LIVANTA
From practical innovations to results.

AREA #5

BFCC-QIO 11TH SOW

ANNUAL MEDICAL SERVICES REPORT

08/01/2016 - 07/31/2017

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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.
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 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 quality of care, medical necessity, and readmissions.[1]

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, 2016 through July 31, 2017. Readers will find the overall Area 5 data in the first 12 sections of this report, and state specific data in the Appendix section of the report. This report underscores our commitment to transparency by providing key performance metrics from the second 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.

[1] *Overview. (2016, November 30). Retrieved October 04, 2017, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html*

LIVANTA QIO AREA #5 – SUMMARY

1) TOTAL # 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 types of reviews we conducted.

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Coding Validation (120 - HWDRG)[2]	7,374	11.75%
Coding Validation (All Other Selection Reasons)[2]	6	0.01%
Quality of Care Review (101 through 104 - Beneficiary Complaint)	1,153	1.84%
Quality of Care Review (All Other Selection Reasons)	304	0.48%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	22,223	35.41%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	47	0.07%
Notice of Non-coverage (118 - BIPA)	7,133	11.36%
Notice of Non-coverage (117 - Grijalva)	14,092	22.45%
Notice of Non-coverage (121 through 124 - Weichardt)	10,290	16.39%
Notice of Non-coverage (111 - Request for QIO Concurrence)	72	0.11%

[2] *Coding Validations and Utilization Reviews: Livanta reviews medical records to verify that the coding is accurate, that the care provided was medically necessary, and that the care provided was delivered in the most appropriate setting. Certain hospital claims submitted as part of hospital billing trigger reviews by Livanta, as the proposed changes to billing codes would allow the hospital to receive more money for the care delivered. Currently, CMS refers all claims of this type in Area 5 to Livanta for review. We ensure that the care provided accurately matches the provider's claim for payment, and that the claim was coded correctly for billing purposes.*

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day[3]	69	0.11%
EMTALA 60 Day[3]	2	0.00%
Total	62,765	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	# of Beneficiaries	Percent of Beneficiaries (%)
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	109,936	35.08%
2. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	30,069	9.59%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	27,698	8.84%
4. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	27,504	8.78%
5. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	21,711	6.93%
6. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	21,644	6.91%
7. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	20,946	6.68%
8. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	19,045	6.08%
9. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	17,764	5.67%
10. I639 - CEREBRAL INFARCTION, UNSPECIFIED	17,075	5.45%
Total	313,392	100.00%

[3] *EMTALA Reviews: Livanta reviews cases that may be in violation of the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA is a federal law requiring that patients who need stabilization for an emergency medical condition receive that care, regardless of their ability to pay. CMS refers cases of this kind to Livanta in Area 5 on an as-needed basis. We determine whether the medical screening was adequate, whether an emergency medical condition existed, and if so, whether the patient was stabilized before a transfer. We also review the quality of care provided.*

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	# of Providers	Percent of Providers (%)
0: Acute Care Unit of an Inpatient Facility	505	20.30%
1: Distinct Psychiatric Facility	34	1.37%
2: Distinct Rehabilitation Facility	26	1.05%
3: Distinct Skilled Nursing Facility	1,349	54.22%
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 RHC	1	0.04%
9: Provider Based RHC	2	0.08%
C: Free Standing Ambulatory Surgery Center	5	0.20%
G: End Stage Renal Disease Unit	4	0.16%
H: Home Health Agency	221	8.88%
N: Critical Access Hospital	44	1.77%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	37	1.49%
R: Hospice	238	9.57%
S: Psychiatric Unit of an Inpatient Facility	2	0.08%
T: Rehabilitation Unit of an Inpatient Facility	7	0.28%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	2	0.08%
Y: Federally Qualified Health Centers	8	0.32%
Z: Swing Bed Designation for Critical Access Hospitals	2	0.08%
Other	0	0.00%
Total	2,488	100.00%

4) QUALITY OF CARE CONCERNS CONFIRMED

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 Information System (CRIS). 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 are provided education and 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	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C01: Apparently did not obtain pertinent history and/or findings from examination	15	2	13.33%	0
C02: Apparently did not make appropriate diagnoses and/or assessments	329	35	10.64%	10
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)]	866	102	11.78%	17
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	393	53	13.49%	18
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	112	12	10.71%	20
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	15	7	46.67%	1
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	35	5	14.29%	0
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	18	1	5.56%	0
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	46	3	6.52%	1

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	63	10	15.87%	9
C11: Apparently did not demonstrate that the patient was ready for discharge	90	13	14.44%	1
C12: Apparently did not provide appropriate personnel and/or resources	2	0	0.00%	0
C13: Apparently did not order appropriate specialty consultation	56	4	7.14%	1
C14: Apparently specialty consultation process was not completed in a timely manner	12	2	16.67%	1
C15: Apparently did not effectively coordinate across disciplines	15	2	13.33%	0
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	185	21	11.35%	15
C17: Apparently did not order/follow evidence-based practices	52	5	9.62%	5
C18: Apparently did not provide medical record documentation that impacts patient care	9	1	11.11%	3
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%	0
C99: Other quality concern not elsewhere classified	98	14	14.29%	5
Total	2,412	292	12.11%	107

5) DISCHARGE/SERVICE TERMINATION

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, 2016 through April 30, 2017. A shortened timeframe is necessary to allow for maturity of claims data, which are the source of "Discharge Status" for these cases.

Discharge Status	# of Beneficiaries	Percent of Beneficiaries (%)
01: Discharged to home or self-care (routine discharge)	785	23.10%

Discharge Status	# of Beneficiaries	Percent of Beneficiaries (%)
02: Discharged/transferred to another short-term general hospital for inpatient care	39	1.15%
03: Discharged/transferred to skilled nursing facility (SNF)	1,493	43.92%
04: Discharged/transferred to intermediate care facility (ICF)	23	0.68%
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	720	21.18%
07: Left against medical advice or discontinued care	24	0.71%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	51	1.50%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	5	0.15%
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	2	0.06%
50: Hospice - home	89	2.62%
51: Hospice - medical facility	25	0.74%
61: Discharged/transferred within this institution to a hospital-based Medicare approved swing bed	5	0.15%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	57	1.68%
63: Discharged/transferred to a long term care hospital	60	1.77%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	2	0.06%
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	11	0.32%
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	5	0.15%

Discharge Status	# of Beneficiaries	Percent of Beneficiaries (%)
Other	3	0.09%
Total	3,399	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	# of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
105: Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	7	42.86%	57.14%
106: Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	1	0.00%	100.00%
107: Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	38	28.95%	71.05%
108: Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0.00%	0.00%
111: Notice of Non-coverage Request for QIO Concurrence	68	10.29%	89.71%
117: MA Appeal Review (CORF, HHA, SNF)	12,072	24.43%	75.57%
118: FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	6,319	20.59%	79.41%
121: Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	5,648	10.68%	89.32%
122: Notice of Non-coverage Continued Stay Notice Concurrent Non-immediate Review	30	6.67%	93.33%
123: Notice of Non-coverage Continued Stay Retrospective	25	8.00%	92.00%
124: MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	4,195	8.53%	91.47%
Total	28,403	18.43%	81.57%

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 one to three 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 also included.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	UpToDate: Treatment of Hospital-acquired, Ventilator-associated, and Healthcare-associated Pneumonia in adults	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision support.
	Heart Failure	UpToDate: Evaluation of the Patient with Suspected Heart Failure	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision support.
	Pressure Ulcers	UpToDate: Clinical Staging and Management of Pressure Ulcers	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision support.
	Acute Myocardial Infarction	UpToDate: Overview of the Acute Management of ST Elevation Myocardial Infarction	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision support.
	Urinary Tract Infection	UpToDate: Acute Complicated Cystitis and Pyelonephritis	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision support.
	Sepsis	UpToDate: Sepsis and the Systemic Inflammatory Response Syndrome: Definitions, Epidemiology, and Prognosis	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision support.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Adverse Drug Events	UpToDate: Drug Prescribing for Older Adults	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision support.
	Falls	UpToDate: Falls: Prevention in Nursing Care Facilities and the Hospital Setting	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision support.
	Patient Trauma	UpToDate: Initial Management of Trauma in Adults	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision.
	Surgical Complications	UpToDate: Surgical Complications/Procedure Specific	UpToDate is a web-based resource that provides multiple evidence based standards of care and clinical decision support.

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.

Review Type	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Appeals	Pub 100-02 Medicare Benefit Policy; Transmittal 179 (CR8458)	Coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. • No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims that require skilled care. Medicare has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition).
	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."
	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."
	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."
	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.
	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." **42 CFR 409.32(c)** The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.

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: Appeals Reviews by Geographic Area – Urban and Rural:

Geographic Area	# of Providers	Percent of Providers in Service Area (%)
Appeal Reviews		
Urban	2,128	88.85%
Rural	259	10.81%
Unknown	8	0.33%
Total	2,395	100.00%

Table 8B: Quality of Care Reviews by Geographic Area – Urban and Rural:

Geographic Area	# of Providers	Percent of Providers in Service Area (%)
Quality of Care Reviews		
Urban	470	91.09%
Rural	43	8.33%
Unknown	3	0.58%
Total	516	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 and to educate customers in the roles and purposes of the Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO). Ensuring that relevant parties have access and exposure to this information is vital to quality control, an efficient use of resources, and a positive customer experience. The availability of information and education initiatives allows Livanta to clearly establish expectations with customers and providers and to educate stakeholders on the roles and purposes of each player. Employing regularly used platforms of communication, Livanta provides pertinent information to stakeholders in an efficient and effective manner. This document outlines Livanta's efforts to provide user-friendly access of information and educational efforts to all major stakeholders in the BFCC-QIO process.

Beneficiaries and Families

To ensure that beneficiaries and their families have access to the services of the BFCC-QIO, Livanta provides a toll-free HelpLine at 1-877-588-1123. The HelpLine is available from 9:00-5:00 pm on weekdays and from 11:00-3:00 pm on weekends and holidays. A 24-hour voicemail service is available and messages are timestamped to ensure timeliness requirements are maintained. 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 and translate any written correspondence 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 better engage stakeholders and beneficiaries, the Livanta Communications Team has successfully developed and launched a social media presence. The rapidly maturing audience of social media as a platform for engagement, communication, and critical messaging has allowed the Livanta as BFCC-QIO to engage with tens of thousands of beneficiaries and stakeholders in Area 5. This effort has successfully introduced the services of the BFCC-QIO Program at minimal cost to the government. In addition to social media, the Livanta Communications Team has successfully engaged in a targeted radio campaign to connect with caregivers advocates, and beneficiaries at minimal cost. This effort was targeted towards geographically isolated populations, and rural areas where access to information is limited.

Successful Engagement

After a collaboration meeting and site visit with the Portland, Oregon branch of the American Cancer Society, the Communications team developed a joint outreach strategy to be deployed in late 2017. Working together with the American Cancer Society, Livanta will utilize an extensive network of volunteers, patient navigators, and family support groups already in used by the ACS. These individuals work with beneficiaries and act as force multipliers, which will allow Livanta to substantially increase awareness of the BFCC-QIO Program. Additionally, patient navigators are currently deployed in hospitals with oncology departments and work directly with cancer patients, their families, and caregivers before, during, and after treatments, which will provide direct access for Livanta to the beneficiaries. During the months of November and December, these volunteers and patient navigators will hold meetings where critical information regarding health care delivery

and patient support will be discussed. The Livanta team will be providing training for the volunteers, patient navigators, and family support teams of the American Cancer Society in Oregon.

Providers

Livanta continues to regularly engage the provider community by conducting webinars, presentations, and publications to support ongoing provider education. The information presented can be used by all providers to better understand the role of the BFCC-QIO program in the delivery of quality healthcare. Livanta's BFCC-QIO content is routinely updated to keep providers informed about program requirements, CMS updates, news of interest, and frequently asked questions. In addition to the regular provider communications and web-based electronic platforms, Livanta continues to engage provider associations to more efficiently disseminate information in a timely and targeted fashion. This proactive engagement of the provider community promotes a better understanding of the BFCC-QIO program as well as the rapid dissemination of critical programmatic information.

The Livanta Communications team conducts regularly held collaboration and education teleconferences with major provider groups in Area 5, including the California Hospital Association and the Oregon Association of Health and Hospital Systems. During the reporting period, the Livanta Communications team produced and published Livanta Provider Bulletins IV, V, and VI, which covered critical topics such as sampling methodology for case review, medical record best practices, and updates to the Quality Improvement Organization Manual Chapter 5 - Quality of Care Review.

Advocates

Through consistent and targeted outreach, Livanta has engaged directly with advocate groups in every state in Area 5. Livanta maintains regular contact with area agencies on aging, State Health Insurance Assistance Program (SHIP) and Senior Health Insurance Benefits Advisors (SHIBA) offices at the state and regional level and state ombudsman programs, Congressional constituent services offices, and ethnic and cultural advocacy groups. In the past year, Livanta has had on-site collaboration meetings with 16 critical advocate stakeholders. In order to conduct these meetings, Livanta has invested considerable research time in order to identify the most effective partner-advocates. Meetings were held on-site in the various states in territories including Washington, Oregon, Nevada, and Arizona. Efforts are ongoing to stay in close communication with advocates to facilitate engagement and education as Livanta innovates to meet the changing needs of Medicare beneficiaries.

Education through Communication

Livanta is committed to providing up-to-date BFCC-QIO information to the public and to beneficiaries and stakeholders. To educate customers on these updates, the Livanta Communications team has engaged in innovative and novel approaches to engaging with beneficiaries and stakeholders. Livanta has studied and analyzed both legacy and developing platforms for education through different mediums. Livanta has concluded that a multi-pronged approach using both legacy communications media such as radio and innovative media via online communication and the Livanta BFCC-QIO website would most effectively engage the target audience.

During the reporting period, the Livanta Communications Team successfully engaged with large numbers of beneficiaries and stakeholders through appearances on radio stations in Arizona, Oregon and Nevada. Outside of legacy media mediums, Livanta successfully interacted with targeted demographics in sections of Area 5 with lower utilization rates through social media driving users to Livanta's innovative health care topics blog. These efforts engaged with geographically isolated and vulnerable populations.

Other Partners

Livanta maintains a close working relationship with CMS and works in collaboration with the Contracting Officer Representatives (CORs) assigned to the Livanta contract. Livanta also works in conjunction with other Medicare contractors who support the BFCC-QIO, and will often combine resources to sponsor outreach initiatives for increased efficiency and effectiveness. Livanta has also collaborated with state survey and licensing bodies in Area 5.

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.

# of Beneficiary Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
Immediate Advocacy Reviews		
1,581	500	31.63%

11) EXAMPLE/SUCCESS STORY

Quality Success Stories. The following are two accounts of interactions with Livanta from the patient's perspective.

Example 1:

"I recently went to my mailbox and saw a fourth bill for a medication I was no longer taking. I had called dozens of times to tell the pharmacy to stop, but they told me it was the doctor's office. I called the doctor again. The receptionist insisted that I needed the medicine and that she was only following the doctor's orders. I was completely frustrated. The doctor told me that I didn't need the medication any more. I didn't know how I was going to get this to stop.

Then I remembered that a few months ago, I had met with the Senior Health Insurance Benefits Advisors (SHIBA) counselor to discuss Medicare options. I remembered that there was this thing called the QIO Program and that they helped people with Medicare issues. I made the call.
After just a few seconds, I was connected with Barbara, who could help me. After describing in detail the months of frustration and wasted money and bills, Barbara offered to talk to my doctor. It would just take a few minutes to clear things up. Barbara called me back shortly to let me know that everything was squared away and I would only be receiving the medications I needed. After trying to resolve this by myself, I found the help that I needed."

Example 2:

"I received instructions from my doctor to make an appointment to see a specialist and receive a test. I called the phone number that the doctor gave me, but no one answered the phone. I left several messages. I was getting concerned that it was taking so long to schedule the appointment. I called my doctor to see if they could help, but they couldn't get a return call either. Thinking about everything I learned about Medicare when I enrolled, I remembered what the State Health Insurance Assistance Program (SHIP) counselor had told me down at the library. If there was ever any trouble with Medicare, call Livanta and see if they can help. I called and spoke with Shirley. She said that she would make a call to the specialist and would let me know when she heard back. After a few hours, the phone rang. It was Shirley with good news. They had scheduled an appointment for me on Monday afternoon. I felt grateful."

12) BENEFICIARY HELPLINE STATISTICS

This table provides Livanta's Area 5 beneficiary HelpLine statistics for the period from August 1, 2016 through July 31, 2017.

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	125,515
Total Number of Calls Answered	82,992
Total Number of Abandoned Calls	2,182
Average Length of Call Wait Times	0:11 Seconds
Number of Calls Transferred by 1-800Medicare	1,583

CONCLUSION:

As demonstrated in this report, Livanta provides significant value to Medicare beneficiaries, providers, and the Medicare program. 365 days per year, Livanta advocates on behalf of beneficiaries to ensure they receive the quality care they are entitled to under the program. Leveraging our unique advocacy position, Livanta partners with providers to further guarantee beneficiaries are receiving both quality and medically necessary services. Through innovative services, we offer patient support along the entire continuum of care – from initial symptom recognition to health maintenance.

- Beneficiary complaints and appeals provides beneficiaries with a caring advocate who can voice their expert perspective while also conveying the unique needs of beneficiaries, to healthcare providers. In addition, Livanta combines these concerns and nationally recognized standards of care to empower providers to improve future care for all beneficiaries.
- The Immediate Advocacy reviews allow a rapid resolution to problems with concurrent care. For example, Immediate Advocacy can resolve logistical issues with care, such as access to expected supplies or equipment.
- Within Livanta's Quality of Care Program, when a quality of care concern is confirmed, educational feedback is delivered to the provider regarding how care can be improved in future cases. Moreover, where a systemic issue is identified, cases are referred to the state's local Quality Innovation Network – Quality Improvement Organization (QIN-QIO). The QIN-QIO provides local technical assistance to the

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.

Livanta supports CMS's plan of ensuring that all Medicare beneficiaries receive quality care every time by ensuring that the medical care is paid for 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 beneficiaries and the Medicare program.

APPENDIX

LIVANTA QIO AREA #5 – STATE OF ALASKA

1) TOTAL # OF REVIEWS

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Coding Validation (120 - HWDRG)	57	22.09%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 - Beneficiary Complaint)	3	1.16%
Quality of Care Review (All Other Selection Reasons)	2	0.78%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	132	51.16%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	2	0.78%
Notice of Non-coverage (118 - BIPA)	22	8.53%
Notice of Non-coverage (117 - Grijalva)	4	1.55%
Notice of Non-coverage (121 through 124 - Weichardt)	36	13.95%
Notice of Non-coverage (111-Request for QIO Concurrence)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	258	100.00%

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	# of Beneficiaries	Percent of Beneficiaries (%)
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	999	29.22%
2. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	409	11.96%
3. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	384	11.23%
4. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	337	9.86%
5. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	288	8.42%
6. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	259	7.58%
7. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	224	6.55%
8. I639 - CEREBRAL INFARCTION, UNSPECIFIED	184	5.38%
9. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	173	5.06%
10. M1611 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT HIP	162	4.74%
Total	3,419	100.00%

3) BENEFICIARY DEMOGRAPHICS

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender		
Female	124	52.54%
Male	112	47.46%
Unknown	0	0.00%
Total	236	100.00%
Race		
Asian	4	1.69%
Black	11	4.66%
Hispanic	0	0.00%
North American Native	45	19.07%
Other	5	2.12%
Unknown	2	0.85%
White	169	71.61%
Total	236	100.00%

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Age		
Under 65	40	16.95%
65-70	58	24.58%
71-80	73	30.93%
81-90	51	21.61%
91+	14	5.93%
Total	236	100.00%

4) PROVIDER REVIEWS SETTINGS

Setting	# of Providers	Percent of Providers (%)
0: Acute Care Unit of an Inpatient Facility	9	40.91%
1: Distinct Psychiatric Facility	1	4.55%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	5	22.73%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	1	4.55%
N: Critical Access Hospital	2	9.09%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	4.55%
R: Hospice	0	0.00%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	2	9.09%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	1	4.55%
Other	0	0.00%
Total	22	100.00%

5) QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%	0
C02: Apparently did not make appropriate diagnoses and/or assessments	2	0	0.00%	0
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%	0
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	4	0	0.00%	0
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%	0
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%	0
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%	0
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%	0
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%	0
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	0	0.00%	0
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%	0
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%	0
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%	0

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%	0
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%	0
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%	0
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%	0
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%	0
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%	0
C99: Other quality concern not elsewhere classified	2	1	50.00%	0
Total	12	1	8.33%	0

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

Appeal Review by Notification Type	# of Reviews	(%) of Total
105: Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	1	1.67%
106: Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	0	0.00%
107: Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	1	1.67%
108: Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0.00%
111: Notice of Non-coverage Request for QIO Concurrence	0	0.00%
117: MA Appeal Review (CORF, HHA, SNF)	3	5.00%
118: FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	19	31.67%
121: Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	34	56.67%
122: Notice of Non-coverage Continued Stay Notice Concurrent Nonimmediate Review	0	0.00%

123: Notice of Non-coverage Continued Stay Retrospective	0	0.00%
124: MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	2	3.33%
Total	60	100.00%

7) REVIEWS BY GEOGRAPHIC AREA – URBAN AND RURAL

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Appeal Reviews			
Urban	6	30.00%	88.85%
Rural	13	65.00%	10.81%
Unknown	1	5.00%	0.33%
Total	20	100.00%	100.00%

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Quality of Care Reviews			
Urban	3	100.00%	91.09%
Rural	0	0.00%	8.33%
Unknown	0	0.00%	0.58%
Total	3	100.00%	100.00%

8) IMMEDIATE ADVOCACY REVIEWS

# of Beneficiary Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
Immediate Advocacy Reviews		
5	2	40.00%

LIVANTA QIO AREA #5 – STATE OF ARIZONA

1) TOTAL # OF REVIEWS

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Coding Validation (120 - HWDRG)	522	8.33%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 - Beneficiary Complaint)	163	2.60%
Quality of Care Review (All Other Selection Reasons)	50	0.80%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	2,105	33.59%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	0	0.00%
Notice of Non-coverage (118 - BIPA)	821	13.10%
Notice of Non-coverage (117 - Grijalva)	1,708	27.25%
Notice of Non-coverage (121 through 124 - Weichardt)	897	14.31%
Notice of Non-coverage (111-Request for QIO Concurrence)	1	0.02%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	6,267	100.00%

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	# of Beneficiaries	Percent of Beneficiaries (%)
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	10,352	29.06%
2. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	3,603	10.12%
3. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	3,505	9.84%
4. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	3,326	9.34%
5. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	3,310	9.29%
6. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	3,121	8.76%
7. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	2,335	6.56%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	2,125	5.97%
9. M1611 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT HIP	2,018	5.67%
10. I639 - CEREBRAL INFARCTION, UNSPECIFIED	1,924	5.40%
Total	35,619	100.00%

3) BENEFICIARY DEMOGRAPHICS

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender		
Female	2,600	55.48%
Male	2,065	44.07%
Unknown	21	0.45%
Total	4,686	100.00%
Race		
Asian	42	0.90%
Black	176	3.76%
Hispanic	131	2.80%
North American Native	101	2.16%
Other	48	1.02%

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Unknown	46	0.98%
White	4,142	88.39%
Total	4,686	100.00%
Age		
Under 65	676	14.43%
65-70	833	17.78%
71-80	1,485	31.69%
81-90	1,339	28.57%
91+	353	7.53%
Total	4,686	100.00%

4) PROVIDER REVIEWS SETTINGS

Setting	# of Providers	Percent of Providers (%)
0: Acute Care Unit of an Inpatient Facility	61	22.43%
1: Distinct Psychiatric Facility	6	2.21%
2: Distinct Rehabilitation Facility	10	3.68%
3: Distinct Skilled Nursing Facility	123	45.22%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	1	0.37%
C: Free Standing Ambulatory Surgery Center	1	0.37%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	40	14.71%
N: Critical Access Hospital	2	0.74%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	2	0.74%
R: Hospice	26	9.56%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	272	100.00%

5) QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C01: Apparently did not obtain pertinent history and/or findings from examination	1	1	100.00%	0
C02: Apparently did not make appropriate diagnoses and/or assessments	57	6	10.53%	2
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)]	125	11	8.80%	2
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	55	8	14.55%	4
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	11	1	9.09%	2
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	1	100.00%	0
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	5	0	0.00%	0
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	0	0.00%	0
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	5	0	0.00%	0
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	10	3	30.00%	2
C11: Apparently did not demonstrate that the patient was ready for discharge	8	1	12.50%	0
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%	0
C13: Apparently did not order appropriate specialty consultation	11	1	9.09%	0

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C14: Apparently specialty consultation process was not completed in a timely manner	3	0	0.00%	0
C15: Apparently did not effectively coordinate across disciplines	2	0	0.00%	0
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	23	3	13.04%	3
C17: Apparently did not order/follow evidence-based practices	11	1	9.09%	0
C18: Apparently did not provide medical record documentation that impacts patient care	1	0	0.00%	0
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%	0
C99: Other quality concern not elsewhere classified	8	1	12.50%	1
Total	338	38	11.24%	16

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

Appeal Review by Notification Type	# of Reviews	(%) of Total
105: Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	0	0.00%
106: Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	0	0.00%
107: Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	0	0.00%
108: Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0.00%
111: Notice of Non-coverage Request for QIO Concurrence	1	0.03%
117: MA Appeal Review (CORF, HHA, SNF)	1,523	48.24%
118: FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	767	24.30%
121: Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	441	13.97%
122: Notice of Non-coverage Continued Stay Notice Concurrent Nonimmediate Review	0	0.00%

Appeal Review by Notification Type	# of Reviews	(%) of Total
123: Notice of Non-coverage Continued Stay Retrospective	0	0.00%
124: MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	425	13.46%
Total	3,157	100.00%

7) REVIEWS BY GEOGRAPHIC AREA – URBAN AND RURAL

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Appeal Reviews			
Urban	227	87.31%	88.85%
Rural	32	12.31%	10.81%
Unknown	1	0.38%	0.33%
Total	260	100.00%	100.00%

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Quality of Care Reviews			
Urban	64	88.89%	91.09%
Rural	8	11.11%	8.33%
Unknown	0	0.00%	0.58%
Total	72	100.00%	100.00%

8) IMMEDIATE ADVOCACY REVIEWS

# of Beneficiary Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
Immediate Advocacy Reviews		
196	49	25.00%

LIVANTA QIO AREA #5 – STATE OF CALIFORNIA

1) TOTAL # OF REVIEWS

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Coding Validation (120 - HWDRG)	4,646	11.09%
Coding Validation (All Other Selection Reasons)	4	0.01%
Quality of Care Review (101 through 104 - Beneficiary Complaint)	682	1.63%
Quality of Care Review (All Other Selection Reasons)	164	0.39%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	14,694	35.08%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	31	0.07%
Notice of Non-coverage (118 - BIPA)	4,624	11.04%
Notice of Non-coverage (117 - Grijalva)	9,276	22.14%
Notice of Non-coverage (121 through 124 - Weichardt)	7,632	18.22%
Notice of Non-coverage (111-Request for QIO Concurrence)	68	0.16%
EMTALA 5 Day	67	0.16%
EMTALA 60 Day	2	0.00%
Total	41,890	100.00%

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	# of Beneficiaries	Percent of Beneficiaries (%)
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	66,204	37.00%
2. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	17,137	9.58%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	15,563	8.70%
4. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	14,397	8.05%
5. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	13,676	7.64%
6. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	12,542	7.01%
7. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	10,837	6.06%
8. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	9,946	5.56%
9. I639 - CEREBRAL INFARCTION, UNSPECIFIED	9,703	5.42%
10. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	8,907	4.98%
Total	178,912	100.00%

3) BENEFICIARY DEMOGRAPHICS

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender		
Female	15,744	58.02%
Male	11,304	41.66%
Unknown	86	0.32%
Total	27,134	100.00%
Race		
Asian	1,833	6.76%
Black	2,443	9.00%
Hispanic	1,522	5.61%
North American Native	122	0.45%
Other	1,006	3.71%
Unknown	300	1.11%
White	19,908	73.37%

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Total	27,134	100.00%
Age		
Under 65	3,629	13.37%
65-70	4,086	15.06%
71-80	7,783	28.68%
81-90	8,334	30.71%
91+	3,302	12.17%
Total	27,134	100.00%

4) PROVIDER REVIEWS SETTINGS

Setting	# of Providers	Percent of Providers (%)
0: Acute Care Unit of an Inpatient Facility	302	20.39%
1: Distinct Psychiatric Facility	19	1.28%
2: Distinct Rehabilitation Facility	10	0.68%
3: Distinct Skilled Nursing Facility	824	55.64%
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 RHC	1	0.07%
9: Provider Based RHC	1	0.07%
C: Free Standing Ambulatory Surgery Center	3	0.20%
G: End Stage Renal Disease Unit	3	0.20%
H: Home Health Agency	113	7.63%
N: Critical Access Hospital	7	0.47%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	24	1.62%
R: Hospice	160	10.80%
S: Psychiatric Unit of an Inpatient Facility	2	0.14%
T: Rehabilitation Unit of an Inpatient Facility	3	0.20%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	7	0.47%
Z: Swing Bed Designation for Critical Access Hospitals	1	0.07%
Other	0	0.00%
Total	1,481	100.00%

5) QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C01: Apparently did not obtain pertinent history and/or findings from examination	9	0	0.00%	0
C02: Apparently did not make appropriate diagnoses and/or assessments	162	18	11.11%	3
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)]	510	54	10.59%	3
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	227	28	12.33%	9
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	70	6	8.57%	9
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	8	6	75.00%	1
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	24	5	20.83%	0
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	14	1	7.14%	0
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	30	3	10.00%	1
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	38	7	18.42%	7
C11: Apparently did not demonstrate that the patient was ready for discharge	51	7	13.73%	1
C12: Apparently did not provide appropriate personnel and/or resources	2	0	0.00%	0
C13: Apparently did not order appropriate specialty consultation	35	3	8.57%	1

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C14: Apparently specialty consultation process was not completed in a timely manner	6	2	33.33%	1
C15: Apparently did not effectively coordinate across disciplines	7	0	0.00%	0
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	116	12	10.34%	8
C17: Apparently did not order/follow evidence-based practices	31	3	9.68%	4
C18: Apparently did not provide medical record documentation that impacts patient care	5	1	20.00%	3
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%	0
C99: Other quality concern not elsewhere classified	59	8	13.56%	2
Total	1,405	164	11.67%	53

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

Appeal Review by Notification Type	# of Reviews	(%) of Total
105: Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	5	0.03%
106: Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	1	0.01%
107: Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	25	0.13%
108: Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0.00%
111: Notice of Non-coverage Request for QIO Concurrence	67	0.34%
117: MA Appeal Review (CORF, HHA, SNF)	7,999	40.68%
118: FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	4,173	21.22%
121: Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	4,179	21.25%
122: Notice of Non-coverage Continued Stay Notice Concurrent Nonimmediate Review	22	0.11%
123: Notice of Non-coverage Continued Stay Retrospective	17	0.09%

Appeal Review by Notification Type	# of Reviews	(%) of Total
124: MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	3,176	16.15%
Total	19,664	100.00%

7) REVIEWS BY GEOGRAPHIC AREA – URBAN AND RURAL

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Appeal Reviews			
Urban	1,383	96.78%	88.85%
Rural	40	2.80%	10.81%
Unknown	6	0.42%	0.33%
Total	1,429	100.00%	100.00%

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Quality of Care Reviews			
Urban	285	96.28%	91.09%
Rural	9	3.04%	8.33%
Unknown	2	0.68%	0.58%
Total	296	100.00%	100.00%

8) IMMEDIATE ADVOCACY REVIEWS

# of Beneficiary Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
Immediate Advocacy Reviews		
964	335	34.75%

LIVANTA QIO AREA #5 – STATE OF HAWAII

1) TOTAL # OF REVIEWS

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Coding Validation (120 - HWDRG)	68	8.53%
Coding Validation (All Other Selection Reasons)	1	0.13%
Quality of Care Review (101 through 104 - Beneficiary Complaint)	21	2.63%
Quality of Care Review (All Other Selection Reasons)	1	0.13%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	293	36.76%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	10	1.25%
Notice of Non-coverage (118 - BIPA)	115	14.43%
Notice of Non-coverage (117 - Grijalva)	181	22.71%
Notice of Non-coverage (121 through 124 - Weichardt)	107	13.43%
Notice of Non-coverage (111-Request for QIO Concurrence)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	797	100.00%

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	# of Beneficiaries	Percent of Beneficiaries (%)
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	2,276	38.25%
2. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	838	14.08%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	599	10.07%
4. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	389	6.54%
5. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	388	6.52%
6. I639 - CEREBRAL INFARCTION, UNSPECIFIED	367	6.17%
7. J690 - PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT	277	4.66%
8. A4151 - SEPSIS DUE TO ESCHERICHIA COLI (E. COLI)	273	4.59%
9. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	272	4.57%
10. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	271	4.55%
Total	5,950	100.00%

3) BENEFICIARY DEMOGRAPHICS

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender		
Female	347	56.42%
Male	266	43.25%
Unknown	2	0.33%
Total	615	100.00%
Race		
Asian	173	28.13%
Black	7	1.14%
Hispanic	5	0.81%
North American Native	1	0.16%
Other	174	28.29%
Unknown	4	0.65%
White	251	40.81%

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Total	615	100.00%
Age		
Under 65	75	12.20%
65-70	105	17.07%
71-80	161	26.18%
81-90	183	29.76%
91+	91	14.80%
Total	615	100.00%

4) PROVIDER REVIEWS SETTINGS

Setting	# of Providers	Percent of Providers (%)
0: Acute Care Unit of an Inpatient Facility	13	23.21%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	1.79%
3: Distinct Skilled Nursing Facility	33	58.93%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	5	8.93%
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	4	7.14%
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	56	100.00%

5) QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%	0
C02: Apparently did not make appropriate diagnoses and/or assessments	5	0	0.00%	0
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)]	14	1	7.14%	0
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	8	0	0.00%	0
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%	0
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%	0
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	0	0.00%	0
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%	0
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%	0
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	0	0.00%	0
C11: Apparently did not demonstrate that the patient was ready for discharge	2	0	0.00%	0
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%	0
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%	0

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%	0
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%	0
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	3	0	0.00%	0
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%	0
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%	0
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%	0
C99: Other quality concern not elsewhere classified	1	0	0.00%	0
Total	37	1	2.70%	0

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

Appeal Review by Notification Type	# of Reviews	(%) of Total
105: Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	1	0.26%
106: Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	0	0.00%
107: Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	10	2.65%
108: Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0.00%
111: Notice of Non-coverage Request for QIO Concurrence	0	0.00%
117: MA Appeal Review (CORF, HHA, SNF)	160	42.33%
118: FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	106	28.04%
121: Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	56	14.81%
122: Notice of Non-coverage Continued Stay Notice Concurrent Nonimmediate Review	1	0.26%

Appeal Review by Notification Type	# of Reviews	(%) of Total
123: Notice of Non-coverage Continued Stay Retrospective	0	0.00%
124: MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	44	11.64%
Total	378	100.00%

7) REVIEWS BY GEOGRAPHIC AREA – URBAN AND RURAL

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Appeal Reviews			
Urban	37	69.81%	88.85%
Rural	16	30.19%	10.81%
Unknown	0	0.00%	0.33%
Total	53	100.00%	100.00%

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Quality of Care Reviews			
Urban	6	85.71%	91.09%
Rural	0	0.00%	8.33%
Unknown	1	14.29%	0.58%
Total	7	100.00%	100.00%

8) IMMEDIATE ADVOCACY REVIEWS

# of Beneficiary Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
Immediate Advocacy Reviews		
27	6	22.22%

LIVANTA QIO AREA #5 – STATE OF IDAHO

1) TOTAL # OF REVIEWS

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Coding Validation (120 - HWDRG)	208	20.39%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 - Beneficiary Complaint)	19	1.86%
Quality of Care Review (All Other Selection Reasons)	7	0.69%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	464	45.49%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	0	0.00%
Notice of Non-coverage (118 - BIPA)	95	9.31%
Notice of Non-coverage (117 - Grijalva)	163	15.98%
Notice of Non-coverage (121 through 124 - Weichardt)	64	6.27%
Notice of Non-coverage (111-Request for QIO Concurrence)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	1,020	100.00%

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	# of Beneficiaries	Percent of Beneficiaries (%)
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	3,369	30.37%
2. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	1,122	10.11%
3. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	1,072	9.66%
4. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	965	8.70%
5. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	963	8.68%
6. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	887	7.99%
7. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	769	6.93%
8. M1611 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT HIP	703	6.34%
9. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	664	5.98%
10. M1612 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT HIP	581	5.24%
Total	11,095	100.00%

3) BENEFICIARY DEMOGRAPHICS

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender		
Female	441	53.91%
Male	374	45.72%
Unknown	3	0.37%
Total	818	100.00%
Race		
Asian	4	0.49%
Black	2	0.24%
Hispanic	8	0.98%
North American Native	6	0.73%
Other	3	0.37%
Unknown	9	1.10%
White	786	96.09%

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Total	818	100.00%
Age		
Under 65	142	17.36%
65-70	163	19.93%
71-80	291	35.57%
81-90	161	19.68%
91+	61	7.46%
Total	818	100.00%

4) PROVIDER REVIEWS SETTINGS

Setting	# of Providers	Percent of Providers (%)
0: Acute Care Unit of an Inpatient Facility	13	15.12%
1: Distinct Psychiatric Facility	2	2.33%
2: Distinct Rehabilitation Facility	1	1.16%
3: Distinct Skilled Nursing Facility	51	59.30%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	3	3.49%
N: Critical Access Hospital	9	10.47%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	3	3.49%
R: Hospice	4	4.65%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	86	100.00%

5) QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%	0
C02: Apparently did not make appropriate diagnoses and/or assessments	4	2	50.00%	0
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)]	16	2	12.50%	3
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	7	3	42.86%	1
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	0	0.00%	0
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	0	0.00%	0
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%	0
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%	0
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%	0
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%	0
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%	0
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%	0
C13: Apparently did not order appropriate specialty consultation	2	0	0.00%	0

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C14: Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%	0
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%	0
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	2	0	0.00%	0
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%	0
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%	0
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%	0
C99: Other quality concern not elsewhere classified	1	0	0.00%	0
Total	41	7	17.07%	4

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

Appeal Review by Notification Type	# of Reviews	(%) of Total
105: Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	0	0.00%
106: Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	0	0.00%
107: Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	0	0.00%
108: Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0.00%
111: Notice of Non-coverage Request for QIO Concurrence	0	0.00%
117: MA Appeal Review (CORF, HHA, SNF)	148	51.03%
118: FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	85	29.31%
121: Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	33	11.38%
122: Notice of Non-coverage Continued Stay Notice Concurrent Nonimmediate Review	0	0.00%
123: Notice of Non-coverage Continued Stay Retrospective	1	0.34%

Appeal Review by Notification Type	# of Reviews	(%) of Total
124: MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	23	7.93%
Total	290	100.00%

7) REVIEWS BY GEOGRAPHIC AREA – URBAN AND RURAL

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Appeal Reviews			
Urban	36	43.90%	88.85%
Rural	46	56.10%	10.81%
Unknown	0	0.00%	0.33%
Total	82	100.00%	100.00%

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Quality of Care Reviews			
Urban	4	36.36%	91.09%
Rural	7	63.64%	8.33%
Unknown	0	0.00%	0.58%
Total	11	100.00%	100.00%

8) IMMEDIATE ADVOCACY REVIEWS

# of Beneficiary Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
Immediate Advocacy Reviews		
23	5	21.74%

LIVANTA QIO AREA #5 – STATE OF NEVADA

1) TOTAL # OF REVIEWS

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Coding Validation (120 - HWDRG)	652	15.23%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 - Beneficiary Complaint)	119	2.78%
Quality of Care Review (All Other Selection Reasons)	53	1.24%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	1,595	37.26%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	0	0.00%
Notice of Non-coverage (118 - BIPA)	401	9.37%
Notice of Non-coverage (117 - Grijalva)	728	17.01%
Notice of Non-coverage (121 through 124 - Weichardt)	730	17.05%
Notice of Non-coverage (111-Request for QIO Concurrence)	1	0.02%
EMTALA 5 Day	2	0.05%
EMTALA 60 Day	0	0.00%
Total	4,281	100.00%

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	# of Beneficiaries	Percent of Beneficiaries (%)
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	7,347	36.88%
2. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	2,048	10.28%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	2,018	10.13%
4. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	1,689	8.48%
5. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	1,510	7.58%
6. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	1,480	7.43%
7. J9621 - ACUTE AND CHRONIC RESPIRATORY FAILURE WITH HYPOXIA	1,005	5.04%
8. J9601 - ACUTE RESPIRATORY FAILURE WITH HYPOXIA	992	4.98%
9. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	951	4.77%
10. I639 - CEREBRAL INFARCTION, UNSPECIFIED	883	4.43%
Total	19,923	100.00%

3) BENEFICIARY DEMOGRAPHICS

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender		
Female	1,422	54.97%
Male	1,154	44.61%
Unknown	11	0.43%
Total	2,587	100.00%
Race		
Asian	92	3.56%
Black	320	12.37%
Hispanic	74	2.86%
North American Native	14	0.54%
Other	68	2.63%
Unknown	34	1.31%

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
White	1,985	76.73%
Total	2,587	100.00%
Age		
Under 65	500	19.33%
65-70	481	18.59%
71-80	800	30.92%
81-90	645	24.93%
91+	161	6.22%
Total	2,587	100.00%

4) PROVIDER REVIEWS SETTINGS

Setting	# of Providers	Percent of Providers (%)
0: Acute Care Unit of an Inpatient Facility	23	20.54%
1: Distinct Psychiatric Facility	3	2.68%
2: Distinct Rehabilitation Facility	3	2.68%
3: Distinct Skilled Nursing Facility	44	39.29%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	1	0.89%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	10	8.93%
N: Critical Access Hospital	5	4.46%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	5	4.46%
R: Hospice	14	12.50%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	4	3.57%
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	112	100.00%

5) QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C01: Apparently did not obtain pertinent history and/or findings from examination	2	1	50.00%	0
C02: Apparently did not make appropriate diagnoses and/or assessments	64	7	10.94%	3
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)]	91	20	21.98%	6
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	41	8	19.51%	2
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	13	3	23.08%	3
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%	0
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	0	0.00%	0
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	0	0.00%	0
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	5	0	0.00%	0
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	5	0	0.00%	0
C11: Apparently did not demonstrate that the patient was ready for discharge	8	1	12.50%	0
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%	0
C13: Apparently did not order appropriate specialty consultation	2	0	0.00%	0

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C14: Apparently specialty consultation process was not completed in a timely manner	2	0	0.00%	0
C15: Apparently did not effectively coordinate across disciplines	2	1	50.00%	0
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	26	3	11.54%	1
C17: Apparently did not order/follow evidence-based practices	5	1	20.00%	1
C18: Apparently did not provide medical record documentation that impacts patient care	3	0	0.00%	0
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%	0
C99: Other quality concern not elsewhere classified	8	2	25.00%	1
Total	282	47	16.67%	17

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

Appeal Review by Notification Type	# of Reviews	(%) of Total
105: Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	0	0.00%
106: Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	0	0.00%
107: Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	0	0.00%
108: Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0.00%
111: Notice of Non-coverage Request for QIO Concurrence	1	0.06%
117: MA Appeal Review (CORF, HHA, SNF)	639	37.48%
118: FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	363	21.29%
121: Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	424	24.87%
122: Notice of Non-coverage Continued Stay Notice Concurrent Nonimmediate Review	4	0.23%
123: Notice of Non-coverage Continued Stay Retrospective	4	0.23%

124: MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	270	15.84%
Total	1,705	100.00%

7) REVIEWS BY GEOGRAPHIC AREA – URBAN AND RURAL

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Appeal Reviews			
Urban	94	92.16%	88.85%
Rural	8	7.84%	10.81%
Unknown	0	0.00%	0.33%
Total	102	100.00%	100.00%

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Quality of Care Reviews			
Urban	43	91.49%	91.09%
Rural	4	8.51%	8.33%
Unknown	0	0.00%	0.58%
Total	47	100.00%	100.00%

8) IMMEDIATE ADVOCACY REVIEWS

# of Beneficiary Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
Immediate Advocacy Reviews		
173	55	31.79%

LIVANTA QIO AREA #5 – STATE OF OREGON

1) TOTAL # OF REVIEWS

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Coding Validation (120 - HWDRG)	433	15.00%
Coding Validation (All Other Selection Reasons)	1	0.03%
Quality of Care Review (101 through 104 - Beneficiary Complaint)	64	2.22%
Quality of Care Review (All Other Selection Reasons)	11	0.38%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	1,052	36.45%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	0	0.00%
Notice of Non-coverage (118 - BIPA)	273	9.46%
Notice of Non-coverage (117 - Grijalva)	732	25.36%
Notice of Non-coverage (121 through 124 - Weichardt)	320	11.09%
Notice of Non-coverage (111-Request for QIO Concurrence)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	2,886	100.00%

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	# of Beneficiaries	Percent of Beneficiaries (%)
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	5,972	31.76%
2. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	1,802	9.58%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	1,644	8.74%
4. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	1,630	8.67%
5. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	1,618	8.60%
6. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	1,524	8.10%
7. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	1,407	7.48%
8. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	1,111	5.91%
9. M1611 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT HIP	1,074	5.71%
10. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	1,024	5.45%
Total	18,806	100.00%

3) BENEFICIARY DEMOGRAPHICS

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender		
Female	1,216	55.35%
Male	972	44.24%
Unknown	9	0.41%
Total	2,197	100.00%
Race		
Asian	31	1.41%
Black	50	2.28%
Hispanic	20	0.91%
North American Native	22	1.00%
Other	27	1.23%

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Unknown	27	1.23%
White	2,020	91.94%
Total	2,197	100.00%
Age		
Under 65	378	17.21%
65-70	392	17.84%
71-80	655	29.81%
81-90	554	25.22%
91+	218	9.92%
Total	2,197	100.00%

4) PROVIDER REVIEWS SETTINGS

Setting	# of Providers	Percent of Providers (%)
0: Acute Care Unit of an Inpatient Facility	35	19.44%
1: Distinct Psychiatric Facility	1	0.56%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	96	53.33%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	22	12.22%
N: Critical Access Hospital	9	5.00%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	0.56%
R: Hospice	15	8.33%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	0.56%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	180	100.00%

5) QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C01: Apparently did not obtain pertinent history and/or findings from examination	1	0	0.00%	0
C02: Apparently did not make appropriate diagnoses and/or assessments	16	1	6.25%	0
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	9	18.37%	1
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	19	1	5.26%	2
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	5	1	20.00%	2
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%	0
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	0	0.00%	0
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	0	0.00%	0
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%	0
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	2	0	0.00%	0
C11: Apparently did not demonstrate that the patient was ready for discharge	8	1	12.50%	0
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%	0
C13: Apparently did not order appropriate specialty consultation	2	0	0.00%	0

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%	0
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%	0
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	6	2	33.33%	1
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%	0
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%	0
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%	0
C99: Other quality concern not elsewhere classified	4	0	0.00%	0
Total	117	15	12.82%	6

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

Appeal Review by Notification Type	# of Reviews	(%) of Total
105: Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	0	0.00%
106: Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	0	0.00%
107: Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	0	0.00%
108: Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0.00%
111: Notice of Non-coverage Request for QIO Concurrence	0	0.00%
117: MA Appeal Review (CORF, HHA, SNF)	632	53.11%
118: FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	251	21.09%
121: Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	162	13.61%
122: Notice of Non-coverage Continued Stay Notice Concurrent Nonimmediate Review	0	0.00%

Appeal Review by Notification Type	# of Reviews	(%) of Total
123: Notice of Non-coverage Continued Stay Retrospective	1	0.08%
124: MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	144	12.10%
Total	1,190	100.00%

7) REVIEWS BY GEOGRAPHIC AREA – URBAN AND RURAL

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Appeal Reviews			
Urban	127	71.75%	88.85%
Rural	50	28.25%	10.81%
Unknown	0	0.00%	0.33%
Total	177	100.00%	100.00%

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Quality of Care Reviews			
Urban	22	70.97%	91.09%
Rural	9	29.03%	8.33%
Unknown	0	0.00%	0.58%
Total	31	100.00%	100.00%

8) IMMEDIATE ADVOCACY REVIEWS

# of Beneficiary Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
Immediate Advocacy Reviews		
86	25	29.07%

LIVANTA QIO AREA #5 – STATE OF WASHINGTON

1) TOTAL # OF REVIEWS

Review Type	# of Reviews	Percent of TOTAL Reviews (%)
Coding Validation (120 - HWDRG)	788	14.69%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 - Beneficiary Complaint)	82	1.53%
Quality of Care Review (All Other Selection Reasons)	16	0.30%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	1,888	35.18%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	4	0.07%
Notice of Non-coverage (118 - BIPA)	782	14.57%
Notice of Non-coverage (117 - Grijalva)	1,300	24.23%
Notice of Non-coverage (121 through 124 - Weichardt)	504	9.39%
Notice of Non-coverage (111-Request for QIO Concurrence)	2	0.04%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	5,366	100.00%

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	# of Beneficiaries	Percent of Beneficiaries (%)
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	13,686	32.43%
2. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	4,116	9.75%
3. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	3,717	8.81%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	3,703	8.77%
5. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	3,493	8.28%
6. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	3,135	7.43%
7. I639 - CEREBRAL INFARCTION, UNSPECIFIED	2,701	6.40%
8. J9601 - ACUTE RESPIRATORY FAILURE WITH HYPOXIA	2,592	6.14%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	2,542	6.02%
10. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	2,517	5.96%
Total	42,202	100.00%

3) BENEFICIARY DEMOGRAPHICS

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender		
Female	2,338	57.19%
Male	1,745	42.69%
Unknown	5	0.12%
Total	4,088	100.00%
Race		
Asian	93	2.27%
Black	153	3.74%
Hispanic	34	0.83%
North American Native	67	1.64%
Other	82	2.01%
Unknown	54	1.32%

Demographics	# of Beneficiaries	Percent of Beneficiaries (%)
White	3,605	88.18%
Total	4,088	100.00%
Age		
Under 65	658	16.10%
65-70	714	17.47%
71-80	1,198	29.31%
81-90	1,092	26.71%
91+	426	10.42%
Total	4,088	100.00%

4) PROVIDER REVIEWS SETTINGS

Setting	# of Providers	Percent of Providers (%)
0: Acute Care Unit of an Inpatient Facility	49	17.56%
1: Distinct Psychiatric Facility	2	0.72%
2: Distinct Rehabilitation Facility	1	0.36%
3: Distinct Skilled Nursing Facility	173	62.01%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based RHC	0	0.00%
9: Provider Based RHC	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	1	0.36%
H: Home Health Agency	27	9.68%
N: Critical Access Hospital	10	3.58%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	0.36%
R: Hospice	15	5.38%
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	279	100.00%

5) QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C01: Apparently did not obtain pertinent history and/or findings from examination	2	0	0.00%	0
C02: Apparently did not make appropriate diagnoses and/or assessments	19	1	5.26%	2
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)]	58	5	8.62%	2
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	32	5	15.63%	0
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	9	1	11.11%	4
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	0	0.00%	0
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	0	0.00%	0
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%	0
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	4	0	0.00%	0
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	6	0	0.00%	0
C11: Apparently did not demonstrate that the patient was ready for discharge	12	3	25.00%	0
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%	0
C13: Apparently did not order appropriate specialty consultation	3	0	0.00%	0

Quality of Care ("C" Category) PRAF Category Codes	# of Concerns	# of Concerns Confirmed	Percent Confirmed Concerns (%)	# of Concerns Referred as Quality Improvement Initiatives (QII)
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%	0
C15: Apparently did not effectively coordinate across disciplines	2	1	50.00%	0
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	9	1	11.11%	2
C17: Apparently did not order/follow evidence-based practices	5	0	0.00%	0
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%	0
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%	0
C99: Other quality concern not elsewhere classified	15	2	13.33%	1
Total	180	19	10.56%	11

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

Appeal Review by Notification Type	# of Reviews	(%) of Total
105: Notice of Non-coverage FFS Preadmission Notice Concurrent Immediate Review	0	0.00%
106: Notice of Non-coverage FFS Preadmission Notice Non-immediate Review	0	0.00%
107: Notice of Non-coverage FFS Admission Notice Concurrent Immediate Review	4	0.17%
108: Notice of Non-coverage FFS Admission Notice Non-immediate Review	0	0.00%
111: Notice of Non-coverage Request for QIO Concurrence	2	0.08%
117: MA Appeal Review (CORF, HHA, SNF)	1,159	49.01%
118: FFS Expedited Appeal (CORF, HHA, Hospice, SNF)	718	30.36%
121: Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	341	14.42%
122: Notice of Non-coverage Continued Stay Notice Concurrent Nonimmediate Review	3	0.13%
123: Notice of Non-coverage Continued Stay Retrospective	2	0.08%

124: MA Notice of Non-coverage Continued Stay Notice Immediate Review - Attending Physician Concurs	136	5.75%
Total	2,365	100.00%

7) REVIEWS BY GEOGRAPHIC AREA – URBAN AND RURAL

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Appeal Reviews			
Urban	218	80.15%	88.85%
Rural	54	19.85%	10.81%
Unknown	0	0.00%	0.33%
Total	272	100.00%	100.00%

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

Geographic Area	# of Providers	Percent of Providers in State (%)	Percent of Providers in Service Area (%)
Quality of Care Reviews			
Urban	43	87.76%	91.09%
Rural	6	12.24%	8.33%
Unknown	0	0.00%	0.58%
Total	49	100.00%	100.00%

8) IMMEDIATE ADVOCACY REVIEWS

# of Beneficiary Complaints	# of Immediate Advocacy Reviews	(%) of Total Beneficiary Complaints Resolved by Immediate Advocacy
Immediate Advocacy Reviews		
107	23	21.50%

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