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June 3, 2015

Subject: Retroactive Rate Adjustments of Pharmacy Claims

Dear Provider:

In no less than 60 days from the date of this letter, Xerox State Healthcare, LLC (Xerox) will reprocess claims for pharmacy services for dates of service from June 1, 2011, through February 6, 2014 to apply a 10 percent payment reduction pursuant to the provisions of Assembly Bill 97 (Chapter 3, Statutes of 2011) to claims for which payment was previously made without the 10 percent reduction being applied. Pending CMS approval, the 10 percent reduction will not be retroactively applied to claims for drugs that the Department of Health Care Services (DHCS) initially identified as being exempt from the 10 percent reduction pursuant to State Plan Amendment 12-014. This action will result in the calculation of an overpayment for affected providers based on the difference between the higher amount paid and the amount payable according to AB 97. The claim adjustments and your resulting overpayment will appear on *Remittance Advice Details* (RAD) forms beginning in August 2015, with code **0981: State initiated claim adjustment**.

Welfare and Institutions Code (W&I Code), Sections 14176 and 14177, and *California Code of Regulations* (CCR), Title 22, Section 51458.1(a)(1) authorize DHCS to recover overpayments to providers. Your overpayment will be converted to an accounts receivable (AR). After the overpayment is calculated, 5 percent of future weekly checkwrite amounts will be withheld until the AR is paid in full. If the reprocessing of a previously paid claim goes into suspense status (for example, flagged for manual review), the amount of the overpayment on that claim will not be calculated in the claims system until manual review is completed so the claim can be reprocessed. Any such overpayment will be converted to a separate AR. The system will withhold an additional 5 percent from future weekly check writes for any such additional ARs until satisfied.

To the extent that DHCS is unable to recover an overpayment by withholding a percentage of weekly check writes (for example, provider has ceased operation or is no longer receiving regular Medi-Cal payments), DHCS is authorized by law to pursue recovery by other means.

If you feel your overpayment has been miscalculated, you may submit a *Claims Inquiry Form* (CIF) within six months of the new RAD date or you may submit an *Appeal Form* within 90 days of the new RAD date. For CIF completion instructions, please refer to the *CIF Completion* and *CIF Special Billing Instructions* sections in the appropriate Part 2 manual or on the Medi-Cal website (www.medi-cal.ca.gov). For *Appeal Form* completion instructions please refer to the *Appeal Form Completion* section in the appropriate Part 2 manual or on the Medi-Cal website. Neither the CIF process nor the appeal process is available to challenge the validity of AB 97 mandated rates nor DHCS's authority to recoup overpayments incurred by a provider.



If you have questions regarding this adjustment, please call the Telephone Service Center at 1-800-541-5555, option 1 (for English), option 1 (for Provider), option 5 (for HAP, Family PACT, CHDP, CCS, GHPP, Crossover, LTC and other general billing inquiries), followed by option 6 (for general billing).

Sincerely,

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