AetInfo's Standard Universal Files
July 1, 2005

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.

Although we initially planned to provide updates about the U Pharm File in a separate document, we decided to address both U Files in separate sections of this document. U Pharm File topics are covered on page 2 and U Med/Dent File topics on all other pages. For reference, prior editions of this bulletin are dated December 15, 2003, March 1, 2004, June 10, 2004, October 1, 2004, January 1, 2005 and April 1, 2005.

We hope you will consider revising your intake/load program based on this update. 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.

Abbreviations: Below are some of the abbreviations referenced in this document.

ACAS = Automatic Claim Adjudication System (that is, Field #7, Source System Platform = "27")

AetInfo = Aetna Integrated Informatics®

AHF = Aetna HealthFund®

U Med/Dent File = Universal Medical/Dental File

U Pharm File = Universal Pharmacy File

U File = Universal File (Med/Dent, Pharm or both)

Warehouse = Aetna's enterprise Data Warehouse (that is, the source of U File data)

Additions/Changes to CONTENT Since Last Update: No additions or changes were made to AetInfo's U Files since our last bulletin. Therefore, this section exclusively addresses possible future content additions/changes.

- Based largely on feedback from U File recipients, AetInfo has decided NOT to extend the length of our U Files during 2005, although we may use the remaining filler space to add data elements. If we replace filler space with one or more additional data elements (for example, type or model of AHF), file recipients would NOT be impacted. You will have complete flexibility to determine if and when you will begin using these additional items for reporting.

- In 2006, further consideration will be given to extending the U Med/Dent File from its current length of 1,160 positions to 1,500 positions. These additional 340 positions would enable data elements to continue to be appended to the end of the file. If the U Med/Dent File is extended during 2006, the change would most likely become effective in January or July 2006. 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: Only minor refinements have been made to U File documentation thus far during 2005. Therefore, no revised record layouts or data dictionaries have been posted on our Internet website (see link below).

http://www.aetna.com/info/aetinfo/

Data CONTENT Alerts (U Med/Dent File):

From an overall perspective, An Aetna enterprise-wide initiative has the potential to change the content of U Files, primarily in the way ACAS data values are coded and formatted. Based on what we have seen thus far, these changes have had positive effects, such as the return to Medicare-specific Action or Reason Codes "060" and "065" and Not Covered Amounts. The changes impacting ACAS data were implemented for the March data that began to be reported on a "go forward" basis in April 2005.

ACAS Facility Claims: Since our last bulletin, we have learned more about a change that positively impacted ACAS facility claims. We have been advised and confirmed that additional details began to be reported on these claims effective March 1, 2005. A comprehensive description of what we've learned to date is provided at the end of this document.

Data CONTENT Alerts (U Pharm File):

Field #13, Employee's SSN: A U Pharm File recipient identified pharmacy claims records that did NOT include (but should have included) values in this SSN field. The Warehouse team traced the missing SSNs to the source system NOT passing downstream all of the required member-specific identifiers. The magnitude of the problem was confirmed to affect less than one percent of pharmacy claims records. A "workaround" that may be effective for many records involves isolating SSN values in Positions #8 - #16 within Field #19, Employer-Assigned Member ID. We have referred the issue to the Warehouse team and will keep you apprised of resolution plans.

Field #17, Member's SSN: In concert with a U Pharm File recipient, we have identified pharmacy claims records where the employee's SSN has been inappropriately reported in the member's SSN data field. This has occurred where the member was NOT the employee; therefore, the SSN values should have been different. The Warehouse team's preliminary findings have quantified the scope of the problem to be approximately .6 percent (less than one percent) of total pharmacy claims records. The problem appears to be triggered when an employee has changed "account structure" groups (Fields #3, #5 and #6; Hierarchy Levels 3, 5 and 6). We will keep you apprised of resolution plans.

Field #56, Paid Amount: Aetna Pharmacy Management has requested that we inform or remind U Pharm File users/recipients about the need to exclude "zero pay" records from the calculation of fee discounts. By "zero pay," we are referring to a pharmacy record with the value of zero in this Paid Amount data field. The reason for this exclusion relates to the manner data is entered into the claims system and passed downstream for reporting, when the dollar amount in the Member Out-of-Pocket Amount (Field #55) exceeds the amount that would have paid in the absence of out-of-pocket provisions. We will provide additional specifics regarding the rationale for this exclusion in a future version of this bulletin.

Field #57, AHF Paid Amount and Field #59, Benefit Plan Paid Amount: These data fields are applicable to AHF pharmacy products only. The Warehouse team has informed us that the values in these fields were universally set to zero for pharmacy claims processed on or after January 1, 2005. The cause of the problem has been pinpointed and is slated to be corrected in August. It's our understanding that the correction will be retroactive to the January 1 inception date. The problem does NOT impact AHF pharmacy claims processed before January 1. Also, it does NOT affect AHF medical claims in the U Med/Dent File.

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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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Data CONTENT Alert (ACAS Facility Claims in U Med/Dent File):

Due to the length and level of detail in this particular data content alert, it was positioned at the end of this document. Before March 1, 2005, the majority of facility claims that were adjudicated on the ACAS online platform were subsequently re-formatted, when they were passed downstream through a series of offline interfaces into the Warehouse. This offline process was in place for many years. It was used to feed claim data into the Warehouse for reporting purposes.

The change is unique to ACAS facility (in contrast to professional) claims that were processed on or after March 1st and that were paid on a per diem or case rate basis. Per diem or case rate arrangements represent the most commonly used reimbursement methods for facility claims. Facility claims can include inpatient, outpatient and emergency room treatment settings.

AetInfo has been advised that the primary objectives associated with this change were to provide additional details for facility claims and to ensure that the offline versions of facility claims more closely reflect the details entered upstream when the data was captured online. We anticipate that you will find this change to represent a positive enhancement in Aetna's reporting capabilities.

How can the claims affected by the March 1, 2005 change be identified?

At this point, our research indicates that the common characteristics of these claims are as follows:

- Date Processed (Field #59, also Field #62) is on or after March 1, 2005.
- Source System Platform (Field #7) = "27."
- Type of Service (Field #74) is "50" (Room & Board) or "51" (Hospital Ancillary).
- There will be one or more expense line records where, despite Covered Amount and Paid Amount values of zero dollars, the Status of Claim (Field #113) will have a value of "P" (Paid).

Formerly, such records would have had a Status value of "D" (Denied). This enhancement reflects the fact that ACAS adjudicated and paid the claim at the claim level, not the expense-line level. It also helps users to avoid inadvertently excluding records from their data store based on a Status of "D" when those records are needed in order to get a complete and accurate picture of the overall claim transaction.

Also, we are evaluating the addition of a "Pricing Type Code" to the U-Med file, which would greatly facilitate the identification of case rate and per diem facility claims that were paid at the claim level. We will of course keep you updated on that effort as the project evolves.

What is meant by the term "rolled up to the claim level?"

Before discussing the specifics of differences between rolled-up claims, before and after the change, it might be helpful to first review the concept, in terms of exactly what we mean when we say "rolled up to the claim level."

Each claim transaction has a unique value, which is reported in Field #33, Source-Specific Transaction ID Number (which, from here forward we'll refer to as the "Claim ID" for brevity's sake).

A claim contains one or more expense-line records, one for each different charge billed by the healthcare provider. Each of the expense-line records associated with a claim is given a numeric value (examples: 001, 002, 003), which is reported in Field #37, Expense/Pay Line Number. Thus, for this discussion, terms such as "expense-line level," "line level," or "record level" all simply refer to the same thing – an individual expense line record within a given Claim ID, which can be expressed as a concatenation (linking together) of Claim ID (Field #33) and Expense/Pay Line Number (Field #37).

Let's look at a graphic illustration of what is meant by "rolling up to the claim level." The claim below (a hypothetical example), with Claim ID ECXZ1R76RB00, contains 6 expense-line records, 001 through 006. In the ACAS claim environment, when actually adjudicated, Covered Expenses for the claim would look like this:

Before roll-up to claim level

Claim ID (Field #33)	Expense Line # (Field #37)	Covered Expense (Field #91)
ECXZ1R76RB00	001	$100
ECXZ1R76RB00	002	$75
ECXZ1R76RB00	003	$125
ECXZ1R76RB00	004	$20
ECXZ1R76RB00	005	$60
ECXZ1R76RB00	006	$45

When a claim, due to contractual provisions including case rate and per diem, is adjudicated at the claim level, the sum of all of the individual covered expense amounts is "rolled up" to the claim level. On your Universal Medical-Dental file, the claim would look like this:

After roll-up to claim level

Claim ID (Field #33)	Expense Line # (Field #37)	Covered Expense (Field #91)
ECXZ1R76RB00	001	$425
ECXZ1R76RB00	002	$0
ECXZ1R76RB00	003	$0
ECXZ1R76RB00	004	$0
ECXZ1R76RB00	005	$0
ECXZ1R76RB00	006	$0

Please note that the expense line record containing the summed amount may not always be the '001' expense line. It's safer to identify the summed record by first grouping all records by Claim ID (Field #33), and looking at each record within that claim, than it is to assume that the total for a rolled-up field will always be found in expense line 001.

Also, please note that, when a roll-up to claim level occurs, there will be some financial fields that are not summed, and instead will still contain dollar amounts on each expense line record within the claim. Generally, the reason that some financial fields are exempted from the roll-up process is that they are calculated fields which are created downstream of where the roll-up activity occurs. More details on that will follow.

What are the essential facts associated with this change?
Case rate and per diem facility claims from the ACAS claim engine are adjudicated at the claim level. As of March 1, 2005 (date processed), the manner in which such claims are presented on the U Med/Dent File has changed in the following ways:

Separate, expense-line-level values for Gross Submitted Expense (Field #83) and Net Submitted Expense (Field #84) are reported. These were formerly rolled up to the claim level on these claims, but as of 3/1 they are not. These billed charges are left as they were entered online, at the expense-record level. This enhancement allows the user to see the specific billed charges associated with the facilities UB92 Revenue Center code (Field #79).

Type of Service "51" is now reliably recorded (this resolves the Type of Service = "N" issue for these case rate and per diem claims)
Due to an upstream data-mapping issue, the roll-up to claim level of facility ancillary charges on these claims resulted in the Type of Service value (Field #74) defaulting to "N" (unknown). As of this March 1, 2005 enhancement, the true Type of Service value is reported.

The value for the Status of Claim indicator (also known as "the denied indicator) is correctly set to "P" (paid) for all expense-line records on case rate and per diem facility claims that were adjudicated at the claim level, and on which any amount was paid. Prior to this enhancement, individual expense-lines within these claims that showed zero dollars in Covered Amount and Paid Amount (due to the roll-up to claim level of those fields) were assigned a Status of Claim value of "D" (denied). This could cause end-users to omit those records from their data store (some users employ logic that excludes records with a Status of Claim equal to "D"). Because these claims are literally paid at the claim level, it is important to retain all of the individual expense line records within such claims.

The graphic below shows before-and-after examples encompassing the three points described above, for a hypothetical claim:

In the following example, a case rate facility claim that was adjudicated prior to March 1, 2005, Gross Submitted, Net Submitted, and Covered Amount are rolled up to the claim level. For all of the expense-line records except for the record with the rolled-up financial totals, Type of Service defaults to "N" and Claim Line Status is "D" (denied).

Claim ID ECXZ1R76RB00

Type Serv	Revenue Code	Gross Submitted	Net Submitted	Covered Amount	Paid Amount	Claim Line Status
51	460	$5,470	$5,470	$2,736	$2,460	P
N	250	$0	$0	$ 0	$ 0	D
N	370	$0	$0	$ 0	$ 0	D
N	636	$0	$0	$ 0	$ 0	D
N	360	$0	$0	$ 0	$ 0	D
N	275	$0	$0	$ 0	$ 0	D

In the following example, the same case rate facility claim as it would appear on the Universal Medical/Dental file if it was adjudicated on or after March 1, 2005. Gross Submitted and Net Submitted are not rolled up to the claim level. Type of Service does not default to "N" for any of the expense-line records in this claim, and Claim Line Status is "P" (paid) for all expense-line records in the claim (because it was a claim-level adjudication, and a payment was made).

Claim ID ECXZ1R76RB00

Type Serv	Revenue Code	Gross Submitted	Net Submitted	Covered Amount	Paid Amount	Claim Line Status
51	460	$2,500	$5,470	$2,736	$2,460	P
51	250	$1,500	$1,500	$ 0	$ 0	D
51	370	$500	$500	$ 0	$ 0	D
51	636	$470	$470	$ 0	$ 0	D
51	360	$300	$300	$ 0	$ 0	D
51	275	$200	$200	$ 0	$ 0	D

Key Point: Case rate and per diem claims paid at the claim level must be kept at the claim level.

Perhaps the single most important fact to keep in mind for case rate and per diem claims paid at the claim level, is that, for analytical or balancing efforts, they really do need to be viewed at the claim level. That's why changing the manner in which Claim Line Status is applied for these claims, so that each expense-line record within a paid claim is assigned a "paid" value, was a critical enhancement.

For this category of claim, the dollar amounts in some financial fields will be rolled up to the claim level, while others will be left at the expense-line level, which again emphasizes how important it is to view these as a whole claim. Grouping your records by Claim ID (Field #33, Source-Specific Transaction ID Number) and then looking at the totals for that Claim ID is the proper way to analyze these claims.

Financial fields usually "rolled up" on claim-level case-rate/per diem facility claims
Covered Amount, Allowed Amount, Copayment Amount, Deductible Amount, Coinsurance Amount, Benefit Payable Amount, and Paid Amount.

Financial fields NOT usually rolled up on claim-level case-rate/per diem facility claims
Gross Submitted Amount, Net Submitted Amount, Administrative Savings Amount, Savings – Negotiated Fee.

Recommendation

Our general recommendation for users of the Universal Medical/Dental claim file is that you review any current logic or algorithms that you are applying against any financial data fields at the expense-line record level, especially logic that keys off of Not Covered, or other dollar amounts associated with Action/Reason Codes. You may need to modify that logic, in order to calculate all financial amounts at the claim level, in terms of your existing logic – at least for those claims that have the characteristics of case raid or per diem facility claims, as described on the first page of this document.