Louisiana Department of Health and Hospitals
Health Plan Advisory 14-12
July 24, 2014

Administrative Corrections for Retro Enrolled Newborns and Excluded Populations

DHH has determined that in some instances, Administrative Retroactive Corrections to member linkages are necessary to ensure compliance with internal policies and the approved Medicaid state plan. These corrections, also known as retro, may address multiple months, and significantly impact paid claims and PMPMs. In an effort to correct audit trails, the following processes are being implemented:

- On or about the 5th of every month, DHH and Molina will review all changes made by the Enrollment Broker (Maximus) for the prior month, to identify retro enrolled newborns and retro disenrolled excluded populations, identify paid claims, and associated adjustments needed to PMPMs.
- Based on this review, mid-month Molina will void identified Shared Savings Plan and Legacy claims paid by an incorrect entity, with denial reason code 999 – Administrative Correction, and providers will receive notice via 835s.
- Providers must check MEVS to obtain correct entity information based on the date of service. Please note that MEVs only returns information for one year from the date of service, but REVs may be used for anything older than one year from the date of service.
- A monthly report of affected members is given to all Bayou Health Plans and Molina Provider Relations. This report includes detailed information to assist Plans in anticipating claims which should be billed to them for their retro enrolled members including:
  - Member name, Medicaid ID and voided claim detail;
  - If applicable, original authorization (PA and Pre-cert) numbers;
  - Identification of the entity that paid the original claim; and
  - Identification of the correct entity responsible for prior paid claims due to the retro enrollment.
- For the clean-up of August 2014, a list of all affected providers will be available on the Making Medicaid Better website for review by providers. This list will contain provider's names, partial Medicaid Provider IDs (to maintain privacy), number of claims, number of recipients, and totals of payments to be voided.

- The correct entity (Bayou Health Plan or Molina) must accept and honor authorizations (PA or Pre-cert) approved by the prior incorrect entity (unless the original authorization violates state or federal regulations), and payment shall be made whether provider is in-or out-of-network, within 30 days of receipt.

- Providers are required to submit **paper/hard copy** claims to the corrected entity (Bayou Health Plan or Molina) no later than 6 months from the date the claim is voided and:
    - Providers will not be required to obtain authorization (PA or Pre-cert) for these claims.
    - Providers must attach documentation supporting the void.
    - Claims cannot be denied for failure to meet timely filing, unless the claim is received more than 6 months after the date the claim is voided.

REMINDER: Prepaid Plans shall, within 30 days of receipt of retro disenrollment notice (via daily, weekly or reconciliation 834s from Maximus) perform recoupment processes of inappropriately paid claims.