Please note in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

In accordance to industry standards, please deposit checks within 14 calendar days from the date of the check delay of check cashing may result in request for check attestation.

FCS IPA requires a National Drug Code on all claims that include drugs covered by medical benefits. All claims must include the 11-digit NDC number, unit of measure, and quantity with the applicable Healthcare Common Procedure Coding System (HCPCS) or Common Procedural Terminology (CPT) drug codes.

Notice to Providers

This payment is for HMO members and per the items of CMS, DMHC, DHCS, and Knox Keene, the member cannot be balance billed except for the applicable co-pays, deductibles and non-covered services. The preceding message does not apply to services provided to commercial members by non-contracted, non-authorized providers.
Non-contracted providers are paid 100% of the prevailing Medicare Fee Schedule for Medicare members, 100% of the Medi-Cal Fee Schedule for Medi-Cal members (some services may have an applicable 1% Medi-Cal reduction based on provider type, reference to Welfare and Institutions Code (W&I) Section 14105.191), and the IPA's usual and customary rates for Commercial members. Contracted providers are paid at contracted rates.

MEDI-CAL PROVIDERS:
Appeals or Disputes must be submitted in writing preferably with the approved "Provider Dispute Resolution Request" (PDR) form, within 365 calendar days of payment/denial. You can obtain a PDR form on the FCS IPA website at https://altais.com/fcs-ipa under the provider resources tab. Disputes should be mailed to FAMILY CARE SPECIALISTS PO Box 72670 Oakland, CA 94612 to the attention of "Provider Dispute Resolution". Disputes must state reason of the dispute, the expected outcome and may include a copy of the claim(s) form and any supporting documentation. You will be notified in writing within 45 working days of the outcome of the dispute.

COMMERCIAL PROVIDERS:

1. Contracted Paid/Denied Claims:
   Under the Knox Keene Act, an eligible member to whom services were provided shall not be liable for any portion of the bill, except for applicable cost share, which may include deductible, co-insurance and/or copayments. The contracted provider should not bill the member or attempt to collect against the member, unless the member was not eligible at the time the services were rendered or non-emergency services were not authorized and/or directed by the participating medical group or primary care physician.

   Pursuant to the Knox Keene Act of the State of California, the enrollee to whom prior approved services were provided is not liable for any portion of the bill, except for co-payments, deductibles, other cost sharing components, or non-covered benefits as defined in the enrollee's Evidence of Coverage documents.

   In the event the member appeared eligible no more than 72 hours prior to services being rendered and an authorization or eligibility is provided that the specific provider relied upon to render services and the member later appears ineligible on date of services, Knox-Keene requires that the provider and member be held harmless and you cannot recover payment.

2. Non-Contracted (This is being sent to the provider and **NOT** the member) (these are all **non-ER** services)

   a. Paid Claims:
      For dates of services on or after July 1, 2017; non-contracted providers may **NOT** balance bill a member for non-emergency services when covered services are rendered in a Participating Facility. The health plan has many participating specialists and regional facilities available to FAMILY CARE SPECIALISTS. In the event FAMILY CARE SPECIALISTS elects to use a non-participating Facility and FAMILY CARE SPECIALISTS does not enter into a Letter of Agreement that protects the member, all authorized services for non-emergency providers must be paid at billed charges minus the member's applicable cost-sharing.

   b. Denied Claims:
      You may file a written appeal to: FAMILY CARE SPECIALISTS PO Box 72670 Oakland, CA 94612 with a clear & concise reason for questioning/disputing the denial decision.

3. PDR Process (Contracted & Non-Contracted **Emergency Services** Claims)
Under AB1455 if you feel there is an error in payment, you may dispute in writing to:
FAMILY CARE SPECIALISTS PO Box 72670 Oakland, CA 94612. A complete description of the dispute process can be found at https://altais.com/fcs-ipa.

Pursuant to California Code of Regulations Title 28, Sections 1300.71 and 1300.71.38, a provider may file a written dispute to: FAMILY CARE SPECIALISTS to challenge, appeal, or request for a reconsideration on a claim(s) that has been denied, adjusted, or contested.

Provider Disputes must be filed to FAMILY CARE SPECIALISTS within 365 days from the last date of written notification that led to the dispute. For instructions and forms for submitting a dispute, go to our website at https://altais.com/fcs-ipa or contact our Provider Services Department at 855-513-4007.

The dispute request must include the following information:
1. Name address and phone number of the provider of service
2. Provider s tax id number
3. Patient name
4. Insurer s information
5. Date of service
6. A complete and accurate explanation of the issue supporting documentation including copies of claims, claim number, medical records, or supporting documentation to challenge reports, as necessary, from the initial adverse determination.

4. Non-Emergency Services Independent Dispute Resolution Process (AB 72 IDRP)
The law requires that the Department of Managed Health Care conduct an independent dispute resolution process (AB 72 IDRP) that allows a non-contracting provider who rendered services at, or as a result of services at, a contracting health facility, or a payor, to dispute whether payment of the specified rate was appropriate. Once a
non-contracting provider or payor submits an AB 72 IDRP Application, the opposing party is required by law to participate in the AB 72 IDRP. AB 72 does not apply to emergency services and care.

Eligible Claims
Eligible claim disputes are those disputes that are subject to DMHC jurisdiction and meet **all** of the following criteria:

- The disputed claim must be for services rendered on or after July 1, 2017.
- The disputed claim must be for non-emergency services. If there is an unresolved dispute as to whether the health care service(s) at issue is non-emergent, the claim does not qualify for the AB 72 IDRP.
- The disputed claim must be for covered services provided at a contracting health facility, or provided as a result of covered services at a contracting health facility, by a non-contracting individual health professional.
- The non-contracting provider has completed the health plan or payor's Provider Dispute Resolution (PDR) process within the last 365 days.
- The non-contracting provider is not a dentist.
- The payor is not a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services.

For more information or to submit a dispute under the IDRP process, please go the California Department of Managed Health Care's website at:
https://www.dmhc.ca.gov/fileacomplaint/providercomplaintagainstaplan/nonemergencyservicesindependent disputeresolutionprocess.aspx

CONTRACTED MEDICARE PROVIDERS:
Claims are paid at your contracted rate, refer to your contract reimbursement section.

NON-CONTRACTED MEDICARE PROVIDERS:
Medicare FFS Claims: 2% Payment Adjustment Suspended (Sequestration)
The Coronavirus Aid, Relief, and Economic Security (CARES) Act suspended the payment adjustment percentage of 2% applied to all Medicare Fee-For-Service (FFS) claims from May 1 through December 31, 2020. The Consolidated Appropriations Act, 2021, signed into law on December 27, extends the suspension period to March 31, 2021. As of 12/15/2021, the House and Senate passed legislation extending the Medicare Sequestration moratorium through March 30, 2022.

The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare Fee-for-Service (FFS) claims:
1% payment withhold adjustment April 1 - June 30, 2022.
2% payment withhold adjustment July 1, 2022 to current.

You may not Bill the Member; Member is only responsible for Copayments/Coinsurance amounts. As an MAO provider, some of the plan's services may also be covered by Medi-Cal in the State of California for dual eligible members. Contact the State of California for member eligibility and how to bill secondary payer at: 1-800-952-5252 or call TTY at 1-800-735-2929.

Payment Dispute Process for Non-Contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted health care professionals may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider contends the amount paid by the Plan for a Medicare covered service is less than the amount that would have been paid under Original Medicare. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

A statement indicating factual or legal basis for the dispute
A copy of the original claim
A copy of the remittance notice showing the claim payment
Any additional information, clinical records or documentation to support the dispute

Mail the payment dispute to: FAMILY CARE SPECIALISTS
PO box 72670
Oakland, CA 94612

If you have additional questions relating to a dispute decision made, you may contact us at:
Phone: 855-513-4007
Mail: FAMILY CARE SPECIALISTS
PO Box 72670
Oakland, CA 94612

If not satisfied with the initial provider dispute resolution, you may submit a second level review request, within 180 days directly to the health plan.

Appeals Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination, in whole or in part including issues related to bundling, level of care, or down coding of services/DRG. Non-Contracted providers must include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal. To appeal a claim denial, submit a written request within 65 calendar days of the remittance notification date and include at a minimum:

A statement indicating factual or legal basis for appeal
A signed Waiver of Liability form. You may obtain a copy by going to:
https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip
A copy of the original claim
A copy of the remittance notice showing the claim denial
Any additional information, clinical records or documentation

Please submit all Medicare appeals and 2nd level PDRs to the addresses below for the corresponding health plans, we are not delegated to process Medicare Appeals on behalf of the health plan.

Health Plan Addresses for 2nd level PDRs:

Aetna Medicare Part C Grievance and Appeal Unit PO Box 14067 Lexington, KY 40512 Fax: 1-866-604-7092	Alignment Health Plan P.O. Box 14012 Orange, CA 92863	Blue Shield of California Initial Appeal Resolution Office P.O. Box 272620 Chico, CA 95927-2620	Blue Shield Promise Provider Dispute Resolution Department P.O. Box 3829 Montebello, CA 90640
Brand New Day PO BOX 93122 Long Beach, CA 90809-3122	Central Health Appeals & Grievances 1540 Bridgegate Drive Diamond Bar, CA 91765	Health Net of California, Inc. Medicare Claims PO Box 9030 Farmington, MO 63640-9030	Wellcare. Attn: Appeals Department P.O. Box 31368 Tampa, FL 33631-3368
LA Care Health Plan Appeals & Grievance Unit P.O. Box 811610 Los Angeles, CA 90081	United Healthcare Mail Stop CA 120-0360 P.O. Box 6106 Cypress, CA 90630		

Health Plan Addresses for Non-Contracted Appeal/Reconsideration:

Aetna Medicare Part C Grievance and Appeal Unit PO Box 14067 Lexington, KY 40512 Fax: 1-866-604-7092	Alignment Health Plan Attn: Appeals Dept P.O. Box 14012 Orange, CA 92863	Blue Shield of California P.O. Box 272620 Chico, CA 95927-2620	Blue Shield Promise Provider Dispute Resolution Department P.O. Box 3829 Montebello, CA 90640
Brand New Day PO BOX 93122 Long Beach, CA 90809-3122	Central Health Appeals & Grievances 1540 Bridgegate Drive Diamond Bar, CA 91765	Wellcare by Health Net Provider Appeal PO Box 3060 Farmington, MO 63640-3822	Wellcare. Attn: Appeals Department P.O. Box 31368 Tampa, FL 33631-3368
LA Care Health Plan Appeals & Grievance Unit P.O. Box 811610 Los Angeles, CA 90081	United Healthcare Mail Stop CA 120-0360 P.O. Box 6106 Cypress, CA 90630		

For United Healthcare Medicare Advantage members only:

Appeals Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or downcoding of services. To appeal a claim denial, submit a written request within 65 calendar days of the remittance notification date and include at a minimum:

_ A statement indicating factual or legal basis for appeal
_ A signed Waiver of Liability form (you may obtain a copy by going to https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip)
_ A copy of the original claim
_ A copy of the remittance notice showing the claim denial
_ Any additional information, clinical records or documentation

Mail the appeal request to: UnitedHealthcare P.O. Box 6106, Cypress, CA 90630 MS: CA120-0360.

Your claim appeal will be processed according to your participating contract status with the UnitedHealthcare. Please refer to your appeal determination notice for information on additional rights you may have at the conclusion of your appeal review.

Payment Dispute Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted health care professionals may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider contends the amount paid by the Plan for a Medicare covered service is less than the amount that would have been paid under Original Medicare. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

_ A statement indicating factual or legal basis for the dispute
_ A copy of the original claim
_ A copy of the remittance notice showing the claim payment
_ Any additional information, clinical records or documentation to support the dispute

Mail the payment dispute to FAMILY CARE SPECIALISTS
PO box 72670
Oakland, CA 94612

If you have additional questions relating to a dispute decision made, you may contact us at:
Phone: 855-513-4007
Mail: PO Box 72670, Oakland, CA 94612
Email: customerservice@altais.com

Billing Alerts

Section 1905(n) of the Social Security Act prohibits a provider from billing an individual with coverage as a Qualified Medicare Beneficiary (QMB), with or without other Medicaid coverage, or someone receiving Supplemental Security Income benefits and Medicare for the Medicare deductible or coinsurance.