CREATING HEALTHCARE SOLUTIONS

Remittance Advice Guide

This document will help to better acquaint you with the Remittance Advice (RA) while posting claims back to your system.

What's Different?

The following outlines what modifications have been made to the Remittance Advice since implementing a new adjudication system on October 1st, 2016. The Alliance is adjusting our paper process to align better with National Electronic Standards. Please see the appropriate sections within the document for more details.

- Quantity has been split into two columns:
  - Quantity Billed
  - Quantity Allowed
- Withhold Amount has been removed
- Explain Codes for most paid claim lines have been removed, i.e. 10, 14 were removed, however, 11, 1B, 1C remain
- Medi-Cal, provider, group RA totals have been removed from bottom of the RA
- Interest and claim totals have been added to the bottom of the RA

Sort Order

RAs are separated based on the provider's billing number (typically the National Provider Identifier). In the event that you are part of a group or have arranged for multiple doctors in the same practice to receive claims data on the same RA, the Alliance may have "grouped" your practices/facilities together.

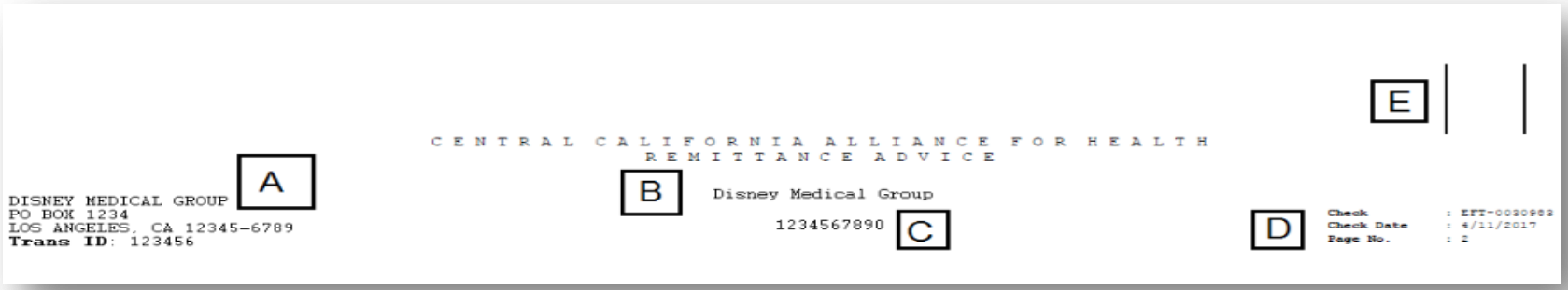
Claims are then sorted by Member Last Name and are grouped by Patient Account number.
Within each Patient Account number grouping, the data is then sorted by Claim number and lastly by Line number.

Please note: All Denied Claim lines and Paid Claim lines where the paid amount has been modified like capitated and late submission claims will be assigned an Explain Code (or codes). Explain Code Descriptions are provided on the last page of the RA in order to assist you with account reconciliation and posting. The explain codes will have a paid status identifier and a crosswalk to the HIPAA claim adjustment group code, claim adjustment reason code and remittance advice remark codes where applicable.

Please note: It is possible that if all claims on the RA have denied, you will not receive a check. You will, however, receive an RA indicating the status of each claim.

Section I

The following Heading section will repeat on each page of your RA. The information contained in this section is as follows:



A. The Provider's Name and Address on file for payment is displayed in this location. This will also contain a unique transaction identification number (Trans ID) for the remittance advice.

B. This section will display the Provider's name that is associated with the National Provider Identifier (NPI) on file.

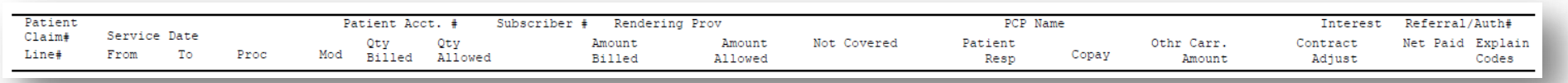
C. The Provider's NPI will appear on this line. This should be the same billing number submitted on claims to the Alliance.

D. The first line will display the check number if a payment is due. The second line will display the date the check and/or RA is printed. The third line identifies the page number of the RA.

E. These lines are for our mailing machine and can be ignored.

Section II

This section contains heading labels that identify where data will be printed (see Section III). This section will repeat on each page of



Patient Claim# Line#	Service Date From	To	Proc	Mod	Patient Acct. #	Subscriber #	Rendering Prov			PCP Name			Interest	Referral/Auth#
					Qty Billed	Qty Allowed	Amount Billed	Amount Allowed	Not Covered	Patient Resp	Copay	Othr Carr. Amount	Contract Adjust	Net Paid Explain Codes

your RA.

Patient: This is the name of the Alliance member as per our records and is displayed as Last Name, First Name, and MI. If the Alliance is unable to locate the member using the information provided on the form, the text "NOT ON FILE, RECIPIENT" will appear in this location.

Patient Acct. #: This is the Patient Account number that was provided on the claim by your office. The Alliance is printing this information on the RA in order to assist you with posting the claim back to your system.

Subscriber #: This is the Alliance Member Identification number and should be the number used when billing your claims to the Alliance. If the Alliance is unable to locate the member using the information provided on the form, the original recipient ID number submitted on the claim will appear in this location. Depending on the claim status code (Denied vs. Suspended), you may need to submit corrected claim information to the Alliance or contact the Claims department for more information.

Rendering Prov: This is the Rendering Provider number as indicated on the claim submitted by your office.

PCP Name: The full name of the member's PCP will be printed here. In the event that the member is an "Administrative Member", the PCP will be displayed as "The Alliance".

Interest: The dollar amount paid resulting from the interest amount due for the whole claim. (Note: This is no longer reported at the service line level)

Referral/Auth#: If a Referral Consultation Request or an Authorization number was submitted in conjunction with the claim, it will be displayed in this location for informational purposes only.

Claim#: A unique 10-digit number is assigned for each claim received and processed. This number is also referred to as the Claims Control Number (CCN). Please reference this number when contacting the Alliance about specific claims questions. Next to the Claim# the member's "Plan" is identified and displayed.

Line#: Each service line submitted on the claim is assigned a specific line number by our system. It is then reported on the RA. 0100, for example, pertains to the 1st detail line. 0200 is the 2nd detail line and so on. In the event that the Alliance performed a Correction or Reversal to a previously submitted claim detail line, the numbering schema will append a number to the last digit of the original detail line.

Service Date (From): This is the effective date of service as submitted on the claim.

Service Date (To): This is the ending date of service as submitted on the claim.

Proc: This pertains to the Procedure code and/or Revenue Code as submitted on the claim for Medical and Hospital RA's.

NDC/Drug#: This pertains to the National Drug Code/Medical Supply Code and is specific to Pharmacy RA's. The heading of Pharmacy RA's will display "NDC/Drug#" in lieu of "Proc" number.

Modifier: The Modifier code, as submitted on the claim, will be reported in this column.

Qty Billed: This pertains to the Quantity or units of service as submitted on the claim.

Qty Allowed*:* This pertains to the Quantity or units of service as allowed on the claim.

Amount Billed*:* The dollar Amount Billed by your office for each detail line will be reflected in this column.

Amount Allowed: In this column, the Alliance will reflect the dollar amount ***allowed*** for the service line per contractual guidelines. If the service is capitated, the Amount Allowed will always equal $0.00.

Not Covered*:* The Alliance will indicate the applicable dollar amount that is not covered in this column.

Patient Resp: The patient responsibility reflects a member's Share of Cost (SOC) payment as submitted on the claim. This amount is deducted from the Allowed Amount.

Copay: In the event that the member has a co-payment obligation, this dollar amount will be reflected in this column and deducted from the Allowed Amount.

Othr Carr. Amount: If this is a crossover or secondary claim (i.e., Medicare, Blue Cross, Kaiser, etc.), the Alliance will reflect the amount ***paid*** by Medicare or the Other Health Coverage (OHC) carrier up to the Alliance's Allowed Amount (less any OHC Contractual Adjustment) in order to accurately reflect coordination of benefits pricing guidelines. These dollar amounts will appear for "Paid" and "Adjusted" claims only. "Denied" and "Suspended" claims will reflect $0.00 in this column.

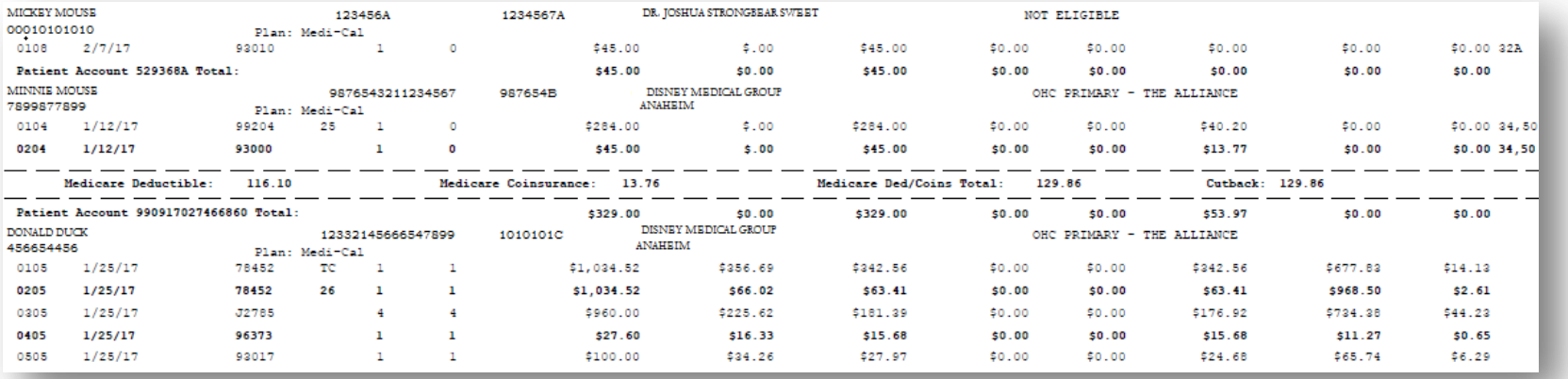
Contract Adjust: The dollar amount reflected in this column (for "Paid" claims only) should assist you with determining the Contractual Adjustment (a.k.a. write off) amount for the claim. This is the difference between the Amount Billed and the Amount Allowed.

Net Paid: This is the Net Amount paid by the Alliance after the Allowed Amount has been reduced by other factors (such as a Member's Share of Cost, OHC payment, etc.). If the service is capitated, the Net Paid will equal $0.00 and an Explanation Code of 11 is assigned. The Net Paid will no longer contain the interest amount as it will be reported separately.

Explain Codes*:* Most paid claim lines will NOT have an explain code. Every denied claim line will have an explain code. The description of each Explain Code can be found on the Summary page of the RA (see Section V). These Explain Codes support the reason a claim service was Paid or Denied.

Section III

This section contains the claims data. The explanation of the various column headings in Section II, should make interpreting the claims data specific to your RA in this section relatively straightforward.



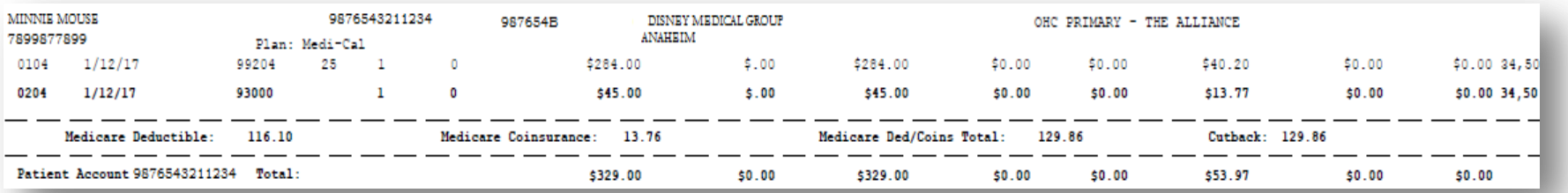
MICKEY MOUSE				123456A		1234567A	DR. JOSHUA STRONGBEAR SWEET			NOT ELIGIBLE				
000101010101O			Plan: Medi-Cal											
0108	2/7/17	93010		1	0	$45.00	$.00	$45.00	$0.00	$0.00	$0.00	$0.00	$0.00	32A
Patient Account 529368A Total:						**$45.00**	**$0.00**	**$45.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	
MINNIE MOUSE				9876543211234567		987654B	DISNEY MEDICAL GROUP ANAHEIM			OHC PRIMARY - THE ALLIANCE				
7899877899			Plan: Medi-Cal											
0104	1/12/17	99204	25	1	0	$284.00	$.00	$284.00	$0.00	$0.00	$40.20	$0.00	$0.00	34,50
0204	**1/12/17**	**93000**		**1**	**0**	**$45.00**	**$.00**	**$45.00**	**$0.00**	**$0.00**	**$13.77**	**$0.00**	**$0.00**	**34,50**
Medicare Deductible: 116.10						**Medicare Coinsurance: 13.76**			**Medicare Ded/Coins Total: 129.86**			**Cutback: 129.86**		
Patient Account 990917027466860 Total:						**$329.00**	**$0.00**	**$329.00**	**$0.00**	**$0.00**	**$53.97**	**$0.00**	**$0.00**	
DONALD DUCK				12332145666547899		1010101C	DISNEY MEDICAL GROUP ANAHEIM			OHC PRIMARY - THE ALLIANCE				
456654456			Plan: Medi-Cal											
0105	1/25/17	78452	TC	1	1	$1,034.52	$356.69	$342.56	$0.00	$0.00	$342.56	$677.83	$14.13	
0205	**1/25/17**	**78452**	**26**	**1**	**1**	**$1,034.52**	**$66.02**	**$63.41**	**$0.00**	**$0.00**	**$63.41**	**$968.50**	**$2.61**	
0305	1/25/17	J2785		4	4	$960.00	$225.62	$181.39	$0.00	$0.00	$176.92	$734.38	$44.23	
0405	**1/25/17**	**96373**		**1**	**1**	**$27.60**	**$16.33**	**$15.68**	**$0.00**	**$0.00**	**$15.68**	**$11.27**	**$0.65**	
0505	1/25/17	93017		1	1	$100.00	$34.26	$27.97	$0.00	$0.00	$24.68	$65.74	$6.29	

Section IV

Totals will appear in various locations on the RA and are intended to assist in summarizing assorted groups of claims data. The totals are as follows:

Medicare Totals: If the claim has been processed as a Medicare Crossover (i.e., Medicare is primary and the Alliance is secondary), the RA will indicate the following Claim Summary information just before the Patient Account Totals.

- Medicare Deductible: The total Medicare Deductible as reported on the Explanation of Medicare Benefits (EOMB). Medicare Coinsurance: The total Medicare Coinsurance as reported on the EOMB.
- Medicare Ded/Coins Total: The summation of the Medicare Deductible & Medicare Coinsurance amounts.
- Cutback: This is the difference between the Medicare Ded/Coins Total and the Net Paid plus Withhold Amount. Typically, the contractual write-off in this scenario is the un-recovered Deductible & Coinsurance portions of the billing.



MINNIE MOUSE 7899877899			9876543211234 Plan: Medi-Cal			987654B	DISNEY MEDICAL GROUP ANAHEIM			OHC PRIMARY - THE ALLIANCE			
0104	1/12/17	99204	25	1	0	$284.00	$.00	$284.00	$0.00	$0.00	$40.20	$0.00	$0.00 34,50
0204	1/12/17	93000		1	0	$45.00	$.00	$45.00	$0.00	$0.00	$13.77	$0.00	$0.00 34,50
Medicare Deductible: 116.10					Medicare Coinsurance: 13.76			Medicare Ded/Coins Total: 129.86			Cutback: 129.86		
Patient Account 9876543211234 Total:						$329.00	$0.00	$329.00	$0.00	$0.00	$53.97	$0.00	$0.00

Patient Account # Totals: At each change in Patient Account number, totals of all dollar amount columns are printed for your convenience.

PRINCESS AURORA 0123456789			10000A Plan: Medi-Cal			99000000A	DR.DRAKKEN				DISNEY MEDICAL CENTER - ORLANDO		
0107	1/13/17	93010		1	1	$45.00	$8.85	$.00	$0.00	$0.00	$0.00	$36.15	$8.85
0207	1/13/17	93010		1	1	$45.00	$8.85	$.00	$0.00	$0.00	$0.00	$36.15	$8.85
Patient Account 10000A Total:						$90.00	$17.70	$0.00	$0.00	$0.00	$0.00	$72.30	$17.70

Note: If multiple claims share the same Patient Account number, they will appear together and will only be totaled once. Furthermore, if the Rendering Provider number or PCP Name changes within the same Claim number, a new Patient line will be printed and will only be totaled once by Patient Account number.

INTEREST PAYMENT								$39.99
CLAIMS PAYMENT								$142,500.59
TOTAL PAYMENT	$4,049,652.81	$242,095.38	$272,545.24	$0.00	$0.00	$90,567.34	$3,634,606.98	$142,540.58

Interest Payment: The sum of all interest paid to the group will be displayed here.

Claims Payment: The sum of all claims paid to the group will be displayed here.

Total Payment: The sum of interest and claims payment to the group will be displayed here. Also, other claim specific amounts are summed here.

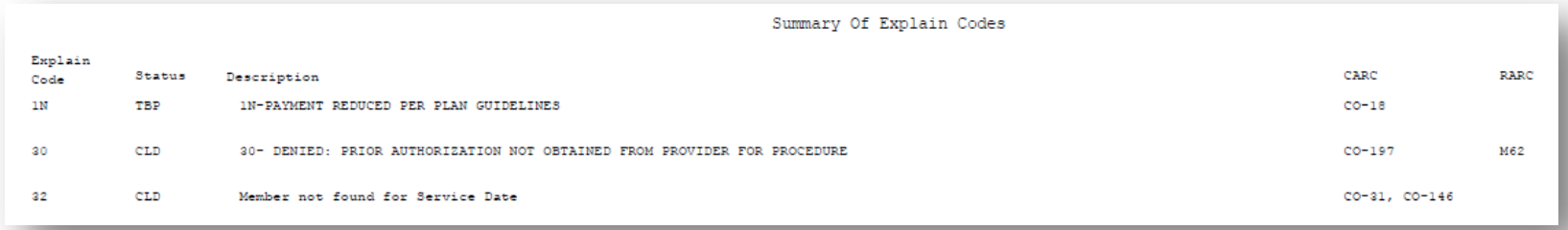
Checks Received: This area displays information regarding the check(s) received by the Alliance regarding overpayment reimbursement. This area is strictly informational and will not result in a net payment reduction.

CHECKS RECEIVED FROM PROVIDER SINCE LAST REMITTANCE ADVICE

CHECK#	FCN	CHECK DATE	CHECK AMOUNT
1234567	12346	07/13/11	$26.73
1234568	12347	07/14/11	$280.46

Section IV

A summary of all Alliance Explain Codes along with their corresponding paid status, descriptions, HIPAA claim adjustment group code, claim adjustment reason code (CARC) and remittance advice remark codes (RARC), where applicable, are printed here. The paid status associated with each explain code will be either ENC (Encounter), CLD (Denied) or TBP (PAID).



Summary Of Explain Codes

Explain Code	Status	Description	CARC	RARC
1N	TBP	1N-PAYMENT REDUCED PER PLAN GUIDELINES	CO-18	
30	CLD	30- DENIED: PRIOR AUTHORIZATION NOT OBTAINED FROM PROVIDER FOR PROCEDURE	CO-197	M62
32	CLD	Member not found for Service Date	CO-31, CO-146	