Louisiana Department of Health and Hospitals
Health Plan Advisory 15-16
Revised May 28, 2015

Managed Care Organization (MCO) Claims and Encounter Instructions for Retro Dis-enrolled Members

The following processes are being created to ensure timeliness and uniformity across all entities (legacy Medicaid and MCOs) in submitting claims and encounters for retro dis-enrolled members.

- MCOs shall create a new void reason code **(999 – Administrative Correction)** to align with established processes performed by Molina for legacy and Shared Savings Plan claims.
- MCOs shall review the daily 834 files and any manual special processing files provided by Maximus to identify members retro dis-enrolled from their plan. The MCOs shall identify inappropriately paid claims for these members.
- MCOs shall void inappropriately paid claims for members retro dis-enrolled from their plan with the **999** void reason code. **Only paid claims shall be voided, including those paid at zero.**
- This new process of voiding paid claims replaces the MCO's current recoupment processes for retro dis- enrollment reasons only.
- MCOs are required to send written notice to providers two weeks prior to the void. Posting a Remittance Advice (RA) message for two consecutive weeks satisfies this requirement.
    - The RA message should instruct providers to check Molina's Medicaid Eligibility Verification System (MEVS) or the MCO's eligibility system application to obtain correct entity information based on the date of service. **NOTE:** MEVS only returns information for one year from the date of service, and Recipient Eligibility Verification System (REVS) may be used for dates of service older than one year.
- **Providers should be notified that all pharmacy claims resubmitted to legacy Medicaid or Shared Saving Plan should be submitted using the National Council for Prescription Drug Programs (NCPDP) universal claim form along with documentation verifying the void.** All correct entities (MCO 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 the provider is in or out-of-network.
- Unless an MCO has established other means of identifying these claims, providers are required to submit **paper/hard copy** claims to the corrected entity (MCO or Molina) no later than six months from

the date the claim is voided.

- Providers will not be required to obtain authorization (PA or Pre-cert) for these claims.
- Providers must attach documentation supporting the void. This can be the RA indicating the void.
- Claims cannot be denied for failure to meet timely filing, unless the claim is received more than six months after the date the claim is voided.

- **Encounters for voided claims shall be sent to Molina**