Aetna Medicare Open[SM] Plan -- Provider Q&As

Overview

The Aetna Medicare Open Plan is a fully insured Private Fee-For-Service (PFFS) Medicare Advantage plan that offers all benefits that are covered under Original Medicare and more, such as unlimited hospitalization and full coverage for preventive services. This PFFS plan is available to employer groups for their retirees in all 50 states, and for individuals in certain markets.

General Aetna Medicare Open Plan Information

Is the Aetna Medicare Open Plan offered to both groups and individuals?
We offer the Aetna Medicare Open Plan to both individual and group members. While we maintain a national group service area in all counties and all 50 states, in addition to the District of Columbia, the individual service areas that are available are more limited. A spreadsheet posted on our website indicates all the Aetna Medicare Open Plan individual counties and their service areas.

Does the Aetna Medicare Open Plan include a Medicare Part D drug plan?
Many of the Aetna Medicare Open Plans include a Medicare Prescription Drug Plan.

If a Medicare group plan had a lifetime maximum benefit (for example, $1 million) is that carried over to the PFFS Medicare plan?
No. Medicare Advantage plans, including the Aetna Medicare Open Plan, do not include a lifetime maximum benefit restriction.

Who notifies the previous Medicare Advantage Organization if the member moves to the PFFS plan with Aetna?
Our PFFS plan is filed with CMS as a Medicare Advantage (MA) product, therefore we follow all CMS Medicare Advantage enrollment and disenrollment processing guidelines. If a Medicare beneficiary who is currently enrolled in a MA plan offered by another MA plan carrier decides to join Aetna's PFFS plan, Aetna must send the new enrollee an acknowledgement upon receipt of his/her enrollment form and a confirmation letter when CMS approves his/her enrollment. In addition, CMS will transmit a disenrollment transaction to the former MA plan and they are required to advise the individual in writing that they have been disenrolled as a result of joining another MA plan and the effective date of disenrollment. This process applies to both individuals and group members enrolled in MA plans.

How should providers handle member cost share for "dual eligible" Medicare/Medicaid members?

A "dual eligible" is an individual who qualifies for both Medicare and Medicaid. Medicaid will help pay for medical costs for people with limited income and resources. Individuals enrolled in the Aetna Medicare Open Plan who've been deemed "dual eligible status" may qualify to have their Aetna Medicare Open Plan cost sharing paid by their state Medicaid program. Most, but not all, state Medicaid programs consider the provider paid in full for a

dual eligible individual if the provider has been paid at least as much as allowed under the state Medicaid program. If the provider is contracted with the state Medicaid program, they cannot legally collect the Aetna Medicare Open Plan copays from the dual eligible member, but are allowed to balance bill the state Medicaid program for this amount. As long as the Aetna Medicare Open Plan copay is less than the Original Medicare cost share and the dual eligible member qualifies to have their Medicare cost sharing covered by their state Medicaid benefits, the provider cannot collect the Aetna Medicare Open Plan copays from the member.

Will the frequency guidelines that apply under Original Medicare apply to the Aetna Medicare Open Plan?
Aetna will follow Original Medicare frequency guidelines where they are established. The Aetna Medicare Open Plan also provides coverage for some preventive services that Medicare does not cover.

What preventative services are covered at 100 percent* under the Aetna Medicare Open Plan?
Currently, the following preventative services are covered at 100 percent under most Aetna Medicare Open Plans:

- Bone mass
- Colorectal screening
- Flu immunization
- Hepatitis B immunization
- Mammogram
- Pap smear
- Pelvic exam
- Pneumonia immunization
- PSA
- Routine hearing exam
- Routine physical exam

At this time, all of the preventative services listed above are covered at 100 percent (with no member cost-sharing applied) under the Aetna Medicare Open Plan, with the exception noted below.

*Beginning January 1, 2009, Aetna may not cover all of the preventative services listed above at 100 percent with respect to all Aetna PFFS plans. Some plan sponsors may elect to require copayments or coinsurance for some of these preventative services, and, under these circumstances, Aetna would not cover those preventative services at 100 percent.

Please review our Reimbursement Grid and our $0 copayment information related to preventive services posted on our websites at:
http://www.aetna.com/members/medicare/data/MedicarewZeroCopay.pdf

Does the PFFS plan cover behavioral health services?
Yes, as described in the member's Evidence of Coverage.

Provider Information Regarding Accepting PFFS

What are the benefits to a provider for accepting the Aetna Medicare Open Plan ("Plan")?

- No contracts required –Aetna has decided to offer a non-network PFFS plan, so there are no contracts to sign before providing covered services to Plan members. Licensed providers who are eligible to receive payment under Original Medicare. , who agree to provide covered service to Plan members, and have reasonable access to the Aetna Medicare Open Plan's Terms and Conditions of Participation ("Terms and Conditions") are considered participating in the Aetna Medicare Open Plan and are referred to as "Deemed Providers." **Please refer to the Terms and Conditions for more information.**
- Medicare allowable rates paid for covered services rendered by Deemed Providers participating in the Aetna Medicare Open Plan.
- Ease of administration – precertification is encouraged but not required.
- Simplified billing – one bill, one remittance. We pay claims for covered services directly to providers, in contrast to Original Medicare, which requires that providers wait for intermediaries, carriers and supplemental plans to administer their claims.
- Lower out-of-pocket member cost share, compared to Original Medicare.
- More covered benefits offered under Aetna Medicare Open Plan than under Original Medicare.
- Increased emphasis on disease and case management versus concurrent review.

What qualifications must a health care provider have to be eligible to deliver services to Medicare beneficiaries enrolled in the Aetna Medicare Open Plan?

Aetna Medicare Open Plan members may receive covered health plan services from any provider who is eligible to receive payment under Original Medicare, and willing to render services to a PFFS member. Physicians and facilities must be state licensed and have a Medicare billing number or be eligible to obtain one. Institutional providers treating PFFS members, such as hospitals and skilled nursing facilities, must be Medicare certified. Aetna does not credential providers with respect to the Aetna Medicare Open Plan, because this is a non-network based Medicare Advantage PFFS product.

What if a provider has been sanctioned or opted out of Original Medicare?

Aetna PFFS members cannot receive items or services from providers that have been sanctioned or opted out of Original Medicare, and these providers may not treat PFFS members.

What are the Terms and Conditions of Participation in the Aetna Medicare Open Plan?

The Terms and Conditions of Participation in the Aetna Medicare Open Plan establish the rules providers must follow when they choose to render services to a member of our PFFS plan. At a minimum, the Terms and Conditions include guidance on:

- The payment Aetna will make to a provider for services covered under our PFFS plan.
- Aetna Medicare Open Plan provider billing procedures.
- The amount the provider is permitted to bill and collect from a PFFS member.
- Aetna Medicare provider appeal procedures.

The Centers for Medicare & Medicaid Services (CMS) requires Aetna to make its Terms and Conditions of Participation reasonably available to providers located in the United States from whom our PFFS members may receive covered items and/or services. Aetna has

posted its Terms and Conditions on our website at www.aetna.com. In addition, we make them available upon written or telephone request. Physicians and other health care professionals should call our Provider Service Center at 1-800-624-0756 to obtain printed copies of the Terms and Conditions if they do not have access to the Internet.

How will providers know when the Aetna Terms and Conditions of Participation are changed?

Generally, Aetna will only make changes to the Aetna Terms and Conditions of Participation on a quarterly basis, unless we determine that we must immediately change the Terms and Conditions to ensure compliance with Medicare laws, rules or regulations or CMS instructions, or to ensure the clarity and accuracy of requirements described in the Terms and Conditions. Content changes made by Aetna to the Terms and Conditions will be submitted to CMS for review prior to posting on Aetna's website at www.aetna.com.

Providers may also obtain copies of the Terms and Conditions and information regarding the Terms and Conditions by calling our Provider Service Center telephone number at 1-800-624-0756. Aetna will provide copies of the Terms and Conditions and provide information regarding the Terms and Conditions by phone, mail or by fax, as requested by the provider. Providers are responsible for understanding Aetna's Terms and Conditions.

How does a provider know that a member is enrolled in the Aetna Medicare Open plan?

In most cases, an Aetna Medicare Open Plan member will inform a provider before obtaining a service that he/she is enrolled in a PFFS plan. The member will have an Aetna Medicare Open Plan ID card that will indicate that he or she is a PFFS plan member and include a web address and a phone number that providers can use to obtain the Aetna Medicare Open Plan Terms and Conditions of Participation.

What does it mean for a provider to be "deemed" by a PFFS organization?

A provider becomes "deemed" as participating in the Aetna Medicare Open Plan if the following conditions are met:

a) the provider knows that the patient is enrolled in the Aetna Medicare Open Plan prior to rendering services; and

b) the provider was informed of or has a reasonable opportunity to obtain the Plan's Terms and Conditions of Participation; and

c) the provider renders items or services that are covered under the Aetna Medicare Open Plan.

A provider is not required to render services to members of a PFFS plan or accept Aetna's Terms and Conditions of Participation. However, when a provider chooses to furnish services to a PFFS member and the deeming conditions are met, the provider is automatically considered a deemed provider (for that member) and must follow the PFFS plan's Terms and Conditions of Participation. If a provider chooses not to be deemed and not to accept Aetna's Terms and Conditions, that provider must not provide services to the Plan member, except when emergency or urgently needed services are required.

What is a non-contracted provider under the Aetna Medicare Open Plan?

If a provider furnishes a service to a PFFS member but the deeming requirements are not met, that provider will be considered a **non-contracted provider** under the Aetna Medicare Open Plan for that member and for that service. A provider may be a non-contracted

provider in an emergency or urgent situation where the provider cannot communicate with the patient before furnishing care, or in certain situations where the member does not inform the provider of his/her enrollment in the Aetna Medicare Open Plan.

Can a carrier or intermediary furnish providers with more information about the Aetna Medicare Open Plan?
No. To obtain information about the Aetna Medicare Open Plan, a provider must visit the Aetna website at www.aetna.com or contact our Provider Service Center at 1-800-624-0756.

General Reimbursement Information

Is a provider who accepts Medicare assignment required to accept Aetna Medicare Open Plan members?
No. Providers are not required to accept Aetna Medicare Open Plan members. However, if a provider furnishes care to an Aetna Medicare Open Plan member, and the deeming conditions have been met, the provider is bound by the Aetna Medicare Open Plan's Terms and Conditions of Participation (for that member).

As described more fully above, we believe that there are good reasons for providers to accept the Aetna Medicare Open Plan Terms and Conditions of Participation and participate in our PFFS plan, including more expeditious claims processing, simplified billing procedures and ease of overall plan administration.

If a deemed provider does not accept Medicare assignment and provides covered services to an Aetna Medicare Open Plan member, what will the provider be paid?
Aetna will reimburse the provider the Medicare allowable amount, and the provider can bill the member up to the Medicare limiting charge. Please refer to the Plan Terms and Conditions and Reimbursement Grid for further information regarding payments under the Aetna Medicare Open Plan.

How much will a non-contracted provider be paid?
A provider is a "non-contracted provider" if the provider does not know that an individual is a Plan member before furnishing services (e.g., in an emergency or urgent situation), or the provider does not have reasonable access to the Plan's Terms and Conditions of Participation. In these situations, the non-contracted provider is entitled to receive payment in the amount the provider would have received as payment in full for the covered service under Original Medicare. Specifically, the amount a non-contracted provider is allowed to collect from a Plan member in these situations, combined with the amount Aetna pays, cannot be less than what the non-contracted provider would have received for the covered service under Original Medicare. If a provider believes the payment received from Aetna for a covered service is less than the Medicare allowable charge, the provider may appeal to Aetna and request a reconsideration of the plan payment. Provider appeal procedures can be accessed at www.aetna.com.

If a non-contracted provider accepts Medicare assignment, the provider may only collect from Plan members the cost sharing amount allowed under the Aetna Medicare Open Plan. If the non-contracted provider does not accept Medicare assignment, the provider may balance bill the member up to the Medicare limiting charge. If a provider mistakenly collects

more from the member than the PFFS plan allows, then the provider must refund the difference to the member.

A provider will only be paid once as non-contracted provider for an Aetna Medicare Open Plan member. Once the non-contracted provider has been paid by Aetna, from that point forward, the provider will be aware of the individual's Plan membership and, therefore, will be considered a deemed provider for all future care for that member.

What happens if Aetna pays a deemed provider less than what the provider believes he/she is entitled to receive?
The total amount of payment that a deemed provider is entitled to receive under the Aetna Medicare Open Plan is based upon the Medicare allowable amount, and is described in the PFFS plan's Terms and Conditions of Participation and the Aetna Medicare Open Plan Reimbursement Grid. Aetna has posted the Aetna Medicare Open Plan and the Reimbursement Grid on our website at www.aetna.com. The provider is responsible for collecting any applicable cost sharing directly from the member at the point of service. Specific member cost sharing is included on the member's Aetna Medicare ID card or may be accessed through the Aetna website or by contacting our Provider Service Center at 1-800-624-0756.

What is an estimated Medicare payment amount?
Payment for covered items and services are based on the Medicare allowable fee schedule. Aetna has developed an Aetna Medicare Open Plan Reimbursement Grid that specifies the payment amount that deemed providers are entitled to receive for covered items and services. When Medicare lacks a fee schedule or prospective payment amount that can be readily used by Aetna, the provider will be paid an estimated Medicare payment amount for those services.

The Aetna Medicare Open Plan Reimbursement Grid will disclose whether the payment amount associated with a covered service will be an estimated Medicare payment amount. If the payment amount a provider receives from Aetna under the PFFS plan (including the member cost sharing collected) is less than the Medicare allowable fee schedule, or if the provider believes payment is less than what the provider should receive under Medicare, the provider can appeal the payment amount to Aetna. To appeal the payment amount, the provider must provide reasonable documentation to Aetna of the Original Medicare payment amount that applies to the service.

How long will it take the Aetna Medicare Open Plan to pay a provider for a covered service?
Aetna will follow the prompt pay requirements that apply to PFFS organizations under the Medicare Advantage ("MA) regulations. Currently, MA regulations require PFFS organizations to process clean claims (as defined in the Aetna Reimbursement Grid) within 30 calendar days of receipt by the PFFS Plan, and pay interest at the federal treasury rate on clean claims that are not processed within 30 calendar days of receipt.

What is your payment for Influenza and Pneumococcal vaccines?
Currently, claims for influenza and pneumococcal vaccines are paid at 100 percent of the CMS Average Sale Price (ASP) fee schedule for drugs and injectibles, as described in the Reimbursement Grid.

Do Aetna capitated programs apply to the Aetna Medicare Open Plan?
No. The Aetna Medicare Open Plan is a non-network based PFFS product, so any existing contracts between Aetna and providers do not apply with respect to the Aetna Medicare Open Plan, and any capitated reimbursement arrangements set forth in such provider contracts do not apply.

How should providers bill for pap and pelvic exams under the PFFS product? Should these services be billed separately?
Pap and pelvic exams do not need to be billed separately.

Where can providers find additional information regarding Medicare Advantage PFFS reimbursement policy?
Additional information can be located on the CMS website at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf

Doing Business with Aetna

Are we required to supply a provider's Medicare UPIN number on a claim until full implementation of NPI?
Yes. Providers must bill with both the Aetna PIN and the UPIN until the NPI process goes into effect.

How should providers handle deductibles and coinsurance?
Each of the Aetna Medicare Open Plans may impose different member cost sharing amounts. In almost all of the plans, the cost sharing amount is lower than Original Medicare. In each situation, providers should collect the applicable deductibles and/or coinsurance from patients enrolled in the Aetna Medicare Open Plan.

Are Clinical Laboratory Improvement Act (CLIA) and Mammography certificate numbers required on claims?
Yes

Do National Coverage Determination (NCD) and Local Coverage Determination (LCD) guidelines apply?
Yes

Precertification and Referral Information

Is precertification or referrals required for this product?
Precertification is encouraged but not required. We recommend precertification for certain services, including inpatient care, skilled nursing, home health and some DME. To precertify covered services on behalf of a PFFS member, the provider must call our Provider Service Center at 1-800-624-0756. Aetna Medicare Open Plan members are not required to select a PCP and there are no referrals required for these members.

General Claims/Billing Information

How does a provider bill Aetna for covered services provided under the Aetna

Medicare Open Plan?
Providers must send their claims for covered services to the address (or electronic address) provided in Aetna's Medicare Open Plan Terms and Conditions of Participation. This claims address is also provided below. All claims should be submitted to Aetna using the CMS 1500 or UB-92/UB-04 form.

Electronic payer ID: #60054
or
Aetna Life Insurance Company
P.O. Box 981107
El Paso, TX 79998-1107

Providers should collect any applicable member cost sharing at the time of service. Specific member cost sharing is included on the member's Aetna Medicare ID card or may be accessed through Aetna's website at www.aetna.com or by contacting our Provider Service Center at 1-800-624-0756. Original Medicare (intermediaries and carriers) will not accept claims for individuals enrolled in a Medicare Advantage PFFS plan; however, providers must continue to bill Medicare directly for hospice services.

If a provider bills Original Medicare for an Aetna Medicare Open Plan member, will the claims be denied?
Yes. If a claim for services provided to an Aetna Medicare Open Plan member is submitted to Original Medicare for payment, with the exception of hospice services, it will be rejected by the carrier or intermediary. Providers must bill Aetna for all claims in accordance with the plan's Terms and Conditions of Participation. Claims for covered services may be submitted to the Aetna address indicated above using the standard CMS 1500 or UB-92 form. Providers should continue to bill Medicare directly for hospice services.

What about procedure codes that are not on the Original Medicare fee schedule?
Not all service codes used under the Aetna Medicare Open Plan are affiliated with a Medicare fee schedule. We encourage providers to use codes associated with the Original Medicare fee schedule wherever possible to help facilitate timely claims processing. There are certain procedures that will be covered under the Aetna Medicare Open Plan for which no Medicare allowable rate exists. These services may include preventive care, such as annual physicals and routine eye care.

What if Local Coverage Determinations (LCDs) differ from Aetna's policies?
By law, a Medicare Advantage plan, including the Aetna Medicare Open Plan, must provide members with at least the same benefits they are entitled to receive under Original Medicare. Aetna will follow all Original Medicare Local Coverage Determinations applicable to covered services. If the local-level policies differ from Aetna's clinical policies, the Medicare LCDs will prevail. All LCDs are based on the location of the treating provider.

How will claims be processed under the Aetna Medicare Open Plan?
Claims will be processed in accordance with Original Medicare billing rules, the Medicare Fee Schedule, and all prospective payment system requirements and Local Coverage Determinations (LCDs). With respect to Bundling/Unbundling Logic, Aetna will use Correct Coding Initiative (CCI). The link to CCI on the CMS website is:
http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp

Can a provider bill a PFFS Plan member if the services that are rendered are not covered under the Aetna Medicare Open Plan?
If a Plan member has agreed in advance in writing to receive non-covered services from a provider, the provider may collect payment for these non-covered services from the member. For example, if the Aetna Medicare Open Plan does not cover hearing aids, but a Plan member agrees in writing to receive a hearing aid from a provider, the provider may collect payment for the hearing aid from the member. Neither Aetna nor Medicare will pay for non-covered services.

Hospital and other Facility Information

How will hospitals be reimbursed for covered services under the Aetna Medicare Open Plan?
Acute Care Hospitals that are deemed providers and render covered services to Aetna Medicare Open Plan members will be reimbursed in accordance with Medicare's Inpatient Prospective Payment System (IPPS) (i.e., DRG, etc.).

Does Aetna's PFFS plan reimburse for Capital & Operating Indirect Medical Education (IME), Graduate Medical Education (GME) and disproportionate share specific to our facility?
Aetna does not include Operating Indirect Medical Education (IME) or Graduate Medical Education (GME) in the Inpatient Prospective Payment System (IPPS) payment for acute care hospitals. Per 42 CFR Section 422.216(a)(4), these amounts must be paid by the Fiscal Intermediary for Medicare Advantage members. Capital IME and disproportionate share are included in the Aetna payment.

Does Aetna perform a "Year End Settlement" for facilities/hospitals?
Aetna does not cost settle with providers for the Aetna Medicare Open Plan.

Bad Debt Allowance
Aetna does not reimburse for bad debt as the benefits offered by Aetna are richer than Original Medicare and generally result in a lower out of pocket expense for Aetna members.

How does Aetna handle reimbursement for post-acute care transfers?
Post-acute care transfers are a qualified discharge from one of the CMS defined Diagnosis-Related Groups (DRG)s to a post-acute care provider, which will be treated as a transfer case and reimbursed based on the per diem methodology.

How does Aetna handle reimbursement for in-patient outliers?
With respect to in-patient outliers, Aetna follows the CMS guidelines for including additional payment for both length of stay and cost outliers.

Rural Health Care Centers (RHC), Federally Qualified Health Centers (FQHC) and Physician Shortage Areas

How are Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) reimbursed under Aetna's Medicare Open Plan?

Aetna will follow the established guidelines for reimbursing each of these facility types using the interim rate published in the Fiscal Intermediary (FI) Interim Rate letter as a basis for payment of RHC/FQHC designated services. CMS has published a formula that pays 80% of the interim rate, subject to a national limit for freestanding RHCs, plus 20% of billed charges, as described in our Reimbursement Grid.

Non-RHC/FQHC designated services are paid in accordance with the applicable Medicare fee schedule, as described in our Reimbursement Grid.

How are rate changes for Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) addressed and when?
When an RHC/FQHC receives an updated Fiscal Intermediary Interim Rate Letter, they should contact our Provider Service Center at 1-800-624-0756 and submit the updated letter to be loaded and used for future claims payments.

How does the plan address Rural Health Care (RHC) services provided by PA/NP/CNM?
Claims for RHC services from PA/NP/CNM are paid using the current all inclusive rate from the Interim Rate Letter.

How does Aetna handle the Medicare Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) bonus payments?
This bonus payment is paid by Aetna for eligible providers on either a quarterly or semi-annual basis. Payments are made in accordance with the CMS guidelines, which can be accessed on the CMS website at the following address:
http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/01_overview.asp

Physical/Occupational/Speech Therapy

Does the Aetna Medicare Open Plan apply the Physical/Occupational/Speech Therapy cap that applies under Original Medicare? If so, will the Aetna Medicare Open Plan follow the Therapy cap processes and require specific diagnosis codes in order to exceed the Therapy cap?
The Aetna Medicare Open Plan does not apply the Physical/Occupational/Speech Therapy caps that are applied under Original Medicare; therefore, the Aetna Medicare Open Plan does not follow the Therapy cap processes or require the specific diagnoses codes necessary to exceed the Therapy cap.

Skilled Nursing Facilities

What is the member coinsurance for covered services received from skilled nursing facilities?
Each of the Aetna Medicare Open Plans establishes its own coinsurance and copays amounts. The amounts will be listed on the ID card if there is a specific copay for the type of service. We have attempted to limit our plans so there are not too many differences.

Home Health Care / Home Infusion / Hospice

What data should be included in a Home Health Care claim?
Providers should bill Aetna for PFFS as they would bill Original Medicare under the Home Health Prospective Payment System (HHPPS).

Does Aetna require submission of OASIS data?
No. Please do not submit OASIS data to Aetna.

Are you set up to receive claims submitted electronically in Home Health Resource Group (HHRG) format?
Yes.

Will paper claims be accepted from home health care agencies?
Yes, paper claims will be accepted.

What will the Explanation of Benefits look like?
The EOB has not changed, however, the plan name will be clearly listed as Aetna Medicare Open Plan for claim details related to these members.

How is Aetna addressing Home Infusion Therapy for PFFS members?
Original Medicare does not cover skilled nursing services associated with home infusion therapy, so the Aetna Medicare Open Plan also does not cover these services. However, some group plan sponsors may offer home infusion therapy as an enhanced benefit under the Aetna Medicare Open Plan, so providers should contact the Aetna Provider Service Center to verify coverage prior to rendering this service.

Where should providers send claims for hospice services?
Providers should continue to bill Medicare directly for hospice services for most of Aetna's Medicare Advantage Plans. Aetna has started offering a Part B only PFFS plan that includes Hospice services as of 1/1/08. All other claims for covered services provided to Aetna Medicare Open Plan members should be submitted to Aetna using the standard CMS 1500 or UB-04 form.

Durable Medical Equipment

Is the use of the Advanced Beneficiary Notification (ABN) required?
Yes.

If so, should the related modifiers also be billed?
Yes.

Do you require that DME (Durable Medical Equipment) providers be Medicare participating to be eligible to render covered services to an Aetna Medicare Open Plan member?
Yes.

Do you require that "deemed" DME providers include the Medicare DME supplier number on the claim?
Yes.