

In an effort to ensure that Medicaid pays for nursing facility services at the appropriate time the Division of HealthCare Financing is implementing the Xerox® Appropriate Payer Solution, a procedure that evaluates dual eligible residents to determine whether Medicare Part A or Medicaid is the appropriate payer. It is a system that makes determinations about the appropriate payer according to submitted Minimum Data Set (MDS) data.

Medicare Part A provides coverage for skilled medical care for up to 100 days. Some residents have multiple conditions that qualify them for Medicare reimbursement, otherwise known as co-qualifying conditions and at times facilities make a decision to start billing the Medicaid program prior to the covered Medicare days being exhausted. Besides negatively impacting the Medicaid Program as Medicaid is paying for services that could be covered by another program, it also prevents the facility from receiving the appropriate and many times higher reimbursement from Medicare.

### **System Overview**

MDS data is loaded nightly into the Appropriate Payer Solution, which analyzes the most recently submitted MDS to establish whether the resident still appears to clinically qualify for Medicare payment. If the resident has Medicare and still qualifies for rehab extensive care, special rehab, extensive services, special care high, special care low, or clinically complex that stay is placed on hold and that status is transmitted to the MMIS.

When a nursing facility claim is processed and is placed on hold, that claim will be denied and trigger edit 356. Your remittance advice will identify this claim with EOB 384 and the message will be: CLIENT ELIGIBLE FOR MEDICARE STAY.REFER TO [HTTPS://PORTAL.APVERIFY.COM](https://portal.apverify.com) OR CALL 800.758.2453.

A hold is released when a new MDS is submitted that no longer clinically qualifies for Medicare or if the provider wishes can access Xerox's Appropriate Payer Solution URL and completes the AP survey. Based on current information from the most recent MDS submitted or the information directly entered into the AP Survey, the system will evaluate whether the resident still qualifies for Medicare payment.

If you disagree with the 'hold' status and still believe that Medicaid is the appropriate payer, for example the resident has exhausted their 100 day benefit, then you must complete the AP survey to verify that it is appropriate to bill Medicaid. Once the clinical survey is completed and the 'hold' status has been removed, the resident can be appropriately billed to Medicaid.

### **Facility Impact**

Appropriate Payer is intended to ensure that Medicaid is the payer of last resort. If there are conditions that require skilled care and the resident qualifies for Medicare, the resident's payer source should be Medicare. As a result, the impact to your facility should be positive since the rates for Medicare are greater than the Medicaid counterpart.