



Provider Manual 2026

This document and the information contained herein is confidential and proprietary to Brown & Toland Physicians and Altai's. Information in this manual is subject to change from time to time and will be updated annually. If you have questions, please reach out to your Physician Services Advisor or Contract Manager.

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Brown & Toland Physicians: Who We Are

Brown & Toland Physicians is a network of more than 4,500 primary care and specialty physicians delivering high-quality, compassionate care to hundreds of thousands of patients across the San Francisco Bay Area. For more than 30 years, we've helped independent physicians thrive—preserving clinical autonomy while advancing coordinated, patient-centered care.

Now part of Altais, we are aligned with a broader mission to transform care delivery—making it high-quality, technology-enabled, and sustainably affordable. Through Altais, our physicians and care teams have access to expanded tools, technology, and services that reduce administrative burden, improve coordination, and restore the joy of practicing medicine. While Brown & Toland continues to operate under its own name and multi-payer model, we are fully integrated into a physician-led organization that shares our values and strengthens our ability to meet the moment—whether by responding to industry change, improving outcomes, or deepening our community roots.

Together, we are shaping the future of healthcare—grounded in compassion, built for agility, and powered by a shared commitment to supporting physicians and improving lives.

Our Mission

To ignite an exceptional healthcare system that cultivates the health and well-being of physicians, patients, and the clinical community.

Our Vision

We envision a future where every person receives exceptional care—led by supported physicians, connected by innovative technology, and rooted in trust, compassion, and community.

Our Values

Compassion – We act with empathy and a deep respect for the challenges faced by physicians and their patients. Our work is driven by a genuine commitment to improving lives.

Community – We build trusted relationships with physicians, patients, and partners to create a unified, collaborative ecosystem focused on advancing care.

Leadership – We lead with integrity and vision, empowering others to drive change and shape

the future of care.

Excellence – We are accountable, results-driven, and dedicated to delivering measurable value across every aspect of care.

Agility – We embrace change, respond with purpose, and act quickly to meet the evolving needs of physicians and patients.

About Altais

Brown & Toland Physicians is proud to be part of Altais, a physician-led care delivery organization dedicated to simplifying healthcare and supporting high-performing clinical teams. Altais empowers doctors with the technology, services, and insights they need to deliver affordable, high-quality care—while reducing administrative complexity and restoring joy in the practice of medicine.

By combining local independence with system-wide innovation, Altais helps us move faster, collaborate more effectively, and stay focused on what matters most: caring for patients and strengthening our communities.

Purpose

This Provider Manual is designed to supply contracted network providers and office staff with BTP's policies and procedures so they can effectively care for mutual members in accordance with BTP and industry standards. Contact information for key Brown & Toland and Altais staff is included in each section. You may reproduce any forms included in this manual as needed.

This Provider Manual is available on the Altais website at www.altais.com. Updates to this Provider Manual will occur periodically.

Contact Information

Brown & Toland Physicians, Altais Corporate Headquarters
601 12th Street, 16th Floor Oakland, CA 94607

Customer Service

Phone: 1.800.225.5637

Customer Service Inquiry Form: <https://altais.com/contact-us/>

Hours: Monday–Thursday 8:00am–5:00pm and Friday 9:00am 5:00pm

Physician Services

Physician Services

Email: physicianrelations@altais.com

Credentialing

Email: Credentialingdept@altais.com

Network Development

New Provider Inquiry Form: <https://altais.com/for-providers/altais-networks/>

IT Service Desk

Phone: 877.786.1552

Email: support@altais.com

Insta Med EFT

Email: connect@instamed.com

Sagility CRM Access

Email: DL_RCMAPPSITSUPPORT@sagility.com

Health Plan Partners

Brown & Toland Physicians proudly accepts members from the following health plan partners:

Commercial Plans (individual or family plans):

Plan	Phone Number	Website
Aetna	800.756.7039	aetna.com
Anthem	800.677.6669	Anthem.com/ca
Blue Shield	888.568.3560	Blueshieldca.com
Cigna	800.244.6224	Cigna.com
Health Net	800.638.3889	Healthnet.com
UnitedHealthcare	800.624.8822	Uhc.com

Covered California

Plan	Phone Number	Website
Blue Shield	510.607.2000	https://www.blueshieldca.com/shop/covered-california

Medicare Plans (Medicare Advantage):

Plan	Phone Number	Website
Aetna	855.335.1407	Aetnamedicare.com
Alignment Health Plan	888.979.2247	Alignmenthealthplan.com
Anthem	855.363.9328	Anthem.com/ca/medicare
Blue Shield	800.633.4227	Blueshieldca.com/medicare
Wellcare/Health Net	800.977.6738	Healthnetadvantage.com
SCAN Health Plan	800.559.3500	Scanhealthplan.com
UnitedHealthcare	877.596.3258	Uhc.com/medicare

Medi-Cal Plans:

Plan	Phone Number	Website
San Francisco Health Plan	415.547.7800	Sfhp.org

PPO Plans:

Plan	Phone Number	Website
Aetna	888.632.3862	Aetna.com
America's Choice Provider Network	855.300.8664	Acpnusa.com
Blue Shield	888.568.3560	Blueshieldca.com
Cigna	800.882.4462	Cigna.com
Coventry	800.937.6824	enlyte.com
First Health	800.937.6824	Directprovider.com
HealthNet	800.641.7761	Healthnet.com
Health Smart (Interplan)	800.687.0500	healthsmart.com
Humana MA	855.538.1983	Humana.com
MultiPlan	800.950.7040	Multiplan.com
Provider Network of America	800.472.2636	Pnoa-ppo.com
Sutter Select	866.868.2703	sutterselect.tpa.com
Three Rivers Provider Network	800.966.8776	Trpnppo.com
UnitedHealthcare	877.842.3210	Uhc.com
USA MCO	800.872.3860 x4889	Usamco.com
Zelis/NPPN	888.311.3505	Zelis.com

ACO

Plan	Phone Number	Website
Aetna	888.632.3862	Aetna.com
Anthem	866.791.5538	Anthem.com
Blue Shield	800.393.6130	Blueshieldca.com
Cigna	800.882.4462	Cigna.com
UnitedHealthcare	877.842.3210	Uhc.com

For the most recent listing of participating plan products, please contact your PSA.

Lines of Business

Commercial HMO

A "Commercial HMO" refers to a Health Maintenance Organization (HMO) health insurance plan offered by a private insurance company (ie Aetna, Cigna, Blue Shield, etc), where enrollees must use doctors within their designated network to receive covered services and typically need a referral authorization from their assigned primary care physician to see specialists. Enrollees may be subject to co-payments, co-insurance, deductibles, cost-share, etc. for certain covered services.

Covered California

Covered California is a free service that helps California residents buy health insurance. The health insurance plans may offer Bronze, Silver, Gold and Platinum plans (i.e. Anthem, Blue Shield) which offer different levels of coverage. Eligible Covered California members are managed similar to Commercial HMO. Enrollees may be subject to co-payments, co-insurance, deductibles, cost-share, etc for certain covered services.

Medicare Advantage Plans

Medicare Advantage plans are offered by various health insurance plans (ie Aetna, Anthem, Blue Shield, etc). They provide Medicare covered services to eligible enrollees over 65 years or sometimes under 65 years old with qualifying disabilities. The plan covers Part A (hospital services) and Part B (medical insurance). Enrollees must use doctors within their designated network to receive covered services and typically need a referral authorization from their assigned primary care physician to see specialists. Enrollees may be subject to co-payments, co-insurance, deductibles, cost-share, etc for certain covered services.

Preferred Provider Organization ("PPO") (Commercial/Medicare)

PPO plans allow enrollees to choose from an extensive list of physicians. Enrollees are not assigned to primary care physicians. Typically, enrollees do not require a referral from a primary care physician to see a specialist. PPO enrollees have access to in-network and out-of-network physicians. Enrollees may be subject to co-payments, co-insurance, deductibles, cost-share, etc for certain covered services.

Medi-Cal Plans

Medi-Cal is California's version of the Medicaid program. Certain health insurance plans (i.e. SFHP, etc.) offer HMO Medi-Cal covered services to eligible enrollees at no cost or low-cost. Enrollees must use physicians within their designated network to receive covered services and typically need a referral authorization from their assigned primary care physician to see

specialists. Typically, Medi-Cal enrollees do not have premiums, co-payments, or out of pocket costs.

Altais Website

Altais/Brown & Toland's website www.altais.com provides contracted providers and members with access to timely information. Existing and potential members can explore the physician directories, urgent care locations, hospitals, and current news. Existing and potential members can access our physician search mechanism that allows members to review our updated list of affiliated physicians. The physician search mechanism was designed to assist members in identifying a doctor that best meets their current needs within their preferred service area by specialty, name and location.

Brown & Toland Service Area

Brown & Toland Physicians operates in the following counties:

	Commercial HMO	Medicare Advantage	Medi-Cal	PPO
Alameda	☒	☒		☒
Contra Costa	☒	☒		☒
Marin	☒	☒		☒
Monterey				☒
Napa	☒			☒
San Francisco	☒	☒	☒	☒
Sacramento	☒			☒
San Mateo	☒	☒		☒
San Joaquin	☒			☒
Santa Clara	☒	☒		☒
Santa Cruz	☒			☒
Solano	☒			☒
Sonoma	☒			☒
Stanislaus				☒



Physician Services

The Physician Services Department is committed to building a relationship with the physicians and their office staff. Physician Services provides support from the time a physician expresses interest in joining Altais Care Network, throughout the credentialing process, and once a physician becomes fully active in the Altais Care Network. Each physician has a designated Physician Services Advisor (PSA) to provide a solid working relationship with you and your office staff. Your PSA has a direct phone number and email address along with a personal voice mail, so they are reachable with an expected response time within one (1) business day.

Interactions with Physician Services include, but are not limited to:

- Credentialing/Re-credentialing Process
- Contract Questions
- Physician Office Orientations
- Office Site Reviews
- Educational Site Visits – organizational initiatives and network news
- Change of Information (Practice demographics, Billing Changes, Tax Identification, Leave of Absence, Notification of Termination)
- Training and assistance with Altais Clinical Results Reporting (CRR), Secure Provider Website, and our suite of Physician Practice Solutions (PPS) applications
- Business growth and development
- Prior Authorization – education regarding referral services and processes
- Claims Escalations
- Payments – capitation, bonuses, compensation questions, payment verification

Office Site Review

Prior to contracting with Brown & Toland, primary care physicians and OB/GYNs may be required to have an Office Site Review performed. An Office Site Review is also required for a Brown & Toland physician opening a new office or when a Brown & Toland physician is joining an existing Brown & Toland office that has not had an Office Site Review within the past three years. The purpose of the Office Site Review is to assure compliance with regulatory body requirements, including but not limited to safety, emergencies, laboratory services, accessibility, infection control, and storage of medication and narcotics. The site visit also provides a mechanism for physician education and continuous improvements with patient care and service.

Brown & Toland enforces a passing score of 100% prior to becoming a contracted provider. Providers are notified of their score within seven (7) days of the review. If a provider scores

less than 100%, a Corrective Action Plan (CAP) will be requested of the physician until a score of 100 percent is achieved.

New Physician Orientation Process

As a newly contracted provider, your assigned PSA will contact you to schedule a New Physician Orientation. During the meeting, your PSA will review the following:

- Confirm your contract details
- ABI455 Provider Notice
- Member Rights and Responsibilities Statement
- Provider Dispute Resolution Information
- Code of Conduct and required trainings and attestations
- Change of Information Form
- References and forms pertinent to your practice/specialty (Clinical guidelines, Ancillary provider listings, Prior Authorization Lists, etc.)
- Set up access for Cozeva (PCP and Pediatrics only)
- EpicLink Access
- Sagility CRM Access (PPO claims)
- Instamed Access/Set-up

After the New Physician Orientation, providers and their designated PSA will have regular ongoing visits to discuss business development and communicate Brown & Toland Physicians initiatives and updates.

Electronic Tools Training

See the Electronic Tools section of this manual for details and access to the electronic tools provided by Altais.

- EpicLink
- Sagility CRM
- Instamed
- COZEVA (Primary Care Providers only)

Business Growth and Development

Your Brown & Toland Physician Services Advisor can provide assistance with sustainability, retention, growth and succession planning of your practice. At the regularly scheduled meetings with your PSA, you may discuss marketing opportunities, health technology, industry updates, and other resources that may be available to your practice.

Physician Relations Inquiries

Payment – Providers may have questions about capitation payments and reports, bonuses, compensation or payment verification. Inquiries should be directed to Physician Services. All capitation reports are posted on EpicLink and PPO claim rejection reports are posted on Sagility CRM.

Claims – EpicLink and Sagility allow provider offices 24-hour access to check claims status online. For additional claims information contact Brown & Toland's Customer Service Department. For inquiries on possible trends in claims processing, contact your PSA. Please provide specific claim examples as well as a documented CRM number to expedite the inquiry.

Prior Authorization – EpicLink allows provider offices 24-hour access to submit authorization requests and view authorization status. For additional training or education on EpicLink, Contact Brown & Toland EpicLink support at 877-786-1552 or support@altais.com.

Covering Providers

Each contracted Brown & Toland provider is required to designate a covering physician(s) for the practice. Providers must designate coverage in the initial credentialing application. The covering physician(s) must be of the same specialty. Brown & Toland acknowledges that coverage information may change frequently. A "**Provider Change of Information**" form must be submitted to the Credentialing Department when a designated covering physician changes.

Contracted providers must ensure that the covering provider: (1) looks solely to Provider for compensation for services covered under capitation; (2) accepts IPA's fee-for-service rate for authorized services; (3) will not directly bill Enrollees for Covered Services under any circumstances; (4) will accept and comply with the IPA's peer review procedures and all quality programs and policies; (5) will comply with the IPA's policies and procedures (6) will comply with the IPA's utilization management program and policies; and (7) will comply with any applicable regulatory requirements.

Change of Demographic Information

Physicians are responsible for notifying Physician Services of changes to the practice at least thirty (30) days in advance. These include changes in office or billing addresses, phone/fax numbers, taxpayer identification numbers (TINs), and other vital demographic information. Current information helps to ensure that claims are paid efficiently and accurately, and that

authorization reports reach physicians in a timely manner. A "Provider Change of Information Form" is available on www.altais.com. The W-9 Request for Taxpayer Identification Number and Certification Form is also included for TIN and billing address changes. Brown & Toland reserves the right to accept or deny the request to change physician information.

Physicians are also responsible to notify Physician Services of any staff changes in their practice. Physician Services will alert Brown & Toland's IT Department to de-activate any access to EpicLink. Physician Services will also submit requests for username and password requests for any new staff to the practice.

Provider Resignation or Termination

Providers may terminate their agreements with Brown & Toland via written notice in accordance with their contract. The notice must be in writing and sent to the Contracting Department 90 days in advance at NetworkContracting@altais.com with a copy to physicianrelations@altais.com

The following information must be included in the termination notice:

- Name of terminating Provider
- Date of termination
- And, if a PCP, include the name of the recommended replacement PCP (must be an active, credentialed, Brown & Toland PCP with an open panel).

If a provider wants to update their roster by removing physicians or allied health professionals that are no longer part of the practice, the provider must fill out a Change of Information form and send it to their PSA. The Change of Information Form can be found at www.altais.com

This will initiate a contract amendment which will be sent to the provider's contract signor via DocuSign for signature.

Notification to Health Plans – Brown & Toland is responsible for notifying all Brown & Toland contracted health plans regarding a physician's termination and maintains continuity of care to patients in accordance with federal and state regulations. The terminating PCP or Specialist cannot solicit his/her members to disenroll from Brown & Toland for any reason.

Patient Notification PCP – If the physician is a PCP, patients must receive thirty days' notice of their PCP termination under California law. All Brown & Toland contracted health plans are responsible for notifying the terminating physician's patients. Under no circumstances can Brown & Toland guarantee the transfer of any patients to the recommended replacement PCP.

Specialist – If the physician is a Specialist, Brown & Toland will notify his/her patients and will oversee their continuity of care in accordance with California Health & Safety Code Section 1373.96. The terminating Specialist must continue to offer covered and pre-authorized services to patients until such services are completed consistent with medical, ethical, and legal requirements for continuity of patient care. No authorization requests from the terminating physician will be approved for any dates of service after the effective termination date, unless the request is for continuity of care purposes.

Provider Contracts

Brown & Toland holds the following types of contracts with providers:

- Primary Care
- Specialist
- Ancillary
- Hospital

Brown & Toland Physicians (“BTP”) is the contracting entity for professional and some ancillary services. Brown & Toland Health Services, Inc. (“BTHS”) has a limited California Knox-Keene license and is the contracting entity for institutional providers.

Demographic information is included as part of the contract. It is important that Brown & Toland is notified of any demographic information updated prior to the change so internal systems can be updated timely. Demographic changes initiate contract amendments which are sent to the contract signor via DocuSign. Once amendments are signed Brown & Toland internal systems are updated and the updated information is reported to contracted health plans. This information is reflected on websites and internal and external rosters.

It is important for every Brown & Toland contracted provider to review and understand the terms of their contracts. If you have any questions regarding your Primary Care or Specialist agreement, please contact your PSA. If you have any questions regarding your Ancillary or Hospital agreement, please contact your Contract Manager.

Electronic Tools

Brown & Toland provides at no charge electronic tools to improve administrative efficiencies in the ancillary and physician offices.

EpicLink

EpicLink is a web-based software tool developed by Epic to meet the specific needs of medical groups and Brown & Toland physicians. It is required to be used by all Brown & Toland provider offices for:

- Claims – HMO
- Prior Authorizations – HMO
- Referrals – HMO
- Eligibility – HMO

EpicLink enables Brown & Toland physicians to:

- Review member's health plan benefits, including co-payments
- Confirm eligibility for health plan members
- Determine claim status (paid, pending or denied)
- Submit authorization requests
- Request specialist referrals
- Check status of submitted authorizations and referrals

Prior to your new physician orientation, your PSA will provide information on getting set up with EpicLink. To get started:

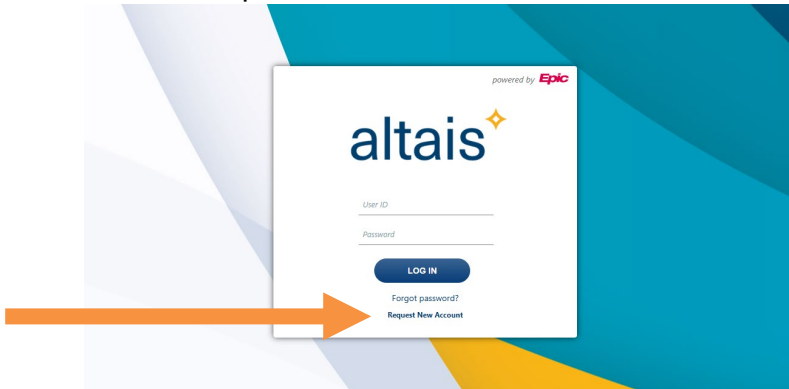
1. Visit epiclink.browndandtoland.com, click "Request New Account".
2. Fill out requested information and press submit.
 - a. Please note: access can take up to 10 business days from request.
3. Your EpicLink username and password will be emailed to you.
 - a. If you have not received this email after 10 business days. please check your junk/spam inbox.
 - b. If you have not received your email, please contact the helpdesk.
4. Once you receive your login information, you will have to go through a 2-factor authentication process to support enhanced security before logging in.

Claims training modules are available on EpicLink, and we highly recommend reviewing these once you receive your EpicLink access. Please contact the PPO health plan directly for PPO member eligibility and benefits.

EpicLink account Request

Required Steps

1. Launch EpicLink using the following URL <https://epiclink.browndtoland.com/>
2. Click Request New Account



3. Select type of accounts(s) being requested.



4. Complete access request form being sure to complete all required fields (marked with red stop sign icons), select Terms & Conditions, and verify request.
5. Click Submit Request. (Please note: access can take up to 10 business days from request)

A screenshot of the EpicLink account request form. The form is titled 'Provider name: Dr. Andrew Test' with an 'Add' button. Below this is a section for 'CREDENTIALS' with a 'TIN#' field (123456789) and a 'Comment' field. There is an 'Other' section with a 'Comments' field. The 'Terms and Conditions' section is expanded, showing the 'TERMS AND CONDITIONS (EpicLink) Privacy, Confidentiality, and Information Security' and a checkbox for 'I agree to the Terms and Conditions above.' which is checked. The 'Verification' section has a green checkmark and the text 'I'm not a robot' next to a reCAPTCHA icon. The 'Requested by:' field contains 'Maria Test'. At the bottom, there is a 'Site Administrator' section with a checkbox for 'Make this user a site administrator'. The 'Submit Request' button is highlighted with a red box.

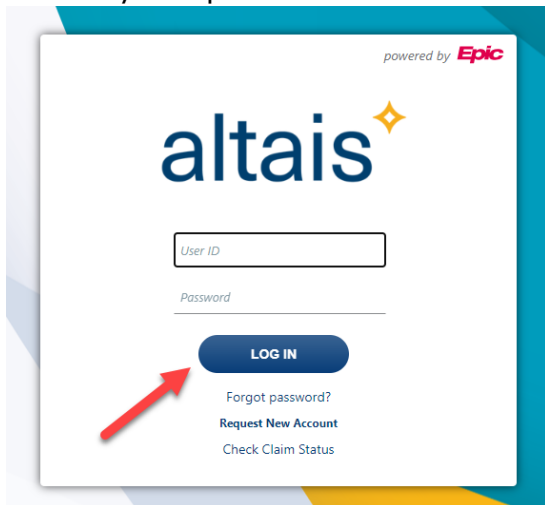
6. Your EpicLink username and password will be emailed to you.
 - a. If you have not received this email after 10 business days. please check your junk/spam inbox.
 - b. If you have not received your email, please contact the helpdesk.

Logging into EpicLink for the first time using Two- Factor Authentication

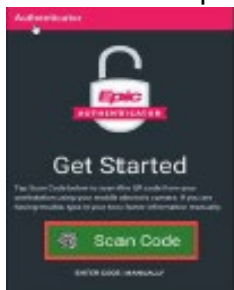
Instructions for logging into EpicLink using the Epic Authenticator for Two-Factor Authentication.

Required Steps

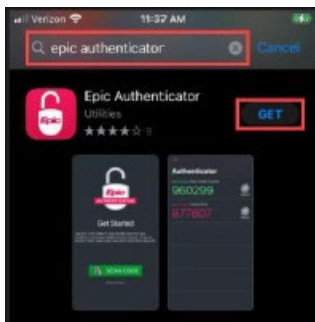
1. Launch EpicLink using the following URL <https://epiclink.browndtoland.com/>
2. Enter your EpicLink User ID and Password and click Log In.



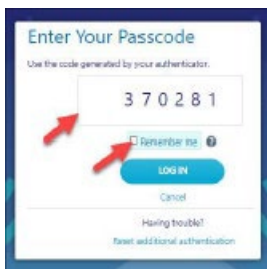
3. You will be prompted to Scan Code. You will need to complete this using your Mobile Device.



4. On your SmartPhone/mobile Device (Apple or Android) Open the App Store or Play Store and search for Epic Authenticator. Click Get or Download.



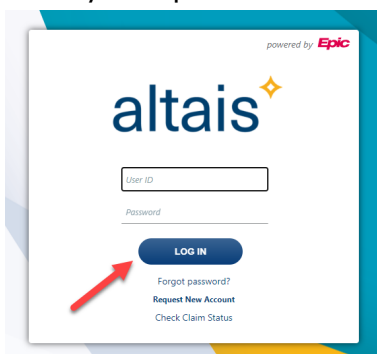
5. Once downloaded, open the Epic Authenticator application on your smartphone/Mobile device and Scan the QR Code on your computer.
6. The Epic Authenticator application on your smartphone/mobile device displays a 6-digit code that you must enter on the EpicLink login page.
7. Enter the 6-digit code and checkmark the remember me box
 - a. This will remember your login for 24 hours. After 24 hours you will be prompted to enter a new code



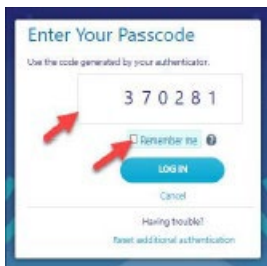
Subsequent Logins

Launch EpicLink using the following URL: <https://epiclink.browndtoland.com>

Enter your EpicLink **User ID** and **Password** and click **LOG IN**.



Enter the 6-digit code sent to your Mobile App or Email and checkmark the **Remember me** box. Click **Log In**.



This will remember your login for 24 hours. After 24 hours you will be prompted to enter a new code. For any additional questions, training or log in issues related to EpicLink contact the ServiceDesk at support@altais.com.

Sagility CRM

Sagility is a third-party administrator with deep experience in claims operations and is Brown & Toland's solution for PPO claims. Sagility manages PPO claims processing, denials, appeals, and other support functions. Claims status and rejection reports are available in Sagility.

Creating Sagility User Account

In order to access Sagility for the first time, you need to create a user account. After your initial user account is created, you can provision additional accounts directly through the Sagility portal.

New User Access:

Email the following information to: dl_rcmappsitsupport@sagility.com

- First Name
- Last Name
- Email Address
- Phone Number
- TIN
- TIN Owner
- Region: (will be Northern California)

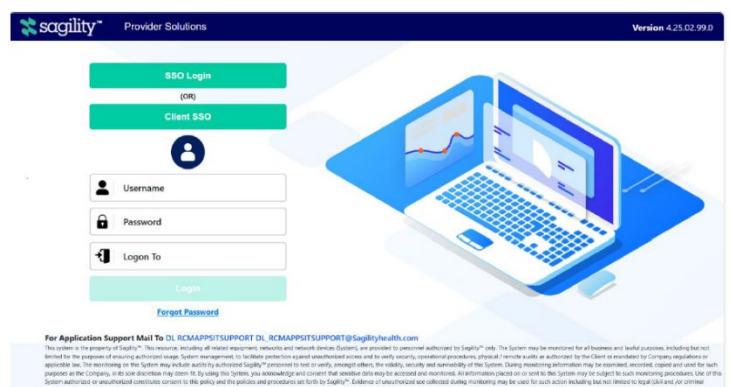
Accessing Sagility:

1: Visit the Sagility CMS portal by clicking here: <https://rcm.sagility.com/v4/>

2. Enter your username and password

3. Input the logon To code as "ALT"

4. Contact your PSA if you do not have a username or password for Sagility



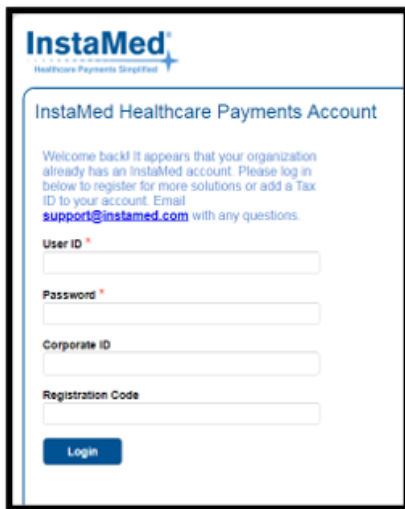
Instamed

InstaMed is a leading health insurance payment service provided free to all Altais physicians and providers.

Providers are required sign up with InstaMed for electronic remittance advice (ERA) and electronic funds transfer (EFT) in order to receive payment for claims.

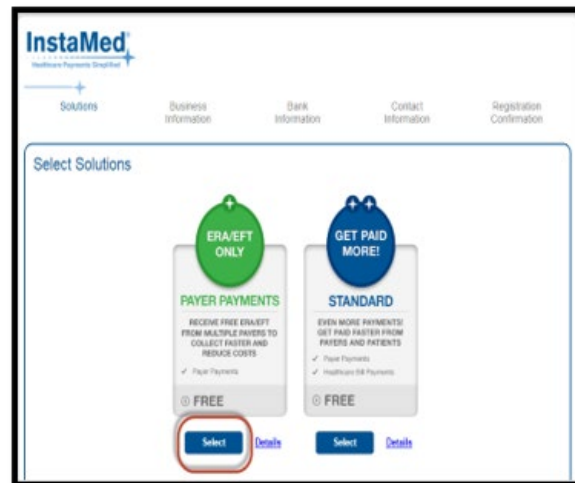
InstaMed Process to Request EFT and ERA

The enrollment process for InstaMed is available online through the payer's website: <https://register.instamed.com/eraeft>



The image shows the InstaMed Healthcare Payments Account login page. It features the InstaMed logo at the top left. Below the logo, the text reads: "Welcome back! It appears that your organization already has an InstaMed account. Please log in below to register for more solutions or add a Tax ID to your account. Email support@instamed.com with any questions." There are four input fields: "User ID", "Password", "Corporate ID", and "Registration Code". Each field has a red asterisk indicating a required field. Below the input fields is a blue "Login" button.

NOTE: If you try to register with your Practice TIN and you already have an account with Instamed you will receive this message.



The image shows the InstaMed "Select Solutions" screen. At the top, there is a navigation bar with links: "Solutions", "Business Information", "Bank Information", "Contact Information", and "Registration Confirmation". Below the navigation bar, the "Select Solutions" section contains two main options: "ERA/EFT ONLY PAYER PAYMENTS" and "GET PAID MORE! STANDARD". The "ERA/EFT ONLY PAYER PAYMENTS" option is highlighted with a green circle and includes the text: "RECEIVE FREE ERA/EFT FROM MULTIPLE PAYERS TO COLLECT FASTER AND REDUCE COSTS". It also lists "Paper Payments" and "Healthcare DR Payments" with checkmarks. Below this option is a "FREE" label and a "Select" button, which is circled in red. The "GET PAID MORE! STANDARD" option includes the text: "EVEN MORE PAYMENTS! GET PAID FASTER FROM PAYERS AND PATIENTS". It also lists "Paper Payments" and "Healthcare DR Payments" with checkmarks. Below this option is a "FREE" label and a "Select" button.

NOTE: If your organization is not yet enrolled you will move to this screen (i.e., Select Solutions screen). Click "Select" below the ERA/EFT ONLY PAYER PAYMENTS option.

InstaMed
Healthcare Payments Simplified

Solutions Business Information Bank Information Contact Information Registration Confirmation

Enter Business Information

Legal Business Name * [Need Assistance?](#)
info@instamed.com
(215) 789-3552

Doing Business As (DBA) *

Business Address Line 1 * Business Address Line 2 *

City * State * Zip *

SELECT ONE

☐ Use Business Address for Mailing Address

Phone * Business Website

(202) 555-0000

Principal or Officer Information

As it relates to business, a principal can range from a company's representative dealing with a contractor to the company's leader.

First Name * Last Name *

Practice Information

Practice Management System *

Remittance Delivery

Provider Panel *

Enter the billing provider NPI(s) for your organization below. You do not need to include service provider NPI(s) unless your organization uses them for billing.

Billing Provider NPI * Billing Provider Name *

[Add Provider](#)

Back Next

NOTE: After you click "Select", enter all the required data in the Enter Business Information screen. Once the information is added and NEXT is selected, the next information needed is bank account for EFT setup.

NOTE: Once the bank account information screen is completed, the final information needed is the Practice Contact information.

InstaMed
Healthcare Payments Simplified

Solutions Business Information Bank Information Contact Information Registration Confirmation

Enter Bank Account Information

Enter the checking account where funds will be deposited. [Need Assistance?](#)
info@instamed.com
(215) 789-3552

Bank Name *

John Adams
123 Main Street
New York, NY 12345-6789
123

Check From Your Current Account \$123.45

Checking Account Number: 1234567899

C123456789C 1234567899 0123

Routing Number Account Number

Routing Number *

Account Number *

Confirm Account Number *

Back Next

NOTE: Once the Practice Contact information screen is completed, you will go to the registration confirmation screen.

NOTE: This completes the online registration process to request for ERA through InstaMed.

For ChangeHealth users (PPS/Allscripts Practices):

The last step is to fax the ChangeHealth enrollment form to ChangeHealth. This is to confirm you have completed the InstaMed online enrollment process.

Cozeva:

During your new physician orientation, your PSA will provide you with information and training on using COZEVA. COZEVA is used to manage HMO patient care, track performance, and stay on top of important health metrics.

Credentialing

Contact Information

For additional information not found below regarding the credentialing process, or a copy of any credentialing policies and procedures, please contact the Credentialing Department at CredentialingDept@altais.com.

Provider Credentialing Process

The Credentialing Program ensures that applicants meet the standards of professional licensure and certification. The process enables Altais to recruit and retain a quality network of providers to serve its members and ensure ongoing access of care. Through the Credentialing Program, Altais objectively assesses the education, training, licensure, competency and qualifications of providers seeking to contract with Brown & Toland Physicians for the first time; to monitor their continued competence through tri-annual re-evaluations; and to meet HMO and PPO delegated responsibilities to health plans. Brown & Toland Physicians considers many factors, including the physician's clinical practice, complaints, pending or settled lawsuits, Altais' network need, and the initial office site review results, prior to recommending a physician for membership. Brown & Toland Physicians does not discriminate against any provider based on race, ethnicity, national identity/origin, gender, age, sexual orientation, religious convictions, marital status, or medical treatment of high-risk populations.

Physicians are required to successfully complete the Brown & Toland Physicians credentialing and contracting process prior to treating patients. Brown & Toland Physicians ensures that credentialed physicians meet required credentialing standards prior to treating its patients. The credentialing process may take approximately 60-90 days, upon receipt of all required application documents.

Initial Provider Credentialing Information

Request for Consideration – Physicians who are interested in participation with Brown & Toland will need to be accepted for consideration to be credentialed. Physicians will need to fill out the Physician Interest Form on Altais.com: <https://altais.com/for-providers/altais-networks/>.

After the form is submitted, someone from the Network Management team will reach out with next steps in the application process.

If denied, the Credentialing Department will notify the potential applicant in writing of the Department's decision within 30 calendar days.

Initial Provider Application Process

Verification of information begins when the application meets criteria to be considered complete. All applications will be verified for the following:

1. A current and valid, unencumbered California State Medical License
2. Clinical privileges in good standing from the applicant's primary admitting facility (exception: non-physicians need not provide) If a physician does not attest to having admitting privileges, then the physician must complete a Hospital Waiver form. On the Hospital Waiver form the physician is required to identify which provider is delegated for admitting on their behalf or identify that they utilize the hospitalist program to care for their patients when hospitalized.
3. Covering Provider/AKA On-Call Coverage
4. Valid DEA certification
5. Verification of graduation from an accredited graduate school or professional school and completion of a residency, as appropriate.
6. Work History
7. Current, adequate malpractice insurance as determined by BTP (currently \$1/3 mil.)
8. Professional liability claims history
9. Application for membership (attestation and acknowledgement/release statement)
10. Verification of board certification.
11. Site visit evaluation. A prospective physician office on-site visit report is required of new PCPs (participating in managed Medi-Cal), OB/GYNs, and Behavioral Health care providers.
12. Queries. The following queries must be done with recognized monitoring organizations:
 - a. National Practitioner Data Bank (NPDB)
 - b. Medical Board of California
 - c. Verification of other state licenses by the appropriate state medical board, if applicable
 - d. DEA
 - e. Details related to any reports of disciplinary action, restrictions, limitations, etc., as noted on the application
 - f. Office of the Inspector General (OIG)
 - g. System for Award Management (SAM)
 - h. Medicare Opt-Out. BTP will not employ or contract with a provider who has opted out of participating in the Medicare program (with the exception of

- Pediatricians or physicians who do not see Medicare members)
- i. Medi-Cal Provider Suspended and Ineligible List
- j. National Plan & Provider Enumeration System (NPPES) – NPI
- k. NEBO Systems, Inc (UPIN)
- l. Social Security Death Master
- m. CMS Preclusion List

13. Professional references

The verified application is presented to the Chief Medical Officer and/or Committee for approval. If the Chief Medical Officer or Committee approves the application, Altais will send a letter of acknowledgement and a new contract will be sent to non-contracted providers for review and signature. If the group is already contracted and are adding additional practitioners, Provider Contracting will send a letter notifying the group of the new practitioner's contract effective date. If the Chief Medical Officer and/or Committee denies the Application, the Credentialing Department will send a letter of denial to the applicant.

Provider agrees to immediately report or within ten (10) calendar days, any change in status of the information maintained in the Credentialing Department's files.

Re-Credentialing

BTP contracted physicians are required to successfully complete re-credentialing every three (3) years. This ensures that physicians meet the minimum credentials and performance standards for continued membership in Brown & Toland. If the re-credentialing application or process is not completed by the physician within the three-year period, the physician will be deemed as resigned, and have terminated their physician agreement with Brown & Toland Physicians.

The physician will be required to review, update, and approve a pre-populated application form or have attested to a standardized CAQH Application within 180 days. The re-credentialing process may also entail a review of specific quality improvement information, such as an office site review, medical record review, review of medical quality and service issues, patient complaints, and compliance with quality improvement activities.

If issues are identified through the re-credentialing process that bears upon re-credentialing of the physician, the Peer Review Committee Chair or Chief Medical Officer will evaluate the physician's re-credentialing application.

If the re-credentialing application is approved, the Credentialing Department will send a letter of reappointment. If the re-credentialing application is denied, the applicant will be notified of denial in writing within 30 calendar days.

Physician Leave of Absence

A physician may request a leave of absence only after they have been a Brown & Toland contracted physician for at least two (2) consecutive years. A leave of absence may be granted for reasons other than vacation, provided that the physician submits a formal written request to the Credentialing Department at CredentialingDept@altais.com and obtains approval from the Chief Medical Officer. The Chief Medical Officer will use the following criteria in reviewing the leave of absence request:

- The initial leave of absence may be for a period of up to but no longer than six (6) months.
- A physician may not be on leave of absence for a total of more than twelve (12) months during any seven (7) year period.
- A physician may make no more than four (4) leave of absence requests during any seven (7) year period. A physician must return to his/her practice and assigned patients within the specified leave of absence or extension period.

BTP contracted physicians who require and initiate a leave of absence must submit a written request to the Credentialing Department no later than sixty (60) calendar days prior to the desired date unless the leave is the result of a disabling illness or family emergency. The notification must specify the date such leave will begin and end and explain the reasons for the leave of absence. The leave of absence request will be reviewed within thirty (30) calendar days of receipt of the written request. The Credentialing Department will notify the physician in writing of the decision.

Obtaining an Extension of a Leave of Absence

To obtain an extension to the original leave of absence, the physician must submit a written request to the Credentialing Department no later than sixty calendar (60) calendar days prior to the expiration of the original leave of absence.

The written request must explain the reason(s) for the extension and the revised leave of absence end date. At the discretion of the Chief Medical Officer, an extension may be granted for a period of up to an additional six (6) months.

Arranging for Covering Services

Physicians must arrange for the provision of services to their assigned Brown & Toland

patients during the leave of absence through another BTP contracted physician. The BTP Credentialing Department will confirm that the temporary replacement physician is available to provide services. The physician must notify all their patients of the leave of absence, including the physician to whom patients will be reassigned.

Health Plan Notification

BTP's Credentialing Department will notify all contracted health plans of the physician's leave of absence and recommended replacement physician. BTP cannot make any guarantee to the physician that the health plans will reassign previously transferred patients back to their panel upon expiration of the approved Leave of Absence.

Benefit Changes during the Leave of Absence Period

During an approved leave of absence period, any benefits of exclusivity will be suspended for PCPs. Any accrual of time specific to tenure requirements will be suspended during the physician's approved Leave of Absence.

Resumption of Medical Practice

No later than one (1) month prior to expiration of the approved leave of absence, or any approved extension thereof, the physician must provide written confirmation to the Credentialing Department of the resumption of their medical practice and provision of services to BTP patients.

Closing PCP Practice to New Patients

Primary Care Providers may voluntarily close their panel to new patients if they meet BTP's volume requirements, provided they close their panels to all Plans. The minimum volume requirements are as follows:

- **PCPs with Participating Agreements** must have a minimum of 400 BTP patients on their PCP panel before closing it to new patients.
- **PCPs with Preferred Agreements** must have a minimum of 400 BTP patients on their PCP panel before closing it to new patients.
- **PCPs with Subspecialties ("Twofers")** must have a minimum of 300 BTP patients on their PCP panel before closing it to new patients.

PCPs with closed panels whose average patient volume falls below the minimum volume specified above and remains below the requirement for six (6) months or more will be required to re-open their patient panels within thirty (30) calendar days of notification from the BTP Credentialing Department. In such cases, PCPs with prior closed panels must

maintain an “open to new patients” status for at least six (6) months.

Organizational Provider Credentialing

BTP’s Credentialing Program ensures that organizational providers directly contracted with BTP meet standards for participation in BTP. Verification is conducted on all potential organizational providers prior to contracting with BTP. Organizational providers of BTP must meet all state and federal licensing and regulatory requirements. Organizational provider must be approved by a recognized accrediting body; otherwise, an onsite quality assessment must be performed. BTP confirms at least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body. The criteria for selection, evaluation, and retention does not discriminate against health care professionals who serve high risk populations or who specialize in the treatment of costly conditions.

Verification of information begins when the application meets criteria to be considered complete. All applications will be verified for the following:

1. A copy of unrestricted State of California license (Department of Health Care Services) and expiration date
2. If a state license is not issued by the DHCS, the facility should have a business license, certificate of occupancy or a Fictitious Name Permit (FNP).
3. Confirmation that the provider is in good standing with state and federal regulatory bodies
4. Federal Regulatory Bodies:
 - a) Review of OIG, or Medicare/Medicaid sanctions
 - b) CMS Institutional provider and suppliers must be certified by CMS.
5. Confirmation that the provider has been reviewed and approved by an accrediting body. *CMS or state review or certification does not serve as accreditation of an institution.*
6. Confirmation that Medicare facilities have a Medicare certification number.
7. Professional and general liability coverage for new providers and suppliers with the minimum of \$1,000,000 per occurrence and \$3,000,000 in aggregate for non-hospital facilities. Professional and general liability coverage with the minimum of 3,000,000 per occurrence and 10,000,000 in aggregate for hospital facilities.
8. Confirmation of an on-site quality assessment if the provider is not accredited.
9. Site visit for non-accredited facilities to ensure that the organizational provider credentials its providers.

Free standing surgery centers must either be accredited or certified to participate in the Medicare Program.

10. BTP accepts the following site audit tools or letters: Department of Health and Human Services (DHHS), California Department of Public Health (CDPH), Department of Health Care Services (DHCS), Centers for Medicare and Medical Services (CMS) approval letter, Department of Aging.
11. BTP may conduct its own site review or substitute a CMS or state review in lieu of the required site visit.

Organizational providers agree to immediately report or within ten (10) calendar days, any change in status of the information maintained in the Credentialing Department's files.

Organizational Provider Re-Credentialing

BTP reassess organizational providers a minimum of every three (3) years at which time the Credentialing Department determines if the organizational providers continue to meet BTP's standards of participation criteria. If the re-credentialing application or process is not completed by the organization provider within the three-year period, the organizational provider will be deemed as resigned, and have terminated their organizational provider agreement with BTP.

Customer Service

The Customer Service Department answers questions and resolves issues raised by Brown & Toland providers and members. The department's goal is to provide answers and resolve issues in a timely, professional manner. Please contact the Customer Service Department either by email, phone, or EpicLink regarding:

- Claim status and/or adjustment requests
- PPO invoice status and/or adjustment requests
- Authorization status
- Eligibility and benefit clarification
- Quality of care and service issues
- Network information
- Brown & Toland policies and procedures

Contact Customer Service

Customer Service Department Hours of Operation

Monday through Thursday 8:00 AM – 5:00 PM

Friday 9:00 AM – 5:00 PM

E-Mail

Providers and members may contact Brown & Toland via email by clicking Contact Us on our website, altais.com.

HIPAA Reminder: If you are a "Covered Entity" health care provider as defined in the HIPAA regulation, any email or electronic file containing Protected Health Information must be encrypted or electronically secured prior to transmission.

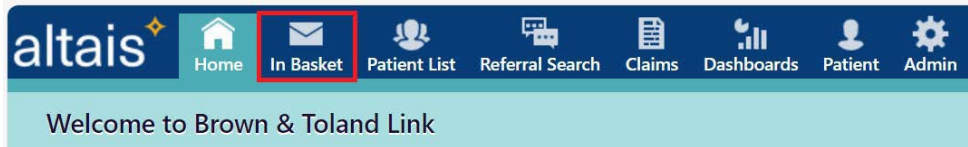
Phone

800.225.5637

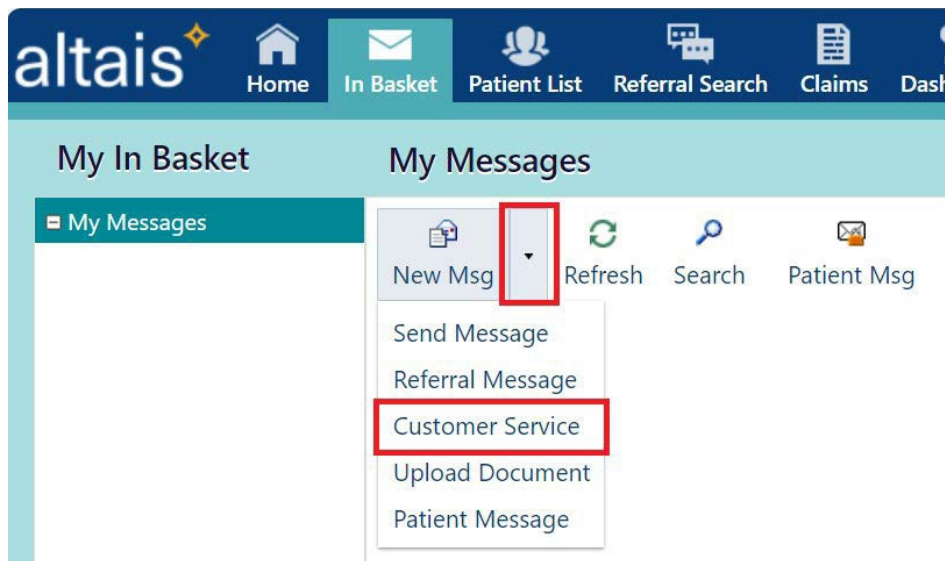
EpicLink

Use the In Basket in EpicLink to send messages to and receive messages from Altais Customer Service. To request an EpicLink account or sign in, please visit epiclink.browndtoland.com.

1. Click **In Basket** on the main toolbar.



2. Click the arrow to the right of New Msg > **Customer Service**



3. Click the **Topic** field to select a specific Customer Service Request message topic.

New Customer Service Request

Topic:

Summary:

- Report a problem
- ROI Request
- Referral
- Claims (EpicLink)
- Plan Benefits
- PPO UHC Claim Appeal (EpicLink)
- PPO Claims
- EVR (Eligibility Verification Request)
- Vendor Record Changes
- Provider Relations EpicLink
- Credentialing EpicLink
- PPO UHC Claim Reconsideration (Epiclink)
- PPO Medical Records Only (EpicLink)

4. The Topic you select determines the messaging form and required fields which display.
- These messages automatically route to the appropriate Altais team for follow- up and eliminate the need to call these teams directly.

Topic	Altais Team
Report a problem	EpicLink Technical support
ROI Request	Release of Information
Referral	Utilization Management
Claims	Customer Service
Plan Benefits, Enrollment and Eligibility, & EVR from EpicLink	Enrollment and Eligibility
Vendor Record Changes & Provider Relations EpicLink	Provider Relations
Credentialing EpicLink	Credentialing

5. Complete fields such as Subtopic and Details as required.

New Customer Service Request

Topic:

Subtopic:

Summary:

Patient

⚠ Patient:

Details

⚠ Details:

Priority

☐ High

☒ Routine

☐ Low

Request

Behavioral Health

Update

MA Post claim review

Pharmacy

6. Dependent upon message type, attach patient records, claims, referrals, or attachments to the message.

New Customer Service Request

Topic:

Subtopic:

Summary:

Priority

☐ High

☒ Routine

☐ Low

Patient

Patient:

Attachments:

ID	Referred By	Referred To	Status	Start	Expires
 189656	TAPESTRY, GENERAL EXTERNAL PROVIDER	CPMC-PACIFIC CAMPUS	PEND	10/21/2020	04/19/2021

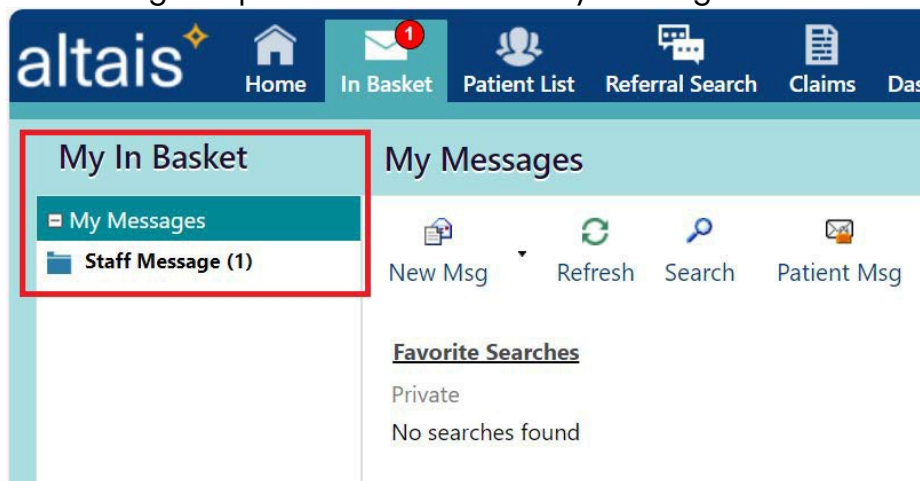
Details

Details:

7. When complete, click **Submit**.

Reply to Messages From Altais Teams

1. Message responses will file to the My Messages section of the In Basket.



2. Click a folder to review messages and select desired message.

3. Message details display in the bottom portion of the activity, including message content from the sender.

The screenshot shows the 'My Messages' interface. At the top, there are tabs for 'My In Basket', 'My Messages', and 'Staff Message'. Below the tabs, there is a toolbar with icons for 'New Msg', 'Refresh', 'Reply', 'Forward', 'Done', 'Open Patient', 'Search', 'Sort', and 'Properties'. A table lists messages with columns for 'Priority', 'Status', 'Msg Date', 'Msg Time', 'Sent By', and 'Subject'. One message is highlighted with a red box: 'Test Training' from 'WOLF, ELIZABETH' on '07/23/2024' at '10:31 AM'. Below the table, there are links for 'Message', 'More Info', 'Patient Info', 'Meds/Problems', 'Vitals/Labs', 'Last Note', and 'Help'. The message details are displayed below, showing the subject 'Test Training' and the content 'Testing for Training', which is highlighted with a red box.

4. Use one of the following options to act on the message:
- a. **Reply** – Reply to sender(s)
 - b. **Done** – Move this message to your Completed Work folder, signals that all tasks associated with this message are complete
 - c. **Help** – Review this report for additional instruction on why this message is in your In Basket and how to act on it

The screenshot shows the 'My Messages' interface. At the top, there are tabs for 'My In Basket', 'My Messages', and 'Staff Message'. Below the tabs, there is a toolbar with icons for 'New Msg', 'Refresh', 'Reply', 'Forward', 'Done', 'Open Patient', 'Search', 'Sort', and 'Properties'. A table lists messages with columns for 'Priority', 'Status', 'Msg Date', 'Msg Time', 'Sent By', and 'Subject'. One message is highlighted with a red box: 'Test Training' from 'WOLF, ELIZABETH' on '07/23/2024' at '10:31 AM'. Below the table, there are links for 'Message', 'More Info', 'Patient Info', 'Meds/Problems', 'Vitals/Labs', 'Last Note', and 'Help'. The 'Help' link is highlighted with a red box and labeled with a red 'C'. The message details are displayed below, showing the subject 'Test Training' and the content 'Testing for Training'.

Eligibility

The Brown & Toland Eligibility Department receives HMO member information from the health plans via monthly eligibility files. The Eligibility Department reviews these files for accuracy using the health plan portals for verification. Eligibility is maintained in our Epic system.

Members can change their primary care physician (PCP) selection from month to month by contacting their health plan, which may also change their Medical Group/IPA affiliation.

The Eligibility Department maintains the following current and historical information on Brown & Toland members:

- Effective date and termination date with the Brown & Toland and their assigned PCP
- Employer group name and number
- Member demographics including date of birth and gender, and in some cases address information.
- PCP assignments

Verifying Member's Eligibility with Brown & Toland

Providers **must** verify eligibility no more than 48 hours prior to providing services and to ensure the most current information and verify eligibility again on the date of service. This applies to follow-up visits as well. Brown & Toland physicians should always verify a member's eligibility prior to treating the member. Even if a member produces a health plan ID card, the ID card in and of itself is not considered proof of eligibility with Brown & Toland or the health plan. ID cards can expire and information on cards can become outdated.

The following is the minimum information needed to verify a patient's eligibility:

- Full name
- Date of birth
- Current health plan insurance or HMO
- Subscriber's health plan/HMO member ID number
- Gender

Methods to Verify

Physician offices should always validate member eligibility directly with the Health Plan. In addition to the health plans, physician offices can check member eligibility and PCP assignment via Epic Hyperspace or EpicLink.

Epic Hyperspace

Physician offices using Altais' instance of Epic as their primary Electronic Health Record (EHR) will use Epic Hyperspace to verify eligibility. Reference your Learning Home Dashboard for additional instruction. To open your Learning Home Dashboard, Press F1 and select your role-specific Learning Home Dashboard in the Open the Learning Home Dashboards section.

If Epic does not list the member as eligible, but the member believes that they are a Brown & Toland member, send a Customer Relationship Management (CRM) via the Guarantor Account or Member Inquiry activities in Epic. Once the Eligibility Department receives the request, Eligibility will be verified by way of health plan portal. The Eligibility Department will then update the Altais system and respond to the request via Epic. An electronic response will appear in the **In Basket** > **CRM** folder after Altais staff has researched and completed the request. For instructions on CRM creation and management, see the Clinic Workflow for Managed Care (IPA) Patients tip sheet available on any Learning Home Dashboard.

To complete visit registration for a patient who believes that he or she is a Brown & Toland member, but Epic does not list the member as eligible, practice users will apply the **AHS MC Non-Verified** benefit plan under visit coverage. The Eligibility Department will then verify patient eligibility and update in Epic. For instructions on visit registration for a Brown & Toland member, see the Clinic Workflow for Managed Care (IPA) Patients tip sheet available on any Learning Home Dashboard.

EpicLink

Physician offices not using Altais' instance of Epic as their primary Electronic Health Record (EHR) will use EpicLink to verify eligibility. Reference the Training Guides section of your EpicLink Homepage for additional instructions.

If EpicLink does not list the member as eligible, but the member believes that he or she is a Brown & Toland member, then send an electronic request through the **New Msg > Customer Service** function in the EpicLink **In Basket**. Once the Eligibility Department receives the request, Eligibility will be verified by way of health plan portal. The Eligibility Department will then update the Brown & Toland system and respond to the request via EpicLink. An electronic response will appear in the EpicLink In Basket after Brown & Toland staff has researched and completed the request.

Customer Service

Physicians may contact the Customer Service Department to verify member eligibility. PCP

offices should also ask to verify the member's PCP assignment.

Reporting and Resolving Duplicate Medical Record Numbers (MRNs)

If you find that one patient has two Medical Record Numbers (MRNs), physician offices should notify the Eligibility Department in Epic Hyperspace or EpicLink.

Epic Hyperspace

Use the **Mark Duplicate Patients for Merge** activity in Epic Hyperspace to signal that a single patient is associated with more than one medical record. Once potential duplicate accounts are marked for merge, the Eligibility Department will receive the request, review the records, and merge duplicate patient information.

To contact the Eligibility Department with questions about duplicate patient MRNs, send a Customer Relationship Management (CRM) message via the Guarantor Account or Member Inquiry activities in Epic. The Eligibility Department will then update the Altais system and respond to the request via Epic. An electronic response will appear in the **In Basket > CRM** folder after Altais staff has researched and completed the request. For instructions on CRM creation and management, see the Clinic Workflow for Managed Care (IPA) Patients tip sheet available on any Learning Home Dashboard.

EpicLink

Send an electronic request through the **New Msg > Customer Service** function in the EpicLink **In Basket** to signal that a single patient is associated with more than one medical record. Once the Eligibility Department receives the request, it will review the potential duplicate accounts. The Eligibility Department will then merge duplicate patient information in the Brown & Toland system and respond to the request via EpicLink. An electronic response will appear in the EpicLink In Basket after Brown & Toland staff has researched and completed the request.

PPO Claims

All questions related to claims can be directed to Customer Service. See the Customer Service section for Customer Service contact information.

The Brown & Toland Physicians PPO Program, which expanded in 2019, provides contracted Brown & Toland physicians and their patients with high-quality clinical integration that allows the network access to a wider variety of payers and plans. This expansion resulted in improved PPO contracts, along with annual adjustments.

Providers who contract with Brown & Toland for PPO must participate with Brown & Toland exclusively and cannot hold individual contracts with those PPO plans that Brown & Toland is contracted with.

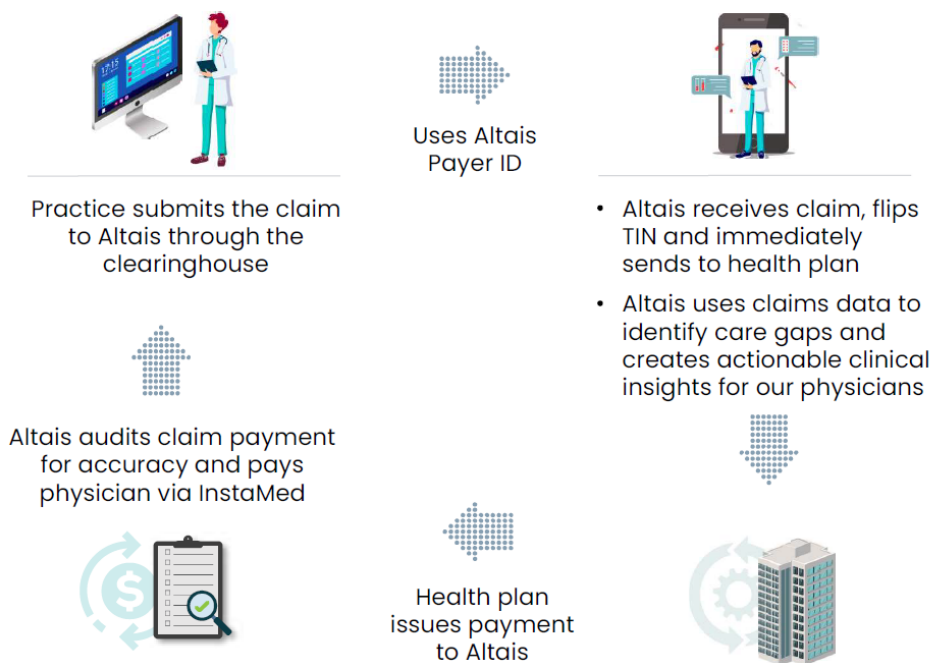
Who qualifies: Primary Care Physicians and most Specialty Care physicians.

Who does not qualify: Ancillary and hospital-based providers.

Claims Integration

All PPO claims must be submitted to Brown & Toland Physicians (BTP)/Altas directly.

Submitting claims to the insurers will put your practice out of compliance and you will no longer qualify to participate in the BTP PPO program. You would also need to enter into an independent contract with each insurance company to submit claims.



Please be sure to inform your office staff and your billing service providers so that they are aware of the requirements. If you should have any, please reach out to your Physician Services Advisor at physicianrelations@altais.com.

Please contact your Physician Services Advisor for details on each plan and any restrictions by service area. Your Physician Services Advisor can also provide you with the rates per plan. Brown & Toland does not hold a group PPO contract with Anthem Blue Cross, however we are part of an Accountable Care Organization, which allows providers contracted with Brown & Toland for PPO to receive an elevated rate from Anthem Blue Cross. Providers must hold a direct contract with Anthem Blue Cross for PPO Prudent Buyer product and not be part of any other ACO with Anthem Blue Cross. The Anthem ACO requires approval on the Anthem side before providers can be enrolled in this ACO.

Clinical Integration is an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and creates a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

Brown & Toland has invested in the administrative, clinical and technical infrastructure to be able to receive and analyze such data to support clinical integration. The foundation for the clinically integrated activities is rooted in Brown & Toland's investment in capturing a rich data

set and utilizing industry-level analytics tools as part of our daily workflows. With data analytics as our driving source, we can go beyond the limitations of a patient's health plan product and focus on meeting the needs of our patients where they are in the health continuum as well as meeting the needs of our physicians to support comprehensive support to their entire panel. In an effort to ensure complete and accurate submission of claims data, Brown & Toland provides support to physicians. Brown & Toland has assisted physician offices and their billing agencies in identifying and implementing a claims data submission process for each physician office.

Administration Fee

As of March 15, 2022, a 4% administration fee will be applied to all PPO Claims.

- The administration fee will be applied to each line item, based on the paid amount.
- The administration fee will not be applied to HCPCS Level II codes, J-codes, payments from Health Savings Accounts (HSAs), or Consumer Accounts.
- The administrative fees can be viewed in Sagility CMS and also in the provider EOB/ERA files in InstaMed.

PPO Claims Processing

After contracting is completed, please allow 60-90 days before you begin submitting your PPO Claims.

Brown & Toland Physicians uses Sagility CRM for PPO claims processing, denials, appeals, and other support functions. Call center support and claims inquiries are routed to Sagility's team when contacting Altais customer service.

All claims status and rejection reports are available through Sagility CRM. Please refer to the Electronic Tools section of this provider manual for instructions on provisioning and accessing Sagility CRM.

HMO Claims

All questions related to claims can be directed to Customer Service. See the Customer Service section for Customer Service contact information.

Overview

The BTP Claims Department examines and adjudicates claims in a timely manner in accordance with the Centers for Medicare and Medicaid (CMS) and health plan guidelines as well as state and federal regulations.

Claims Billing Guidelines

The following Claims Billing Guidelines apply only to covered services for which Brown & Toland is financially responsible, and that are provided to patients who are eligible Brown & Toland members on the date of service.

Timely Claims Submission Policy

Contracted Providers: Claims must be submitted to Brown & Toland within the timeframe specified on the provider contract. Claims submitted after the contracted timeframe will be denied payment due to "Late Billing." Physicians cannot bill patients for claims denied due to late submission.

- If a patient has dual coverage and Brown & Toland is the secondary payor, then the physician has the timeframe listed on the provider contract from the date the primary payor processed the claim to submit it to Brown & Toland. The claims processing date is on the primary payor's Remittance Advice. Please submit the claim with a copy of the primary payor's Remittance Advice.

Coding Guidelines

Providers shall bill in a manner consistent with nationally accepted coding standards.

Brown & Toland adjudicates claims based on industry accepted billing procedures such as Medicare Guidelines and Correct Coding Initiative, and based on rates, provided by written contract, that Brown & Toland has with the Provider rendering the authorized services. Please note that Brown & Toland is authorizing the specific service and not necessarily the CPT Code(s) submitted with such service authorization request. Brown & Toland reserves the right to adjust payment to correct for any mistakes or deviations from the coding and billing guidelines within each claim.

- **Miscellaneous Codes**

Providers must include a detailed description for all codes that do not have a standard description or are miscellaneous codes.

- **Audits**

Pre- and post-payment chart audits may be conducted by Brown & Toland to determine compliance with standard billing principles. Audit findings are subject to review by the Brown & Toland Utilization Management Committee, Brown & Toland Peer Review Committee and, as applicable, Brown & Toland Credentialing Committee. All appeals regarding audit findings are reviewed by a Brown & Toland Medical Director and addressed consistent with Brown & Toland policies and/or existing regulations.

- **Referral Forms**

Referral forms do not need to be sent with the claims.

- **Claim Editing Process**

Brown & Toland's claim editing process includes the use of versions of Optum's CES® software products, which are reviewed, approved, and customized by Brown & Toland.

The CES® software products contain a knowledge base that incorporates a comprehensive set of data and rules. The software applications are designed to assist Brown & Toland by automating correct coding and medical policy decisions. Using the above applications, Brown & Toland can detect coding irregularities, conflicts, or errors and make recommendations for correction.

CES® uses clinically-based rules to:

- Assess provider information including CPT/HCPCS procedure codes and evaluate ICD-10 diagnosis codes against the knowledge base and recommend CPT/HCPCS procedure codes and request additional claims information, when necessary.
- Optum's Clinical Affairs Department develops the clinical knowledge base to reflect the current state of health care delivery supported by clinical science and best practices. Sources of information used are reputable references from generally recognized and authoritative materials including, but not limited to:
 - CPT, CPT Assistant, and the CPT coding symposium Medicare and Medicare's National Correct Coding Initiative (CCI) Centers for Medicare and Medicaid Services (CMS) Specialty society guidelines AMA's Department of Coding and Nomenclature

- Brown & Toland's claim editing process is used to audit claims in accordance with Brown & Toland health plan contracts, patient coverage, reimbursement policy, and clinical guidelines.
- An explanation is included in the physicians' remittance if the claims editing rules find that the coding is inappropriate for claims payment. If a provider disagrees with the decision, then the provider may appeal the denial. Provider appeals are addressed consistent with Brown & Toland policies and existing regulations. A Brown & Toland Medical Director reviews all denial appeals.

Claim Form Requirements

Brown & Toland providers must bill on the standard CMS-1500 or UB04 claim forms or the electronic equivalent using standard CPT, ICD-10, HCPCS, and Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) coding methodologies for procedure and diagnosis codes. All codes must be current and valid for the date of service billed. Please include a detailed description for codes that are miscellaneous codes or do not have a standard description.

Please reference the following link for Medicare guidelines on billing CMS-1500 claims:

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf>

Please reference the following link for Medicare guidelines on billing UB-04

claims: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf> Payments will be delayed or not paid if:

- Any item is not accurately entered on the claim form.
- Patient is not eligible with Brown & Toland on the date of service.

Covering Provider Billing

Covering Provider Primary Care Services

The following guidelines are used to determine payment for Primary Care Physician (PCP) covering services.

It is the responsibility of all PCPs to inform Brown & Toland of their covering physician arrangements. The claims system will be updated to allow for accurate adjudication of claims for services provided by the covering physician. Failure to provide this information

may delay payment or result in a denial to physicians providing coverage for your practice.

Covering physician payments will be made using the Brown & Toland payment methodology of the member's assigned PCP. If the service provided is a capitated service, the member's assigned PCP will receive the capitation. Payment for the capitated services provided by an covering physician is the responsibility of the member's assigned PCP. Services provided that are not capitated and are paid using a fee-for-service methodology will be paid directly to the covering physician.

Physicians billing under the same tax id number will be considered covering for the PCP whether the physician is contracted with Brown & Toland. You must complete box 17 and 17a of the CMS-1500 form or its electronic equivalent.

Physicians not billing under the same tax id number: You must complete box 17 **and 17a** of the CMS-1500 form or its electronic equivalent. Failure to complete these areas may result in denial of the claim as "Incorrect PCP." For more information regarding a noncontracted on call provider, please see below.

Non-Contracted Physicians Providing Covering Services: If you are using a non-contracted physician for coverage, you must make sure they agree in advance to abide by Brown & Toland's payment methodology and policies, and to not balance bill the Brown & Toland patient prior to providing covering services. Once the non-contracted physician is no longer providing coverage, the patient may not continue to seek care from that physician without obtaining prior authorization from Brown & Toland.

The patient's financial liability is limited to their co-insurance, co-payment, or payment for services that are not covered by their health plan as described in their evidence of coverage. The patient's financial liability amount is indicated on the EOP, which is included with the PCP's reimbursement.

Covering Specialist Services

The following guidelines are used to determine payment for covering services for specialist physicians.

It is the responsibility of a contracted specialist to inform Brown & Toland of their covering arrangements. Failure to provide this information may delay payment or result in a denial of payment to physicians providing coverage for your practice.

You must be sure that physicians providing coverage for you fully understand the following:

- Payments will be paid using the contracted provider's reimbursement rate.
- If the service provided is a capitated service, the provider receiving the capitation through the capitation program will continue to receive the payment.
- If the service provided is paid on a fee-for-service basis, the payment will be made directly to the covering provider.
- The patient's financial liability is limited to their co-insurance, co-payment, or payment for services that are not covered by their health plan as described in their evidence of coverage.
- The patient's financial liability amount is indicated on the EOP, which is included with the specialist's reimbursement.

The covering specialist is a non-contracted physician

If the specialist is not contracted with Brown & Toland but is covering for a contracted Brown & Toland specialist (e.g., they are partners in the same practice or in the same covering group), the specialist is required to complete Box 17 and 17a of the CMS-1500 claim form or its electronic equivalent. The specialist must indicate in these areas that they are covering and indicate the name of the specialist for whom they are covering. This applies to claims submitted either via paper or electronically. Specialists acting in an covering provider capacity for a contracted Brown & Toland specialist must agree in advance to accept reimbursement at the same rate as the contracted specialist without balance billing the patient prior to providing covering services to Brown & Toland patients.

Covering Twofer Services

A twofer is a physician who is credentialed both as a PCP and a Specialist and is contracted with Brown & Toland for both services. Reimbursement for both the PCP and specialty service is dependent upon the PCP assignment of the patient.

If a "Twofer" physician provides PCP or specialty services to **patients assigned to his/her own PCP** panel, then the services will be paid per the PCP's contracted reimbursement methodology.

If the "Twofer" provides PCP or specialty services to a member that is assigned to another PCP within his/her practice or call group, the claim would be processed as a specialty service.

If a "Twofer" physician provides PCP or specialty services to a patient **who is not in his/her own PCP** panel or in the panel of his/her practice or call group, then the claim will be processed as a specialty service.

Coordination of Benefits (COB) Guideline

For all patients who are covered by two (2) or more health plans, please follow the guidelines as detailed below.

Determination of Primary Coverage

Before submitting a claim to Brown & Toland, please determine whether Brown & Toland is the primary payor. The following guidelines are designed to assist providers in this determination. If a provider is unclear who the primary payor is for a patient, they may contact the patient's health plan(s).

Dual Coverage – Subscriber and Spouse/Domestic Partner

If the patient has coverage through both his or her own employer and coverage under a spouse or domestic partner's employer, then the coverage through his or her own employer becomes the primary payor. The coverage through a spouse or domestic partner becomes the secondary payor.

If the patient has coverage through both his or her own employer and coverage under a spouse/domestic partner, but his or her employer is a retirement benefit program, then the coverage under the working spouse or domestic partner becomes the primary payor. The coverage under his or her employer's retirement benefit program becomes the secondary payor.

Dual Coverage – Dependent Children

For dependent children of parents who are neither separated nor divorced, the parent whose birthday falls first in the calendar year (mm/dd) is considered the primary payor. This is known as the "birthday rule".

For dependent children of parents who are legally separated or divorced, the primary coverage is determined as follows: The primary coverage for the dependent child is based on the parent who maintains a court mandated custody for medical care unless the court has given that medical care to the non- custodial parent.

If the custodial parent has remarried, then the step-parent's coverage is secondary, and the non-custodial parental coverage is last. [for example, wife is the custodial parent and the primary insurer. Once she remarries, the new husband's (stepparent) coverage is secondary, and the ex-husband's coverage would be last.] The primary coverage remains with the custodial parent.

If both parents have joint custody, then the birthday rule applies.

Submission of a COB Claim

If Brown & Toland is the primary payor, submit the claim to Brown & Toland. If Brown & Toland is the secondary payor, file the claim with the primary payor first. Once the primary payor has paid the claim, attach a copy of the primary payor's EOP to the claim and submit to Brown & Toland. COB claims must be submitted within the timely filing limit on the provider's contract of receipt of the other payor's EOP. COB claims submitted outside of the six- month time frame will be denied by Brown & Toland. For patients where Brown & Toland is both the primary and secondary payor, please refer to the "Dual Brown & Toland Coverage" section.

Dual Brown & Toland Coverage

Dual coverage applies to patients where Brown & Toland is the IPA for both primary insurance and secondary insurance. Physicians may not collect a co-payment from a patient with dual Brown & Toland coverage.

Dual Brown & Toland coverage claims should be submitted with both:

The primary Brown & Toland health plan and group number in Box 11 on the CMS-1500 or its electronic equivalent; and the secondary Brown & Toland health plan and group number in Box 9 on the CMS-1500 or its electronic equivalent.

Once processed, the claim may appear twice on the EOP. This does not mean that the claim has been paid twice, only that the patient has dual Brown & Toland coverage.

COB Payment Calculations

For those claims that are secondary, Brown & Toland will coordinate benefits and pay balances up to the amount the physician would have received had Brown & Toland been primary.

For example:

Physician submits claim for CPT 99218 for patient John Smith for \$200.00 in billed charges. Aetna PPO is the primary payor, and Brown & Toland is the secondary payor. Aetna PPO pays its contracted rate of \$125.00. Brown & Toland's contracted rate for CPT 99218 is \$150.00. Upon being billed as secondary payor, Brown & Toland would pay the physician the difference of \$25.00 (\$150 contracted rate less \$125 from the primary insurance).

Patients with dual coverage will generally not be responsible for co-payments or deductibles for covered services. Therefore, please do not bill patients until payment has been received from all payors.

Electronic Claims Submission

Brown & Toland will accept electronic claims submitted through Change Healthcare and Office Ally.

TRADING PARTNERS		
<u>Company</u>	<u>Payer ID</u>	<u>Claim Type</u>
Change Healthcare	94316	HMO Professional/Institutional
Change Healthcare	BTSS1	PPO Professional
Office Ally	94316	HMO Professional/Institutional
Office Ally	BTSS1	PPO Professional

Generally, clearinghouses will only process standard Medicare codes, and will recognize standard Medicare codes dating back three (3) years.

For information regarding Change Healthcare electronic claims submission please contact your Physician Services Representative or visit Change Healthcare's web site at www.changehealthcare.com or call 866-371-9066.

To confirm the status of claims submitted to an electronic claims clearinghouse, please review the status/rejection reports sent to you by the clearinghouse after each claim submission. For more information regarding claim submission reports, please contact your electronic claim vendor.

Claim Review Requests

If you believe an error occurred in your original payment after reviewing your Remittance Advice, please call the Brown & Toland Customer Service Department. If the issue cannot be immediately resolved over the phone, Customer Service will investigate the claim and provide you with a response.

Claim Adjustment Requests

Brown & Toland physicians must submit requests for claims adjustments within 365 days from the last action date. The last action date may be but is not limited to the date of the claims payment, the date of the claims denial, or the last EOP date. It is very important to review EOPs in a timely manner in order to request an adjustment to the claim. Should you

believe there is an error in payment received, please call the Claims Service Department at 800.225.5637 to have the claim reviewed.

Corrected Claims

Brown & Toland physicians may submit corrected claims electronically for certain scenarios. Instructions below must be followed to ensure proper handling.

Corrections may be needed for claims that have already been processed by Brown & Toland. It is important to file the corrected claim according to the instructions below to ensure that Brown & Toland can identify the original claim, when necessary, understand the correction that is required and ensure that the resubmitted claim is not denied as a duplicate. **Please include all services rendered, including previously paid services, on any corrected claim.** Please also remember that when submitting a corrected claim, you must ensure that your corrected claim contains a valid Member ID and Billing Provider Tax ID that match the original claim. If the Member ID or Billing Provider Tax ID need to be corrected, the procedure is to VOID the original claim (using frequency code 8) and to submit a new, clean claim using the correct Member ID and/or Billing Provider Tax ID.

Note: Electronic resubmissions of claims are preferred to hard-copy paper. However, the electronic resubmission cannot support electronic attachments at this time. For claims initially denied for primary carrier Explanation of Benefits, please resubmit electronically with the necessary data fields that represent the payment amount and member responsibility amount(s) reported by the primary payer.

1. Original claim was partially denied by Brown & Toland

a. Partial denial due to request for attachments (e.g., operative notes, treatment plan, etc.) NOTE: Any documentation received without a claim attached will not be processed.

Must be submitted on paper – Complete a duplicate of the previously processed claim and add the information below. Claims that are submitted without the information below will be returned or denied as duplicates:

- Indication that the claim is a replacement claim: Box 22, Resubmission Indicator 7
- Brown & Toland claim ID of claim being corrected: Box 22
- Please note, when multiple resubmission claims are on file, use the ID of the most recent paid claim. Once a claim is corrected, it is replaced by the new

claim and cannot be corrected again.

- Reason for the attachments: Box 19

Providers should not file another claim if the attachments have already been reviewed by a Medical Director or Medical Staff.

EXAMPLE

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Lab requisition with results and referring provider notes attached				20. OUTSIDE LAB? ☐ YES ☐ NO		\$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. C3412 B. C. ICD Ind. 0				22. RESUBMISSION CODE 7		ORIGINAL REF. NO. 19303E0033726	

b. Partial denial requiring corrected claim information (e.g., incorrect diagnosis codes, add a modifier)

Electronic resubmission is preferred to paper claim – Submit a claim with the corrected claim information and all the correct services originally billed. Corrected claims that are submitted without the information below will be returned (if paper). If electronic, the corrected claim may be processed as a replacement claim, which would create an offset to prior payment and result in a negative balance, if below is not provided.

- Indication that the claim is a replacement claim
- Brown & Toland claim ID of claim being corrected
- Reason for the correction

EXAMPLE

Requirement	Electronic 837P version 5010 (Preferred)	Paper CMS-1500
Indication of replacement claim	Loop 2300 CLM05-3 (Claim Frequency Code) = "7" (Replacement)	Block 22 - Resubmission Code Code = "7" (Replacement)

Brown & Toland claim ID of claim to be corrected	Loop 2300 REF – Payer Claim Control Number REF01 = "F8" (Original Reference Number) REF02 = Brown & Toland claim ID of claim to be corrected	Block 22 – Resubmission Code Original Ref. No. must contain Brown & Toland claim ID of claim to be corrected
Reason for correction	Loop 2300 NTE – Claim Note Segment NTE01 = "ADD" NTE02 = text explaining reason for correction <i>Optional – NTE segment at Loop 2400 line level if more space is needed.</i>	Block 19 – Reserved For Local Use Include text explaining reason for correction

Do not file another claim if the amount of payment received or denial of services as billed on the claim is being disputed. Refer to the instructions on submitting a provider correspondence inquiry, fee review or an appeal.

2. Original claim was paid by Brown & Toland or is in process

There are two ways to correct claims that were already paid by Brown & Toland or are in process:

- Void the claim that is paid or in process and submit an entirely new claim
- Submit corrections to a paid claim

a. Void/cancel a paid or in process claim

Electronic resubmission is preferred to paper claim – **Claims that were filed with Brown & Toland in error or filed under the wrong patient or wrong provider must be canceled from Brown & Toland's claims processing system.** Do not submit a corrected claim with Resubmission Code 7 for these situations. Submit a void claim as soon as you become aware of the error, rather than wait for the claim to be paid or denied. The void claim must contain the exact claim data as submitted on the

claim being voided. Void claims that are submitted without the information fields below will be returned or denied as duplicates:

- Indication that the claim is a void claim
- Brown & Toland claim ID of claim being voided

Requirement	Electronic 837P version 5010 (Preferred)	Paper CMS-1500
Indication of void claim	Loop 2300 CLM05-3 (Claim Frequency Code) = "8" (Void)	Block 22 - Resubmission Code Code = "8" (Void)
Brown & Toland claim ID of claim being voided	Loop 2300 REF - Payer Claim Control Number REF01 = "F8" (Original Reference Number) REF02 = Brown & Toland claim ID of claim being voided	Block 22 - Resubmission Code Original Ref. No. must contain Brown & Toland claim ID of claim being voided

EXAMPLE

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB?		\$ CHARGES	
Lab requisition with results and referring provider notes attached				☐ YES ☐ NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.	0	22. RESUBMISSION CODE	
A. C3412	B. _____	C. _____	D. _____			8	ORIGINAL REF. NO. 19303E0033726

b. Submit corrections to a paid claim

Electronic resubmission is preferred to paper claim – Submit a claim with the corrected claim information and the correct services originally billed. Corrected claims that are submitted without the information below will be returned (if paper). If electronic, the corrected claim may be processed as a replacement claim, which would create an offset to prior payment and result in a negative balance, if below is not provided.

- Additional or corrected claim data, including those billed previously and paid correctly on the original claim
- Indication that the claim is a replacement claim
- Brown & Toland claim ID of claim to be corrected
- Reason for the correction

EXAMPLE

Requirement	Electronic 837P version 5010 (Preferred)	Paper CMS-1500
Indication of the replacement claim	Loop 2300 CLM05-3 (Claim Frequency Code) = "7" (Replacement)	Block 22 - Resubmission Code Code = "7" (Replacement)
Brown & Toland claim ID of claim to be corrected	Loop 2300 REF - Payer Claim Control Number REF01 = "F8" (Original Reference Number) REF02 = Brown & Toland claim ID of claim to be corrected	Block 22 - Resubmission Code Original Ref. No. must contain Brown & Toland claim ID of claim to be corrected
Reason for the correction	Loop 2300 NTE - Claim Note Segment NTE01 = "ADD" NTE02 = text explaining reason for correction <i>Optional - NTE segment at Loop 2400 line level if more space is needed.</i>	Block 19 - Reserved For Local Use Text explaining reason for correction

Providers should not file another claim if the amount of payment received or denial of services as billed on the claim is being disputed. Refer to the instructions on submitting a provider correspondence inquiry, fee inquiry or an appeal.

Appeals

To appeal a claim payment denial, physicians may call the Customer Service Department

at 415.972.6002 or complete a Provider Dispute Resolution Request.

Dispute Resolution Process for Contracted Providers (for Claims Regarding Commercial Members)

- A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to IPA and/or the member's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination. In addition, a contracted provider may also submit a written notice regarding a contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered). Also, a contracted provider may submit a written notice disputing IPA's request for reimbursement of an overpayment on a claim.

Each contracted provider dispute must contain, at a minimum the following information: provider's name, provider's identification number, provider's contact information, and:

- i. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from IPA to a contracted provider the following must be provided: a clear identification of the disputed item such as the claim number, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;
- ii. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and
- iii. If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

To facilitate the submission of dispute by a contracted provider, IPA asks that a contracted provider use IPA's "Provider Dispute Resolution Request Form," which will capture all the required information listed above. Please see below (section II B) for

instructions about how a contracted provider can submit a dispute to IPA.

- B. Sending a Contracted Provider Dispute to IPA. To submit a dispute to IPA, a provider must use a "Provider Dispute Resolution Request Form". The "Provider Dispute Resolution Request Form" is available at www.altais.com. All contracted provider disputes must be sent to the attention of Claims Appeals & Disputes using the following:

Via Mail:	Brown & Toland Claims Appeals & Disputes
	P.O. Box 72710
	Oakland, CA 94612-8910

- C. Time Period for Submission of Provider Disputes.
- i. Contracted provider disputes must be received by IPA within three hundred sixty-five (365) calendar days from IPA's action (or the most recent action if there are multiple actions) the led to the dispute, or
 - ii. In the case of IPA's inaction, contracted provider disputes must be received by IPA within three hundred sixty-five (365) calendar days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired;
 - iii. Contracted provider disputes that do not include all required information as set forth above in Section II.A. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to IPA within thirty (30) working days of your receipt of a returned contracted provider dispute.
- D. Acknowledgment of Contracted Provider Disputes. IPA will acknowledge receipt of all contracted provider disputes as follows:
- i. Electronic: Contracted provider disputes will be acknowledged by IPA within two (2) working days if the date of receipt by IPA.
 - ii. Paper: Contracted provider disputes will be acknowledged by IPA within fifteen (15) working days of the date of receipt by IPA.
- E. Contact IPA Regarding Contracted Provider Disputes. All inquiries regarding the status

of a contracted provider dispute or about filing a contracted provider dispute must be directed to the Customer Service Department at (415) 972-6000.

- F. Instructions for Filing Substantially Similar Contracted Provider Disputes. Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

Please use the "Provider Dispute Resolution Request Form" located on [altais.com](https://www.altais.com). Please check the "Multiple 'LIKE' Claims" box in the Claim Information section and complete the spreadsheet.

- G. Time Period for Resolution and Written Determination of Contracted Provider Dispute. IPA will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute.

- H. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute (see Section II. C. iii above) involves a claim and is determined in whole or in part in favor of the provider, IPA will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

Reconsideration Process (For Claims Regarding Medicare Advantage Members)

Contracted providers may submit a claim inquiry/reconsideration request and or file a formal appeal.

Claims Inquiries/Reconsideration Request: A claim inquiry/reconsideration request is a telephonic or written request to explain the status or rationale for a decision, delay, or denial of a claim. Issues or questions may be resolved at the inquiry level. An inquiry may or may not alter the original decision. Providers may initiate an inquiry regarding a decision by Brown & Toland, including but not limited to, a claims processing determination. **Reconsiderations must be requested and completed before filing a formal appeal.**

STEP ONE: RECONSIDERATION

Contracted Brown & Toland providers may initiate a claims inquiry/reconsideration request

by doing one of the following:

1.) Contacting Brown & Toland's Claims Customer Service Department by calling: (415) 972-6002 or by sending a message in EpicLink. Our agents are trained to answer many of your claims questions and can initiate contact with other Brown & Toland departments when further review or research is needed.

a.) Please note the reference number issued to you by the Claims Service Associate.

b.) If your inquiry is not resolved by phone, you will receive a letter from Brown & Toland within 30 days. Please allow us time to properly research and resolve your inquiry before contacting us again.

2.) Completing and submitting the Brown & Toland Provider Claim Reconsideration Request Form. Be sure to complete all required fields on the form to avoid delay of review.

Reconsideration request forms should be mailed to:

Brown & Toland Physicians – Claims CQA Dept.
P.O. Box 72710
Oakland, CA 94612-8910

STEP TWO: FORMAL APPEAL

If you disagree with the determination of our response to your initial inquiry, you may escalate your concern by submitting a formal written appeal within 365 days from date of original Explanation of Payment (EOP) or Electronic Remittance Advice (ERA) with supporting documentation.

Formal Appeals should be mailed to:

Brown & Toland Physicians – Claims CQA Dept.
P.O. Box 72710
Oakland, CA 94612-8910

Additional information regarding the reconsideration process can be located at the Altais website under Physician Dispute Resolution section:

<https://altais.com/physician-dispute-resolution/>

Dispute Resolution Process for Non-Contracted Providers

A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a

non-contracted provider's written notice to IPA challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contract information, and:

- i. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from IPA to provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;
- ii. If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

- B. Dispute Resolution Process. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth above in sections II.B., II.C., II.D., II.E., II.F., II.G. and II.H.

To facilitate the submission of dispute by a non-contracted provider, IPA asks that a non-contracted provider use IPA's "Provider Dispute Resolution Request Form" which will capture all the required information listed above (see section A). The "Provider Dispute Resolution Request Form" is available at www.altais.com.

Explanation of Payment (EOP)/Electronic Remittance Advice (ERA)

Physicians are encouraged to review their EOPs on a consistent basis. EOP statements can be found on Instamed.

Claim Payment Policies

National Drug Code (NDC) Requirements

Effective **September 15, 2019**, all claims received by Brown & Toland Physicians (BTP) for payment, *regardless of date of service*, must include the appropriate National Drug Code

(NDC) number and the corresponding quantity for each NDC unit dispensed. Claims submitted for payment must also include the appropriate HCPCS/CPT code and the corresponding quantity for each HCPCS/CPT unit dispensed. Provider must submit claims using the correct NDC and HCPCS/CPT codes. Additionally, reimbursement may be denied if claim does not list NDC and HCPCS/CPT code detail.

BTP reimbursement policy will now require that claims submitted for reimbursement for drug-related revenue codes, Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes for all members **must** include:

- ✓ **A valid NDC number** ✓ **The quantity** ✓ **A unit of measure (UOM)**

This applies to the following Member Claim Types:

Member Claim Types		
Commercial HMO & PPO	Medicare Advantage	Medi-Cal
For commercial member claims, the policy applies to facility outpatient and professional drug claims.	The policy applies to Medicare Advantage member claims based on the claim type: Facility outpatient drug claims - Unlisted drug codes – the policy applies for all care providers - Listed drug codes – the policy doesn't apply Professional drug claims - Unlisted drug codes – the policy applies for all care providers - Listed drug codes – the policy only applies for contracted care providers	The policy applies to all Medi-Cal member claims except Medi-Cal crossover claims and Child Health & Disability Prevention (CHDP) claims.

By requiring NDC numbers, Brown & Toland can differentiate and target drugs that share the same revenue or HCPCS code for drug preferences. As the industry standard identifier for drugs, NDC numbers provide full transparency of the medication administered. They accurately identify the manufacturer, drug name, dosage, strength, package size and quantity.

You will find the National Drug Code (NDC) Requirements FAQ on the Altais website. If you

should have any additional questions, please contact your PSA at physicianrelations@altais.com.

Claims Pricing Policy

Effective Date
12/1/2025
HMO Claims Pricing

POLICY OBJECTIVE

Define a clear logic hierarchy determining how an HMO claim will be priced to provide for consistent and efficient claims processing.

AFFECTED PARTIES

Claim Operations, Business Application Configuration (Ops Integrity), Epic, Contracting, Physician and Provider Reimbursement (PPR)

PROCEDURES

Note: Division of Financial Responsibility (DOFR) takes precedent over the below language when determining whether BTP will pay a given service. If the service is the health plan's responsibility per the DOFR, then we will deny the service as such and route to the health plan for payment. Likewise, industry standard correct coding guidelines will take precedent over the below language when determining if a service should be paid or denied due to invalid coding (e.g. NCCI (CMS), AMA, etc.).

Contracts and Notices

1. Physician, Ancillary and Facility contracts ("Contracts") will have defined reimbursement terms outlined in the compensation exhibit, which may be amended from time to time. Contract reimbursement rates may also be changed from time to time by way of formal company notices ("Notices"), which will include specific reimbursement rates and terms in writing.
2. All Contracts and Notices will be shared with BTP internal operational departments, including but not limited to system configuration teams (Ops Integrity and Epic). Contracts and Notices will be shared via our VCRF (Vendor Contract Request Form) process, or its successor process as determined by another company policy and procedure.
3. Configuration team will update the system based on reimbursement terms as

written in the Contracts and/or Notices.

4. For services that are not defined by the Contract or Notice, the system will be configured to price a claim based on the following hierarchy:

Commercial	Medicare	Medi-Cal
100% of Current Year Medicare	100% of Current Year Medicare	100% of Current Year Medi-Cal
Drug claims only: 90% of Current Year Medicare; if no Medicare rate then 70% of AWP	Drug claims only: 90% of Current Year Medicare; if no Medicare rate then 70% of AWP	70% of Current Year Medicare
100% of Current Gap Fill Fee Schedule	100% of Current Gap Fill Fee Schedule	Drug claims only: 80% of Current Year Medicare; if no Medicare rate, then 70% of AWP
Twenty percent (20%) of billed charges	Twenty percent (20%) of billed charges	70% of Current Gap Fill Fee Schedule
		Twenty percent (20%) of billed charges

- a. Geographical adjustments will be made
- b. All industry standard claim adjudication processes will apply

Letters of Agreement (LOA)

5. Ongoing Letters of Agreement (LOA), agreements which span multiple claims over a defined effective period, will be shared with BTP internal operational departments, including but not limited to system configuration teams (Ops Integrity and Epic). Ongoing LOAs will be shared via our VCRF (Vendor Contract Request Form) process, or its successor process as determined by another company policy and procedure.
6. Configuration team will update the system based on reimbursement terms as written in the Ongoing LOA.
7. For services that are not defined by the Ongoing LOA the system will be configured to price a claim based on the following hierarchy:

Commercial	Medicare	Medi-Cal
100% of Current Year Medicare	100% of Current Year Medicare	100% of Current Year Medi-Cal

Drug claims only: 90% of Current Year Medicare; if no Medicare rate, then 70% of AWP	Drug claims only: 90% of Current Year Medicare; if no Medicare rate, then 70% of AWP	70% of Current Year Medicare
100% of Current Gap Fill Fee Schedule	100% of Current Gap Fill Fee Schedule	Drug claims only: 80% of Current Year Medicare; if no Medicare rate, then 70% of AWP
Twenty percent (20%) of billed charges	Twenty percent (20%) of billed charges	70% of Current Gap Fill Fee Schedule
		Twenty percent (20%) of billed charges

- a. Geographical adjustments will be made
- b. All industry standard claim adjudication processes will apply
- 8. Member specific LOAs, also known as Single Case Agreements, will be communicated directly to the Claims team for the purpose of manually processing impact claims.
- 9. Member specific LOAs will not be configured in the system.

Fee Schedules

- 10. Fee Schedules are available upon request to your Physician Services Advisor.
- 11. PPR team will communicate changes to the Medicare and Medi-Cal fee schedules via our Fee Schedule Update Process
- 12. PPR team will make quarterly updates to the Gap Fill Fee Schedule. A ticket to communicate these changes is submitted to the system configuration teams (OPS INTEGRITY and Epic) via our Fee Schedule Update Process. Questions regarding the Gap Fill schedule should be directed to any member of the PPR Team.
- 13. OPS INTEGRITY and Epic teams will be responsible for ensuring our systems are configured according to provided requirements

Non-contracted Reimbursement

- 14. Providers who are not contracted with BTP and have not acquired authorization for services may have their claims denied for lack of authorization. The following scenarios are exceptions where the claims will be processed/paid:
 - a. If the service is ER related and was rendered in an office or outpatient hospital setting, the claim can be processed. Only the initial service is payable, subsequent visits (ie. follow up care) should be denied as "Not

Authorized” unless an authorization has been obtained.

- b. Claims for ER professional services (place of service 23) should be paid, regardless how many times the patient was seen in the ER on the same date of service. Claims history, however, should be reviewed for duplicate claims.
- c. All inpatient professional fees related to an ER admit are payable without an authorization.

15. Providers who are not contracted with BTP, but have been authorized to service a BTP member or meet one of the exception scenarios above, will be paid as follows:

Commercial	Medicare	Medi-Cal
ER Visit codes (99281 – 99285) with ER place of service will be priced at 150% of current year Medicare	100% of Current Year Medicare	100% of Current Year Medi-Cal
Professional Services conducted in a Facility (based on place of service) will be paid at 100% of Current Year Medicare	\$0 – Deny for no Medicare allowable	\$0 – Deny for no Medi-Cal allowable
Anesthesiology time-based codes will be priced at \$50.00 per ASA unit.		
125% of Current Year Medicare		
Manually priced by PPR team		

16. If a BTP Physician is not indicated as the referring Physician and the services rendered are not related to Urgent/Emergent Care, the claim should be denied as “Not Authorized”. Before a claim is denied as ‘Not Authorized’, verify if the member has a POS plan.

- a. If the member has a Point of Service (POS) plan, the claim should be forwarded to the health plan for processing.

DEFINITIONS

- Fee Schedule Update Process
- Current Year Fee Schedule
- Single Case Agreement
- Ongoing Letter of Agreement (LOA)
- Current Year Medicare: this incorporates the following Medicare fee schedules, in this hierarchical order:

UB-04 Claim Form (ANSI 837I file)	CMS-1500 Claim Form (ANSI 837P file)
• Medicare Physician Fee Schedule • Clinical Lab • ASP • Anesthesia • Radiopharmaceutical • DMEPOS Fee Schedule (standard rates only) • Contractor C-Status	• Medicare Physician Fee Schedule • Clinical Lab • ASP • Anesthesia • Radiopharmaceutical • DMEPOS Fee Schedule (standard rates only) • Contractor C-Status

- OPPS Criteria:
 - Claim Form: UB-04
 - Type of Bill: 13X (where X is a wildcard)
 - HCPCS code associated to one of the following SI codes: G, J1, J2, K, N, P, Q1, Q2, Q3, R, S, T, U, V, X

Electronic Funds Transfer

ERA/EFT Required for Claim Payment

Providers are required sign up for electronic remittance advice (ERA) and electronic funds transfer (EFT) in order to receive payment for claims. Enrollment is through InstaMed, a leading healthcare payment network. Please see the Electronic Tools section of this provider manual for enrollment details and instructions.

Benefits of InstaMed ERA/EFT

At no cost, providers, office managers and billers can use InstaMed to:

- Save time and money by eliminating paper checks and EOPs.
- Accelerate payments with EFT directly deposited into an existing bank account.
- Receive fully reconciled remittances electronically.

Access a secure portal to view and print remittances and transaction details 24/7.

Register online

To register for free ERA/EFT transactions from Brown & Toland Physicians, visit

<https://register.instamed.com/eraeft>

Providers that are currently enrolled with InstaMed to receive ERA/EFT from the other 100+ payers on the InstaMed Network may automatically begin receiving ERA/EFT from Brown & Toland.

To see the InstaMed Payer List visit: www.instamed.com/payer-payments/payer-lists.html.

Contact information

For questions on the enrollment process, or to add Brown & Toland/Altais as a payer to your existing InstaMed account, please contact InstaMed at 866.945.7990 or connect@instamed.com.

Sequestration**Reimbursement:**

- Effective April 1, 2022, all Medicare Advantage paid claims will be reduced by a 1% sequestration
- Effective July 1, 2022, all Medicare Advantage paid claims will be reduced by a 2% sequestration

Likewise, capitation revenue paid to Brown & Toland Physicians from its contracted health plan partners will be reduced by this same amount of sequestration.

HMO Provider Compensation

Brown & Toland uses a variety of methodologies to contract with and compensate providers. Compensation methods include capitation, fee-for-service payments, case rates and other special arrangements as applicable.

Primary Care Compensation

Overview Fee-For-Service (FFS)

If the PCP elects to be paid Fee For Service, clean and approved claims will be paid per contract on a fee for service basis.

Monthly Capitation

Capitation is a fixed rate of payment, which a PCP accepts in return for providing primary care services to a group of patients. Each PCP is expected to provide basic care services as outlined in the "Primary Care Physician Scope of Standard Services," in exchange for the capitation payment.

Capitation payments are:

- Based on the age and sex of each patient
- Determined by the number of patients assigned to the PCP
- Made monthly on a per member per month (PMPM) basis which is calculated based on all patients eligible with the PCP on the 15 of each month and made regardless of the services provided to the member.

Retroactive Capitation Adjustments

If patients who are anticipated to be included in a physician's capitation are not listed on the monthly Capitation Report, please notify Brown & Toland as soon as possible.

Capitation Retroactivity Limit

Brown & Toland has established a maximum of six months as an adjustment limit for capitation payments on all retroactivities (adds/deletes/changes). This policy applies to all PCPs with assigned patients.

Encounter Submission

Submitting all your encounters is a contractual requirement and is critical for the following reasons:

- Collection of member utilization data
- Analysis and reporting (potential impact on health plan negotiations)

- Requirement of health plans contracts
- Calculation of potential bonus dollars
- Impact on PCP stop loss reimbursement

Co-Payments

The PCP is responsible for collecting a co-payment from each patient. A co-payment is a member's share of cost and should be collected by the PCP at the time of service. The amount of each patient's co-payment may be found on the patient's most current health plan ID card. For Commercial and Medicare Advantage patients, there is typically an annual maximum out-of-pocket expense to patients; physicians may no longer collect co-payments from patients who have reached their maximum co-payment limit.

Dual Brown & Toland Coverage

Dual coverage applies to patients where Brown & Toland is the IPA for both primary insurance and secondary insurance. Physician may not take a co-payment from a patient with dual Brown & Toland coverage.

Once processed, the claim may appear twice on your EOP. This does not mean that the claim has been paid twice, rather it indicates that the patient has dual Brown & Toland coverage.

Fee-for-Service Component

Carve-Outs

Carve-out services are paid fee-for-service in addition to a PCP's regular capitation payment. By incorporating immunizations and other preventive care services into the carve-out schedule, Brown & Toland encourages PCPs to follow wellness guidelines. The PCP carve-out fee schedule is available upon request by your Provider Services Advisor.

Newborn Care

Charges for newborns where the mother is eligible with Brown & Toland on the date of service are covered for the first 30 days of the newborn's life. PCPs and specialists, if applicable, will be compensated on a fee-for-service basis per the provider's contract for all primary care services provided to newborns during the first month of life.

Patient's Right to Privacy

One of the basic rights of patients is the right to privacy regarding their individual medical circumstances. Brown & Toland physicians are reminded of the primacy of patient confidentiality, particularly regarding patients included within the Brown & Toland "Special

Pool.” Specific guidelines regarding patient confidentiality are addressed in the Brown & Toland Office Site Review which is provided by your Physician Services Representative.

PCP Capitation Reports

Brown & Toland provides Capitation Reports monthly. These reports provide the information needed to manage patients and reconcile accounts. An up-to-date patient listing with additions and terminations is included monthly.

- The monthly capitation reports for Brown & Toland PCPs are:
 - Physician/Member Capitation Detail Report – lists all patients and their individual capitation payments.
 - Physician Capitation Summary – a summary of total capitation payments.
- Physician/Member Capitation Detailed Report Field Explanations (Please refer to the corresponding reports above):
 - Current paid enrollment is the capitation payment made for patients enrolled during the current month.
 - Retro-enrollment is the payment for patients who retroactively enroll or terminated.
 - The total sum of payment including any retro adjustments.
 - The total member months paid for each patient.
 - Time is described in months and year and is the range of periods for which the capitation dollars are applied.
- Capitation is calculated based on the following metrics:
 - member age/sex
 - member illness severity for Medicare Advantage members
 - based on dual eligible membership for Medicare/Medi-Cal eligible members

Specialist Compensation Overview

Most specialists are paid on a fee-for-service basis. Please reference your contract for the most current rates.

Patient Billing

Physicians may only bill patients for services if Brown & Toland and/or the health plan determine that the service is a non-covered service and if the patient has agreed in advance in writing to be responsible for payment of the services. Most physicians require

that patients sign an agreement to be responsible for non-covered services when they register as a new patient. **Patient billing for any other reason is strictly prohibited under Brown & Toland physician participation agreements, health plan contracts and policies, and California law (Knox-Keene and Section 1300.71(g)(4), Title 28, California Code of Regulations).**

Due to the variability in patient benefit coverage, the patient's health plan reserves the right to determine actual patient benefits and co-payments. In the event of a discrepancy, Brown & Toland will work with the patient's health plan to determine the patient's benefit coverage and/or appropriateness of the patient billing concern.

The following are examples of services that may be appropriate to bill patients with the patient's informed written consent under most health plans.

You are unable to verify the patient's eligibility: If you cannot verify eligibility through Brown & Toland and the patient has no proof (e.g. health plan ID card, enrollment form, etc.) physician may request a partial or full payment for a service if eligibility has not been confirmed. Be sure the patient fills out an eligibility waiver form.

Completion of administrative forms: These are forms that are not required as part of direct care delivery: A form completion fee may be charged for some forms such as: school forms, DMV forms, camp forms, sport physicals, leave of absence, insurance forms, adoption forms, flight physicals, and/or employment forms. Physician may bill the patient only if the patient provides his/her advance written acceptance of financial responsibility.

Patients request to copy medical records. A copying fee may be charged to defray the cost of copying medical records. Per the California Health and Safety Code, the fee cannot exceed twenty-five cents (\$ 0.25) per page for paper copies. Before making any copies, the physician must receive a written request from the patient specifying the medical records to be copied. Physician may bill the patient only if the patient provides his/her advance written acceptance of financial responsibility. (This does not include transfer of medical records. Please refer to examples of inappropriate patient billing.)

Non-covered services and all associated services (e.g. cosmetic services, etc.): Physician offices must make a good faith effort to determine whether the service is a covered benefit prior to providing the service. This could be done by contacting the Brown & Toland Customer Service department or the patient's health plan. Physician may bill the patient only if it is discussed with the patient, and the patient provides his/her advance written acceptance of financial responsibility.

Missed or cancelled appointment charge: These types of charges must be clearly posted in the reception area for the patients. When scheduling an appointment, patients must be informed of these types of charges either over the phone or in person. Please note that whether or not missed and cancelled appointment charges are allowed is dependent on the patient's health plan and benefit plan. A physician may bill the patient only if the patient provides his/her advance verbal or written acceptance of financial responsibility and the missed appointment charge is allowed/permitted and in compliance with the patient's benefit plan.

Inappropriate Billing Procedures:

The following are examples of services that are inappropriate to bill a patient for under most health plans. In these instances, physicians must write off the charges:

- Concierge fees
- Balance for any covered services (e.g. medical supplies, IUDs, etc.): Physicians cannot charge the patient for any covered service. If physician is eligible for payment from Brown & Toland and/or the patient's health plan, physician cannot then charge the patient for any remaining balance. Physician must accept the Brown & Toland or health plan reimbursement plus any applicable co-payment or deductible as payment in full.
- Charges for denied claims for any of the following reasons:
 - Authorization is denied for lack of medical necessity. Patients who elect to pay out-of-pocket for services that are denied for lack of medical necessity must sign a written waiver prior to obtaining services.
 - Services are denied due to failure to obtain authorization.
 - You are not the PCP of record, and you fail to have the patient sign an eligibility waiver.
 - You filed the claim beyond the time frame allowed per your contract.
- Transfer of medical records from one Brown & Toland physician to another Brown & Toland physician or for case management purposes.
- Office co-payments for patients with dual Brown & Toland coverage.

- Non-reimbursable CPT/HCPCS codes (e.g., incidental codes, miscellaneous codes, etc.).
- Completion of any medical related forms (e.g., disability forms, health plan's drug prior authorization forms, etc.).

Possible Sanctions for Inappropriate Patient Billing

In order to reimburse the patient to timely resolve an inappropriate billing concern, Brown & Toland may pay the patient and then recover the inappropriately billed amount by an offset against the physician's current or future capitation or claims payments.

Based on the number of inappropriate billings, the following sanctions may be imposed.

- First Occurrence: If billing is corrected and physician office agrees to reimburse patient, then only a letter will be mailed to the physician summarizing the patient concern and the resolution. No further action will be taken against the physician for this occurrence.
- Second Occurrence – occurs within six months of first occurrence:
 - A letter will be mailed to the physician summarizing the patient concern and the resolution.
 - At the discretion of the Brown & Toland Chief Medical Officer (CMO), financial penalties may be imposed against the physician for the amount that was inappropriately billed to the patient plus a nominal administrative fee as determined by the Brown & Toland CMO.
- Third or More Occurrence – occurs within six months of previous occurrence or a total of three occurrences within a twelve-month period:
 - A letter will be mailed to the physician summarizing the patient concern and the resolution.
 - At the discretion of the Brown & Toland CMO, financial penalties may be imposed against the physician for the amount that was inappropriately billed to the patient plus an additional fee of up to \$1,000.

- At the discretion of the Brown & Toland CMO, physicians may be referred to the Brown & Toland Peer Review Committee.
- At the discretion of the Brown & Toland Peer Review Committee, physicians may be terminated from Brown & Toland based on violation of the provider's contract.

If an inappropriate billing practice is egregious, Brown & Toland reserves the right to open a complaint file against the physician when appropriate. This decision will be determined by the Brown & Toland CMO. In accordance with quality improvement policies and procedures, a physician may be referred to the Brown & Toland Peer Review Committee for further consideration and possible sanctions.

Appeal Process

Providers have the right to appeal any occurrence that Brown & Toland deemed as an inappropriate billing practice. The appeal must be submitted in writing to the Claims Department to the address listed in the Claims section above within thirty (30) business days of receipt of the Brown & Toland Inappropriate Billing letter.

If the specific occurrence is not forwarded to Brown & Toland Peer Review Committee, then a Brown & Toland Medical Director will review the case. The provider will be notified in writing of the decision within seven (7) business days of receipt of the appeal. If the occurrence is forwarded to Brown & Toland Peer Review Committee, then the peer review process will apply.

Contacts for Questions about Physician Compensation

Questions regarding Physician Compensation should be directed to your Physician Services Advisors by emailing physicianservices@altais.com.

Clinical Performance

Committed to the quintuple aim of healthcare—providing the right care at the right time in the right forum while balancing patient and clinician satisfaction—Brown & Toland's Clinical Performance department is a multifaceted group posited to improve the patient and clinician healthcare experience. Within the team, we have 5 key functional areas: (1) Clinical Oversight, (2) Clinical Performance Data Management, (3) Clinical Quality, Population Health & Patient Experience, (4) Clinical Documentation and (5) Clinical Education & Assessment

Clinical Oversight

Our Clinical Oversight team is the centralized aggregation point for audit & corrective action intake and response. They also manage responses specific to delegated Clinical functions pursuant to the value-based contracts we have with our health plan partners. They write & catalogue policy related to clinical delegated functions and produce compliance reporting specific to delegated clinical functions. You may even get a call from one of our Clinical Oversight Secret Shoppers making sure your office complies with federally regulated standards for Provider Appointment Access Standards. This team also supports health plan research requests, quality improvement organization (QIO) and clinically based provider dispute appeals and grievances sent to us by the health plan, the peer review process and support of patient experience activities.

All provider appeals and grievances should follow the Provider Dispute Resolution process; for member appeals and grievance, please recommend patients contact their health plans.

Clinical Performance Data Management

Our Clinical Performance Data Management team works in concert with departments across our organization to cull all data pertinent to measuring clinical performance. This includes measuring patient and physician satisfaction to providing suspecting for open quality and risk gaps at the point of care to composing our clinician scorecards.

Clinical Performance Technology

Altas is proud to offer our Brown & Toland Physician practices COZEVA, a cloud-based application that helps to manage performance in the key areas of quality and risk adjustment. COZEVA is the source of truth for quality and risk adjustment (HCC management) at Altas. Independent practices will use COZEVA to assist in the documentation of quality care gaps and hierarchical condition codes (HCCs).

Cozeva: Provides robust reporting and dashboard functionalities, empowering providers with actionable insights and data-driven decision-making capabilities. Its reporting tools enable providers to track key performance indicators, monitor patient outcomes, and analyze trends in healthcare delivery.

Not on Epic but want to participate in our Annual Health Assessment incentive program or perform recommended screenings with confidence? We have clinicians and coding analysts available to help you structure your own templates to better assist getting at the data that matters for clinical performance all while maximizing clinical workflow. For more information on Cozeva, please contact your Physician Services Advisor.

Clinical Quality, Patient Experience & Population Health

Our Clinical Quality, Patient Experience & Population Health team works on those programs that guide clinical quality to encourage between clinical management and outcomes, including those recommended screenings for all our lines of business across the ages, including colorectal, breast and cervical cancer screenings, statin use among our diabetics and cardiovascular patients, vaccinations for our adolescents, annual depression screenings for all, sexual transmitted disease testing, best practices for antibiotic prescribing, and the annual health assessment for our seniors, among others. And knowing when a patient has rapport with their physician and their office, they are more likely to adhere to those best practices, this team is also to helping you and your staff cultivate the best patient experience. We have a robust randomly administered surveying program of patients to learn of their experience. We try to make things better through our Patient Recovery program and offer classes throughout the year to equip you and your staff with time tested proven strategies to given meaningful patient experience.

Mail Order Lab Program: Periodically throughout the year, we may mail mail-order lab kits to your patients to help close important quality gaps. These include iFOBT kits for colorectal cancer screening, A1C Now for diabetes A1C monitoring and kidney function tests that collect specimens for microalbumin and eGFR testing. Should your patient receive one of these kits in the mail, please encourage them to complete either the kit or with you in the office through our regular lab access channels.

Clinical Documentation

The goal of the Clinical Documentation team is to support physicians in their capture of our member's acuity to ensure adequate support of our clinical programs. The team hosts, in partnership with our Clinical Education & Assessment team, several education sessions

throughout the year as well as one on one courses and feedback audits specific to your office, if desired. They also administer our Annual Wellness, Provider Incentive and Retrospective Chart Review programs.

Retrospective Chart Review:

Every year we will contact you through one of our contracted vendors to collect your patient charts. This is an important part of our program and your participation is appreciated. We have several ways to ease the burden of chart retrieval—just contact us to learn more at wellness@altais.com.

The Clinical Documentation department can be reached at wellness@altais.com. Contact us to ask questions or schedule training for your office.

Clinical Education & Assessment

One of the advantages of being connected with Brown & Toland is our team of clinical educators. We offer a wide array of clinician led courses specific to best practice acuity documentation, telehealth and screening technology and health screenings and prevention. This team also supports our network by performing annual health assessments and other quality health prevention screenings using convenient telehealth technology to see patients in the convenience of their home.

Scorecards

We provide monthly scorecards illustrating who of your patients are due for their preventative screenings. These scorecards identify who on your Medicare Advantage panel are due for their Annual Health Assessment as well as many cancer and diabetes screenings including who is at risk for visiting the Emergency Room unnecessarily so you can intercede as needed. While the scorecard is not the alpha and omega of all needed screenings, it identifies those that we think are most important and we know, part of good clinical care given the patient's medical record.

Annual Health Assessment Incentive Program

Our annual health assessment program can provide insight into our patient's health conditions, help us proactively manage care and mitigate future health risks. We've developed a proven, cost effective and efficient model that focuses on key quality areas and captures a more complete and accurate patient health profile for reimbursement and care management.

Our Medicare Advantage patients can be some of the most challenging for whom to care as

they often have complex needs and comorbidities. We also know, the recommended screenings they require every year can take more time too and we want to compensate you for that added level of care you provide to these patients. We have multiple ways in which you can earn additional monies for the extra level of care you provide to these patients. Please discuss with your PSA details on the Annual Health Assessment Incentive Program.

Adult Primary Care Physician Scope of Standard Services

The Health and Safety Code of California (Section 1367.69) and existing Knox-Keene regulations define PCPs as physicians who have the "responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referrals for specialist care. This means providing care for the majority of health care problems, including but not limited to, preventive services, acute and chronic conditions, and psychological issues."

Within the parameters of a managed care delivery system, expectations exist regarding the scope of services delivered by PCPs. Standards have been developed to clearly define the scope of services within which Brown & Toland PCPs are expected to practice. Physicians who wish to function in the role of a PCP, regardless of their clinical specialty, must meet those standards.

It is recognized that no single physician is expected to provide the entire scope of services (every skill listed) which are described within this document. Rather, the PCP is expected to meet the intent of the definition by initiating care, maintaining continuity of care, and providing care for the majority of health care problems.

These standards delineate those services, which may be provided appropriately, within each individual physician's knowledge or skill level, by PCPs. It is acknowledged that physicians with varying levels of education and experience may require continuing education focused on specific skills or topics to retain the designation of PCP. The standards provide a guideline for Brown & Toland to identify circumstances when additional knowledge or skills may be needed before a physician may be considered a PCP.

Situations are also identified where consultation with or referral to a specialist may be appropriate. It is assumed that consultations or referrals to a specialist for care will take place in the most appropriate, timely, and cost effective manner in light of the specific patient situation under consideration. Patients being referred to a specialist for an initial consultation should have had a prior PCP evaluation within 6 weeks of the referral.

POLICY STATEMENTS

- A. The PCP is responsible for providing attending coverage for patients during acute hospitalization in contracted facilities or coordinating this care with the hospitalist, if available. The PCP or hospitalist, as applicable, is responsible for communicating with assigned attending physicians in non-contracted or out-of-area hospitals for the purpose of facilitating repatriation of their patients into the Brown & Toland network. The PCP or hospitalist, as applicable, is responsible for assuring that timely case management and discharge planning occur. For patients in a skilled nursing facility or nursing home, the PCP is expected to provide attending coverage or coordinate this care with the contracted SNFist, if available.
- B. A copy of the discharge summary or discharge instructions will be faxed or electronically transferred to the PCP within 24 hours of discharge from the acute setting or skilled nursing facility. Following discharge from hospital or skilled nursing facility, the PCP is to ensure timely access to follow-up visit based upon discharge instructions. These visits are considered high priority.
- C. The PCP is responsible for providing the majority of and coordinating all the services required by the patient, except when precipitous emergency circumstances preclude the PCP's role.
 - 1. The "majority" of services are defined as the ability to perform ninety-five percent (95%) of the functions included on the Clinical Skills list below.
 - 2. The PCP is expected to provide periodic evaluation of all body systems, preventive services, acute and chronic care and to address psychosocial issues. For pediatricians and family physicians caring for children this includes assessment of growth and development, and nutritional status.
- D. The PCP's responsibility is continuous.
 - 1. The PCP is required to perform all duties expected of a PCP, such as on-call rotation and/or coverage for emergencies.
 - 2. When care by one or more specialists is required, the responsibility of the PCP is to coordinate all services, not only his or her own, but also all services rendered by one or more specialists.

- E. The PCP is expected to provide those services that can be provided within his or her skills, and to obtain consultation when additional knowledge or skills are required.
- F. The PCP is expected to understand the primary concepts of benefit coverage. PCPs are expected to relay health plan decisions to patients in a positive manner. When the primary purpose of the visit is for a non-covered service, the PCP must inform the patient and obtain written acknowledgment. Once accomplished, the physician has the option of passing the cost of the service onto the patient.
- G. When the PCP has determined that a referral to a specialist is required, it is the responsibility of the PCP to forward all relevant clinical and diagnostic data to the specialist prior to the consultation.

CLINICAL SKILLS

The following standards define those clinical skills or services ordinarily provided by a PCP and those ordinarily requiring consultation or referral.

Allergic Syndromes

- a. Elicit a thorough allergy history and use environmental controls before allergy referral.
- b. Treat acute and chronic asthma. Consider consultation or referral if treatment is unsuccessful, hospitalization is necessary or chronic steroid treatment is needed.
- c. Treat all seasonal allergies when symptoms last less than six (6) weeks per year or occur in two (2) seasons but for less than one (1) month each time. Consider consultation or referral for symptoms lasting longer than this perennially or unresponsive to treatment.
- d. Treat chronic rhinitis and consider consultation or referral if problem is unresponsive to 6 weeks of therapy
- e. Treat hives and seek cause. Consider consultation or referral if urticaria becomes chronic and not controlled with antihistamines.
- f. Initial referral to an allergist should only occur if patient has been seen by PCP in preceding 6 weeks.

Cardiovascular System

1. Recognize congenital and valvular disease by history and physical examination. Include electrocardiogram and chest x-ray in the evaluation if a diagnosis other than a functional systolic ejection murmur is being considered. Consult when congenital or valvular disease has been diagnosed to determine plan of treatment and follow-up.
2. Provide education, and prophylaxis against, acute rheumatic fever or bacterial endocarditis.
3. Evaluate and treat coronary risk factors including diabetes, hyperlipidemia, hypertension and smoking.
4. Recognize and evaluate chest pain by history, physical examination, and electrocardiogram. Consider consultation or stress testing in patients with atypical chest pain and 2 or more risk factors. Consider consultation if the clinical picture is confusing, if new onset chest pain suggests angina pectoris or stable chest pain changes with increased frequency or duration or decreased threshold for occurrence.
5. Treat angina medically with risk factor/lifestyle modification and nitrates, beta-blockers, calcium channel blockers, and other medication as appropriate. Consult for:
 - Angina occurring despite maximal medical treatment.
 - Non-invasive tests suggest a poor prognosis.
 - Increasing angina after myocardial infarction.
 - Sub-endocrinal myocardial infarction with or without angina.
6. Treat hypertension to achieve satisfactory control. Consult if hypertension is refractory to treatment, if cardiomegaly, chest pain or congestive heart failures are associated, or if more critical complications such as encephalopathy, pulmonary edema, major vascular accidents or rapidly progressive nephropathy require immediate control.
7. Recognize and treat congestive heart failure, particularly maintenance treatment for those who are stable. Consult for patients with diastolic dysfunction, valvular disease, pericardial disease, or non-ischemic cardiomyopathy. Consult for acute congestive heart failure associated with myocardial infarction, arrhythmia, ischemia, and hypertension or if the cause of acute congestive heart failure is not known.
8. Determine if syncope is cardiovascular, for example, valvular, arrhythmic, or autonomic. Consult if the patient has known heart disease or for

recurrent episodes when the cause has not been identified. If a transient cause has not been identified and episodes are recurrent.

9. Recognize minor and major arrhythmias and their significance. Consults for patients with successful resuscitation, ventricular tachycardia, symptomatic bradycardia, recurrent paroxysmal bradycardia, recurrent paroxysmal atrial fibrillation, Wolff-Parkinson-White syndrome, AV Nodal Re-entrant tachycardia and for supraventricular arrhythmias refractory to medical treatment.
10. Distinguish acute pericarditis from other chest pain syndromes by history, physical examination, and electrocardiogram. Consult for pericardial effusion and other complications of acute or chronic pericardial disease.

Dermatology

Initial referral to a Dermatologist should only occur if patient has been evaluated by PCP in preceding 6 weeks and other criteria as delineated below are met.

Pre-Cancerous Skin Lesions and Skin Cancers

Dermatologists will be the primary referral source for evaluation of patients presumed to have skin cancers or pre-cancerous lesions regardless of lesion size or location.

Psoriasis

Manage limited cases of psoriasis. Refer if:

- a. Diagnosis in question.
- b. Lack of satisfactory response to topical treatment.
- c. Pustular lesions present.
- d. Arthritis present.
- e. Special treatments such as phototherapy (UVB or PUVA), immunosuppressive, retinoid or intralesional corticosteroids are being considered.

Warts

Attempt conservative methods. Genital warts (Condyloma Acuminatum) often can be managed by the PCP but in females may also be referred to a gynecologist. PCP to specialist referral suggested

if:

- f. Diagnosis in question.
- g. Warts are large, numerous or symptomatic or involving face, plantar, or foot area.
- h. Lack of satisfactory response to treatment.

Molluscum

Contagiosum

Referral suggested

if:

- i. Diagnosis is in question.
- j. Lack of satisfactory response to treatment.

Hair Loss

Diagnose post-partum, post-surgical or male pattern baldness. Referral suggested if:

- k. Cause is not obvious by history and scalp inspection and underlying illnesses ruled out such as hypothyroidism, iron deficiency anemia, and Tinea capitis.
- l. Scarring alopecia is present.
- m. Unresponsive to therapy or recommendations

Fungus Infections

Use potassium hydroxide (KOH) examinations and/or fungal cultures to diagnose some cases of dermatophyte infections: tinea capitis, tinea corporis, tinea cruris, tinea pedis, tinea manuum, and onychomycosis, candida and tinea versicolor. Referral suggested if:

- n. Diagnosis in question.
- o. Lack of satisfactory response to antifungal treatment after 2 weeks for skin and 12 weeks for nail infections.

Herpes Simplex Infection

May diagnose some cases of oral, labial, or genital herpes simplex virus infections and

begin treatment with topical measures or oral antiviral agents. Referral suggested if:

- p. Diagnosis in question.
- q. Lack of adequate response to antiviral treatment after 1 week.

Acne

Initiate treatment for most cases of acne. Referral suggested if:

- r. Lack of satisfactory response to treatment, e.g., topical or oral antibiotics after a reasonable amount of time (usually 2 months).
- s. Cysts or nodules present.
- t. Isotretinoin (Accutane) considered.
- u. Scarring actively occurring.
- v. Special treatment such as intra-lesion corticosteroid injection or acne surgery is contemplated.
- w. Acne is associated with signs of androgen excess, such as hirsutism and androgenic alopecia.

Herpes Zoster

May diagnose and treat herpes zoster. Referral suggested if:

- x. Diagnosis in question.
- y. Lack of satisfactory response to treatment.

Impetigo and Pyoderma

May diagnose and treat impetigo and other bacterial pyodermas with oral or topical antibiotics. Referral is suggested if:

- z. Diagnosis in question.
- aa. Lack of satisfactory response to treatment.

Dermatoses

Diagnose and treat common inflammatory dermatoses (“rashes”) such as:

- a. Contact dermatitis
- b. Drug and other allergic eruptions
- c. Seborrheic dermatitis
- d. Atopic dermatitis

e. Eczema

Referral suggested if diagnosis in question or lack of satisfactory treatment response.

Keloids

Evaluate patients: small, asymptomatic keloids in covered areas may not require treatment. Larger or symptomatic keloids commonly need treatment. Suggest referral to dermatologists for management of keloids. If physician determines service is cosmetic, then patient is financially responsible for the treatment. Please have patient sign a "Financial Liability Consent Form for Non-Covered Medical Services." If physician determines that service is not cosmetic, then please submit prior authorization request with documents of medical necessity.

Endocrine System

1. Diagnose and manage non insulin-dependent and insulin-dependent diabetes.
 - a. Consider consultation or referral if unstable or unable to achieve optimal control.
 - a. Consider referral to education programs at Brown & Toland contract locations for newly diagnosed or unstable diabetics.
 - b. Management per Brown & Toland Diabetes guidelines.
2. Diagnose and treat thyroid disorders.
 - a. Consider consultation or referral for hyperthyroidism/congenital hypothyroidism.
 - b. Initiate work-up, (for example, fine needle aspiration, basic labs, for thyroid nodule, etc.) prior to referral.
3. Diagnose and treat lipid disorders with diet and/or at least two (2) medications for minimum of six (6) months. Consider consultation or referral if goals of treatment are not met, especially with high risk patients, within six (6) months to one (1) year.

Female Reproductive System

- a. Provide pelvic exams and Pap smears.
- b. Diagnose and treat common GYN conditions, including vaginitis, sexually transmitted diseases, and menstrual disorders such as dysmenorrhea or

vaginal bleeding. Attempt treatment for vaginal warts; refer when unresponsive to treatment.

- c. Perform endometrial biopsies, D & C's, and termination of pregnancies when adequately trained.
- d. Provide contraceptive counseling and management.
- e. Identify breast lumps; refer for surgical management.

GI System

1. Diagnose and treat common GI conditions including esophageal reflux disease, hiatal hernia, hyperacidic and duodenal ulcer disease, H pylori, diarrhea, protracted vomiting, functional bowel disease, obstruction, and diverticulitis. Initial evaluation to include: stool culture and O & P (Ova and Parasites). Treat acute symptoms consistent with peptic disease. Consider consultation or referral if unresponsive to treatment after (one) 1 month or for recurrent unresponsive disease.
2. Undertake evaluation and diagnosis of liver disorders. Consider consultation or referral for undiagnosed hepatocellular disease, obstruction or intractable ascites.
3. Diagnose and treat symptomatic hemorrhoids and fissures. May enucleate thrombosed external hemorrhoids when clinically appropriate. Consider referral if additional intervention is required.
4. May perform screening flexible sigmoidoscopy if equipped and adequately trained.

Hematology

1. Diagnose and manage anemia (for example, iron deficiency, etc.)
2. Consultation for anemia of unknown cause, suspected thalassemia/sickle cell or oncologic anemia
3. Consider referral for bleeding/clotting disorder

Infectious Diseases

1. Diagnose HIV or hepatitis based on risk factors. Obtain cultures (blood, sputum, urine) and interpret results.
2. Diagnose tuberculosis.
3. Recognize meningitis/CNS infection and refer.
4. Diagnose endocarditis.

5. Diagnose and treat viral exanthemes.
6. Vaccinate appropriately (for example, tetanus–diphtheria, Hepatitis A and B, Pneumovax, etc.).
7. Manage HIV disease per Brown & Toland HIV guidelines or refer to Brown & Toland HIV specialist.
8. Diagnose and treat STDs. Consider referral to ID specialist if patient does not respond to treatment or is HIV positive.
9. Provide standard travel vaccinations or refer to a Brown & Toland contracted vendor.

Mental Health

1. Treat depressive and anxiety disorders and manage medication for stable psychiatric disorders (for example, schizophrenia or bipolar illness). Identify and manage substantial abuse disorders. Refer to Mental Health when necessary.

Musculoskeletal System

1. Diagnose and treat low back pain and sciatica without neurological deficit as described under “Nervous System” section.
2. Diagnose and treat common musculoskeletal medical and traumatic problems including osteoarthritis, runner’s knee, sprains, and acute inflammatory conditions. Consider consultation or referral for intractable problems after a minimum of 6 (six) weeks’ conservative medical therapy.
3. Manage chronic pain if consultation ruled out surgery.
4. Perform soft tissue or joint injection when clinically appropriate.
5. Diagnose and treat common foot problems including conservative care (for example, trim toe nails, paring or chemical treatment of corns or calluses, treat sprains and strains with anti- inflammatory medications, appropriate shoe gear, and prescribe antibiotics and soaks for ingrown toe nails, etc.)
6. Refer for significant congenital orthopedic diagnoses.

Nervous System

1. Diagnose and treat neurologic pain syndromes, including headaches and migraines, myofascial pain and TMJ syndrome, low back pain, lumbosacral disk disease, and sciatica. Consider consultation or referral if neurologic deficit present or unresponsive to conservative measures and/or no

improvement after therapy. This does not preclude investigation and treatment of suspected intracranial disorders, which may warrant more immediate intervention.

2. Manage uncomplicated stroke and TIA.

Nutrition

Perform standardized nutrition screenings appropriate for age, stage or growth (i.e. peds & prenatal), patient population, and presence of, or risk for chronic conditions.

1. Measure an accurate weight and height without shoes at all routine medical office visits.
2. Calculate Body Mass Index (BMI) and utilize current BMI classification for adults. Utilize age and gender adjusted growth charts for children, as well as monitor trends in BMI over time in both adults and pediatric patients.
3. Provide information on current dietary guidelines for healthy individuals for the pediatric, adult and geriatric populations. Provide additional guidance for overweight individuals.
4. Perform nutrition screening along with risk assessment for chronic health conditions. Determine the need for specialized nutrition counseling in individuals with diabetes, renal disease, hyperlipidemia, and other medical conditions requiring specialized nutrition guidance or treatment by a specialist provider.
5. Facilitate treatment for obesity in adult and pediatric population. Utilize evidence-based guidelines for screening, assessment and diagnosis of obesity and determine appropriate referrals to specialist care.

Ophthalmology Services

1. Perform a thorough ophthalmologic history, eliciting factors of family history, symptoms, subjective visual acuity. Provide common eye related services including distant, near, and color vision testing, gross visual field testing by confrontation, alternative cover testing, physical examination including direct fundoscopy without dilation, extra-ocular muscle function evaluation, and red reflex testing in pediatric patients.
2. Diagnose and treat common eye conditions including viral, bacterial and

allergic conjunctivitis; blepharitis; hordeolum; chalazion; small subconjunctival hemorrhage; and dacryocystitis. Consultation or referral is recommended where a high index of suspicion for herpes exists.

3. May remove corneal foreign bodies and treat corneal abrasion including fluorescein staining, patching and slit lamp examination if available. Consider consultation, if needed.
4. Consider consultation or referral for sudden visual change or loss, lens opacification, visual change accompanied by pain, abnormal fundoscopic examination, any eye symptom not responding to treatment, and pediatric patients with disconjugate gaze or other ophthalmologic problems.

Otolaryngology (ENT)

1. Treat tonsillitis and strep infections. Consider consultation or referral if three (3) documented episodes occur within four (4) or six (6) months within 1 year.
2. Treat acute otitis media. Consider a referral for evaluation of otitis media based on documentation of one or more:
 - a. Chronic: defined as infections unresponsive to antibiotic therapy and producing a hearing loss demonstrated through audiometry and/or clinical evaluation.
 - b. Recurrent: defined as four or more acute infections per year and/or breakthrough infections while on low dosage maintenance antibiotics.
 - c. Persistent: defined as middle ear effusion (also referred to as serious otitis or "glue ear") in excess of three (3) months, not improving with an adequate trial of medication.
 - d. Persistent retraction of the tympanic membrane.
 - e. Complicating co-morbidity (for example, Down's syndrome or facial structure anomalies, cleft palate) complicating the treatment of otitis media.
3. Treat acute and chronic sinusitis with up to two (2) courses of antibiotics. Consider consultation or referral if infection is not responsive after two (2) weeks.
4. Treat nasal obstruction, vasomotor or allergic rhinitis. Consider consultation or referral if problem persists more than three (3) months.
5. Remove ear wax.
6. Consider consultation or referral for Bell's Palsy.
7. Obtain consultation or referral for acute hearing loss, persistent hearing loss

not attributable to fluid or wax, parotid masses, hoarseness persistent more than three weeks, or hemoptysis.

Pain Management

1. Diagnose and initiate treatment for acute pain problems, including, but not limited to musculoskeletal pain, neuralgias, and acute inflammatory conditions. Consider consulting a pain management specialist for complex pain problems not responsive after four (4) weeks of conservative management.
2. Manage chronic pain problems after consultation and treatment plan implemented by pain management specialist.

Renal System

1. Evaluate and manage renal insufficiency: identify systemic cause (for example, CVD, diabetes, hypertension, medications, obstructive.)
2. Obtain consultation for cases with unclear diagnosis or progression.

Respiratory System

1. Diagnose and treat common respiratory conditions including asthma, acute bronchitis, pneumonia, and COPD.
2. Manage asthma per Brown & Toland asthma guidelines.
3. Consider consultation or referral for persistent pleural effusion, unresolved pneumonia, hemoptysis, lung mass, interstitial disease, sarcoid, TB, cystic fibrosis, unusual infections, or dyspnea of unknown etiology.

Rheumatology

1. Diagnose and treat common rheumatologic conditions including non-specific musculoskeletal pain, bursitis, tendonitis, and osteoarthritis. Consider consultation or referral if unresponsive after two (2) to three (3) months of therapy, or if functional impairment exists.
2. Diagnose and treat acute inflammatory arthritic diseases. Consider consultation or referral to establish long-term management if unresponsive to treatment plan or aspiration and/or injection

is needed.

3. Diagnose and treat uncomplicated collagen vascular diseases. Consider consultation or referral depending on the extent and severity of manifestations.

Urinary System

1. Diagnose and treat both initial and recurrent urinary tract infections.
Consider consultation or referral for unexplained hematuria.
2. Diagnose and initiate medical treatment for BPH.
3. Evaluate and treat male sexual dysfunction. Refer cases unresponsive to therapy.

Timely Access to Care Standards

The Department of Managed Healthcare (DMHC) and the Department of Healthcare Services (DHCS) require you to complete appointment requests within these timelines. These standards guarantee that patients have timely access to care.

Please review these standards with all staff and audit your own office for compliance. Ensure that hours and days of operation are consistent with what you have reported. If there are changes, please notify us immediately.

Timely Access to Care Requirements

Distance: Access to a Primary Care provider or hospital must be provided within a 15-mile radius from where the enrollee lives, or 30 miles from where they work.

Availability: Health Plans should provide enrollees telephone services 24/7.

Interpreter: Services must be coordinated with scheduled appointments for Health Care to ensure interpreter services are available at the time of the appointment.

For more information please visit: Department of Managed Healthcare (DMHC) California Department of Managed Health Care or contact the DMHC Help Center at: 888-466-2219 or www.HealthHelpca.gov.

Urgent Care

- Prior Authorization not required by the Health Plan: Wait Time: 2 days
- Prior Authorization required by the Health Plan: Wait Time: 4 days
- Services that do require prior authorization: Wait Time: 4 days

Non Urgent Appointments

- Primary Care Physician, Regular/Routine Wait Time: 10 business days, (Specialty Care Physician) 15 business days
- Preventive Care: Wait Time: 30 calendar days
- Mental Health Appointment (non-physician): Wait Time: 10 business days, (ancillary provider) 15 business days
- Other services to diagnose or treat a health condition: Wait Time: 15 business days

Follow-Up Care

Mental Health / Substance Use Disorder Follow-up Appointment (non-physician): Wait Time: 10 business days from prior appointment (effective July 1, 2022)

After Hours Access Requirements

After-Hours Access audits are routinely conducted to ensure that physician offices have appropriate after-hours telephone recordings that direct patients to an emergency room or urgent care facility to access immediate care. An on-call phone number or nurse's line must be provided during the message.

Primary Care Physicians are to be available by telephone 24 hours per day, 7 days per week within 30 minutes of member call. An effective telephone service after normal business hours provides for callers to reach a live voice within 30 seconds. All calls must be returned within 30 minutes to meet DMHC Access Requirements. A sample script is available on [Altais.com](https://www.altais.com) and may be used by your office or medical group as an example for ensuring members have access to timely medical care after normal business hours.

Access to Records

Providers must provide access to any medical, financial, or administrative records related to services provided to Family Care Specialists IPA members. Maintain these records for at least 10 years. Providers must establish policies that safeguard privacy and maintain accurate medical records that abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information.

Administration of Health Assessments

An Initial Health Assessment (IHA) must be provided to all members 18 months or older within one hundred twenty (120) days of enrollment and within sixty (60) days of enrollment for members under age 18 months. This consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). Follow the Staying Healthy

Assessment (SHA) Periodicity Schedule. The SHA policy letter, forms, and provider training materials are found here: dhcs.ca.gov

Initial Health Assessment (IHA) Components and Requirements

PCPs are responsible for reviewing each member's IHA in combination with:

- Medical history, conditions, problems, medical/testing results, and member concerns
- Social history, including member's demographic data, personal circumstances, family composition, member resources, and social support
- Local demographic and epidemiologic factors that influence risk status

The IHA consists of:

A. Comprehensive History must be sufficiently comprehensive to assess and diagnose acute and chronic conditions including:

- History of present illness
- Past medical history
- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies
- Age-appropriate immunization status
- Age-appropriate feeding and dietary status
- Social history
- Marital status and living arrangements
- Current employment
- Occupational history
- Use of alcohol, drugs, and tobacco
- Level of education
- Sexual history
- Any other relevant social factors
- Review of organ systems

A. Preventive Services

Asymptomatic healthy adults must adhere to the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF), specifically USPSTAF "A" and "B" recommendations for providing preventive screening, testing, and counseling services. Document status of current recommended

- Members younger than 21 years of age provide preventive services by the most recent American Academy of Pediatrics age specific guidelines and periodicity schedule.
 - Perinatal services for pregnant members must be provided according to the most current standards of guidelines of the American College of Obstetrics and Gynecology (ACOG). A DHCS approved comprehensive risk assessment tool must be used for all pregnant members. This must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up and documented in the medical record.
- B. Comprehensive Physical and Mental Status exam must be sufficient to assess and diagnose acute and chronic conditions.
- C. Diagnoses and Plan of Care the plan of care must include all follow up activities
- E. Individual Health Education Behavioral Assessment (IHEBA)
- IHEBA requirement administer an age specific
 - IHEBA as part of the IHA. Assessment tools used to complete the IHEBA must be approved by the Medi-Cal Managed Care Division (MMCD) prior to use
 - Exceptions for transferring members
 - the IHEBA requirement for members transferring from an outside group may be met if the medical record indicates in the IHEBA tool or a behavioral risk assessment has been completed within the last 12 months.

The age specific and age-appropriate behavioral risk assessment should cover:

- Diet and weight issues
- Dental care
- Domestic violence
- Drugs and alcohol
- Exercise and sun exposure
- Medical care from other sources
- Mental health
- Pregnancy
- Birth control
- STIs/STDs
- Sexuality
- Safety prevention
- Tobacco use and exposure

Please contact your PSA for information regarding provider training and education opportunities on a variety of topics including, but not limited to: clinical guidelines and useful information regarding HCC scores, CPSP/CHDP/Regional Programs, Cultural Linguistics, Nurse Advice Lines and useful training and tips like Advanced Directives, When to Release Health Information under HIPAA Law, and Critical Incident Reporting.

Who Can Perform the IHA?

The member's PCP of record

- Perinatal Care Providers
- Primary Care Providers

Non-Physician Mid-Level Practitioners

Staying Healthy Assessment (SHA) Periodicity Schedule

Members must complete a SHA in accordance with the following guidelines and time frames listed. Document a member's refusal to complete the SHA on the appropriate age-specific form and keep in their records.

New members must complete the SHA within 120 days of the effective date of enrollment. The effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System (MEDS) that a member is eligible to receive services.

Current members who have not completed an updated SHA must complete it during the next preventive care office visit, according to the SHA periodicity table.

Pediatric members—Members 0–17 years of age must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group. PCPs must review the SHA annually with the patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group.

Adolescents (12–17 years) should complete the SHA without parental/guardian assistance beginning at 12 years of age, or at the earliest age possible. This helps to get accurate responses to sensitive questions. You should determine the most appropriate age, based on discussion with the parent/guardian and the family's ethnic/cultural background.

Adult and senior members—There are no designated age ranges for the adult and senior assessments. It is intended for use by ages 18 to 55 years. The age at which the PCP should

begin administering the senior assessment to a member should be based on the patient's health and medical status, and not exclusively on age. The adult or senior assessment must be re-administered every three to five years, at a minimum. You must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered.

Although not required, SHA annual administration is highly recommended for the adolescent and senior groups because behavioral risk factors change frequently during these years.

Periodicity Table:

	Periodicity	Administer	Administer/Re-administer		Review
DHCS Form Number	Age Groups	Within 120 days of enrollment	1 st scheduled exam (after entering new age group)	Every 3-5 years	Annually (intervening years)
DHCS 7098 A	0-6 Months	X	X		
DHCS 7098 B	7-12 Months	X	X		
DHCS 7098 C	1-2 Years	X	X		X
DHCS 7098 D	3-4 Years	X	X		X
DHCS 7098 E	5-8 Years	X	X		X
DHCS 7098 F	9-11 Years	X	X		X
DHCS 7098 G	12-17 Years	X	X		X
DHCS 7098 H	Adult	X		X	X
DHCS 7098 I	Senior	X		X	X

SHA Documentation by PCP

- A. Sign print your name, and date the "Clinic Use Only" section of a newly administered SHA to verify you reviewed and discussed it with the member.
- B. Document specific behavioral-risk topics and patient counseling, referral, anticipatory guidance, and follow-up provided, by checking the appropriate boxes in the "Clinical Use Only" section.
- C. Sign print your name, and date the "SHA Annual Review" section of the questionnaire to document that an annual review was completed and discussed with the member.
- D. If a member refuses the service:
 - Enter the member's name (or person completing the form), date of birth, and date of refusal in the header section of the questionnaire.
 - Check the box "SHA Declined by Patient."

- Sign, print your name, and date the “Clinic Use Only” section of the SHA.
- Keep the SHA refusal in the member’s medical record.

Clinical Skills

The following standards define those clinical skills or services ordinarily provided by a PCP and those ordinarily requiring consultation or referral.

Allergic Syndromes

- a. Elicit a thorough allergy history and use environmental controls before allergy referral.
- b. Treat acute and chronic asthma. Consider consultation or referral if treatment is unsuccessful, hospitalization is necessary or chronic steroid treatment is needed.
- c. Treat all seasonal allergies when symptoms last less than six (6) weeks per year or occur in two (2) seasons but for less than one (1) month each time. Consider consultation or referral for symptoms lasting longer than this perennially or unresponsive to treatment.
- d. Treat chronic rhinitis and consider consultation or referral if problem is unresponsive to 6 weeks of therapy
- e. Treat hives and seek cause. Consider consultation or referral if urticaria becomes chronic and not controlled with antihistamines.
- f. Initial referral to an allergist should only occur if patient has been seen by PCP in preceding 6 weeks.

Cardiovascular System

- a. Recognize congenital and valvular disease by history and physical examination. Include electrocardiogram and chest x-ray in the evaluation if a diagnosis other than a functional systolic ejection murmur is being considered. Consult when congenital or valvular disease has been diagnosed to determine plan of treatment and follow-up.
- b. Provide education, and prophylaxis against, acute rheumatic fever or bacterial endocarditis.
- c. Evaluate and treat coronary risk factors including diabetes, hyperlipidemia, hypertension and smoking.
- d. Recognize and evaluate chest pain by history, physical examination, and electrocardiogram. Consider consultation or stress testing in patients with atypical chest

pain and 2 or more risk factors. Consider consultation if the clinical picture is confusing, if new onset chest pain suggests angina pectoris or stable chest pain changes with increased frequency or duration or decreased threshold for occurrence.

- e. Treat angina medically with risk factor/lifestyle modification and nitrates, beta-blockers, calcium channel blockers, and other medication as appropriate. Consult for:
 - Angina occurring despite maximal medical treatment.
 - Non-invasive tests suggest a poor prognosis.
 - Increasing angina after myocardial infarction.
 - Sub-endocrinal myocardial infarction with or without angina.
- f. Treat hypertension to achieve satisfactory control. Consult if hypertension is refractory to treatment, if cardiomegaly, chest pain or congestive heart failures are associated, or if more critical complications such as encephalopathy, pulmonary edema, major vascular accidents or rapidly progressive nephropathy require immediate control.
- g. Recognize and treat congestive heart failure, particularly maintenance treatment for those who are stable. Consult for patients with diastolic dysfunction, valvular disease, pericardial disease, or non-ischemic cardiomyopathy. Consult for acute congestive heart failure associated with myocardial infarction, arrhythmia, ischemia, and hypertension or if the cause of acute congestive heart failure is not known.
- h. Determine if syncope is cardiovascular, for example, valvular, arrhythmic, or autonomic. Consult if the patient has known heart disease or for recurrent episodes when the cause has not been identified. If a transient cause has not been identified and episodes are recurrent.
- i. Recognize minor and major arrhythmias and their significance. Consults for patients with successful resuscitation, ventricular tachycardia, symptomatic bradycardia, recurrent paroxysmal bradycardia, recurrent paroxysmal atrial fibrillation, Wolff-Parkinson-White syndrome, AV Nodal Re-entrant tachycardia and for supraventricular arrhythmias refractory to medical treatment.
- j. Distinguish acute pericarditis from other chest pain syndromes by history, physical examination, and electrocardiogram. Consult for pericardial effusion and other complications of acute or chronic pericardial disease.

Dermatology

Initial referral to a Dermatologist should only occur if patient has been evaluated by PCP in

preceding 6 weeks and other criteria as delineated below are met.

Pre-Cancerous Skin Lesions and Skin Cancers

Dermatologists will be the primary referral source for evaluation of patients presumed to have skin cancers or pre-cancerous lesions regardless of lesion size or location.

Psoriasis

Manage limited cases of psoriasis. Refer if:

- a. Diagnosis in question.
- b. Lack of satisfactory response to topical treatment.
- c. Pustular lesions present.
- d. Arthritis present.
- e. Special treatments such as phototherapy (UVB or PUVA), immunosuppressive, retinoid or intralesional corticosteroids are being considered.

Warts

Attempt conservative methods. Genital warts (Condyloma Acuminatum) often can be managed by the PCP but in females may also be referred to a gynecologist. PCP to specialist referral suggested if:

- a. Diagnosis in question.
- b. Warts are large, numerous or symptomatic or involving face, plantar, or foot area.
- c. Lack of satisfactory response to treatment.

Molluscum Contagiosum

Referral suggested if:

- a. Diagnosis is in question.
- b. Lack of satisfactory response to treatment.

Hair Loss

Diagnose post-partum, post-surgical or male pattern baldness. Referral suggested if:

- a. Cause is not obvious by history and scalp inspection and underlying illnesses ruled out such as hypothyroidism, iron deficiency anemia, and Tinea capitis.
- b. Scarring alopecia is present.
- c. Unresponsive to therapy or recommendations

Fungus Infections

Use potassium hydroxide (KOH) examinations and/or fungal cultures to diagnose some

cases of dermatophyte infections: tinea capitis, tinea corporis, tinea cruris, tinea pedis, tinea manuum, and onychomycosis, candida and tinea versicolor. Referral suggested if:

- a. Diagnosis in question.
- b. Lack of satisfactory response to antifungal treatment after 2 weeks for skin and 12 weeks for nail infections.

Herpes Simplex Infection

May diagnose some cases of oral, labial, or genital herpes simplex virus infections and begin treatment with topical measures or oral antiviral agents. Referral suggested if:

- a. Diagnosis in question.
- b. Lack of adequate response to antiviral treatment after 1 week.

Acne

Initiate treatment for most cases of acne. Referral suggested if:

- a. Lack of satisfactory response to treatment, e.g., topical or oral antibiotics after a reasonable amount of time (usually 2 months).
- b. Cysts or nodules present.
- c. Isotretinoin (Accutane) considered.
- d. Scarring actively occurring.
- e. Special treatment such as intra-lesion corticosteroid injection or acne surgery is contemplated.
- f. Acne is associated with signs of androgen excess, such as hirsutism and androgenic alopecia.

Herpes Zoster

May diagnose and treat herpes zoster. Referral suggested if:

- a. Diagnosis in question.
- b. Lack of satisfactory response to treatment.

Impetigo and Pyoderma

May diagnose and treat impetigo and other bacterial pyodermas with oral or topical antibiotics. Referral is suggested if:

- a. Diagnosis in question.
- b. Lack of satisfactory response to treatment.

Dermatoses

Diagnose and treat common inflammatory dermatoses ("rashes") such as:

- a. Contact dermatitis
- b. Drug and other allergic eruptions
- c. Seborrheic dermatitis
- d. Atopic dermatitis
- e. Eczema

Referral suggested if diagnosis in question or lack of satisfactory treatment response.

Keloids

Evaluate patients: small, asymptomatic keloids in covered areas may not require treatment. Larger or symptomatic keloids commonly need treatment. Suggest referral to dermatologists for management of keloids. If physician determines service is cosmetic, then patient is financially responsible for the treatment. Please have patient sign a "Financial Liability Consent Form for Non-Covered Medical Services." If physician determines that service is not cosmetic, then please submit prior authorization request with documents of medical necessity.

Endocrine System

- a. Diagnose and manage non insulin-dependent and insulin-dependent diabetes.
 - Consider consultation or referral if unstable or unable to achieve optimal control.
 - Consider referral to education programs at Altais contract locations for newly diagnosed or unstable diabetics.
 - Management per Altais Diabetes guidelines.
- b. Diagnose and treat thyroid disorders.
 - Consider consultation or referral for hyperthyroidism/congenital hypothyroidism.
 - Initiate work-up, (for example, fine needle aspiration, basic labs, for thyroid nodule, etc.) prior to referral.
- c. Diagnose and treat lipid disorders with diet and/or at least two (2) medications for minimum of six (6) months. Consider consultation or referral if goals of treatment are not met, especially with high risk patients, within six (6) months to one (1) year.

Female Reproductive System

- a. Provide pelvic exams and Pap smears.
- b. Diagnose and treat common GYN conditions, including vaginitis, sexually transmitted diseases, and menstrual disorders such as dysmenorrhea or vaginal bleeding. Attempt treatment for vaginal warts; refer when unresponsive to treatment.
- c. Perform endometrial biopsies, D & C's, and termination of pregnancies when adequately trained.
- d. Provide contraceptive counseling and management.

- e. Identify breast lumps; refer for surgical management.

GI System

- a. Diagnose and treat common GI conditions including esophageal reflux disease, hiatal hernia, hyperacidic and duodenal ulcer disease, H pylori, diarrhea, protracted vomiting, functional bowel disease, obstruction, and diverticulitis. Initial evaluation to include: stool culture and O & P (Ova and Parasites). Treat acute symptoms consistent with peptic disease. Consider consultation or referral if unresponsive to treatment after (one) 1 month or for recurrent unresponsive disease.
- b. Undertake evaluation and diagnosis of liver disorders. Consider consultation or referral for undiagnosed hepatocellular disease, obstruction or intractable ascites.
- c. Diagnose and treat symptomatic hemorrhoids and fissures. May enucleate thrombosed external hemorrhoids when clinically appropriate. Consider referral if additional intervention is required.
- d. May perform screening flexible sigmoidoscopy if equipped and adequately trained.

Hematology

- a. Diagnose and manage anemia (for example, iron deficiency, etc.)
- b. Consultation for anemia of unknown cause, suspected thalassemia/sickle cell or oncologic anemia
- c. Consider referral for bleeding/clotting disorder

Infectious Diseases

- a. Diagnose HIV or hepatitis based on risk factors. Obtain cultures (blood, sputum, urine) and interpret results.
- b. Diagnose tuberculosis.
- c. Recognize meningitis/CNS infection and refer.
- d. Diagnose endocarditis.
- e. Diagnose and treat viral exanthems.
- f. Vaccinate appropriately (for example, tetanus–diphtheria, Hepatitis A and B, Pneumovax, etc.).
- g. Manage HIV disease per Alta's HIV guidelines or refer to Alta's HIV specialist.
- h. Diagnose and treat STDs. Consider referral to ID specialist if patient does not respond to treatment or is HIV positive.
- i. Provide standard travel vaccinations or refer to an Alta's contracted vendor.

Mental Health

Treat depressive and anxiety disorders and manage medication for stable psychiatric disorders (for example, schizophrenia or bipolar illness). Identify and manage substantial abuse disorders. Refer to Mental Health when necessary.

Musculoskeletal System

- a. Diagnose and treat low back pain and sciatica without neurological deficit as described under “Nervous System” section.
- b. Diagnose and treat common musculoskeletal medical and traumatic problems including osteoarthritis, runner’s knee, sprains, and acute inflammatory conditions. Consider consultation or referral for intractable problems after a minimum of 6 (six) weeks’ conservative medical therapy.
- c. Manage chronic pain if consultation ruled out surgery.
- d. Perform soft tissue or joint injection when clinically appropriate.
- e. Diagnose and treat common foot problems including conservative care (for example, trim toenails, paring or chemical treatment of corns or calluses, treat sprains and strains with anti-inflammatory medications, appropriate shoe gear, and prescribe antibiotics and soaks for ingrown toenails, etc.)
- f. Refer for significant congenital orthopedic diagnoses.

Nervous System

Diagnose and treat neurologic pain syndromes, including headaches and migraines, myofascial pain and TMJ syndrome, low back pain, lumbosacral disk disease, and sciatica. Consider consultation or referral if neurologic deficit present or unresponsive to conservative measures and/or no improvement after therapy. This does not preclude investigation and treatment of suspected intracranial disorders, which may warrant more immediate intervention. Manage uncomplicated stroke and TIA.

Nutrition

Perform standardized nutrition screenings appropriate for age, stage or growth (i.e. peds & prenatal), patient population, and presence of, or risk for chronic conditions.

- a. Measure an accurate weight and height without shoes at all routine medical office visits.
- b. Calculate Body Mass Index (BMI) and utilize current BMI classification for adults. Utilize age and gender adjusted growth charts for children, as well as monitor trends in BMI over time in both adults and pediatric patients.
- c. Provide information on current dietary guidelines for healthy individuals for the pediatric, adult and geriatric populations. Provide additional guidance for overweight individuals.
- d. Perform nutrition screening along with risk assessment for chronic health conditions.

Determine the need for specialized nutrition counseling in individuals with diabetes, renal disease, hyperlipidemia, and other medical conditions requiring specialized nutrition guidance or treatment by a specialist provider.

- e. Facilitate treatment for obesity in adult and pediatric population. Utilize evidence-based guidelines for screening, assessment and diagnosis of obesity and determine appropriate referrals to specialist care.

Ophthalmology Services

- a. Perform a thorough ophthalmologic history, eliciting factors of family history, symptoms, subjective visual acuity. Provide common eye related services including distant, near, and color vision testing, gross visual field testing by confrontation, alternative cover testing, physical examination including direct fundoscopy without dilation, extra-ocular muscle function evaluation, and red reflex testing in pediatric patients.
- b. Diagnose and treat common eye conditions including viral, bacterial and allergic conjunctivitis; blepharitis; hordeolum; chalazion; small subconjunctival hemorrhage; and dacryocystitis. Consultation or referral is recommended where a high index of suspicion for herpes exists.
- c. May remove corneal foreign bodies and treat corneal abrasion including fluorescein staining, patching and slit lamp examination if available. Consider consultation, if needed.
- d. Consider consultation or referral for sudden visual change or loss, lens opacification, visual change accompanied by pain, abnormal fundoscopic examination, any eye symptom not responding to treatment, and pediatric patients with disconjugate gaze or other ophthalmologic problems.

Otolaryngology (ENT)

- a. Treat tonsillitis and strep infections. Consider consultation or referral if three (3) documented episodes occur within four (4) or six (6) months within 1 year.
- b. Treat acute otitis media. Consider a referral for evaluation of otitis media based on documentation of one or more:
 - Chronic: defined as infections unresponsive to antibiotic therapy and producing a hearing loss demonstrated through audiometry and/or clinical evaluation.
 - Recurrent: defined as four or more acute infections per year and/or breakthrough infections while on low dosage maintenance antibiotics.
 - Persistent: defined as middle ear effusion (also referred to as serious otitis or "glue ear") in excess of three (3) months, not improving with an adequate trial of medication.

- Persistent retraction of the tympanic membrane.
- Complicating co-morbidity (for example, Down's syndrome or facial structure anomalies, cleft palate) complicating the treatment of otitis media.
- c. Treat acute and chronic sinusitis with up to two (2) courses of antibiotics. Consider consultation or referral if infection is not responsive after two (2) weeks.
- d. Treat nasal obstruction, vasomotor or allergic rhinitis. Consider consultation or referral if problem persists more than three (3) months.
- e. Remove ear wax.
- f. Consider consultation or referral for Bell's Palsy.
- g. Obtain consultation or referral for acute hearing loss, persistent hearing loss not attributable to fluid or wax, parotid masses, hoarseness persistent more than three weeks, or hemoptysis.

Pain Management

- a. Diagnose and initiate treatment for acute pain problems, including, but not limited to musculoskeletal pain, neuralgias, and acute inflammatory conditions. Consider consulting a pain management specialist for complex pain problems not responsive after four (4) weeks of conservative management.
- b. Manage chronic pain problems after consultation and treatment plan implemented by pain management specialist.

Renal System

- a. Evaluate and manage renal insufficiency: identify systemic cause (for example, CVD, diabetes, hypertension, medications, obstructive.)
- b. Obtain consultation for cases with unclear diagnosis or progression.

Respiratory System

- a. Diagnose and treat common respiratory conditions including asthma, acute bronchitis, pneumonia, and COPD.
- b. Manage asthma per Alais asthma guidelines.
- c. Consider consultation or referral for persistent pleural effusion, unresolved pneumonia, hemoptysis, lung mass, interstitial disease, sarcoid, TB, cystic fibrosis, unusual infections, or dyspnea of unknown etiology.

Rheumatology

- a. Diagnose and treat common rheumatologic conditions including non-specific musculoskeletal pain, bursitis, tendonitis, and osteoarthritis. Consider consultation or

referral if unresponsive after two (2) to three (3) months of therapy, or if functional impairment exists.

- b. Diagnose and treat acute inflammatory arthritic diseases. Consider consultation or referral to establish long-term management if unresponsive to treatment plan or aspiration and/or injection is needed.
- c. Diagnose and treat uncomplicated collagen vascular diseases. Consider consultation or referral depending on the extent and severity of manifestations.

Urinary System

- a. Diagnose and treat both initial and recurrent urinary tract infections. Consider consultation or referral for unexplained hematuria.
- b. Diagnose and initiate medical treatment for BPH.
- c. Evaluate and treat male sexual dysfunction. Refer cases unresponsive to therapy.

Utilization Management

Brown & Toland Utilization Management (UM) policies and procedures that support the provision of quality health care services. The goal of UM is to provide Members with the right care, in the right venue, within the most appropriate timeframe. The UM program staff can provide guidance to Providers in order to help support care in all clinical settings and situations including acute care, Long Term Acute Care, Emergency situations, ancillary support, and Hospital admissions for both acute and psychiatric diagnoses. The key objective of Brown & Toland's UM Program is to improve access to care, maintain the highest quality, and create healthy outcomes while providing the most cost-effective care possible. The UM team is composed of Prior Authorization, Inpatient Case Management, Outpatient Case Management, and Pharmacy.

Prior Authorization

Brown & Toland requires all covered services for physical and behavioral health conditions that require authorization, be submitted to the Brown & Toland utilization management (UM) department for review for medical necessity.

Brown & Toland physicians and other licensed clinical staff apply national standards of care to determine the medical necessity for outpatient services. Utilization management decisions are based only on appropriateness of care, benefits for service, and current eligibility.

Hours of Operation

Brown & Toland Prior Authorization staff members are available Monday through Friday from 8:00 am to 5:00 pm excluding holidays listed below:

New Year's Day
Martin Luther King Jr. Day
Memorial Day
Juneteenth
Independence Day
Labor Day
Thanksgiving Day
Fall Holiday Day (Day After Thanksgiving)
Christmas Day

Submitting Requests for Authorizations

All prior authorization can be submitted directly online through EpicLink or via fax.

Online is the preferred method, because by submitting referrals online, Providers have immediate access to the status of the referral.

For all questions, please contact Customer Service at: 800-225-5637 (TTY 711)

Turnaround Time

The turnaround time for a prior Authorization depends on the status of the request:

- **Urgent Request:** Within seventy-two (72) hours of receipt of Authorization request
- **Routine Request:** Within five (5) Working Days of receipt of Authorization request for Commercial, Medi-Cal, and Covered California members only.
- **Routine Request:** Within fourteen (14) Calendar Days of receipt of Authorization request for Medicare Advantage members only.

Definition of an Urgent Request: An imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member.

Prompt Authorization determinations are made in accordance with the guidelines when all supporting clinical information that supports medical necessity is submitted along with the Authorization request.

Prior Authorization List

SERVICE	AUTHORIZATION TYPE
Out of Network	All
Elective Hospital Admission	Hospital Admission
All Unlisted Codes	All
All DME (Includes Orthotics and Prosthetics)	Durable Medical/Medical Supplies
Any procedure with anesthesia/nerve block	Outpatient/Office Services
Acupuncture	Outpatient Rehab
Ambulance - Non-Emergency	Ambulance
Biofeedback	Outpatient Rehab Therapy
Brachytherapy	Outpatient/Office Services
Cardiac CT (Angiography)	Imaging
Cardiac Rehab	Outpatient Rehab Therapy
Child Development Services	Outpatient/Office Services
Chemotherapy-Outpatient	Pharmacy
Chiropractic Services	Outpatient Rehab Therapy
Cosmetic & Reconstructive Procedures	Outpatient/Office Services

Dental (Oral) (surgery related to a medical condition)	Outpatient/Office Services
Dialysis	Outpatient/Office Services
Genetic Counseling	Outpatient/Office Services
Genetic Testing	Genetic Testing
Home Health Services	Home Health
Home Infusion	Home Infusion
Hospice	Hospice (Non-Senior)
Hyperbaric Chamber	Outpatient/Office Services
Immunizations (Travel and Non-Routine)	Vaccines
Infertility (Consultation, Testing, Treatment – Basic and Advanced, Injectables)	Infertility
Infusion Therapy	Outpatient/Office Services
Injectables	Pharmacy
Interventional Radiology	Imaging
Investigational/Experimental procedures	Outpatient/Office Services
Lymphedema therapy/treatment	Outpatient Rehab Therapy
MOHs surgery	Outpatient/Office Services
MRI/MRAs	Imaging
Neuropsych Testing	Outpatient/Office Services
OB Care, including delivery or elective c-section	OB/GYN Inpatient
Occupational Therapy	Outpatient Rehab Therapy
Pain Management Treatment	Outpatient/Office Services
Pelvic Floor Therapy	Outpatient Rehab Therapy
PET Scans	Imaging
Phototherapy (PUVA)	Outpatient/Office Services
Physical Therapy (For non-capitated providers; Children's Hospital-Oakland, Kentfield Rehabilitation Hospital, Pelvic Health & Rehabilitation Center)	Outpatient Rehab Therapy
Pulmonary Rehab	Outpatient Rehab Therapy
Radiation Therapy	Radiation Therapy
Sclerotherapy	Outpatient/Office Services
Speech Therapy	Outpatient Rehab Therapy
Surgery, Inpatient	Hospital-Inpatient
Transplant Evaluation	Pre-Transplant Services
Vestibular Rehab	Outpatient Rehab Therapy
Wound Care & Burn Care	Outpatient/Office Services

No Auth Required List

Brown & Toland permits a Member to obtain some Covered Services without a referral or prior Authorization.

However, the following Covered Services never need a referral from a Provider. Members may choose an in- network Provider for:

- Emergency/Urgent Services
- OBGYN
- Ophthalmology Consult
- Podiatry Consult

Referrals to In-Network/Out of Network Providers

Brown & Toland maintains a wide network of Providers to ensure that the majority of health care needs can be provided within the Service Area. Providers are best prepared to accept referrals and operate within parameters established by Brown & Toland.

If Providers are experiencing difficulty in locating a local Provider that can meet the Member's medical needs, they should contact Customer Service at: 800.225.5637 (TTY 711).

In some cases, Brown & Toland may have exclusive contracts with specialty Providers. In these instances, referrals must be directed to these Providers. Currently all laboratory, all behavioral health, and some vision and durable medical equipment services are contracted through specific vendors. For more information on referral to providers please contact Customer Service at: 800.225.5637 (TTY 711).

New Medical Technology

The use of new medical technology needs Prior Authorization, which will be provided on a case-by-case review by Brown & Toland professional medical staff. All requests must be submitted to Brown & Toland with documentation prior to implementation of the treatment plan.

Second Opinion

Provider or Member requests for 2nd opinion in network:

- Physician will fax or submit the request via EpicLink or Hyperspace
- In network 2nd opinion will be approved

Provider or Member request for 2nd opinion out network

- Physician will fax or submit the request via EpicLink or Hyperspace

- If physician is requesting out of network provider, it will be denied and redirected to an in-network provider
- If member is requesting out of network provider, it will be denied, and member will be referred to their health plan to exercise their right to a second opinion

Peer to Peer

If the treating physician would like to discuss this case with the physician or health care professional reviewer or obtain a copy of the criteria used to make this decision, please call the Medical Director which made determination on the referral.

Inpatient Admission Requirements

All inpatient admissions (including elective) to acute care facilities, skilled nursing facilities, or Long-Term Acute Care facilities require prior Authorization except in the case of an Emergency. Providers are also required to admit Members only to Hospitals contracted with the health plan (Commercial) or Brown & Toland Health Services (Medicare).

Hours of Operation

Brown & Toland Inpatient staff members are available Monday through Friday from 8:00 am to 5:00 pm to receive and respond to inquiries regarding issues from Members and Providers. Inpatient staff members can be reached by contacting customer service at 800.225.5637 (TTY 711).

After Hours

Hospitals or Providers who need assistance after normal business hours (including weekends and holidays) by calling 415.972.4231.

Turnaround Times

Prompt Authorization determinations are made in accordance with the guidelines when all supporting clinical information that supports medical necessity is submitted along with the Authorization request.

Emergency/Urgent Services

Emergency Services are available at any time without prior Authorization. Brown & Toland does not deny claims for Emergency Services including screening (triage) even when the condition does NOT meet the medical definition of "Emergency Services". Brown and Toland applies prudent layperson Guidelines for all Emergency Department Claims.

PCPs should counsel Members if they are using hospital Emergency Services for routine, non-Emergency medical conditions. As appropriate, Members should use urgent care facilities for

urgent non-Emergency conditions. Brown & Toland has contracted with urgent care centers throughout the Service Area and they offer both convenient hours and, in most cases, shorter waiting times than Emergency Rooms.

Observation Stay

Certain health plans and Brown & Toland hospital service agreements contain a provision for an observation stay. An observation stay means a period of up to a maximum of 72 hours where a member's medical condition requires continuous monitoring on an out-patient basis to evaluate a Member's medical condition or determine the need for an inpatient admission. An observation stay is only covered when ordered by a physician and meets medical necessity criteria.

Inpatient Concurrent Review

To ensure that both quality and cost-effective inpatient care is provided to Members, it is imperative that Members receive the appropriate level of care while they are in the inpatient setting. Brown & Toland's goal is a safe, efficient Member discharge from inpatient facilities.

When Members are admitted to an inpatient facility, the Member's care is reviewed by a Concurrent Review Nurse (CCN) to ensure that the Member is receiving both good quality and cost-effective inpatient care at the appropriate level of care. This applies if Member receives care in an acute, rehabilitation, skilled, or other inpatient facility. To ensure Brown & Toland is notified of admission, facility is required to fax member face sheet to the Utilization Management (UM) department within 24 hours of admission. The CCN's objective is to successfully coordinate Member's medical care while in an inpatient facility. This requires a team approach between the facility staff and the CCN. To achieve this objective, the CCN or the Medical Director may need to contact the Attending Physician. It is essential that timely and accurate communication occurs between facility care management staff, the Attending Physician, and the Brown & Toland UM staff.

All members admitted to acute care require the treating facility to notify Brown & Toland within 24 hours of stability admission or the stay could be denied for untimely notification.

Brown & Toland performs concurrent review as well as collaborate with the hospital's UM/CM departments to ensure members are at the medically necessary level of care.

Additionally, Brown & Toland works with the facility to facilitate discharge planning and to ensure the member is discharged to the appropriate level of care. This needs to be done concurrently with the member's inpatient stay and updated to meet regulatory guidelines.

Clinical review should be submitted to Brown & Toland as well as the treating facility

providing concurrent UM/CM contact information to collaborate on discharge planning.

Brown & Toland physicians and other licensed clinical staff apply national standards of care (*Milliman Care Guidelines*) to determine the medical necessity for the inpatient stay and the level of care, namely, acute medical- surgical, telemetry, intermediate or intensive care unit level of care, and post-acute levels of care. If the medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the inpatient stay or for the level of care requested, the inpatient stay may be denied by the Medical Director.

The Facility and Provider are provided the reason for the denial and the appeal rights. If the level of care that is delivered to the Member is deemed inappropriate, the level of care billed by a facility is subject to denial.

Admissions directly to Skilled Nursing Facility

Providers may admit patients directly to Skilled Nurses Facility. Prior Authorization is required, and patient must meet medical necessity. Providers can call 800.225.5637 (TTY 711) for authorization

Transplants

For inpatient admission for transplants, please directly contact the individual health plan provider.

Peer to peer

If the attending physician does not agree with the Medical Director denial for admission or continued stay, the attending physician may request a peer to peer by contacting the Brown & Toland Inpatient Nurse or calling 800.225.5637 (TTY 711).

Outpatient Case Management:

Brown & Toland Physicians (BTP) provides a comprehensive suite of care coordination services that offers a continuum of care. These services include:

- Complex Case Management (CCM)
- Care Coordination
- Diabetes Disease Management
- Health Net SNP Program
- Emergency Department (ED) and Inpatient/ Transition of Care (TOC) Program
- Behavioral Health Navigation
- Medication Reconciliation
- Social Work

- Palliative Care Program

The BTP Care Management Departments goal is to provide patient-centered, physician-focused services across all lines of business. Brown & Toland's care management programs are designed to support optimal health outcomes for our members and support physician practices. An integrated care team addresses, the patient's health care needs across the continuum of care through the identification, development, and execution of targeted, evidence-based interventions. BTP Medical Directors participate in clinical rounds, provide input on clinical assessments, as well as one-to-one clinical consults with care managers as needed. Medical Services Clinical Leadership team also provides oversight and direction to all BTP care management programs.,

All Care Management program activities are evaluated by the Value Committee biannually. Comprised of the Board of Directors physician members, the Value committee ensures services and programs align with the organization's vision, optimal patient outcomes and delegated requirements from our health plan partners. One of the functions of the committee is managing the multiple NCQA-defined standard delegated activities such as but not limited to development, implementation, and evaluation of all BTP care and disease management programs.

Brown & Toland views care coordination as a collaboration between the patients, providers, and the health plan. Our common goal is to ensure high-quality, cost-effective care.

The specific goals of care coordination programs are (1) to achieve efficient and effective communication between patients and providers, and (2) to utilize appropriate resources which enable members to improve their health status and self-management skills.

Brown & Toland care coordination programs provide a consistent method to identify, address, and document the health care and social needs of patients along the continuum of care. Once a patient has been identified for case management or disease management, a nurse will work with the patient to:

- Support and enhance a Brown & Toland physician's plan of care
- Complete a comprehensive initial assessment
- Determine benefits and resources available to the member
- Develop and implement an individualized care plan in partnership with the member, providers, and family or caregiver
- Identify barriers to care
- Monitor and follow up on progress toward collaborative care management goals

Hours of Operation

Brown and Toland Outpatient Case Management staff members are available Monday through Friday from 8:00 am to 5:00 pm excluding holidays listed below:

New Year's Day
Martin Luther King Jr. Day
Memorial Day
Juneteenth
Independence Day
Labor Day
Thanksgiving Day
Fall Holiday Day (Day After Thanksgiving)
Christmas Day

To contact the BTP Care Management team please call: 415.972.4544.

Complex Case Management (CCM)

Complex Case Management (CCM) consists of coordinated care services provided to patients who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the health care system to facilitate appropriate delivery of care and services. CCM promotes behavior change through self- management education to reduce the exacerbation of chronic illness and the related costs.

CCM addresses the patient's social, physical, and behavioral health needs in-order-to maximize disease prevention and promote patient wellness in a high-quality, cost-effective manner. This may involve coordination of care, assisting patients in accessing community-based resources, providing education on self-management, improving adherence to medication and other treatment regimens, or any of a broad range of interventions designed to improve the quality of life and functionality of patients.

Brown & Toland CCM programs are designed to improve communication between patients and Providers and to make efficient use of the available health care and community-based resources. patients are identified for the CCM program through analysis of encounter data, utilization data, and claims and pharmacy reporting.

Patients can also self-refer to this program.

Care Coordination

Care coordination focuses on organizing patient care activities; removing barriers to care; identifying resources; assisting patients to navigate through health systems and health care and improving access to care. Health Navigators work with the Care team to promote safer and more effective care and work directly with patients to meet their care needs. Health Navigators provide the following services to patients and their families/caregivers:

- Verification of health plan benefits
- Scheduling appointments
- Assisting with referrals
- Coordination of Home Health services
- Assistance with Durable Medical Equipment
- Obtaining Primary Care Providers
- Providing Urgent Care information
- Mailing educational Material
- Assistance with resources
- Post discharge and emergency room follow up calls

Diabetes Disease Management

Members enrolled in the Diabetes Disease Management Program receive educational materials to empower them with the knowledge of the disease condition, their medications, and the importance of screening tests such as HgA1c, kidney functions, blood lipids, and blood pressure. High-risk Members receive individualized Case Management. The case manager works with the provider and the Member to develop a care plan for the Member and follows the Member's progress with the care plan.

Emergency Department (ED) and Inpatient/ Transition of Care (TOC) Program

Outpatient Care Management team (OPCM) uses monthly data reports to identify and engage members who have chronic conditions and had avoidable ED visits > 3 visits in the past 6 months. Each identified member is called to enquire how the member is doing, to reconnect them to their Primary Care Physician (PCP), and to educate the member about the use of Urgent Care. Members are offered enrollment in the Case Management program, as deemed appropriate. ED frequent users with significant overuse or serious medical or psychosocial issues are discussed in biweekly rounds.

In addition, Inpatient team flags HMO members discharged from Acute and Skilled Nursing Facilities (SNF) for transition of care (TOC) calls.

The Brown & Toland Patient Discharge Follow up Support Program is designed to mitigate any clinical issues a patient may have in the crucial 30 days post discharge. Key interventions highlight the following:

- Connecting the patients to their Brown & Toland physician,
- Providing medication management and education,
- Coordination of care services
- Facilitating necessary referrals

The program targets all Brown & Toland Medicare Advantage and medically complex patients regardless of reason for admission type and complex commercial members and patients referred by the ED initiative at CPMC Pacific Campus. Outreach is prioritized by risk levels of identified patients; risk will be based on a color code system, red, and yellow. Dependent on risk and certain common readmission conditions, the Transition of Care team will outreach patients.

Behavioral Health

Access to Behavioral Health Care services is challenging for all members in the current health care system. Brown & Toland is committed to improving the accessibility and decreasing the time spent to obtain an appointment with a Behavioral Healthcare provider.

The Behavioral Health team communicates with provider and patients about goals and treatment options and assist patient to navigate the health systems. The team is doing patient assessments, depression screening, substance screening, provide resources, etc.

If a provider or the Brown & Toland member want assistance with Behavioral Health referrals, please call the Altais Care Management Phone Number: 415.972.4544 (24/7) and leave a message for the Altais Care Management team or email CMReferrals@altais.com. Calls will be returned by the next business day.

Medication Reconciliation

Brown and Toland Pharmacists and Nurse Care Managers review medications with members and caregivers with each transition of care from the hospital or skilled nursing facilities. The team supports the member and caregiver by helping them understand any medication therapy changes, providing counseling on the correct use of new medications, and communicating any discrepancies or drug therapy problems with the primary care physician. They work closely with members and caregivers to ensure that medications are taken properly to prevent adverse drug events and hospital readmissions.

Pharmacy Services

Managing prescription medications can be a complex process, especially for those who take multiple medications daily. Pharmacists and Pharmacy Technicians are part of the member's Care Team and engages with members and caregivers to ensure they understand their medication regimen and to take their medications safely.

Pharmacy Services include:

- Saving money on medications through patient assistance programs, mail-order services, formulary alternatives, and the use of generics or biosimilars.
- Providing Medication Adherence support through 30 to 90-day supply conversions
- Providing Medication education
- Medication non-compliance and medication side effects counseling
- Comprehensive medication review to optimize therapy e.g., Statin Therapy for Cardiovascular Disease

The Pharmacy Team partners with the multi-disciplinary Care Management team to evaluate individual cases, manage pharmacy-specific member issues, and advise the team with recommendations on drug therapy. From time-to-time the provider or the member may receive written communication about opportunities for improvement in the member's care specific to medication management.

For questions or assistance with a member, please contact the Brown & Toland Care Management Department at 415.972.4544 or email pharmacyteam@altais.com.

California Specialty Pharmacy

Brown & Toland Physicians' preferred pharmaceutical vendor is California Specialty Pharmacy. Contact your local representative by calling 877.602.7779 or by visiting csprx.com. You can also send your referral directly via fax **866.853.6555** or eScribe to California Specialty Pharmacy today.

Social Work

Brown & Toland's Social Work team is available to help patients and families cope with the many psychological and social problems that may arise during illness, hospitalization, and medical treatment.

Our experienced and sensitive social workers act as patient advocates by serving as counselors, helping to find resources, and solving problems. When it's medically necessary,

social workers also help arrange alternate types of care, which may include rehabilitation facilities, skilled nursing facilities, hospice or board and care homes. Any concerns related to the psychological, practical, or social well-being of patients and their loved ones may be discussed openly with our social workers.

Brown & Toland's social workers offer a wide range of services, including:

- Answering questions related to health insurance, Medi-Cal, Medicare, Social Security, and state disability
- Case coordination to help you decide on the best arrangements for you while at home or in a facility
- Psychosocial evaluations and treatment planning
- Supportive and adjustment counseling, including coping with the loss of a loved one
- Crisis intervention
- Financial assessment and referral services
- Referrals to support groups for patients and their loved ones
- Abuse assessment and reporting
- Education and consultative services
- Advance directive assistance
- Community resources

Palliative Care Program

Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family.

Palliative care provides an extra layer of support. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

The palliative care team communicates with patients about goals and treatment options and assist patient to navigate the health systems. The palliative care team works in partnership with BTP PCPs, specialist to refer patient to contracted palliative care provider for services.

Hospice

Brown & Toland understands that that end-of-life care and treatment discussions are difficult but necessary for patients and their families to ensure their wishes are informed and supported by their health care team. When a patient is admitted the hospital or faces chronic or terminal illness, it is critical to discuss end of life care options. The Concurrent

Review Nurse and Outpatient Care Management Team work collaboratively across all healthcare settings in partnership with Brown & Toland PCPs, specialist to refer patient to contracted hospice care provider for services.

For questions or assistance with a member, please contact Altais Care Management Department at 415.972.4544 or email supportivecareprogram@altais.com.

Compliance

Provider Training Requirement

Providers that are contracted with Brown & Toland Physicians are required to complete various trainings upon hire and annually/bi-annually thereafter.

Please visit: <https://altais-9451496.hs-sites.com/altais-required-provider-training> access the required training modules.

Upon completion of the trainings, please complete the corresponding attestation(s) which are located on the same webpage.

Non-compliance will result in a corrective action plan being issued.

If you have any questions about this training, please contact the Compliance Department at Compliance@altais.com

Reporting Compliance Concerns to Brown & Toland

If you have any compliance concerns, such as HIPAA or patient privacy incidents or instances of suspected fraud, waste, and abuse, please report these concerns to:

The Compliance Department

Email: Compliance@altais.com

U.S. Mail:

Brown & Toland Physicians

P.O. Box 72710

Oakland, CA 94612-8910

Attn: Compliance

Department

Make an anonymous report

To communicate compliance concerns to Brown & Toland anonymously, please use one of the following methods:

- **Online:** Go to www.browndtoland.ethicspoint.com and select the blue "make a Report" tab. This website is secure and is not part of the Brown & Toland Physicians website.
- **Phone:** Call EthicsPoint toll-free at 888.201.7305.

The information you provide will be sent by EthicsPoint to Brown & Toland on a totally confidential and anonymous basis if you so choose.

Information on Brown & Toland's Compliance Program can also be found on www.altais.com.