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Universal Medical/Dental File
Data Dictionary

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NOTE: The Universal File is a tab-delimited, fixed-length, text file without a header record. Delivery methods for these files are: FTP (preferred method of delivery), but also encrypted CD/DVD and secure e-mail (depending upon the size of the file).

What is the Universal Medical/Dental File?

The Universal Medical/Dental File contains processed claim transaction data at the line level from the upstream claim systems. The file contains member, patient, provider, financial and clinical information specific to each claim and the expense lines that comprise each claim.

The Universal File does NOT contain paid/recorded data from our financial/banking systems; therefore, it does not include issued or recorded dates or amounts. The recorded data can be found in Claim Detail Reports (CDRs) and is summarized to the claim level (it does not contain detailed line item data). Also, note that there is not a simple or standard 1 to 1 connection between the Recorded and Processed data.

Below is the information regarding the differences between processed and recorded data:

From a global perspective of Aetna's health claim reporting capabilities, Aetna supports two separate types of reporting data sources. Each is uniquely designed to accomplish a different set of health plan administration functions. One type of data source is comprised of upstream claim transaction information and the other, downstream banking information is fully adjusted and charged to the financial accounting experience of Aetna's plan sponsors. E.PSM and AHIA reports and Universal data files exclusively contain upstream claim processed data. The main differences between processed and paid/recorded/banking data are highlighted below.

- Products. The Universal Data files do not contain financial information for FSA (flexible spending accounts), LTC (long term care), or Disability whereas the 'wire transfer information/reports' may contain paid amounts associated with these products.

- Time lag. Upstream processed claims typically become available for reporting 10 - 15 calendar days before recorded claims are reported. These different points in time may be attributed to "bulk payments" made to providers, banking system "float" and time lag between the claim being processed in the claim system and the claim payment clearing the banking system. "Bulk payment" refers to a process in which claims are accumulated and providers are paid aggregated amounts, in contrast to issuing a separate payment for each individual claim. "Float" pertains to the process during which claim payment checks are routed through the Federal Reserve banking system and clear all of Aetna's reconciliation processes before being charged to a plan sponsor's financial account. Overall processing time lag is when a claim is processed at the end of Month A; it typically does not clear the banking system until Month B. When comparing processed to recorded data on a month by month basis, this situation often comes into play.

- Level of detail. Diagnoses, treatment procedures and utilization "counts" (e.g., number of bed days, number of office visits) are reported in upstream processed claim data but these details are not passed/carried downstream into Aetna's banking and financial accounting system (recorded/paid data).

- Manual checks and credit transmittals. Under limited and controlled circumstances, banking system checks/drafts can be issued without generating upstream claim transactions. Also, previously processed and recorded claims can be subtracted from a plan sponsor's banking and financial accounting information using credit transmittal records. Because processed reporting databases exclusively contain data from upstream claim system transactions, related records

transacted on other than an Aetna claim platform are only available to Aetna's banking system and are not reflected in upstream reporting databases of processed claim data.

- Capitation Payments. The Universal Medical/Dental file includes both claims and encounters information; however, capitation payments are NOT included on the file. A separate capitation payment file that can be produced if needed. Capitation Payments are included in the banking data.

- National Advantage Program (NAP) fees. Upstream Processed Paid Amounts for facility/hospital claims are reduced by the full amount of NAP discounts. In contrast, the Recorded Paid Amounts in downstream banking data reflect only the plan sponsor's portion of NAP facility discounts. This will result in the Processed Paid Amount to be lower than the Recorded Paid Amount when NAP Fees are involved.

Other fees that are included in the recorded paid data amounts, but NOT in the processed paid data are:

* NAP Fees (detailed above)
* MASS Surcharge Fees
* Capitation Fees (not applicable here)
* VBM Pricing Fees (value based medical)
* Vendor Recovery Fees

* Stops and Voids (When a claim is processed, but the check is made void.)

1. Hierarchy Level 1 (Most Summarized):
- **Format:** Character
- **Length:** 16
- **Positions:** 1 - 16
- **Definition:** A unique identifier assigned by Aetna to each plan sponsor. These "Plan Sponsor Unique" values were added to Aetna's Data Warehouse during 2003.

2. Hierarchy Level 2:
- **Format:** Character
- **Length:** 8
- **Positions:** 18 - 25
- **Definition:** An Aetna-assigned hierarchy value known as the "Policyholder Number" or "Customer Number."

3. Hierarchy Level 3:
- **Format:** Character
- **Length:** 8
- **Positions:** 27 - 34
- **Definition:** An Aetna-assigned value known as the "Control Number" or "Group Number."

4. Filler:
- **Format:** Character
- **Length:** 3
- **Positions:** 36 – 38
- **Definition:** Reserved for future use

5. Hierarchy Level 5:
- **Format:** Character
- **Length:** 8
- **Positions:** 40 - 47
- **Definition:** An Aetna-assigned value known as the "Suffix Number" or "Sub-group."

6. Hierarchy Level 6 (Most Granular):
- **Format:** Character
- **Length:** 5
- **Positions:** 49 - 53
- **Definition:** An Aetna-assigned value known as the "Account Number" if the record is processed in ACAS otherwise, this field is blank.

7. Source System Platform:
- **Format:** Character
- **Length:** 2
- **Positions:** 55 - 56
- **Definition:** A numeric value that identifies the claim payment system in which a claim was adjudicated. Refer to the Appendices for a list of values and their definitions.

8. Adjustment Code:

- **Format:** Character
- **Length:** 1
- **Positions:** 58
- **Definition:** An entity that classifies the transaction type that a given claim record represents. The valid values are A = adjustment, O = original, P = pend and U = unknown. This field can be useful in conjunction with other fields to identify ***ACAS adjustment and reversal records*** (Source System Platform = '27'). Reversal records are created by the Data Warehouse, with negative values in the financial and utilization fields, and are designed to negate (ledger-book accounting style) a prior incorrect record. This negative "reversal" record brings the net totals for the incorrect, original record plus the reversal record to zeroes. Then the reprocessed "correct" record yields the correct net totals (refer to the Appendices for a more detailed explanation and examples)***.***
  Non-ACAS (old HMO system) adjustment records (Source System Platform = "03") can be identified with a value of 'A'. The old HMO system adjustment process is not ledger-book accounting style and reversals do not back out original records.

9. Preferred vs Non-Preferred Benefit Level:

- **Format:** Character
- **Length:** 1
- **Positions:** 60
- **Definition:** An entity indicating if the claim was adjudicated at an in-network benefit level or an out-of-network benefit level. Indicates 'Y' if the claim record was paid at an out-of-network benefit level. In other words, 'Y' in this field indicates that the record did **not** receive an in-network benefit level. Refer to the Appendices for the full list of values and definitions.

10. General Category of Health Plan:

- **Format:** Character
- **Length:** 2
- **Positions:** 62 - 63
- **Definition:** The code identifying the product line associated with the plan of benefits for a claim. For example: PPO Medical, Managed Choice and Managed Behavioral Health. Refer to the Appendices for the full list of values and definitions.

11. Line of Business:

- **Format:** Character
- **Length:** 2
- **Positions:** 65 – 66
- **Definition:** A rollup of product lines into industry-recognized health plan lines of business, for example, HMO, POS, Indemnity, etc. Refer to the Appendices for the full list of values and definitions.

12. Classification Code:
- **Format:** Character
- **Length:** 1
- **Positions:** 68
- **Definition:** A value that depicts the primary designation of a claim record as being either a regular fee for service or claim or a capitated encounter. Valid values are C = capitated medical encounters (please note that these are not the same as capitated medical payments, which are not included on the Universal Med/Dent file), F = fee-for-service medical claims and U = unknown.
- **Note:** Capitated Encounters should be excluded from financial audits.

13. Benefit Identification Code (BIC):
- **Format:** Character
- **Length:** 5
- **Positions:** 70 - 74
- **Definition:** A source system-assigned code that uniquely identifies a package of benefit components (e.g., medical, dental, etc.) in which members enroll for coverage. This field is not applicable to non-ACAS data. Refer to the Appendices for the full list of values and definitions.

14. Plan Code or Extension of Hierarchy:
- **Format:** Character
- **Length:** 5
- **Positions:** 76 - 80
- **Definition:** A value assigned by the enrollment source system, which identifies a subdivision of a plan sponsors' structure. The definition of this field varies, depending on the Product (refer to Field #10, General Category of Health Plan). For all claims adjudicated in the ACAS claim system, this field will contain the Plan Summary Code. It is not populated for non-ACAS or Encounter claims.

15. Benefit Tier:
- **Format:** Character
- **Length:** 1
- **Positions:** 82
- **Definition:** Applicable to USAccess plans only, this field indicates whether adjudication was at the Tier 1, Tier 2 or Tier 3 level. Refer to the Appendices for the full list of values and definitions.

16. Funding Arrangement:
- **Format:** Character
- **Length:** 1
- **Positions:** 84
- **Definition:** A code that specifies the type of service contract arrangement under which the benefit is administered. For example: fully insured or full risk, self-insured or split-funded. The identification of the funding arrangement associated with a member plan of benefits may be used to ensure compliance with HIPAA federal privacy regulations and state insurance laws relative to disclosing protected, member-specific health information. Refer to the Appendices for the full list of values and definitions.

17. Employee SSN:
- **Format:** Character
- **Length:** 11
- **Positions:** 86 - 96
- **Definition:** A unique identifier of the subscribing employee under the plan of benefits, usually based on the employee Social Security Number. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk financial arrangements. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement.
- **Note**: For surviving-spouse coverage or split-family coverage (employee on Medicare, spouse not on Medicare), the spouse's SSN will be used in place of the Employee SSN.

18. Employee Last Name:
- **Format:** Character
- **Length:** 30
- **Positions:** 98 – 127
- **Definition:** The last name of the subscribing employee. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement.

19. Employee First Name or Initial:
- **Format:** Character
- **Length:** 30
- **Positions:** 129 - 158
- **Definition:** The First Name or initial of the subscribing employee. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement.

20. Employee Gender:
- **Format:** Character
- **Length:** 1
- **Positions:** 160
- **Definition:** Indicates the gender of the subscribing employee as M = male, F= female, or U = unknown.
- **Note:** This field is only populated on employee claims; it is not populated on dependent claims.

21. Employee Date of Birth:
- **Format:** Date (CCYY-MM-DD)
- **Length:** 10
- **Positions:** 162 - 171
- **Definition:** The date of birth of the subscribing employee. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement.

22. Employee Zip Code:
- **Format:** Character
- **Length:** 5
- **Positions:** 173 - 177
- **Definition:** The Zip Code for the residential address of the subscribing employee. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement.
- **Note**: For non-ACAS HMO claim and encounter records, the value is defaulted to 'U' (unknown).

23. Employee State:
- **Format:** Character
- **Length:** 2
- **Positions:** 179 – 180
- **Definition:** The subscriber's state postal code at the time of claim adjudication. The state postal code is the two-position alphabetic code (e.g., CT, PA, DC) established by the U.S. Postal Service.
- **Note**: For non-ACAS HMO claim and encounter records, this field is blank.

24. Coverage/Enrollment Tier:
- **Format:** Character
- **Length:** 1
- **Positions:** 182
- **Definition:** A code that represents the type of rate that is associated with the subscribing employee coverage, such as single, family, etc. Refer to the Appendices for the complete list of values and definitions.
- **Note:** This field is only populated for non-ACAS HMO / QPOS data.

25. Member SSN:
- **Format:** Character
- **Length:** 11
- **Positions:** 184 - 194
- **Definition:** The member Social Security Number. A "member" refers to any covered life under the subscribing employee health plan. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement.
- **Note:** For non-SSN users, the Employee SSN typically contains the "badge number". For the employee, the field will contain only the badge number; for other dependents, the field will contain the badge number plus a 2 position dependent number.

26. Member ID (Assigned in Data Warehouse):

- **Format:** Character
- **Length:** 20
- **Positions:** 196 - 215
- **Definition:** A unique identifier for a member, assigned by Aetna's Data Warehouse. A "member" is defined here as a covered life under the subscriber's health plan.
- **Note:** A February 2005 enhancement to the Aetna Informatics Data Warehouse entails moving to a single upstream source for ACAS Member data. This enhancement will cause the values in the Member ID field to change, for ACAS records only. For this reason, avoid using Member ID as selection criteria for any reruns of reports or analyses, after February 2005, which was originally performed prior to February 2005. In general, it is safest to avoid using this field as selection criteria when comparing results over time.

27. Member Number:

- **Format:** Character
- **Length:** 2
- **Positions:** 217 - 218
- **Definition:** Within a unique family (concatenate Hierarchy Levels 1, 2 and 3 and Member SSN) this entity can be used to separate or group by unique family members within that family.
- **Note:** This field is not applicable (and not populated) for non-ACAS HMO / QPOS claim or encounter records.

28. Member Last Name:

- **Format:** Character
- **Length:** 30
- **Positions:** 220 - 249
- **Definition:** The last name of the enrolled member. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement. Although this field is described as being 30 bytes in length, the number of bytes actually populated depends upon what the upstream data system sends down. If only ten bytes (characters) are sent down, then only the first ten bytes will be populated, and the remaining 20 bytes will be blank.

29. Member First Name:

- **Format:** Character
- **Length:** 30
- **Positions:** 251 - 280
- **Definition:** The first name of the enrolled member. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement. Although this field is described as being 30 bytes in length, the number of bytes actually populated depends upon what the upstream data system sends down. If only ten bytes (characters) are sent down, then only the first ten bytes will be populated, and the remaining 20 bytes will be blank.

30. Member Gender:
- **Format:** Character
- **Length:** 1
- **Positions:** 282
- **Definition:** Indicates the gender of the enrolled member as M = male, F = female or U = unknown.

31. Member Relationship to Employee:
- **Format:** Character
- **Length:** 1
- **Positions:** 284
- **Definition:** A code which describes the familial or sponsor relationship between an enrolled member and the employee subscriber under whose plan of benefits the member is enrolled. Please refer to the Appendices for a list of the specific values and their definitions.
- **Note:** Please refer to the Appendices for details.

32. Member Date of Birth:
- **Format:** Date (CCYY-MM-DD)
- **Length:** 10
- **Position:** 286 - 295
- **Definition:** The date of birth of the enrolled member. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement.

33. Source-Specific Transaction ID Number:
- **Format:** Character
- **Length:** 19
- **Position:** 297 - 315
- **Definition:** A value that depicts ***the unique identifier associated with a claim*** as it was represented in its source system. This field, **NOT** Field #36, should be used for rolling up or grouping by claims transactions. For non-ACAS (old HMO system) claims (Source System Platform, Field #7 = 03), this field is typically 14 positions in length and is made up of the following fields:

  * Receipt Date (YYMMDD)
  * Type of Entity (1 position)
  * Receipt Number (typically 5 positions, but can be greater)
  * Segment Number (typically 2 positions, but can be greater)

  A value greater than 00 in the segment number, along with an Action/Reason Code 1 (Field #88) value beginning with an 'A' typically identifies an adjustment.

  A sample Source-Specific Transaction ID for non-ACAS (old HMO system) looks like this: '020107E0756804'

  For ACAS claims (Source System Platform, Field #7 = 27), this field is 9 positions in length with a 2 position segment at the end, for a total of 11 positions. A sample Source-Specific Transaction ID for ACAS looks like this: 'E34KZHH3300'.

  For encounter records (Source System Platform, Field #7 = 04), this field may not contain a unique claim id as they are physician-patient encounter records, not true claims.

34. ACAS Generation/Segment Number:
- **Format:** Character
- **Length:** 2
- **Positions:** 317 - 318
- **Definition:** A component of Source-Specific Transaction ID Numbers (Field #33) specific to the ACAS claim engine. An ACAS claim may contain many segments due to the number of expense lines allowed by the claim system and may also contain many segments because it was adjudicated more than once due to an adjustment. Refer to the Appendices for an explanation on ACAS adjustments.
- **Note:** This field is not populated for non-ACAS data.

35. ACAS Pointer Back to Previous Gen/Seg:
- **Format:** Character
- **Length:** 2
- **Positions:** 320 - 321
- **Definition:** This field, used for ACAS transactions that are "adjustments" of a prior claim transaction, points back to the specific prior transaction that is being adjusted by the current transaction. For an original transaction, the value in this "pointer back to previous segment" will be blank. For an adjustment transaction, the "pointer back" will be equal to or greater than "00." For example, if an ACAS Claim ID with a segment number of "00" is subsequently adjusted, that adjustment claim will have a segment number of "01" and the "pointer back to previous segment" will have a value of "00" as the "00" segment is the record to which the "01" segment is making an adjustment.
- **Note:** This field is not populated for non-ACAS data.

36. Traditional Claim ID:
- **Format:** Character
- **Length:** 15
- **Positions:** 323 - 337
- **Definition:** This derived transaction control number (TCN) employs the transaction-identifier methodology employed by Aetna legacy systems. Essentially, this field is a concatenation of values representing the claim office that adjudicated the claim, the date the claim was processed, and the transaction sequence number automatically assigned by the claim engine.
- **Note:** This field is not populated for non-ACAS claims.
- **Note:** *Field #33 (Source-Specific Transaction ID Number),* ***not this field,*** *should be used to identify and research specific claims within the non-ACAS (old HMO) or ACAS claim processing systems.*

37. Expense/Pay Line Number:
- **Format:** Character
- **Length:** 3
- **Positions:** 339 - 341
- **Definition:** This value represents the sequence in which an expense line record falls within a given claim (i.e., "001" through "006"').

38. Claim Line ID (Assigned In Data Warehouse):
- **Format:** Decimal
- **Length:** 12
- **Positions:** 343 - 354
- **Definition:** A unique, expense-line-level identifier assigned by the Aetna Data Warehouse to each expense-line record.

39. Employee Network ID:
- **Format:** Character
- **Length:** 5
- **Positions:** 356 - 360
- **Definition:** The Aetna-assigned code which identifies an area where gated health products are in force for a given member; this code is used to group data by product and geography for reporting purposes.

40. Servicing Provider Network ID:
- **Format:** Character
- **Length:** 5
- **Positions:** 362 - 366
- **Definition:** The Aetna-assigned code which identifies an area where gated health products are in force for the servicing provider on a given claim record; this code is used to group data by product and geography for reporting purposes. Please refer to the Appendices for values and definitions.

41. Referral Type:
- **Format:** Character
- **Length:** 1
- **Positions:** 368
- **Definition:** A code which represents the way service was obtained such, as a referral by the PCP, a self-referral by the member; a non-authorized referral; etc. Please see the Appendices for a list of values and definitions.

42. PCP IRS Tax Identification Number (TIN) Format Code:
- **Format:** Character
- **Length:** 1
- **Positions:** 370
- **Definition:** The type of format associated with the PCP tax identification number, Valid values are E = Federal Tax Identification Number, S = Social Security Number, D = dummy TIN assigned to foreign provider or blank = unknown.

43. PCP IRS Tax Identification Number (TIN):
- **Format:** Character
- **Length:** 9
- **Positions:** 372 - 380
- **Definition:** The tax identification number associated with the member primary care physician (PCP).

44. PCP Name (Last or Full):
- **Format:** Character
- **Length:** 40
- **Positions:** 382 - 421
- **Definition:** The name of the primary care physician for the member associated with a given claim record.

45. Servicing Provider Tax ID Number (TIN) Format Code:
- **Format:** Character
- **Length:** 1
- **Positions:** 423
- **Definition:** The type of format associated with the PCP Tax Identification Number (TIN), Valid values are E = Federal Tax Identification Number, S = Social Security Number, D = dummy TIN assigned to foreign provider or blank = unknown.

46. Servicing Provider Tax ID Number (TIN):
- **Format:** Character
- **Length:** 9
- **Positions:** 425 - 433
- **Definition:** The tax identification number associated with the servicing provider or organization.

47. Servicing Provider PIN:
- **Format:** Numeric
- **Length:** 7
- **Positions:** 435 - 441
- **Definition:** A "Provider Identification Number" (PIN) is an Aetna-assigned number applied to healthcare providers as a method of unique identification. This field stores the PIN of the provider of the healthcare services associated with a given claim record.

48. Servicing Provider Name (Last or Full):
- **Format:** Character
- **Length:** 40
- **Positions:** 443 - 482
- **Definition:** The name of the servicing provider associated with a given claim record.

49. Servicing Provider Street Address 1:
- **Format:** Character
- **Length:** 35
- **Positions:** 484 – 518
- **Definition:** The first line of information relevant to the servicing provider mailing address. This field may contain such information as street number, suite number, Post Office box, building name, etc. Any address information located after the provider name, but prior to the provider city and state, may be found here.

50. Servicing Provider Street Address 2:
- **Format:** Character
- **Length:** 35
- **Positions:** 520 – 554
- **Definition:** The second line of information relevant to the servicing provider mailing address. This field may contain such information as street number, suite number, Post Office box, building name, etc. Any address information located after the provider name, but prior to the provider city and state, may be found here.

51. Servicing Provider City:
- **Format:** Character
- **Length:** 30
- **Position:** 556 – 585
- **Definition:** The name of the city, from the most current primary address stored on Aetna's provider database, for the servicing provider associated with a given claim record.

52. Servicing Provider State:
- **Format:** Character
- **Length:** 2
- **Positions:** 587 - 588
- **Definition:** The two position alpha state code (ex: CT, PA, DC, etc.) established by the U.S. Postal Service, from the most current primary address stored on Aetna's provider database, for the servicing provider associated with a given claim record.

53. Servicing Provider ZIP Code:
- **Format:** Character
- **Length:** 5
- **Positions:** 590 - 594
- **Definition:** The Postal ZIP Code, from the most current primary address stored on Aetna's provider database, for the servicing provider associated with a given claim record.

54. Servicing Provider Type:
- **Format:** Character
- **Length:** 3
- **Positions:** 596 - 598
- **Definition:** A value that reflects the primary type of an individual provider or provider group or facility. For example, "NP" translates to Nurse Practitioner and "PMC" translates to Pain Management Center. Refer to the Appendices for the full list of values and definitions.

55. Servicing Provider Specialty Code:
- **Format:** Character
- **Length:** 5
- **Positions:** 600 - 604
- **Definition:** The primary practice specialty associated with the servicing provider for a given claim record. Refer to the Appendices for the full list of values and definitions.

56. Assignment of Benefits to Provider Code:
- **Format:** Character
- **Length:** 1
- **Positions:** 606
- **Definition:** This code indicates which party received the payment, for claims where a payment was issued. P = Provider, M = Member or O = Other. This field will be blank for any claims that do not contain a complete and valid Provider TIN or Provider PIN, such as claims for supplies bought at a medical supply store, claims from a foreign healthcare provider, or a new-practice provider not yet added to our provider database.

57. Participating Provider Code:

- **Format:** Character
- **Length:** 1
- **Positions:** 608
- **Definition:** Indicates if the paid provider, at the time of claim adjudication, was under contract (also referred to as "participating" or "par") with Aetna under the member health plan. Valid values are 'Y' (yes, participating) – NAP (National Advantage Program) providers who are assigned a NAP-specific network ID will be flagged with a 'Y'; 'N' (no, not participating); 'U' (unknown).
- **Note:** National Advantage Providers (NAP) claims should be viewed as non-participating claims in any discount analysis being done for comparative/validation purposes to Aetna's discount reports. While the National Advantage Program does provide discounts, Aetna does not represent that these providers are a part of Aetna's contracted network delivery or network service area and are thus excluded from the Aetna delivered discount analysis. Aetna's National Advantage Program specifically uses Aetna's national rental provider networks, such as Multiplan, to give discounts in rural areas, not in Aetna's network service area.

  NAP Providers are tagged with a Participating Provider Code = Y because they have Network Numbers assigned to them.

58. Date Claim Submission Received:

- **Format:** Date
- **Length:** 10 (CCYY-MM-DD)
- **Positions:** 610 - 619
- **Definition:** The date that the claim was received by Aetna, electronically or by mail.
- **Note:** This field is not modified for adjustment claims; therefore, adjustment claims should not be used in any TAT (turnaround time) analysis.

59. Date Processed (ACAS only):

- **Format:** Date
- **Length:** 10 (CCYY-MM-DD)
- **Positions:** 621 - 630
- **Definition:** The date that the claim was fully adjudicated (closed) in the claims processing system. This field does not apply to non-ACAS claims. Please use Field #62, Date Processed (All) for non-ACAS claims. As its name implies, Field #62 can be used for all products, while Field #59 applies to ACAS products only.

60. Date Service Started:

- **Format:** Date
- **Length:** 10 (CCYY-MM-DD)
- **Positions:** 632 - 641
- **Definition:** The "from" portion of the from-through date range for expressing dates of incurred services at the expense-line level. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement.

61. Date Service Stopped:
- **Format:** Date
- **Length:** 10 (CCYY-MM-DD)
- **Positions:** 643 - 652
- **Definition:** The “through” portion of the from-through date range for expressing dates of incurred services at the expense-line level. This field may not be populated, or may contain a "default" date of 1999-12-31 on dental claims; we recommend that you use the Date Service Started as the default for those dental claims. In accordance with HIPAA privacy requirements, this field is not populated for split-funded or full-risk customers. For self-insured customers, this field is populated only if the customer has signed a confidentiality agreement.

62. Date Processed (All):
- **Format:** Date
- **Length:** 10 (CCYY-MM-DD)
- **Positions:** 654 - 663
- **Definition:** The date on which a claim was processed. This field can be used as the "date processed" for both ACAS and non-ACAS products.
- **Note:** Records where Field #7, Source System Platform, = '48' (Diversified Data Design Institutional Encounters and Magellan Institutional Delegated Claims) are claims that have not gone through an adjudication process on Aetna systems. For these records, the Date Processed will indicate the date on which it was received, via Gateway, for subsequent loading onto the Data Warehouse, not an actual adjudication date.

63. Filler:
- **Format:** Character
- **Length:** 6
- **Positions:** 665 - 670
- **Definition:** Reserved for future use

64. Filler:
- **Format:** Character
- **Length:** 6
- **Positions:** 672 - 677
- **Definition:** Reserved for future use

65. Filler:
- **Format:** Character
- **Length:** 6
- **Positions:** 679 - 684
- **Definition:** Reserved for future use

66. Major Diagnostic Category (MDC):

- **Format:** Character
- **Length:** 2
- **Positions:** 686 - 687
- **Definition:** MDCs are two-byte classification codes established by HCFA; they are created by mapping ICD-9 diagnostic data in to a convenient, industry-standard classification system. If a DRG value is reported for a given claim record, the MDC reported in this field will be the MDC associated with that DRG. If a DRG is not reported for the claim record, the MDC value corresponding to Diagnosis Code 1 (Field #153) will be reported in this field. Refer to the Appendices for values and definitions.

67. Diagnosis Related Group (DRG):

- **Format:** Character
- **Length:** 3
- **Positions:** 689 - 691
- **Definition:** This field contains the DRG Grouper – assigned DRG value. The Grouper assigns a DRG value to inpatient hospital room & board records, based on diagnostic, age, gender, and status information submitted by the hospital with the claim. DRGs encompass a group of diseases, disorders, and procedures that are used by hospitals to classify inpatients into a manageable number of categories. DRGs are an industry-standard classification system for monitoring quality of care and utilization of services in a hospital setting. They are designed to assess the type and condition of the patients a given hospital treats (i.e., it's "case mix") to the cost of services rendered in treating those patients.

  As of February 2008, all DRG values, regardless of source system or product, will be based on DRG Grouper assignment. Until February 2008, DRG for non-ACAS records is assigned by the DRG Grouper, while DRG for ACAS records is simply the DRG billed on the UB-92 billing form by the hospital provider of services.

  HOWEVER, it is important to note that the records on this file are point-in-time 'snapshots' of claim data. Any actual DRG reporting or analysis should be based on DRG data from Medical Case / Confinement data, NOT from this Universal Medical/Dental file.

68. Line-Level Procedure Code (CPT, HCPCS, ADA, CDT):

- **Format:** Character
- **Length:** 5
- **Positions:** 693 - 697
- **Definition:** A code that represents the procedure performed by the provider of service.
- **Note:** A value of 'A' in this field is an ACAS claim system default value, indicating that a CPT-4 procedure code was not entered. This occurs primarily on facility claims, and most of those records will contain a revenue code (Field #79, UB02 Revenue Center). Files created prior to 12/10/2012 will contain a value of 'NDCRX' in this field which indicates that the record is a drug-related claim. The NDC code associated with that drug can be found in Field #111 (National Drug Code).
- **Note 2:** For Source System Platform '03' (Field #7), the procedure code does not appear when the NDC Code is populated.

69. Line-Level Procedure Code Modifier (1):

- **Format:** Character
- **Length:** 2
- **Positions:** 699 - 700
- **Definition:** A two-position code that is used to describe variations of procedures described by the Line-Level Procedure Code (Field #68).

70. Line-Level Procedure Code Type:
- **Format:** Character
- **Length:** 1
- **Positions:** 702
- **Definition:** The code that identifies what type of procedure is described by the procedure code two-position code that is used to describe variations of procedures described by the procedure code. Refer to the Appendices for the full list of values and definitions.

71. Filler:
- **Format:** Character
- **Length:** 5
- **Positions:** 704 - 708
- **Definition:** Reserved for future use

72. Filler:
- **Format:** Character
- **Length:** 5
- **Positions:** 710 - 714
- **Definition:** Reserved for future use

73. Filler:
- **Format:** Character
- **Length:** 5
- **Positions:** 716 - 720
- **Definition:** Reserved for future use

74. Type of Service:
- **Format:** Character
- **Length:** 2
- **Position:** 722 – 723
- **Definition:** A value that depicts the HCFA-standardized classification of a healthcare, such as Medical; Surgery; Consultation; etc. Refer to the Appendices for a full listing of values and definitions.
- **Note:** This field should only be used for ACAS (Field #7 - Source System Platform = '27') claims. For non-ACAS claims (Field #7 - Source System Platform = '03'), use Field #75 (Service Benefit Code).

75. Service Benefit Code:
- **Format:** Character
- **Length:** 3
- **Positions:** 725 - 727
- **Definition:** A value which defines the type of health care rendered for a given service occurrence. This field can be used for both non-ACAS and ACAS claims. Refer to the Appendices for a listing of values and definitions.

76. Tooth Number:
- **Format:** Character
- **Length:** 5
- **Positions:** 729 - 733
- **Definition:** A tooth number, or tooth quadrant (e.g., "ULQ" for upper left quadrant), as on a dental chart, to which a given ADA or CDT dental procedure code refers.

77. Place of Service:
- **Format:** Character
- **Length:** 2
- **Positions:** 735 – 736
- **Definition:** The codes and definitions for the place or setting in which health care treatment was rendered. Please refer to the Appendices for a list of the specific values, their definitions and corresponding HCFA Code Set of Place of Service values.
- **Note:** The HCFA Place of Service is in Field #139.

78. UB92 Patient/Discharge Status:
- **Format:** Character
- **Length:** 2
- **Positions:** 738 - 739
- **Definition:** A value that depicts the condition of a patient at the time of billing for an inpatient stay. Please refer to the Appendices for a list of the specific values and their definitions.

79. UB92 Revenue Center:
- **Format:** Character
- **Length:** 4
- **Positions:** 741 – 744
- **Definition:** A value which represents the revenue center to which a hospital assigns a given charge on its UB92 billing form. Please refer to the Appendices for a list of the specific values and their definitions.

80. UB92 Bill Type:
- **Format:** Character
- **Length:** 3
- **Positions:** 746 - 748
- **Definition:** A value that depicts the type of facility bill that was received for a member as it was represented on a standardized UB92 claim form. Please refer to the Appendices for a list of the specific values and their definitions.

81. Number/Units of Service:

- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 750 - 759
- **Definition:** The number of units associated with a claim line healthcare service after the application of a financial algorithm. The algorithm sets the number of units to zero when the Net Submitted Expense (Field #84) is zero. Decimal values (i.e., to the right of the implied decimal point) indicate that the units of service reflect anesthesia services, which are billed by providers expense line is for anesthesia mostly/only anesthesia Types of Service will reflect values of less than one (to the right of the implied decimal point) due to the way providers render and bill for anesthesia services as units of time.
- **Note:** This field will contain negative values on ACAS reversal and non-ACAS negative adjustment records.

82. Source Number/Units of Service:

- **Format:** Numeric
- **Length:** 12.2 (signed; implied decimal)
- **Positions:** 761 - 772
- **Definition:** The number of units associated with a claim line healthcare service as it was entered in the claim system, with no downstream financial algorithm applied. Decimal values (i.e., to the right of the implied decimal point) indicate that the units of service reflect anesthesia services, which are billed by providers expense line is for anesthesia mostly/only anesthesia Types of Service will reflect values of less than one (to the right of the implied decimal point) due to the way providers render and bill for anesthesia services as units of time. Typically, anesthesia conversion is based on 15 minutes = 1 unit.

83. Gross Submitted Expense:

- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 774 - 783
- **Definition:** The amount submitted by a provider for a provided service (this amount reflects what was actually entered into the source system without any financial cleaning applied to it).
- **Note:** *This field is masked on all standard files. An exception can be requested via the Aetna Account Manager to have the field unmasked.*

84. Net Submitted Expense:

- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 785 – 794
- **Definition:** The net amount billed by a provider for a provided service. This amount reflects what was billed after removing duplicates
- **Note:** *This field is masked on all standard files. An exception can be requested via the Aetna Account Manager to have the field unmasked*.

85. Not Covered Amount 1:

- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 796 - 805
- **Definition:** The dollar amount that is not covered by the member benefit plan. When portions of the submitted amount are denied for different reasons, there can be a maximum of three occurrences for Not Covered Amount. This field is not populated for non-ACAS data (Field #7, Source System Platform = '03' or '04').

86. Not Covered Amount 2:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 807 - 816
- **Definition:** The dollar amount that is not covered by the member benefit plan. When portions of the submitted amount are denied for different reasons, there can be a maximum of three occurrences for Not Covered Amount. This field is not populated for non-ACAS data (Field #7, Source System Platform = '03' or '04').

87. Not Covered Amount 3:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 818 - 827
- **Definition:** The dollar amount that is not covered by the member benefit plan. When portions of the submitted amount are denied for different reasons, there can be a maximum of three occurrences for Not Covered Amount. This field is not populated for non-ACAS data (Field #7, Source System Platform = '03' or '04').

88. Action or Reason Code 1:
- **Format:** Character
- **Length:** 4
- **Positions:** 829 - 832
- **Definition:** A code assigned by the claim system. This code is used to clarify how the claim was processed and/or explain benefit determination (explain why an amount was or was not covered). Please refer to the Appendices for a list of the specific values and their definitions.

89. Action or Reason Code 2:
- **Format:** Character
- **Length:** 4
- **Positions:** 834 – 837
- **Definition:** A code assigned by the claim system. This code is used to clarify how the claim was processed and/or explain benefit determination (explain why an amount was or was not covered). Please refer to the Appendices for a list of the specific values and their definitions.

90. Action or Reason Code 3:
- **Format:** Character
- **Length:** 4
- **Positions:** 839 – 842
- **Definition:** A code assigned by the claim system. This code is used to clarify how the claim was processed and/or explain benefit determination (explain why an amount was or was not covered). Please refer to the Appendices for a list of the specific values and their definitions.

91. Covered Expense:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Position:** 844 – 853
- **Definition:** The amount covered by the plan of benefits, including any covered copay (member copayment) amounts.
- **Note concerning Allowed versus Covered:** Because some categories of healthcare expenses can be "allowed" under a benefit plan, yet contractually denied (i.e., "not covered") on a given claim for reasons such as failure to obtain a hospital precertification, or benefits having reached a plan-year maximum, or other reasons, the Covered Expense field may be considered more reliable or useful than the Allowed Amount field, especially for calculations involving financial "step-downs" (e.g. following each financial calculation from Submitted down to Paid). A key point to consider is that "allowed" means that an expense is "eligible for benefit determination." However, the outcome of that benefit determination may result in a covered amount that is less than the allowed amount. Again, this will most often be due to coverage denials related to lack of precertification or benefit-year maximums having been reached.
- **Note:** This field should be used for ACAS claims.

92. Allowed Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Position:** 855 – 864
- **Definition:** The portion of the provider submitted amount considered eligible for benefit determination. This amount is prior to application of any copay, deductible, coinsurance, COB, pre-certification penalty or withholds. The amount reported in this field may have been adjusted by a financial algorithm.
- **Note concerning Allowed versus Covered:** Please refer to the definition of Field #91 (Covered Expense) for important notes regarding the difference between "Allowed" and "Covered."
- **Note:** This field should be used for non-ACAS claims (Source System Platform "03").

93. Filler:
- **Format:** Character
- **Length:** 10
- **Position:** 866 – 875
- **Definition:** Reserved for future use

94. Copayment Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 877 - 886
- **Definition:** The amount of copayment that was charged to the member. The amount reported in this field may have been adjusted by a financial algorithm. If so, the original Source Copayment Amount can be seen in Field #95. See Field #171 for Aetna Health Fund Copay Amount.

95. Source Copayment Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 888 – 897
- **Definition:** The amount of copayment that was charged to the member, as entered in the claim payment system. The amount reported in this field has not been adjusted. This field is not used in the financial "step-down" algorithm.

96. Deductible Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 899 - 908
- **Definition:** The amount of eligible expenses that must be paid by the member to satisfy deductible provisions under the plan of benefits. See Field #172 for Aetna Health Fund Member Deductible Amount.

97. Coinsurance:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 910 - 919
- **Definition:** The dollar amount of the provider allowed or eligible (that is, charges remaining after the deductible have been met) that the member is responsible for paying. This amount is calculated using the benefit coinsurance percentage under the provisions of the plan of benefits. The amount reported in this field may be adjusted by a financial algorithm. For the unadjusted Source Coinsurance Amount, see Field #98. See Field #170 for Aetna Health Fund Member Share of Coinsurance Amount.

98. Source Coinsurance Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 921 - 930
- **Definition:** The dollar amount of the provider allowed or eligible (that is, charges remaining after the deductible have been met) that the member is responsible for paying. This amount is calculated using the benefit coinsurance percentage under the provisions of the plan of benefits. The amount reported in this field is the source coinsurance amount, as entered in the claim payment system. This field is not used in the financial "step-down" algorithm.

99. Benefit Payable:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 932 - 941
- **Definition:** The amount payable to the member or provider after copayment; coinsurance; and/or deductible has been applied to the covered amount.

100. Paid Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 943 - 952
- **Definition:** The amount paid for a healthcare service after all plan benefit provisions, including copayment, coinsurance, and/or deductibles has been applied.
- **Note:** This field includes the amount paid by both the Aetna Health Fund (when applicable) and the Base Medical Plan.

101. COB Paid Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 954 - 963
- **Definition:** The amount paid under a coordination of benefits provision that was available through another group insurance plan covering the member.

102. Aetna Health Fund – Before Fund Deductible:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 965 – 974
- **Definition:** The deductible amount, determined during plan design, prior to the application of any payments by an Aetna Health Fund arrangement.

103. Aetna Health Fund - Payable Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 976 – 985
- **Definition:** The payment from the Aetna Health Fund account before the application of the Coordination of Benefits (COB) provision that was included in Paid Amount (Field #100). This is the amount for which the Aetna is liable after the copayment and/or deductible have been subtracted.

104. Savings – Negotiated Fee:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 987 - 996
- **Definition:** A dollar amount which represents what monies have been calculated to be saved for a given service rendered, via a reduced cost due to a negotiated contractual agreement between the provider of the service and the owner of the medical program. Savings due to NAP are included in this field.
- **Note:** *This field is masked on all standard files. An exception can be requested via the Aetna Account Manager to have the field unmasked.*
- **Note:** This field is not populated for non-ACAS claims.

105. Savings – R&C:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 998 - 1007
- **Definition:** The dollar amount that reflects a standardized total for what has been deemed to be the 'norm' for the delivery of a particular health care service.
- **IMPORTANT: This amount is also reported in the Not Covered Amount (Fields #85 - #87) so use caution when bringing both amounts into any reports or systems.**
- **Note:** This field is not populated for non-ACAS claims.

106. Savings - COB:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 1009 - 1018
- **Definition:** The amount associated with the savings resultant from the application of a coordination-of-benefits provision. The amount reported in this field may be adjusted by a financial algorithm. For the unadjusted, source system COB Savings Amount; see Field #107 (Savings – Source COB).
- **Note:** This field is not populated for non-ACAS claim or encounter data.

107. Savings – Source COB:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 1020 - 1029
- **Definition:** The amount associated with the savings resultant from the application of a coordination-of-benefits provision. The amount reported in this field is the source COB savings amount, as entered in the claim payment system.
- **Note:** This field is not populated for non-ACAS claim or encounter data.

108. Medicare Code:
- **Format:** Character
- **Length:** 1
- **Positions:** 1031
- **Definition:** This code describes the type of Medicare integration (in the context of COB) applied to a given transaction. This field is also commonly used to classify data as Aetna Primary versus Medicare primary. Please refer to the Appendices for a full list of valid values and definitions.
- **Note:** This field is not populated for non-ACAS data.

109. Type of Expense - COB:
- **Format:** Character
- **Length:** 1
- **Positions:** 1033
- **Definition:** The type of COB plan provisions under which benefits were coordinated or this claim. **Note:** As of the January 2016 Data Warehouse refresh, the determination of the primary payer on a claim has been enhanced by combining this field and Field #110, COB Code. Rather than having distinct valued and definitions for these two fields separately, they should now be used in combination for the determining of the primary payer on the claim. **Please refer to the worksheet shown under this field in the Appendices.** Also, note that these fields do not apply for HMO claims with a Field #7 File ID value of '03'.

110. COB Code:

- **Format:** Character
- **Length:** 1
- **Positions:** 1035
- **Definition:** For ACAS claim data (Field #7 Source System Platform = '27'), a value that indicates the type of COB that was associated with the member plan of benefits on the day that the billed service was incurred. **Note:** As of the January 2016 Data Warehouse refresh, the determination of the primary payer on a claim has been enhanced by combining this field and Field #109, Type of Expense-COB. Rather than having distinct valued and definitions for these two fields separately, they should now be used in combination for the determining of the primary payer on the claim. **Please refer to the worksheet shown under Field #109 in the Appendices.** Also, note that these fields do not apply for HMO claims with a Field #7 File ID value of '03'.

111. National Drug Code:

- **Format:** Character
- **Length:** 11
- **Positions:** 1037 - 1047
- **Definition:** An 11-digit FDA-assigned code used to identify drug products. Generally, the first five digits identify the manufacturer of the drug; the remaining digits, assigned by the manufacturer, identify the drug product (bytes 6-9), and quantity (bytes 10-11).

  NDC claims are found on the Universal Medical File in unusual scenarios where a pharmacy could NOT process an APM claim on the APM system at the time a prescription was dispensed for a non-ACAS member, and the member was forced to have the claim settled at a later date on the non-ACAS platform. Possible reasons for this scenario include situations where the pharmacy was NOT yet connected to the APM system, the connection between the pharmacy and APM system malfunctioned or the member eligibility information had NOT been updated in Aetna's membership database.

112. Member 'CUMBID':

- **Format:** Character
- **Length:** 22
- **Positions:** 1049 - 1070
- **Definition:** For non-ACAS HMO claims, this is the Aetna-assigned Employee Id Number that appears on the member group health ID card, not the CUMBID. It is often referred to as the "W" Number; however, the leading "W" is not included in the number on the Universal File. The root number is the same for all members of a family and the last position identifies the specific family member and makes the number unique. An example of a non-ACAS HMO Number for a family:

John Smith	BBF0K1YA	Employee
Jane Smith	BBF0K1YB	Spouse
Johnny Smith	BBF0K1YC	Child

  For ACAS claims, the root number is this field represents the employee CUMBID. It is the same for each family member with the exception of the last 3 positions. The last 3 positions uniquely identify members within the family. An example of an ACAS CUMBID for a family:

John Smith	12736025M01	Employee
Jane Smith	12736025W02	Spouse

113. Status of Claim:
- **Format:** Character
- **Length:** 1
- **Positions:** 1072
- **Definition:** A value which represents the disposition or status of a service occurrence at a point in time. Please refer to the Appendices for a listing of the specific values and their definitions.
- **Note:** Do not use Recorded Encounters (records with a value of "R") for audits.

114. Non-SSN Employee ID:
- **Format:** Alpha/Numeric
- **Length:** 22
- **Positions:** 1074 - 1095
- **Definition:** A unique employer-assigned identifier for a member on a given source system. The primary intent of this field is to capture employer-assigned "badge numbers" or other forms of employer-assigned, non-SSN identifiers. When a "badge number" is captured, the number is located in different positions of the field. For the employee, the last 11 bytes of the 22 byte field represent the badge number and for a dependent, the "badge number" is in the first 11 bytes of the field.

  For example:

John Smith	00000000000000000520729	Employee
Jane Smith	00000520729000520729 01	Spouse
Johnny Smith	00000520729000520729 02	Child

  For non-ACAS HMO claims, when a badge number is not assigned, this is typically the number on the member insurance ID card. For ACAS claims, this field will contain the employee SSN or the employee SSN and the member SSN.

115. Reversal Code:
- **Format:** Alpha/Numeric
- **Length:** 2
- **Positions:** 1097 - 1098
- **Definition:** A value which depicts a type of adjustment that a claim line might represent as a means of altering a previously adjudicated claim line; (e.g., a reversal of a payment; a correction of an underpayment). This field is right-justified (the first byte is 'space'). Valid values are '(blank)R' (reversed), and '(blank)N' (not reversed).

116. Admit Counter:
- **Format:** Alpha/Numeric
- **Length:** 2
- **Positions:** 1100 - 1101
- **Definition:** A counter which is set for records identified by Aetna Informatics Data Warehouse as representing an inpatient admission. This field can be summed to get a **"ballpark"** admit count, but the Universal Medical-Dental file is not designed to offer true Episode-of-Care data.
- **Note:** This is a "signed" field to allow for negative values on reversal records.

117. Administrative Savings Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 1103 - 1112
- **Definition:** The amount deducted from the billed amount and not paid because of contractual exclusions/limitations on coverage. This should NOT include copays, deductibles, precertification penalties, COB, withholds, and/or coinsurance.
- **Note:** This field is not populated for non-ACAS claims.

118. Aexcel Provider Designation Code:
- **Format:** Alpha/Numeric
- **Length:** 3
- **Positions:** 1114 - 1116
- **Definition:** Identifies whether the servicing provider on the claim was Aexcel Designated or Aexcel Non-Designated at time of adjudication. Valid values are:

  201 = Aexcel Designated
  202 = Aexcel Non-Designated
  NA = Aexcel Not Applicable

119. Aexcel Plan Design Code:
- **Format:** Alpha/Numeric
- **Length:** 1
- **Positions:** 1118
- **Definition:** Identifies whether the Aexcel Plan Design for the claim is structured as Incentive, Disincentive or a combination of both Incentive and Disincentive. Valid values are:
  B = Both Incentive and Disincentive Plan Design
  D = Disincentive Plan Design
  I = Incentive Plan Design
  N= Aexcel Not Applicable

120. Aexcel Benefit Tier Code:
- **Format:** Alpha/Numeric
- **Length:** 2
- **Positions:** 1120 - 1121
- **Definition:** Identifies the Aexcel benefit level that was paid for the claim. Please refer to the Appendices for a listing of the specific values and their definitions.

121. Aexcel Designated Provider Specialty:
- **Format:** Alpha/Numeric
- **Length:** 4
- **Positions:** 1123 - 1126
- **Definition:** The Aexcel specialty category for which the provider is designated (aka designated Provider Business Grouping type). Please refer to the Appendices for a listing of the specific values and their definitions.

122. Product Distinction Code

- **Format:** Character
- **Length:** 1
- **Positions:** 1128
- **Definition:** Identifies whether the record is associated with an non-ACAS HMO-based product (value = 'H') or a Traditional-based product (value = 'T')
- **Note:** This field is only populated for records with a Source System (Field #7) value of '27' (ACAS).

123. Billed Eligible Amount: (DO NOT USE IF UNMASKED)

- **Format:** Numeric
- **Length:** 10 (10.2 implied decimal, signed)
- **Positions:** 1130 - 1139
- **Definition:** For ACAS claim data (Source System Platform 27), the Billed Eligible Amount is defined as the sum of Covered Amount (field #91) plus Savings-Negotiated Fee Amount (field #104) plus Savings - R&C (field #105).
- **IMPORTANT:** **This is not a reliable field and should not be used for any reporting** – use Net Submitted Expense (field #84) in its place.

  It has recently been determined that components of Administrative Savings Amount (field #117) should also be factored into the Billed Eligible Amount field to determine actual billed charges that were eligible for benefits adjudication under the plan, prior to the application of negotiated fees and contractually defined "reasonable and customary fee" provisions. Until the calculation is updated, this field will be masked on all files – without any exceptions. If it is unmasked for any reason, we strongly recommend not using this information and instead using Net Submitted Expense (field #84) as the closest approximation to the actual Billed Eligible Amount.

  For non-ACAS HMO claim data (Source System Platform 03), the Billed Eligible Amount is defined as Net Submitted Expense (field #84).

124. Servicing Provider Class Code:

- **Format:** Character
- **Length:** 3
- **Positions:** 1141 - 1143
- **Definition:** A classification scheme that assigns code values, useful for classifying providers into commonly used business entities, for reporting and analysis purposes. Please refer to the Appendices for a listing of the specific values and their definitions.

125. Present on Admission Code (1):
- **Format:** Character
- **Length:** 1
- **Positions:** 1145
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values:
  Y = Diagnosis in Field #153, Diagnosis Code 1, was present at the time of inpatient admission.
  N= Diagnosis in Field #153, Diagnosis Code 1, was not present at the time of the inpatient admission.
  U = Documentation insufficient to determine if condition described by Field #153, Diagnosis Code 1, was present at the time of inpatient admission.
  W = clinically undetermined. Provider is unable to clinically determine whether the condition described by Field #153, Diagnosis Code 1, was present at the time of the inpatient admission.
  1 or Spaces = Unreported/not used. Exempt from POA reporting.

126. Present on Admission Code (2):
- **Format:** Character
- **Length:** 1
- **Positions:** 1147
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values: Same as POA Code 1 (Field # 125)

127. Present on Admission Code (3):
- **Format:** Character
- **Length:** 1
- **Positions:** 1149
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values: Same as POA Code 1 (Field # 125)

128. Filler:
- **Format:** Character
- **Length:** 6
- **Positions:** 1151 - 1156
- **Definition:** Reserved for future use

129. Filler:
- **Format:** Character
- **Length:** 6
- **Positions:** 1158 - 1163
- **Definition:** Reserved for future use

130. Filler:
- **Format:** Character
- **Length:** 6
- **Positions:** 1165 - 1170
- **Definition:** Reserved for future use

131. Pricing Method Code:
- **Format:** Character
- **Length:** 1
- **Positions:** 1172
- **Definition:** The values in this field will represent the type of method used to determine benefits paid (ex: daily rate, paid as billed, etc.). Please refer to the Appendices for a listing of the specific values and their definitions.

132. Servicing Provider Type Class Code:
- **Format:** Character
- **Length:** 1
- **Positions:** 1174
- **Definition:** This field is a 1-byte indicator that facilitates grouping records by facility or non-facility. This indicator based on Provider Type values. The values and definitions for this field are:
  'F' = Facility, 'N' = Non-facility
- **Note**: There will be some claim lines where the value in this field indicates non-facility even though there is a revenue code on the claim line. This situation occurs for a select few provider types that can either represent facility or non-facility services (i.e., lab). In these instances, Revenue Code should also be interrogated to determine if the service was provided by a facility. For example, if Servicing Provider Type Class Code = N and Revenue Code is populated and non-zero, then assign a value of F.

133. Servicing Provider Specialty Category Code:
- **Format:** Character
- **Length:** 4
- **Positions:** 1176 - 1179
- **Definition:** This field allows grouping of provider specialty codes into general categories of specialty. Please refer to the Appendices for a listing of the specific values and their definitions.

134. Servicing Provider NPI:
- **Format:** Character
- **Length:** 20
- **Positions:** 1181 - 1200
- **Definition: I**s a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The length of our field is 20 bytes to allow for any possible future expansions.
- **Note:** This field is populated on most facility claims but is not populated on professional claims in the downstream data at this time (11/2012). As of November 2013, the NPI became available in the downstream data (and therefore the Universal Medical file) for most physician claims; however, it is still not passed downstream on non-physician professional and DME claims. The claim system uses the NPI for claim processing, but does not pass it downstream for non-physician or facility claims.

135. Total Deductible Met Indicator:
- **Format:** Character
- **Length:** 1
- **Positions:** 1202
- **Definition: DO NOT USE THIS FIELD, IT IS NOT POPULATED.**
  Currently this is a “place-holder” for future development of an indicator that will show whether a member has met the plan deductible for the benefit year in which the associated services were incurred.

136. Total Interest Amount:

- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 1204 - 1213
- **Definition:** This field reports any additional payments due to the payee as a result of late payment of the claim, or other charges. This field is only populated for claims processed on the ACAS claim adjudication system.
- **Note:** The Benefit Payable Amount (Field #99) reported back to the plan sponsor is reduced by the amount of that TTL Interest, but the actual Paid Amount (Field #100, Paid Amount), which is the dollars paid out the door to the provider, is not reduced. The PSA (physician settlement agreement) or LCI (late claim interest) is not billed back to the plan sponsor. In the downstream banking systems, this amount is taken out of the amount billed back to the plan sponsor.

137. Total Surcharge Amount:

- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 1215 - 1224
- **Definition:** In simplest high-level terms, a 'surcharge', as its name implies, is a fee added on to another existing fee, for any reason. A representative example of surcharges in healthcare claim data is the New York Healthcare Reform Act (HCRA), which has imposed financing laws that govern hospital reimbursement methodologies and targets funding for a multitude of health care initiatives.

  By the addition of this field, you will be able to see how much of the Paid Amount (Field #100) was due to a surcharge such as New York HCRA. In the past, the NY HCRA payment was on a separate segment so the Data Warehouse (and Universal Files) were able to report on the specific NY HCRA payments (not Graduate Medical Education payments or GME) using provider TIN/PIN combinations. In the claim system, processing the NY HCRA amount to a separate segment was a manual, complicated process and has since been automated.

  With the automation of the NY HCRA processing, the NY HCRA payment is on a single claim segment along with the payment to the provider. In the online claim system, the separate payments to the provider and NY HCRA are identified, but on the downstream data in the data warehouse (and the Universal File) the amounts were not separately identified.

  With the addition of the Total Surcharge Amount, it can be determined how much of the Paid Amount was associated with a surcharge.

  Hypothetical example (a very simple example in which a bill is paid at 100%):
  Regular hospital bill = $1,500
  Hospital bill with applicable surcharge amount: let's say it was $1,500 × 1.0885 = $1,632.75
  Allowed/Covered = $1,632.75 (modified during claim processing, see note below)
  Paid Amount = $1632.75

  The Paid Amount on the claim is $1,632.75 and is reported in Field #100, Paid Amount.
  The NY HCRA Surcharge Amount is $132.75 and will be reported in the Total Surcharge Amount, Field #137 (this amount is also included in Paid Amount, Field #100).
- **Note:** The claim still balances from Allowed to Paid with the addition of the surcharge amount to the Paid Amount field because during claim processing the Allowed Amount is modified to include both the Negotiated Rate and the NY HCRA Tax Amount (which in turn understates Aetna's discounts) in the downstream data warehouse and data files.
- **Note:** This field is only populated for claims processed on the ACAS claim adjudication system.

138. Filler:
- **Format:** Character
- **Length:** 4
- **Positions:** 1226 - 1229
- **Definition:** Reserved for future use

139. HCFA Place of Service Code:
- **Format:** Character
- **Length:** 2
- **Positions:** 1231 - 1232
- **Definition:** A value which depicts a standardized HCFA (CMS) code which represents the place or setting in which health care treatment was rendered. Please refer to the Appendices for a listing of the specific values and their definitions.
- **Note:** HCFA Place of Service Code is not populated for dental claims. At this time, this field is not populated for all medical claims. If this field is blank, refer to field #77, Place of Service.

140. HCFA Admit Source Code:
- **Format:** Character
- **Length:** 1
- **Positions:** 1234
- **Definition:** A value which depicts the source of a member admission to a facility as it was represented on a standardized UB92 facility claim form. Please refer to the Appendices for a listing of the specific values and their definitions.

141. HCFA Admit Type Code:
- **Format:** Character
- **Length:** 1
- **Positions:** 1236
- **Definition:** A value which represents a classification of a member admission to a facility as it would be represented on a standardized UB92 claim form. Please refer to the Appendices for a listing of the specific values and their definitions.

142. Admission Date:
- **Format:** Date (CCYY-MM-DD)
- **Length:** 10
- **Positions:** 1238 - 1247
- **Definition:** The original date of inpatient admittance to a facility as it was received from a source system.
- **Note:** This is not a required entry field on the record coming in from non-ACAS Claim, so do not expect the same frequency of population as you will find on records from ACAS Claim.

143. Discharge Date:
- **Format:** Date (CCYY-MM-DD)
- **Length:** 10
- **Positions:** 1249 - 1258
- **Definition:** The original date of inpatient discharge from a facility as it was received from a source system.
- **Note:** This is not a required entry field on the record coming in from non-ACAS Claim, so do not expect the same frequency of population as you will find on records from ACAS Claim.

144. Line-Level Procedure Code Modifier (2):
- **Format:** Character
- **Length:** 2
- **Positions:** 1260 -1261
- **Definition:** A two-position code that is used to describe variations of procedures described by the Line-Level Procedure Code (Field #68).

145. Line-Level Procedure Code Modifier (3):
- **Format:** Character
- **Length:** 2
- **Positions:** 1263 -1264
- **Definition:** A two-position code that is used to describe variations of procedures described by the Line-Level Procedure Code (Field #68).

146. Present on Admission Code (4):
- **Format:** Character
- **Length:** 1
- **Positions:** 1266
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values: Same as POA Code 1 (Field # 125)

147. Present on Admission Code (5):
- **Format:** Character
- **Length:** 1
- **Positions:** 1268
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values: Same as POA Code 1 (Field # 125)

148. Present on Admission Code (6):
- **Format:** Character
- **Length:** 1
- **Positions:** 1270
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values: Same as POA Code 1 (Field # 125)

149. Present on Admission Code (7):
- **Format:** Character
- **Length:** 1
- **Positions:** 1272
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values: Same as POA Code 1 (Field # 125)

150. Present on Admission Code (8):
- **Format:** Character
- **Length:** 1
- **Positions:** 1274
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values: Same as POA Code 1 (Field # 125)

151. Present on Admission Code (9):
- **Format:** Character
- **Length:** 1
- **Positions:** 1276
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values: Same as POA Code 1 (Field # 125)

152. Present on Admission Code (10):
- **Format:** Character
- **Length:** 1
- **Positions:** 1278
- **Definition:** A code used to indicate whether the corresponding diagnosis code was present at the time of admission.
  Values: Same as POA Code 1 (Field # 125)

153. Diagnosis Code 1:
- **Format:** Character
- **Length:** 8
- **Positions:** 1280 - 1287
- **Definition:** The primary ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.
- **Note**: The default value for this field is 799.9 for ICD-9 codes or R69 for ICD-10 codes which are the industry-standard defaults.

154. Diagnosis Code 2:
- **Format:** Character
- **Length:** 8
- **Positions:** 1289 - 1296
- **Definition:** The secondary ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.

155. Diagnosis Code 3:
- **Format:** Character
- **Length:** 8
- **Positions:** 1298 - 1305
- **Definition:** The tertiary ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.

156. Diagnosis Code 4:
- **Format:** Character
- **Length: 8**
- **Positions:** 1307 - 1314
- **Definition:** The fourth ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.

157. Diagnosis Code 5:
- **Format:** Character
- **Length:** 8
- **Positions:** 1316 - 1323
- **Definition:** The fifth ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.

158. Diagnosis Code 6:
- **Format:** Character
- **Length:** 8
- **Positions:** 1325 - 1332
- **Definition:** The sixth ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.

159. Diagnosis Code 7:
- **Format:** Character
- **Length:** 8
- **Positions:** 1334 - 1341
- **Definition:** The seventh ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.

160. Diagnosis Code 8:
- **Format:** Character
- **Length:** 8
- **Positions:** 1343 - 1350
- **Definition:** The eighth ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.

161. Diagnosis Code 9:
- **Format:** Character
- **Length:** 8
- **Positions:** 1352 - 1359
- **Definition:** The ninth ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.

162. Diagnosis Code 10:
- **Format:** Character
- **Length:** 8
- **Positions:** 1361 - 1368
- **Definition:** The tenth ICD-9 or ICD-10 Diagnosis Code associated with the services on a given claim record.

163. Claim-Level ICD Procedure Code 1:
- **Format:** Character
- **Length:** 7
- **Positions:** 1370 - 1376
- **Definition:** A value in the ICD-9 or ICD-10 medical coding system, identifying an operating room procedure as it is was recorded by a hospital facility on a standardized UB92 inpatient billing claim form. This field contains the primary ICD-9 or ICD-10 procedure code, as identified by the hospital. This field is populated only for inpatient facility claims (Type of Service (Field #74 = '50') and Place of Service (Field #77 = 'I')).
- **Note:** We have noticed that some hospitals, when electronically submitting their claims, incorrectly enter a HCPCS code instead of an ICD-9 or ICD-10 procedure code in this field. If you find what appears to be an invalid ICD-9 or ICD-10 procedure code, and the first byte of that code is a "letter" value, the code is probably a truncated HCPCS code. For example, if the hospital enters the HCPCS code E1390 in this field, the field formatting will display that code on this record as E13.9 (the decimal is inserted based on the expectation that the code would be an ICD-9 procedure code).

164. Claim-Level ICD Procedure Code 2:
- **Format:** Character
- **Length:** 7
- **Positions:** 1378 - 1384
- **Definition:** A value in the ICD-9 or ICD-10 medical coding system, identifying an operating room procedure as it is was recorded by a hospital facility on a standardized UB92 inpatient billing claim form. This field contains the secondary ICD-9 or ICD-10 procedure code, as identified by the hospital. This field is populated only for inpatient facility claims (Type of Service (Field #74 = '50') and Place of Service (Field #77 = 'I')).
- **Note:** See Field #163 (Claim-Level ICD Procedure Code 1) for a discussion of the appearance of HCPCS codes in this field.

165. Claim-Level ICD Procedure Code 3:
- **Format:** Character
- **Length:** 7
- **Positions:** 1386 - 1392
- **Definition:** A value in the ICD-9 or ICD-10 medical coding system, identifying an operating room procedure as it is was recorded by a hospital facility on a standardized UB92 inpatient billing claim form. This field contains the tertiary ICD-9 or ICD-10 procedure code, as identified by the hospital. This field is populated only for inpatient facility claims (Type of Service (Field #74 = '50') and Place of Service (Field #77 = 'I')).
- **Note:** See Field #163 for a discussion of the appearance of HCPCS codes in this field.

166. Claim-Level ICD Procedure Code 4:
- **Format:** Character
- **Length:** 7
- **Positions:** 1394 - 1400
- **Definition:** A value in the ICD-9 or ICD-10 medical coding system, identifying an operating room procedure as it is was recorded by a hospital facility on a standardized UB92 inpatient billing claim form. This field contains the fourth ICD-9 or ICD-10 procedure code, as identified by the hospital. This field is populated only for inpatient facility claims (Type of Service (Field #74 = '50') and Place of Service (Field #77 = 'I')).
- **Note:** See Field #163 for a discussion of the appearance of HCPCS codes in this field.

167. Claim-Level ICD Procedure Code 5:
- **Format:** Character
- **Length:** 7
- **Positions:** 1402 - 1408
- **Definition:** A value in the ICD-9 or ICD-10 medical coding system, identifying an operating room procedure as it is was recorded by a hospital facility on a standardized UB92 inpatient billing claim form. This field contains the fifth ICD-9 or ICD-10 procedure code, as identified by the hospital. This field is populated only for inpatient facility claims (Type of Service (Field #74 = '50') and Place of Service (Field #77 = 'I')).
- **Note:** See Field #163 for a discussion of the appearance of HCPCS codes in this field.

168. Claim-Level ICD Procedure Code 6:
- **Format:** Character
- **Length:** 7
- **Positions:** 1410 - 1416
- **Definition:** A value in the ICD-9 or ICD-10 medical coding system, identifying an operating room procedure as it is was recorded by a hospital facility on a standardized UB92 inpatient billing claim form. This field contains the sixth ICD-9 or ICD-10 procedure code, as identified by the hospital. This field is populated only for inpatient facility claims.
- **Note:** See Field #163 for a discussion of the appearance of HCPCS codes in this field.

169. Aetna Health Fund Determination Order Code:
- **Format:** Character
- **Length:** 3
- **Positions:** 1418 - 1420
- **Definition:** A code that identifies the sequence of how fund dollars are applied to expenses (e.g. the fund pays first, then the base plan; or plan pays first, then the fund).

  Values and definitions are:
  000 - Fund pays until depleted; then base plan pays
  001 - Base plan pays first; then fund pays member responsibility

170. Aetna Health Fund Member Share of Coinsurance Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 1422 - 1431
- **Definition:** The amount of the coinsurance for the expense-line record (Field #97, Coinsurance Amount) that was paid from the Fund, as opposed to the entire amount being paid by the member.

171. Aetna Health Fund Member Copay Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 1433 - 1442
- **Definition:** The amount of the copay for the expense-line record (Field #94, Copayment Amount) that was paid from the Fund, as opposed to the entire amount being paid by the member.

172. Aetna Health Fund Member Deductible Amount:
- **Format:** Numeric
- **Length:** 10.2 (signed; implied decimal)
- **Positions:** 1444 - 1453
- **Definition:** The amount of the deductible for the expense-line record (Field #96, Deductible Amount) that was paid from the Fund, as opposed to the entire amount being paid by the member.

173. Filler:
- **Format:** Character
- **Length:** 1
- **Positions:** 1455
- **Definition:** Reserved for future use

174. Filler:
- **Format:** Character
- **Length:** 1
- **Positions:** 1457
- **Definition:** Reserved for future use

175. ICD-10 Indicator:
- **Format:** Character
- **Length:** 1
- **Positions:** 1459
- **Definition:** An indicator that shows whether the ICD Diagnosis Code for a given record contains ICD-9 or ICD-10 (or neither) Code.

Value	Definition
Y	ICD-10 Diagnosis Code
N	ICD-9 Diagnosis Code
(blank)	Neither ICD-9 nor ICD-10 Diagnosis Code

176. Exchange Identifier:
- **Format:** Alpha/Numeric
- **Length:** 9
- **Positions:** 1461 - 1469
- **Definition:** The identifier of a Private Exchange, which is a health insurance marketplace run by a private sector company or non-profit agency. All other organization types, including Public Exchanges and Carriers, will carry the default value of all 9s. Please see the appendices for a complete list of values and descriptions/definitions.

177. Filler:
- **Format:** Character
- **Length:** 8
- **Positions:** 1471 - 1478
- **Definition:** Reserved for future use

178. End of Record Marker:
- **Format:** Alpha/Numeric
- **Length:** 1
- **Positions:** 1480
- **Definition:** A value of “X” marks the end of each record.

Universal Medical/Dental File

Appendices

"TOP DOWN" DOLLAR EXPLANATION – STANDARD: The financial step-down displayed below represents the STANDARD for the majority of Aetna's claim data records. This template is applicable to non-ACAS claim records and ACAS claim records including the type of Aetna Health Fund claim records where the Fund payments do NOT reduce Deductible Amounts.

This explanation only applies to fee-for-service claim records and do not apply to encounter records.

In addition, please note that this is a theoretical explanation. Sometimes the elements of claim adjudication do not balance to these templates, as a result of special plan designs or other considerations. For example, not all of the referenced financial fields are available or are not 100% reliable for non-ACAS data records. This is because the non-ACAS claim system platform doesn't capture these data elements. As a result, these financial amounts had to be approximated.

Dollars	Comments
Gross Submitted Expense (Field #83)*	Excludes fully pended claims (please see the additional comments below).
minus duplicate and pended expenses For ACAS data, the duplicate/pended expenses can be confirmed by the associated Not Covered Amounts (fields #85 - #87) and Action or Reason Codes (fields #88 - #90)	Expense line records that have been fully pended for additional information before they can be adjudicated are excluded from the Universal File. Dental Pre-Determinations are also excluded from this file.
= Net Submitted Expense (Field #84)*	
minus the sum of Savings: • **Savings - Negotiated Fee (Field #104)*** • Savings – R&C (Field #105) • Administrative Savings Amount (Field #117)	These fields are not populated on non-ACAS claim records.
= Allowed Amount (Field #92)	
minus Precertification Penalty Amount	Calculated as the total of Not Covered Amount where the associated Action or Reason Code is 827, 891 or 921
= Covered Expense (Field #91)	For non-ACAS records, Covered Expense is estimated, and is *after* Copay amounts are excluded.
minus the sum of member out-of-pocket expenses: • Coinsurance (Field #97) • Deductible Amount (Field #96) • Copayment Amount (Field #94)	Deductible Amount includes hospital deductibles.
= Benefit Payable (Field #99)	Estimated for non-ACAS records
minus Savings - COB (Field #106)	Not populated for non-ACAS records
= Paid Amount (Field #100)	
*** These fields are masked on all standard files. An exception can be requested via the Aetna Account Manager to have these fields unmasked.**	

"TOP DOWN" DOLLAR EXPLANATION – AHF: This template is unique to Aetna Health Fund claim records where the plan design specifies that Fund payments reduce Deductible and/or Coinsurance Amounts.

This AHF financial step-down is intended as a guideline which will work for the claim data of many plan sponsors; however, there are variations in the administration of AHF for some plan sponsors. **Accordingly, these guidelines will not work for all plan sponsors.** If you encounter a situation where the AHF financial step-down is not working for you, send the details (preferably including sample records) to the same Regional mailbox that the original file request was sent to, and we will assist you in resolving any questions.

Aetna Health Fund claim records warrant a separate top-down template, because these claims include data fields that are not populated in standard fee-for-service claims. The recipient of a Universal Medical/Dental File may need to contact Aetna's Account Manager or Aetna Informatics to determine for a given plan sponsor exactly how Deductible/Coinsurance Amounts were updated (i.e., in an online or off-line mode) and if the fund pays first or if the fund covers member out of pocket amounts.

Dollars	Comments
Gross Submitted Expense (Field #83)*	Excludes fully pended claims (please see the additional comments below).
minus duplicate and pended expenses For ACAS data, the duplicate/pended expenses can be confirmed by the associated Not Covered Amounts (fields #85 - #87) and Action or Reason Codes (fields #88 - #90)	Expense line records that have been fully pended for additional information before they can be adjudicated are excluded from the Universal File. Dental Pre-Determinations are also excluded from this file.
= Net Submitted Expense (Field #84)*	
minus the sum of Savings: • **Savings - Negotiated Fee (Field #104)*** • Savings – R&C (Field #105) • Administrative Savings Amount (Field #117)	These fields are not populated on non-ACAS claim records.
= Allowed Amount (Field #92)	
minus Precertification Penalty Amount	Calculated as the total of Not Covered Amount where the associated Action or Reason Code of 827, 891 or 921
= Covered Expense (Field #91)	For non-ACAS records, Covered Expense is estimated, and is *after* Copay amounts are excluded.
minus Calculated "Member OOP After Fund Paid": • The amount is calculated as the sum of Coinsurance (Field #97) plus Deductible Amount (Field #96) minus the Aetna Health Fund – Payable Amount (Field #103)	
Covered Expense minus Calculated "Member OOP After Fund Paid"	Not an actual field on the file; must be calculated as shown on the left.

Dollars	Comments
Minus Calculated "Amount paid by base medical plan": • This amount is calculated as Paid Amount (Field #100 fund dollars plus plan dollars) minus AHF Payable Amount (Field #103 dollars pulled from the fund component of the plan) – calculated	Portion of total paid attributed to base medical plan
plus Aetna Health Fund – Payable Amount (Field #103)	Portion of total paid attributed to the Fund
minus Savings - COB (Field #106)	Not populated for non-ACAS records
= Total Amount Paid (Field #100) base medical plan plus Aetna Health Fund – Payable Amount	Not populated for non-ACAS records
* These fields are masked on all standard files. An exception can be requested via the Aetna Account Manager to have these fields unmasked.	

ACAS Adjustments: There are two ways in which claims may be adjusted in Aetna's ACAS claim engine (Field #7, Source System Platform = '27'):

1. Reprocess the original claim, using the same Claim ID

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 example below:

Field #33 Source-Specific Claim ID	Field #35, ACAS Pointer Back to Previous Segment	Field #91 Covered Expense	Field #96 Deductible	Field #100 Paid Amount	Field #113 Status of Claim	Field #8 Adjust-ment Code	Field #115 Reversal Code	Field #62 Processed Date All
EQJMY1Z9Z00	(blank)	$100.00	$80.00	$20.00	P	O	R	2009-02-07
EQJMY1Z9Z00	(blank)	($100.00)	($80.00)	($20.00)	P	A	R	2009-03-23
EQJMY1Z9Z01	00	$100.00	$90.00	$10.00	P	O	N	2009-03-23
NET		$100.00	$90.00	$10.00				Net Total

2. Void the original Claim, and reprocess using a different Claim ID

When this method is used, the claim office issues a 'void' record for the original claim, and then reprocesses that claim under a new, different Claim ID. This process is illustrated in the worksheet below:

Field #33 Source-Specific Claim ID	Field #35, ACAS Pointer Back to Previous Segment	Field #91 Covered Expense	Field #96 Deductible	Field #100 Paid Amount	Field #113 Status of Claim	Field #8 Adjust-ment Code	Field #115 Reversal Code	Field #62 Processed Date All
EQJMY1Z9Z00	(blank)	$100.00	$80.00	$20.00	P	O	R	2009-02-07
EQJMY1Z9Z00	(blank)	($100.00)	($80.00)	($20.00)	P	A	R	2009-03-23
EQJMY1Z9Z01	00	$0.00	$0.00	$0.00	D	O	N	2009-03-23
NET		$0.00	$0.00	$0.00				Net Total
Next the claim is reprocessed correctly under a **different Claim ID**								
PXBC08AB00	(blank)	$100.00	$90.00	$10.00	P	O	N	2009-03-23

Fields #1 through #6, Hierarchy Levels

The terminology used to describe the hierarchy of Aetna's "account structure" levels varies according to the type of product (i.e., health plan) and system platform. As shown below, Aetna supports 2 basic categories of products / systems. Traditional plans are viewed as those administered on Aetna's ACAS system platform. Remaining plans are being transitioned from the non-ACAS (old HMO) system to the ACAS system.

Hierarchy Level 1
This emerging value will be uniform across all products / plans

Hierarchy Level 2
Policyholder Number or Customer Number (typically, the same value as Group Number)

Hierarchy Level 3
Control Number or Group Number

Hierarchy Level 5
Suffix or Sub-Group

Hierarchy Level 6
Account Number (on ACAS records) or blank (on non-ACAS records)

Field #7: Source System Platform

The list below does not contain all valid Data Warehouse values. It includes only values that could appear on the Universal Medical/Dental file.

Value	Description
03	USHC HMO/POS Medical Claim
04	USHC HMO/QPOS Medical Encounter
13	MCRDB Claims
27	ACAS Indemnity/PPO POS Medical & Dental Claim
29	Aecclaims/Indemnity/PPO
44	HMO Dental Encounter
48	Institutional Encounters and Delegated Claims
60	Encounter System (HNO)

Field #8: Adjustment Code

Value	Description
A	Adjustment
O	Original

Field #9: Preferred vs Non-Preferred Benefit Level

Value	Description
N	Claim Paid - Full benefit level for members enrolled under USHC POS or PPO Plan (preferred)
U	Unknown
Y	Claim Paid - Reduced benefit level for members enrolled under USHC POS or PPO Plan (non-preferred)

Field #10: General Category of Health Plan

Field 10 General Category of HP.xls

Field #11: Line of Business

Field 11 Line of Business.xls

Field #13: Benefit Identification Code (BIC)


13_BIC_Code.xls

Field #15: Benefit Tier (applies to USAccess Records only)

Value	Description
1	Claim Paid - Tier 1 benefits for members enrolled under USAccess Plan (PCP directed In area)
2	Claim Paid - Tier 2 benefits for members enrolled under USAccess Plan (Self-referred to contracted provider)
3	Claim Paid - Tier 3 benefit for members enrolled under USAccess Plan (in-area member, out of network provider)
U	Unknown

Field #16: Funding Arrangement

Value	Definition
A	Fully Insured
B	Self Insured
C	Split Funded (partially insured)
U	Unknown

Field #20: Employee Gender

Value	Definition
M	Male
F	Female
U	Unknown

Field #24: Coverage/Enrollment Tier

Usage Comment: Currently not reported for claim records (i.e., defaults to 'N') on the ACAS Claim System (Source System Platform, Field #7 = '27').

Value	Definition
C	Couple
D	Dependent
F	Family
N	Not Applicable
P	Parent/Child
Q	Parent/Children
S	Single
U	Unknown

Field #30: Member Gender

Value	Definition
M	Male
F	Female
U	Unknown

Field #31: Member Relationship to Employee

For records where the Universal Med-Dent file was created on/after November 2013, the values and definitions for this field are:

Value	Definition
C	Child
D	Dependent Only
E	Enrollee (Subscriber)
F	Sponsored Dependent
G	Grandchild
H	Handicapped Dependent
L	Legal Dependent
O	Other
P	Domestic Partner (applies only to non-ACAS records)
S	Spouse
T	Student
U	Unknown
X	Confidential Domestic Partner (applies only to non-ACAS records)

Field #39 Employee Network ID and
Field #40: Servicing Provider Network Area ID (NOTE: Spreadsheet below is 300+ pages.)

Network_Service_Areas_Sept_2015.xls

Field #41: Referral Type

Usage Comment: Not applicable USHC claim or encounter data.

Value	Definition
(blank)	Not applicable
1	PCP treated
2	Provider associated with PCP treated
3	PCP-authorized service (referral)
4	Non-authorized service or provider type

Field #54: Servicing Provider Type

54_Servicing_Provider_Type_Descriptions.x

Field #55: Servicing Provider Specialty Code

Specialty_Codes_Sept_2015.xls

Field #56: Assignment of Benefits to Provider Code

Value	Definition
(blank)	Unknown/no payment
M	Member reimbursement
O	Pay other for claim
P	Payment to provider

Field #57: Participating Provider Code

Value	Definition
Y	Yes, participating provider under contract
N	No, not participating provider under contract
U	Unknown

Field #66: Major Diagnostic Category (MDC)

Value	Definition
00	Unclassifiable
01	Diseases and Disorders of the Nervous System
02	Diseases and Disorders of the Eye
03	Diseases and Disorders of the Ear, Nose and Throat
04	Diseases and Disorders of the Respiratory System
05	Diseases and Disorders of the Circulatory System
06	Diseases and Disorders of the Digestive System
07	Diseases and Disorders of the Hepatobiliary System and Pancreas
08	Diseases and Disorders of the Musculoskeletal System and Connective Tissue
09	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast
10	Endocrine, Nutritional and Metabolic Diseases and Disorders
11	Diseases and Disorders of the Kidney and Urinary Tract
12	Diseases and Disorders of the Male Reproductive System
13	Diseases and Disorders of the Female Reproductive System
14	Pregnancy, Childbirth and the Puerperium
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period
16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological
17	Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms
18	Infectious and Parasitic Diseases
19	Mental Diseases and Disorders
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders
21	Injuries, Poisonings and Toxic Effects of Drugs
22	Burns
23	Factors Influencing Health Status and Other Contacts with Health Services
24	Multiple Significant Trauma
25	Human Immunodeficiency Virus Infections

Field #70: Line-Level Procedure Code Type

Value	Definition
(blank)	Unknown/no payment
A	ASA-Anesthesia
B	BEN - Benefit Codes
C	CPT4- - Physician's Current Procedural Terminology
D	DME - Durable Medical Equipment
E	AETN - Aetna Homegrown Codes
F	CDT Dental Codes
G	MESU Maine Medicaid Codes
H	HCPCS - HCFA Common Procedure Coding System
I	ICD-9/ICD-10 - International Classification of Diseases & Procedures
M	MCS Dummy Code
N	NDC - National Drug Code
P	PHC - Prudential Homegrown
R	REV - Revenue
S	SPCD - Dental FOC Cap Codes
T	NJSU- NJ State Medicaid Referral Codes
U	USHC - US Healthcare Homegrown Codes
W	WASU - Washington State Unique - Medicaid only
X	Unknown
Y	NYLC - NYLCare Homegrown Codes

Field #74: Type of Service

74_Type_of_Service_Descriptions.xls

Field #75: Service Benefit Code

75_Serv_Ben_Code.xls

Field #77: Place of Service

Aetna Code	Definition	Corresponding HCFA Codes/Descriptions
E	Emergency Room	23 - Emergency Room
I	Inpatient hospital	21 - Inpatient
C	Clinic	20 - Urgent Care Facility
F	Office	11 - Office
H	Home	12 - Home
O	Outpatient	22 - Outpatient
S	Short Procedure Unit	24 - Ambulatory Surgical Center
U	Unknown	99 - Other

Field #78: UB92 Patient/Discharge Status

78_Disch_Status.xls

Field #79: UB92 Revenue Center

79_Revenue_Code.xls

Field #80: UB92 Bill Type

80_Bill_Type.xls

Field #'s 88-90: Action or Reason Code (1, 2, or 3)

88_90_Action_Code_Descriptions.xls

Field #108: Medicare Code

Value	Definition
(blank)	Not applicable
0	Under 65, No Medicare - Aetna primary
1	Medicare Part A only - Medicare primary
2	Medicare Part B only - Medicare primary
3	Medicare Parts A & B - Medicare primary
4	Over 65, No Medicare - Aetna primary
5	Active Employee Over 65 - Aetna primary

Field #109: Type of Expense – COB

Usage Comment: To properly identify COB with Aetna as Primary on ACAS claims (Field #7, Source System Platform = '27'), please use both this field as the subsequent field #110 (COB Code) and the below table.

COB-Info-for-Universa
l-medical-dental-files-

Field #110: COB Code
Usage Notes:
ACAS records (i.e., records where Field #7, Source System Platform = '27'): Use above table and both Fields #109 and #110 to determine COB.

HMO Encounters (Field #7, Source System Platform = '04'): Does not apply.

Non-ACAS Claims (Field #7, Source System Platform = '03'):

Value	Definition
(blank)	no COB
1	Other Carrier Primary

Field #113: Status of Claim

Value	Definition
D	***Denied**
E	Maybe Denied
M	Miscellaneous
N	Partially Pended
O	Other
P	Paid
R	Recorded Encounter (do not use these records for audits)

***Note:** For inpatient facility claims processed on ACAS (Source System Platform = '27'), the financials for multiple expense lines may be "rolled up" to the first room and board and/or ancillary expense line (i.e., all of the covered and paid dollars for that claim will be shown on the first expense line).

The remaining expense lines (usually ancillary records) will show a Status of Claim value of 'D' but they were not technically denied. The 'D' in such cases is only used to denote that none of the paid dollars for the claim will be found on the expense-lines carrying the 'D" value for Status of Claim.

If the purpose of the reporting is to review all records associated with a facility claim, then records with a Status of Claim value of 'D' should not be excluded.

Field #120: Aexcel Benefit Tier Code (you will find additional information about this field, immediately following the definitions listed below).

Value	Definition
01	Aexcel Disincentive In-Network Tier 1
02	Aexcel Disincentive Out of Network
03	Aexcel Plus Disincentive In-Network Tier 1
04	Aexcel Plus Disincentive In-Network Tier 2
05	Aexcel Plus Disincentive Out of Network
06	Aexcel Plus Combo In-Network Tier 1
07	Aexcel Plus Combo In-Network Tier 2
08	Aexcel Plus Combo In-Network Tier 3
09	Aexcel Plus Combo Out of Network
10	Aexcel Incentive In-Network Tier 1
11	Aexcel Incentive In-Network Tier 2
12	Aexcel Incentive Out of Network
13	Aexcel Plus Incentive In-Network Tier 1
14	Aexcel Plus Incentive In-Network Tier 2
15	Aexcel Plus Incentive Out of Network
U	Unknown

Additional Information about Aexcel Benefit Tier Codes

The following information is intended to supplement the values and definitions for the Benefit Tier Code by providing additional background and context.

Background
Aetna has created an "Aexcel" network of specialist providers, who have specialties in one or more of 12 selected specialty categories, and who qualified as "designated" Aexcel providers based on a combination of performance factors, including case volume, clinical performance, and efficiency. Specialist providers who have met the Aexcel criteria and are participating in the Aexcel network are referred to as "designated" providers.

Incentives/Disincentives/Combo = Steerage
As is typical of network-based benefit plans, the fundamental basis underlying Aexcel and Aexcel Plus plan designs is steerage of members to network physicians.

In the Aexcel and Aexcel Plus product designs, the usual concept of in-network is enhanced to encourage steerage to physicians who, in addition to being in-network, have also have met the criteria to be "designated" as Aexcel specialist providers. For more details as to how this is designed to work, read on.

Classification of Providers in Aexcel/Aexcel Plus
There is a 4-level classification strata for physicians under Aexcel/Aexcel Plus. Knowledge of these 4 classifications is essential to understanding the different Aexcel models and benefit tiers, and how the appropriate benefit level is determined when claims are adjudicated. The 4 types are:

(1) "Aexcel-designated providers": PAR providers who have a specialty in one or more of the 12 Aexcel specialty categories and have met Aexcel performance criteria,

(2) "Aexcel Non-designated providers": PAR providers who have a specialty in one or more of the 12 Aexcel specialty categories, and have not met Aexcel performance criteria,

(3) "All Other PAR Providers": PAR providers who do not have a specialty in one or more of the 12 Aexcel specialty categories.

(4) Non-PAR providers

Aexcel Models: Disincentive and Incentive
Steerage mechanisms for Aexcel plans include an "incentive" model and a "disincentive" model.

In the "disincentive" Aexcel model, there is only one tier (benefit level) of in-network benefits, applied equally to all PAR providers whether they are Aexcel-designated or not (provider classifications 1, 2, and 3, above).

In the "incentive" Aexcel model, there are two tiers of in-network benefits:

1. The normal in-network benefit for non-designated PAR providers (provider classifications 2 and 3, above)

2. A higher in-network benefit for PAR providers who are also Aexcel-designated specialist (provider classification 1)

And of course, the out-of-network benefit applies to all Non-PAR providers (provider classification 4).

Aexcel Plus Models: Disincentive, Incentive, and Incentive/Disincentive ("Combo")

Additional Information about Aexcel Benefit Tier Codes (continued)
Steerage mechanisms for Aexcel Plus plans include an "incentive" model, a "disincentive" model, and an "incentive/disincentive" model (also called a "combo").

In the "disincentive" Aexcel Plus model, there are two tiers of in-network benefits:

The highest level of in-network benefit is applied to Aexcel-designated specialists and all other PAR providers except for non-Aexcel-designated providers (provider classifications 1 and 3, above).

The second tier of in-network benefit applies providers who are PAR but are non-Aexcel-designated (provider classification 2, above).

And of course, the out-of-network benefit applies to all Non-PAR providers (provider classification 4).

In the "incentive" Aexcel Plus model, there are again two tiers of in-network benefits:

The highest level of in-network benefit is applied only to Aexcel-designated specialists (provider Classification 1).

The second tier of in-network benefit applies to both Aexcel non-designated providers and PAR/All Other providers (provider classifications 2 and 3).

And of course, the out-of-network benefit applies to all Non-PAR providers (provider classification 4).

In the "incentive/disincentive" or "combo" Aexcel Plus model, there are three tiers of in-network benefits:

The highest level of in-network benefit is applied only to Aexcel-designated specialists (provider classification 1).

The second tier of in-network benefit applies to PAR/All Other providers (provider classification 3) but not to Aexcel non-designated providers (provider classification 2).

The third tier of in-network benefit applies to Aexcel non-designated providers (provider classification 2).

And of course, the out-of-network benefit applies to all Non-PAR providers (provider classification 4).

Another way to illustrate these distinctions, that might provide a handier, at-a-glance reference, is the following:

Here's a graphic representation of the alignment between the above factors and the in-network benefit tier level, using the four provider categories described above (in the second bullet-point under 'Benefit Tiers') :

Aexcel Disincentive:
One tier only of in-network benefit: applies to designated providers and to all other PAR providers except for non-designated providers.

Out-of-network benefit to Non-PAR providers and to providers who are PAR, but do not meet Aexcel's designation criteria.

Aexcel Incentive
Two tiers of in-network benefits
Tier 1 in-network benefit is paid for Designated providers
Tier 2 in-network benefit is paid for PAR/All Other providers
Out-of-network benefit to Non-PAR and non-designated providers

Additional Information about Aexcel Benefit Tier Codes (continued)

Aexcel Plus Disincentive
Two tiers of in-network benefit:
Tier 1 for Designated providers and PAR/All Other providers
Tier 2 for Non-designated providers
Out-of-network benefit to non-PAR providers

Aexcel Plus Incentive
Two tiers of in-network benefit:
Tier 1 for Aexcel-designated providers
Tier 2 for Aexcel non-designated providers and all other PAR providers
Out-of-network benefit to all non-PAR providers

Aexcel plus Disincentive/Incentive (aka 'combo')
Three tiers of in-network benefit:
Tier 1 for Aexcel-designated providers
Tier 2 for PAR/All other providers, except for non-designated providers (PAR, but do not meet Aexcel's designation criteria).
Tier 3 for non-designated providers
Out-of-network benefit to non-PAR providers

Field #121: Aexcel Designated Provider Specialty

Value	Definition
NA	Aexcel Not Applicable
XCAR	Aexcel Cardiology
XCTS	Aexcel Cardio Thoracic Surgery
XGST	Aexcel Gastroenterology
XNEL	Aexcel Neurology
XNPH	Aexcel Nephrology
XNSR	Aexcel Neurosurgery
XOBG	Aexcel Obstetrics-Gynecology
XORT	Aexcel Orthopedics
XOTL	Aexcel Otolaryngology
XPLS	Aexcel Plastic Surgery
XSUR	Aexcel Surgery
XURO	Aexcel Urology
XVAS	Aexcel Vascular Surgery

Field #124: Servicing Provider Class Code

Value	Definition
AEX	Aexcel
BUS	Business
GRP	Group
HCO	HAI Clinical Office
HOS	Hospital
IND	Individual
NA	Non Applicable
RX	Pharmacy
U	Unknown

Field #131 Pricing Method Code

Value	Definition
1	Paid as Claim Level Case Rate or Per Diem
3	Paid as Claim Level PERBIL with service Grouper paid as ER
4	Paid as Claim Level PERBIL with service Grouper paid as Service Code
5	Paid as Claim Level PERBIL with service Grouper paid as DRG
6	Paid as Claim Level DRGWT (Drug Weightage) with DEFAULT Drug
A	Paid as contracted benefit, flat rate
B	Paid as contracted benefit, pct of billed
C	Paid as contracted benefit, pct of REF
D	Paid as contracted per diem, flat rate
E	Paid as contracted per diem, daily rate
F	Paid as contracted procedure, flat rate
G	Paid as contracted procedure, pct of billed
H	Paid as contracted procedure, pct of REF
I	Paid as contracted diagnosis
J	Paid as contracted DRG
K	Paid by DRG, non-contract
L	Paid as billed
M	Physician, office visit
N	Physician, non-office visit
O	Other
P	Paid as billed, but contracted (billed < contract) - effective 6/7/93
Q	Contracted Modifier, any method
R	Contracted Category, any method including Service Code method C
S	Service Code, method: P
T	Benefit Default M (% of Medicare)
U	Service Code M (% of Medicare)
V	Contracted DRG B
W	Contracted DRG E
X	Contracted DRG U
Z	Other contracted
(blank)	Unknown/No Payment

Field #133 Servicing Provider Specialty Category Code

133_Provider_Specialty_Category_Code_De

Field #139 HCFA Place of Service Code

HCFA_Place_Of_Service.xls

Field #140 HCFA Admit Source Code

Field #141 HCFA Admit Type Code

Field #176: Exchange Identifier

Value	Exchange Name/Description
011944131	Mercer Marketplace
014402321	Liazon National Multi-Carrier Exchange
015283640	USAA Health Insurance Marketplace
024410320	Aetna Marketplace
029677131	RightOpt
035607669	Aetna Marketplace for Sam's Club
041538497	Aon Active Health Exchange
062465695	Towers Watson OneExchange
079211305	Aon Retiree Health Exchange
087033646	Costco
999999999	Off Exchange (no participation in above exchanges at the time of claim)