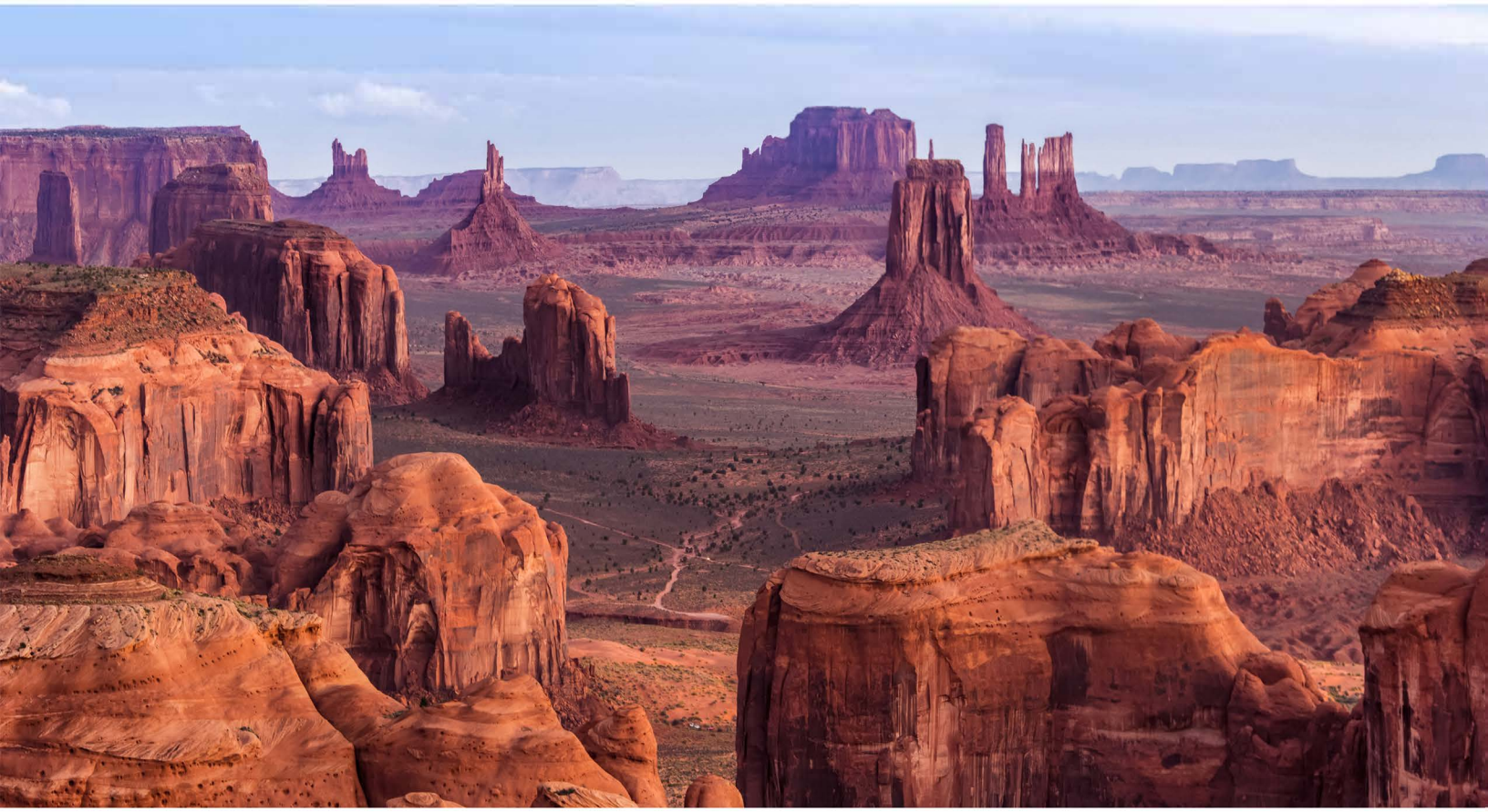
AREA #5

BFCC-QIO 11TH SOW

ANNUAL MEDICAL SERVICES



REPORT 8/1/2018-3/15/2019

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

LIVANTA

From practical innovations to results.

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INTRODUCTION:

Livanta LLC is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Area #5, which includes the states of Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, and Washington, as well as the territories of Guam, American Samoa, and the Northern Mariana Islands. Statistics for Guam, American Samoa, and the Northern Mariana Islands have been included in the figures for Hawaii.

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 #5 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 #5 – SUMMARY

1) TOTAL NUMBER OF REVIEWS

Livanta completed reviews on behalf of Medicare beneficiaries receiving care in Area #5. 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)	4,239	17.37%
Coding Validation (Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	294	1.20%
Quality of Care Review (All Other Selection Reasons)	242	0.99%
Utilization/Medical Necessity (All Selection Reasons)	4,270	17.49%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	16	0.07%
Notice of Non-coverage (BIPA)	4,486	18.38%
Notice of Non-coverage (Grijalva)	7,743	31.72%
Notice of Non-coverage (Weichardt)	7,299	29.91%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	51	0.21%
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day	6	0.02%
EMTALA 60 Day	0	0.00%
Total	28,646	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 #5.

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	71,153	35.78%
2. N179 - Acute Kidney Failure, Unspecified	17,957	9.03%
3. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure and Stage 1-4/Unspecified Chronic Kidney	17,694	8.90%
4. I110 - Hypertensive Heart Disease with Heart Failure	15,857	7.97%
5. I214 - Non-ST Elevation (NSTEMI) Myocardial Infarction	15,535	7.81%
6. J189 - Pneumonia, Unspecified Organism	15,211	7.65%
7. N390 - Urinary Tract Infection, Site Not Specified	12,498	6.29%
8. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	11,517	5.79%
9. M1711 - Unilateral Primary Osteoarthritis, Right Knee	11,202	5.63%
10. M1712 - Unilateral Primary Osteoarthritis, Left Knee	10,215	5.14%
Total	198,839	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 #5.

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	463	20.50%
1: Distinct Psychiatric Facility	35	1.55%
2: Distinct Rehabilitation Facility	25	1.11%
3: Distinct Skilled Nursing Facility	1,265	56.00%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.04%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	2	0.09%
9: Provider Based Rural Health Clinic (RHC)	2	0.09%
C: Free Standing Ambulatory Surgery Center	2	0.09%
G: End-Stage Renal Disease Unit	2	0.09%
H: Home Health Agency	150	6.64%
N: Critical Access Hospital	37	1.64%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	30	1.33%
R: Hospice	205	9.07%
S: Psychiatric Unit of an Inpatient Facility	8	0.35%
T: Rehabilitation Unit of an Inpatient Facility	11	0.49%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	3	0.13%
Y: Federally Qualified Health Centers	14	0.62%
Z: Swing Bed Designation for Critical Access Hospitals	4	0.18%
Other	0	0.00%
Total	2,259	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	4	2	50.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	136	17	12.50%

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), procedures (see C07 or C08) and consultations (see C13 and C14)]	588	84	14.29%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	92	19	20.65%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	39	9	23.08%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	15	3	20.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	47	13	27.66%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	14	2	14.29%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	20	2	10.00%
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	5	1	20.00%
C13: Apparently did not order appropriate specialty consultation	35	2	5.71%
C14: Apparently specialty consultation process was not completed in a timely manner	8	3	37.50%
C15: Apparently did not effectively coordinate across disciplines	6	4	66.67%
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	10	3	30.00%
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	1,019	164	16.09%

This table provides the total number of quality of care concerns referred to the 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**
68	41 %
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner acting on laboratory and imaging testing results	2
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner determining medical necessity of procedure/surgery	2
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner diagnosis and evaluation of patients	1
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner general treatment planning/administration	27
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner obtaining patient history and performing physical examination	3
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner ordering necessary laboratory and imaging tests	2
Practitioner - Patient Care by Practitioner: Improvement needed in practitioner ordering of, coordination with or completion of practitioner specialty consultation	4
Provider – Other Administrative	1
Provider – Patient Care by Staff: Improvement in staff assessments	5
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	7
Provider – Patient Care by Staff: Improvement needed in staff monitoring/reporting of patient changes and response to or adjusting care	4
Provider – Patient Rights: Improvement needed in notice of noncoverage issues	3

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)	1	33.33%
02: Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03: Discharged/transferred to skilled nursing facility (SNF)	0	0.00%
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	1	33.33%
30: Still a patient	0	0.00%
40: Expired at home (Hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or free standing Hospice)	0	0.00%
42: Expired – place unknown (Hospice claims only)	0	0.00%
43: Discharged/transferred to a federal hospital	0	0.00%
50: Hospice - home	0	0.00%
51: Hospice - medical facility	0	0.00%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	0	0.00%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	1	33.33%
63: Discharged/transferred to a long-term care hospital	0	0.00%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66: Discharged/transferred to a critical access hospital	0	0.00%
70: Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%
Other	0	0.00%
Total	3	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)	16	37.50%	62.50%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	51	17.65%	82.35%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	7,742	16.73%	83.27%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	4,484	19.60%	80.40%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	4,263	9.03%	90.97%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (MA Weichardt)	3,033	8.31%	91.69%
Total	19,589	18.14%	81.86%

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	Rationale for Evidence/Standard of Care Selected
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

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

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
			Management of HF includes management of contributing and associated conditions, lifestyle modification, drug therapy, device therapy as indicated, cardiac rehabilitation, and preventive care.
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.

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

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

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

Review Type	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
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) Reviews by Geographic Area

These tables provide information for Area #5 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	1,905	89.86%
Rural	203	9.58%
Unknown	12	0.57%
Total	2,120	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	257	91.13%
Rural	24	8.51%
Unknown	1	0.35%
Total	282	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, an 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 1-877-588-1123. The HelpLine is available locally from 9:00 a.m. to 5:00 p.m. on weekdays and from 11:00 a.m. to 3:00 p.m. 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 1-855-887-6668 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. Using consistent social media outreach via Facebook, Twitter, and blogging; Livanta shared pertinent information related to a multitude of health topics and BFCC-QIO services. Specifically, we were able to reach a million beneficiaries and family members who were impacted by the wildfires in California. Livanta used social media to remind those impacted of the services available in the community and to contact Livanta if there were any barriers to health observed.

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 Nevada, 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 Nevada SMP now refers cases regularly to Livanta. 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.

Providers

After the successful conclusion of Livanta's unique and innovative series of Medicare rights symposia held in San Francisco and Seattle, the Livanta Communications Team embarked on a major effort to engage the acute care provider networks in Area #5. 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.

Livanta's Data team sampled 1,750 medical records from Area #5. 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. During the initial review and remeasurement, Livanta staff conducted individual webinar-based remediation sessions with non-compliant providers. After remeasurement, significant improvements were noted among providers who had participated in this education. As a result of this experience, the Livanta Communications Team developed an educational webinar for acute care hospital staff. The Healthcare Association of Hawaii was the first provider group to partner with Livanta for a statewide educational webinar in Area #5. The webinar format is uniquely suited for geographically remote areas such as the Pacific states and territories. By conducting these educational sessions via webinar, the Livanta team can ensure widespread parBelow are stories where Livanta helped patients successfully resolve their issues regarding healthcare concerns. ticipation and budget neutrality. Through its partnership with the Healthcare Association of Hawaii, representatives from nearly all facilities and islands participated in the education session. Throughout the remainder of the 11th Statement of Work, the Livanta Team has conducted or scheduled webinars with all states in Area #5. These successful ventures in collaboration with providers and provider groups represent significant potential 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
1,026	715	69.69%

11) EXAMPLES/SUCCESS STORIES

Example #1:

A 53-year-old beneficiary suffered from mental health issues, including panic attacks, for several years. Fortunately, his primary care doctor had finally determined the exact combination of psychotropic medications that alleviated his symptoms and kept him stable and able to function at home.

When a new primary care physician was assigned, the beneficiary called to obtain a prescription to refill his prescriptions which were necessary to control his symptoms. Otherwise, the beneficiary would be at risk for re-hospitalization.

He contacted the new office and was told that he would not need to come into the office; he could participate in a telemedicine appointment instead. He agreed and was contacted by a nurse practitioner via her telemedicine platform. She spoke with him briefly and said that she would review his records and phone in his latest prescription to the pharmacy.

Later, the beneficiary reported that he was surprised at the ease – and the brevity – of this interaction. Who knew it could be so easy? But an issue arose at his local pharmacy. There were no prescriptions called in by the nurse practitioner and no medications waiting. He called the new physician's office and left voice mails that were not returned.

When he called Livanta, he was informed that Immediate Advocacy could help him resolve this issue. A Livanta representative contacted the physician office and spoke with the staff, who agreed to follow up on the beneficiary's prescriptions. After ensuring that the prescriptions had been called in, the representative related this information to the beneficiary. The grateful beneficiary thanked Livanta for working on his behalf to quickly get him access to the medications that he needed.

Example #2:

A 50-year old beneficiary reported that she was hospitalized for pneumonia and required intravenous (IV) antibiotics and blood tests every few hours. Because of the size and fragility of her veins, they would collapse shortly after IV access was achieved, and her blood tests required multiple painful sticks before a successful draw could be completed.

When the ordeal of IV reinsertions became more than she could bear, she requested that a peripherally inserted central catheter line be placed. It seemed to be the best solution for continued IV administration and the best way to avoid feeling like a human pin cushion during those painful blood draws.

When her doctor failed to order central line placement, the beneficiary called Livanta. After reviewing the beneficiary's information, the Livanta representative contacted the care facility's nurse manager, who agreed to present the concerns to the attending physician. Shortly thereafter, the beneficiary received a bedside visit from her doctor, who ordered central line placement. With a more consistent medication delivery, the beneficiary reported that she was feeling better and was very grateful for Livanta's intervention.

Example #3:

This 84-year old beneficiary went to the hospital after suffering multiple falls from dizzy spells, where testing revealed a 90% carotid artery blockage. She was instructed to suspend her daily blood-thinning medications for three days to prepare for surgery. During the admission process, the beneficiary was told that she had no insurance coverage at that hospital.

After three days without her medications, the beneficiary had become seriously unstable from decreased circulation. When her husband called Livanta, he expressed fear for his wife's safety. The longer her surgery was delayed, the greater the risk to the beneficiary.

Through Immediate Advocacy, a Livanta representative contacted the Risk Management Department at the hospital regarding the urgency of the situation. The information was referred to the facility's internal Care Coordination Unit for review and resolution. When the Livanta representative next spoke with the beneficiary's spouse, the spouse reported that everything had been resolved, and surgery was pending.

A follow-up phone call revealed that the beneficiary was doing well after the procedure. Both the beneficiary and her husband were extremely grateful for Livanta's help.

12) BENEFICIARY HELPLINE STATISTICS

This table provides Livanta's Area #5 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	46,712
Total Number of Calls Answered	26,509
Total Number of Abandoned Calls	695
Average Length of Call Wait Times	10 seconds
Number of Calls Transferred by 1-800-Medicare	139

Conclusion**:**

As demonstrated in this report, Livanta provides significant value to Medicare beneficiaries, providers, and the Medicare program. 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 that beneficiaries are receiving both high 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 provide 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 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

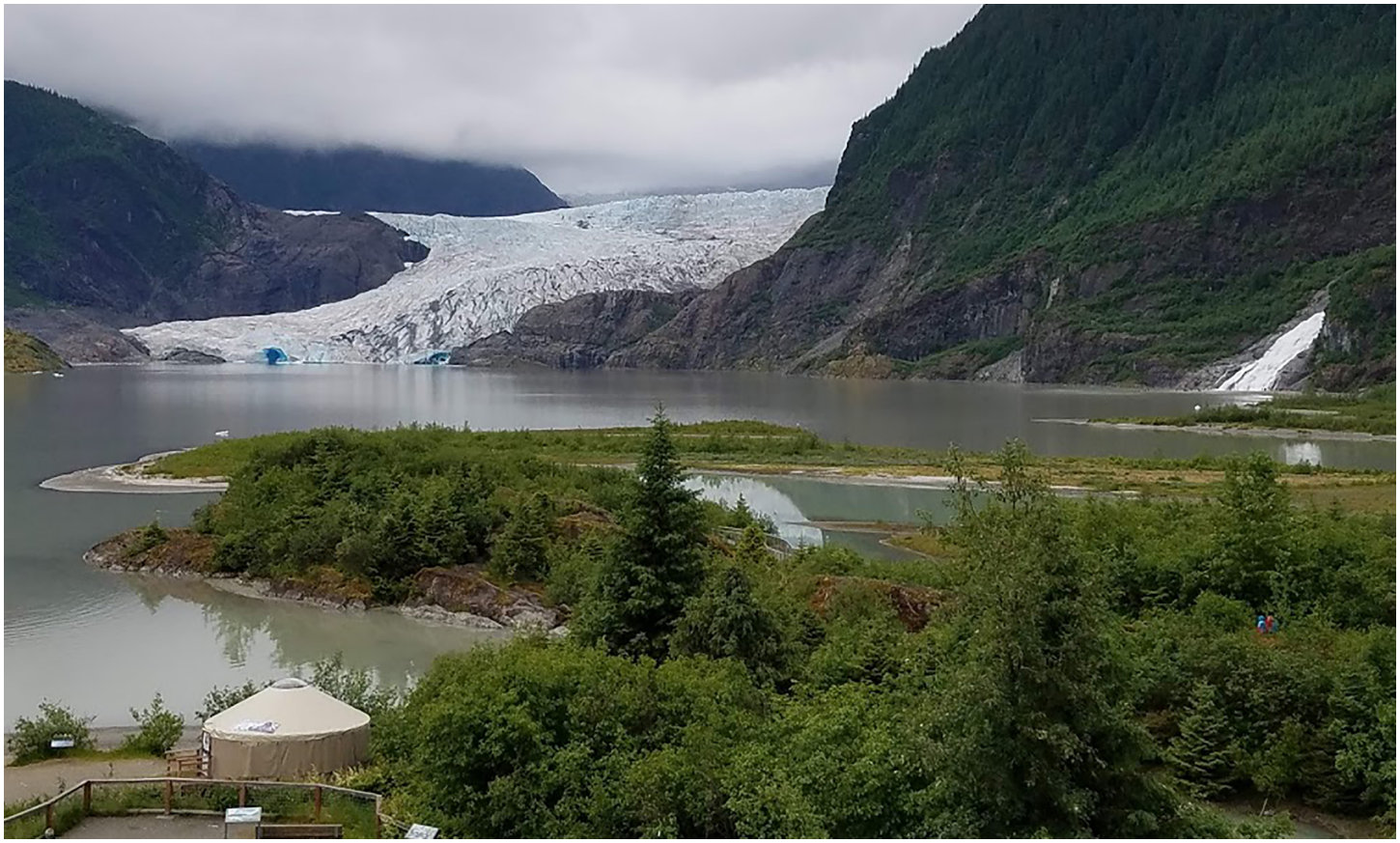
care that is invasive but not medically necessary, there will be the risk of unnecessary harm to the patient.

- 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 and 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 #5 – State of Alaska



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	89	37.24%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	1	0.42%
Quality of Care Review (All Other Selection Reasons)	0	0.00%
Utilization/Medical Necessity (All Selection Reasons)	87	36.40%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	1	0.42%
Notice of Non-coverage (BIPA)	12	5.02%
Notice of Non-coverage (Grijalva)	0	0.00%
Notice of Non-coverage (Weichardt)	48	20.08%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.42%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	239	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	913	32.64%
2. I214 - Non-ST Elevation (Nstemi) Myocardial Infarction	263	9.40%
3. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	243	8.69%
4. M1711 - Unilateral Primary Osteoarthritis, Right Knee	225	8.04%
5. M1712 - Unilateral Primary Osteoarthritis, Left Knee	209	7.47%
6. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	208	7.44%
7. I110 - Hypertensive Heart Disease With Heart Failure	205	7.33%
8. J189 - Pneumonia, Unspecified Organism	193	6.90%
9. I639 - Cerebral Infarction, Unspecified	171	6.11%
10. N179 - Acute Kidney Failure, Unspecified	167	5.97%
Total	2,797	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	75	53.96%
Male	64	46.04%
Unknown	0	0.00%
Total	139	100.00%
Race		
Asian	3	2.16%
Black	5	3.60%
Hispanic	0	0.00%
North American Native	21	15.11%
Other	2	1.44%
Unknown	0	0.00%
White	108	77.70%
Total	139	100.00%
Age		
Under 65	27	19.42%
65-70	32	23.02%
71-80	42	30.22%
81-90	33	23.74%
91+	5	3.60%
Total	139	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	7	38.89%
1: Distinct Psychiatric Facility	1	5.56%
2: Distinct Rehabilitation Facility	0	0.00%

Setting	Number of Providers	Percent of Providers
3: Distinct Skilled Nursing Facility	5	27.78%
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	1	5.56%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	1	5.56%
R: Hospice	1	5.56%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	5.56%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	5.56%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	18	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)	3	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	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%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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	4	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)	1	1.61%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	1.61%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	0	0.00%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	12	19.35%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	47	75.81%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	1	1.61%
Total	62	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	9	52.94%	89.86%
Rural	8	47.06%	9.58%
Unknown	0	0.00%	0.57%
Total	17	100.00%	100.00%

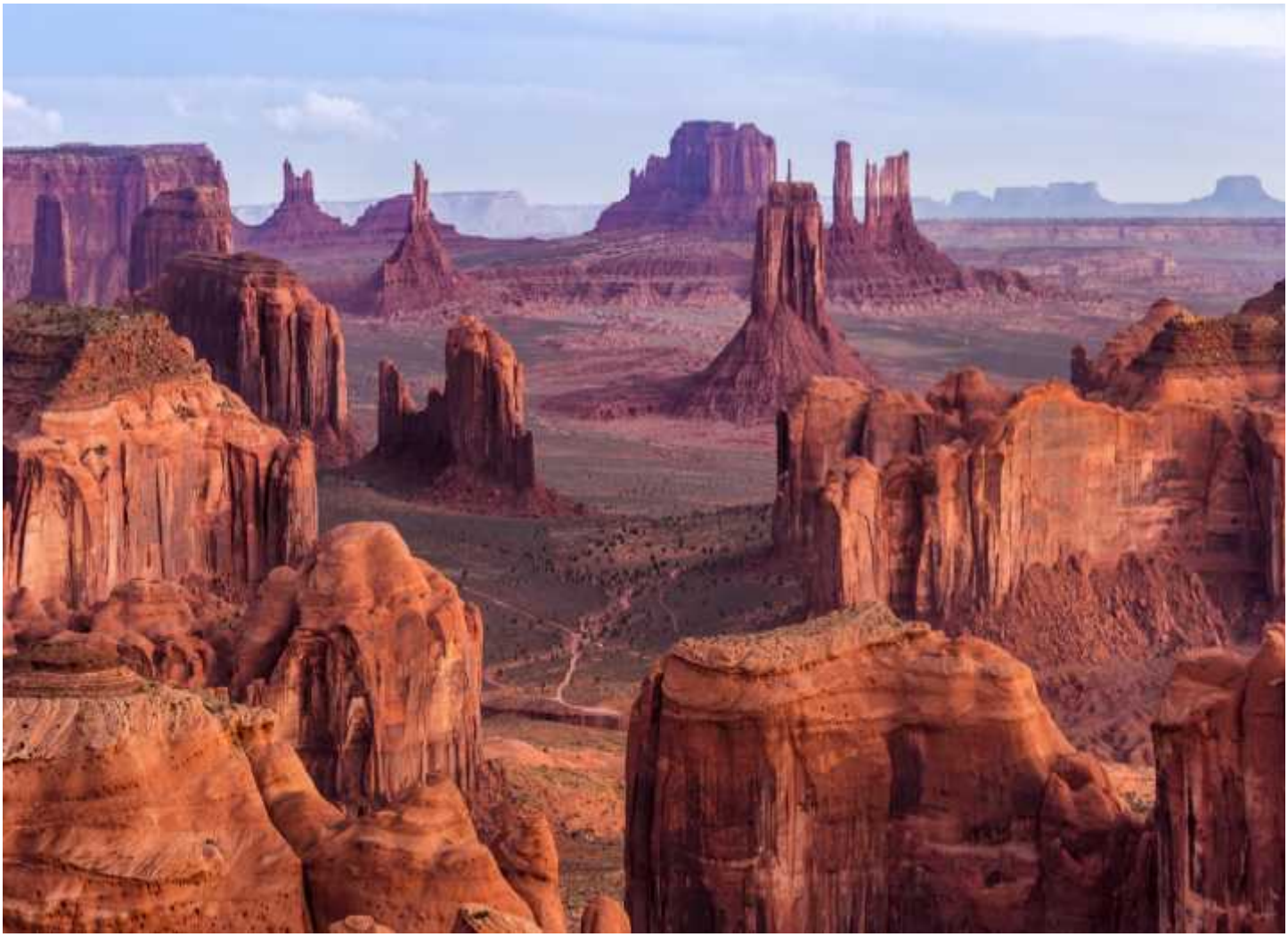
Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural:

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	1	100.00%	91.13%
Rural	0	0.00%	8.51%
Unknown	0	0.00%	0.35%
Total	1	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	2	66.67%

Livanta BFCC-QIO Area #5 – State of Arizona



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	275	9.23%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	45	1.51%
Quality of Care Review (All Other Selection Reasons)	29	0.97%
Utilization/Medical Necessity (All Selection Reasons)	280	9.39%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	530	17.78%
Notice of Non-coverage (Grijalva)	1,103	37.00%
Notice of Non-coverage (Weichardt)	717	24.05%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	2	0.07%
EMTALA 60 Day	0	0.00%
Total	2,981	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	7,510	30.17%
2. J189 - Pneumonia, Unspecified Organism	2,324	9.34%
3. N179 - Acute Kidney Failure, Unspecified	2,204	8.85%
4. I214 - Non-ST Elevation (Nstemi) Myocardial Infarction	2,185	8.78%
5. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	2,021	8.12%
6. I110 - Hypertensive Heart Disease With Heart Failure	1,991	8.00%
7. M1711 - Unilateral Primary Osteoarthritis, Right Knee	1,918	7.70%
8. M1712 - Unilateral Primary Osteoarthritis, Left Knee	1,797	7.22%
9. M1611 - Unilateral Primary Osteoarthritis, Right Hip	1,476	5.93%
10. N390 - Urinary Tract Infection, Site Not Specified	1,469	5.90%
Total	24,895	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,813	57.16%
Male	1,354	42.69%
Unknown	5	0.16%
Total	3,172	100.00%
Race		
Asian	21	0.66%
Black	144	4.54%
Hispanic	84	2.65%
North American Native	45	1.42%
Other	48	1.51%
Unknown	32	1.01%
White	2,798	88.21%
Total	3,172	100.00%
Age		
Under 65	469	14.79%
65-70	557	17.56%
71-80	1,054	33.23%
81-90	850	26.80%
91+	242	7.63%
Total	3,172	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	51	20.48%
1: Distinct Psychiatric Facility	7	2.81%
2: Distinct Rehabilitation Facility	10	4.02%

Setting	Number of Providers	Percent of Providers
3: Distinct Skilled Nursing Facility	124	49.80%
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	23	9.24%
N: Critical Access Hospital	5	2.01%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	3	1.20%
R: Hospice	25	10.04%
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	0.40%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	249	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	1	100.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	22	1	4.55%
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)	86	13	15.12%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	13	3	23.08%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	8	3	37.50%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	4	1	25.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	8	1	12.50%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	4	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	4	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	3	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	2	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	155	23	14.84%

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	39 %

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	1,103	46.96%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	530	22.56%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	357	15.20%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	359	15.28%
Total	2,349	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	208	89.66%	89.86%
Rural	23	9.91%	9.58%
Unknown	1	0.43%	0.57%
Total	232	100.00%	100.00%

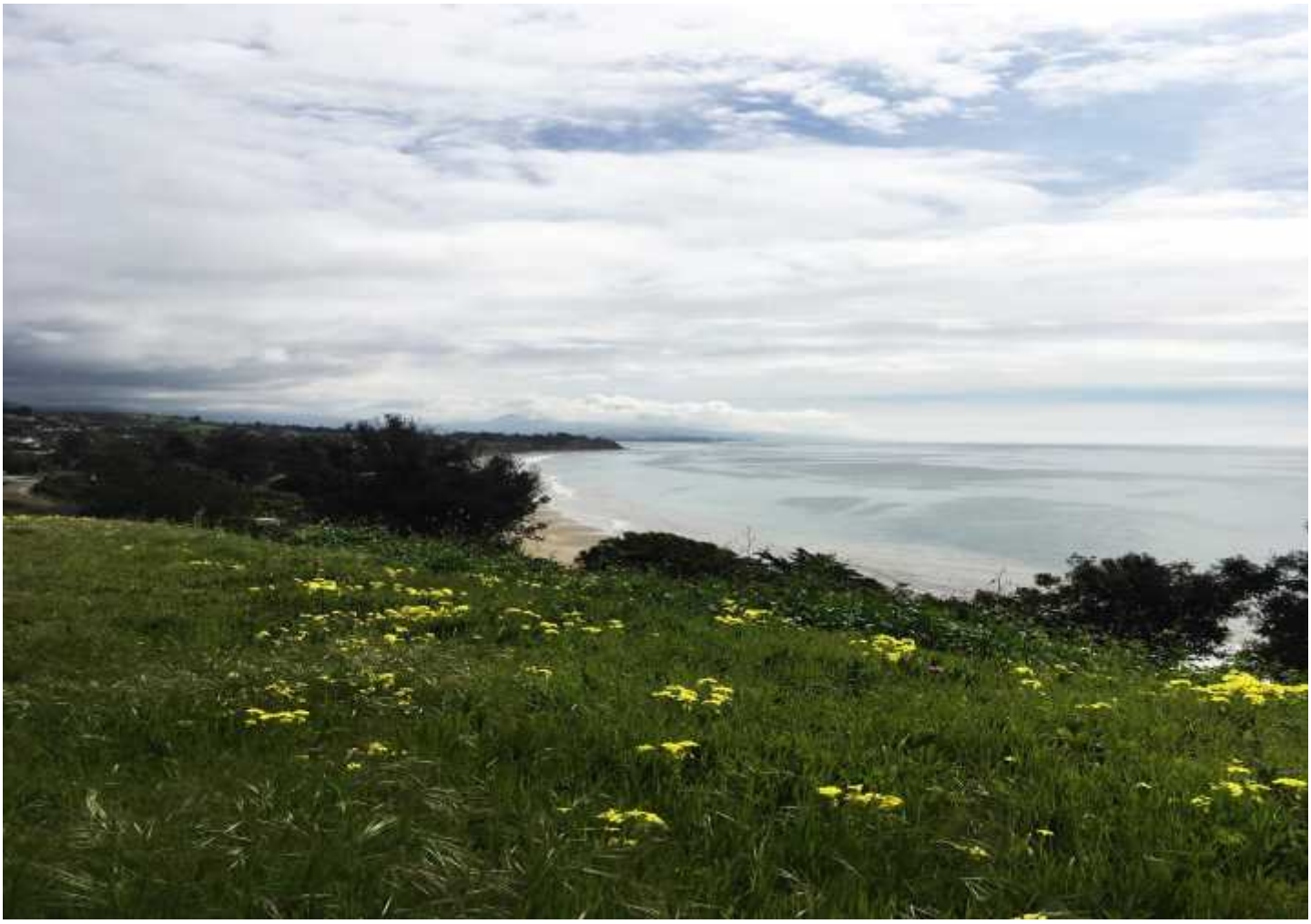
Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural:

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	36	87.80%	91.13%
Rural	5	12.20%	8.51%
Unknown	0	0.00%	0.35%
Total	41	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
124	75	60.48%

LIVANTA BFCC-QIO AREA #5 – STATE OF CALIFORNIA



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	2,575	14.29%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	179	0.99%
Quality of Care Review (All Other Selection Reasons)	138	0.77%
Utilization/Medical Necessity (All Selection Reasons)	2,586	14.35%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	8	0.04%
Notice of Non-coverage (BIPA)	2,760	15.32%
Notice of Non-coverage (Grijalva)	4,532	25.15%
Notice of Non-coverage (Weichardt)	5,191	28.81%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	47	0.26%
EMTALA 5 Day	4	0.02%
EMTALA 60 Day	0	0.00%
Total	18,020	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	43,315	38.09%
2. N179 - Acute Kidney Failure, Unspecified	10,270	9.03%
3. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	10,128	8.91%
4. I110 - Hypertensive Heart Disease With Heart Failure	8,855	7.79%
5. J189 - Pneumonia, Unspecified Organism	8,242	7.25%
6. I214 - Non-ST Elevation (Nstemi) Myocardial Infarction	8,105	7.13%
7. N390 - Urinary Tract Infection, Site Not Specified	7,643	6.72%
8. J441 - Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation	6,528	5.74%
9. M1711 - Unilateral Primary Osteoarthritis, Right Knee	5,381	4.73%
10. A4151 - Sepsis Due To Escherichia Coli Âe. Coliã	5,247	4.61%
Total	113,714	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	9,098	57.56%
Male	6,704	42.41%
Unknown	4	0.03%
Total	15,806	100.00%
Race		
Asian	1,065	6.74%
Black	1,611	10.19%
Hispanic	875	5.54%
North American Native	56	0.35%
Other	595	3.76%
Unknown	148	0.94%
White	11,456	72.48%
Total	15,806	100.00%
Age		
Under 65	1,965	12.43%
65-70	2,329	14.73%
71-80	4,702	29.75%
81-90	4,903	31.02%
91+	1,907	12.07%
Total	15,806	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	283	20.85%

Setting	Number of Providers	Percent of Providers
1: Distinct Psychiatric Facility	15	1.11%
2: Distinct Rehabilitation Facility	7	0.52%
3: Distinct Skilled Nursing Facility	777	57.26%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.07%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	2	0.15%
9: Provider Based Rural Health Clinic (RHC)	2	0.15%
C: Free Standing Ambulatory Surgery Center	2	0.15%
G: End Stage Renal Disease Unit	1	0.07%
H: Home Health Agency	82	6.04%
N: Critical Access Hospital	9	0.66%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	19	1.40%
R: Hospice	141	10.39%
S: Psychiatric Unit of an Inpatient Facility	3	0.22%
T: Rehabilitation Unit of an Inpatient Facility	4	0.29%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	9	0.66%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	1,357	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	76	12	15.79%
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)	352	56	15.91%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	54	12	22.22%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	19	3	15.79%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	6	2	33.33%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	31	10	32.26%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	6	1	16.67%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	10	1	10.00%
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	3	1	33.33%
C13: Apparently did not order appropriate specialty consultation	19	2	10.53%
C14: Apparently specialty consultation process was not completed in a timely manner	6	3	50.00%
C15: Apparently did not effectively coordinate across disciplines	3	3	100.00%
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	2	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	592	109	18.41%

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
46	42 %

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)	8	0.06%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	47	0.37%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	4,531	36.15%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	2,758	22.00%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	2,979	23.77%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	2,211	17.64%
Total	12,534	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	1,237	96.94%	89.86%
Rural	31	2.43%	9.58%
Unknown	8	0.63%	0.57%
Total	1,276	100.00%	100.00%

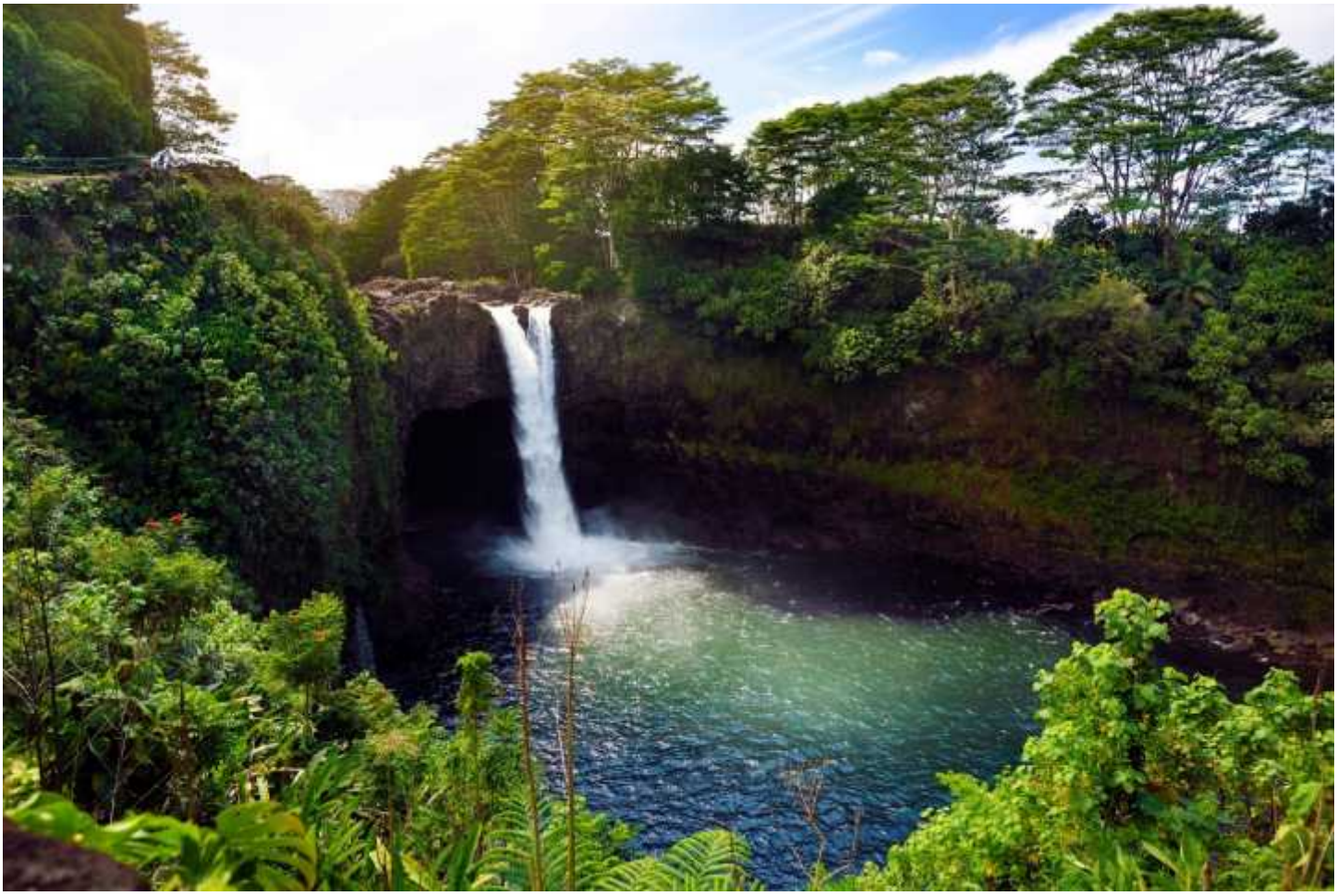
Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural:

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	156	97.50%	91.13%
Rural	4	2.50%	8.51%
Unknown	0	0.00%	0.35%
Total	160	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
660	472	71.52%

Livanta BFCC-QIO Area #5 – State of Hawaii



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	16	4.12%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	1	0.26%
Quality of Care Review (All Other Selection Reasons)	7	1.80%
Utilization/Medical Necessity (All Selection Reasons)	16	4.12%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.52%
Notice of Non-coverage (BIPA)	82	21.13%
Notice of Non-coverage (Grijalva)	164	42.27%
Notice of Non-coverage (Weichardt)	99	25.52%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.26%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	388	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	1,526	37.41%
2. I214 - Non-ST Elevation (Nstemi) Myocardial Infarction	432	10.59%
3. J189 - Pneumonia, Unspecified Organism	408	10.00%
4. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	288	7.06%
5. N179 - Acute Kidney Failure, Unspecified	266	6.52%
6. I639 - Cerebral Infarction, Unspecified	257	6.30%
7. I110 - Hypertensive Heart Disease With Heart Failure	256	6.28%
8. J690 - Pneumonitis Due To Inhalation Of Food And Vomit	249	6.10%
9. J441 - Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation	203	4.98%
10. N390 - Urinary Tract Infection, Site Not Specified	194	4.76%
Total	4,079	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	209	56.18%
Male	163	43.82%
Unknown	0	0.00%
Total	372	100.00%
Race		
Asian	122	32.80%
Black	10	2.69%
Hispanic	1	0.27%
North American Native	1	0.27%
Other	108	29.03%
Unknown	5	1.34%
White	125	33.60%
Total	372	100.00%
Age		
Under 65	48	12.90%
65-70	58	15.59%
71-80	101	27.15%
81-90	113	30.38%
91+	52	13.98%
Total	372	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	13	23.64%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	1.82%

Setting	Number of Providers	Percent of Providers
3: Distinct Skilled Nursing Facility	32	58.18%
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	7.27%
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	5	9.09%
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	55	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	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)	11	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	2	66.67%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	1	100.00%
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%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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	3	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	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	22	3	13.64%

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
2	67 %

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	2	0.57%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.29%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	164	47.13%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	82	23.56%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	54	15.52%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	45	12.93%
Total	348	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	34	64.15%	89.86%
Rural	19	35.85%	9.58%
Unknown	0	0.00%	0.57%
Total	53	100.00%	100.00%

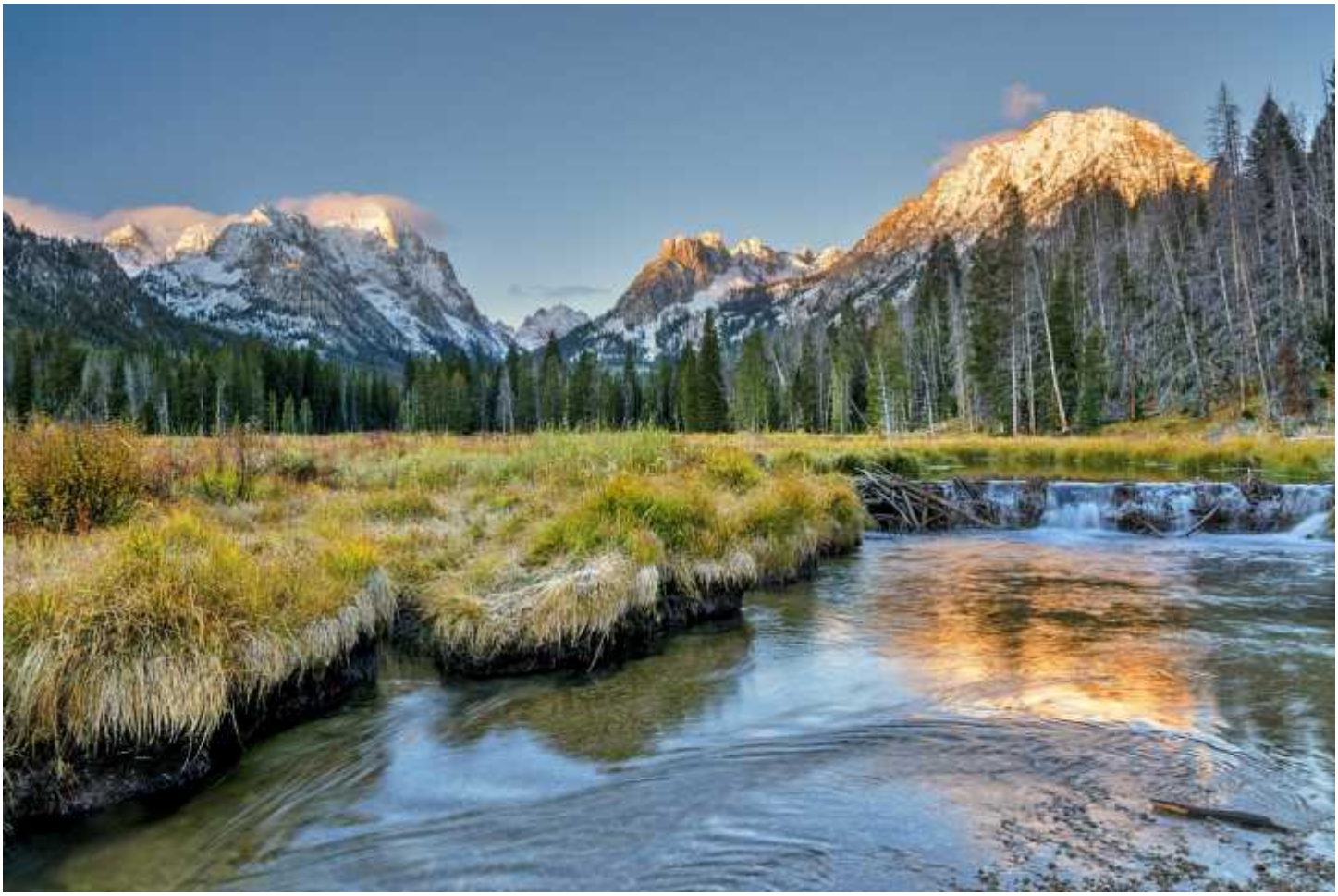
Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural:

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	3	60.00%	91.13%
Rural	1	20.00%	8.51%
Unknown	1	20.00%	0.35%
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
8	7	87.50%

Livanta BFCC-QIO Area #5 – State of Idaho



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	113	25.51%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	5	1.13%
Quality of Care Review (All Other Selection Reasons)	5	1.13%
Utilization/Medical Necessity (All Selection Reasons)	115	25.96%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	68	15.35%
Notice of Non-coverage (Grijalva)	100	22.57%
Notice of Non-coverage (Weichardt)	36	8.13%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.23%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	443	100.00

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	1,729	30.63%
2. M1711 - Unilateral Primary Osteoarthritis, Right Knee	581	10.29%
3. M1712 - Unilateral Primary Osteoarthritis, Left Knee	522	9.25%
4. N179 - Acute Kidney Failure, Unspecified	494	8.75%
5. J189 - Pneumonia, Unspecified Organism	457	8.10%
6. I214 - Non-St Elevation (Nstemi) Myocardial Infarction	414	7.34%
7. M1611 - Unilateral Primary Osteoarthritis, Right Hip	392	6.95%
8. J441 - Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation	385	6.82%
9. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	359	6.36%
10. N390 - Urinary Tract Infection, Site Not Specified	311	5.51%
Total	5,644	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	216	54.82%
Male	178	45.18%
Unknown	0	0.00%
Total	394	100.00%
Race		
Asian	1	0.25%
Black	0	0.00%
Hispanic	6	1.52%
North American Native	2	0.51%
Other	5	1.27%
Unknown	1	0.25%
White	379	96.19%
Total	394	100.00%
Age		
Under 65	49	12.44%
65-70	64	16.24%
71-80	137	34.77%
81-90	107	27.16%
91+	37	9.39%
Total	394	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	11	16.92%
1: Distinct Psychiatric Facility	2	3.08%
2: Distinct Rehabilitation Facility	1	1.54%

Setting	Number of Providers	Percent of Providers
3: Distinct Skilled Nursing Facility	43	66.15%
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	3.08%
N: Critical Access Hospital	2	3.08%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	4	6.15%
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	65	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	1	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14)	11	1	9.09%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	1	0	0.00%
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	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%
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	16	1	6.25%

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	100 %

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.49%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	100	48.78%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	68	33.17%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	22	10.73%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	14	6.83%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Total	205	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	28	45.90%	89.86%
Rural	33	54.10%	9.58%
Unknown	0	0.00%	0.57%
Total	61	100.00%	100.00%

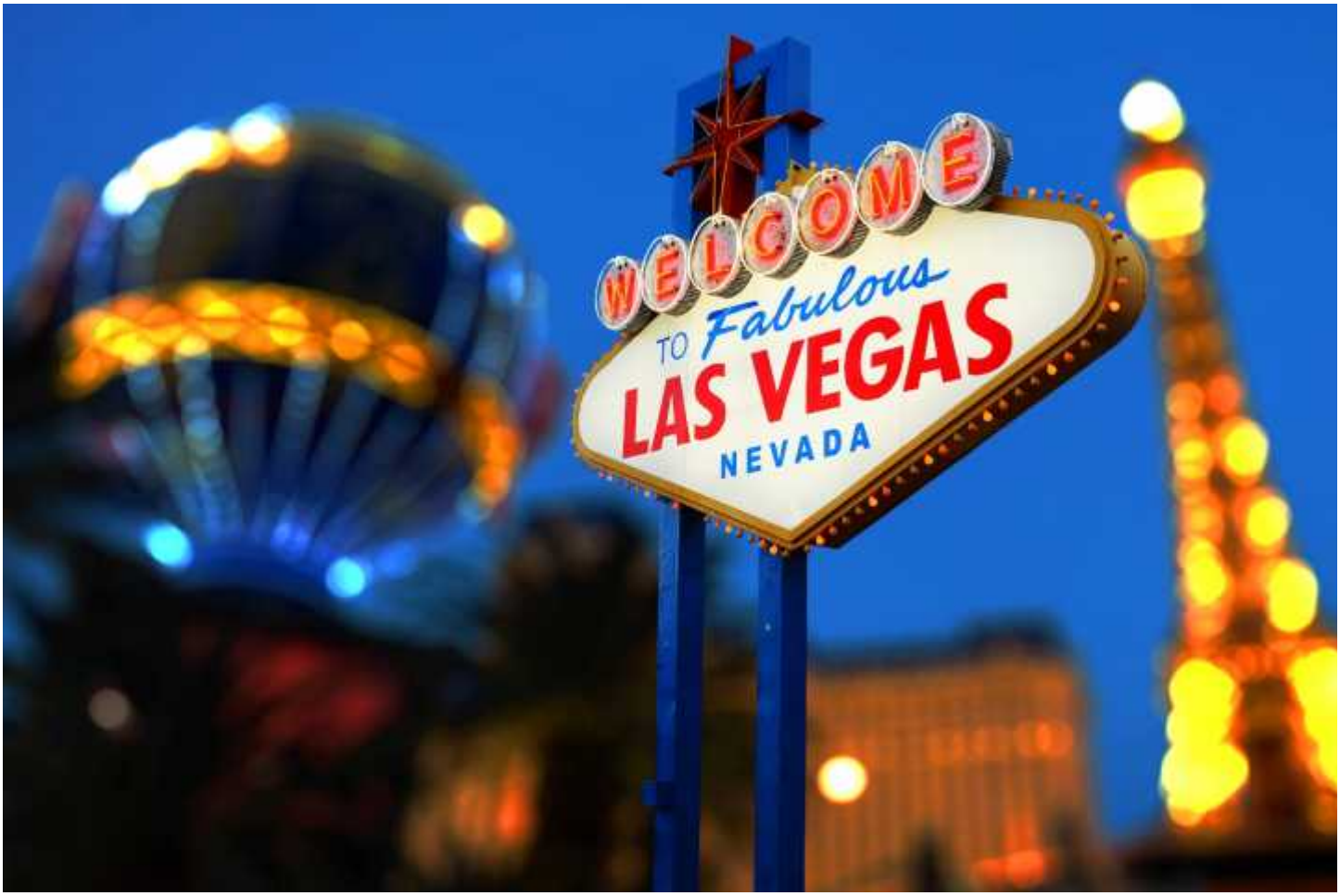
Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural:

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	3	60.00%	91.13%
Rural	2	40.00%	8.51%
Unknown	0	0.00%	0.35%
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
8	3	37.50%

Livanta BFCC-QIO Area #5 – State of Nevada



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	272	15.27%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	22	1.24%
Quality of Care Review (All Other Selection Reasons)	21	1.18%
Utilization/Medical Necessity (All Selection Reasons)	278	15.61%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	236	13.25%
Notice of Non-coverage (Grijalva)	414	23.25%
Notice of Non-coverage (Weichardt)	538	30.21%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	1,781	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	4,580	35.37%
2. N179 - Acute Kidney Failure, Unspecified	1,307	10.09%
3. J189 - Pneumonia, Unspecified Organism	1,135	8.76%
4. I110 - Hypertensive Heart Disease With Heart Failure	1,076	8.31%
5. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	979	7.56%
6. I214 - Non-ST Elevation (Nstemi) Myocardial Infarction	920	7.10%
7. N390 - Urinary Tract Infection, Site Not Specified	894	6.90%
8. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	803	6.20%
9. J9601 - Acute Respiratory Failure With Hypoxia	636	4.91%
10. J9621 - Acute And Chronic Respiratory Failure With Hypoxia	620	4.79%
Total	12,950	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	897	54.83%
Male	738	45.11%
Unknown	1	0.06%
Total	1,636	100.00%
Race		
Asian	48	2.93%
Black	237	14.49%
Hispanic	41	2.51%
North American Native	14	0.86%
Other	41	2.51%
Unknown	13	0.79%
White	1,242	75.92%
Total	1,636	100.00%
Age		
Under 65	327	19.99%
65-70	280	17.11%
71-80	541	33.07%
81-90	377	23.04%
91+	111	6.78%
Total	1,636	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	21	19.63%
1: Distinct Psychiatric Facility	5	4.67%
2: Distinct Rehabilitation Facility	4	3.74%
3: Distinct Skilled Nursing Facility	45	42.06%
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	9	8.41%
N: Critical Access Hospital	4	3.74%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	5	4.67%
R: Hospice	9	8.41%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	5	4.67%
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	107	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	12	3	25.00%
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)	48	5	10.42%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	8	2	25.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	1	25.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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	3	1	33.33%
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	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	3	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	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	81	12	14.81%

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**
5	42 %

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)	414	34.88%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	236	19.88%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	367	30.92%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	170	14.32%
Total	1,187	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	86	90.53%	89.86%
Rural	9	9.47%	9.58%
Unknown	0	0.00%	0.57%
Total	95	100.00%	100.00%

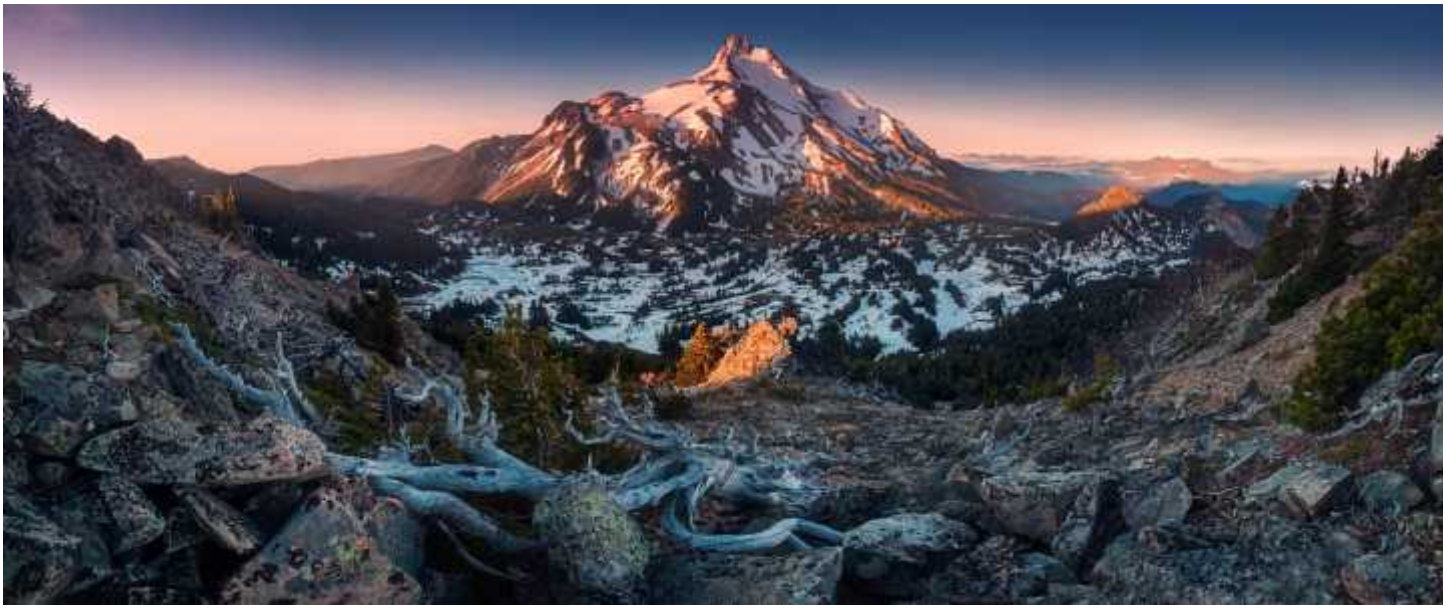
Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural:

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	21	95.45%	91.13%
Rural	1	4.55%	8.51%
Unknown	0	0.00%	0.35%
Total	22	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
88	64	72.73%

Livanta BFCC-QIO Area #5 – State of Oregon



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	299	19.32%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	21	1.36%
Quality of Care Review (All Other Selection Reasons)	10	0.65%
Utilization/Medical Necessity (All Selection Reasons)	304	19.64%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.13%
Notice of Non-coverage (BIPA)	187	12.08%
Notice of Non-coverage (Grijalva)	475	30.68%
Notice of Non-coverage (Weichardt)	250	16.15%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	1,548	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	3,727	30.63%
2. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	1,203	9.89%
3. I110 - Hypertensive Heart Disease With Heart Failure	1,148	9.44%
4. N179 - Acute Kidney Failure, Unspecified	1,062	8.73%
5. I214 - Non-ST Elevation (Nstemi) Myocardial Infarction	1,054	8.66%
6. M1711 - Unilateral Primary Osteoarthritis, Right Knee	861	7.08%
7. M1611 - Unilateral Primary Osteoarthritis, Right Hip	803	6.60%
8. J441 - Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation	799	6.57%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
9. M1712 - Unilateral Primary Osteoarthritis, Left Knee	778	6.39%
10. J189 - Pneumonia, Unspecified Organism	731	6.01%
Total	12,166	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	793	57.30%
Male	590	42.63%
Unknown	1	0.07%
Total	1,384	100.00%
Race		
Asian	19	1.37%
Black	39	2.82%
Hispanic	10	0.72%
North American Native	15	1.08%
Other	21	1.52%
Unknown	15	1.08%
White	1,265	91.40%
Total	1,384	100.00%
Age		
Under 65	204	14.74%
65-70	250	18.06%
71-80	424	30.64%
81-90	372	26.88%
91+	134	9.68%
Total	1,384	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	32	20.51%
1: Distinct Psychiatric Facility	2	1.28%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	86	55.13%
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	0.64%
H: Home Health Agency	16	10.26%
N: Critical Access Hospital	7	4.49%
O: Setting does not fit into any other existing setting code	0	0.00%

Setting	Number of Providers	Percent of Providers
Q: Long-Term Care Facility	0	0.00%
R: Hospice	9	5.77%
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	2	1.28%
Z: Swing Bed Designation for Critical Access Hospitals	1	0.64%
Other	0	0.00%
Total	156	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	6	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)	28	4	14.29%
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	2	1	50.00%
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	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	1	50.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	3	1	33.33%
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	2	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C15: Apparently did not effectively coordinate across disciplines	1	1	100.00%
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	8	14.55%

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	0.22%
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)	475	51.97%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	187	20.46%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	147	16.08%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	103	11.27%
Total	914	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	106	74.65%	89.86%
Rural	35	24.65%	9.58%
Unknown	1	0.70%	0.57%
Total	142	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	12	70.59%	91.13%
Rural	5	29.41%	8.51%
Unknown	0	0.00%	0.35%
Total	17	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
57	35	61.40%

Livanta BFCC-QIO Area #5 – State of Washington

1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Coding Validation (HWDRG)	600	18.48%
Coding Validation (All Non-HWDRG)	0	0.00%
Quality of Care Review (Beneficiary Complaint)	20	0.62%
Quality of Care Review (All Other Selection Reasons)	32	0.99%
Utilization/Medical Necessity (All Selection Reasons)	604	18.61%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	3	0.09%
Notice of Non-coverage (BIPA)	611	18.82%
Notice of Non-coverage (Grijalva)	955	29.42%
Notice of Non-coverage (Weichardt)	420	12.94%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.03%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	3,246	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - Sepsis, Unspecified Organism	8,035	32.29%
2. I130 – Hypertensive Heart & Chronic Kidney Disease Without Heart Failure And Stage 1-4/Unspecified Chronic Kidney	2,578	10.36%
3. I214 - Non-ST Elevation (Nstemi) Myocardial Infarction	2,264	9.10%
4. N179 - Acute Kidney Failure, Unspecified	2,216	8.91%
5. I110 - Hypertensive Heart Disease With Heart Failure	2,070	8.32%
6. J189 - Pneumonia, Unspecified Organism	1,860	7.48%
7. M1711 - Unilateral Primary Osteoarthritis, Right Knee	1,606	6.45%
8. M1712 - Unilateral Primary Osteoarthritis, Left Knee	1,445	5.81%

9. M1611 - Unilateral Primary Osteoarthritis, Right Hip	1,439	5.78%
10. I639 - Cerebral Infarction, Unspecified	1,369	5.50%
Total	24,882	100.00%

3) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,737	60.31%
Male	1,141	39.62%
Unknown	2	0.07%
Total	2,880	100.00%
Race		
Asian	89	3.09%
Black	141	4.90%
Hispanic	31	1.08%
North American Native	37	1.28%
Other	55	1.91%
Unknown	27	0.94%
White	2,500	86.81%
Total	2,880	100.00%
Age		
Under 65	419	14.55%
65-70	495	17.19%
71-80	889	30.87%
81-90	788	27.36%
91+	289	10.03%
Total	2,880	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	45	17.86%
1: Distinct Psychiatric Facility	3	1.19%
2: Distinct Rehabilitation Facility	2	0.79%
3: Distinct Skilled Nursing Facility	153	60.71%
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	14	5.56%
N: Critical Access Hospital	9	3.57%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	2	0.79%
R: Hospice	11	4.37%

Setting	Number of Providers	Percent of Providers
S: Psychiatric Unit of an Inpatient Facility	5	1.98%
T: Rehabilitation Unit of an Inpatient Facility	1	0.40%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	2	0.79%
Y: Federally Qualified Health Centers	2	0.79%
Z: Swing Bed Designation for Critical Access Hospitals	3	1.19%
Other	0	0.00%
Total	252	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	17	1	5.88%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14)	49	5	10.20%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	7	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	4	1	25.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	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	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	5	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	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	1	25.00%
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	94	8	8.51%

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**
5	63 %

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)	3	0.15%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.05%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	955	47.99%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	611	30.70%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	290	14.57%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	130	6.53%
Total	1,990	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	197	80.74%	89.86%
Rural	45	18.44%	9.58%
Unknown	2	0.82%	0.57%
Total	244	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	25	80.65%	91.13%
Rural	6	19.35%	8.51%
Unknown	0	0.00%	0.35%
Total	31	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
78	57	73.08%