AetInfo's Standard Universal Files
July 30, 2006

Purpose: We want to update you about format, content and/or documentation changes in the standard AetInfo® Universal Files. The scope of this communication is global, and the subject matter is generic. It does not include references to individual customers or customized file formats.

This update includes information that may require you to revise your intake/load program. If you have questions about these changes (or about other aspects of U Files), please contact any of the AetInfo contacts listed later in this document.

Additions/Changes to CONTENT Since Last Update: AetInfo made no additions or changes to the U Files since our last bulletin. We are not planning any content changes to the U Med/Dent file at this time. Plans for possible changes in 2007 will be announced as they develop. We will keep you apprised of our plans and provide sufficient advance notice before introducing a material modification.

Additions/Changes to DOCUMENTATION Since Last Update: There have been no additions or changes to the posted record layouts or data dictionaries since the updated links for FSA and APM files were added in April 2006.

Data CONTENT Alerts (U Med/Dent File):
#1. "Zeroed-out" claim records have been added to the Universal Medical/Dental file for non-HMO (Field #7, Source System Platform) = '27') claims processed on or after May 20, 2006.

Background
This is an enhancement to the Universal Medical/Dental file that eliminates an overstating of financial and utilization amounts that was formerly caused when an adjusted/reprocessed claim was reprocessed with a different Claim ID than had been used on the original claim transaction.

Details
There are two ways in which claims may be adjusted in Aetna's ACAS claim engine for non-HMO/QPOS claims:

1. Reprocess the original claim, using the same Claim ID.
This is the method that most regular users of the Universal files are familiar with. When an original claim requires subsequent adjustment, the claim is reprocessed as a new segment of the same Claim ID, (Field #33, Source-Specific Transaction ID Number) with a pointer back to the original transaction (Field #35, ACAS Pointer Back to Previous Gen/Seg). The pointer alerts our data warehouse of the need to create a reversal record in order to "net zero" the financial and utilization totals associated with the original claim transaction. With the totals associated with the original transaction set back to zero, the subsequent corrected claim transaction is recorded, and the net total of all associated records (the original, the reversal, and the adjustment) will be correct.
The key to this method is that the same root 'Claim ID' (Field #33, Source-Specific Claim ID) is used for all 3 components of the transaction (original, reversal, adjustment), and each of those three components can be recognized by utilizing combinations of the Claim ID, the ACAS Pointer, the Adjustment Code, and the Reversal Code, as illustrated in the worksheet below (double-click to open):

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ACAS Claim Adjustme

There is a second method employed to adjust claims; that method, prior to this enhancement, has caused a degree of overstatement in financial and utilization totals. The degree of overstatement would vary according to the volume of claims adjusted by this method, and the financial and utilization totals associated with those claims.

2. Void the original Claim, and reprocess using a different Claim ID
When this method is employed, the adjudicating claim office issues a 'void' record for the original claim, and then reprocess that claim under a new, different Claim ID. Prior to this enhancement, our data warehouse did not receive those voided original claim records, and therefore did not have the means to create a reversal record to "net zero" the totals associated with the original records. Because both the original and the adjusted claim were captured on the Universal file, but no reversal record was created to net-zero the original, a degree of financial and utilization overstatement would occur, with the degree varying according to the number of voided claims generated by a given claim office in the field, and the totals associated with those voided claims.

Solution
As of claims processed on or after May 20, 2006, AetInfo is receiving voided claim records. This enables our data warehouse to create reversal records, with a "net" effect of eliminating the overstatement that was formerly associated with claim adjustments of this type. This process is illustrated in the worksheet below (double-click to open):

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#2. Fields #85 - #87, Not Covered Amount 1 – 3, are not populated for pre-2005 claims.
A recent Data Warehouse problem has zeroed out the contents of a data field known as a Not Covered Amount. All other data fields appear to be intact and appropriately represented.

Background
For Universal Medical/Dental files where (a) the file was created on or after March 21, 2006, and (b) the claim was processed in 2003 or 2004, all Not Covered Amounts (Fields #'85, #86, and #87) have been incorrectly defaulted to zero.

Details
This problem originated when the AetInfo data warehouse was totally re-loaded between March 18th and 21st off this year. Their were a few very selective scenarios in which the Not Covered amounts needed to be defaulted to zero for the reload. Unfortunately, the default-to-zero logic was inadvertently applied to all non-HMO records with a Date Processed (Field #62) prior to January 1, 2005. (i.e., all records where Field #7, Source System Platform, is equal to '27'). This means that any Universal Medical/Dental file that was (a) created on or after March 21, 2006 and (b) included claims that have processed dates (Field #62, Processed Date – All) in 2003 or 2004, will have unpopulated Not Covered Amounts.
The good news is that none of the financial fields that are essential to top-down financial analysis and balancing (please refer to the **"Top-Down Dollar Explanation"** charts in the appendices of the Universal Medical/Dental Data Dictionary at http://www.aetna.com/info/aetinfo/) were affected by this problem. AetInfo has consistently long advised users to employ the Top-Down fields instead of the not Covered Amount fields, for greater accuracy and balance in financial studies of the claim data.
To put this problem into perspective, please keep in mind that: (1) only the oldest data is affected, (2) only claims adjudicated on the ACAS platform have been impacted, (3) the missing information is expected to be re-added to the Warehouse in an August/September timeframe, (4) the Top-Down financial process is not affected. After weighing all of these factors, the vast majority of reported data is usable "as is."

Solution
The missing 2003 and 2004 NC Amounts are forecasted to be added back into the Warehouse as part of the **August 15th, 2006** monthly update.

3. Field #96, Deductible Amount, and Field #98 Coinsurance, are inappropriately defaulted to zero dollars for HMO in-network claims only.

Background
This recently-discovered issue appears to be associated with some older program intake logic, from a time when it was assumed that HMO in-network claims could not and should not have deductibles or coinsurances. As healthcare products have evolved and changed, we know that defaulting such claims to zero for deductible and coinsurance dollars is no longer a valid process.

Details
This issue will only effect data from plan sponsors who have deductible and/or coinsurance provisions even for in-network HMO claims. We do not yet have precise quantification studies for this issue, but it is acknowledged that HMO plans with in-network coinsurance or deductible represent a small proportion of current HMO-product plan sponsors. This issue may occur on

records where Field #7, Source System Platform = '03' (HMO claim), and where the specific plan under which the claim was adjudicated had deductible and/or coinsurance provisions even for in-network claims.

Solution
None as of this publication. AetInfo has, however, assigned a HIGH priority to the investigation and resolution of this issue, and we will share any further developments with you in a timely manner.

#4. ER Visits Overstatement

Background

The Place of Service field (field #77 Place of Service on the Universal Medical/Dental File) is not populated correctly for HMO and ACAS inpatient claims for members that are admitted to the hospital via the emergency room. For ACAS claims (Source System Platform '27'), this issue started with claims processed as of March 2005; for HMO claims (Source System Platform '03'), this issue started with claims processed as of May 2002.

These emergency room components of inpatient confinements are incorrectly reported in the Aetna Data Warehouse and the Universal Medical/Dental File in a manner that could erroneously inflate the count of stand-alone ER visits.

Based on the Data Warehouse team's research, the number of ER Visits per 1,000 is overstated by approximately 10%. Please note, that the 10% overstatement is an average and it does not appear to be greater than 15% for any plan sponsor.

Details

The cause of the ER Visits overstatement is due to an issue with the Place of Service logic used in the Data Warehouse. The Place of Service is a direct move from the source system to the Data Warehouse except when the incoming Place of Service is blank. If a blank place of service comes from the source system, the additional logic added in 2002 intends to assign a place of service of "E" if there is an ER Revenue Code or an ER Procedure Code. Unfortunately, this logic is OVERRIDING the Place of Service coming from the source system. Therefore, when a patient is admitted through the ER, the inpatient Place of Service associated with the ER revenue code is being overridden with an E. In most instances, the source Place of Service is being overwritten when the incoming record has a Place of Service of Inpatient and a Revenue Code of 450.

All records within an inpatient claim have the correct Place of Service value of inpatient (I) except for the records with a Revenue Code 450. The records with a Revenue Code of 450 have a Place of Service value of emergency room (E). This scenario occurs when a member is admitted to the hospital via the emergency room. This incorrect value can give the false impression that services were performed on an outpatient basis in the Emergency Room when, in fact, the member was admitted through the ER. An example of how this appears on a single claim is shown below:

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The place of service should not always be "E" when there is a revenue code of 450 (emergency room). If the member was confined, then the place of service should be 'Inpatient' for the entire claim, including the record with a revenue code of 450. The hospital bill should not be split by place of service. The Aetna claim policy and facility contracts treat ER admissions as inpatient only.

You many wonder: if the code was added in 2002, why didn't this appear on the ACAS data sooner? This issue did not appear on the ACAS claim data until March 2005 because of the incoming source files used in the Data Warehouse. As you may know, prior to 2005, the ACAS claim data was sourced from the 8K and 20K files, which rolled financial data up on inpatient claims to a room and board and an all-inclusive ancillary revenue code. In early 2005, the source of ACAS claim data changed to the RCE, which itemizes the financial data for each revenue code; therefore, causing the 'increase' in ER visits

Solution

Metrics focusing on ER visits are critical and commonly used; this, therefore, being treated as a high priority issue. In August 2006 the Aetna Data Warehouse team expects to correct the programming error and ensure that the data is reported correctly with an Inpatient treatment setting.

We project that this issue will be corrected as of August 2006 on a go-forward basis, for both the ACAS and HMO claim data. Historical information will be corrected as of January, 2007 with the full refresh of the Data Warehouse

Data CONTENT Alerts (U Pharmacy File):

Field #32 Prescribing Provider Id

Information Only

This field is currently populated with the prescribing provider's DEA Number . As you may be aware, the Drug Enforcement Agency is now requesting that all carriers discontinue the use of DEA numbers as a provider identifier.

Accordingly, we are ramping up to phase out DEA number, and phase in National Provider Identifier (NPI), for our 'Prescribing Provider ID' field on the Universal Pharmacy file.

Beginning in November 2006, any given occurrence of Field #32, Prescribing Provider ID, may be populated by the prescribing provider's NPI or their DEA Number. We are working towards adding an indicator to the Universal Pharmacy file that will inform you as to which type of identifier is present in Field #32 for a given record, as well as interim work-around methodology for making

that distinction until the indicator can be added to the file. We will keep you informed as this issue develops, and we welcome your input, questions, and concerns on this matter.

Contacts: Below are the primary contacts for U File questions. All work in the Plan Sponsor Information Services group within AetInfo.

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