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QAPI: What is the billing department's role?

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For years, there were two separate quality programs in long-term care required by CMS: Quality Assurance (QA) and Performance Improvement (PI). In 2011, these programs merged into one. Quality Assurance and Performance Improvement (QAPI) was formed, which takes the best parts of each initiative to create a single, unique methodology to improve quality in healthcare delivery.

The QA process, which is reactive to the identification of negative outcomes, and the PI process, which is proactive, look at how to improve processes to decrease the incidence of specific potential outcomes. Jointly, they explore data, but they also go beyond exploration. The QAPI program requires the involvement of the interdisciplinary team to identify potential problems, prevent or manage them if they occur, and investigate ways to improve the overall functioning of a facility through further root-cause analysis.

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in SNFs. The activities of QAPI involve members at all levels of the organization to:

- Identify opportunities for improvement
- Address gaps in systems or processes
- Develop and implement an improvement or corrective plan
- Continuously monitor the effectiveness of interventions

HCPro has published several titles to help guide SNFs through their own QAPI process and implementation, including *Quality Assurance and Performance Improvement: A Nursing Home's Guide to Implementation and Management* and *Reduce Lawsuit Risk: A QAPI Approach for Long-Term Care.*

CMS has also published a guide for establishing an effective QAPI program in nursing homes. It is available at *https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf.*

The elements of QAPI

There are five elements of the QAPI program:

1. **Design and scope,** which supports the idea of an ongoing, comprehensive program that includes all services offered by all departments in the facility. This element emphasizes the involvement of all systems of care and management.
2. **Governance and leadership,** which includes the role of the governing body or administration in providing the support needed to involve all staff, residents, and representatives.
3. **Feedback, data systems and monitoring,** which explores the implementation of systems to monitor, receive feedback, and manage any identified areas that need process change to improve facility and staff performance.
4. **Performance improvement projects,** which focus on a particular problem or system that may have issues.
5. **System analysis and systemic action,** which identifies the organized approach to understanding the problems. Through root cause analysis, the scope, cause, and implications of a problem or potential problem will be identified along with methods for improvement.

An in-depth explanation of these elements can be found at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/qapifiveelements.pdf.*

How does QAPI affect billing?

With this information in mind, let's talk about how billing personnel are relevant to the implementation of a QAPI program. At first glance, it may appear that the intent of a QAPI program is to improve patient/resident care and the delivery of services. But, upon further examination, it becomes obvious that cash flow and materials are integral parts of a facility's ability to deliver quality care. Any item that has a negative impact on resident care must be examined as part of the QAPI process. Items specific to billing professionals include:

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- Citations for not submitting proper beneficiary notices
- Claims that are rejected secondary to ICD-10 coding

Although each facility has many departments, no department is an island unto itself. What nursing, social service, and activity personnel do, under certain circumstances, may have an impact on what the business office does or how the office does it. The following case studies provide examples and logic for why QAPI implementation must involve the entire disciplinary team. Without proper communication, the facility is the loser.

Case study #1

- **Scenario:** A Medicare Part A recipient needs to go to an outside vendor for an MRI. The family makes the arrangements, and the nursing staff documents the resident's departure. The resident returns to the facility by 5 p.m. the same day and continues nursing and therapy services for another 10 days, at which time he is discharged from the Medicare stay and returns home.

Billing submits the final UB-04 discharge claim type of bill 214, which includes charges for therapy services, nursing supplies, and pharmacy costs. Six weeks later, a $15,000 invoice is received from the provider of the MRI. The facility biller does not think the invoice is correct, since there was no indication from nursing to the billing department that the resident went outside the SNF to receive this service. Upon investigation, the business office is informed that the resident did receive an MRI on the date indicated, and the facility is 100% responsible because in this instance, the resident received the MRI at a freestanding site. Per consolidated billing regulations, only MRI services received in a hospital are excluded; all others are the responsibility of the SNF.

- **Result:** In this situation, the facility might have avoided the MRI invoice in its entirety had it notified the billing office of the order; billing would have then reminded nursing that under consolidated billing, the MRI would only be excluded if performed in a hospital setting. Nursing could have spoken with the family to find out where the MRI was taking place, and if necessary, involved the administrator to negotiate a contract with the provider to pay a less costly fee.

The billing department should have been made aware of the appointment to anticipate receipt of the invoice, which would have resulted in the billing department calling the provider to request a more suitable arrival time. In this situation, the facility was responsible for a very costly procedure, and a corrected bill had to be submitted.

Case study #2

- **Scenario:** A business office thinks therapy is issuing beneficiary notices, but therapy is unaware that the business office has that impression. In actuality, neither department is issuing the notices. Another business office, as a result of a similar lack of communication, ends up issuing an incorrect, outdated notice to patients for at least a year before the error is noticed and corrected.
- **Result:** Beneficiary notices are another frequent casualty of miscommunication. The wrong notice, issued at the wrong time, without proper completion, will cause a denial in payment. Had they been requested for review, all claims with a missing or outdated beneficiary notice would have been denied.

It is important that the business office be aware of who is giving the notice and when it is completed. Each facility should have a process for the delivery of beneficiary notices, and the bookkeeping or billing department should know what that process is. If a QAPI activity were established, this error would be identified prior to the request for ADRs. Another suggestion is to discuss the last covered during the Medicare meetings: By doing so, the lack of a process would have been realized, and the discussion would prevent the improper delivery of the notice.

Case study #3

- **Scenario:** A facility is on a payment ban, but no one has informed the admission department. Twelve new (i.e., not readmitted) Medicare and Medicaid residents are admitted without payment from any payer source. The facility is responsible for the entire cost of these residents' care.
- **Result:** This scenario happens when communication within the SNF is not shared. A payment ban occurs only when the facility is not found to be in substantial

compliance with the requirement of participation. This status is determined after a survey, which may be a complaint, annual, or follow-up survey.

How to prevent negative outcomes

The previous examples show how a facilitywide QAPI program can prevent negative outcomes by identifying processes or policies that need to change. These policies or processes may be related to:

- Resident discharges
- Consolidated billing
- Admissions

A well-planned and organized QAPI program will identify problems that exist or have the potential to occur. The case studies above incorporate several departments and potentially identify several hot spots within SNFs that require further review. Think about your own facility; what areas can you recognize that have the potential for a negative outcome? Think about bringing these areas up with your own QAPI committee.

QAPI resources

For further information and assistance with developing a QAPI program in your facility, please use the following resources:

- *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIAta-Glance.pdf*
- *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessTool-Framework.pdf*
- *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/nhqapi.html*
- *Reduce Lawsuit Risk: A QAPI Approach for Long-Term Care,* published by HCPro
- *Quality Assurance and Performance Improvement: A Nursing Home's Guide to Implementation and Management,* published by HCPro