STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Governor

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Michael J. Lewis, MD, Ph.D.
Cabinet Secretary

MEMORANDUM

TO: WV Long Term Care Providers (Nursing Facilities)

FROM: Bureau for Medical Services

DATE: August 1, 2011

RE: AAA Mismatch and Resource Mismatch

West Virginia nursing facilities may begin to notice the following additional reason codes and remit codes reflected on their remittance advices:

- Reason Code 15 (The authorization number is missing, invalid, or does not apply to the billed services or provider) and Remark Code N54 (Claim information is inconsistent with pre-certified / authorized services)

- Reason Code 125 (Submission / billing error(s)) and Remark Code N58 (Missing / incomplete / invalid patient liability amount)

Reason Code 15 and Remark Code N54 will populate on the remittance advice when the case-mix score billed on the claim (AAA score) does not match the case-mix score (AAA score) populated within the system authorization determined by the MDS assessment submitted. It is the responsibility of the nursing facility to notify their contracted software vendor to assure that the MDS assessment case-mix scores are being calculated according to WV case-mix specifications. Vendors and providers may obtain the current WV Case-mix Classification Workbook by visiting www.dhhr.wv.gov/bms for case-mix specifications.

Reason Code 125 and Remark Code N58 will populate on the remittance advice when the resource amount billed on the claim does not match the resource amount on file for the specific member on that date of service. Effective January 1, 2012, nursing facility providers will also be required to submit the condition code "M1" on the claim when a partial resource amount is billed. Situations when billing a partial resource amount may include, but are not limited to, the following situations:

- When a member's care for the month is split between the nursing facility and the hospice provider contracted to deliver services within the nursing facility
- When a member's care for the month is split between skilled care and non-skilled care within the nursing facility

It is the responsibility of the nursing facility provider to notify their contracted software vendor of the addition of the "M1" condition code requirement when partial resource amounts are being billed. The "M1" requirement should not be reflected on the claim when the local DHHR office prorates a resource upon a member's admission to or discharge from a nursing facility.

At the present time, the above reason / remark codes are associated with a WARN disposition on the remittance advice. This is to allow nursing facility providers and vendors ample time to assure that their billing and MDS software comply with WV specific requirements and specifications. Effective January 1, 2012, the WARN disposition will be changed to DENY. This means that nursing facility providers will experience denied claims when the billed case-mix score does not match the case-mix score calculated from the MDS and / or the resource amount billed does not match the resource amount submitted to WV Medicaid by the local DHHR office.

LTC Billing Instructions can be found on Molina's website at www.wvmmis@molinahealthcare.com . Questions regarding claims submissions or dispositions can be addressed by calling Molina Provider Relations at 304-348-3360 or 888-483-0793. Additional questions regarding the information contained within this memo or vendor specifications can be addressed by calling Kelley Johnson at 304-356-4886 or Emily McCoy at 304-356-4889.