Medicare Coverage of Kidney Dialysis and Kidney Transplant Services

If you have permanent kidney failure, this booklet is for you.

It tells you . . .

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

This booklet also has special information about pancreas transplants, see page 36.

To find out how to use this booklet, see page 5.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The Centers for Medicare & Medicaid Services would like to thank the American Association of Kidney Patients (AAKP) and its Executive Director, Kris Robinson, for providing the photos and quotes from AAKP members for this booklet. Thanks to the following AAKP members for sharing themselves and their experiences:

Bonny Willburn, Hemodialysis patient
Donald Dowe, MSW, Transplant patient
Rosalyn Feldman, Hemodialysis patient
Brenda Dyson, Transplant patient

A Letter from Kidney Patients to Kidney Patients

Learning that you have permanent kidney failure is not easy. We are here to tell you that even though you may feel sad, confused, or even frustrated, you can adjust and take control of your life. The fact that you're reading this booklet is a start.

You may be worried about how to pay your medical costs. We know we were. But did you know that there is a program that will help pay your kidney dialysis and transplant costs, even if you're under age 65? That program is called Medicare, a Federal health insurance program. That's what this booklet is about. You can read more about what Medicare is and how to sign up for it on pages 6–11 of this booklet.

"I found out about Medicare coverage after a meeting with my social worker, who gave me all the information that was available."

- Bonny
Hemodialysis patient

"I had no knowledge of the relationship of ESRD and Medicare. I found out that Medicare covered dialysis from a co-worker. Thankfully, I followed that co-worker's advice."

- Don
Transplant
patient

"My End-Stage Renal Disease was sudden in 1987 and I did not know that Medicare was available to help cover the cost of dialysis treatments and other medical costs. When I learned that my disease made me eligible for Medicare, the burden of my hospital and medical costs were resolved."

- Rosalyn
Hemodialysis patient

Learning all of the "ins" and "outs" of Medicare can be confusing. If you have questions after reading this booklet, don't be afraid to ask someone for help. There are phone numbers of people that can help you on pages 50 and 51. You can also talk to the social worker at your dialysis facility or transplant center to get help understanding what is and isn't covered by Medicare.

Take care,

Bonny, Don, & Rosalyn
Kidney patients

Finding What You Want to Know

Finding What You Want to Know

This booklet explains how Medicare helps pay for kidney dialysis and kidney

Introduction

transplant services in the Original Medicare Plan, also known as "fee-for-service." If you are in a Medicare Advantage Plan (new name for Medicare + Choice), which includes Medicare Managed Care Plans, Medicare Private Fee-for-Service Plans and Medicare Preferred Provider Organization Plans, your plan must give you at least the same coverage that the Original Medicare Plan gives, but it may have different rules. Your costs, rights, protections, and/or choices of where you get your care may be different if you are in one of these plans, and you may be able to get extra benefits. Read your plan materials or call your benefits administrator for more information.

This booklet does not have detailed information about kidney failure, dialysis treatments, and kidney transplants. To learn more about these things, talk with your health care team. Your doctors, nurses, social workers, dieticians, and dialysis technicians make up your health care team. They are there to help you. You should also talk with your doctor about your treatment options. You and your doctor can decide what's best for you based on your situation.
This booklet has 10 sections. You can tell which section

"My kidney failure was very sudden. I had no time to prepare my mind or think about how I was going to pay for it. I was pleased to find out that I was eligible for Medicare. It took a great deal of stress away knowing that I had help paying for my illness."

- Brenda
Transplant
patient

Remember, terms in **red** are defined on pages 57–58.

you are reading by the heading at the top of each page. Terms in red are defined on pages 57–58.

Do you:	**Read page(s):**
Want to find a specific topic in this booklet?	59–60 - **Index:** An alphabetical list of all topics in this booklet and the page(s) where you will find the information you need.
Want to find out if you are eligible for Medicare?	9
Want to sign up for Medicare?	10–11
Want to know what Medicare covers for kidney dialysis?	22–23
Want to know what Medicare covers for kidney transplants?	34–37
Have an Employer Group Health Plan?	15–17
Want to know where to get help?	47–51
Have a problem or complaint?	41–42
Want to know about transportation to dialysis?	32
Want to know about dialysis when you travel?	31–32
Want to know what you pay for kidney dialysis?	25–31
Want to know what you pay for kidney transplants?	37–38
Want to know about transplant drugs?	35–36
Want to know other ways to get help with your health care costs?	43–46

1 Medicare Basics

What is Medicare?

Medicare is a health insurance program for:

- People age 65 and older.
- Some people with disabilities under age 65.
- Most people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant sometimes called ESRD).

The Two Parts of Medicare

Medicare has two parts:

To get more details about what Medicare covers, look at the Medicare Part A and Part B coverage charts on pages 52–55.

1. Part A (Hospital Insurance) helps pay for:

- Inpatient hospital care
- Some skilled nursing facility care
- Hospice care
- Some home health care

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.

2. Part B (Medical Insurance) helps pay for:

- Doctors' services
- Outpatient hospital care
- Some other medical services that Part A doesn't cover (like some home health care)

Part B helps pay for these covered services and supplies when they are medically necessary.

(Continued on page 7)

Remember, terms in **red** are defined on pages 57–58.

The Two Parts of Medicare (continued)

*Any change in the Part B premium amount will be available on January 1st of each year.

2. **Part B (Medical Insurance), continued**

Everyone must pay a monthly premium for Medicare Part B. The Medicare Part B premium for 2004 is $66.60* per month. Premium rates can change yearly. This amount may be higher if you do not sign up for Part B when you first become eligible. The cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not sign up for it. You may have to pay the higher premium for as long as you have Part B. If you are paying a higher premium because you did not sign up for Part B when you were first eligible for Medicare based on age or disability, the higher premium will be removed when you sign up for Part B based on ESRD (see page 10).

> Your Medicare Part B will stop if you do not pay the monthly premiums or if you decide to cancel it.

If you need Medicare because of kidney failure, see page 10 to find out how to sign up for it.

Medicare Health Plan Choices

Today's Medicare is about choice. Your health plan choices include:

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

(Continued on page 8)

Medicare Health Plan Choices (continued)

*Any change in the Part B premium amount will be available on January 1st of each year.

You may not be able to join a Medicare Advantage Plan if you have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). People 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. You must continue to pay the monthly Part B premium of $66.60* in 2004.

If you've had a successful kidney transplant, you may be able to join a plan. Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare health plans.

If you have ESRD and are in a plan and the plan leaves Medicare or no longer provides coverage in your area, you can join another Medicare Advantage Plan if one is available in your area.

For more information about your 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. You can also read or print a copy of this handbook at www.medicare.gov on the web. Select "Publications."

Medicare does not pay for everything. There are some types of insurance that may pay some of the health care costs that Medicare doesn't pay (see pages 43–46).

Medicare for People with Kidney Failure

Who is Eligible?

You can get Medicare Part A no matter how old you are if your kidneys no longer work and you need regular dialysis or have had a kidney transplant, and:

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

If you get Medicare Part A you can also get Medicare Part B. Enrolling in Part B is your choice.

You will need both Part A and Part B in order for Medicare to cover certain dialysis and kidney transplant services.

If you can't get Medicare, you may be able to get help from your state to pay for your dialysis treatments (see page 45).

*Call the Social Security Administration at 1-800-772-1213 for more information about the required amount of time needed under Social Security, the Railroad Retirement Board, or as a government employee to be eligible for Medicare based on ESRD.

Medicare for People with Kidney Failure

How to Sign Up for Medicare

- If you need Medicare because of ESRD (permanent kidney failure), you can enroll in Medicare Part A and Part B based on ESRD at your local Social Security office. Call or visit your local Social Security office or call Social Security at 1-800-772-1213 to make an appointment to enroll in Medicare based on ESRD.

The cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not sign up for it. **In order to keep from having to pay a higher Part B premium, you should enroll in Medicare Part B when you apply for Medicare Part A based on ESRD**. Call or visit your 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 you have Medicare Part A because of age or disability, but did not take Part B, or your Part B coverage was stopped, you can enroll in Part B without paying a higher premium rate if you enroll in Medicare based on End-Stage Renal Disease. Call or visit your local Social Security Office or call Social Security at 1-800-772-1213 to make an appointment to enroll in Medicare based on End-Stage Renal Disease.

If you are paying a higher Part B premium because you didn't enroll in Part B when you were first eligible for Medicare based on age or disability, the premium will be reduced to the base rate of $66.60*, per month in 2004 when you are entitled to Medicare based on ESRD, (see "Important Note" below).

*Any change in the Part B premium amount will be available on January 1st of each year.

Important Note:
In order to stop paying the higher premium rate, you must enroll in Medicare based on ESRD.
Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD.

Medicare for People with Kidney Failure

How to Sign Up for Medicare (continued)

"When I started dialysis, I already had Medicare because I was 67 years old. I had Medicare Parts A and B, but was paying a higher Part B premium because I didn't take it when I first got Medicare. My social worker told me to go to Social Security to enroll in Medicare based on ESRD. When I did that, the cost of my Part B premium went down."

-Linda
Transplant patient

Paying for Medicare Part B

When you sign up for Medicare Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Office of Personnel Management payment. If you don't get any of these payments, Medicare sends you a bill for your Part B premium every 3 months. You should get your Medicare premium bill by the 10th of the month. If you don't get your bill by the 10th, call the Social Security Administration at 1-800-772-1213.

Remember, you must pay your Medicare Part B premium. If you don't pay your Part B premium, or if you choose to cancel it, your Medicare Part B coverage will end.

When Medicare Coverage Begins

When you enroll in Medicare based on ESRD (permanent kidney failure) and you are on dialysis, your Medicare coverage usually starts the fourth month of dialysis treatments. For example, if you start getting your hemodialysis treatments in July, your Medicare coverage would start on October 1.

If you are covered by an employer group health plan, your Medicare coverage will still start the fourth month of dialysis treatments. Your employer group health plan will pay first on your health care bills and Medicare will pay second for a 30-month coordination period. See pages 15–17, "How Medicare Works with Employer Group Health Plan Coverage."

If you don't have employer group health plan coverage, there are other types of insurance and programs that may help to pay some of your health care costs (see pages 43–46).

There Are Four Ways You May Be Able to Get Medicare Coverage Sooner

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

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

   - You take part in a home dialysis training program in a Medicare-approved training facility, to teach you how to give yourself dialysis treatments at home; and
   - You begin home dialysis training before the fourth month of dialysis; and
   - You expect to finish home dialysis training and give yourself dialysis treatments.

   Talk to your doctor about your dialysis treatment options.

When Medicare Coverage Begins (continued)

2. **Medicare coverage can start the month you are admitted to a Medicare-approved hospital for a kidney transplant, or for health care services that you need before your transplant if . . .**

   - Your transplant takes place in that same month or within the 2 following months.

3. **Medicare coverage can start 2 months before the month of your transplant if . . .**

   - Your transplant is delayed more than 2 months after you are admitted to the hospital for the transplant or for health care services you need before your transplant (see Example, below).

Example:
Mrs. Perkins was admitted to the hospital on May 25th for some tests she needed before her kidney transplant. She was supposed to get her transplant on June 15th. However, her transplant was delayed until September 15th. Therefore, Mrs. Perkins' Medicare coverage will start in July, two months **before** the month of her transplant.

4. **Medicare coverage starts the first month of dialysis if...**

   - You had a prior period of Medicare based on ESRD.

When Medicare Coverage Ends

If you have Medicare only because of kidney failure, your Medicare coverage will end:

- 12 months after the month you stop dialysis treatments, or
- 36 months after the month you have a successful kidney transplant.

Your Medicare coverage will not end if:

- You have to start dialysis again or you get a kidney transplant within 12 months after the month you stopped getting dialysis, or
- You start dialysis or get another kidney transplant within 36 months after a transplant.

Important:
Remember, in order for Medicare to pay for kidney dialysis and some transplant services, you need both Medicare Part A and Part B. If you don't pay your Medicare Part B **premium** or if you choose to cancel it, your Medicare Part B will end.

How Medicare Works With Employer Group Health Plan Coverage

If you are eligible for Medicare only because of permanent kidney failure, your Medicare coverage usually will not start until the fourth month of dialysis (see page 12). Medicare will not pay anything during your first 3 months of dialysis unless you already have Medicare because of age or disability. Therefore, your employer group health plan is the only payer for the first 3 months of dialysis.*

*If your employer plan does not pay all costs for dialysis, you may have to pay some of the costs. You may be able to get help to pay these costs (see pages 43–46).

When you are eligible for Medicare because of kidney failure (usually the fourth month of dialysis), there is a period of time when your employer group health plan will pay first on your health care bills and Medicare will pay second. This period of time is called a 30-month coordination period. This means that if your employer plan doesn't pay 100% of your health care bills during the 30-month coordination period, Medicare may pay 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 you are able to get Medicare because of kidney failure (usually the fourth month of dialysis), even if you have not signed up for Medicare yet. For example, if you start dialysis in June, the 30-month coordination period will start September 1, the fourth month of dialysis.

(Continued on page 16)

Remember, terms in **red** are defined on pages 57–58.

How Medicare Works With Employer Group Health Plan Coverage

When the 30-Month Coordination Period Starts (continued)

If you take a course in self-dialysis training or get 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 you have employer group health plan coverage during the 30-month coordination period, tell the person who provides your medical care that you have an employer group health plan. This is very important in order to make sure that your 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. Your employer group health plan coverage may pay for services not covered by Medicare. Check with your plan's benefits administrator.

How the 30-Month Coordination Period Works if You Enroll in Medicare More Than Once

There is a separate 30-month coordination period each time you enroll in Medicare based on kidney failure. For example, if you get a kidney transplant that continues to work for 36 months, your Medicare coverage will end. If after 36 months you enroll in Medicare again because you start dialysis or get another transplant, your Medicare coverage will start right away. There will be no 3-month waiting period before Medicare begins to pay. There will be a new 30-month coordination period if you have employer group health plan coverage.

How Medicare Works with Employer Group Health Plan Coverage

Do I Have to Get Medicare Because My Kidneys Fail, if I Already Have an Employer Group Health Plan?

No, but you should think carefully about this decision. If you already have an employer group health plan, consider the following:

1. If you get a kidney transplant, Medicare will cover your immunosuppressive drugs (see pages 35–36) only if:
   - You have Medicare Part A at the time of the transplant and the transplant is paid for by Medicare; or
   - You have Medicare Part A at the time of the transplant and Medicare does not pay for the transplant because Medicare is secondary payer to your employer group health plan; or
   - You have Medicare Part A at the time of the transplant and you become eligible for Medicare because of age or disability.

   In both instances, the transplant surgery must have taken place in a Medicare-approved facility. In addition to the above conditions, you must have Medicare Part B coverage at the time you receive the immunosuppressive drugs.

2. If your group health plan coverage has a yearly deductible or a coinsurance to pay, enrolling in Medicare Parts A and B could help pay those costs.

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

Call or visit your local Social Security office to make an appointment to enroll in Medicare based on ESRD.

For More Information About How Employer Group Health Plan Coverage Works With Medicare . . .

- Get a copy of your plan's benefits booklet, or
- Call your benefits administrator and ask how the plan pays when you have Medicare.

2 Kidney Dialysis

What is Dialysis?

Dialysis is a treatment that cleans your blood when your kidneys don't work. It gets rid of harmful wastes and extra salt and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments help you feel better and live longer, but they are not a cure for permanent kidney failure.

Where to Get Dialysis Treatments

Dialysis can be done at home or in a medical facility. In order for Medicare to pay for your treatments, the facility must be approved to provide dialysis (even if they already provide other Medicare-covered health care services).

At the dialysis facility, a nurse or a trained technician may give you the treatment. At home, you can treat yourself with the help of a family member or friend. If you decide to do home dialysis, you and your helper will get special training. (See page 20, "Home Dialysis Treatment Options").

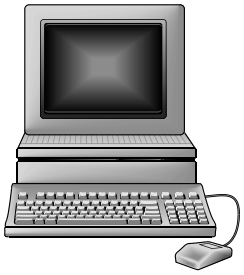
Remember, terms in **red** are defined on pages 57–58.

Do you have a problem with the care that you're getting from your dialysis facility? If so, you have the right to file a grievance (complaint) to resolve your problem. See Section 5 on page 42, "Filing a Grievance (Complaint)" for more information.

How to Find a Dialysis Facility

In most cases, the facility your kidney doctor works with is where you will get dialysis treatments. However, you have the right to choose to get your treatments from another facility at any time. Keep in mind, this could mean changing doctors.

You can also call your local ESRD Network (see pages 50–51) to find a facility that is close to you.



"Dialysis Facility Compare," on the Web

Dialysis Facility Compare has important information about Medicare-certified dialysis facilities in your area and around the country. Look at www.medicare.gov on the web. Select "Dialysis Facility Compare." You can find information such as facility addresses and phone numbers, how far certain facilities are from you, and what kind of dialysis services the facilities offer. You can also compare facilities by the services they offer and by certain quality of care information. Helpful websites, publications, and telephone numbers are also available. You can discuss the information on this website with your health care team.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

Home Dialysis Treatment Options

There are two types of dialysis that can be used at home, hemodialysis and peritoneal dialysis.

1. Hemodialysis uses a special filter (called a dialyzer) to clean your blood. The filter connects to a machine. During treatment, your blood flows through tubes into the filter to clean out wastes and extra fluids. Then the newly cleaned blood flows through another set of tubes and back into your body. This treatment is also used for home dialysis.

2. Peritoneal dialysis uses a cleaning solution, called dialysate, that flows through a special tube into your abdomen. After a few hours, the dialysate gets drained from your abdomen, taking the wastes from your blood with it. Then you fill your abdomen with fresh dialysate and the cleaning process begins again.

How do I know what type of dialysis I need?

You should work with your doctor and your health care team to decide the type of dialysis you need. You and your doctor can decide what's best for you based on your situation. The goal is to help you stay healthy.

"I was 32 years old when I first found out that I had kidney failure. I had a college degree and planned on working, so I worked with my doctor and we chose home hemodialysis."

- Brenda
Transplant
patient

Knowing How Well Your Dialysis is Working

Most dialysis patients get hemodialysis. You can tell how well the hemodialysis is working by keeping track of your URR or Kt/V number. Blood test results can tell you your URR and Kt/V numbers. These numbers tell your doctor or nurse how well dialysis is removing wastes from your body. Your doctor or nurse usually keeps track of one or both of these numbers, depending on which test your dialysis facility uses. Check with your doctor or nurse to find out which test they use.

Medicare has more detailed information on knowing how well the hemodialysis is working in a brochure called *Know Your Number . . . Are You Getting Adequate Hemodialysis?* This brochure also tells you what to do if you are not getting the right amount of dialysis. Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of this brochure. You can also read or print a copy of this brochure at www.medicare.gov on the web. Select "Publications."

Section 2: Kidney Dialysis

Dialysis Services and Supplies Covered by Medicare

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

Service or Supply	Medicare Part A	Medicare Part B
Inpatient dialysis treatments (if you are admitted to a hospital for special care)	✓	
Outpatient dialysis treatments (when you get treatments in any Medicare-approved dialysis facility)		✓
Self-dialysis training (includes instruction for you and for the person helping you with your home dialysis treatments)		✓
Home dialysis equipment and supplies (like 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 your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply)		✓
Certain drugs for home dialysis (see page 23)		✓
Outpatient doctors' services		✓
Most other services and supplies that are a part of dialysis, like laboratory tests		✓

To find out what you pay for these services, see pages 25–31.

Dialysis Services and Supplies Covered by Medicare

Home Dialysis Drugs Covered by Medicare

The most common drugs that Medicare Part B covers for home dialysis are:

- ✓ heparin,
- ✓ the antidote for heparin when medically necessary,
- ✓ topical anesthetics, and
- ✓ Epogent or Epoetin alfa.

Talk with your doctor or any member of your health care team about the use of these and any other drugs.

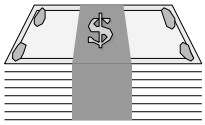
Section 2: Kidney Dialysis

Dialysis Services and Supplies NOT Covered by Medicare

Medicare does **not pay** for:

Service or Supply	Not covered
Paid dialysis aides to help with home dialysis	✗
Any lost pay to you and the person who may be helping you during self-dialysis training	✗
A place to stay during your treatment	✗
Blood or packed red blood cells for home self dialysis unless part of a doctors' service or is needed to prime the dialysis equipment	✗
Transportation to the dialysis facility (see page 32 for coverage in special cases)	✗

What YOU Pay for Dialysis Services



The costs listed in this section are for dialysis services in the Original Medicare Plan. If you are in a Medicare Advantage Plan, your costs may be different. Read your plan materials or call your benefits administrator to get information about your costs.

Dialysis in a Dialysis Facility

In the Original Medicare Plan, if you get 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's located. Medicare pays 80% of the composite rate. You pay the remaining 20% coinsurance that Medicare does not pay. See Example below.

Example

Let's say the composite rate is $130 per treatment. After you pay the $100 Part B yearly deductible:

- Medicare Part B pays the facility 80% of $130 (or $104).
- You pay the remaining 20% coinsurance (or $26).

There may be other services that may not be included in the composite rate. Your dialysis facility can give you 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. You must pay the 20% coinsurance.

(Continued on page 26)

Remember, terms in **red** are defined on pages 57–58.

Section 2: Kidney Dialysis

What YOU Pay for Dialysis Services

Dialysis in a Hospital

If you are admitted to a hospital and get dialysis, your treatments will be covered by Medicare Part A as part of the costs of your covered inpatient hospital stay. See the Medicare Part A coverage chart on page 52.

Doctors' Services

Outpatient Doctors' Services:

In the Original Medicare Plan, Medicare pays your kidney doctors once a month. The same monthly amount is paid for each Medicare patient the doctor cares for, whether dialysis is done in the home or in a dialysis facility. After you pay the $100 Part B yearly deductible, Medicare Part B pays 80% of the monthly amount. You pay the remaining 20% coinsurance. See Example below.

Example

Let's say the monthly amount that Medicare pays your doctor for each patient is $100. After you pay the $100 Part B yearly deductible:

- Medicare pays 80% of the $100 (or $80).
- You pay the remaining 20% coinsurance (or $20).

Inpatient Doctors' Services:

In the Original Medicare Plan, your kidney doctor can choose to be paid one of two ways for your inpatient hospital care:

1. Continue to get a monthly payment (the same payment for outpatient doctors' services). In this case, you must pay 20% of the monthly amount for your doctor's services.

2. Bill separately for inpatient services that are covered by Medicare Part A. In this case, your kidney doctor's monthly payment will be less based on the number of days you stay in the hospital. See the Medicare Part A coverage chart on page 52.

What YOU Pay for Dialysis Services

Self-Dialysis Training

Self-dialysis training is covered by Medicare Part B on an outpatient basis. Self-dialysis training costs more than dialysis treatments. The costs may be different from one dialysis facility to another, depending on the type of facility and where it's located. In the Original Medicare Plan, after you pay the $100 Part B yearly deductible, Medicare Part B will pay 80% of the training costs. You must pay the remaining 20% coinsurance. See Example below.

Example

Let's say the cost per training session is $150. After you pay the $100 Part B yearly deductible:

- Medicare Part B pays 80% of the $150 (or $120 per session).
- You must pay the remaining 20% coinsurance (or $30 per session).

Home Dialysis

You have two payment options for home dialysis:

1. **Dealing with Your Dialysis Facility (Method 1)**
   Under Method 1, you must get all services, equipment and supplies needed for home dialysis from your 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 you pay the $100 Part B yearly deductible, Medicare pays 80% of the composite rate. You pay the 20% coinsurance.

(Continued on page 28)

Remember, terms in **red** are defined on pages 57–58.

What YOU Pay for Dialysis Services

Home Dialysis (continued)

*For more information on how assignment works, call 1-800-MEDICARE (1-800-633-4227) to get a free copy of *Does your doctor or supplier accept assignment?*
You can also read or print a copy of this booklet at www.medicare.gov on the web.

2. **Dealing Directly With a Supplier (Method 2)**
   Under Method 2, you must get your dialysis equipment and supplies from one supplier. Your supplier must accept assignment.* This means that if you are in the Original Medicare Plan, your supplier agrees to accept Medicare's fee as full payment. Your supplier must also have a written agreement with a dialysis facility to make sure that you will get all necessary home dialysis support services. In the Original Medicare Plan, after you pay the $100 Part B yearly deductible, Medicare will pay 80% of the Medicare-approved charges for the items and services. You must pay the 20% coinsurance.

Under both Method 1 and Method 2, you must get your support services from your dialysis facility in order for Medicare to pay. Medicare will pay the facility directly for these services.

The chart on page 29 has specific information on what you pay for home dialysis equipment, supplies, and support services in the Original Medicare Plan using the Method 1 and Method 2 payment options.

Method 1 and Method 2 Payment Chart for Home Dialysis Equipment, Supplies, and Support Services in the Original Medicare Plan

Method	Home Dialysis Equipment	Home Dialysis Supplies	Home Dialysis Support Services
Dealing With Your Dialysis Facility (Method 1)	Medicare pays 80% of the facility's composite rate. You pay the 20% coinsurance.*	Medicare pays 80% of the facility's composite rate. You pay the 20% coinsurance.*	Medicare pays 80% of the facility's composite rate. You pay the 20% coinsurance.*
Dealing Directly With a Supplier (Method 2)	If you buy or rent home dialysis equipment, Medicare Part B will cover it. You must pay the $100 Part B yearly deductible (see note below). Medicare Part B usually makes monthly payments. If you buy the equipment, Medicare will pay 80% of the monthly payment purchase price. You pay the 20% coinsurance. The monthly Part B payment includes any interest or carrying charges. If you rent the equipment, Medicare Part B pays 80% of the approved monthly rental charge. You pay the 20% coinsurance.	After you pay the $100 Part B yearly deductible (see note below), Medicare Part B pays 80% of the approved charges for all covered supplies. You pay the 20% coinsurance.	After you pay the $100 Part B yearly deductible (see note below), Medicare Part B pays the facility 80% of the approved charges for all covered services. You pay the 20% coinsurance.

*Each year, you pay a total of one $100 Part B deductible.

Remember, terms in red are defined on pages 57–58.

What YOU Pay for Dialysis Services

Deciding Which Payment Option to Choose For Home Dialysis

Look at the Method 1 and Method 2 payment chart on page 29. It can help you decide which payment option is best for you if you are in the Original Medicare Plan. If you still have trouble deciding, ask your social worker to help you.

After you have finished self-dialysis training and are ready to make a choice, you must:

1. Fill out a Beneficiary Selection Form CMS-382
2. Sign Form CMS-382
3. Return Form CMS-382 to your dialysis facility

You can get a copy of Form CMS-382 from your dialysis facility. Once you make your choice and turn in the form, you must stay with that payment option until December 31 of that year. For example, if you decide to go with the Method 2 payment option in August 2004, you must stay with that option until December 31, 2004.

You 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 you fill out your Form CMS-382 to change to Method 1 and return it to your dialysis facility in October 2004, this change will not start until January 1, 2005.

Important:

No matter which method you choose, you can make a change at any time to get your treatment with a dialysis facility, or choose another facility.

What YOU Pay for Dialysis Services

How Long Will Medicare Pay For Home Dialysis Equipment?

Medicare Part B will pay for home dialysis equipment as long as you need dialysis at home. If you no longer need home dialysis, Part B will stop paying. For example, if you had a kidney transplant and no longer need home dialysis, then Part B would stop paying for your equipment.

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

Dialysis When You Travel

You need to make plans for your dialysis treatment along the route of your trip before your travel. Your dialysis facility will help you with these plans. Before you make your plans, think about the following:

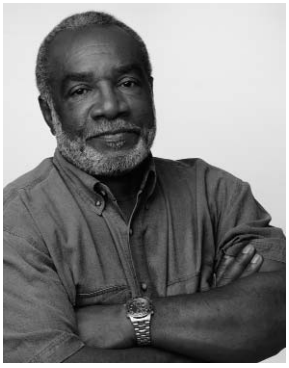
- ❒ Is the dialysis facility approved by Medicare to give dialysis?
- ❒ Does the facility have the space and time to give me care when I need it?
- ❒ Does the facility have enough information about me to give me the right treatment?
- ❒ Where is the facility located?

There are over 3,500 facilities around the country. Your facility or the ESRD Network (see pages 50–51) can help you get the names and addresses of those facilities.

(Continued on page 32)

You can also get information about Medicare-certified dialysis facilities in your area at www.medicare.gov on the web. Click on "Dialysis Facility Compare."

Dialysis When You Travel (continued)



"I travel to cities all over California for my job. The overnight trips are not a problem as long as I make plans for dialysis ahead of time in the cities I visit."

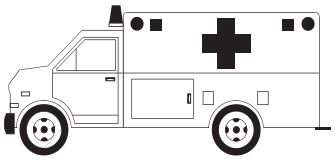
- Michael
Hemodialysis
patient

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

Caution:
Do you get your dialysis services from a Method 2 supplier (see page 28) or a Medicare Advantage Plan?

If so, your supplier or Medicare Advantage Plan may be able to help you arrange to get the dialysis you need while you travel. **You may have to pay all of the costs for your dialysis treatments.** Contact your supplier or health plan for more information.

Transportation to Dialysis Facilities



Does Medicare Pay for Transportation to Dialysis Facilities?

In most cases, no. Medicare covers roundtrip ambulance services from home to the nearest dialysis facility **only** if other forms of transportation would be harmful to your health.

The ambulance supplier must get a written order from your doctor before you get the ambulance service. The doctor's written order must be dated no earlier than 60 days before you get the ambulance service.

For more information about ambulance coverage, call the Social Security Administration at 1-800-772-1213.

3 Kidney Transplants

What is a Kidney Transplant?

A kidney transplant is a type of surgery that is done to put a healthy kidney from another person into your body. This new kidney does the work that your own kidneys can't do. You may get a kidney from someone who has recently died or from someone who is still living, like a family member. The blood and tissue of the person who gives you the kidney must be tested. This is done to see how well they match yours so that your body won't reject the new kidney.

Where to Get a Kidney Transplant

Your kidney transplant must be done in a hospital that is approved by Medicare to do kidney transplants.

Do you have a problem with the care that you're getting for your transplant? If so, you have the right to file a grievance (complaint) to resolve your problem. See page 42, "Filing a Grievance (Complaint)," for more information.

Remember, terms in **red** are defined on pages 57–58.

Kidney Transplant Services Covered by Medicare

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

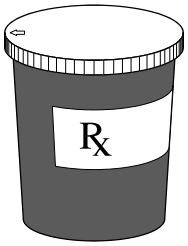
Service or Supply	Medicare Part A	Medicare Part B
Inpatient hospital services in an approved hospital (see the Medicare Parts A and B coverage charts on pages 52–55)	✓	
Kidney Registry Fee	✓	
Laboratory and other tests needed to evaluate your medical condition*	✓	
Laboratory and other tests needed to evaluate the medical conditions of potential kidney donors*	✓	
The costs of finding the proper kidney for your transplant surgery (if there is no kidney donor)	✓	
The full cost of care for your kidney donor (including all reasonable preparatory, operation, and postoperative recovery costs)	✓	
Any additional inpatient hospital care for your 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)		✓
Doctor's services for your kidney donor during their hospital stay		✓
Immunosuppressive drugs (for a limited time after you leave the hospital following a transplant, see pages 35–36)		✓
Blood (whole or units of packed red blood cells, blood components, and the cost of processing and giving you blood, see pages 39–40)	✓	✓

*These services are covered whether they are done by the Medicare-approved hospital where you will get your transplant, or by another hospital that participates in Medicare.

Transplant Services Covered by Medicare

To find out what you pay for the services in the chart on page 34, see pages 37–40.

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



Transplant Drugs (called Immunosuppressive Drugs)

What are Immunosuppressive Drugs?

Immunosuppressive drugs are transplant drugs used to reduce the risk of your body rejecting your new kidney after your transplant. You will need to take these drugs for the rest of your life.

Important note:
In order to be covered by Medicare for immunosuppressive drugs, the conditions on page 17 must be met.

What if I Stop Taking My Transplant Drugs?

If you stop taking them, your body may reject your new kidney and the kidney could stop working. If that happens, you may have to start dialysis again. Talk to your doctor before you stop taking your transplant drugs.

How Long Will Medicare Pay for Transplant Drugs?

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

If you have Medicare only because of kidney failure, this does not apply to you. Your Medicare and drug coverage will end when your 36-month period is up.

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

(Continued on page 36)

Transplant Services Covered by Medicare

What if I Can't Pay for the Transplant Drugs?

Transplant drugs can be very costly. If you have Medicare because of kidney failure, your immunosuppressive drugs are only covered for 36 months after the month of the transplant. If you are worried about paying for them, talk to your doctor, nurse, or social worker. There may be other ways to help you pay for these drugs. (See pages 43–46 to learn more about other health insurance.)

Special Information About Pancreas Transplants

If you have ESRD and need a pancreas transplant, Medicare covers pancreas transplants if it's done

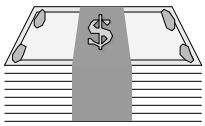
- at the same time you get a kidney transplant, or
- after a kidney transplant.

If you have Medicare only because of kidney failure, and you have the pancreas transplant after the kidney transplant, Medicare will pay for your immunosuppressive drug therapy for 36 months after the month of the kidney transplant. If you already had Medicare because of age or disability before you got ESRD, or if you became eligible for Medicare because of age or disability after receiving a transplant, Medicare will continue to pay for your immunosuppressive drugs with no time limit.

If you have diabetes and your diabetes did not cause your kidney failure, this coverage does not apply to you.

Transplant Services Covered by Medicare

What YOU Pay for Kidney Transplant Services



The amounts listed in this section are for transplant services in the Original Medicare Plan. If you are in a Medicare Advantage Plan, your costs may be different. Read your plan materials or call your benefits administrator to get information about your costs.

Do I Have to Pay for My Kidney Donor?

No. Medicare will pay the full cost of care for your kidney donor. There is no deductible, coinsurance, or other costs that you have to pay for your donor's hospital stay.

Remember, terms in **red** are defined on pages 57–58.

What YOU Pay for Kidney Transplant Services

Doctors' Services

In the Original Medicare Plan, you must pay the $100 Part B yearly deductible. After you pay the deductible, Medicare Part B pays 80% of the Medicare-approved amount. You must pay the remaining 20% coinsurance.

Important:
There is a limit on the amount your doctor can charge you, even if your doctor doesn't accept assignment. If your doctor doesn't accept assignment, you only have to pay the part of the bill that is over the Medicare-approved amount up to the limit that Medicare allows your doctor to charge.
Call 1-800-MEDICARE (1-800-633-4227) to get a free copy of *Does your doctor or supplier accept assignment?* This booklet will give you detailed information on how assignment works.

Note: See the chart on page 52 for details about what you pay under Medicare Part A.

4 How Medicare Pays for Blood

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

- ✓ whole blood units or packed red blood cells,
- ✓ blood components, and
- ✓ the cost of processing and giving you blood.

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

What YOU Pay for Blood

Under Medicare Part A, you pay for:

The first three units of whole blood or units of packed red cells that you get during a benefit period while you are staying in a hospital or skilled nursing facility. You can choose to either pay the hospital costs for the blood or packed red cells or you can have the blood replaced (see "How to Have Blood Replaced," on page 40).

Note: If you have paid for or replaced some units of blood under Medicare Part B during the calendar year (January 1 through December 31), you don't have to do so again under Medicare Part A.

Under Medicare Part B, you pay for:

The first three units of whole blood or units of packed red cells that you get in a calendar year. You can choose to either pay the hospital costs for the blood or packed red cells or you can have the blood replaced (see "How to Have Blood Replaced," on page 40).

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

(Continued on page 40)

Remember, terms in **red** are defined on pages 57–58.

What YOU Pay for Blood (continued)

Note: If you have paid for or replaced blood under Medicare Part A during a calendar year (January 1 through December 31), you don't have to do so again under Medicare Part B.

How to Have Blood Replaced

You can replace the blood yourself by donating blood ahead of time, or getting another person or organization to replace the blood for you. The blood that is replaced does not have to match your blood type. If you decide to replace the blood yourself, check with your doctor first before donating blood.

Can I Be Charged for the Blood That I Have Replaced?

No. A hospital or skilled nursing facility can't charge you for any of the first three pints of blood you have already replaced or will have replaced. Also, if your provider receives donated blood or red cells, the blood or red cells is considered to be replaced.

5 Appeals and Grievances

Appeals

Your Medicare Rights

If you have Medicare, you have certain guaranteed rights to help protect you. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. **Whether you are in the Original Medicare Plan or a Medicare Advantage Plan, you always have the right to appeal.** Some of the reasons you may appeal are when:

- You don't agree with the amount that is paid.
- A service or item isn't covered and you think it should be covered.
- A service or item is denied and you think it should be paid.

Appeal Rights in The Original Medicare Plan

If you are in the Original Medicare Plan, you can file an appeal for any of the reasons listed above. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal.

Appeal Rights in a Medicare Advantage Plan

If you are in a Medicare Advantage Plan, you can file an appeal for any of the reasons listed above. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. You may also call 1-800-MEDICARE (1-800-633-4227) to ask for more information about your rights during an appeal. TTY users should call 1-877-486-2048.

Remember, terms in **red** are defined on pages 57–58.

Filing a Grievance (Complaint)

What to Do if You Have Problems With the Services You Get

- Talk with your doctor, nurse, or facility administrator first to see if they can help you solve your problem. Most problems can be handled at your facility.
- If talking to your health care team does not solve the problem, you can file a grievance (a written complaint) with your facility.

Every facility has a grievance policy for accepting and trying to work out your problems or concerns. If you don't know your facility's grievance policy, you can ask for a copy of it.

If you file a grievance with your facility and you still feel that your problem has not been solved, you have the right to file a grievance with the ESRD Network in your area. Call the ESRD Network to find out what you have to do in order to file a grievance (see pages 50–51).

You can also call your State Survey Agency to complain about your care. Your calls and who you are will be kept private. Call 1-800-MEDICARE (1-800-633-4227) and ask for the number to your State Survey Agency, or look at www.medicare.gov on the web and click on "Helpful Contacts."

Remember, terms in **red** are defined on pages 57–58.

Other Kinds of Health Insurance

There are several kinds of health insurance coverage that may help pay for the services you need for the treatment of kidney failure. They include:

1. Employee or Retiree Coverage From an Employer or Union (see below)
2. A Medigap Insurance Policy (see below)
3. Medicaid (see page 45)
4. Veteran Administration Benefits (see page 46)

1. 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 you can get if you buy a policy yourself, and employers pay part of the cost. Call your benefits administrator to find out if you have or can get health care coverage based on your or your spouse's past or current employment, or your parents' current employment.

In some cases, employer group health plans will have to pay before Medicare pays (see page 15).

2. 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 you. All Medigap policies are clearly marked "Medicare Supplement Insurance."

(Continued on page 44)

Remember, terms in **red** are defined on pages 57–58.

2. A Medigap Insurance Policy (continued)

Some insurance companies will sell Medigap policies to people with Medicare under age 65. However, these policies may cost you more. Call your State Health Insurance Assistance Program for information about buying a Medigap policy if you are disabled or have ESRD (see pages 50–51).

For more detailed information about Medigap policies:

✓ Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *Guide to Health Insurance for People with Medicare*.

✓ Visit www.medicare.gov on the web to get information on Medigap policies in your state. Select "Medicare Personal Plan Finder." When you use this website, you will get a personalized summary page with general information to help you compare plans in your area. You can get detailed information about all the plans available in your area, or just the ones you are most interested in. This website has information on:

- Which Medigap policies are sold in your state.
- Comparing Medigap policies.
- What each policy covers.
- Your out-of-pocket costs.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

3. Medicaid

This 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 you qualify for both Medicare and Medicaid.

States also have programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurances for certain people who have Medicare and a low income. To qualify for these programs, you must:

- Have Medicare Part A (hospital insurance). If you're not sure if you have Part A, look on your red, white, and blue Medicare card or call the Social Security Administration at 1-800-772-1213.

- Have a monthly income of less than $1,068 for an individual or $1,426 for a couple in 2004. These income limits are slightly higher in Hawaii and Alaska. Income limits will change slightly in 2005.

- Have savings $4,000 or less for an individual or $6,000 for a couple. Savings include money in a checking or savings account, stocks, or bonds.

To get more information on these programs, call 1-800-MEDICARE (1-800-633-4227), and ask for information on **"Savings for People with Medicare."** TTY users should call 1-877-486-2048.

Remember, terms in **red** are defined on pages 57–58.

4. Veteran Administration Benefits

If you are a veteran, the U.S Department of Veteran Affairs can help pay for ESRD treatment. For more information, call the U.S. Department of Veteran Affairs at 1-800-827-1000. If you or your spouse are retired from the military, call the Department of Defense at 1-800-538-9552 for more information.

"When my kidneys failed, I had employer group health insurance along with Medicare. When I lost my job, I was able to get medical care from the Veteran's Administration."

- Don
Transplant
patient

Other Ways to Get Help

- In most states there are agencies that help with some of the health care costs that Medicare doesn't pay.
- Some states have Kidney Commissions that also help people pay the costs that Medicare doesn't pay.
- Call your State Health Insurance Assistance Program if you have questions about health insurance (see pages 50–51).

7 Where to Get More Information

Talk with your health care team to learn more about kidney dialysis and transplants and your situation. Your doctors, nurses, social workers, dieticians, and dialysis technicians make up your health care team.

Special Kidney Organizations

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

American Association of Kidney Patients
100 S. Ashley Dr. Suite 280
Tampa, Florida 33602
1-800-749-2257
www.aakp.org (on the web)

American Kidney Fund
6110 Executive Blvd, Suite 1010
Rockville, MD 20852-3903
1-800-638-8299
www.akfinc.org (on the web)

National Kidney Foundation, Inc.
30 E. 33rd Street, 11th Floor
New York, NY 10016
1-800-622-9010
www.kidney.org (on the web)

National Kidney and Urologic Diseases Information Clearinghouse
3 Information Way
Bethesda, Maryland 20892
301-654-4415
www.niddk.nih.gov (on the web)

Section 7: Where to Get More Information

End-Stage Renal Disease (ESRD) Networks

You can call your local ESRD Network Organization (see pages 50–51) to get information about:

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

Your ESRD Network makes sure that you are getting the best possible care, and uses mailings to keep your facility aware of important issues about kidney dialysis and transplants.

State Health Insurance Assistance Program (SHIP)

Call your State Health Insurance Assistance Program (see pages 50–51) if you have 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 makes sure that Medicare standards are met. Your State Survey Agency can also help you if you have a complaint about your care. Call 1-800-MEDICARE (1-800-633-4227) and ask for the number to your State Survey Agency, or look at www.medicare.gov on the web and click on "Helpful Contacts." **Your calls and who you are will be kept private.**

– Section 7: Where to Get More Information –

Other Medicare Booklets for Kidney Patients

Medicare has two booklets:

1. ***Know Your Number . . . Are You Getting Adequate Hemodialysis?***

   This booklet tells you how to check on how well your dialysis is working. It also tells you what to do if you're not getting the right amount of dialysis.

2. ***Preparing for Emergencies, A Guide for People on Dialysis.***

   This guide gives you important facts about what to do in case of an emergency that leaves you without power or water. It guides you through the information you should have ready, provides lists of supplies to have on hand to prepare for emergencies, and gives helpful ideas on how to manage until conditions return to normal.

To get your free copy of these booklets, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also look at or print a copy of these booklets at www.medicare.gov on the web. Select "Publications."

Important Phone Numbers

ESRD Networks and State Health Insurance Assistance Program phone numbers are on pages 50–51. At the time of printing, these phone numbers were correct. Phone numbers sometimes change. To get the most updated phone numbers, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, look on the web at www.medicare.gov and click on "Helpful Contacts."

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

8 Medicare Part A Coverage Chart

Medicare Part A (Hospital Insurance) helps cover your medically necessary:	What YOU Pay in 2004* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care you get in critical access hospitals and mental health care. This doesn't include private duty nursing, or a television or telephone in your room. It also doesn't 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 $876 for a hospital stay of 1–60 days. • $219 per day for days 61–90 of a hospital stay. • $438 per day for days 91–150 of a hospital stay. • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) 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 $109.50 per day for days 21–100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary.**
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.	• Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary.**
Hospice Care: For people 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 your home (which may include a nursing home if it's your 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).	• A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care. The amount you pay for respite care can change each year. Medicare generally doesn't pay for room and board except in certain cases. For example, room and board aren't covered if you get 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. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary.**
Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.	• For the first three pints of blood, unless you or someone else donates blood to replace what you use.

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

** If you have general questions about Medicare Part A, call your Fiscal Intermediary. To get the telephone numbers for Fiscal Intermediaries or Regional Home Health Intermediaries, look at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

–Section 8: Medicare Part B Coverage Chart -

Medicare Part B (Medical Insurance) helps cover your medically necessary:	What YOU pay in 2004* 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 isn't 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.)	• $100 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.
Clinical Laboratory Service: Blood tests, urinalysis, some screening tests, and more.	• 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.	• Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage call your Regional Home Health Intermediary.**
Outpatient Hospital Services: Hospital services and supplies received as an outpatient as part of a doctor's care.	• A coinsurance or copayment amount, which may vary according to the service.
Blood: Pints of blood you get as an outpatient or as part of a Part B covered service.	• For the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

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

** **Note:** Actual amounts you must pay may be higher if the doctor or supplier doesn't accept assignment **and you may have to pay the entire charge at the time of service**. Medicare will then send you its share of the charge. If you have general questions about Medicare Part B, call your Medicare carrier. If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC). For their telephone numbers, look at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

–Section 8: Medicare Part B Coverage Chart -

Medicare Part B covered preventive services	Who is covered...	What YOU pay in the Original Medicare Plan...
Bone Mass Measurements: Once every 24 months for qualified individuals and more frequently if medically necessary.	Discuss with your doctor to see if you qualify.	20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.
Colorectal Cancer Screening: • Fecal Occult Blood Test (FOBT) - Once every 12 months. • Flexible Sigmoidoscopy - Once every 48 months. • Colonoscopy - Once every 24 months if you are at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, once every ten years, but not within 48 months of a screening flexible sigmoidoscopy. • Barium Enema - Doctor can use this instead of flexible sigmoidoscopy or colonoscopy. It's covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.	All people with Medicare age 50 and older. Note: There is no minimum age for having a colonoscopy.	Nothing for the fecal occult blood test (FOBT). For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount after the yearly Part B deductible if the test is done in a hospital outpatient department.
Diabetes Services: • Diabetes self-management training.	Certain people with Medicare who are at risk for complications from diabetes. Your doctor or other health care provider must request these services.	20% of the Medicare-approved amount after the yearly Part B deductible.
Glaucoma Testing: Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.	People with Medicare who are at high risk for glaucoma, including people with diabetes, a family history of glaucoma, or African Americans age 50 and older.	20% of the Medicare-approved amount after the yearly Part B deductible.

Note: To find out what services and supplies are covered by Medicare, look at www.medicare.gov on the web. Select "Your Medicare Coverage." Or, you can get a free copy of *Your Medicare Benefits* (CMS Pub. No. 10116) by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

–Section 8: Medicare Part B Coverage Chart -

Medicare Part B covered preventive services	Who is covered...	What YOU pay in the Original Medicare Plan...
Pap Test and Pelvic Examination (includes a clinical breast exam): Once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months.	All women with Medicare.	Nothing for the Pap lab test. For Pap test collection, and pelvic and breast exams, 20% of the Medicare-approved amount (or a copayment amount) with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older (coverage begins the day after your 50th birthday).	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the Prostate Specific Antigen (PSA) Test.
Screening Mammograms: • Once every 12 months (11 full months must have elapsed from the last screening). • Medicare also covers new digital technologies for screening mammograms.	All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.	20% of the Medicare-approved amount with no Part B deductible.
Shots (vaccinations): • Flu Shot* - Once a flu season in the fall or winter. • Pneumococcal Shot - One shot may be all you will ever need. Ask your doctor. • Hepatitis B Shot	All people with Medicare. All people with Medicare. Certain people with Medicare at medium to high risk for Hepatitis B.	Nothing for flu and pneumococcal shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.

* The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 65 and older, and people of any age with certain chronic medical conditions. You need a flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect you from the flu for about one year. There is a chance that you may still get the flu, but your symptoms will be less severe.

Notes

9 Definitions of Important Words

Appeal
An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint.

Assignment
In the Original Medicare Plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. **You still pay your share of the cost of the doctor visit.**

Benefit Period
The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance
The percent of the Medicare-approved amount that you have to pay after you pay 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 (like 20%).

Coordination Period
A period of time when your employer group health plan will pay first on your health care bills and Medicare will pay second. If your employer group health plan doesn't pay 100% of your health care bills during the coordination period, Medicare may pay the remaining costs.

Deductible
The amount you 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 (ESRD)
Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

General Enrollment Period (GEP)
The GEP is January 1 through March 31 of each year. If you enroll in Part B during the GEP, your coverage starts on July 1.

Grievance
A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem with the cleanliness of the health care facility, problems calling the plan, staff behavior, or operating hours. A grievance is not the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

– Section 9: Definitions of Important Words –

Medically Necessary
Services or supplies that:
- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

Medicare Advantage Plan
A Medicare program that gives you 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
This is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Managed Care Plan
These are health care choices in some areas of the country. In most plans, you 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, like extra days in a hospital. Your costs may be lower than in the Original Medicare Plan.

Medicare Preferred Provider Organization (PPO)
Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-for-Service Plan
A private insurance plan that accepts people with Medicare. You 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 you will pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Original Medicare Plan
A fee-for-servive health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Premium
What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Secondary Payer
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.

10 Index

Section 10: Index

Important Phone Numbers

Phone Number

Doctor

_____ _____-_____ - _____

Social Worker

_____ _____- _____ - _____

Dialysis Facility

_____ _____- _____ - _____

Health Insurance Company

_____ _____- _____ - _____

ESRD Network

_____ _____- _____ - _____

State Survey Agency

_____ _____- _____ - _____

_____ _____- _____ - _____

_____ _____- _____ - _____

_____ _____- _____ - _____

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HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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Publication No. CMS - 10128
Revised August 2004

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