THE ALLIANCE®

THIRD-PARTY ADMINISTRATOR KIT

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

—December 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 • Machine Readable Files • Transparency Regulation Support	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 birthday
- 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."

Alliance Claims Repricing Definitions

Coordination of Benefits

See page 34 for information on coordination of benefits.

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

See page 33 for information on 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.

Alliance Claims Repricing Definitions

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

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 or 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 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

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

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

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

Wabasha County

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

Winona County

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

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 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 into 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.

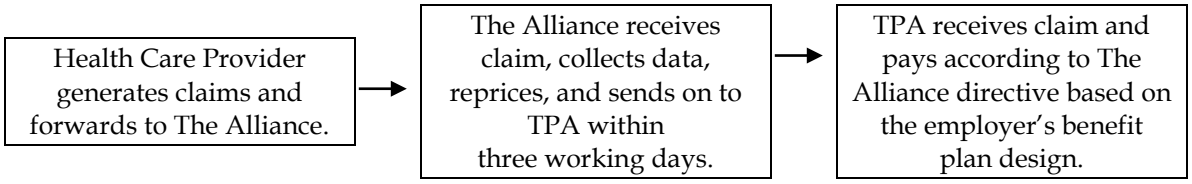
- Employers may "opt in" at any time, however once "opted in" they must remain in that network for one calendar year.

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



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:

ALLIANCE CLAIM STATUS MESSAGES CMS 1500

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"
MERCY EPO Pay "Repriced" amount	Mercy and select Rock County providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
PREMIER NETWORK RED Pay "Repriced" amount	University of Wisconsin Hospital and Clinics, Marshfield Clinic providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
NEHA ASPIRUS NARROW PREFERRED Pay "Repriced" amount	Par providers in any location	Payment should be based on NEHA repriced amount; the provider will write off any "discount"
NEHA ASPIRUS NARROW Pay "Repriced" amount	Par providers in any location	Payment should be based on NEHA 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

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.

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"
MERCY EPO Pay "Repriced" amount	Mercy and select Rock County providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
PREMIER NETWORK RED Pay "Repriced" amount	University of Wisconsin Hospital and Clinics, Marshfield Clinic providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
NEHA ASPIRUS NARROW PREFERRED Pay "Repriced" amount	Par providers in any location	Payment should be based on NEHA repriced amount; the provider will write off any "discount"
NEHA ASPIRUS NARROW Pay "Repriced" amount	Par providers in any location	Payment should be based on NEHA repriced amount; the provider will write off any "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

UB04 claims 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

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.

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

Claims Processing Guidelines

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.

Federal Regulation Support

Machine Readable File Support

As negotiators of network contract rates, The Alliance acknowledges its role in supplying our TPA partners with information to support our employer-members' compliance with federal transparency regulations.

The Alliance can supply the following menu of products for TPA partners (or their designees) to best fulfill the regulatory requirements:

- A monthly JSON and/or CSV formatted files with in-network negotiated rates for providers as defined by CMS
- A weekly CSV listing of all in-network providers and specialties
- README files containing details around the production, content, and intended use of each of the above products

The Alliance does not offer a hosted link to this information.

A copy of our Machine-Readable File Companion Guide can be found in Appendix E.

Qualified Payment Amount – QPA

The Alliance supports the QPA provision of the No Surprises Act by providing interested TPA partners with our 2019 median contracted rates by state and Metropolitan Service Area (MSA) in a Machine-Readable flat file format. This file is available upon request.

Continuity of Care Provision

To support this process, The Alliance will provide TPA partners upon request with access to a weekly termination file.

If the plan determines that a participant's care with a terminated provider qualifies under the continuity of care provision, TPA should notify The Alliance via e-mail using our Continuity of Care Notification form.

Upon receipt of this completed form, Alliance staff will flag plan participant's record allowing for services to continue to be repriced in network through approved transition period

A copy of the Alliance Continuity of Care Notification from can be found in Appendix E.

Appendix A Alliance Enrollment Form

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

_____ _____

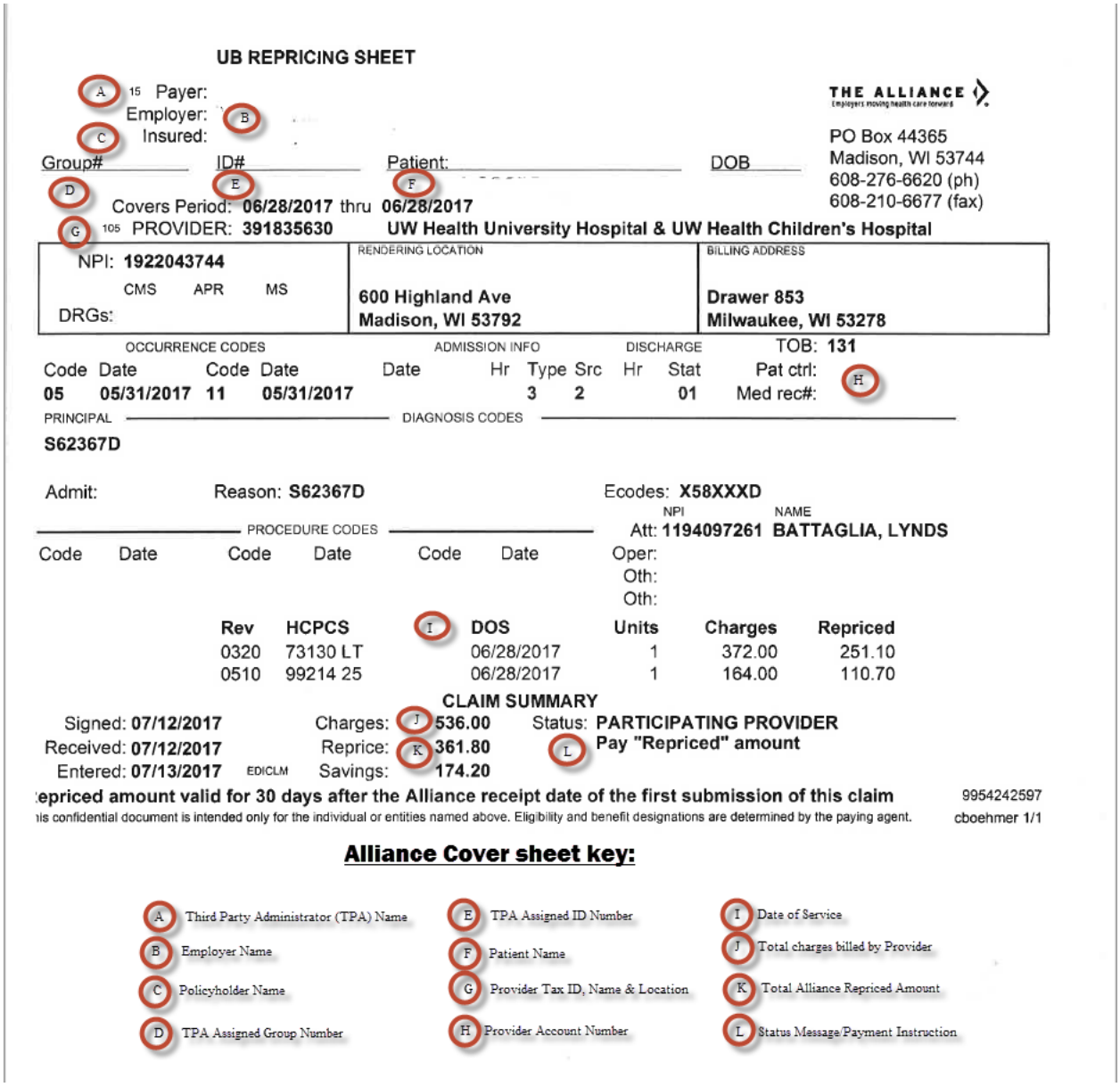
Authorized signature Date

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

APPENDIX B ALLIANCE COVER SHEET AND REPRICING MESSAGES



UB REPRICING SHEET

A 15 Payer:
Employer: B
C Insured:

THE ALLIANCE
Employers moving health care forward

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

Group# ID# Patient: DOB

D E F

Covers Period: **06/28/2017** thru **06/28/2017**

G 105 PROVIDER: **391835630** **UW Health University Hospital & UW Health Children's Hospital**

	RENDERING LOCATION	BILLING ADDRESS
NPI: **1922043744** 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#: H

PRINCIPAL — DIAGNOSIS CODES

S62367D

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

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

PROCEDURE CODES

Code	Date	Code	Date	Code	Date

Oper:
Oth:
Oth:

Rev	HCPCS	I 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**
Received: **07/12/2017**
Entered: **07/13/2017** EDICLM

Charges: J **536.00**
Reprice: K **361.80**
Savings: **174.20**

Status: **PARTICIPATING PROVIDER**
L **Pay "Repriced" amount**

epriced amount valid for 30 days after the Alliance receipt date of the first submission of this claim 9954242597

his 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:

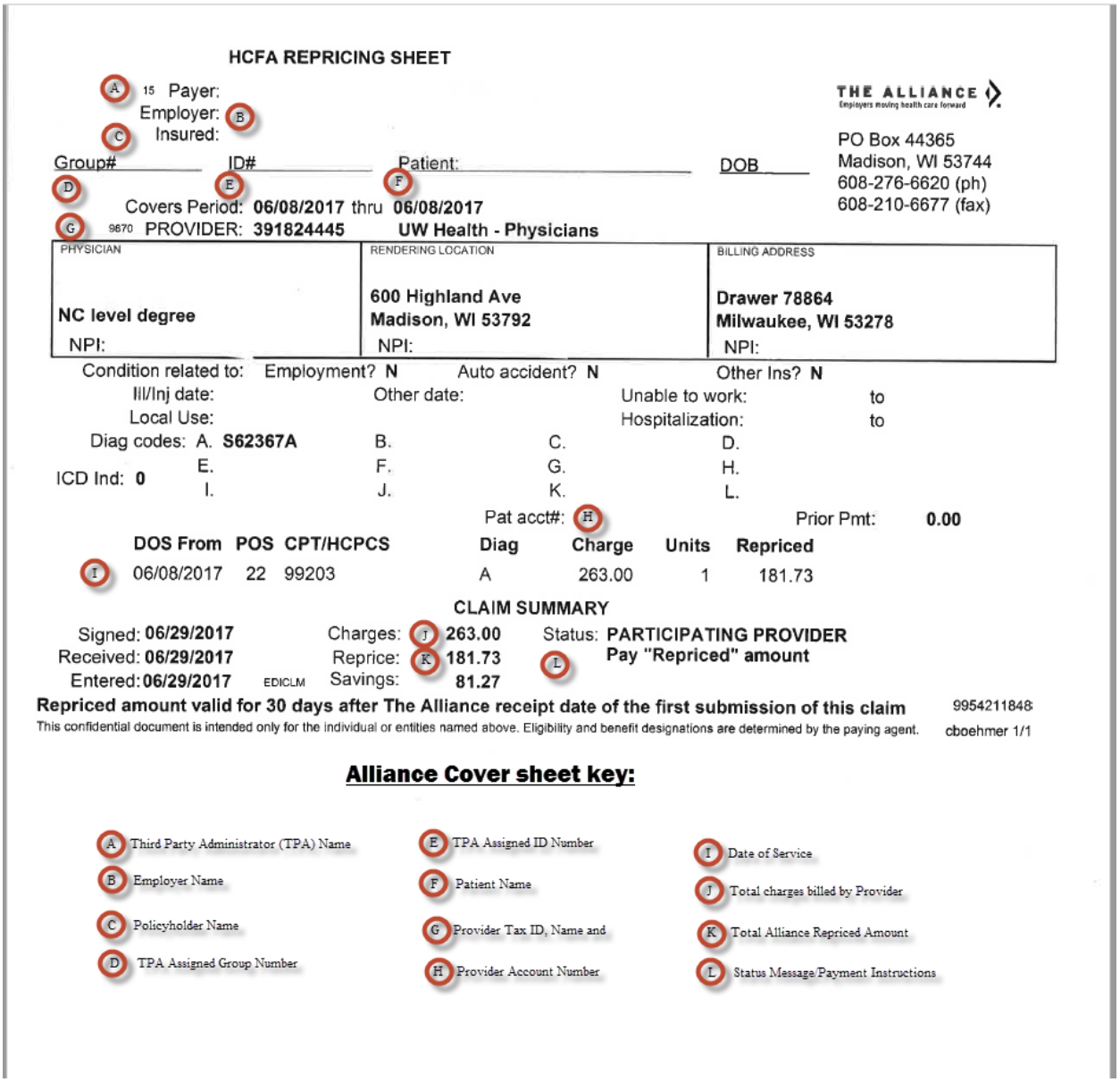
- A Third Party Administrator (TPA) Name
- B Employer Name
- C Policyholder Name
- D TPA Assigned Group Number
- E TPA Assigned ID Number
- F Patient Name
- G Provider Tax ID, Name & Location
- H Provider Account Number
- I Date of Service
- J Total charges billed by Provider
- K Total Alliance Repriced Amount
- L 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"
MERCY EPO Pay "Repriced" amount	Mercy and select Rock County providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
PREMIER NETWORK RED Pay "Repriced" amount	University of Wisconsin Hospital and Clinics, Marshfield Clinic providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
NEHA ASPIRUS NARROW PREFERRED Pay "Repriced" amount	Par providers in any location	Payment should be based on NEHA repriced amount; the provider will write off any "discount"
NEHA ASPIRUS NARROW Pay "Repriced" amount	Par providers in any location	Payment should be based on NEHA repriced amount; the provider will write off any "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

UB 04 Repricing Status Messages Continued:

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:

THE ALLIANCE
Employers moving health care forward

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

Group# (D) ID# (E) Patient: (F) DOB

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**	**Drawer 78864**
NPI:	**Madison, WI 53792**	**Milwaukee, WI 53278**
	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.

ICD Ind: **0** E. F. G. H.

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**
Received: **06/29/2017**
Entered: **06/29/2017** EDICLM

Charges: (J) **263.00**
Reprice: (K) **181.73**
Savings: **81.27**

Status: **PARTICIPATING PROVIDER**
Pay "Repriced" amount (L)

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"
MERCY EPO Pay "Repriced" amount	Mercy and select Rock County providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
PREMIER NETWORK RED Pay "Repriced" amount	University of Wisconsin Hospital and Clinics, Marshfield Clinic providers in any location	Payment should be based on Alliance repriced amount; the provider will write off any "discount"
NEHA ASPIRUS NARROW PREFERRED Pay "Repriced" amount	Par providers in any location	Payment should be based on NEHA repriced amount; the provider will write off any "discount"
NEHA ASPIRUS NARROW Pay "Repriced" amount	Par providers in any location	Payment should be based on NEHA 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

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 The Alliance Members

Approval required

To get ID card approval from The Alliance, email it to salessupport@the-alliance.org prior to issuing ID cards. The Alliance logo should be the largest logo on the card and must be placed on the top-front of the card. A sample ID card is shown below.

Sample card front

Sample card back

What to look for

A clear ID card can prevent misdirected claims and phone calls, leaving customers more satisfied. Please use the following checklist to review your ID cards:

- Is it clear to providers where to send claims? The Alliance must receive all medical claims.
- Is it easy for employees to determine who to call with questions about benefits or precertification?
- Is it clear where pharmacy or dental claims should be routed (especially if a separate vendor is involved)?

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 salessupport@the-alliance.org

Our possible logos, depending on the member plan:

The Alliance Self-Funding Smart | Premier Network by The Alliance | The Alliance Self-Funding Smart | Trilogy

info@the-alliance.org | the-alliance.org | 800.223.4139

The Alliance Self-Funding Smart

IDCard062021_TPA

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:

https://the-alliance.org/i-am-a-tpa/information-resources/

Appendix E

Transparency in Coverage

Machine Readable Files: Companion Guide - Version 0.6.0.6

Scope

Provide a companion guide to compliment The Alliance data intended to assist data partners in the production of compliant Machine-Readable Files for In-Network Rates defined in the Transparency in Coverage final rule. This companion guide also provides The Alliance an underlying strategy to help offer context around the design of the data files produced.

Updates

The current document is in draft form and will remain a working level document to stay consistent and up to date with draft CMS changes. Additionally, there are several outstanding unresolved questions posed on the specified file schema design. The Alliance may choose to modify included data if file schema guidance updates warrant a change. Updates to each companion guide will follow the convention of using the Transparency in Coverage data specification for the first three digits and The Alliance internal version of the solution in the last update.

Version 0.6.0.6 Updates

- Bug in prior version: Transitioned JSON structures for provider groups and negotiated prices to arrays rather than single objects
- Bug in prior version: Updated name from negotiated price to negotiated prices per schema definition
- Bug in prior version: Updated tin listing to denote type and value per schema definition
- Bug in prior version: Updated plan id to format as a string
- New implementation per schema: Updated to include billing class

Version 0.4.1.5 Updates

- Update to JSON schema to correct type from service codes vice service code per schema definition
- Inclusion of assumed provider charge in description where available
- Update to Milestones including CMS commitment for V1.0.0 specification lock
- Updates to JSON schema to support latest version architecture schema definition V0.4.1
- Refinement of how degree level reductions are taken for certain providers

Version 0.2.0.2 Updates

- As of V0.2.0.2 of the Transparency in Coverage Rule specification schema, the JSON schema allows for Place of Service to be produced as an array vs. as a string. With this update The

Alliance will translate the professional Place of Service designation (previously FAC and NON-FAC) to the associated array of CMS Place of Service codes.

- After review of our contracts, we have updated certain facility outpatient services to include billing code types beyond APC. Most facility outpatient services will still be APC billing codes.
- Refinement of methodologies to increase the number of services (~10% larger)
- Updates to add clarity to areas that were previously uncertain.
- Alignment of specification with flat file data content (new columns listed in specification)

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Underlying Alliance Strategy

The Alliance will support a production of data to inform the negotiated rate Machine-Readable Files and pass information to TPAs or their designees to transform and host. The Alliance underlying aims are to:

- Be transparent
- Supply necessary data to support compliance with the intent of the federal rules associated with the negotiated rate files
- When and where possible, limit the size of data produced
- Reduce the number of customizations needed to support different TPA/data partners
- Ensure timely and accurate processing of information
- Continuously improve

System Concept

Overall

TPAs will act as the 'hub' to support the hosting of Machine-Readable Files. The Alliance will support TPAs by providing relevant in-network negotiation rate files monthly via secure connection.

TPAs will not publish rate information prior to 1/1/2022. TPAs may choose to host The Alliance file directly or may choose to integrate other network information (HIOS IDs, Trilogy, wrap networks, transplant networks, etc.) with The Alliance information to produce a consolidated file.

The end-user support of file hosting, public file transfers, and guidance to the selection of appropriate files are anticipated to be TPA responsibilities.

Milestones

- July 31st, 2021: Initial mapping and companion guide detailing tri-department published schema and design decisions The Alliance has made related to the schema.
- August 31st, 2021: Preliminary draft of The Alliance Machine-Readable Files in designated file formats produced, companion guide produced, and call for FTP transfer details issued
- October 1st, 2021: First draft of final files produced and released to partners; companion guide finalized
- November 1st, 2021: Second draft of go-live files produced and released to partners

- December 6th, 2021: Final 'go-live' files produced and released to partners
- January 10th, 2022: Go-live files updated (later than typical month to account for fee schedule updates)
- January 21st, 2022: Documentation of all partners 'compliance' of hosting Alliance files assessed
- Monthly – first Monday of each following month – new files released to partners
- March 1, 2022: V1.0 release locked by CMS
- April 3, 2022: First V1.0.0.X files available from The Alliance.
- July 21st, 2022: Documentation of all partners 'compliance' of hosting Alliance files reassessed

Deliverable Content

Background

The Alliance's machine-readable file formats and data elements are derived from the schema specified online in the final Transparency in Coverage rule. However, in accordance with The Alliance's underlying strategy to limit the file sizes of data produced, and that The Alliance does not intend to be the final producer of the compliant files, some modifications to the underlying recommended schema have been made and comment is provided here.

File Formats

The Alliance intends to produce two structurally distinct files, both archived as .zip files, to reduce the underlying file size for transport. The two underlying formats are a pipe (|) delimited flat file and a hierarchical JSON file.

File Naming

<YYYY-MM-DD>_TheAlliance_<plan name>_in-network-rates.<file extension>

<file type name> will be csv or json. For a file produced on December 6, 2021 for the Comprehensive Network Plan the filenames would be listed as:

- 2021-12-06_TheAlliance_Comprehensive_in-network-rates.json
- 2021-12-06_TheAlliance_Comprehensive_in-network-rates.txt

To support reduced file size for data transfers the files will be archived in a zip file prior to sending. The zip archive files will contain one raw file per archive and in the above example be named as:

- 2021-12-06_TheAlliance_Comprehensive_in-network-rates_json.zip
- 2021-12-06_TheAlliance_Comprehensive_in-network-rates_txt.zip

Companion Files

The Alliance will provide a TPA specific pipe (|) delimited flat file listing:

- EmployerName
- plan_name
- plan_id
- EIN
- JSON_Filename
- Flat_Filename
- MD5 hashsum of zipped JSON file

- Unzipped JSON file size (MB)
- MD5 hashsum of zipped flat file
- Unzipped flat file size (MB)
- Row Count of number of records in the flat file

Data Content

Objects and fields are referenced against those listed in the final rule schema. While data are enclosed in quotes to identify what information The Alliance will include, they will not be in the final file and are provided here for clarity to distinguish the data content from the exposition.

In-Network File Object

reporting_entity_name: 'The Alliance'

reporting_entity_type: 'Self funded Employer Cooperative'

reporting_plans: An array, currently of a single object indicating the plan. More details are available in the Reporting Plans Object.

version: Current full version, currently V0.4.1.5

Reporting Plans Object

plan_name: To be determined. We will produce one file per Alliance network configuration and document a crosswalk between Employers and Alliance **plan_name**

plan_id_type: '' (We will leave this blank)

plan_id: An internal numeric reference to the plan names above. These listings are available in the crosswalk table. We do not plan to fill this with HIOS IDs or EINs but rather to allow the TPA to fill this detail.

plan_market_type: 'group'

In-Network Object

negotiation_arrangement: The Alliance will utilize the following billing code types: 'ffs' and 'bundle'. Nearly all services will fall under the 'ffs' negotiation arrangement. APC and MS-DRG billing code types are considered 'ffs' by The Alliance even though those code types reflect an aggregation performed by The Alliance rather than a code billed by the Provider.

name: The Alliance will use names defined from underlying fee schedules from MS-DRG, APC, CPT and HCPCS codes – the name field will not all contain the billing code. Abbreviations are likely and names are not guaranteed to be unique.

billing_code_type: The Alliance will utilize the following billing code types: 'MS-DRG', 'CPT', 'HCPCS', 'APC' and 'RC'. Revenue Codes are not currently utilized but may be in future releases.

billing_code_type_version: Current versions of billing code versions will be utilized. MS-DRGs will list the MS-DRG version (currently 38). All other data will list the current year Code Set. For 2021 rates these would be reflected as '2021'.

billing_code: MS-DRGs will be 3-digit strings, APC codes and Revenue codes will be 4 digits with leading 0s if appropriate. CPT and HCPCS codes will be either 5 or 7 characters. The Alliance has chosen to interpret CPT codes as including up to one modifier. The Alliance has chosen to include modifiers when listed in underlying fee schedules such as TC, 26, NU, RR, etc. The Alliance has not chosen to include modifiers that may lead to adjustment in professional payment such as AS, 80, 81, 55, 56, 53, etc. A complete listing of currently included modifiers is available upon request. For bundle arrangements, the listed code will be reflected as a 'trigger' code, or the costliest service that uniquely defines the bundle arrangement.

description: The description will be the name of the service suffixed with the underlying billing_code in parentheses. For services such as anesthesia services, the presumed number of units are also listed. The assumed charge is also available.

negotiated_rates: Used by The Alliance – see the Negotiated Rate Details Object section

bundled_codes: Used by The Alliance – see the Bundle Code Object section

covered_services: Not used by The Alliance

Bundle Code Object

billing_code_type: The Alliance will utilize the following billing code types: 'MS-DRG', 'CPT', 'HCPCS', 'APC'.

billing_code_type_version: Current versions of billing code versions will be utilized. MS-DRGs will list the MS-DRG version (currently 38). All other data will list the current year Code Set. For 2021 rates, these would be reflected as '2021'.

billing_code: The billing_codes that are most likely to be included as part of the bundle arrangement. The same formats will be used as described in the Reporting Plans Object

plan_name: To be determined. We will produce one file per Alliance network configuration and document a crosswalk between Employers and Alliance **plan_name**

plan_id_type: '' (We will leave this blank)

plan_id: An internal numeric reference to the plan names above. These listings are available in the crosswalk table. We do not plan to fill this with HIOS IDs or EINs but rather to allow the TPA to fill this detail.

plan_market_type: 'group'

In-Network Object.

description: The description of the billing_code that are included as part of the bundle arrangement. The same formats will be used as described in the Reporting Plans Object

plan_name: To be determined. We will produce one file per Alliance network configuration and document a crosswalk between Employers and Alliance **plan_name**

plan_id_type: '' (We will leave this blank)

plan_id: An internal numeric reference to the plan names above. These listings are available in the crosswalk table. We do not plan to fill this with HIOS IDs or EINs but rather to allow the TPA to fill this detail.

plan_market_type: 'group'

In-Network Object.

Covered Services Object

Not currently used by The Alliance

Negotiated Rate Details Object

negotiated_prices: Used by The Alliance – see Negotiated Price Object section.

provider_groups: Used by The Alliance – see the Provider Object section.

Provider Object

providers: For professional services, The Alliance maintains a listing of all active physicians that are tied to each tin. We will also impute the services that each provider may bill based on the providers NPI and taxonomy. Details on this methodology are available in the Estimation of What Providers Can Render What Service section of the Appendix. For professional services, an array of NPIs will be listed.

For institutional services, NPIs are not listed unless the negotiated rate explicitly contracts for a specific facility NPI. Organizational NPIs may be created whenever a provider determines it should create a new subpart per CMS[1]. Providers are not required to notify The Alliance for The Alliance to maintain a current listing of facility NPIs as it does not impact the contracted rate. As such, for many institutional rates this field will be left blank indicating the rate would apply to whatever facility NPI is listed.

tin: 9-digit tin provided for every record with leading 0s if applicable.

Negotiated Price Object

negotiated_type: The Alliance will use 'negotiated' for all services.

negotiated_rate: Dollar rates will be produced for all services including services based on percentage of charge contracted rates. The Alliance imputes underlying charge structures by provider using techniques addressed in the Estimation of Underlying Charges section of the Appendix.

expiration_date: To be the date in which the contract is set to expire if known or replaced with 9999-12-31 in ISO 8601 per specification.

service_code: The Alliance negotiated rates are determined by whether the claim is an institutional (CMS-1450) or professional (CMS-1500). Place of Service Codes are not present on institutional claims, for institutional negotiated rates the service code field is used to designate "IP" for or "OP" for Inpatient and Outpatient negotiated institutional rates.

[1] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf page 7, accessed on 7/21/2021.

For professional services, The Alliance has contracted services based on whether the service is rendered in a facility or a non-facility setting consistent with the general guidance from CMS. For these services, rather than listing every Place Of Service as a unique listing in the flat file, The Alliance will designate listings as 'FAC' and 'NON-FAC' to indicate a facility place of service, non-facility place of service, or either. A crosswalk of CMS two-digit codes to facility designations is available in the Crosswalk of CMS-Place of Service Values to service_code Mappings in the Appendix. For the JSON file, due to its hierarchical nature, we will list map the FAC and NON-FAC listings to the full array of CMS codes for these professional services.

The Alliance does not assess whether the provider is able to render care at every listed site of service, just what the contracted rate would be if they did render care at that particular site of service.

billing_class: Set to professional or institutional dependent on the rate type provided.

Flat File Format

The flat file format will include much of the same content as the hierarchical schema. Fields are intended to be pipe delimited with a header row included. Data content should be parsed as string data. There are no leading quotes in a field and data content are guaranteed to not include pipes (|). The following fields are anticipated in the flat file format, delimited by the pipe character and line per row of data:

Field Name	Maximum Length	Will be blank?	Comment
reporting_entity_name	20	No	Will be listed as 'The Alliance'
reporting_entity_type	63	No	Will be listed as 'Self funded Employer Cooperative'
plan_name	63	No	Crosswalks between plan_names and employers will be included in a companion file
plan_id_type	10	Yes	Will be blank
plan_id	15	No	Crosswalks between plan_ids and employers will be included in a companion file
plan_market_type	10	No	Will be 'group'
negotiation_arrangement	10	No	
name	255	No	
billing_code_type	8	No	
billing_code_type_version	15	No	
billing_code	7	No	
description	255	No	
provider	10	Conditionally	Provider ID may not be populated for certain facility service_codes
tin	9	No	
service_code	7	No	See Appendix for comment

negotiated_type	12	No	
negotiated_rate	9	No	decimal(9,2)
expiration_date	10	No	Open term dates listed as 9999-12-31
bundle_code_code_type	8	Conditionally	Only populated for negotiation_arrangement of bundle
bundle_code_code_type_version	15	Conditionally	Only populated for negotiation_arrangement of bundle
bundle_code_billing_code	7	Conditionally	Only populated for negotiation_arrangement of bundle
bundle_code_description	255	Conditionally	Only populated for negotiation_arrangement of bundle
last_updated_on	10	No	Date the file was last updated
version	14	No	Version of file

Deliverable File Exchange

File Availability

The Alliance projects to produce 9 distinct plans based on its current distinct network configuration. Each plan is likely to have a file size of ~600 MB for a flat file archived zip file (~5.6 GB when unzipped) and ~120 MB for an archived JSON file (~660MB when unzipped). Files will be made available to support testing for individuals via OneDrive folder access and, if necessary, via FTP. Moving forward, The Alliance will work with each TPA to identify the preferred mechanism for transport.

The Alliance will archive at least one year of data files that have been made available for TPA partners and will log deliveries and/or downloads of files.

Appendix

Estimation of What Providers Can Render What Service

The Alliance contracts typically do not specify the codes a provider is 'allowed' to bill. Rather, The Alliance typically specifies how codes would be repriced if billed. However, due to The Alliance philosophy to reduce file size and to improve the relevance of the files, The Alliance has made the decision to limit the file size by eliminating codes that are unlikely to ever be billed by providers. The Alliance receives and processes many claims and has chosen to use this historical claim information to inform what services should be listed in the negotiated rate, machine readable file. Updates to this methodology are, over time, expected to best reflect a complete estimation of the services an in-network provider may be able to perform.

Professional Services

The Alliance imputes what services a professional may be able to perform based upon the providers taxonomy code. The Alliance performed a survey of publicly available sources to seek definition and crosswalk of provider taxonomy to likely CPT and HCPCS codes that the taxonomy could provide, but did not find such a resource.

Therefore, The Alliance used its own claims history dating back to 2015 to form a determination of what services a professional may reasonably be expected to perform even with no demonstrated history based upon their taxonomy codes. Services are not inadvertently assigned to all providers with a given taxonomy without a threshold number of providers with the specialty also performing the same service. However, we do ensure that any provider with demonstrated history of performing a specific service will be listed even if they do not qualify based on our threshold prevalences.

Institutional Services

Institutional services are generally listed as MS-DRGs for inpatient facility services and APCs for outpatient facility services. The Alliance starts by defining every MS-DRG or APC we have seen in our historical claims data. These form a master list that we ascribe to all providers that we allow to bill facility claims. As new DRGs and APCs are introduced they will also be incorporated. From that master list, The Alliance may further tailor the list to eliminate services The Alliance is aware that a given provider or Tax Identification Number does not perform.

For certain contractual arrangements that The Alliance maintains, some outpatient facility services may include CPT / HCPCS code or Revenue Codes.

Crosswalk of CMS-Place of Service Values to service_code Mappings

In the flat file, a short-hand service_code is used to identify the valid Place Of Service codes for which the identified rate applies. In the JSON file format, the CMS two-digit codes are listed explicitly in an array for professional services.

Short-hands of 'IP' and 'OP' are still used for Facility services as the Alliance does not support different rates based on more granular sites of service, other than whether the service was Inpatient or Outpatient. Particular mapping of these designators to service_codes is left to the particular implementation choices of the final consumer of the file since 2-digit place of service codes are not present on institutional claims.

Code	Description	service_code
01	Pharmacy	NON-FAC
02	Telehealth	FAC
03	School	NON-FAC
04	Homeless Shelter	NON-FAC
05	Indian Health Service Free-standing Facility	NON-FAC
06	Indian Health Service Provider-based Facility	NON-FAC
07	Tribal 638 Free-Standing Facility	NON-FAC
08	Tribal 638 Provider-Based Facility	NON-FAC
09	Prison/Correctional Facility	NON-FAC
11	Office	NON-FAC
12	Home	NON-FAC
13	Assisted Living Facility	NON-FAC
14	Group Home	NON-FAC
15	Mobile Unit	NON-FAC
16	Temporary Lodging	NON-FAC

17	Walk-in Retail Health Clinic	NON-FAC
18	Place of Employment-Worksite	NON-FAC
19	Off Campus-Outpatient Hospital	FAC
20	Urgent Care Facility	NON-FAC
21	Inpatient Hospital	FAC
22	Outpatient Hospital	FAC
23	Emergency Room-Hospital	FAC
24	Ambulatory Surgical Center	FAC
25	Birthing Center	NON-FAC
26	Military Treatment Facility	FAC
31	Skilled Nursing Facility	FAC
32	Nursing Facility	NON-FAC
33	Custodial Care Facility	NON-FAC
34	Hospice	FAC
41	Ambulance - Land	FAC
42	Ambulance - Air or Water	FAC
49	Independent Clinic	NON-FAC
50	Federally Qualified Health Center	NON-FAC
51	Inpatient Psychiatric Facility	FAC
52	Psychiatric Facility-Partial Hospitalization	FAC
53	Community Mental Health Center	FAC
54	Intermediate Care Facility/Mentally Retarded	NON-FAC
55	Residential Substance Abuse Treatment Facility	NON-FAC
56	Psychiatric Residential Treatment Center	FAC
57	Non-residential Substance Abuse Treatment Facility	NON-FAC
60	Mass Immunization Center	NON-FAC
61	Comprehensive Inpatient Rehabilitation Facility	FAC
62	Comprehensive Outpatient Rehabilitation Facility	NON-FAC
65	End-Stage Renal Disease Treatment Facility	NON-FAC
71	State or Local Public Health Clinic	NON-FAC
72	Rural Health Clinic	NON-FAC
81	Independent Laboratory	NON-FAC
99	Other Place of Service	NON-FAC

Estimation of Underlying Charges

While The Alliance aims to contract on a prospective basis, we still hold a number of contracts that depend upon the underlying charges billed by The Provider. The Alliance does not have control over line-item charges billed by the provider. The Alliance aims therefore, to estimate the underlying charge structure of all services listed in the negotiated rate file for all providers by using:

- Observed history specific to the TIN and provider and service
- Observed history specific to the TIN and service

- Observed history specific to the TIN, other services, and underlying standard fee schedules to estimate the unknown service
- Where volumes are especially small across all services for a TIN, we may utilize other data such as Alliance network averages, regional averages, or data from state or national repositories such as all payer claims databases

Each data update will perform a new imputation of underlying charges based on the latest history of data.

Testing, Validation, and Accuracy

The Alliance will routinely be testing the validity and accuracy of the files against collected claims data. The goal of the accuracy data is to test at a plan, tax identification number, and place of service level. Accuracy testing aims to expose:

- Unexpected providers billing within a Tax Identification number
- Unexpected codes billed by providers
- Accuracy of charge estimation techniques
- Accuracy of in-network rates

Many contracted services may not be uniquely determined due to underlying factors such as chargemaster updates from providers, inlier rates, more complex arrangements which may conditionally reduce the allowed amount of a DRG service based on other data, and other factors. The goal for the accuracy is to help expose any areas with systematic errors for further refinements of the methodology. The Alliance testing results may be made available upon request.

Alliance Continuity of Care Notification Form

TO: Alliance Claims Department		DATE:	
FROM: *TPA CONTACT NAME*			
TPA Contact Phone Number:		TPA Contact E-mail	
Patient Detail			
Patient Name			
Patient Date of Birth		Patient ID Number	
Treatment Detail			
Provider Name		Provider Tax ID	
Description of Care covered during transition:			
Transition End Date:	MM/DD/YYYY		
Please e-mail completed form to CSR@the-alliance.org			