CMS Medicare Manual System

Pub. 100-16 Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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I. SUMMARY OF CHANGES:

CLARIFICATION – EFFECTIVE DATE: Not Applicable

Section 20.2 - End Stage Renal Disease (ESRD) - Added text to clarify that individuals who regain native kidney function, as well as individuals that receive a successful kidney transplant, are eligible to enroll in an M+C plan.

Section 40.2.4 - ESRD and Enrollment - Added text to require the M+C organization to request medical documentation on individuals as described in the update to §20.2.

Section 50.2.1.2 - Effective Date - Technical corrections to the first sentence of both paragraphs 1 and 2.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	2/20.2/End Stage Renal Disease (ESRD)
R	2/40.2.4/ESRD and Enrollment
R	2/50.2.1.2/Effective Date

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification
	Recurring Update Notification

20.2 - End-Stage Renal Disease (ESRD)

(Rev. 51, 04-16-04)

Except as provided under exceptions discussed below, an individual is not eligible to elect an M+C plan if he/she has been medically determined to have ESRD. ESRD means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. A Medicare beneficiary will be assigned ESRD status by the Medicare ESRD system as a result of the attending physician certifying the ESRD status of the enrollee and completing a CMS Form CMS-728-U3. For purposes of M+C eligibility, an individual's ESRD status begins:

- The date regular dialysis begins, as reported on the Form CMS-2728-U3;or
- The month an individual is admitted to a hospital for a kidney transplant, or for health care services needed before a transplant if the transplant takes place in the same month or within the two following months; or
- The first day of the month dialysis began if the individual trained for self-dialysis.

An individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of M+C eligibility. Such an individual may elect to enroll in a M+C plan, if he/she meets other applicable eligibility requirements. If an individual is only eligible for Medicare on the basis of ESRD (i.e., not based on disability or age), the individual would only be permitted to remain enrolled as an M+C enrollee during his or her remaining months of Medicare eligibility.

In addition, an individual who initiated dialysis treatments for ESRD, but subsequently recovered native kidney function and no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of M+C eligibility. Such an individual may also elect to enroll in a M+C plan, if he/she meets other applicable eligibility requirements.

The M+C organization is permitted to ask at the time of the election whether the applicant has ESRD. This question is not considered impermissible health screening since the law does not permit a person with ESRD to elect an M+C plan, except as provided in the following paragraphs. *If a beneficiary no longer requires regular dialysis or has had a successful transplant, the beneficiary should obtain a note or records from the beneficiary's physician showing that the ESRD status has changed and submit it with the enrollment election.* An M+C organization must deny enrollment to any individual medically determined to have ESRD, except as provided in the following paragraphs. The CMS will reject the enrollment if Medicare records indicate the applicant has ESRD, and no exception permitting enrollment applies.

Procedures for identifying whether an individual is medically determined to have ESRD are included in §40.2.4.

40.2.4 - ESRD and Enrollment

(Rev. 51, 04-16-04)

If an M+C organization is aware that an individual electing a plan *no longer requires regular dialysis or* has received a kidney transplant (e.g., the individual informs the M+C organization that this has occurred), then the M+C organization should request that the individual submit medical documentation (i.e., a letter from the physician that documents that the individual has received a kidney transplant *or* no longer requires a regular course of dialysis to maintain life), using the procedures outlined in §40.2.2. Upon receipt of this documentation, the M+C organization should enroll the beneficiary using the override procedures described in Chapter 19 (Managed Care and M+C Systems Requirements).

If an individual indicates on the enrollment election that he/she does not have ESRD, but the M+C organization receives a reply listing containing a "code 45" or "code 15" rejection (an explanation of reply listing codes is contained in Chapter 19), the M+C organization should investigate further to determine whether the individual is eligible to enroll. To determine eligibility, the M+C organization should contact the individual to request medical documentation using the procedures outlined in §40.2.2. Contact can be made orally, in which case the M+C organization must document the contact and retain the documentation in its records.

If the M+C organization learns that the individual has received a kidney transplant which has restored kidney function *or* that the individual no longer requires a regular course of dialysis to maintain life, then the individual must be permitted to enroll in the M+C plan if other applicable eligibility requirements are met. When this occurs, the M+C organization must contact its RO to override the system rejection. The following documentation must be submitted to the RO:

1. Evidence of contact with the individual after the system rejection, including the individual's explanation for rejection (i.e., successful transplant), and medical documentation, i.e., a letter from the physician.

2. A copy of the Reply Listing or, if using the services of a CMS subcontractor, a report indicating the M+C organization's attempts to enroll the individual and the resulting rejection.

Once received and approved, the RO will override the enrollment rejection for the individual.

ESRD and M+C Plan Terminations

Certain individuals with ESRD who have been impacted by M+C terminations will be permitted to make one election into a new M+C plan (refer to §20.2 for a discussion of who is eligible to make an election). Beneficiaries will be instructed to save their notification letters to present, if requested, to M+C organizations as proof of their eligibility to join a plan. The CMS' system will edit incoming enrollment transactions for ESRD beneficiaries to determine:

1. If they were a member of a terminating or terminated M+C plan; and

2. If they have already used their one election.

Enrollments for these individuals should be submitted as normal transactions with all other transactions. The enrollment will be allowed if the individual is eligible, and will be rejected if not.

50.2.1.2 - Effective Date

(Rev. 51, 04-16-04)

Generally disenrollments for **reasons 1, 4, *5*, and *6*** above are effective the first day of the calendar month after the date the member begins residing outside of the M+C plan's service area (or continuation area, as appropriate) AND after the M+C organization has been notified by the member or his/her legal representative. However, if the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the 1st of the month after the move), the M+C organization can submit this request to the RO for consideration of retroactive action.

Disenrollment for **reasons 2, *3* and *7*** above is effective the first day of the calendar month after 6 months have passed. Disenrollment for reason 3 is effective the 1st day of the 13th month (or the length of the visitor/traveler program if less than 12 months) after the individual left the service area.

Unless the member elects another Medicare managed care plan during an applicable election period, any disenrollment processed under these provisions will result in a change of election to Original Medicare.

A SEP, as defined in §30.4.1, applies to members who are disenrolled due to a change in residence. A member may choose another M+C plan, or Original Medicare, during this SEP. The rules for this SEP will determine the effective date in the new M+C plan or Original Medicare.