

## Aetna Medicare Open<sup>SM</sup> Plan (Private Fee-for-Service) Reimbursement Grid

The Aetna Medicare Open Plan Reimbursement Grid describes how Aetna will calculate payment to deemed providers for clean claims submitted to Aetna for items and services that are covered under the Aetna Medicare Open Plan and rendered to Aetna Medicare Open Plan members.

Effective January 1, 2010

Service Category	Service Sub-category or Payment Component	Payment Methodology
Acute Care Hospital	<u>Inpatient Services</u>	Payments for covered inpatient services are based upon the Acute Hospital Inpatient Prospective Payment System (IPPS), and includes payments for capital, Disproportionate Share Hospital (DSH), capital Indirect Medical Education (IME), clotting factors, member organ acquisition and other pass-through payments as applicable under the payment methodology described in this Reimbursement Grid. Operating IME and Direct Graduate Medical Education (DGME) costs are fully carved out of the diagnosis related group (DRG) payment, and will not be paid by Aetna, per 42 CFR Section 422.216(a)(4). Maryland hospitals are excluded from IPPS, and are not entitled to the payments described in this Reimbursement Grid; see section on Maryland hospitals below for further information. Payments for some pass-through items, such as capital for the first two years of a new hospital and cost based Nursing and Allied Health amounts, are paid via a per diem pass-through added to the base DRG price as long as the pass-through per diems are published by the Centers for Medicare and Medicaid Services (CMS) and the Fiscal Intermediary within the Inpatient Prospective Payment System Provider Specific File.
	<u>Inpatient Outliers</u>	Both cost and length of stay outliers are paid in accordance with CMS guidelines.
	<u>Inpatient Transfers (Acute to Acute)</u>	For most DRGs, the first hospital is paid a per diem rate equal to the DRG amount divided by

		the average length of stay for that DRG. However on the first day, twice the per diem is paid. A maximum of the full DRG is paid to the first hospital. The second hospital is paid the full DRG.
	<u>Inpatient Transfers (Acute to Post Acute)</u>	A qualified discharge to a post acute care provider will be treated as a transfer case and reimbursed using the same per diem payment methodology as the Acute to Acute transfers previously described
	<u>Outpatient Services</u>	Payments for covered outpatient hospital services are based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule. Hospitals exempt from OPPS include those in Maryland, Indian Health Service, and Critical Access Hospitals.
	<u>Outpatient Outliers</u>	When the cost of a hospital outpatient service exceeds 1.75 times the Ambulatory Payment Classification (APC) payment rate and the cost exceeds \$1,825 (for 2007) over the APC payment rate, the hospital will receive an outlier payment of 50% of the difference between 1.75 times the payment amount and the cost of furnishing the service.  Hospitals exempt from OPPS include those in Maryland, Indian Health Service, and Critical Access Hospitals.
<b>Acute Long Term Care (LTC)</b>	<u>Inpatient Services</u>	Long Term Care Hospitals are paid using the Long Term Care Prospective Payment System. There are outlier adjustments for certain short stays.
	<u>Outpatient Services</u>	Payments for covered outpatient hospital services are based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.  Hospitals exempt from OPPS include those in Maryland, Indian Health Service, and Critical Access Hospitals.
<b>Ambulance Independent and Provider Based</b>		<b>Prior to 1/1/06:</b> Covered services were paid on a blend of "reasonable charges" and a fee schedule. <b>On/after 1/1/06:</b> Covered services are paid at 100% of the ambulance fee schedule. Extra payments are made for ground transportation exceeding 50 miles, and for providers in certain rural areas.

<b>Anesthesia</b>	<u>Physician Performed</u>	Anesthesia services are paid using a system of base and time units. The base and time units are summed and multiplied by the anesthesia conversion factor.
	<u>Physician Medical Direction of 2, 3, or 4 CRNAs, AA, residents or interns concurrently</u>	Anesthesia services are paid using a system of base and time units. The base and time units are summed and multiplied by the anesthesia conversion factor. Payment rate is on the basis of 50% of the allowance for the service performed by the physician alone.
<b>Ambulatory Surgical Centers (ASC)</b>		Payments to ASCs are based upon the Medicare Ambulatory Surgical Center payment system. Effective January 1, 2008 payment is made at the lesser of billed charges or the Medicare ASC allowable amount.
<b>Assignment of Claims</b>	<u>Providers not accepting assignment of Medicare Claims</u>	<p>Providers that render covered services to Aetna Medicare Open Plan members and do not accept assignment and are eligible for payment up to the Medicare Limiting Charge, Aetna will pay at 95% of the current Medicare-approved (i.e., Medicare allowable) amount less any applicable member cost-sharing amounts. Providers that do not accept assignment may balance bill members up to the Medicare limiting charge for Medicare covered services (i.e., 15% over the Medicare-approved (i.e., Medicare allowable) amount, unless the state has established a different amount). If a Provider collects more from a member than the amounts permitted under these Terms and Conditions of Participation, the Provider must refund the difference to the member.</p> <p>However, some Group Plan Sponsors who offer the Aetna Medicare Open Plan option to their retirees may opt to pay the full Medicare Limiting Charge amount on behalf of their retirees.</p> <p>Durable Medical Equipment (DME) services are excluded from Medicare limiting charge rules.</p>
<b>Assistant at Surgery</b>	<u>Physicians</u>	For covered assistant at surgery services, the allowed amount is 16% of the amount for the global surgery under the Medicare fee schedule. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
	<u>Physician Assistant</u>	For covered assistant at surgery services, the allowed amount is 85% of the amount paid to a physician who serves as an assistant at surgery. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Bad Debt</b>		Aetna will reimburse eligible facilities for bad debt in accordance with CMS guidelines for

		services rendered July 1, 2008 or after. Please see program details in the Bad Debt Reference Guide on our website.
<b>Blood</b>		For hospital outpatient services, blood is reimbursed under the Outpatient Prospective Payment System (OPPS). For hospital inpatient services, all covered blood and blood processing expenses are included in the DRG payment.
<b>Cancer Hospitals</b>	<u>Inpatient Services</u>	Cancer Hospitals are excluded from IPPS. The Cancer Hospital must submit a copy of their most recent interim rate letter from their Medicare fiscal intermediary (FI). Aetna will make payment for covered inpatient services at 102% of the rate noted in the FI interim rate letter supplied by the Cancer Hospital.
	<u>Outpatient Services</u>	Payment for covered outpatient cancer hospital services are based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS will be reimbursed according to the applicable Medicare fee schedule. Transitional Outpatient Payments (TOPs) are also made to Cancer Hospitals for outpatient services.
<b>Children's Hospitals</b>	<u>Inpatient Services</u>	Children's hospitals are excluded from IPPS. Payment is made on a cost basis. Children's Hospitals will be requested to submit a copy of their recent interim rate letter from their Medicare fiscal intermediary (FI).
	<u>Outpatient Services</u>	Payment for covered outpatient hospital services is based upon the Outpatient Prospective Payment System (OPPS). Children's hospitals are held "harmless," under OPPS, meaning that they cannot be paid less in aggregate under OPPS than they were paid under the prior system. Services excluded from OPPS are reimbursed according to the applicable fee schedule.
<b>Clinical Nurse Specialist</b>		Payment for covered services at 85% of the Medicare Physician Fee Schedule amount. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Clinical Psychologist</b>		Payment for covered services at 100% of the Medicare Physician Fee Schedule amount. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Clinical Social Workers</b>		Payment for covered services at 75% of the Medicare Physician Fee Schedule amount. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.

H5736\_7F\_81011\_R1 (12/2009)

<b>Clinical Trial Services</b>		Payment for covered services provided to a Medicare Advantage enrollee enrolled in an eligible Clinical Trial is made by the applicable Original Medicare FFS contractor. These services are not the financial responsibility of the MA plan.
<b>Community Mental Health Centers</b>		Payment for covered outpatient services is based upon the Outpatient Prospective Payment System (OPPS).
<b>Comprehensive Outpatient Rehabilitation Facility (CORF)</b>		Payment for covered services will be based on the Medicare Physician Fee Schedule. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Co-Surgeons</b>		The Medicare Physician Fee Schedule amount applicable to the payment for each co-surgeon is 62.5% of the global surgery fee schedule amount. Team surgery (for example modifier 66) is paid for on a "by report" basis. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Critical Access Hospital (CAH)</b>		Critical Access Hospitals are excluded from the Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (OPPS). Payment is made on a reasonable cost basis, so Critical Access Hospitals must submit a copy of their most recent interim rate letter received from their Medicare fiscal intermediary (FI). Aetna will make payment for covered inpatient services at 102% of the inpatient rate noted in the FI interim rate letter supplied by the Critical Access Hospital, and will increase the percentage of billed charges for covered outpatient services by 2%.
<b>Diabetic Shoes</b>		Payment will be based on the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) fee schedule.
<b>Drugs</b>		Effective 1/1/05, payment is based on 106% of the "average sales price" (ASP) for most drugs. Exceptions include blood, drugs delivered through DME, influenza, pneumococcal and hepatitis B vaccines, and certain new drugs which are all still paid based on 95% Average Wholesale Price (AWP).

<b>Durable Medical Equipment (DME)</b>		<p>Payment based on 100% of the Medicare Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Fee Schedule.</p> <p>Payment is made at the lesser of billed charges or the Medicare Fee Schedule.</p>
<b>e.Prescribing Physician Bonus</b>		<p>PFFS plans are required to issue e.Prescribing bonus payments for PFFS plan members in accordance with CMS guidelines.</p> <p>Aetna will reimburse e.Prescribing bonus amounts in accordance with the timeframes established by CMS upon the publication of the final supporting data files for the specified e.Prescribing payment period.</p>
<b>End Stage Renal Disease (ESRD) Facility Independent and Hospital Based</b>		<p>Payment for ESRD services from independent and hospital-based ESRD facilities will be based upon the composite rate, with additional payments made to those facilities that have received an approved exception from their Fiscal Intermediary. In general, the composite rate is payment for the complete dialysis treatment, except for physicians' professional services, separately billable laboratory services, and separately billable drugs. Effective January 1, 2005, Epoetin Alfa (EPO) will be paid based on the Average Sales Price (ASP) Pricing File.</p>
<b>Federally Qualified Health Centers (FQHC) Independent and Provider Based</b>		<p>The 2010 National Rate Limit is \$125.72 for urban centers and \$108.81 for rural centers.</p> <p>The 2009 National Rate Limit is \$119.29 for urban centers and \$102.58 for rural centers. FQHCs are paid 80% of the Medicare allowed charge, plus 20% of the actual charge, minus the member's cost sharing amount. The FQHC must submit a copy of their most recent interim rate letter from their Medicare fiscal intermediary (FI) with their first claim.</p>
<b>Health Professional Shortage Area (HPSA)</b>		<p>Payment for covered services is based upon 100% of the Medicare Physician Fee Schedule for eligible health professionals. Eligible providers in a HPSA designated area are paid an additional 10% of the payment amount on a quarterly basis.</p>
<b>Hemophilia clotting factors</b>		<p>For inpatient care, payment is an add-on to the DRG rate, as noted in the Acute Care Hospital section. For outpatient services, payment is made according to the Outpatient Prospective Payment System (OPPS) guidelines.</p>
<b>Home Health Agencies Independent and</b>		<p>Payment is made based upon the Home Health Resource Group (HHRGs). Payments cover</p>

H5736\_7F\_81011\_R1 (12/2009)

<b>Provider Based</b>		episodes of care up to 60 days. Adjustments are made for shortened episodes and for outliers. DME paid in accordance with the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS).
<b>Home Infusion Therapy (HIT) Services</b>		<p>Skilled Nursing Services provided in conjunction with home infusion therapy services are generally not covered under the Aetna Medicare Open Plan. However, some Group Plan Sponsors who offer the Aetna Medicare Open Plan option to their retirees have elected to include coverage for these services as an enhanced benefit.</p> <p>If you provided home infusion therapy services to a group plan member, and these services are covered as an enhanced benefit under the member's group plan, please submit your bill for these services using the appropriate CPT4 or HCPCS codes. If covered as noted above, these services will be paid in accordance with the current Aetna Market Fee Schedule (AMFS).</p> <p>Covered Home Infusion Drugs are paid in accordance with the Average Sale Price (ASP) Medicare Fee Schedule with the exception of drugs dispensed from the outpatient department of a hospital, which are paid via OPSS or according to the FI Rate Letter for non-OPSS hospitals.</p> <p>Generally, only drugs covered under Part B are payable under the Aetna Medicare Open Plan. However, some Group Plan Sponsors offering the Aetna Medicare Open Plan to their retirees have elected to include coverage for the Part D drugs administered in conjunction with Home Infusion Therapy as an enhanced benefit. Please contact Aetna to verify member eligibility and confirm coverage of these services as an enhanced benefit.</p>
<b>Hospice (Applies to Part B-only PFFS plans)</b>	<u>Inpatient and Outpatient</u>	<p>The Medicare hospice payment rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(C)(ii) of the Social Security Act . Hospice daily rates are established for;</p> <ul style="list-style-type: none"> <li>▪ Routine Home Care</li> <li>▪ Continuous Home Care</li> <li>▪ Inpatient Respite Care</li> <li>▪ General Inpatient Care</li> </ul> <p>Each daily rate is calculated with a portion that is adjusted by the applicable wage index added to the remaining portion that is non-weighted.</p>

<b>Indian Health Service Facility (IHS)</b>	<u>Inpatient Services</u>	Payment for covered inpatient services is based upon the Inpatient Prospective Payment System (IPPS).
	<u>Outpatient Services</u>	Payment is based upon an all-inclusive rate. Excluded from the Outpatient Prospective Payment System (OPPS). Professional services are based upon the applicable fee schedule.
<b>Laboratory</b>		Payment is based upon 100% of the Medicare laboratory fee schedule. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Mammography Screening/Diagnostic</b>		Payment is based upon 100% of the Medicare Physician Fee Schedule amount. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Maryland Hospitals</b>		Maryland Hospitals are paid at rates set by the Health Services Cost Review Commission (HSCRC) in accordance with Medicare waiver. Discounts for Medicare Advantage, prompt payment and working capital are applied as appropriate.
<b>Medical Nutrition Therapy</b>		Payment is based upon 85% of the Medicare Physician Fee Schedule amount. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Nurse Practitioner</b>		Payment is based upon 85% of the Medicare Physician Fee Schedule amount. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Parenteral and Enteral Nutrition (PEN)</b>		Payment is based upon the PEN Fee Schedule. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Physical Therapy Occupational Therapy Speech Therapy</b>		Payment is based upon 100% of Medicare Physician Fee Schedule. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Physician</b>	<u>MD, DO, Chiropractor, Dentist, Optometrist, Oral and Maxillofacial Surgeon, Podiatrist</u>	Payment for covered services is based upon 100% of the Medicare Physician Fee Schedule for physicians who accept Medicare assignment.  Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Physician Assistant</b>		Payment is based upon 85% of the Medicare Physician Fee Schedule amount. Payment is made at the lesser of billed charges or the

H5736\_7F\_81011\_R1 (12/2009)

		Medicare Fee Schedule.
<b>Physician Quality Reporting Initiative (PQRI)</b>		<p>PFFS plans are required to issue PQRI bonus payments for PFFS plan members in accordance with CMS guidelines.</p> <p>Aetna will reimburse PQRI bonus amounts in accordance with the timeframes established by CMS upon the publication of the final supporting data files for the specified PQRI payment period.</p>
<b>Physician Scarcity Area (PSA)</b>		Payment for covered services is based upon 100% of the Medicare Physician Fee Schedule for eligible physicians. Eligible physicians in a PSA designated area are paid an additional 5% of the payment amount on a quarterly basis.
<b>Preventive Benefits**</b>		Preventive benefits** offered by Aetna at a \$0 member cost sharing.
	<u>Routine Physicals</u>	<p>Preventive benefits** offered by Aetna at a \$0 member cost sharing:</p> <ul style="list-style-type: none"> <li>▪ G0344 (welcome exam) that can be billed along with EKG codes G0366, G0367, G0368.</li> <li>▪ 99381-99397, 99401-99404</li> <li>▪ 99201–99205, 99211-99215 are considered to be preventive if the primary diagnosis code is one of the following: V03.0,-V03.9, V04.0-V04.89, V05.0-V05.9, V06.0-V06.9, V20.0-V20.2, V70.0, V70.3, V70.5</li> </ul>
	<u>Bone Mass Measurement</u>	<p>Preventive benefits** offered by Aetna at a \$0 member cost sharing:</p> <ul style="list-style-type: none"> <li>▪ 76977, 77078, 77079, 77080, 77081, 77083 and G0310 are considered to be preventive if the primary diagnosis code is one of the following: V70.0, V70.3, V70.5, V72.0, V72.3, V72.31 and V82.81</li> </ul>
	<u>Colorectal Screening</u>	<p>Preventive benefits** offered by Aetna at a \$0 member cost sharing:</p> <ul style="list-style-type: none"> <li>▪ G0104, G0105, G0106, G0120, G0121, G0122, G0394, S0605</li> <li>▪ 45378 – 45386, 45300 – 45320, 45330 – 45334, 45338 – 45340, 74270, 74280, 82270 are considered to be preventive if the primary diagnosis code is one of the following: V70.0, V70.3, V70.5, V76.41, V76.50, V76.51</li> </ul>
	<u>Prostate Cancer Screening</u>	<p>Preventive benefits** offered by Aetna at a \$0 member cost sharing:</p> <ul style="list-style-type: none"> <li>▪ G0102 and G0103 and 84152-84154 are</li> </ul>

		considered to be preventive if the primary diagnosis code is one of the following: V70.0, V70.3, V70.5, V76.44, V84.03
	<u>Hepatitis B Vaccine</u>	Preventive benefits** offered by Aetna at a \$0 member cost sharing:  <ul style="list-style-type: none"> <li>▪ 90740, 90746, 90747 and G0010</li> </ul>
	<u>Flu Immunization</u>	Preventive benefits** offered by Aetna at a \$0 member cost sharing:  <ul style="list-style-type: none"> <li>▪ 90655 – 90658, 90661 – 90663, and G0008</li> </ul>
	<u>Pneumonia Immunization</u>	Preventive benefits** offered by Aetna at a \$0 member cost sharing:  <ul style="list-style-type: none"> <li>▪ 90732, 90669, G0009, and S0195</li> </ul>
	<u>Routine GYN Exam</u>	Preventive benefits** offered by Aetna at a \$0 member cost sharing:  <ul style="list-style-type: none"> <li>▪ S0610, S0612, S0613, 99381-99397, 99401-99404, 99201–99205, and 99211-99215 are considered to be preventive if the primary diagnosis code is one of the following: V72.3, V72.31, V72.6, V76.2, V76.46, V76.47, V84.02, V84.04</li> </ul>
	<u>Screening Mammograms</u>	Preventive benefits** offered by Aetna at a \$0 member cost sharing:  <ul style="list-style-type: none"> <li>▪ G0202, 77052, and 77057</li> </ul>
	<u>Pap Smear – Preventive</u>	Preventive benefits** offered by Aetna at a \$0 member cost sharing:  <ul style="list-style-type: none"> <li>▪ G0101, G0123-G0124, G0141-G0148, P3000, P3001, Q0091, S0610, S0612, S0613, 88141-88155, 88164-88167, 88174-88175 are considered preventive if billed with: V72.3, V72.31, V72.6, V76.2, V76.46, V76.47, V84.02, V84.04</li> </ul>
	<u>Pelvic Exams</u>	Preventive benefits** offered by Aetna at a \$0 member cost sharing:  <ul style="list-style-type: none"> <li>▪ G0101</li> </ul>
	<u>Routine Hearing Exam</u>	Preventive benefits** offered by Aetna at a \$0 member cost sharing:  <ul style="list-style-type: none"> <li>▪ V5008 and 92551 – 92561, 92587 are considered to be preventive if the primary diagnosis code is one of the following: V03.0, -V03.9, V04.0-V04.89, V05.0-V05.9, V06.0-V06.9, V20.0-V20.2, V70.0, V70.3, V70.5, V72.1, V72.3, V72.31</li> </ul>

	<u>Routine Vision Exams</u>	Preventive benefits** offered by Aetna at a \$0 member cost sharing: <ul style="list-style-type: none"> <li>▪ S0620, S0621</li> <li>▪ 92002 – 92015 are considered to be preventive when billed with or without a non-routine diagnosis, as long as a member has not had a routine eye exam in the last 12 months.</li> </ul>
<b>Prosthetic Devices</b>		Payment based on 100% of the Medicare Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Fee Schedule. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Psychiatric Hospital</b>	<u>Inpatient Services</u>	Payments for covered inpatient psychiatric services are based upon the Inpatient Psychiatric Facility Prospective Payment System (IPFPPS).
	<u>Outpatient Services</u>	Payment for covered outpatient hospital services is based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.
<b>Registered Dietitian</b>		Payment is based upon 85% of the Medicare Physician Fee Schedule amount. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Rehabilitation Hospital</b>	<u>Inpatient Services</u>	Payment for covered inpatient services is based upon the Inpatient Rehabilitation Facility Prospective Payment System (IRFPPS).
	<u>Outpatient Services</u>	Payment for covered outpatient hospital services is based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.
<b>Religious Non-Medical Health Care Institutions (RNHCI)</b>		Payment for covered services is based upon a predetermined fixed amount per discharge. Payment to RNHCIs for DME items will be made based on the Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) fee schedule. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.  Payment to RNHCIs for nursing visits will be made at 80% of the national standard home health aide visit rate used under the Home Health Prospective Payment System (HHPPS).

<b>Rural Community Hospital (RCH) Demonstration Program</b>	Inpatient Services	Critical Access Hospitals are excluded from the Inpatient Prospective Payment System (IPPS). Payment is made on a reasonable cost basis, so hospitals participating in the RCH Demonstration Program must submit a copy of their most recent interim rate letter received from their Medicare fiscal intermediary (FI). Aetna will make payment for covered inpatient services at 102% of the inpatient rate noted in the FI interim rate letter supplied by the Rural Community Hospital.
	Outpatient Services	Payment for covered outpatient hospital services is based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.
<b>Rural Health Clinic (RHC) Independent and Provider Based</b>		The RHC limit for 2009 is \$76.84 and changes on a yearly basis. RHCs are paid 80% of the allowed charge, plus 20% of the actual charge, minus the member's cost sharing amount. The RHC must submit a copy of their most recent interim rate letter from their Medicare fiscal intermediary (FI) with their first claim.
<b>Skilled Nursing Facilities (SNF)</b>		<p>Payment for covered Skilled Nursing Facility (SNF) services will be based upon the Skilled Nursing Facility Prospective Payment System (SNFPPS). SNFs must bill with Health Insurance Prospective Payment System (HIPPS) Resource Utilization Group (RUG) codes just as they bill traditional Medicare.</p> <p>Some Group Plan Sponsors have elected to include enhanced benefit coverage beyond the CMS SNF limit of 100 days per benefit period. Please contact Aetna to verify member eligibility and confirm coverage of these services as an enhanced benefit. Billing for members enrolled in group plans offering this enhanced benefit coverage (greater than 100 days of skilled medically necessary care per benefit period) must follow SNF PPS and Consolidated Billing guidelines established for days 1 to 100.</p>
<b>Sole Community Hospitals and Low Volume Hospitals</b>	<u>Inpatient Services</u>	Sole Community Hospitals and Low Volume Hospitals are paid based on the Inpatient Prospective Payment System (IPPS).
	<u>Outpatient Services</u>	Payment for covered outpatient hospital services is based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.
<b>Surgical Dressings</b>		Payment for surgical dressings is based upon

H5736\_7F\_81011\_R1 (12/2009)

		the Medicare Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) fee schedule, except when applied "incident to" a physician's professional services, furnished by an HHA and those applied while a patient is being treated in an outpatient hospital department or as an acute care inpatient. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
<b>Swing Beds</b>		Payment for covered Swing Bed Facility services will be based upon the Skilled Nursing Facility Prospective Payment System (SNFPPS). Critical Access Hospital swing beds are exempt from PPS and are paid at 101% of reasonable costs.
<b>Veterans Affairs (VA) Hospitals</b>		A Medicare Advantage Organization (MAO) may not use Medicare funds to pay the VA Healthcare System for VA-covered services rendered to veterans who are also MAO enrollees. However, payment for emergency services rendered to non-veteran enrollees may be made to the VA facility.
<b>X-ray</b>		Payment based upon the lesser of billed charges or Medicare Fee Schedule or OPSS for hospitals.

\*\*Beginning January 1, 2009, Aetna may not cover all of the preventative services listed above at 100 percent with zero copayments with respect to all Aetna PFFS plans. Some plan sponsors offering Aetna PFFS plans 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 with a zero copayment. To verify eligibility, please visit our secure provider website via NaviNet<sup>®</sup>, click on "Plan Central," then "Aetna Health Plan" and then "Eligibility."

22.2.76  
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