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	220	94.42%	88.93%
Rural	11	4.72%	10.73%
Unknown	2	0.86%	0.34%
Total	233	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	27	90.00%	90.08%
Rural	3	10.00%	9.40%
Unknown	0	0.00%	0.52%
Total	30	100.00%	100.00%

8) Immediate Advocacy Reviews

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
52	36	69.23%

Livanta BFCC-QIO Area #1 – State of Massachusetts

1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	250	9.38%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	19	0.71%
Quality of Care Review (All Other Selection Reasons)	122	4.58%
Utilization/Medical Necessity (All Selection Reasons)	249	9.34%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	20	0.75%
Notice of Non-coverage (BIPA)	1,038	38.93%
Notice of Non-coverage (Grijalva)	606	22.73%
Notice of Non-coverage (Weichardt)	362	13.58%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	2,666	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number Of Beneficiaries	Percent Of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	9,604	25.09%
2. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	4,386	11.46%
3. J189 - Pneumonia, Unspecified Organism	3,730	9.75%
4. I110 - Hypertensive Heart Disease With Heart Failure	3,655	9.55%
5. N179 - Acute Kidney Failure, Unspecified	3,640	9.51%
6. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	3,447	9.01%
7. N390 - Urinary Tract Infection, Site Not Specified	2,987	7.80%
8. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	2,422	6.33%
9. M1711 - Unilateral Primary Osteoarthritis, Right Knee	2,280	5.96%
10. J690 - Pneumonitis Due To Inhalation Of Food And Vomit	2,124	5.55%
Total	38,275	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,684	60.47%
Male	1,101	39.53%
Unknown	0	0.00%
Total	2,785	100.00%
Race		
Asian	20	0.72%
Black	124	4.45%
Hispanic	27	0.97%
North American Native	2	0.07%
Other	29	1.04%
Unknown	33	1.18%
White	2,550	91.56%
Total	2,785	100.00%
Age		
Under 65	332	11.92%
65-70	328	11.78%
71-80	752	27.00%
81-90	916	32.89%
91+	457	16.41%
Total	2,785	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	53	13.35%
1: Distinct Psychiatric Facility	9	2.27%
2: Distinct Rehabilitation Facility	5	1.26%
3: Distinct Skilled Nursing Facility	277	69.77%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	21	5.29%
N: Critical Access Hospital	1	0.25%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	6	1.51%
R: Hospice	23	5.79%
S: Psychiatric Unit of an Inpatient Facility	2	0.50%
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	397	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	23	3	13.04%
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) and procedures (see C07 or C08) and consultations (see C13 and C14)	151	3	1.99%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	6	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	1	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	181	6	3.31%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	Percent of Quality of Care Concerns Referred for QII
1	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)	20	0.99%
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)	606	29.91%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	1,038	51.23%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	291	14.36%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	71	3.50%
Total	2,026	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	376	98.69%	88.93%
Rural	5	1.31%	10.73%
Unknown	0	0.00%	0.34%
Total	381	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	47	97.92%	90.08%
Rural	1	2.08%	9.40%
Unknown	0	0.00%	0.52%
Total	48	100.00%	100.00%

8) Immediate Advocacy Reviews

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
82	63	76.83%

Livanta BFCC-QIO Area #1 – State of Maine

1) **Total Number of Reviews**

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	35	6.70%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	2	0.38%
Quality of Care Review (All Other Selection Reasons)	19	3.64%
Utilization/Medical Necessity (All Selection Reasons)	33	6.32%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	18	3.45%
Notice of Non-coverage (BIPA)	87	16.67%
Notice of Non-coverage (Grijalva)	240	45.98%
Notice of Non-coverage (Weichardt)	73	13.98%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.19%
EMTALA 5 Day	5	0.96%
EMTALA 60 Day	9	1.72%
Total	522	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number Of Beneficiaries	Percent Of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	1,877	28.74%
2. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	761	11.65%
3. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	673	10.31%
4. J189 - Pneumonia, Unspecified Organism	628	9.62%
5. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	535	8.19%
6. I110 - Hypertensive Heart Disease With Heart Failure	497	7.61%
7. N179 - Acute Kidney Failure, Unspecified	495	7.58%
8. N390 - Urinary Tract Infection, Site Not Specified	466	7.14%
9. M1612 - Unilateral Primary Osteoarthritis, Left Hip	299	4.58%
10. M1711 - Unilateral Primary Osteoarthritis, Right Knee	299	4.58%
Total	6,530	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	306	59.07%
Male	212	40.93%
Unknown	0	0.00%
Total	518	100.00%
Race		
Asian	1	0.19%
Black	4	0.77%
Hispanic	0	0.00%
North American Native	1	0.19%
Other	5	0.97%
Unknown	1	0.19%
White	506	97.68%
Total	518	100.00%
Age		
Under 65	74	14.29%
65-70	73	14.09%
71-80	144	27.80%
81-90	168	32.43%
91+	59	11.39%
Total	518	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	16	17.78%
1: Distinct Psychiatric Facility	2	2.22%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	60	66.67%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	0	0.00%
N: Critical Access Hospital	9	10.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	1	1.11%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	1.11%
Z: Swing Bed Designation for Critical Access Hospitals	1	1.11%
Other	0	0.00%
Total	90	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14)	24	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	27	0	0.00%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	**Percent of Quality of Care Concerns Referred for QII**
0	0 %

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)	18	4.30%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.24%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	240	57.28%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	87	20.76%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	61	14.56%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	12	2.86%
Total	419	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	41	51.25%	88.93%
Rural	37	46.25%	10.73%
Unknown	2	2.50%	0.34%
Total	80	100.00%	100.00%

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	6	54.55%	90.08%
Rural	4	36.36%	9.40%
Unknown	1	9.09%	0.52%
Total	11	100.00%	100.00%

8) Immediate Advocacy Reviews

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
15	12	80.00%

Livanta BFCC-QIO Area #1 – State of New Hamphire

1) **Total Number of Reviews**

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	94	17.44%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	2	0.37%
Quality of Care Review (All Other Selection Reasons)	31	5.75%
Utilization/Medical Necessity (All Selection Reasons)	92	17.07%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	27	5.01%
Notice of Non-coverage (BIPA)	83	15.40%
Notice of Non-coverage (Grijalva)	126	23.38%
Notice of Non-coverage (Weichardt)	84	15.58%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	539	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number Of Beneficiaries	Percent Of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	2,074	26.25%
2. J189 - Pneumonia, Unspecified Organism	903	11.43%
3. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	775	9.81%
4. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	708	8.96%
5. I110 - Hypertensive Heart Disease With Heart Failure	704	8.91%
6. N179 - Acute Kidney Failure, Unspecified	655	8.29%
7. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	628	7.95%
8. N390 - Urinary Tract Infection, Site Not Specified	567	7.18%
9. M1711 - Unilateral Primary Osteoarthritis, Right Knee	456	5.77%
10. M1611 - Unilateral Primary Osteoarthritis, Right Hip	432	5.47%
Total	7,902	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	316	61.24%
Male	200	38.76%
Unknown	0	0.00%
Total	516	100.00%
Race		
Asian	1	0.19%
Black	8	1.55%
Hispanic	1	0.19%
North American Native	0	0.00%
Other	7	1.36%
Unknown	6	1.16%
White	493	95.54%
Total	516	100.00%
Age		
Under 65	74	14.34%
65-70	87	16.86%
71-80	160	31.01%
81-90	134	25.97%
91+	61	11.82%
Total	516	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	13	17.33%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	2	2.67%
3: Distinct Skilled Nursing Facility	43	57.33%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	4	5.33%
N: Critical Access Hospital	6	8.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	1	1.33%
R: Hospice	4	5.33%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	2	2.67%
Other	0	0.00%
Total	75	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	11	5	45.45%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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) and procedures (see C07 or C08) and consultations (see C13 and C14)	27	3	11.11%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	38	8	21.05%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	**Percent of Quality of Care Concerns Referred for QII**
3	38 %

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)	27	8.44%
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)	126	39.38%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	83	25.94%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	77	24.06%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	7	2.19%
Total	320	100.00%

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	49	69.01%	88.93%
Rural	20	28.17%	10.73%
Unknown	2	2.82%	0.34%
Total	71	100.00%	100.00%

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	7	58.33%	90.08%
Rural	5	41.67%	9.40%
Unknown	0	0.00%	0.52%
Total	12	100.00%	100.00%

8) Immediate Advocacy Reviews

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
9	7	77.78%

Livanta BFCC-QIO Area #1 – State of New Jersey

1) **Total Number of Reviews**

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	591	7.78%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	25	0.33%
Quality of Care Review (All Other Selection Reasons)	241	3.17%
Utilization/Medical Necessity (All Selection Reasons)	580	7.63%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	246	3.24%
Notice of Non-coverage (BIPA)	2,095	27.56%
Notice of Non-coverage (Grijalva)	2,376	31.26%
Notice of Non-coverage (Weichardt)	1,268	16.68%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	151	1.99%
EMTALA 5 Day	28	0.37%
EMTALA 60 Day	0	0.00%
Total	7,601	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, unspecified organism	12,379	27.34%
2. I130 – Hypertensive heart & chronic kidney disease without heart failure and stage 1-4/unspecified chronic kidney	4,863	10.74%
3. I110 - Hypertensive heart disease with heart failure	4,686	10.35%
4. N179 - Acute kidney failure, unspecified	4,580	10.12%
5. N390 - Urinary tract infection, site not specified	3,980	8.79%
6. J189 - Pneumonia, unspecified organism	3,732	8.24%
7. I214 - Non-ST elevation (nstemi) myocardial infarction	3,669	8.10%
8. J441 - Chronic obstructive pulmonary disease w (acute) exacerbation	3,134	6.92%
9. I639 - Cerebral infarction, unspecified	2,242	4.95%
10. J690 - Pneumonitis due to inhalation of food and vomit	2,008	4.44%
Total	45,273	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	4,025	59.70%
Male	2,717	40.30%
Unknown	0	0.00%
Total	6,742	100.00%
Race		
Asian	135	2.00%
Black	1,016	15.07%
Hispanic	134	1.99%
North American Native	2	0.03%
Other	106	1.57%
Unknown	62	0.92%
White	5,287	78.42%
Total	6,742	100.00%
Age		
Under 65	720	10.68%
65-70	891	13.22%
71-80	1,993	29.56%
81-90	2,288	33.94%
91+	850	12.61%
Total	6,742	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	65	14.71%
1: Distinct Psychiatric Facility	5	1.13%
2: Distinct Rehabilitation Facility	7	1.58%
3: Distinct Skilled Nursing Facility	299	67.65%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	24	5.43%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	6	1.36%
R: Hospice	33	7.47%
S: Psychiatric Unit of an Inpatient Facility	1	0.23%
T: Rehabilitation Unit of an Inpatient Facility	1	0.23%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.23%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	442	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	4	1	25.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	24	3	12.50%
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) and procedures (see C07 or C08) and consultations (see C13 and C14)	281	13	4.63%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	4	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	313	17	5.43%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	**Percent of Quality of Care Concerns Referred for QII**
9	53 %

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)	245	3.99%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	151	2.46%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	2,376	38.73%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	2,095	34.15%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	1,024	16.69%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	243	3.96%
Total	6,134	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	430	100.00%	88.93%
Rural	0	0.00%	10.73%
Unknown	0	0.00%	0.34%
Total	430	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	73	100.00%	90.08%
Rural	0	0.00%	9.40%
Unknown	0	0.00%	0.52%
Total	73	100.00%	100.00%

8) **Immediate Advocacy Reviews**

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
154	126	81.82%

Livanta BFCC-QIO Area #1 – State of New York

1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	1,856	13.13%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	59	0.42%
Quality of Care Review (All Other Selection Reasons)	75	0.53%
Utilization/Medical Necessity (All Selection Reasons)	1,844	13.04%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	226	1.60%
Notice of Non-coverage (BIPA)	2,441	17.27%
Notice of Non-coverage (Grijalva)	5,085	35.97%
Notice of Non-coverage (Weichardt)	2,541	17.97%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	8	0.06%
EMTALA 5 Day	2	0.01%
EMTALA 60 Day	0	0.00%
Total	14,137	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number Of Beneficiaries	Percent Of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	23,397	31.31%
2. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	7,041	9.42%
3. I110 - Hypertensive Heart Disease With Heart Failure	6,710	8.98%
4. N179 - Acute Kidney Failure, Unspecified	6,701	8.97%
5. J189 - Pneumonia, Unspecified Organism	6,434	8.61%
6. N390 - Urinary Tract Infection, Site Not Specified	6,415	8.59%
7. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	5,599	7.49%
8. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	5,092	6.81%
9. M1711 - Unilateral Primary Osteoarthritis, Right Knee	3,833	5.13%
10. M1712 - Unilateral Primary Osteoarthritis, Left Knee	3,500	4.68%
Total	74,722	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	7,293	60.50%
Male	4,758	39.47%
Unknown	4	0.03%
Total	12,055	100.00%
Race		
Asian	207	1.72%
Black	1,919	15.92%
Hispanic	335	2.78%
North American Native	9	0.07%
Other	242	2.01%
Unknown	137	1.14%
White	9,206	76.37%
Total	12,055	100.00%
Age		
Under 65	1,341	11.12%
65-70	1,533	12.72%
71-80	3,461	28.71%
81-90	4,055	33.64%
91+	1,665	13.81%
Total	12,055	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	147	19.09%
1: Distinct Psychiatric Facility	3	0.39%
2: Distinct Rehabilitation Facility	1	0.13%
3: Distinct Skilled Nursing Facility	513	66.62%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	2	0.26%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	3	0.39%
H: Home Health Agency	60	7.79%
N: Critical Access Hospital	7	0.91%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	3	0.39%
R: Hospice	18	2.34%
S: Psychiatric Unit of an Inpatient Facility	4	0.52%
T: Rehabilitation Unit of an Inpatient Facility	3	0.39%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	2	0.26%
Y: Federally Qualified Health Centers	3	0.39%
Z: Swing Bed Designation for Critical Access Hospitals	1	0.13%
Other	0	0.00%
Total	770	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	3	1	33.33%
C02: Apparently did not make appropriate diagnoses and/or assessments	56	7	12.50%
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) and procedures (see C07 or C08) and consultations (see C13 and C14)	184	34	18.48%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	13	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	5	1	20.00%
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	1	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	1	100.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	267	44	16.48%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	**Percent of Quality of Care Concerns Referred for QII**
16	36 %

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)	226	2.19%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	8	0.08%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	5,085	49.38%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	2,440	23.69%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	1,748	16.97%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	791	7.68%
Total	10,298	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	657	88.19%	88.93%
Rural	85	11.41%	10.73%
Unknown	3	0.40%	0.34%
Total	745	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	69	93.24%	90.08%
Rural	4	5.41%	9.40%
Unknown	1	1.35%	0.52%
Total	74	100.00%	100.00%

8) **Immediate Advocacy Reviews**

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
313	249	79.55%

Livanta BFCC-QIO Area #1 – State of Pennsylvania

1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	633	5.82%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	55	0.51%
Quality of Care Review (All Other Selection Reasons)	229	2.11%
Utilization/Medical Necessity (All Selection Reasons)	648	5.96%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	9	0.08%
Notice of Non-coverage (BIPA)	2,828	26.01%
Notice of Non-coverage (Grijalva)	5,543	50.99%
Notice of Non-coverage (Weichardt)	917	8.44%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.01%
EMTALA 5 Day	8	0.07%
EMTALA 60 Day	0	0.00%
Total	10,871	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number Of Beneficiaries	Percent Of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	16,475	26.53%
2. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	7,082	11.41%
3. N179 - Acute Kidney Failure, Unspecified	6,886	11.09%
4. I110 - Hypertensive Heart Disease With Heart Failure	5,698	9.18%
5. J189 - Pneumonia, Unspecified Organism	5,374	8.65%
6. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	4,866	7.84%
7. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	4,587	7.39%
8. N390 - Urinary Tract Infection, Site Not Specified	4,399	7.08%
9. M1711 - Unilateral Primary Osteoarthritis, Right Knee	3,505	5.64%
10. M1712 - Unilateral Primary Osteoarthritis, Left Knee	3,223	5.19%
Total	62,095	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	5,815	60.13%
Male	3,854	39.85%
Unknown	2	0.02%
Total	9,671	100.00%
Race		
Asian	49	0.51%
Black	959	9.92%
Hispanic	36	0.37%
North American Native	3	0.03%
Other	54	0.56%
Unknown	60	0.62%
White	8,510	88.00%
Total	9,671	100.00%
Age		
Under 65	949	9.81%
65-70	1,192	12.33%
71-80	2,718	28.10%
81-90	3,422	35.38%
91+	1,390	14.37%
Total	9,671	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	127	14.29%
1: Distinct Psychiatric Facility	6	0.67%
2: Distinct Rehabilitation Facility	18	2.02%
3: Distinct Skilled Nursing Facility	611	68.73%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	53	5.96%
N: Critical Access Hospital	3	0.34%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	11	1.24%
R: Hospice	56	6.30%
S: Psychiatric Unit of an Inpatient Facility	1	0.11%
T: Rehabilitation Unit of an Inpatient Facility	3	0.34%
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	889	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	3	2	66.67%
C02: Apparently did not make appropriate diagnoses and/or assessments	54	6	11.11%
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) and procedures (see C07 or C08) and consultations (see C13 and C14)	317	30	9.46%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	23	2	8.70%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	5	1	20.00%
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	9	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	4	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	416	41	9.86%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	**Percent of Quality of Care Concerns Referred for QII**
13	32 %

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)	9	0.10%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.01%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	5,543	59.63%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	2,826	30.40%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	546	5.87%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	370	3.98%
Total	9,295	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	722	83.95%	88.93%
Rural	138	16.05%	10.73%
Unknown	0	0.00%	0.34%
Total	860	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	91	85.85%	90.08%
Rural	15	14.15%	9.40%
Unknown	0	0.00%	0.52%
Total	106	100.00%	100.00%

8) Immediate Advocacy Reviews

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
187	129	68.98%

Livanta BFCC-QIO Area #1 – Puerto Rico

1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	4	3.39%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	10	8.47%
Quality of Care Review (All Other Selection Reasons)	8	6.78%
Utilization/Medical Necessity (All Selection Reasons)	4	3.39%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	6	5.08%
Notice of Non-coverage (Grijalva)	5	4.24%
Notice of Non-coverage (Weichardt)	80	67.80%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.85%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	118	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number Of Beneficiaries	Percent Of Beneficiaries
1. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	528	19.58%
2. A419 - Sepsis, Unspecified Organism	388	14.39%
3. N390 - Urinary Tract Infection, Site Not Specified	301	11.16%
4. I110 - Hypertensive Heart Disease With Heart Failure	290	10.76%
5. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	260	9.64%
6. J189 - Pneumonia, Unspecified Organism	228	8.46%
7. I25110 - Atherosclerotic Heart Disease Of Native Coronary Artery With Unstable Angina Pectoris	213	7.90%
8. I120 - Hypertensive Chronic Kidney Disease With Stage 5 Chronic Kidney Disease Or End Stage Renal Disease	167	6.19%
9. N179 - Acute Kidney Failure, Unspecified	161	5.97%
10. F333 - Major Depressive Disorder, Recurrent, Severe With Psychotic Symptoms	160	5.93%
Total	2,696	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	92	64.34%
Male	51	35.66%
Unknown	0	0.00%
Total	143	100.00%
Race		
Asian	0	0.00%
Black	10	6.99%
Hispanic	24	16.78%
North American Native	0	0.00%
Other	3	2.10%
Unknown	0	0.00%
White	106	74.13%
Total	143	100.00%
Age		
Under 65	26	18.18%
65-70	19	13.29%
71-80	55	38.46%
81-90	33	23.08%
91+	10	6.99%
Total	143	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	37	77.08%
1: Distinct Psychiatric Facility	1	2.08%
2: Distinct Rehabilitation Facility	2	4.17%
3: Distinct Skilled Nursing Facility	3	6.25%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	2	4.17%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	3	6.25%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	48	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	7	4	57.14%
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) and procedures (see C07 or C08) and consultations (see C13 and C14)	30	11	36.67%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	39	15	38.46%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	**Percent of Quality of Care Concerns Referred for QII**
9	60 %

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	1.09%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	5	5.43%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	6	6.52%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	20	21.74%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	60	65.22%
Total	92	100.00%

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	33	94.29%	88.93%
Rural	2	5.71%	10.73%
Unknown	0	0.00%	0.34%
Total	35	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	100.00%	90.08%
Rural	0	0.00%	9.40%
Unknown	0	0.00%	0.52%
Total	14	100.00%	100.00%

8) Immediate Advocacy Reviews

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
39	29	74.36%

Livanta BFCC-QIO Area #1 – State of Rhode Island

1) **Total Number of Reviews**

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	43	4.87%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	5	0.57%
Quality of Care Review (All Other Selection Reasons)	42	4.76%
Utilization/Medical Necessity (All Selection Reasons)	43	4.87%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	26	2.94%
Notice of Non-coverage (BIPA)	137	15.52%
Notice of Non-coverage (Grijalva)	379	42.92%
Notice of Non-coverage (Weichardt)	208	23.56%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	883	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number Of Beneficiaries	Percent Of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	1,132	27.75%
2. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	500	12.26%
3. N179 - Acute Kidney Failure, Unspecified	427	10.47%
4. I110 - Hypertensive Heart Disease With Heart Failure	418	10.25%
5. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	338	8.29%
6. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	322	7.89%
7. N390 - Urinary Tract Infection, Site Not Specified	293	7.18%
8. J189 - Pneumonia, Unspecified Organism	275	6.74%
9. J690 - Pneumonitis Due To Inhalation Of Food And Vomit	190	4.66%
10. M1711 - Unilateral Primary Osteoarthritis, Right Knee	184	4.51%
Total	4,079	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	492	60.52%
Male	321	39.48%
Unknown	0	0.00%
Total	813	100.00%
Race		
Asian	5	0.62%
Black	35	4.31%
Hispanic	15	1.85%
North American Native	0	0.00%
Other	12	1.48%
Unknown	4	0.49%
White	742	91.27%
Total	813	100.00%
Age		
Under 65	91	11.19%
65-70	113	13.90%
71-80	225	27.68%
81-90	255	31.37%
91+	129	15.87%
Total	813	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	9	9.78%
1: Distinct Psychiatric Facility	1	1.09%
2: Distinct Rehabilitation Facility	1	1.09%
3: Distinct Skilled Nursing Facility	72	78.26%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	6	6.52%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	3	3.26%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	92	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	2	1	50.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14)	47	4	8.51%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	4	1	25.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	55	6	10.91%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	**Percent of Quality of Care Concerns Referred for QII**
1	17 %

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)	26	3.47%
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)	379	50.53%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	137	18.27%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	140	18.67%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	68	9.07%
Total	750	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	90	100.00%	88.93%
Rural	0	0.00%	10.73%
Unknown	0	0.00%	0.34%
Total	90	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	10	100.00%	90.08%
Rural	0	0.00%	9.40%
Unknown	0	0.00%	0.52%
Total	10	100.00%	100.00%

8) Immediate Advocacy Reviews

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
22	17	77.27%

Livanta BFCC-QIO Area #1 – United States Virgin Islands

1) **Total Number of Reviews**

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	0	0.00%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	1	14.29%
Quality of Care Review (All Other Selection Reasons)	0	0.00%
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)	0	0.00%
Notice of Non-coverage (Grijalva)	0	0.00%
Notice of Non-coverage (Weichardt)	6	85.71%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	7	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number Of Beneficiaries	Percent Of Beneficiaries
1. I639 - Cerebral Infarction, Unspecified	25	21.19%
2. N390 - Urinary Tract Infection, Site Not Specified	16	13.56%
3. J189 - Pneumonia, Unspecified Organism	15	12.71%
4. A419 - Sepsis, Unspecified Organism	12	10.17%
5. I110 - Hypertensive Heart Disease With Heart Failure	12	10.17%
6. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	10	8.47%
7. R55 - Syncope And Collapse	9	7.63%
8. E1152 - Type 2 Diabetes With Diabetic Peripheral Angiopathy Without Gangrene	8	6.78%
9. I5021 - Acute Systolic (Congestive) Heart Failure	6	5.08%
10. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	5	4.24%
Total	118	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2	33.33%
Male	4	66.67%
Unknown	0	0.00%
Total	6	100.00%
Race		
Asian	0	0.00%
Black	0	0.00%
Hispanic	1	16.67%
North American Native	0	0.00%
Other	0	0.00%
Unknown	0	0.00%
White	5	83.33%
Total	6	100.00%
Age		
Under 65	2	33.33%
65-70	1	16.67%
71-80	3	50.00%
81-90	0	0.00%
91+	0	0.00%
Total	6	100.00%

4) Provider Reviews Settings

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

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

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

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	1	0	0.00%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	Percent of Quality of Care Concerns Referred for QII
0	0 %

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)	0	0.00%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	0	0.00%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	6	100.00%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	0	0.00%
Total	6	100.00%

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	0	0.00%	88.93%
Rural	2	100.00%	10.73%
Unknown	0	0.00%	0.34%
Total	2	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			
Rural			
Unknown			
Total			

8) Immediate Advocacy Reviews

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
1	0	0.00%

Livanta BFCC-QIO Area #1 – State of Vermont

1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	43	18.78%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	0	0.00%
Quality of Care Review (All Other Selection Reasons)	7	3.06%
Utilization/Medical Necessity (All Selection Reasons)	43	18.78%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.87%
Notice of Non-coverage (BIPA)	58	25.33%
Notice of Non-coverage (Grijalva)	44	19.21%
Notice of Non-coverage (Weichardt)	32	13.97%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	229	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number Of Beneficiaries	Percent Of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	673	22.27%
2. J189 - Pneumonia, Unspecified Organism	345	11.42%
3. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	324	10.72%
4. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	286	9.46%
5. N390 - Urinary Tract Infection, Site Not Specified	264	8.74%
6. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	251	8.31%
7. N179 - Acute Kidney Failure, Unspecified	242	8.01%
8. I110 - Hypertensive Heart Disease With Heart Failure	240	7.94%
9. M1711 - Unilateral Primary Osteoarthritis, Right Knee	217	7.18%
10. M1712 - Unilateral Primary Osteoarthritis, Left Knee	180	5.96%
Total	3,022	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	94	58.02%
Male	68	41.98%
Unknown	0	0.00%
Total	162	100.00%
Race		
Asian	0	0.00%
Black	0	0.00%
Hispanic	1	0.62%
North American Native	1	0.62%
Other	2	1.23%
Unknown	0	0.00%
White	158	97.53%
Total	162	100.00%
Age		
Under 65	18	11.11%
65-70	25	15.43%
71-80	51	31.48%
81-90	51	31.48%
91+	17	10.49%
Total	162	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	6	21.43%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	15	53.57%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	1	3.57%
H: Home Health Agency	0	0.00%
N: Critical Access Hospital	4	14.29%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	0	0.00%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	3.57%
Z: Swing Bed Designation for Critical Access Hospitals	1	3.57%
Other	0	0.00%
Total	28	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14)	7	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	8	0	0.00%

Quality of Care Concerns Referred for Quality Improvement Initiatives (QIIs)	
Number of Concerns Referred for QII	Percent of Quality of Care Concerns Referred for QII
0	0 %

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	1.47%
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)	44	32.35%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	58	42.65%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	32	23.53%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	0	0.00%
Total	136	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	8	30.77%	88.93%
Rural	17	65.38%	10.73%
Unknown	1	3.85%	0.34%
Total	26	100.00%	100.00%

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	1	20.00%	90.08%
Rural	4	80.00%	9.40%
Unknown	0	0.00%	0.52%
Total	5	100.00%	100.00%

8) Immediate Advocacy Reviews

Number of Beneficiary Complaints	Number of Immediate Advocacy Reviews	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
3	3	100.00%