THE ALLIANCE®

THIRD-PARTY ADMINISTRATOR KIT

Prepared for Third-Party Administrators
who work with employers utilizing The Alliance network

—March 2021

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Introduction

The Alliance Mission

The Alliance moves health care forward by controlling costs, improving quality, and engaging individuals in their health.

We are an employee-owned, not-for-profit cooperative of more than 250 employer members providing coverage to more than 100,000 individuals in southern Wisconsin and neighboring counties in Iowa and Illinois

To learn more about us, visit www.the-alliance.org

Introduction

The Alliance and the Plan Administrator

The Alliance services "overlay" an employer's health plan. The "overlay" concept allows for employer autonomy and can be implemented independent of benefit plan design, contribution methods, benefit administrator selection, enrollment periods, or consulting arrangements.

In order to fulfill The Alliance responsibilities to our member companies, we need the cooperation of Third-Party Administrators (TPAs). For operational purposes, the member company must notify The Alliance not less than 60 days prior to changing TPAs.

The member company must establish the following operating procedures with their TPA to accessing The Alliance:

- Determine how The Alliance repriced fee schedule will be applied.
- Determine participation in optional mental health and chiropractic networks and inform TPA of choices.
- Provision of initial employee eligibility information to The Alliance; establish the frequency (minimum monthly) and the method that eligibility updates will be communicated to The Alliance.
- Confirm misdirected claims will be returned to provider to ensure that future submissions are correctly routed to The Alliance for repricing on initial submission
- Decide what I.D. cards, explanation of benefit forms, and remittance advices reflecting Alliance membership/repricing will look like.
- Determine how reconciliation of claims payments will be handled, when necessary.

The Alliance looks forward to working with TPAs who understand, support, and cooperate with the goals and operation of The Alliance on behalf of our mutual employer clients.

Introduction

Alliance Questions—Who to Contact

Questions Regarding…	Call	Phone No.
• Eligibility Information • Questions from Providers • Questions from Plan Administrators • Billing Inquiries Patient Questions Regarding: • Health Education • Provider Inquiries	The Alliance Customer Service Line	608.210.6630 or 800.223.4139
• Monthly Invoices	The Alliance Accounting Department	608.276.6620
• Electronic Data Interchange (EDI) • Alliance Claims Operations • Timeliness of Payment Reports	The Alliance Operations Department	608.276.6620
• Membership Information • Benefits of Membership • Current Alliance Services • Plan Administrator Coordination • Employer Report Questions • Custom Data Requests • Alliance identification (logo)/Directory Needs • ID Card Approval • Employee Orientations • Employee Education Programs	The Alliance Business Development and Member Services	608.276.6620

For up-to-date contact information, please visit www.the-Alliance.org/tpas/contacts

Alliance Claims Repricing Definitions

Alliance Eligible Member

An employee/dependent of an Alliance member company who is eligible for The Alliance repricing service as documented by the following information in The Alliance database:

- Employee and dependent payer assigned identification number
- Employee and dependent unique identifier assigned by The Alliance
- Employee/dependent name
- Employee/dependent birth day
- Employee/dependent gender

The Alliance does not determine benefit eligibility. Current eligibility information on employees/dependents needs to be communicated to The Alliance. Repricing will not be completed on claims for employees/dependents not in The Alliance database. Claims will be stamped non–Alliance member. Upon receipt, the TPA should confirm eligibility and if eligible, return claim with a copy of the enrollment form to The Alliance if the employee/dependent should be enrolled in The Alliance for future claims.

Alliance Participating Providers

A health care provider/facility that has entered into a contractual agreement with The Alliance to provide health care services to employees/dependents of Alliance member companies. These providers have agreed that **The Alliance reimbursement schedule represents total compensation for covered benefits (for non-covered benefits, see page 32).** *Alliance participating providers will accept The Alliance negotiated fee for Alliance employees and dependents regardless of other contractual arrangements that may be in place.*

Alliance Claims Repricing Definitions

Alliance Service Area

The Alliance service area includes Wisconsin counties as well as counties in Iowa and Illinois in which The Alliance has a significant number of participating providers under contract. These counties include:

Wisconsin Counties:
- Adams
- Barron
- Buffalo
- Calumet
- Chippewa
- Clark
- Columbia
- Crawford
- Dane
- Dodge
- Eau Claire
- Fond du Lac
- Grant
- Green
- Green Lake
- Iowa
- Jackson
- Jefferson
- Juneau
- Kenosha
- La Crosse
- Lafayette
- Langlade
- Lincoln
- Marathon
- Marquette
- Milwaukee
- Monroe
- Oneida
- Outagamie
- Ozaukee
- Pepin
- Portage
- Price
- Racine
- Richland
- Rock
- Rusk
- Sauk
- Shawano
- Taylor
- Trempealeau
- Vernon
- Vilas
- Walworth
- Washington
- Waukesha
- Waupaca
- Waushara
- Winnebago
- Wood

Iowa Counties:
- Allamakee
- Clayton
- Clinton
- Dubuque
- Fayette
- Winneshiek

Illinois Counties:

- Boone
- Bureau
- Carroll
- Cook
- DeKalb
- DuPage
- Henry
- Jo Daviess
- Kane
- Knox
- Lake

- La Salle
- Lee Livingston
- McHenry
- Mc Lean
- Ogle
- Peoria
- Stephenson
- Warren
- Whiteside
- Winnebago

Michigan Counties:

- Gogebic
- Houghton

- Iron
- Ontonagon

Minnesota Counties:

- Houston
- Wabasha

- Winona

The Alliance repricing sheet will state "NON-PARTICIPATING PROVIDER", claims for non-participating providers within our service area.

Effective August 15, 2018:
Non–participating providers inside and outside of the counties listed above are considered "out of network "; Alliance negotiated fees are not applied to services from these providers. Secondary network agreements can be accessed and claims may be paid at an in-network level through these agreements if desired by the plan.

Backdating

"Backdating" is the term The Alliance uses to refer to the act of adding eligibility information to our database for employees accessing The Alliance *after care has been rendered*.

The Alliance has established a backdating policy that applies to employees who were not in The Alliance database due to oversight or error on the part of their employer or TPA. This policy states: "Upon Alliance notification, backdating of all eligibility shall not exceed 90 days. The courtesy of backdating within 90 days will be extended to employees who were Alliance eligible at the time services were rendered, but were not in The Alliance data base due to failure to notify on the part of the employer or the TPA. A copy of the original application/enrollment form must be submitted to The Alliance."

Coordination of Benefits

Alliance Claims Repricing Definitions

Incomplete Claims

Any claim that was incurred in The Alliance service area and does not have all the required fields as determined by The Alliance for repricing purposes. Such claims will be returned immediately to the provider for completion. If the incomplete claim was incurred outside The Alliance service area, the claim will be sent on to the plan administrator with instructions to pay their usual and customary fee (U & C).

Medicare

Claims received for eligible plan participants that indicate that a payment has been made by Medicare are entered and repriced by The Alliance. Our coversheet will note "MEDICARE CLAIM" above the status message on our repricing sheet.

Alliance discounts relayed on coversheets that indicate "MEDICARE CLAIM" are not applicable when Medicare is the primary payer as the Medicare allowable amount supersedes The Alliance discount.

Claims received for a terminated plan participant of an active Alliance employer that indicate Medicare will be directed to the payer without being repriced by The Alliance. Green coversheet will indicate "Alliance does not reprice Medicare claims".

Non–Alliance Member

Any person not included in The Alliance database. Any claim for an employee/ dependent that is not identified in The Alliance database will be sent on to the appropriate plan administrator without being repriced. The plan administrator or employer has the opportunity to submit enrollment information for future claims if their records show the individual is Alliance eligible (see information on non-Alliance members and backdating eligibility policy on page 14).

Non–Covered Benefits

Claims for Non-Participating Providers

Claims for services rendered by non-participating provider will be entered and repriced by The Alliance for data collection and cost comparison only. The TPA should apply their usual and customary fee (U&C) or secondary network as instructed by the member employer.

All non-participating provider claims should be routed to The Alliance for data collection and cost comparison regardless of the provider's location.

Alliance Claims Repricing Definitions

Send-Ons

Claims that currently *are not* entered or repriced by The Alliance. They include the following types of claims:

- Prescriptions
- Dental
- Patient billing statements
- Workers' compensation claims
- Pre-estimates/authorizations

These claims will be sent on to the plan administrator with a green half sheet indicating why the claim has not been repriced <u>or</u> with a stamp on it that reads "ALLIANCE REPRICING NOT APPLICABLE". The plan administrator should apply their established usual and customary fee (U&C) or otherwise process as appropriate.

Termination

Employees who are no longer Alliance eligible, for whatever reason (terminated employment, selection of a different health plan, etc.). The Alliance should be provided with a termination or "term" date. ***Do not delete the employee or dependent from your eligibility updates.*** The Alliance will adjust the eligibility database to reflect the actual termination date upon receiving employee or dependent termination information.

Claims received by The Alliance with dates of service prior to the termination date will be entered and repriced. Claims received for services incurred up to 90 days after the termination date will be immediately forwarded to the TPA without repricing. Claims for services received 91 or more days after the termination date are returned to the provider. The employer is not charged any access fees for "termed" employees or dependents.

Employee Eligibility

The Alliance repricing system requires that plan participants be active in our eligibility file for repricing to occur. Claims cannot be entered into our repricing system if:
- An eligibility file is not present for the member
- The date of service is prior to the effective date
- The date of service is after the termination date

To ensure prompt and accurate repricing of claims, TPAs must provide The Alliance with eligibility updates on at least a monthly basis.

Eligibility File Requirements

The following is a .DBF file specification of the eligibility fields we would like to receive along with the preferred format. If you cannot submit the data in this format, use ASCII with fixed field sizes. If that is not an option, please call to discuss other formats available. Include a file specification along with the file, preferably in a README.TXT file.

Field Name	Type	Description	Note
PAYER_ID	Character	Payer-assigned ID number	Typically what's printed on ID card for each family member
FAMILY_ID	Character	Common family ID number	This field is only needed if family members have unique PAYER_ID numbers
RELATION	Character	E = Employee; S = Spouse; D = Dependent	
LNAME	Character	Last name	
FNAME	Character	First name	
MNAME	Character	Middle name/initial	
DOB	Character	Ideally in mmddyyyy format but others ok	
GENDER	Character	Gender (M, F or U)	
ADDR1	Character	Address1	
ADDR2	Character	Address2	
CITY	Character	City	
STATE	Character	State	
ZIP	Character	Zip (5 or 9 digit)	
EFFECTIVE	Character	Effective date with network (same format as DOB)	
TERMINATE	Character	Terminate date with network (same format as DOB if valued, else empty)	
GROUPNUM	Character	Employer's policy or group number	
GROUPNAME	Character	Employer name	
DIVCODE	Character	Division code (if applicable)	
DIVNAME	Character	Division name (if applicable)	

Employee Eligibility

Updating Eligibility Information

The employee and dependent biographical information initially received by The Alliance will be entered into The Alliance eligibility database. A hard copy printout of the information may be generated for verification by the employer.

On at least a monthly basis, changes in employee and dependent status must be communicated to The Alliance. If a member experiences more frequent changes, weekly updates should be considered. The communication can come from the member employer or the member employer's TPA. Eligibility updates should include the following:

- New hires/effective date
- Terminations/effective date
- Changes in status (address, name, single to family)/effective date

This information can be submitted by:

- Electronically through our secure Web site
- Electronically through TPA-hosted FTP site

Employee Eligibility

Non–Alliance Members

As a member of The Alliance, employers want to take advantage of useful and necessary claims information and benefit from The Alliance savings negotiated on their behalf. To accomplish this, The Alliance relies on the most accurate and current eligible employee/dependent biographical information.

The Alliance database consists of information received from Alliance employers or their TPA. If we receive claims for an individual not in the database, The Alliance stamps the claim "Non-Alliance Member". If the stamp is near the insured's ID number field on the claim, we have no eligibility for that insured or their family members. If the stamp is near the patient's name field, we have eligibility for the insured but not for this member of the family. The TPA is requested to:

- Verify Alliance eligibility
- Process claim as usual if patient *is not* Alliance eligible
- Submit a completed Alliance eligibility form to The Alliance for repricing and data collection if the patient *is* Alliance eligible for *future* claims

The Employee Enrollment Form may be copied by the employer or the TPA to update The Alliance database. (See Appendix A)

Backdating Eligibility Policy

To maximize the benefits of Alliance membership, it is vital for The Alliance to receive accurate and timely biographical information, or eligibility, regarding employees who are eligible for Alliance services.

"Backdating" is the term The Alliance uses to refer to the act of adding eligibility information to our database for employees accessing The Alliance *after care has been rendered*.

The Alliance has established a backdating policy that applies to employees who were not in The Alliance database due to oversight or error on the part of their employer or TPA. This policy states:

> "Upon Alliance notification, backdating of all eligibility shall not exceed 90 days. The courtesy of backdating within 90 days will be extended to employees who were Alliance eligible at the time services were rendered, but were not in The Alliance data base due to failure to notify on the part of the employer or the TPA. A copy of the original application/ enrollment form must be submitted to The Alliance."

In order to minimize the need for backdating, The Alliance will provide employers with a roster of Alliance eligible employees from our database on a regular basis or at the request of an employer/TPA.

Employee Eligibility

Alliance Identification

Employees of Alliance member companies must identify themselves as Alliance members to all providers when accessing physician or hospital services.

Employees should be instructed to notify the provider's *billing office* of their participation in The Alliance each time they seek care, by both verbally informing them of their Alliance participation and by showing proper Alliance identification.

If an Alliance eligible employee, or their dependent, does not show proper Alliance identification, their claims may not initially be sent through The Alliance for repricing and data collection.

TPAs may submit misdirected claims to The Alliance. Re-routing claims decreases efficiency and therefore adds cost to the system. We prefer the TPA deny the claim instructing the provider to resubmit the claim to The Alliance.

To guarantee appropriate Alliance savings and accurate data, it is critical for employees to have proper Alliance identification and inform their health care providers of their participation.

It is often the TPA's responsibility to ensure this identification appears on the employee's/dependent's health card. The medical ID card should prominently display The Alliance logo, name and mailing address. The Alliance logo is available to you via our website at https://the-alliance.org/brokers-tpas/tpas/alliance-logos

The Alliance must receive ***all*** medical/surgical, home health, mental health and chiropractic claims directly, except those for prescription drugs, dental, and vision if they are carved out. This provision applies to all health care providers, whether or not they are Alliance providers.

(Please see appendix C for more detailed information.)

Employee Eligibility

Service Area County ZIP Code Listing

Member Companies have the option of accessing employees and dependents to The Alliance services by:

- Location of health care provider
- Employee and dependent residence
- Location of employer

Below is a list of ZIP codes for counties in which The Alliance has a significant number of participating providers under contract to assist employers when choosing to access employees and dependents by county of residence.

Wisconsin County ZIP Codes

Adams County

539 — 10, 27, 34, 36

546 — 13

Barron County

547 — 28, 33, 62

548 — 05, 12, 13, 18, 22, 26, 29, 41, 57, 68, 89

Buffalo County

546 — 10, 22, 29

547 — 43, 55, 56

Calumet County

530 — 14, 61, 62, 88

541 — 10, 23, 29, 60, 69

Chippewa County

547 — 24, 26, 27, 29, 32, 45, 48, 57, 68, 74

Clark County

544 — 05, 20-22, 25, 36, 37, 46, 56, 60, 93, 98

547 — 46, 71

Columbia County

535 — 55

539 — 01, 11, 23, 25, 28, 32, 35, 54, 55, 57, 60, 65, 69

Crawford County

538 – 21, 26

546 – 26, 28, 31, 40, 45, 54, 55, 57

Dane County

535 — 08, 15, 17, 23, 27-29, 31-32, 58-60, 62, 71-72, 75, 89-90, 93, 96-98

537 — 01-08, 11, 13-19, 25-26, 44, 74, 77-79, 82-86, 88- 94

Dodge County

530 — 03, 06, 16, 32, 34, 35, 39, 47, 48, 50, 59, 78, 91, 98, 99

535 — 57, 79

539 — 16, 22, 33, 56, 63

Eau Claire County

547 — 01, 02, 03, 20, 22, 41, 42

Fond du Lac County

530 — 10, 19, 49, 57, 65, 79

539 — 19, 31, 32, 35-37, 71, 74, 79

Grant County

535 - 18, 54, 69, 73

538 — 01, 02, 04-13, 16- 18, 20, 24, 25, 27

Green County

535 — 02, 20-22, 50, 66, 70, 74

Green Lake County

539 — 26, 39, 46, 47

549 — 23, 41, 68

Iowa County

535 — 03, 06, 07, 26, 33, 35, 43, 44, 53, 65, 80, 82, 95

Jackson County

546 — 11, 15, 35, 42, 43, 59

547 — 54

Jefferson County

530 — 36, 38, 94

531 — 37, 56, 78, 90

535 — 38, 49, 51, 94

Juneau County

539 — 19, 44, 48, 50, 62, 68

546 — 18, 37, 41, 46

Kenosha County

531 — 01, 02, 04, 09, 28, 40-44, 58, 70, 71, 79, 81, 92

La Crosse County

546 — 01, 02, 03, 14, 36, 44, 50, 53, 69

Lafayette County

535 — 04, 10, 16, 30, 41, 86, 87, 99

538 — 03,

Langlade County

544 — 09, 18, 24, 28, 30, 62, 65, 85, 91

Lincoln County

544 — 35, 42, 52, 87

545 — 32

Marathon County

544 — 01, 02, 03, 08, 11, 17, 26, 27, 29, 32, 40, 48, 55, 71, 74, 76, 79, 84, 88

Marquette County

539 — 20, 30, 49, 52, 53, 64

549 — 60

Milwaukee County

531 — 10, 29, 30, 32, 54, 72

532 — 01-28, 33-35, 37, 59, 63, 67-68, 74, 78, 88, 90, 93, 95

Monroe County

546 — 19, 20, 38, 48, 49, 56, 60, 62, 66, 70

Oneida County

544 — 63

545 — 01, 29, 43, 48, 62, 64, 68

Outagamie County

541 — 06, 13, 30, 31, 36, 40, 52, 65, 70

549 — 11-15, 19, 22, 31, 42, 44

Ozaukee County

530 — 04, 12, 21, 24, 74, 80, 92, 97

Pepin County

547 — 21, 36, 59, 69

Portage County

544 — 06, 07, 23, 43, 58, 67, 73, 81, 82, 92

549 — 09, 21

Price County
544 — 59
545 — 13, 15, 24, 37, 52, 55, 56

Racine County
531 — 05, 08, 26, 39, 67, 77, 82, 85
534 — 01-08

Richland County
535 — 40, 56, 81, 84
539 — 24
546 — 64

Rock County
535 — 01, 05, 11, 12, 25, 34, 36, 37, 42, 45-48, 63, 76

Rusk County
545 — 26, 30, 63
547 — 31, 66
548 — 48, 95

Sauk County
535 — 61, 77, 78, 83, 88
539 — 13, 37, 40- 43, 51, 58, 59, 61

Shawano County
541 — 07, 11, 27, 28, 37, 66, 82
544 — 14, 16, 50, 86, 99
549 — 28, 48, 78

Taylor County
544 — 33, 34, 39, 47, 51, 70, 80, 90

Trempealeau County
546 — 12, 16, 25, 27, 30, 61
547 — 38, 47, 58, 60, 70, 73

Vernon County
546 – 21, 23, 24, 32, 34, 39, 51, 52, 58, 65, 67

Vilas County
545 – 12, 19, 21, 38, 40, 45, 54, 57 – 58, 60-61

Walworth County
531 — 14, 15, 20, 21, 25, 28, 38, 47, 48, 57, 76, 84, 90, 91, 95
535 — 85

Washington County
530 — 02, 17, 22, 27, 33, 37, 40, 60, 76, 89, 90, 95

Waukesha County
530 – 05, 07, 08, 18, 45, 46, 51, 52, 56, 58, 64, 66, 69, 72, 89
531 –03, 18, 19, 22, 27, 46, 49-51, 53, 83-89

Waupaca County
549 – 26, 29, 33, 40, 45, 46, 49, 50, 61, 62, 69, 77, 81, 83, 90

Waushara County
549 – 30, 43, 65, 66, 67, 70, 76, 82, 84

Winnebago County
549 – 01-04, 06, 27, 34, 47, 52, 56, 57, 63, 64, 80, 85, 86

Wood County
544 – 04, 10, 12, 13, 15, 41, 49, 54, 57, 66, 69, 72, 75, 89, 94, 95

Iowa County ZIP Codes

Allmakee County
521 — 40, 46, 51, 60, 62, 70, 72

Clayton County
520 — 42-44, 47-49, 52, 66, 72, 77
521 — 56-59

Clinton County
520 — 37
522 — 54
527 — 01, 27, 29-36, 42, 50, 51, 57, 71, 77

Illinois County ZIP Codes
Boone County
610 — 08, 11, 12, 38, 65

Bureau County
613 — 12, 14, 15, 17, 20, 22, 23, 28-30, 37, 38, 44-46, 49, 56, 59, 61, 62, 68, 74, 76, 79

Carroll County
610 — 14, 46, 51, 53, 74, 78
612 — 85

Cook County
600 — 04-09, 16-19, 22, 25, 26, 29, 38, 43, 53, 55, 56, 62, 65, 67, 68, 70, 74, 76-78, 82, 90, 91, 93-95
601 — 04, 07, 30, 31, 33, 41, 53-55, 59-65, 68, 69, 71, 73, 76, 79, 92-96
602 — 01-04, 08, 09, 90
603 — 01-05
604 — 02, 06, 09, 11, 12, 15, 18, 19, 22, 25, 26, 28-30, 38, 39, 43, 45, 52-59, 61-67, 69, 71-73, 75-78, 80, 82, 99
605 — 01, 13, 25, 26, 34, 46, 58
606 — 01-26, 28-34, 36-47, 49, 51-57, 59-61, 64, 66, 68-70, 73-75, 77, 78, 80-82, 84-91, 93-97, 99
607 — 01, 06, 07, 12, 14
608 — 03-05, 27

Dubuque County
520 — 01-04, 32, 33, 39, 40, 45, 46, 53, 56, 65, 68, 73, 78, 79, 99

Fayette County
506 — 06, 55, 62, 64, 81
521 — 35, 41-42, 47, 64, 66, 69, 71, 75

Winneshiek County
521 — 01, 32-33, 44, 49, 61, 65, 68

DeKalb County
601 — 11, 12, 15, 29, 35, 45, 46, 50, 78
605 — 20, 48, 50, 52, 56

DuPage County
601 — 03, 05, 06, 08, 16, 17, 22, 26, 28, 32, 37-39, 43, 48, 57, 72, 81, 84-91, 97, 99
603 — 99
605 — 02, 04, 14-17, 19, 21-23, 27, 32, 40, 55, 59, 61, 63, 65-67, 72, 98, 99

Henry County
612 — 33-35, 38, 41, 54, 58, 62, 73, 74
614 — 13, 19, 34, 43, 68, 90

Jo Daviess County
610 — 01, 25, 28, 36, 41, 59, 75, 85, 87

Kane County
601 — 75, 75, 77, 83
605 — 05, -07, 10, 11, 39, 42, 54, 68

Knox County
614 — 01, 02, 10, 14, 28, 30, 36, 39, 48, 58, 67, 72, 74, 85, 88, 89
615 — 72

Lake County

600 — 02, 10, 11, 15, 20, 30, 31, 35, 37, 40-42, 44-48, 60-61, 69, 73, 75, 79, 83-89, 96, 99

La Salle County

604 — 70
605 — 18, 31, 49, 51, 57
613 — 01, 16, 21, 25, 32, 34, 41, 42, 48, 50, 54, 58, 60, 64, 70, 71, 72, 73

Lee County

605 — 30, 53
610 — 06, 21, 31, 42, 57
613 — 10, 18, 24, 31, 53, 67, 78

Livingston County

604 — 20, 60
609 — 20, 21, 29, 34
613 — 11, 13, 19, 33
617 — 39-41, 43, 64, 69, 75

McHenry County

600 — 01, 12, 13, 14, 21, 33, 34, 39, 50, 51, 71, 72, 81, 97, 98
601 — 02, 42, 52, 56, 80

McLean County

617 — 01, 02, 04, 05, 09, 10, 20, 22, 24-26, 28, 30-32, 36, 37, 44, 45, 48, 52-54, 58, 61, 70, 72, 74, 76, 90, 91, 99

Ogle County

601 - 13
610 — 07, 10, 15, 20, 30, 43, 47, 49, 52, 54, 61, 64, 68, 84, 91

Peoria County

614 — 51
615 — 17, 23, 25, 26, 28, 29, 33, 36, 39, 47, 52, 59, 62, 69
616 — 01-07, 12-16, 25, 29, 30, 33-39, 41, 43, 50-56

Stephenson County

610 — 13, 18, 19, 27, 32, 39, 44, 48, 50, 60, 62, 67, 70, 89

Warren County

614 — 17, 23, 35, 47, 53, 62, 73, 78

Whiteside County

610 — 37, 71, 81

612 — 30, 43, 50-52, 61, 70, 77, 83

Winnebago County

610 — 16, 24, 63, 72, 73, 77, 79, 80, 88
611 — 01-12, 14, 15, 25, 26, 30-32

Michigan County Zip Codes

Gogebic County

499 — 11, 38, 47, 59, 68, 69

Houghton County

499 — 05, 13, 16, 17, 21, 22, 30, 31, 34, 42, 45, 52, 58, 61, 53, 65

Iron County

499 — 02, 03, 15, 20, 27, 35, 64

Ontonagon County

499 — 10, 12, 25, 29, 48, 53, 60, 67, 71

Minnesota County Zip Codes

Houston County
559 — 19, 21, 31, 41, 43, 47, 74

Winona County
559 — 10, 25, 42, 52, 59, 69, 72, 79, 87, 88

Wabasha County
550 — 41
559 — 32, 45, 56, 57, 64, 68, 81, 91

Provider Contracting

Provider Contracting Methodology

The Alliance has negotiated hospital charges using Diagnostic Related Groups (DRGs). The negotiated DRG represents the agreed upon average cost at discharge for each particular diagnosis.

Physician services are negotiated using Resource-based Relative Value Scale (RBRVS) methodology. The Alliance negotiated fee represents the maximum allowable payment for physician services. Payment will be made on either the original billed charge or The Alliance maximum allowable, whichever is less.

The Alliance fee becomes the negotiated, local usual and customary (U&C) fee. On behalf of Alliance member companies, plan administrators **must** pay employee and dependent claims according to The Alliance repricing system. *Alliance participating providers will only accept The Alliance negotiated fee for Alliance employees and dependents regardless of other contractual arrangements that may be in place.* **To reinforce accurate and appropriate payment, refer to the payment directive on The Alliance cover sheet** (see sample cover sheet and actual cover sheet, Appendix B).

The Alliance Fee Schedule and Provider Contracts

The Alliance fee schedule and provider contracts are the proprietary information of The Alliance and will not be published, disclosed, or disseminated. Use of The Alliance fee schedule or repriced amounts for any purpose other than administration of an employer's health plan by plan administrator is not permitted. Furthermore, use of such information by the plan administrator, its subsidiaries, affiliates, or entities with an equity interest in the plan administrator for the purpose of gaining insight into The Alliance's agreements with participating providers or for negotiating their own agreement with participating providers constitutes a breach of membership.

Employer members, employees/dependents, and plan administrators have access to the repricing of individual claims and/or individual Alliance fee quotes by calling The Alliance customer service line, 608.276.6630 or 800.223.4139.

Provider Contracting

Alliance Repriced Fee and Other Contracts

Alliance participating provider contracts *supersede* any and all other contracts TPAs may have negotiated and must be applied to all applicable Alliance eligible claims.

Alliance Participating Provider Updates

The Alliance will update TPAs on a regular basis regarding new Alliance participating providers.

The list will include the names of all Alliance participating providers as well as their:

- Federal tax ID number
- Address
- City
- State
- ZIP code
- Provider network they participate in
- The contract effective date

Not all member companies will opt in to all networks, so it is important that you understand the employer's participation choices in the optional networks (mental health/AODA and chiropractic providers). The Alliance claim cover sheet will say, "Employer has not elected coverage in this network. Repricing not applicable".

An update of providers is available from The Alliance secure website on a weekly basis for TPA staff to download. Please make this information available to all appropriate staff. For further information, regarding secure website access please contact Dave Sell, 608.210.6656.

Provider Contracting

Alliance Repricing of Claims with Modifiers

Alliance repricing reflects adjustments for modifiers where appropriate, using RBRVS recommendations. Modifiers for which adjustments are taken include, but are not limited to multiple procedures (51), bilateral procedures (50) and assistant-at-surgery (80). We apply all applicable reductions when the claim is repriced, regardless of whether the modifier is listed on the claim.

Alliance providers are not required to honor additional cutbacks to Alliance repricing by TPAs or reinsurers, and the patient may be billed for any amounts not paid by the plan, up to the total original repriced amount.

Effective January 1, 2020, multiple procedure cutbacks are applied during the repricing of facility claims under CMS Outpatient Code (OCE) editing logic.

Bundling of Charges

Provider contracts negotiated by The Alliance do not restrict TPAs from utilizing bundling software. However, The Alliance cannot provide repricing for a procedure code assigned by a TPA's bundling software if it did not appear on the original claim. The Alliance must reprice the claim as submitted to us by the provider of service.

Repricing performed by The Alliance is not an endorsement of the coding of any claim received. The Alliance relies on our provider partners to code claims correctly in accordance with CPT ® and accepted coding convention. Since 2009, The Alliance has incorporated National Correct Coding Initiative (NCCI) to catch the most basic of billing errors for professional services, as allowed by our provider contracts.

Effective January 1, 2019, The Alliance will apply limited components of CMS Outpatient Code (OCE) editing logic when repricing facility claims.

Charges that apply to these edits will reprice at $0.00.

Our application of editing logic does not restrict our TPA partners from applying their own bundling logic to claims. Alliance providers are required to accept NCCI edits as well as industry coding and reimbursement adjustments to claims. Because the criteria used to apply bundling differ among TPAs, The Alliance encourages TPA partners who apply bundling logic to claims work collaboratively with the provider of service to improve the matching of claims identified by their bundling/unbundling software.

Bundled Services

The Alliance will not separately reimburse for certain Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes identified by the Centers of Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File with designated status indicator of "B" for bundled service. These charges will reprice at $0.00.

Bundled Codes are not reimbursable services regardless of whether they are billed alone or in conjunction with other services on the same date. If these services are covered, allowance for them is subsumed by the allowance for the services to which they are incidental. (An example is a telephone call from a hospital nurse regarding care of a patient.) Services without direct face-to-face contact are considered to be a component of the overall medical management service.

Service Codes with a Relative Value of Zero

The Alliance participating providers whose contract is based on reimbursement rates calculated from either OPTUM *The Essential RBRVS* or OPTUM *Relative Values for Physicians* shall reprice at $0.00 for service codes valued at 0 (zero) on their respective contracted methodology and these services are not separately reimbursable.

Contracted participating providers whose methodology is OPTUM *The Essential RBRVS* shall only apply the above guideline when the service code is indicated by OPTUM as a gap code.

Category II Codes (Measurement Codes)

Current Procedural Terminology (CPT) Category II codes, often referred to as *Measurement Codes*, are supplemental tracking codes that can be used for performance measurement.

The use of these codes is optional. These Category II codes are not required for correct coding and may not be used as a substitute for Category I codes.

Category II codes are billed in the procedure code field, just as CPT Category I codes are billed. Category II codes describe clinical components usually included in evaluation and management or clinical services and are not associated with any relative value. Therefore, Category II codes are billed with a $0.00 billable charge amount. The Alliance will reprice contracted participating providers billing Category II codes at $0.00 and these services are not separately reimbursable.

Provider Contracting

Optional Networks

Mental Health/Chiropractic Providers

The Alliance offers optional participation in the chiropractic and mental health/AODA provider networks. Similar to the medical surgical network, The Alliance establishes local networks with mental health and chiropractic providers to determine fair market value for their services.

The Alliance Board of Directors agreed to an optional status for these networks based on the varied benefits packages carried by our member employers. In doing so, they set the following parameters.

- Employers may "opt in" at any time, however once "opted in" they must remain in that network for one calendar year.

Workers' Compensation

The **Workers' Compensation Network**, called Healthy People At Work, is available directly to self–insured, self–administered member companies. A separate agreement between the Member Company and The Alliance is necessary prior to implementation of the Healthy People At Work program. If the member company's worker's compensation program is administered by a carrier, The Alliance must first establish an agreement with the carrier.

Claims Processing Guidelines

Claims Flow

Health Care Provider generates claims and forwards to The Alliance.	→	The Alliance receives claim, collects data, reprices, and sends on to TPA within three working days.	→	TPA receives claim and pays according to The Alliance directive based on the employer's benefit plan design.
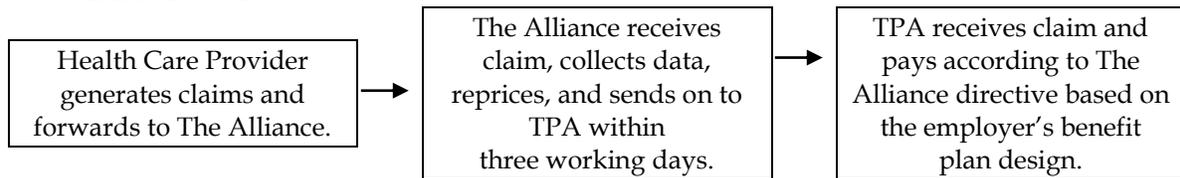
Ideally all claims will be sent to The Alliance for repricing directly from the provider. If claims are received by the TPA first, they should returned to the provider for appropriate routing.

All claims should be sent to The Alliance for data collection regardless of the provider's status as in or out of network or the provider's location.

Paper Transmission from Providers

All incoming claims will be scanned and date stamped upon receipt before noon at The Alliance. The claims are then distributed among the processors for repricing.

Each processor will verify that the patient is an Alliance member prior to processing. Upon identification of the patient's information, the processor will continue to enter the data provided on the claim into the appropriate fields.

If the patient is not in the biographical database, the processor will stamp the claim "Non-Alliance Member" and send the claim to the appropriate payer without repricing. The payer or the employer may submit a completed Alliance eligibility form to The Alliance for repricing and data collection, if their records show the patient is an Alliance eligible employee, for claims. **(Please see page 12 for complete eligibility information.)**

After the claim is entered, it will be repriced by The Alliance system. Cover sheets will be printed indicating the total repriced amount for hospital services or the list of repriced charges for physician services. The cover sheet will also show:

- Patient name
- Patient account number
- Plan administrator name
- Provider name
- Provider federal tax ID number
- Date(s) of service(s)
- Whether the provider is participating or non–participating
- The method of payment (i.e. Alliance repriced amount)

The cover sheets are attached to the appropriate claims. The claims are mailed out to the appropriate payer. This procedure will be completed within three working days.

Claims Processing Guidelines

Electronic Claim Transmission / Electronic Data Interchange

The Alliance accepts claims electronically directly from large volume providers and from some clearinghouses. Claims that are received electronically are processed electronically and forwarded to the TPA electronically or via mail.

Electronic Transmission of Claims to the Third-Party Administrator

The Alliance can transmit claims electronically to the TPA. For further information, please contact Dave Sell, 608.210.6656

Timely Payment of Claims

After The Alliance receives a claim, it has three working days to forward that claim to the plan administrator. The Alliance encourages the TPA to pay all claims in a timely manner. Effective February 1, 2019, some Alliance participating providers have contract language with The Alliance stating that **claims that remain unpaid for over 40 days may result in a 50% reduction of The Alliance negotiated fee to the employer/employee.**

Claims Processing Guidelines

Payment Messages

Each Alliance claim cover sheet shows a status message that is key in determining the payment of the claim. The status message is in the lower right section of the cover sheet. *For an example of an actual cover sheet, please see Appendix B.*

The following grids outline our messages. The first grid is for HCFA-1500 claims and the second grid is for UB04 claims. Each grid gives the message as it appears on the cover sheets, for which providers that message will appear and instructions on whether to apply the repricing for each message.

ALLIANCE CLAIM STATUS MESSAGES

HCFA–1500 claim status messages:

REPRICING COVER SHEET MESSAGE	PROVIDERS/ LOCATIONS	ALLIANCE REPRICE APPLICABILITY
PARTICIPATING PROVIDER Pay "Repriced" amount	Par providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
STRATOSE PROVIDER Pay "Repriced" amount	Zelis/Stratose providers when applicable	Payment should be based on Zelis/Stratose repriced amount; EOB should include text as indicated at the bottom of cover sheet clarifying regional network accessed or provider may not write off "discount"
NON-PARTICIPATING PROVIDER Repricing not applicable	Non-participating provider in any location	Payment should be based on payer usual & customary; Alliance "discount" is not applicable
EMPLOYER DOES NOT HAVE ACCESS TO THIS PROVIDER Repricing not applicable	May apply to participating: - chiropractic* - mental health providers* - providers located outside of Wisconsin	Payment should be based on payer usual & customary; Alliance "discount" is not applicable because employer has opted not to access these subsets of Alliance participating providers
NON-PARTICIPATING PROVIDER: Repricing not applicable	Non-participating oral surgery, vision, acupuncture or "other" service providers**	Payment should be based on payer usual & customary; Alliance "discount" is not applicable
QualityPath Pricing Pay Repriced amt; Not subject to Deductible and Coinsurance	Par providers in any location that are providing pre-surgical services for QualityPath eligible member	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Pricing Pay repriced amount Bundled pricing applied	QualityPath providers and their designates	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount

HCFA–1500 claim status messages continued:

QualityPath Warranty Pay repriced amount, not subject to deductibles and coinsurance	Par providers in any location that is providing services related to a complication from a QualityPath procedure	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Warranty Included in Bundle Pricing No additional payment allowed	QualityPath providers providing services related to a complication from a QualityPath procedure	Claim will be repriced to zero by The Alliance. While no payment will be issued, EOB should be generated to the provider of service

* = This message is not applicable for chiropractic or mental health services provided by a med/surg provider.

** = This message is not applicable for these types of services if provided by a participating provider or if provided by a med/surg, chiropractic or mental health provider.

UB04 claims status messages:

REPRICING COVER SHEET MESSAGE	PROVIDERS/ LOCATIONS	ALLIANCE REPRICE APPLICABILITY
PARTICIPATING PROVIDER Pay "Repriced" amount	Par providers in any location NPPN providers when applicable.	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
STRATOSE PROVIDER Pay "Repriced" amount	Zelis/Stratose providers when applicable	Payment should be based on Zelis/Stratose repriced amount; EOB should include text as indicated at the bottom of cover sheet clarifying regional network accessed or provider may not write off "discount"
Employer has not elected coverage in this network Repricing not applicable	May apply to participating: - chiropractic* - mental health providers* - providers located outside of Wisconsin	Payment should be based on payer usual & customary; Alliance "discount" is not applicable because employer has opted not to participate in the chiropractic or mental health network
NON-PARTICIPATING PROVIDER: Repricing not applicable	Non-participating provider in any location	Payment should be based on payer usual & customary; Alliance "discount" is not applicable
QualityPath Pricing Pay Repriced amt; Not subject to Deductible and Coinsurance	Par providers in any location that are providing pre-surgical services for QualityPath eligible member	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Pricing Pay repriced amount Bundled pricing applied	QualityPath providers and their designates	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Warranty Pay repriced amount, not subject to deductibles and coinsurance	Par providers in any location that is providing services related to a complication from a QualityPath procedure	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Warranty Included in Bundle Pricing No additional payment allowed	QualityPath providers providing services related to a complication from a QualityPath procedure	Claim will be repriced to zero by The Alliance. While no payment will be issued, EOB should be generated to the provider of service

Claims Processing Guidelines

Non–Covered Benefits

Many Alliance participating providers have agreed to accept Alliance repricing as full payment regardless of whether the service is a covered benefit under the plan and regardless of whether the employer, their plan administrator, or the employee is the responsible party for the charges.

For those members who have "opted" into the chiropractic and mental health networks, the employee may also be able to take advantage of Alliance repricing in the instance where the benefit is covered but is limited and the insured has exhausted the dollar amount allowed for that benefit.

For services that are not covered based on the benefit design, or due to limits of coverage, the insured employee should be advised through their Explanation of Benefits (EOB), what The Alliance repriced amount is so that they may submit their payment accordingly to those providers who will accept Alliance repricing for non–covered benefits. The providers have also requested that they be advised of any denials so that they are aware that the patient is responsible for the payment.

It will be the responsibility of the individual employee to determine if their provider will accept The Alliance repriced amount for the non–covered service.

Claims Processing Guidelines

Remittance Advice and Explanation of Benefits

Many of our participating provider agreements contain language that allows Alliance fees to be applied to non–covered benefits. This would include services whose cost falls solely on the employee due to an exhausted dollar threshold. *This creates a need for an Explanation of Benefits (EOB) and Remittance Advice even if no benefit payment is being made*.

The need for clear Explanation of Benefits and Provider Remittance Advices becomes increasingly important with the many contract arrangements available in the health care industry. An employee and provider must be able to identify:

- Billed charges
- Co–payments
- Deductibles
- Paid benefit amounts
- Clearly stated reduction in payment based on Alliance contracted arrangements.

Without accurate and complete information, the employee may be subject to unnecessary balance billing

Coordination of Benefits

The Alliance implemented a change to the language in the provider contracts regarding secondary claims repricing for services after January 1, 1995. The language states:

> **"Provider agrees to accept The Alliance repriced amount as full reimbursement regardless of whether employer is the primary or secondary payer. Medicare Claims are excluded from Alliance repricing."**

All secondary claims will be repriced to reflect The Alliance contracted fee based on total billed charges. Payers will use that information when determining the balance due to the provider after the primary payer has made payment.

EMPLOYEE ENROLLMENT FORM

For notifying The Alliance of changes in employee/dependent biographical information.

Type of Change

o New employee/ dependent   o Termination of employee/ dependent   o Other change

Employer Information

Organization name: _____

Section/ division (if applicable): _____

Employee Information

Name (last, first, m.i.): _____   o Male   o Female

Social Security No.: _____   Date of Birth: _____

Street address: _____

City/ State/ ZIP: _____

Effective date: _____   Termination date: _____

Dependent Information

o Single coverage   o Family coverage (*provide dependent biographical information below*)

	Last Name	First Name	MI	Birthdate	Sex	Eff Date	Term Date
Spouse							
Child 1							
Child 2							
Child 3							
Child 4							
Child 5							
Child 6							

Signature

_____   _____

Authorized signature   Date

Please return this completed form to:

THE ALLIANCE
Employers moving health care forward

PO Box 44365, Madison, WI 53744
Phone: 608-276-6620   Fax: 608-276-6626

UB REPRICING SHEET

Ⓐ 15 Payer:
  Employer: Ⓑ
Ⓒ Insured:

THE ALLIANCE ❯
Employers moving health care forward.

Group#_____ ID#_____ Patient:_____ DOB___

PO Box 44365
Madison, WI 53744
608-276-6620 (ph)
608-210-6677 (fax)

Ⓓ Covers Period: 06/28/2017 thru 06/28/2017
Ⓖ 105 PROVIDER: 391835630 UW Health University Hospital & UW Health Children's Hospital

NPI: 1922043744	RENDERING LOCATION	BILLING ADDRESS
CMS APR MS DRGs:	600 Highland Ave Madison, WI 53792	Drawer 853 Milwaukee, WI 53278

OCCURRENCE CODES			ADMISSION INFO			DISCHARGE		TOB: 131
Code Date	Code Date		Date	Hr Type Src	Hr	Stat	Pat ctrl:	Ⓗ
05 05/31/2017	11 05/31/2017			3 2		01	Med rec#:	

PRINCIPAL ——————————— DIAGNOSIS CODES ———————

S62367D

Admit: Reason: **S62367D**   Ecodes: **X58XXXD**

PROCEDURE CODES

NPI   NAME
Att: **1194097261 BATTAGLIA, LYNDS**

Code	Date	Code	Date	Code	Date	Oper: Oth: Oth:

Rev	HCPCS	Ⓘ	DOS	Units	Charges	Repriced
0320	73130 LT		06/28/2017	1	372.00	251.10
0510	99214 25		06/28/2017	1	164.00	110.70

CLAIM SUMMARY

Signed: 07/12/2017   Charges: Ⓙ 536.00   Status: **PARTICIPATING PROVIDER**
Received: 07/12/2017   Reprice: Ⓚ 361.80   Ⓛ **Pay "Repriced" amount**
Entered: 07/13/2017 EDICLM Savings: 174.20

Repriced amount valid for 30 days after the Alliance receipt date of the first submission of this claim   9954242597
This confidential document is intended only for the individual or entities named above. Eligibility and benefit designations are determined by the paying agent.   cboehmer 1/1

Alliance Cover sheet key:

Ⓐ Third Party Administrator (TPA) Name	Ⓔ TPA Assigned ID Number	Ⓘ Date of Service
Ⓑ Employer Name	Ⓕ Patient Name	Ⓙ Total charges billed by Provider
Ⓒ Policyholder Name	Ⓖ Provider Tax ID, Name & Location	Ⓚ Total Alliance Repriced Amount
Ⓓ TPA Assigned Group Number	Ⓗ Provider Account Number	Ⓛ Status Message/Payment Instruction

UB 04 Repricing Status Messages:

REPRICING COVER SHEET MESSAGE	PROVIDERS/ LOCATIONS	ALLIANCE REPRICE APPLICABILITY
PARTICIPATING PROVIDER Pay "Repriced" amount	Par providers in any location NPPN providers when applicable.	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
STRATOSE PROVIDER Pay "Repriced" amount	Zelis/Stratose providers when applicable	Payment should be based on Zelis/Stratose repriced amount; EOB should include text as indicated at the bottom of cover sheet clarifying regional network accessed or provider may not write off "discount"
Employer has not elected coverage in this network Repricing not applicable	May apply to participating: - chiropractic* - mental health providers* - providers located outside of Wisconsin	Payment should be based on payer usual & customary; Alliance "discount" is not applicable because employer has opted not to participate in the chiropractic or mental health network
NON-PARTICIPATING PROVIDER: Repricing not applicable	Non-participating provider in any location	Payment should be based on payer usual & customary; Alliance "discount" is not applicable
QualityPath Pricing Pay Repriced amt; Not subject to Deductible and Coinsurance	Par providers in any location that are providing pre-surgical services for QualityPath eligible member	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Pricing Pay repriced amount Bundled pricing applied	QualityPath providers and their designates	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Warranty Pay repriced amount, not subject to deductibles and coinsurance	Par providers in any location that is providing services related to a complication from a QualityPath procedure	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Warranty Included in Bundle Pricing No additional payment allowed	QualityPath providers providing services related to a complication from a QualityPath procedure	Claim will be repriced to zero by The Alliance. While no payment will be issued, EOB should be generated to the provider of service

HCFA REPRICING SHEET

(A) 15 Payer:
Employer: (B)
(C) Insured:

Group# _____ ID# _____ Patient: _____ DOB _____

THE ALLIANCE >
Employers moving health care forward

PO Box 44365
Madison, WI 53744
608-276-6620 (ph)
608-210-6677 (fax)

(D) (E) (F)
Covers Period: **06/08/2017** thru **06/08/2017**
(G) 9670 PROVIDER: **391824445**   **UW Health - Physicians**

PHYSICIAN	RENDERING LOCATION	BILLING ADDRESS
NC level degree	**600 Highland Ave** **Madison, WI 53792**	**Drawer 78864** **Milwaukee, WI 53278**
NPI:	NPI:	NPI:

Condition related to: Employment? **N**   Auto accident? **N**   Other Ins? **N**
Ill/Inj date: Other date: Unable to work: to
Local Use: Hospitalization: to
Diag codes: A. **S62367A**   B.   C.   D.
            E.   F.   G.   H.
ICD Ind: **0**   I.   J.   K.   L.

Pat acct#: (H)   Prior Pmt: **0.00**

DOS From	POS	CPT/HCPCS	Diag	Charge	Units	Repriced
(I) 06/08/2017	22	99203	A	263.00	1	181.73

CLAIM SUMMARY

Signed: **06/29/2017**   Charges: (J) **263.00**   Status: **PARTICIPATING PROVIDER**
Received: **06/29/2017**   Reprice: (K) **181.73**   **Pay "Repriced" amount** (L)
Entered: **06/29/2017** EDICLM Savings: **81.27**

Repriced amount valid for 30 days after The Alliance receipt date of the first submission of this claim   9954211848
This confidential document is intended only for the individual or entities named above. Eligibility and benefit designations are determined by the paying agent.   cboehmer 1/1

Alliance Cover sheet key:

(A) Third Party Administrator (TPA) Name
(B) Employer Name
(C) Policyholder Name
(D) TPA Assigned Group Number

(E) TPA Assigned ID Number
(F) Patient Name
(G) Provider Tax ID, Name and
(H) Provider Account Number

(I) Date of Service
(J) Total charges billed by Provider
(K) Total Alliance Repriced Amount
(L) Status Message/Payment Instructions

Alliance HCFA CMS–1500 claim status messages:

REPRICING COVER SHEET MESSAGE	PROVIDERS/ LOCATIONS	ALLIANCE REPRICE APPLICABILITY
PARTICIPATING PROVIDER Pay "Repriced" amount	Par providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
STRATOSE PROVIDER Pay "Repriced" amount	Zelis/Stratose providers when applicable	Payment should be based on Zelis/Stratose repriced amount; EOB should include text as indicated at the bottom of cover sheet clarifying regional network accessed or provider may not write off "discount"
NON-PARTICIPATING PROVIDER Repricing not applicable	Non-participating providers in any location	Payment should be based on payer usual & customary; Alliance "discount" is not applicable
EMPLOYER DOES NOT HAVE ACCESS TO THIS PROVIDER Repricing not applicable	May apply to participating: - chiropractic* - mental health providers* - providers located outside of Wisconsin	Payment should be based on payer usual & customary; Alliance "discount" is not applicable because employer has opted not to access these subsets of Alliance participating providers
NON-PARTICIPATING PROVIDER: Repricing not applicable	Non-participating oral surgery, vision, acupuncture or "other" service providers**	Payment should be based on payer usual & customary; Alliance "discount" is not applicable
QualityPath Pricing Pay Repriced amt; Not subject to Deductible and Coinsurance	Par providers in any location that are providing pre-surgical services for QualityPath eligible member	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Pricing Pay repriced amount Bundled pricing applied	QualityPath providers and their designates	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount

HCFA CMS–1500 claim status messages continued:

QualityPath Warranty Pay repriced amount, not subject to deductibles and coinsurance	Par providers in any location that is providing services related to a complication from a QualityPath procedure	Payment should be made at the QualityPath level of benefits (100%) based on Alliance repriced amount
QualityPath Warranty Included in Bundle Pricing No additional payment allowed	QualityPath providers providing services related to a complication from a QualityPath procedure	Claim will be repriced to zero by The Alliance. While no payment will be issued, EOB should be generated to the provider of service

* = This message is not applicable for chiropractic or mental health services provided by a med/surg provider.

** = This message is not applicable for these types of services if provided by a participating provider or if provided by a med/surg, chiropractic or mental health provider.

Appendix C   Requirements for Medical ID Card

ISSUING ID CARDS FOR ALLIANCE MEMBERS

Approval required

Prior to issuing ID cards for Alliance members, please be sure to get approval of the ID card from The Alliance®. You may fax a copy of the ID card to Member Services at 608.276.6626 or email it to mms@the-alliance.org. A sample ID card is reproduced below for your information.

Sample card front

XYZ Administrators   THE ALLIANCE

Employee Name	Employee No.
Susan Smith	123-45-6789
Employer Name	Group No.
ABC Company	0987

Types of Coverage

For eligibility and benefit verification call:
XYZ Administrators
Toll Free 800.345.6789

| Medical | Drug | Dental |
| Family | N/A | N/A |

Sample card back

Admission notification is required. Preauthorization must be obtained at least 48 hours prior to any non-emergency hospital admission, and within 48 hours following emergency admissions.

Preauthorization:	(phone no.)
Member Assistance:	(phone no.)
Alliance Provider Verification:	1.800.223.4139

Submit All Medical Claims to:
The Alliance | P.O. Box 44365 | Madison, WI 53744
Change Healthcare-88461, Relay Health 1500-2712 UB-1935

To verify your provider is in-network, visit www.the-alliance.org
Other claims: (address)

What to look for

A clear identification card can prevent misdirected claims and telephone calls, leaving customers more satisfied. While you are updating ID cards, please review your current ID cards for clarity.

> Is it clear to providers where to send **claims**? The Alliance must receive *all* medical/surgical, home health, mental health and chiropractic claims.

> Is it easy for employees to determine who to call with questions about **benefits** or **precertification**?

> Is it clear where **pharmacy and/or dental claims** should be routed (especially if a separate vendor is involved)?

> Remember, claims for participants with primary coverage through Medicare should *not* be sent to The Alliance.

The time and effort invested by employers, plan administrators and Alliance staff pays off when the claims payment process keeps running smoothly.

Please route this flyer to the appropriate people in your organization.

Payer Identification Numbers

The Alliance works with two clearinghouses for electronic claims submission, Change Healthcare and Relay Health. We strongly encourage you to include our payer identification numbers for electronic claims submission on your ID cards along with our claims filing address. The Alliance payer identification numbers are as follows:

> Change Healthcare # 88461

> Relay Health 1500 CPID # 2712

> Relay Health UB CPID # 1935

Additional questions or concerns regarding our payer identification numbers or EDI connectivity, can be directed to The Alliance Senior Programmer at 608.210.6656.

Appendix D   *QualityPath®*

Introduced in January 2015, *QualityPath®* is an initiative developed by The Alliance that:

- Identifies doctors and hospitals that – when working together – are at or above national standards for delivering quality care for select surgical procedures and diagnostic tests.
- Focuses on non-emergency surgical procedures and tests that are scheduled in a manner that allows patients to "shop" for care.
- Helps employers create health benefit plans that encourage employees and family members to choose high-value doctors and hospitals for selected procedures.
- Gives patients and family members access to information and easy-to-use tools that can be used to select high-quality, fairly priced health care providers for specific procedures.

Using a combination of enhanced benefits and bundled reimbursement that includes a warranty provision, *QualityPath* guides consumers to doctors and hospitals that – when working together - are at or above national standards for delivering quality care for selected procedures.

Detailed information regarding the *QualityPath* Program including current procedures, physician hospital pairings and operational requirements can be found at the Resources for TPAs page of our website at:

http://www.the-alliance.org/qualitypath/TPAs/