Q Will Medicare pay for a vascular access placement before a patient starts dialysis?

A Unless the patient qualifies for Medicare due to age or another disability prior to initiating dialysis, Medicare will not pay for vascular access placement before the patient initiates out-patient dialysis. This is a primary reason why many patients begin dialysis with a catheter. Once the patient begins dialysis and qualifies for Medicare, they should be evaluated for a permanent vascular access placement which may also include vessel mapping. The best access for the majority of patients is an AV fistula.

Q Can dialysis patients join HMOs?

A No. Traditionally ESRD patients have been prohibited from joining Health Maintenance Organizations but could remain in the group if they contracted ESRD after joining.

If you have any questions, please contact your local Social Security District Office or the Social Worker in the Dialysis Unit or Transplant Program.

MARC

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MEDICARE ISSUES AND ANSWERS

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MEDICARE ENTITLEMENT UPDATE

This brochure attempts to clarify misconceptions regarding Medicare coverage and to answer several commonly asked questions. The Network receives many questions from dialysis personnel, patients and plan administrators regarding Medicare coverage. This publication may be useful to these persons as well as others interested in entitlement issues.

Q What is Medicare Part A?

A Medicare Part A is hospital insurance for the aged, disabled and individuals who have ESRD. Part A helps pay for care in a hospital and skilled nursing facility and for home health and hospice care. There is no cost for Part A for individuals who meet the work requirement or who are the dependent(s) of an individual who meets the work requirement. Individuals age 65 or older who do not meet the work requirement may purchase Part A by paying monthly premiums.

Q What is Medicare Part B?

A Part B is medical insurance which helps pay for doctor bills, outpatient hospital care (including dialysis), and various other services not covered by Part A. Part B is optional and requires the payment of monthly premiums.

Q What does Medicare Coordination of Benefits (COB) mean?

A The COB is a 30-month period in which Medicare is the secondary payer. This begins with the first month the patient is eligible for Medicare due to permanent kidney disease, whether or not the patient applies. In the case of hemodialysis Medicare becomes active on the first day of the 4th month of dialysis, which begins the 30 month COB period. In peritoneal dialysis, transplantation, or home hemodialysis the COB begins on the first month.

The 30-month coordination period also applies to people already entitled to Medicare because of age or disability who later develop ESRD. After 30 months the primary insurer is under no legal obligation to pay as the primary insurer. This applies even if the patient is still employed.

Q Can there be a second coordination period?

A Yes, if the patient has more than one period of Medicare entitlement. For example: If a kidney transplant functions for 36 months, Medicare is terminated. If the transplant fails beyond this 36 month period and the patient returns to dialysis or receives another transplant, the patient must file a new application for Medicare. There is a new 30-month coordination period for individuals covered by an employer group health plan.

In cases where there is no lapse in Medicare coverage, then Medicare would remain primary. For example, if a kidney transplant functions for 36 months, the ESRD Medicare terminates, but the patient qualifies for Medicare to continue based on a different disability or age. The transplant then fails and the patient returns to dialysis. ESRD Medicare would reinstate and Medicare remains primary.

Q Can a patient with employee group coverage delay enrolling in ESRD Medicare until close to the time that Medicare becomes primary?

A Yes. There is no law requiring a patient to file an application for Medicare. If the individual is adequately covered under an employer group health plan he/she may file for Medicare at any time during the coordination period. If the individual wants Medicare coverage to be effective with the first month Medicare is primary payer, the earliest the application can be filed is in the 27th month of the coordination period.

If an individual with group health plan coverage does not want to enroll in Part B and pay the premiums, he/she should be advised to delay filing the application for Part A .

Q Why?

A If an individual does not enroll in Part B at the time he/she files for Part A, he may only enroll in Part B during the general enrollment period -- January through March of each year. Part B coverage becomes effective July 1 of the year of enrollment. **In a worse case scenario**, **this can lead to a delay in receiving Part B benefits of up to 15 months.** In addition, the law requires that the Part B premium be increased by 10% for each full 12-month period the individual was not enrolled in Part B.

Example: A patient applies for Part A Medicare and declines Part B because he has employer group health insurance with good benefits under his spouse's plan. On March 31st, the company goes bankrupt or the spouse is terminated. The patient cannot enroll in Medicare B until the first month of the General Enrollment Period – January – and benefits will not start until July of the following year. Based on the current Medicare basic premium, a 10% surcharge would be assessed for each year of delayed enrollment. If the patient with group coverage had delayed applying for both A and B, he would be eligible to apply for Medicare A and B when the group insurance was terminated and there would be no surcharges.

Q Why should a 2728 still be completed for patients who choose not to enroll in Medicare?

A The CMS-2728 serves two purposes: medical evidence of the end stage renal condition for Medicare entitlement, and registration of the patient with the national renal registry. The form is sent to the Network where it is keyed and electronically sent to CMS. CMS provides the data to the United States Renal Data System (USRDS) for scientific research. Therefore, the form must be completed on all patients, even those not initially applying for Medicare. If the patient is not applying for Medicare because of adequate employer coverage, mark item 11 "no" on the 2728 and submit to the Network as usual. Keep the original form with the patient's medical record. When the patient wants to apply for Medicare, the form should be taken to the local Social Security Office for processing. The Network does not need to be notified of the patient's decision to apply. Instructions for handling the CMS-2728 are in the Renal Dialysis Facilities Manual.

Q Should a patient covered under an employee health plan ever apply for Medicare A and B as soon as he or she becomes eligible?

A If the individual is adequately covered under an employer plan, he/she may file the application for Medicare at any time. The decision rests partly on the adequacy of the group plan, which can vary widely. If the group plan is not comprehensive, Medicare is a secondary insurance. Having Medicare as a secondary insurance may also eliminate some billing problems for the patient: providers must accept the Medicare assignment (negotiated rate). If the group insurer has already paid more than the Medicare assignment, it is likely that the patient can not be billed.

When reviewing their plans, patients should be advised to pay particular attention to caps on services or medications. This is particularly important for patients considering transplants. If there are questions concerning coverage, individuals should be advised to consult an employer health benefits officer or a representative of the group health plan. The individuals must determine whether it is advantageous to file for Medicare when first eligible. The Social Security Office is only obligated to advise individuals about their options and of the consequences of declining Part B when signing up for Part A. **Do not refer patients to SSA for counseling about individual health plans.**

Q Can Medicare require a patient to pay back premiums if he/she signs up for Part B, discontinues paying premiums and later wants to be reinstated?

A Under current law, Part B coverage is terminated if the premium is not paid by the due date. The termination is effective 90 days after receipt of the billing notice. Individuals are notified in the termination letter that Part B coverage may be reinstated if all past due premiums are paid within 60 days of the receipt of the termination letter. If payment is not received within 60 days, Part B coverage will NOT be reinstated. The individual must reenroll in Part B during the general enrollment period.

Q Why should a person who is already entitled to Medicare due to age (65 or older) apply for ESRD Medicare?

A For persons already entitled to Medicare due to age (65 or older), entitlement to Medicare on the basis of ESRD will not be developed unless there is some advantage to the beneficiary. An advantage may accrue if:

- The patient is not currently enrolled in Part B (ESRD provides a second initial enrollment period);
- The patient is paying an increased premium because of late enrollment in Part B;
- The patient has recently become entitled to Medicare on the basis of age and ESRD coverage would result in an earlier entitlement date;
- The patient is paying premiums for Part A.

Q What if a patient is already eligible for Medicare under another disability?

A A disabled individual should file an application for Medicare based on ESRD regardless of the entitlement to Medicare based on disability. It is important to remember that aged, disabled and ESRD Medicare are different programs and different rules apply.

Q If a patient has employer based health insurance, will Medicare be primary for all health costs after 30 months or just renal related expenses?

A Medicare is Medicare. If a person is covered by Medicare based on renal disease, he/she is entitled to any coverage provided by Medicare, not just renal services. Medicare becomes primary for everything after 30 months.

Q Will Medicare pay for immunosuppressive drug therapy in connection with an organ transplant which Medicare did not pay for because a primary insurer paid for the transplant in full?

A Yes. Medicare will cover immuno-suppressive drugs when they did not pay for the transplant if Medicare would have paid for the transplant except for the fact that Medicare was the secondary payer.

Q Under what circumstances will Medicare pay for ambulance transportation to dialysis?

A Ambulance transportation to the closest appropriate ESRD facility is reimbursable when there is sufficient evidence of medical necessity to warrant the transportation. Conditions that would warrant medical necessity include:

- Emergency situations
- Patient can only be moved by stretcher. In this case Medicare pays 80% of the Medicare-approved amount after you meet the yearly Part B deductible. (Medicare's payment may be different if you get services from a hospital-based ambulance company.) You pay 20% of the Medicare approved amount after you meet the Part B deductible.

CMS is strictly adhering to these guidelines and the Office of Inspector General will take legal action against offenders.