PHYSICIAN'S GUIDE TO

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services

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Medicare Learning Network

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Introduction

If you are a physician who has patients with permanent kidney failure, this guide is for you. It tells you:

- How your patients get Medicare if their kidneys fail
- How Medicare helps to pay for kidney dialysis and kidney transplants
- Where to get help

This guide explains how Medicare helps pay for kidney dialysis and kidney transplant services in the Original Medicare Plan, also known as "fee-for-service." If patients are in a Medicare Advantage Plan, which includes Medicare Managed Care Plans, Medicare Private Fee-for-Service Plans, and Medicare Preferred Provider Organization Plans, their plans must give them at least the same coverage as the Original Medicare Plan, but there may be different rules. The costs, rights, protections, and/or choices of where patients receive care may be different if they have one of these plans, and they may be eligible for extra benefits. Encourage patients to read their plan materials or call their benefits administrator for more information if they have questions.

A similar guide has been made available to patients; however, it does not include detailed information about kidney failure, dialysis treatments, or kidney transplants. To learn more about these topics, patients should talk not only with you, their doctor, but with their entire health care team—their nurse, social worker, dietician, and dialysis technician. Based on the situation, you and your patient can then select the best treatment options.

The Two Parts of Medicare

Medicare is a health insurance program for people age 65 and older, some people with disabilities under age 65, and most people with end-stage renal disease (ESRD) (permanent kidney failure that requires dialysis or a transplant, sometimes called ESRD).

The original two basic parts of Medicare are:

- **Part A (Hospital Insurance)**—Most people do not have to pay a monthly payment (premium) for Part A because they (or a spouse) paid Medicare taxes while they were working. Part A helps pay for:
  - Inpatient hospital care
  - Some skilled nursing facility care
  - Hospice care
  - Some home health care

- **Part B (Medical Insurance)**—Part B helps pay for the following covered services and supplies when they are medically necessary:
  - Doctors' services
  - Outpatient hospital care
  - Some other medical services that Part A does not cover (like some home health care)

Everyone must pay a monthly premium for Medicare Part B, and the calendar year 2008 Part B premium amounts are based on beneficiary income parameters as shown in the following table:

Premium/Month	Income Parameters for Determining Part B Premium	
	Individual Income	Combined Income (Married)
$ 96.40	$ 82,000.00 or less	$164,000.00 or less
$122.20	$ 82,000.01–$102,000.00	$164,000.01–$204,000.00
$160.90	$102,000.01–$153,000.00	$204,000.01–$306,000.00
$199.70	$153,000.01–$205,000.00	$306,000.01–$410,000.00
$238.40	$205,000.01 or more	$410,000.01 or more

Premium rates can change yearly, and this amount may be higher if a beneficiary does not sign up for Part B when he/she becomes eligible. The cost of Part B will increase by 10% for each 12-month period during which a beneficiary could have had Part B but did not sign up for it, and there will be a higher premium to pay for as long as that person has Part B. If someone is paying a higher premium because he/she did not sign up for Part B when first becoming eligible for Medicare, based on age or disability, the higher premium will be removed when he/she signs up for Part B based on ESRD.

Note: Medicare Part B will stop if the monthly premiums are not paid or if the beneficiary decides to cancel it.

In addition to Parts A and B, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) added a prescription drug program, also referred to as Part D. More discussion of this drug program is in Section 2 of this guide.

Medicare Health Plan Choices

Today's Medicare is about choice, and health plan choices include:

- The Original Medicare Plan (also known as fee-for-service) available nationwide.
- Medicare Advantage Plans including:
  - Medicare Managed Care Plans
  - Medicare Private Fee-for-Service Plans
  - Medicare Preferred Provider Organization Plans

A patient with ESRD (permanent kidney failure requiring dialysis or a kidney transplant) may not be able to join a Medicare Advantage Plan. People with ESRD who start dialysis and are already in a Medicare Advantage Plan can stay in their current plan or join another offered by the same company in the same state. Beneficiaries must pay the monthly Part B premium of $96.40 in 2008 or the appropriate 2008 amount based on income.

If a patient has had a successful kidney transplant, he/she may be able to join a plan. The patient can call 1-800-MEDICARE (1-800-633-4227) to find out more about ESRD and Medicare health plans.

If a patient has ESRD and is enrolled in a plan that leaves Medicare or no longer provides coverage in his/her area, he/she can join another Medicare Advantage Plan if one is available in his/her area. Medicare does not pay for everything, but there are some types of insurance that may pay some of the health care costs that Medicare does not cover (see Section 7).

For more information about Medicare health plan choices, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *Medicare & You* handbook. TTY users should call 1-877-486-2048. This handbook is also available online at ***http://www.medicare.gov*** on the Centers for Medicare & Medicaid Services (CMS) website. Under the "Search Tool" section, select "Find a Medicare Publication."

SECTION 1:

Medicare Basics

Medicare for People with Kidney Failure

Who Is Eligible?

Medicare beneficiaries can receive Medicare Part A benefits no matter how old they are if their kidneys no longer work, they need regular dialysis, or have had a kidney transplant and:

- They have worked the required amount of time* under Social Security, the Railroad Retirement Board, or as a government employee; or
- They are receiving or are eligible for Social Security or Railroad Retirement benefits; or
- They are the spouse or dependent child of a person (1) who has worked the required amount of time* under Social Security, the Railroad Retirement Board, or as a government employee or (2) who is receiving Social Security, Office of Personnel Management, or Railroad Retirement benefits.

If a person is enrolled in Medicare Part A, he/she may also enroll in Medicare Part B. *Patients with kidney failure will need both Part A and Part B for Medicare to cover certain dialysis and kidney transplant services*. If a person cannot obtain Medicare, he/she may be able to get help from the state to pay for dialysis treatments (see the "Medicaid" discussion in Section 7 of this guide).

*Patients can call the Social Security Administration at 1-800-772-1213 for more information about the required amount of time needed under Social Security to be eligible for Medicare.

How to Sign Up for Medicare

If a patient needs Medicare only because of ESRD, he/she can enroll in Medicare Part A and Part B based on ESRD at the local Social Security office.

If a patient has Part A coverage because of age or disability but did not take Part B or Part B coverage was stopped, he/she can enroll in Part B without paying a higher premium rate if enrolled in Medicare based on ESRD.

Medicare Basics

The cost of Part B increases by 10% for each 12-month period that someone could have had Part B but did not sign up for it. To avoid paying a higher Part B premium, patients should enroll in Medicare Part B when they apply for Medicare Part A based on ESRD. They should call or visit their local Social Security office or call Social Security at 1-800-772-1213 to make an appointment to enroll in Medicare based on ESRD.

If patients are paying higher Part B premiums because they did not enroll in Part B when they first became eligible for Medicare based on age or disability, the premium will be reduced to the base rate when they are entitled to Medicare based on ESRD. To stop paying the higher premium rate, patients must enroll in Medicare based on ESRD.

In all of these situations, patients can call or visit their local Social Security office or call Social Security at 1-800-772-1213 to make an appointment to enroll in Medicare based on ESRD.

Paying for Medicare Part B

When individuals sign up for Part B, the premiums are usually deducted from their monthly Social Security, Railroad Retirement, or Office of Personnel Management payment. If payment is not received, Medicare bills for Part B premiums every 3 months. Individuals should receive a Medicare premium bill by the 10th of each month. If a bill is not received by the 10th of the month, individuals should call the Social Security Administration at 1-800-772-1213.

Patients must pay their Medicare Part B premiums. If Part B premiums are not paid or if a patient cancels coverage, Medicare Part B coverage will end.

When Medicare Coverage Begins

When patients initially enroll in Medicare based on ESRD and they are on dialysis, their Medicare coverage usually starts the fourth month of dialysis treatments. For example, if a patient begins dialysis treatments in July, Medicare coverage would start on October 1.

If patients are covered by an employer group health plan, their Medicare coverage will still start the fourth month of dialysis treatments. Their employer group health plan will pay first on their health care bills, and Medicare will pay second for a 30-month coordination period (see Section 7 of this guide for more details).

If patients do not have employer group health plan coverage, there are other types of insurance and programs that may help to pay some of their health care costs.

Important: Medicare will not cover surgery or other services that are needed to prepare for dialysis (such as surgery for a blood access) if they are performed before Medicare coverage begins.

Getting Medicare Coverage Sooner

There are four possible ways to get Medicare coverage sooner:

1. Medicare coverage can start as early as the first month of dialysis if:

- Patients take part in a home dialysis training program in a Medicare-approved training facility to teach them how to give themselves dialysis treatments at home
- They begin home dialysis training before the fourth month of dialysis
- They expect to finish home dialysis training and give themselves dialysis treatments

Note: You should talk to your patients about dialysis treatment options.

2. Medicare coverage can start the month patients are admitted to a Medicare-approved hospital for a kidney transplant or for health care services that are needed before a transplant if the transplant takes place in that same month or within the 2 following months.

3. Medicare coverage can start 2 months before the month of a patient's transplant if a transplant is delayed more than 2 months after the patient is admitted to the hospital for the transplant or for health care services needed before the transplant.

Example: A patient was admitted to the hospital on May 25 for some tests she needed before her kidney transplant. She was supposed to have her transplant on June 15. However, her transplant was delayed until September 15; therefore, her Medicare coverage will start in July, 2 months before the month of her transplant.

4. Medicare coverage starts the first month of dialysis if a patient had a prior period of Medicare based on ESRD.

When Medicare Coverage Ends

If a patient has Medicare only because of kidney failure, Medicare coverage will end:

- Twelve months after the month dialysis treatments are stopped; or
- Thirty-six months after the month of a successful kidney transplant.

A patient's Medicare coverage will *not* end if:

- He/she must start dialysis again or have a kidney transplant within 12 months after the month dialysis is stopped; or
- He/she starts dialysis or has another kidney transplant within 36 months after a transplant.

Medicare Basics

Important: For Medicare to pay for kidney dialysis and some transplant services, a patient needs both Medicare Part A and Part B. If he/she does not pay the Medicare Part B premium or chooses to cancel coverage, Medicare Part B will end.

Medicare Preventive Benefits

The preventive benefits of Medicare are extensive and include the following screening tests, examinations, and services:

- Bone Mass Measurements
- Colorectal Cancer Screening
- Diabetes Services
- Mammogram Screening
- Pap Smear and Pelvic Examination
- Prostate Cancer Screening
- Shots and Vaccinations

Extensive information regarding Medicare's preventive services is available at ***http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*** on the CMS website.

SECTION 2:

Medicare Legislation

How the Medicare Prescription Drug Improvement and Modernization Act of 2003 Impacts People with Kidney Failure

The MMA allows more Medicare beneficiaries access to prescription drug coverage and reduces the prices they pay for those drugs. This new benefit provides more generous coverage for individuals with limited means and low incomes. The Act also includes:

- Provisions for savings for many state governments
- Better coordination of services for the most needy
- Modernization of the drug delivery infrastructure

Benefits for Medicare Beneficiaries

Medicare's Prescription Drug Coverage

Since January 1, 2006, everyone with Medicare, regardless of income, health status, or prescription drug usage, has had access to Part D prescription drug coverage.

Medicare Part D prescription drug coverage is insurance that covers both brand-name and generic prescription drugs at participating pharmacies and provides protection for beneficiaries who have very high drug costs. Everyone with Medicare is eligible for this coverage regardless of income and resources, health status, or current prescription expenses.

Beneficiaries may sign up when they first become eligible for Medicare (3 months before the month they turn age 65 until 3 months after they turn age 65). If a beneficiary gets Medicare due to a disability, he/she can join from 3 months before to 3 months after their 25th month of cash disability payments. If beneficiaries do

not sign up when they are first eligible, they may pay a penalty. If they did not join when first eligible, their next opportunity to join will be from November 15, 2008 to December 31, 2008.

A Medicare beneficiary's decision about Medicare prescription drug coverage depends on the kind of health care coverage they currently have. There are two ways to get Medicare prescription drug coverage:

- Join a Medicare prescription drug plan
- Join a Medicare Advantage Plan (Health Maintenance Organization [HMO]), Preferred Provider Organization (PPO), Private Fee-for-Service Plan, or another Medicare health plan that offers drug coverage.

These plans may cover more services and have lower out-of-pocket costs than the Original Medicare Plan. Some plans cover prescription drugs. In some plans, like HMOs, a beneficiary may only be able to see certain doctors or go to certain hospitals to get covered services.

Whatever the plan chosen, Medicare drug coverage helps a beneficiary by covering brand-name and generic drugs at pharmacies that are conveniently located to the beneficiary's residence.

Like other insurance, if a beneficiary joins, a monthly premium (which varies by plan) and a yearly deductible are required. A beneficiary will also pay a part of the cost of prescriptions (including a copayment or coinsurance). Costs vary depending on which drug plan is chosen. Some plans may offer more coverage and additional drugs for a higher monthly premium.

Medicare prescription drug coverage provides greater peace of mind by protecting a beneficiary from unexpected drug expenses. Even if a beneficiary does not use a lot of prescription drugs now, he/she should still consider joining. As we age, most people need prescription drugs to stay healthy, and for most people, joining now means protection from unexpected prescription drug bills in the future.

There is extra help for people with limited income and resources. Almost one in three people with Medicare will qualify for extra help, and Medicare will pay for almost all of the prescription drug costs. Individuals can apply or get more information by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778) or visiting ***http://www.socialsecurity.gov/prescriptionhelp/*** on the Internet.

Things to Consider

For a Medicare beneficiary to get coverage for prescription drugs, he/she must choose and join a Medicare drug plan. Regardless of how a Medicare drug plan offers this coverage, there are some key factors that may vary. Some of these factors might be more important to the beneficiary than others, depending on the situation and drug needs. These factors include:

- Cost
- Coverage

- Convenience
- Peace of mind now and in the future

Cost

A beneficiary must pay a monthly premium to join a Medicare drug plan, and premiums vary by plan. When a beneficiary gets a prescription(s) from the pharmacy, he/she must pay a deductible (the amount paid before the plan starts to share in the cost). Just as premiums, deductibles also vary by plan. In 2008, no plan may have a deductible of more than $275. In some plans, a beneficiary pays the same copayment (a set amount paid for prescriptions after paying the deductible) or coinsurance (a percentage of the cost) for any prescription. In other plans, there might be different levels or "tiers" with different costs. For example, a beneficiary might pay less for generic drugs than brand names, or some brand names might have a lower copayment than other brand names. In addition, in some plans a beneficiary's share of the cost can increase when his/her prescription drug costs reach a certain limit.

Coverage (Formulary)

Each plan lists the drugs covered in its formulary, and all plans must cover certain drugs, such as antidepressants or drugs to prevent transplant rejection. However, standard plans do not cover everything, including over-the-counter drugs, vitamins (except Vitamin D), cold medicine, and a few other drugs. Each plan's formulary lists the drugs that are covered.

Prior Authorization

To help ensure that certain drugs are used correctly and only when truly necessary, plans may require a "prior authorization." This means that before the plan will cover these prescriptions, the beneficiary's provider must first contact the plan and show there is a medically necessary indication to use that particular drug.

Coverage Gap

If a beneficiary has high drug costs, he/she may need to consider which plans offer additional coverage until $4,050 for 2008 is spent out-of-pocket.

In some plans, if costs reach an initial coverage limit, the beneficiary pays 100% of the prescription costs. This is called the coverage gap. This gap in coverage is generally above $2,510 in 2008 in total drug costs until the beneficiary spends $4,050 out-of-pocket during 2008. The $4,050 includes the annual deductible and coinsurance payments.

Some plans might offer some coverage during the gap. Even in plans where a beneficiary pays 100% of covered drug costs after a certain limit, he/she would still pay less for prescriptions than he/she would without this drug coverage.

Convenience

Drug plans must contract with pharmacies that are local to Medicare beneficiaries. It is important for a beneficiary to check with the plan to ensure that his/her pharmacy or a pharmacy in the plan is convenient. Also, some plans may offer a mail-order program that will allow a beneficiary to have drugs sent directly to the home. Beneficiaries should consider all options in determining the most cost-effective and convenient way to have prescriptions filled.

Even if a beneficiary does not take a lot of prescription drugs now, he/she still should consider joining a drug plan. Joining now means a beneficiary will pay a lower monthly premium in the future since he/she may have to pay a penalty if choosing to join later. If beneficiaries delay enrolling for more than 3 months after they first become eligible, they will be penalized for the rest of their lives. The penalty will permanently increase their premium 1% for every month they delay. For example, if beneficiaries delay 10 months, they will pay 10% more than almost everyone else. If they delay 2 years, their premium will be nearly 25% higher. This penalty will have to be paid as long as a beneficiary has a Medicare drug plan.

If a beneficiary reaches the point where $4,050 in 2008 has been spent out-of-pocket for drug costs during the year, the plan will pay most of the remaining drug costs. This protection could start even sooner in some plans.

If one of the beneficiaries you are treating decides to join a drug plan, he/she should review specific coverage of kidney dialysis-related drugs prior to choosing.

You can help by providing your patient with a list of drugs to look for that includes the drug names, doses, and the number taken per month. The list of drugs could also include your recommendations regarding the best drugs to take to stay healthy and other drugs that might be needed if health status or treatment changes. A patient can use this list to review a drug plan's formulary and compare plans and costs. A patient should choose the plan that covers all or most drugs being taken now or those that might be needed later if dialysis or a transplant become necessary. The beneficiary should also check to see which drug stores can be used and options for ordering drugs by mail, which may save money on drugs taken all of the time.

There are two ways a beneficiary can get Medicare prescription drug coverage:

- Join a Medicare Prescription Drug Plan that adds coverage to the Original Medicare Plan, some Medicare Private Fee-for-Service Plans, and some Medicare Cost Plans.
- Join a Medicare plan (like an HMO or PPO) that includes prescription drug coverage that is a part of the plan. A beneficiary gets all of his/her Medicare health care including prescription drug coverage through these plans.

A beneficiary can read *Quick Facts about Medicare's New Coverage for Prescription Drugs* at ***http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=11102*** on the CMS website for more information.

How Much Will the Plans Cost?

A beneficiary's costs can vary depending on whether he/she gets extra help paying for Part D costs and which Medicare drug plan is chosen. Since plans vary, a beneficiary may be able to pick a plan with or without a monthly premium, deductible, or coverage gap. In addition, if a beneficiary has limited income and resources, he/she may get extra help to pay for Medicare drug plan costs.

All Medicare drug plans offer at least the standard level of coverage (described as follows). However, drug plans may be designed differently (as long as the plan offers coverage that is, on average, at least as good as the standard level of coverage). In addition, some plans may offer more coverage for higher premiums.

Standard Level of Coverage (the minimum coverage drug plans must provide):

If a beneficiary joins in 2008, for covered drugs he/she will:

- Pay a monthly premium (varies depending on the plan chosen)
- Pay the first **$275** per year (in 2008) for prescriptions (called the "deductible")
- After paying the $275 deductible (in 2008), pay 25% of the next $2,235 drug costs (25% of $2,235 = **$558.75**); the plan pays the other 75% of these costs,

then

- The Donut Hole threshold is reached at $2,510 ($275 + $2,235), and the beneficiary then pays 100% of the next **$3,216.25** (Donut Hole) in drug costs,

then

- Catastrophic coverage starts after the beneficiary has met their $4,050 out-of-pocket spending requirement (**$275** + **$558.75** + **$3,216.25** = **$4,050**)

Some plans may be called standard plans, but they may be designed so that the deductible is lower and the coinsurance is slightly higher. Other plans may charge copayments or set amounts instead of coinsurance.

In general, the beneficiary's out-of-pocket costs should work out to be about the same under all of these plan designs.

How to Enroll

The Medicare Prescription Drug Plan Finder can help a beneficiary:

- Learn about Medicare prescription drug coverage
- Find and compare prescription drug plans that meet his/her personal needs
- Enroll in a chosen prescription drug plan

The Medicare Prescription Drug Plan Finder can be found at ***http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/GeneralQuestions.asp*** on the CMS website.

Changing Plans After Enrolling in a Drug Plan

A beneficiary can switch plans from November 15 through December 31 of every year. Also, in special circumstances, Medicare may give a beneficiary the opportunity to switch to another plan. Special circumstances may include that the beneficiary:

- Permanently moves out of his/her plan's service area
- Gets help from a state Medicaid program paying Medicare premiums and/or cost sharing
- Qualifies for extra help paying for prescription drugs
- Enters, lives in, or leaves a nursing home

For more information, read *Quick Facts about Medicare's New Coverage for Prescription Drugs*, which can be found at ***http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=11102*** on the CMS website.

Also, a beneficiary can call 1-800-MEDICARE (1-800-633-4227), and Medicare will directly help them to enroll. TTY users should call 1-877-486-2048.

New Preventive Benefits with the Medicare Prescription Drug Improvement and Modernization Act

Beginning in 2005, all newly enrolled Medicare beneficiaries are covered for:

- An initial physical examination within 6 months of the effective date of the beneficiary's initial Part B coverage
- Cardiovascular screening blood tests

In addition, those at risk will be covered for a diabetes screen. These new benefits for preventive procedures can be used to screen Medicare beneficiaries for many illnesses and conditions. If these illnesses can be caught early, they can be treated and managed before leading to serious health consequences. Conditions such as obesity, diabetes, heart disease, kidney disease, and asthma could be made far less severe for millions of Medicare beneficiaries. Early detection and treatment of chronic kidney disease can delay and at times prevent the onset of ESRD.

Other Key Provisions of the Legislation

The National Institute of Diabetes and Digestive and Kidney Diseases will be required to conduct a clinical investigation of pancreatic islet cell transplantation. Routine costs, as well as transplantation and appropriate related items and services for Medicare beneficiaries participating in the clinical trial, are to be paid by CMS. Routine costs will include reasonable and necessary routine patient care, immunosuppressive drugs, and other follow-up care.

ESRD Composite Rate System

As a result of the MMA, CMS has released the following transmittal regarding ESRD.

Transmittal: 101

Change Request (CR): 3119

Date: February 20, 2004

Effective Date: March 1, 2004

Implementation Date: April 1, 2004

Subject: Restoring Composite Rate Exceptions for Pediatric Facilities Under the End-Stage Renal Disease (ESRD) Composite Rate System

A hospital-based or independent pediatric renal dialysis facility may request CMS to approve an exception to the composite payment rate and set a higher payment rate if:

- The estimated allowable cost per treatment is higher than your composite rate; and
- The definition of a pediatric ESRD facility is met.

In accordance with MMA requirements, CMS has revised section 422(a)(2) of the Benefits Improvement and Protection Act of 2000 to:

- Provide that pediatric exception rates in effect on October 1, 2002 will continue in effect so long as the exception rate exceeds the facility's updated composite payment rate; and
- Restore the exceptions process for pediatric facilities only. If a qualified facility did not have an approved exception rate as of October 1, 2002, MMA Section 623(b)(1)(D) allows them to submit a request for a new exception to their intermediary between April 1, 2004 and September 27, 2004. The MMA also revises the definition of a pediatric ESRD facility. The statute defines the term "pediatric facility" to mean a renal facility in which at least 50% of the patients are under 18 years of age. If a facility meets these criteria and projects, on the basis of prior years' cost and utilization trends, that they will have an allowable cost per treatment higher than your prospective rate, they may request CMS to approve an exception to that rate and set a higher payment rate.

CMS will adjudicate these exception requests in accordance with the exception criteria contained in 42 CFR 413.180 and the Provider Reimbursement Manual, Part I, Chapter 27. However, the pediatric exception request will be denied if:

- The request is not adequately justified in accordance with regulations or program instructions, and/or
- The request is not received by the intermediary before close of business on September 27, 2004. An exception request is deemed approved unless CMS disapproves it within 60 working days after it is filed with the intermediary. The first day of this 60-working-day deadline is the date that the exception request, containing all of the required documentation, is filed with the intermediary. Therefore, the request to the intermediary must be sent through a method that documents the date of receipt. A postmark or other similar date will not serve as documentation of the date of receipt.

The following table includes relevant MMA provisions related to ESRD:

Bill Provision	Implementation Date	Text Summary
623	January 1, 2005	Payment for renal dialysis services. Establishes basic case-mix adjusted Prospective Payment System (PPS). PPS begins with services provided on January 1, 2005.
623	January 1, 2005	Payment for renal dialysis services. For 2005 and thereafter, pays acquisition costs or under the Average Sales Price method for separately billed drugs and biologicals.

Transmittal: R1389CP; **Change Request (CR) Number:** 5827

MLN Matters Article Number: MM5827

Date: December 7, 2007

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Subject: Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2008

The Social Security Act (Section 1881[b]), as amended by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 623), directed revisions to the composite rate payment system as well as payment for separately billable drugs furnished by ESRD facilities.

For calendar year (CY) 2008, the Centers for Medicare & Medicaid Services (CMS) did not propose any significant changes to composite rate payment methodology.

However, with CR 5827, CMS makes the following payment changes (effective January 1, 2008) to ESRD facilities, and upon the implementation of CR 5827, these payment changes will be applied to all Medicare-certified ESRD facilities:

- Update the drug add-on adjustment to the composite rate for 2008 of 0.5 percent. As a result, the drug add-on adjustment to the composite payment rate for 2008 will increase from 14.9 percent to 15.5 percent; and
- Update the wage data and implement the third year of the wage index transition using a 25/75 blended wage adjusted composite rate.

Wage Index Transition Example:

An ESRD facility has a wage-adjusted composite rate (without regard to any case-mix adjustments) of $135.00 per treatment in CY 2007. Using Core Based Statistical Area (CBSA)-based geographic area designations, the facility's CY 2008 wage-adjusted composite rate, reflecting its wage index value would be $145.00. During the third year (CY 2008) of the 4-year transition period to the new CBSA-based wage index values, this facility's blended rate would be calculated as follows:

CY 2008: (**0.25** × $135.00) + (**0.75** × $145.00) = $142.50.

CR 5827 also clarifies weight calculation instructions for double amputee dialysis patients. Previously reported in CR 4196, the requirement for value code A8 (Weight) is that it should be calculated with pre-amputation weight. In CR 4196, the formula for pre-amputation weight was incorrectly stated as actual weight x 1.5. The correct formula for pre-amputation weight is actual weight x 1.15. Through CR 5827, the instruction for how to calculate the height and weight of double amputee dialysis patients is being placed into Publication 100-04, which is the Medicare Claims Processing Manual.

SECTION 3:

Kidney Dialysis

Dialysis Treatment Options

There are two types of dialysis that can be used: **Peritoneal dialysis** and **hemodialysis**. You and your patients can decide what type of dialysis is best based on each patient's situation.

Peritoneal Dialysis

Peritoneal dialysis treatment is used at home under the routine supervision of a dialysis facility. Peritoneal dialysis is the process of cleansing the body of waste products by diffusion through semipermeable membranes in the abdomen. The process occurs when 1 to 3 L of prescribed solution (dialysate) are introduced into and removed from the peritoneal cavity by means of a single lumen catheter that has been inserted through the abdominal wall and anchored externally. The types of chronic peritoneal dialysis are determined by various schedules:

- Continuous ambulatory peritoneal dialysis has dialysate present in the abdomen day and night with four to five exchanges (removal and replacement) of dialysate during the day.
- Continuous cycler-assisted peritoneal dialysis (CCPD) begins at bedtime when the patient connects him- or herself to a machine that drains and replaces the dialysate in the patient's abdomen while he/she sleeps and leaves dialysate in the abdomen during the day.
- Nocturnal intermittent peritoneal dialysis is CCPD with an increased number of exchanges (five to eight) at night, and the abdomen is drained and left "dry" (without dialysate) during the day.

Hemodialysis

Hemodialysis is the process of cleaning the blood of waste products when the kidneys can no longer perform this job. CMS is leading a national initiative to increase the use of arteriovenous (AV) fistulas in providing hemodialysis for Medicare beneficiaries. The most common AV fistula site is the forearm. Fistulas are the "gold standard" for establishing access to a patient's circulatory system to provide life-sustaining dialysis. They last longer, need less rework, and are associated with lower rates of infection, hospitalization, and death for Medicare beneficiaries than other types of access.

Other vascular access types include AV grafts (a synthetic catheter that is used to connect an artery to a vein usually in the arm) and venous catheters (a dual lumen catheter "permanently" inserted into a vein, usually the internal jugular or the subclavian vein, with an access port either just below or just above the skin). Grafts and catheters require more maintenance, may deliver less than optimal cleaning of the blood, lead to more infections and hospitalizations, and cost more in the long run. A temporary catheter may be needed for dialysis in an emergency or during the period when a fistula is "maturing."

Determining How Well Dialysis Is Working

You can help your patients keep track of their hemodialysis and help them determine how well it is working by providing them with their Urea Reduction Ratio (URR) or Kt/V (K – dialyzer clearance of urea; t – dialysis time; V – patient's total body water) number, depending on which test your dialysis facility uses.

In addition, Medicare has more detailed information on determining how well hemodialysis is working in a publication called *"You Can Live: Your Guide for Living with Kidney Failure."* This patient education brochure helps patients understand the importance of getting adequate dialysis and what they can do to improve the adequacy of their dialysis.

FREE

Patients can call 1-800-MEDICARE (1-800-633-4227) for a free copy of this brochure or read or print a copy of this brochure at ***http://www.medicare.gov*** on the Internet. Under the "Search Tools" section on the left of the page, select "Find a Medicare Publication."

Self-Dialysis Training

Self-dialysis training is covered by Medicare Part B on an outpatient basis. Self-dialysis training costs more than dialysis treatments. Medicare pays a training rate in which the facility is reimbursed an add-on amount to its composite rate, and the amount is dependent on the type of dialysis.

Home Dialysis

Beneficiaries have two payment options for home dialysis:

Method 1: Working with a Dialysis Facility
Under Method 1, a beneficiary must get all services, equipment, and supplies needed for home dialysis from his/her dialysis facility.

In the Original Medicare Plan, the amount that Medicare pays the dialysis facility for these items and services depends on the composite rate, a rate that is set in advance. After the beneficiary pays the Part B yearly deductible, which was $131 in 2007 and is $135 for 2008, Medicare pays 80% of the composite rate. The patient is responsible for paying the 20% coinsurance.

Method 2: Dealing Directly with a Supplier
Under Method 2, the beneficiary must get dialysis equipment and supplies from one supplier, which must accept assignment. This means that if the beneficiary is in the Original Medicare Plan, the supplier agrees to accept Medicare's fee as full payment. Their supplier must also have a written agreement with a dialysis facility to ensure that the patient gets all necessary home dialysis support services.

In the Original Medicare Plan after the beneficiary pays the Part B yearly deductible ($131 in 2007 and $135 for 2008), Medicare will pay 80% of the Medicare-approved charges for the items and services, and the beneficiary pays the 20% coinsurance.

Under both Method 1 and Method 2, beneficiaries must get support services from a dialysis facility for Medicare to pay. Medicare will pay the facility directly for these services.

The following charts specify what a patient will be required to pay for home dialysis equipment, supplies, and support services in the Original Medicare Plan using either the Method 1 or Method 2 payment options.

Method 1 Payment Chart for Home Dialysis Equipment, Supplies, and Support Services in the Original Medicare Plan			
	Home Dialysis Equipment	**Home Dialysis Supplies**	**Home Dialysis Support Services**
Dealing with the Dialysis Facility	Medicare pays 80% of the facility's composite rate. The patient pays the 20% coinsurance.*	Medicare pays 80% of the facility's composite rate. The patient pays the 20% coinsurance.*	Medicare pays 80% of the facility's composite rate. The patient pays the 20% coinsurance.*

* Each year, a beneficiary pays a total of one Part B deductible, which was $131 in 2007 and is $135 for 2008.

Method 2 Payment Chart for Home Dialysis Equipment, Supplies, and Support Services in the Original Medicare Plan			
	Home Dialysis Equipment	**Home Dialysis Supplies**	**Home Dialysis Support Services**
Dealing Directly with a Supplier	If the patient buys or rents home dialysis equipment, Medicare Part B will cover it. The patient must pay the $135 (2008) Part B yearly deductible. Medicare Part B usually makes monthly payments. If the patient buys the equipment, Medicare will pay 80% of the monthly payment purchase price. The patient pays the 20% coinsurance. The monthly Part B payment includes any interest or carrying charges. If equipment is rented, Medicare Part B pays 80% of the approved monthly rental charge. The patient pays the 20% coinsurance.	After the patient pays the Part B yearly deductible, Medicare Part B pays 80% of the approved charges for all covered supplies. The patient pays the 20% coinsurance.	After the patient pays the Part B yearly deductible, Medicare Part B pays the facility 80% of the approved charges for all covered services. The patient pays the 20% coinsurance.

Deciding Which Payment Option to Choose for Home Dialysis

The Method 1 and Method 2 payment charts can be used to help patients decide which payment option is best for them if they are in the Original Medicare Plan, and they can also ask their social worker for assistance.

After a beneficiary has finished self-dialysis training and is ready to make a choice, he/she must:

1. Fill out a Beneficiary Selection Form CMS-382;
2. Sign Form CMS-382; and
3. Return Form CMS-382 to his/her dialysis facility.

Beneficiaries can get a copy of Form CMS-382 from their dialysis facility. Once they make their choice and submit the form, they must stay with that payment option until December 31 of that year. For example, if they decide to go with the Method 2 payment option in March 2008, they must stay with that option until December 31, 2008.

Beneficiaries can change from one method to the other by filling out a new Form CMS-382 at any time, but the change will not start until the following January 1. For example, if the patient fills out a Form CMS-382 to change to Method 1 and returns it to his/her dialysis facility in October 2008, this change will not start until January 1, 2009.

Important: No matter which method is chosen, a beneficiary can still make a change to get treatment at a dialysis facility or to choose another facility.

How Long Will Medicare Pay for Home Dialysis Equipment?

Medicare Part B will pay for home dialysis equipment as long as dialysis at home is needed. When home dialysis is no longer needed, Part B will stop paying for it. For example, if a patient has a kidney transplant and no longer needs home dialysis, then Part B will stop paying for his/her equipment.

If a beneficiary buys dialysis equipment, Part B payments will stop once the Medicare-approved purchase price is reached. For example, if Medicare agrees to pay $200 for dialysis equipment, then Part B payments will stop once Medicare pays $200.

What Is Covered by Medicare?

Medicare covers these dialysis services and pays for part of their costs:

Service or Supplies	Medicare Part A	Medicare Part B
Inpatient dialysis treatments (if admitted to a hospital for special care)	✔	
Outpatient dialysis treatments (treatments in any Medicare-approved dialysis facility)		✔
Self-dialysis training (including instruction for the beneficiary and the person helping with home dialysis treatments)		✔
Home dialysis equipment and supplies (alcohol, wipes, sterile drapes, rubber gloves, and scissors)		✔
Certain home support services (may include visits by trained hospital or dialysis facility workers to check on home dialysis, to help in emergencies when needed, and to check dialysis equipment and water supply)		✔
Certain drugs for home dialysis		✔
Doctors' professional services		✔
Most other services and supplies that are a part of dialysis, such as laboratory tests		✔

Home Dialysis Drugs Covered by Medicare

Medicare Part B covers the following common drugs for home dialysis:

- Heparin
- The antidote for heparin when medically necessary
- Topical anesthetics
- Epoetin Alfa (Epogen, EPO)
- Darbepoetin Alfa (Aranesp)

Of the above five items, the first three are actually included in the composite rate and are not separately billable. Epoetin Alfa and Darbepoetin Alfa are separately billable.

What Is Not Covered by Medicare?

Medicare does not pay for the following:

- Paid dialysis aides to help with home dialysis
- Any lost pay to the beneficiary and the person who may be helping during self-dialysis training
- A place to stay during treatment
- Blood or packed red blood cells for home self-dialysis unless part of a doctor's service or as needed to prime the dialysis equipment
- Transportation to the dialysis facility (except as noted later in this section for coverage in special cases)

What Your Medicare Patients Pay for Dialysis Services

The costs listed in this section are for dialysis services in the Original Medicare Plan. If patients are in Medicare Managed Care Plans or Private Fee-for-Service Plans, their costs may be different. Their plan materials or benefits administrator can provide information about these costs.

Dialysis in a Dialysis Facility

In the Original Medicare Plan, if a beneficiary gets dialysis in a Medicare-approved facility, Medicare Part B pays the facility for dialysis-related services on a per treatment rate (called the composite rate). This rate may be different from one dialysis facility to another depending on the type of facility and where it is located. Medicare pays 80% of the composite rate. The patient is responsible for the remaining 20% coinsurance that Medicare does not pay.

Using the Wage Index Transition Example on page 15 to calculate the facilities blended rate:
An ESRD facility has a wage-adjusted composite rate (without regard to any case-mix adjustments) of $135 per treatment in CY 2007. Using Core Based Statistical Area (CBSA)-based geographic area designations, the facility's CY 2008 wage-adjusted composite rate, reflecting its wage index value would be $145. During the third year (CY 2008) of the 4-year transition period to the new CBSA-based wage index values, this facility's blended rate would be calculated as follows:

CY 2008: *(**0.25** × $135) + (**0.75** × $145) = $142.50.*

Example: Using the above example, this hospital-based facility's composite rate is $142.50 per treatment in 2008. If the beneficiary already satisfied the $135 Part B yearly deductible for 2008:

- Medicare Part B pays the facility 80% of $142.50 (or $114)
- The beneficiary pays the remaining 20% coinsurance (or $28.50)

There may be other services that are not included in the composite rate. The dialysis facility can provide a list of tests and other services that are included in this rate. For services not included in the composite rate, Medicare pays 80% of the Medicare-approved amount. The patient is responsible for the 20% coinsurance.

Dialysis in a Hospital

If a beneficiary is admitted to a hospital and gets dialysis, treatments will be covered by Medicare Part A as part of the costs of a covered inpatient hospital stay. (See the Medicare Part A coverage chart in Section 9 of this guide.)

Doctors' Services

Outpatient Doctors' Services (Full Month)
In the Original Medicare Plan, Medicare pays a doctor once a month for the ongoing management of a patient on dialysis. For a patient who undergoes dialysis in a dialysis center (or other outpatient facility), the monthly payment amount (called the monthly capitation payment) is based on the number of visits during the month and the age of the beneficiary. For a patient who undergoes dialysis at home, the doctor is paid a single monthly rate based on the age of the beneficiary.

If a home dialysis patient receives dialysis in a dialysis center or other outpatient facility during the month, the doctor is paid the management fee for the home dialysis patient and cannot bill the ESRD-related service codes for managing center-based patients. The doctor is paid the monthly management fee for a home dialysis patient regardless of whether the ESRD beneficiary went from home dialysis to center-based dialysis, or vice versa, and regardless of the proportion of the month that the beneficiary was receiving each modality.

After the patient satisfies the Part B yearly deductible, Medicare Part B pays 80% of the monthly amount, and the patient is responsible for the remaining 20% coinsurance.

Outpatient Doctors' Services (Less than a Full Month)
Payment for outpatient ESRD-related services for less than a full month is made on a per diem basis in specific circumstances (e.g., traveling patient, partial month due to hospitalization, transplant, or when the patient expires).

Inpatient Doctors' Services
In the Original Medicare Plan, a doctor bills separately for ESRD-related services furnished to a beneficiary receiving inpatient hospital treatment.

Dialysis When Patients Are Traveling

Beneficiaries should plan for their dialysis treatments along the routes of their trips before traveling, and their dialysis facility will help them with these plans. Before making plans, however, dialysis patients should consider the following:

- Is the dialysis facility approved by Medicare to give dialysis?
- Does the facility have the space and time to give the patient care when needed?
- Does the facility have enough information about the beneficiary to provide the proper treatment?
- Where is the facility located?

There are more than 3,500 facilities around the country. The beneficiary's facility or the ESRD Network may be able to identify a facility for the patient. Also, the CMS website, (go to ***http://www.medicare.gov*** select "Search Tools" on the left of the page and then select "Find Helpful Phone Numbers and Websites") includes the names and addresses of facilities nationwide.

Information about Medicare-certified dialysis facilities can also be found at ***http://www.medicare.gov*** on the Internet. Select "Search Tools" and click on "Dialysis Facility Compare."

In general, Medicare will pay only for hospital or medical care that is provided in the United States.

Does the beneficiary obtain dialysis services from a Method 2 supplier or a Medicare Managed Care Plan? If so, the supplier or managed care plan may be able to help him/her get the dialysis needed while traveling. However, the beneficiary may have to pay for all of the costs for dialysis treatments. He/she can contact the supplier or health plan for more information.

Transportation to Dialysis Facilities

In most cases, Medicare will not pay for transportation to dialysis facilities. Medicare covers roundtrip ambulance services from home to the nearest dialysis facility only if other forms of transportation would be harmful to the beneficiary's health.

The ambulance supplier must get a written order from the patient's primary doctor before providing ambulance service. The doctor's written order must be dated no earlier than 60 days before the patient obtains the ambulance service.

SECTION 4:

Kidney Transplants

What Is Covered by Medicare

Medicare covers these transplant services and pays for part of their costs:

Service or Supplies	Medicare Part A	Medicare Part B
Inpatient hospital services in an approved hospital (see the Medicare Parts A and B coverage charts in Section 9 of this guide)	✔	
Kidney registry fee	✔	
Laboratory and other tests needed to evaluate the beneficiary's medical condition*	✔	
Laboratory and other tests needed to evaluate the medical conditions of potential kidney donors*	✔	
The costs of finding the proper kidney for transplant surgery (if there is no kidney donor)	✔	
The full cost of care for the kidney donor (including all reasonable preparatory, operation, and postoperative recovery costs)	✔	
Any additional inpatient hospital care for the donor in case of problems due to the surgery	✔	
Doctors' services for kidney transplant surgery (including care before surgery, the actual surgery, and care after surgery)		✔
Doctors' services for the kidney donor during the hospital stay		✔
Immunosuppressive drugs (for information on length of coverage, see the next paragraph)		✔
Blood (whole or units of packed red blood cells, blood components, and the cost of processing and giving blood	✔	✔

*These services are covered whether they are performed by the Medicare-approved hospital where the beneficiary will get his/her transplant or by another hospital that participates in Medicare.

Note: Medicare does not pay for the actual kidneys for a transplant. Buying or selling human organs is against the law.

Transplant Drugs (Immunosuppressive Drugs)

Payment for Transplant Drugs

If beneficiaries have Medicare only because of kidney failure, their Medicare will end 36 months after the month of the transplant.

Medicare will not pay for any services (including immunosuppressive drugs) for patients who are not entitled to Medicare. If beneficiaries already had Medicare because of age or disability before they were diagnosed with ESRD, or if they became eligible for Medicare because of age or disability after receiving a transplant that was paid for by Medicare or by private insurance that paid primary to their Medicare Part A Coverage (in a Medicare-certified facility), Medicare will continue to pay for immunosuppressive drugs with no time limit.

If a beneficiary has Medicare only because of kidney failure, this does not apply to him/her. Medicare and drug coverage will end when the 36-month period is up.

Inability to Pay for Transplant Drugs

Transplant drugs can be very costly. If beneficiaries have Medicare only because of kidney failure, immunosuppressive drugs are covered for only 36 months after the month of the transplant. If beneficiaries are worried about paying for the drugs, they should talk with their health care team. There may be other ways to help them pay for these drugs. (See Section 7 of this guide to learn more about other health insurance.)

Special Information about Pancreas Transplants

If a beneficiary has ESRD and needs a pancreas transplant, Medicare covers the transplant:

- When it is done at the same time the beneficiary gets a kidney transplant
- After a kidney transplant

If a beneficiary has Medicare only because of kidney failure and he/she has a pancreas transplant after a kidney transplant, Medicare will pay for immunosuppressive drug therapy for 36 months after the month of the pancreas transplant.

If beneficiaries already had Medicare because of age or disability before they were diagnosed with ESRD, or if they became eligible for Medicare because of age or disability after receiving a transplant, Medicare will continue to pay for their immunosuppressive drugs with no time limit.

If a beneficiary has diabetes and his/her diabetes did not cause the kidney failure, this coverage does not apply.

There are circumstances, effective April 26, 2006, where pancreas transplants alone are covered. For details on this coverage, see the MLN Matters article, MM5093, available at ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5093.pdf*** on the CMS website.

What a Medicare Patient Pays for Kidney Transplant Services

The amounts listed in this section are for transplant services in the Original Medicare Plan. If a beneficiary is in a Medicare Advantage Plan, costs may be different. Beneficiaries should read their plan materials or call their benefits administrators to get cost information.

Paying for Kidney Donors

A patient does not have to pay for the kidney donor. Medicare will pay the full cost of care for the beneficiary's kidney donor. There is no deductible, coinsurance, or other costs that have to be paid for the donor's hospital stay.

Doctors' Services

In the Original Medicare Plan, a beneficiary must pay the Part B yearly deductible ($131 in 2007 and $135 for 2008). After the patient pays the deductible, Medicare Part B pays 80% of the Medicare-approved amount. The patient is responsible for the remaining 20% coinsurance.

Important: There is a limit on the amount a doctor can charge the beneficiary, even if the doctor does not accept assignment. If the doctor does not accept assignment, the patient only has to pay up to the limiting charge.

SECTION 5:

How Medicare Pays for Blood

In most cases, Medicare Parts A and B can help pay for:

- Whole blood units or packed red blood cells
- Blood components
- The cost of processing and giving blood

Medicare does not pay for blood for home self-dialysis unless it is part of a doctor's service or is needed to prime the dialysis equipment.

What Medicare Beneficiaries Pay for Blood

Under Medicare Part A, beneficiaries pay for the first three units of whole blood or units of packed red cells that they get during a benefit period while they are staying in a hospital or skilled nursing facility. They can choose to either pay the hospital costs for the blood or packed red cells or they can have the blood replaced (see "How to Have Blood Replaced" as follows).

Note: If a beneficiary paid for or replaced some units of blood under Medicare Part B during the calendar year (January 1 through December 31), he/she does not have to pay again under Medicare Part A.

Under Medicare Part B, beneficiaries pay for the first three units of whole blood or units of packed red cells that they get in a calendar year. They can choose to either pay the hospital costs for the blood or packed red cells or they can have the blood replaced (see "How to Have Blood Replaced" as follows).

In the Original Medicare Plan, Medicare Part B pays 80% of the approved charges for extra pints of blood in a calendar year. A beneficiary is responsible for the remaining 20% coinsurance.

Note: If a beneficiary has paid for or replaced blood under Medicare Part A during a calendar year (January 1 through December 31), he/she does not have to pay again under Medicare Part B.

How to Have Blood Replaced

Beneficiaries can replace blood by donating their own blood or getting another person or organization to replace the blood for them. The blood that is replaced does not have to match your patient's blood type. If a patient decides to replace the blood through self-donation, Medicare suggests that he/she check with you first before donating blood.

Can a Beneficiary Be Charged for the Blood That They Have Replaced?

A hospital or skilled nursing facility cannot charge for any of the first three pints of blood replaced or that which will be replaced. Also, if a beneficiary's provider receives donated blood or red cells, they are considered replaced.

SECTION 6:

Appeals and Grievances (Complaints)

Appeals

Medicare beneficiaries have certain guaranteed rights to help protect them. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. Whether a beneficiary is in the Original Medicare Plan or a Medicare Advantage Plan, he/she always has the right to appeal. Some of the reasons a beneficiary may appeal include the following:

- He/she does not agree with the amount that is paid
- A service or item is not covered, and he/she thinks it should be covered
- A service or item is denied, and he/she thinks it should be paid

Appeal Rights in the Original Medicare Plan

If the beneficiary is in the Original Medicare Plan, he/she can file an appeal for any of the reasons listed above. If the beneficiary files an appeal, he/she should ask the doctor or provider for any information related to the bill that might help with the case. A beneficiary's appeal rights are on the back of the Medicare Summary Notice that is mailed from a company that handles bills for Medicare. The notice will also inform the beneficiary as to why Medicare did not pay his/her bill and how it can be appealed.

Appeal Rights in a Medicare Advantage Plan

If the beneficiary is in a Medicare Advantage Plan, he/she can file an appeal for any of the reasons listed above. Also, the beneficiary can see his/her plan's membership materials or contact the plan administrator for details about Medicare appeal rights. A beneficiary may also call 1-800-MEDICARE (1-800-633-4227) to ask for more information about his/her rights during an appeal. TTY users should call 1-877-486-2048.

Filing a Grievance (Complaint)

Beneficiaries should first talk with doctors, nurses, or facility administrators to seek help in solving a problem. Most problems can be handled at the facility. If the beneficiaries' health care teams do not solve the problem, the beneficiaries can file a grievance (a written complaint) with their facility.

Every facility has a grievance policy for accepting and attempting to resolve a patient's problems or concerns. If a patient does not know his/her facility's grievance policy, he/she can ask for a copy of it.

If a patient files a grievance with his/her facility but continues to believe the problem has not been solved, the patient has the right to file a grievance with the ESRD Network in his/her area. The patient can call the ESRD Network to find out how to file a grievance or go to ***http://www.medicare.gov*** on the Internet. Scroll down to "Search Tools" on the left of the page and select "Find Helpful Phone Numbers and Websites."

Patients can also call their State Survey Agencies to complain about their care. Their identity and the content of their calls will be kept private.

Contact information for State Survey Agencies can be found by calling 1-800-MEDICARE (1-800-633-4227) or by visiting ***http://www.medicare.gov*** on the Internet. Scroll down to "Search Tools" on the left of the page and select "Find Helpful Phone Numbers and Websites."

SECTION 7:

Other Types of Health Insurance

There are several types of health insurance coverage that may help pay for the services a patient needs for the treatment of kidney failure. These include:

- Employee or Retiree Coverage from an Employer or Union
- A Medigap Insurance Policy
- Medicare Health Plan Choices
- Medicaid
- Veterans Affairs Benefits

Employee or Retiree Coverage from an Employer or Union

This type of group health coverage is for current employees or retirees. Generally, employer plans have better rates than employees can get if they buy a policy themselves, and employers pay part of the cost. Patients can call their benefits administrators to find out if they have or can get health care coverage based on their or their spouse's past or current employment or their parents' current employment. In some cases, employer group health plans will have to pay before Medicare pays.

How Medicare Works with Employer Group Health Plan Coverage

If a patient is eligible for Medicare only because of permanent kidney failure, his/her Medicare coverage usually will not start until the fourth month of dialysis. Medicare will not pay anything during the patient's first 3 months of dialysis unless the patient already has Medicare because of age or disability. Therefore, his/her employer group health plan is the only payer for the first 3 months of dialysis.

If a patient's employer plan does not pay all of the costs for dialysis, the patient may have to pay some of the costs. A patient may be able to get help to pay these costs.

When a patient is able to get Medicare because of kidney failure (usually the fourth month of dialysis), there is a period of time when the patient's employer group health plan will pay first on his/her health care bills, and Medicare will pay second. This period of time is called a 30-month coordination period.

This means that if the patient's employer plan does not pay 100% of his/her health care bills during the 30-month coordination period, Medicare may pay for the remaining costs. Medicare is called the secondary payer during this coordination period.

When the 30-Month Coordination Period Starts

The 30-month coordination period starts the first month a patient is able to get Medicare because of kidney failure (usually the fourth month of dialysis) even if the patient is not enrolled in Medicare yet. For example, if a patient starts dialysis in June, the 30-month coordination period will start September 1, the fourth month of dialysis.

If a patient takes a course in self-dialysis training or gets a kidney transplant during the 3-month waiting period, the 30-month coordination period will start with the first month of dialysis or kidney transplant. During this time, Medicare will be the secondary payer.

Important: If a patient has employer group health plan coverage during the 30-month coordination period, the patient should advise you of this fact to ensure that his/her services are billed correctly.

What Happens When the 30-Month Coordination Period Ends?

At the end of the 30-month coordination period, Medicare will pay first for all Medicare-covered services. The patient's employer group health plan coverage may pay for services not covered by Medicare. The patient can check with his/her plan's benefits administrator to help answer any additional questions.

How the 30-Month Coordination Period Works if a Patient Enrolls in Medicare More Than Once

There is a separate 30-month coordination period each time a patient enrolls in Medicare based on kidney failure. For example, if the patient gets a kidney transplant that continues to work for 36 months, Medicare coverage will end.

If after 36 months, the patient enrolls in Medicare again because he/she started dialysis again or gets another transplant, Medicare coverage will start right away. There will be no 3-month waiting period before Medicare begins to pay, and there will be a new 30-month coordination period if the patient has employer group health plan coverage.

Do Patients Have to Get Medicare Because Their Kidneys Fail if They Already Have Employer Group Health Plans?

No, but patients should think carefully about this decision. If a patient already has an employer group health plan, consider the following:

1. If a patient receives a kidney transplant, Medicare will cover immunosuppressive drugs only if:

- The patient has Medicare Part A at the time of the transplant, and the transplant is paid for by Medicare; or
- The patient has Medicare Part A at the time of the transplant, and Medicare does not pay for the transplant because Medicare is the secondary payer to the patient's employer group health plan; or
- The patient has Medicare Part A at the time of the transplant, and the patient becomes eligible for Medicare because of age or disability.

In these instances, the transplant surgery must have taken place in a Medicare-approved facility. In addition to the above conditions, the patient must have Medicare Part B coverage at the time when immunosuppressive drugs are received.

2. If the patient's group health plan coverage has a yearly deductible or a coinsurance to pay, enrolling in Medicare Parts A and B could help pay these costs.

3. If the patient's group health plan coverage does not have a yearly deductible or a coinsurance and will pay all of the health care costs, the patient may want to delay enrolling in Medicare Part A and Part B until the 30-month coordination period is over. Delaying enrollment means that the patient will not be paying the Part B premium. After the 30-month coordination period, the patient should enroll in Medicare.

For more information about how employer group health plan coverage works with Medicare, patients should:

- Get a copy of their plan's benefits booklet
- Call their benefits administrator and ask how the plan pays when they have Medicare

A Medigap Insurance Policy

A "Medigap" insurance policy fills gaps in Original Medicare Plan coverage. Medigap insurance must follow federal and state laws. These laws protect the patient. All Medigap policies are clearly marked "Medicare Supplement Insurance."

Some insurance companies will sell Medigap policies to people with Medicare who are under age 65. However, these policies may cost more. Beneficiaries should call their State Health Insurance Assistance Program for information about buying Medigap policies if they are disabled or have ESRD.

For State Health Insurance Assistance Program contact information, beneficiaries can visit ***http://www.medicare.gov*** on the Internet. Scroll down to "Search Tools" on the left of the page and select "Find Helpful Phone Numbers and Websites"

For more detailed information about Medigap policies, beneficiaries can call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the "Guide to Health Insurance for People with Medicare."

Beneficiaries can also visit ***http://www.medicare.gov*** on the Internet to get information on Medigap policies in their state. Scroll down to "Search Tools" and select "Compare Health Plans and Medigap Policies in Your Area." This website has information about:

- Medigap policies sold in their state
- Comparing Medigap policies
- What each policy covers
- Out-of-pocket costs for the beneficiary

If the beneficiary does not have a computer, the local library or senior center may be able to help find this information.

Medicare Health Plan Choices

Today's Medicare is about choice, and health plan choices include:

- The Original Medicare Plan (also known as fee-for-service) available nationwide
- Medicare Advantage Plans including:
  - Medicare Managed Care Plans
  - Medicare Private Fee-for-Service Plans
  - Medicare Preferred Provider Organization Plans

A beneficiary may not be able to join a Medicare Advantage Plan if he/she has ESRD. Patients with ESRD who start dialysis and are already in a Medicare Advantage Plan can stay in the plan they are in or join another plan offered by the same company in the same state. They must continue to pay the monthly Medicare Part B premium.

If a patient had a successful kidney transplant, he/she may be able to join a plan and can call 1-800-MEDICARE (1-800-633-4227) for more information about ESRD and Medicare health plans. If a patient has ESRD and he/she is in a plan and the plan leaves Medicare or no longer provides coverage in the patient's area, he/she can join another Medicare Advantage Plan if one is available in his/her area.

For more information about Medicare health plan choices, patients can call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *Medicare & You* handbook. TTY users should call 1-877-486-2048. They can also read or print a copy of this handbook at ***http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf*** on the CMS website.

Medicaid

Medicaid is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. Most health care costs are covered if the person qualifies for both Medicare and Medicaid.

States also have programs that pay some or all of Medicare premiums and may also pay Medicare deductibles and coinsurances for certain people with lower incomes who have Medicare. To qualify for these programs, a beneficiary must:

- Have Medicare Part A (hospital insurance). If the beneficiary is not sure whether he/she has Part A, he/she can look on the red, white, and blue Medicare card or call the Social Security Administration at 1-800-772-1213.
- Have a monthly income below certain thresholds. These income limits are slightly higher in Hawaii and Alaska. Income limits can change slightly each year.
- Have savings of $4,000 or less for an individual or $6,000 for a couple. Savings includes money in a checking or savings account, stocks, or bonds.

FREE

For more information about these programs, beneficiaries can call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for information about "*Savings for People with Medicare*."

Veterans Affairs Benefits

If the patient is a veteran, the U.S. Department of Veterans Affairs can help pay for ESRD treatment. For more information, a veteran can call the U.S. Department of Veterans Affairs at 1-800-827-1000. If the veteran or his/her spouse retired from the military, he/she can call the Department of Defense at 1-800-538-9552 for more information.

Other Ways to Get Help

Most states have agencies that help with some of the health care costs that Medicare does not pay. Some states have Kidney Commissions that also help people pay the costs that Medicare does not pay. Patients can call their State Health Insurance Assistance Programs if they have questions about health insurance. Contact information is available by visiting ***http://www.medicare.gov*** on the Internet. Scroll down and select "Search Tools" on the left of the page and then select "Find Helpful Phone Numbers and Websites."

SECTION 8:

Where to Get More Information

Patients should talk with their health care teams—doctors, nurses, social workers, dieticians, and dialysis technicians—to learn more about kidney dialysis and transplants and the specifics of their situation. The following are sources of more information.

Special Kidney Organizations

There are special organizations that can provide more information about kidney dialysis and kidney transplants. Some of these organizations have members who are on dialysis or have had kidney transplants and who can provide support.

American Association of Kidney Patients
3505 E. Frontage Road, Suite 315
Tampa, FL 33607
1-800-749-2257
info@aakp.org
http://www.aakp.org

National Kidney Foundation, Inc.
30 E. 33rd Street, Suite 1100
New York, NY 10016
1-800-622-9010
http://www.kidney.org

American Kidney Fund
6110 Executive Boulevard, Suite 1010
Rockville, MD 20852-3903
1-800-638-8299
http://www.kidneyfund.org

National Kidney and Urologic Diseases
Information Clearinghouse NKDEP
Office of Communications and Public Liaison, NIDDK, NIH, Building 31, Room 9A06
31 Center Drive, MSC2560
Bethesda, MD 20892-2560
1-800-891-5390
http://www.niddk.nih.gov

End-Stage Renal Disease Networks

The local ESRD Network Organization (see ***http://www.medicare.gov*** on the Internet. Scroll down to "Search Tools" on the left of the page and then select "Find Helpful Phone Numbers and Websites") can provide information about:

- Dialysis or kidney transplants
- How to get help from other kidney-related agencies
- Problems with facilities that are not solved after talking to the staff at the facility
- Location of dialysis facilities and transplant centers

The ESRD Network ensures that patients are getting the best possible care and uses mailings to keep facilities aware of important issues about kidney dialysis and transplants.

State Programs

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (see ***http://www.medicare.gov*** on the Internet. Scroll down to "Search Tools" on the left of the page and select "Find Helpful Phone Numbers and Websites") can be contacted for questions about:

- Medigap policies
- Medicare health plan choices
- Help with filing an appeal
- Other general health insurance questions

State Survey Agency

The State Survey Agency inspects dialysis facilities and ensures that Medicare standards are met. The State Survey Agency can also help with complaints about a patient's care. Patients can call 1-800-MEDICARE (1-800-633-4227) and ask for the number for their State Survey Agency or go to ***http://www.medicare.gov*** on the Internet. Scroll down to "Search Tools" on the left of the page and select "Find Helpful Phone Numbers and Websites." All calls are kept private.

Other Medicare Resources for Kidney Patients

Medicare has developed a number of resources that kidney patients may find valuable:

- The official U.S. Government site for people with Medicare is ***http://www.medicare.gov*** on the Internet. This website was developed and is maintained by the Centers for Medicare & Medicaid Services as a resource for all Medicare beneficiaries. In addition to providing information about the standard program, it includes tools and information specific to kidney disease. For example the "Compare Dialysis Facilities in Your Area" tool allows patients to identify dialysis facilities based on facility name, city, zip code, county, or state and then compare the results of multiple facilities.

- ***You Can Live: Your Guide for Living with Kidney Failure.***
  This guide was designed to provide kidney patients, family members, and caregivers with information about kidney disease and its treatment. It includes information about dialysis and kidney transplants.

- ***Preparing for Emergencies, A Guide for People on Dialysis.***
  This guide provides important facts about what to do in case of an emergency that leaves patients without power or water. It describes the information beneficiaries should have ready, provides a list of supplies to have on hand in case of emergency, and gives helpful ideas about managing until conditions return to normal.

Patients can get free copies of these booklets by calling 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or by viewing or printing copies online from ***http://www.medicare.gov/Publications*** on the CMS website.

ESRD Networks and State Health Insurance Assistance Program phone numbers can be found at ***http://www.medicare.gov*** (Scroll down to “Search Tools” and select “Find Helpful Phone Numbers and Websites”) on the Internet, or to get the most updated phone numbers, call 1-800-MEDICARE (1-800-633-4227; TTY/ TDD: 1-877-486-2048 for the hearing and speech impaired).

SECTION 9:

Medicare Coverage Charts

Medicare Part A Coverage

Medicare Part A (Hospital Insurance) Helps Pay for:	What the Patient Pays in 2008* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care in critical access hospitals and mental health care. This does not include private duty nursing or a television or telephone in the patient's room. It also does not include a private room unless medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period:** • A total of $1,024 for a hospital stay of 1–60 days. • $256 per day for days 61–90 of a hospital stay. • $512 per day for days 91–150 of a hospital stay. • All costs for each day beyond 150 days.
Skilled Nursing Facility Care: **Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related 3-day hospital stay).	**For each benefit period:** • Nothing for the first 20 days. • Up to $128 per day for days 21–100. • All costs beyond the 100th day in the benefit period. For questions about skilled nursing facility care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227).
Home Health Care: **Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech–language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.	**The patient pays:** • Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment. For questions about home health care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227).

Medicare Part A (Hospital Insurance) Helps Pay for:	What the Patient Pays in 2008* in the Original Medicare Plan
Hospice Care: **For beneficiaries with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in the beneficiary's home (may include a nursing home if that is the patient's home). However, Medicare covers some short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).	**The patient pays:** • A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care. The amount the beneficiary pays for respite care can change each year. Medicare generally does not pay for room and board except in certain cases. For example, room and board are not covered if the beneficiary gets general hospice services while a resident of a nursing home or a hospice's residential facility. However, room and board are covered for inpatient respite care and during short-term hospital stays.
Blood: Pints of blood provided at a hospital or skilled nursing facility during a covered stay.	**The patient pays:** • For the first three pints of blood unless the beneficiary or someone else donates blood to replace what the beneficiary used.

* New Parts A and B amounts will be available by January of each year.

** Note: Actual amounts the beneficiary must pay may be higher if the doctor or supplier does not accept assignment, and the beneficiary may have to pay the entire charge at the time of service. Medicare will then send the beneficiary his/her share of the charge. If there are general questions about Medicare Part B, patients should call their Medicare Carrier/intermediary. If patients have questions about durable medical equipment, including diabetic supplies, they should call their durable medical equipment regional carrier. For telephone numbers, go to **http://www.medicare.gov** on the Internet. Select "Find Helpful Phone Numbers and Websites" or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Medicare Part B Coverage Chart

Medicare Part B (Medical Insurance) Helps Pay for:	What the Patient Pays in 2008* in the Original Medicare Plan**
Medical and Other Services: Doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers a second and third surgical opinion for surgery that is not an emergency, outpatient mental health care, and outpatient physical and occupational therapy, including speech–language therapy. (These services are also covered for long-term nursing home residents.)	**The patient pays:** • $135 deductible (once per calendar year). • 20% of the Medicare-approved amount after the deductible (if the doctor or provider accepts "assignment"). • 20% for all outpatient physical, occupational, and speech–language therapy services. • 50% for most outpatient mental health care.

Medicare Part B (Medical Insurance) Helps Pay for:	What the Patient Pays in 2008* in the Original Medicare Plan**
Clinical Laboratory Service: Blood tests, urinalysis, some screening tests, and more.	**The patient pays:** • Nothing for Medicare-approved services.
Home Health Care: ** Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech–language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.	**The patient pays:** • Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment. For questions about home health care and conditions of coverage, patients can call their regional home health intermediary.**
Outpatient Hospital Services: Hospital services and supplies received as an outpatient as part of a doctor's care.	**The patient pays:** • A coinsurance or copayment amount that may vary according to the service. No less than 20% of the Medicare payment amount after the deductible.
Blood: Pints of blood the patient gets as an outpatient or as part of a Part B-covered service.	**The patient pays:** • For the first three pints of blood then 20% of the Medicare-approved amount for additional pints of blood (after the deductible) unless the patient or someone else donates blood to replace what the patient used.

* New Parts A and B amounts will be available by January of each year.

** Note: Actual amounts the beneficiary must pay may be higher if the doctor or supplier does not accept assignment, and the beneficiary may have to pay the entire charge at the time of service. Medicare will then send the beneficiary his/her share of the charge. If there are general questions about Medicare Part B, patients should call their Medicare Carrier/intermediary. If patients have questions about durable medical equipment, including diabetic supplies, they should call their durable medical equipment regional carrier. For telephone numbers, go to ***http://www.medicare.gov*** on the Internet. Select "Find Helpful Phone Numbers and Websites" or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

SECTION 10:

Acronyms and Key Definitions

Acronyms

AV	arteriovenous
CBSA	Core Based Statistical Area
CCPD	continuous cycler-assisted peritoneal dialysis
CMS	Centers for Medicare & Medicaid Services
ESRD	End-stage renal disease
HMO	Health Maintenance Organization
MMA	The Medicare Prescription Drug Improvement and Modernization Act of 2003
PPO	Preferred Provider Organization

Key Definitions

Appeal is a special process patients can use if they disagree with any decision about their health care service; for example, if Medicare does not pay for a service they received. This complaint is made to the Medicare health plan or the Original Medicare Plan. There is usually a special process that patients must follow to make a complaint.

Assignment in the Original Medicare Plan means that a doctor agrees to accept Medicare's fee as full payment. If patients are in the Original Medicare Plan, it can save them money if their doctors accept assignment. They still pay for their share of the cost of a doctor's visit.

Benefit Period is the time that Medicare measures a patient's use of hospital and skilled nursing facility services. A benefit period starts the day the patient goes to a hospital or skilled nursing facility. The benefit period ends when a patient has not

received hospital or skilled nursing care for 60 days in a row. If a patient goes into the hospital after one benefit period has ended, a new benefit period begins. The patient must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods patients can have.

Coinsurance is the percentage of the Medicare-approved amount that a patient has to pay after he/she pays the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (e.g., 20%).

Coordination Period is a period of time when a patient's employer group health plan will pay first on his/her health care bills and Medicare will pay second. If the patient's employer group health plan does not pay 100% of the patient's health care bills during the coordination period, Medicare may pay the remaining costs.

Deductible is the amount a patient must pay for health care before Medicare begins to pay, either each benefit period for Part A or each year for Part B. These amounts can change every year.

End-Stage Renal Disease is kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

General Enrollment Period for Parts A and B is January 1 through March 31 of each year. If a patient enrolls in Part B or Part A (if he/she does not get it automatically without paying a premium) during the general enrollment period, coverage starts on July 1.

Grievance is a complaint about the way a patient's Medicare health plan is providing care. For example, a patient may file a grievance if he/she has a problem with the cleanliness of the health care facility, telephone access to the plan, staff behavior, or operating hours. A grievance is not the same as an appeal, which is the way to address a complaint about a treatment decision or a service that is not covered (see Appeal).

Medically Necessary describes services or supplies that:

- Are proper and needed for the diagnosis or treatment of the patient's medical condition
- Are provided for the diagnosis, direct care, and treatment of the patient's medical condition
- Meet the standards of good medical practice in the medical community of the patient's local area
- Are not mainly for the convenience of the patient's doctor

Medicare Advantage Plan is a Medicare program that gives the beneficiary more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have end-stage renal disease unless certain exceptions apply.

Medicare-Approved Amount is the Medicare payment for an item or service. This is the amount the doctor or supplier is paid by Medicare and the patient for a service or supply. It may be less than the actual amount charged by the doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Managed Care Plan describes health care choices in some areas of the country. In most plans, the beneficiary can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras such as extra days in a hospital. The beneficiary's costs may be lower than in the Original Medicare Plan.

Medicare Preferred Provider Organization is a Medicare Advantage Plan in which the beneficiary uses doctors, hospitals, and providers that belong to a network. The beneficiary can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-for-Service Plan is a private insurance plan that accepts people with Medicare. The beneficiary may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what the beneficiary will pay for the services received. The beneficiary may pay more for Medicare-covered benefits. The beneficiary may receive extra benefits that the Original Medicare Plan does not cover.

Original Medicare Plan is a fee-for-service health plan that lets the beneficiary go to any doctor, hospital, or other health care supplier that accepts Medicare and is accepting new Medicare patients. The beneficiary must pay the deductible. Medicare pays its share of the Medicare-approved amount, and the beneficiary pays his/her share (coinsurance). The Original Medicare Plan has two parts: Part A (hospital insurance) and Part B (medical insurance).

Premium is the amount the beneficiary pays monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Secondary Payer is the insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

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