

The Medicare Counselor

MAY/JUNE 2011

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In these four pages you will find a frequently asked question from our Consumer Helpline, information about Medicare for people with ESRD, and an inquiry from our SHIP inbox about Medicare-covered skilled nursing facility stays.

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Medicare Resources

- **Medicare Interactive:**
<http://www.medicareinteractive.org/>
- **Medicare Rights Center:**
<http://www.medicarerights.org/>
- **Medicare:**
<http://www.medicare.gov>
- **Health Care Reform and Medicare:**
<http://www.medicarerights.org/issues-actions/health-reform-and-medicare.php>

Hot Topic from the Helpline

I think my parents need home health care, will Medicare cover it?

-Helpline Caller

Medicare only covers home health care in certain situations. You may have questions like this from your clients and their loved ones about what qualifies someone to receive Medicare-covered home health care. Home health care is care that is received in the home to treat an injury or illness.

Medicare will only cover home health care if the person receiving the care meets all the following criteria: they are homebound, need skilled nursing care, have a signed home health certification from their doctor, and receive the care from a Medicare-certified home health agency.

Homebound means that leaving the home requires a considerable and taxing effort, such as using a wheelchair or requiring help from another person. A determination of homebound must be made by a doctor over a period of time. Being homebound does not mean that someone can never leave their home. People who are homebound can leave the home for medical treatment, adult day care, religious services, and special non-medical events such as graduations and family reunions.

You may hear from your clients or their loved ones that they need help with activities of daily living such as getting dressed or preparing meals. This is sometimes called custodial care. Medicare only covers custodial care if it is in addition to skilled care. In order to qualify for the home health benefit a person must need skilled care on a part-time basis, for no more than 8 hours a day. Examples of skilled care include helping to change bandages and administer intravenous antibiotics, or providing physical therapy.

Anyone who receives home health care must have a signed certification from their doctor that

they qualify for the Medicare home health benefit because they are homebound and need intermittent skilled care. As part of the certification, the doctor must certify that the patient has had a face-to-face meeting with their doctor, nurse practitioner, clinical nurse practitioner (in collaboration with a doctor), or physician assistant (under the supervision of a doctor). This meeting must take place within 90 days of starting to receive home health care or within 30 days after they have already started getting home health care.

Medicare only covers home care if a Medicare-certified home health agency provides care.

Home health care is covered under Medicare Part A or Part B. It is covered under Part A for people who have been in the hospital for three days as an inpatient prior to needing home health care. For people with Original Medicare, Part A will cover the first 100 days with no coinsurance. After a person has had 100 days of home health care covered under Part A, Part B will begin covering their home health care.

A person does not need to have been in the hospital in order to get Medicare coverage of home health care. All that is necessary is that the requirements listed above are met. In cases where there is no prior hospital stay, Part B covers home health care. For Part B coverage of home health care there is no coinsurance or deductible for people with Original Medicare.

Medicare Advantage plans are required to offer the same home health benefits as Original Medicare. However, Medicare Advantage plans can have different restrictions on how clients can access this coverage. For example, they may have requirements that persons see a network provider. Unlike Original Medicare, they can also charge copays for home health care. Keep in mind, that all Medicare Advantage plans must have a cap on out-of-pocket costs for Part A and Part B services, including home health care. This should protect your clients if they have large medical expenses.

Medicare and ESRD

People who have end-stage renal disease (ESRD) may be eligible for Medicare even if they are not 65 or older or have been receiving Social Security Disability Insurance for at least 24 months. End-stage renal disease is when a person's kidneys are no longer able to function or almost no longer able to function. People who have ESRD usually need dialysis or a kidney transplant.

Eligibility

Someone who has ESRD is eligible for Medicare no matter how old they are as long as

they are getting dialysis or have had a kidney transplant. They must also have enough Social Security work quarters to qualify for Railroad Retirement Board or Social Security benefits. For someone who has ESRD, the required work quarters can come from a spouse or parent if the person is a dependent child. Someone who is eligible for Medicare based on ESRD should enroll by contacting Social Security, even if they are a retired railroad worker.

For someone who has ESRD, when their Medicare starts depends on if they are getting dialysis, are being taught how to give themselves dialysis treatment at home, or if they are getting a kidney transplant.

For people who are getting dialysis, their Medicare begins the first day of the fourth month they are receiving dialysis.

Individuals who are getting dialysis and participate in a self-dialysis training program that will teach them how to give themselves dialysis at home, can get Medicare earlier. Someone undergoing this training can get Medicare retroactive to their first month of dialysis.

For individuals who are getting a kidney transplant, their Medicare will begin the month they are admitted to a Medicare-approved hospital for a kidney transplant, or the services needed before the transplant. Medicare will begin the month of admission as long as the transplant is within that month or the following two months. If the person's transplant is delayed, their Medicare will begin two months before their transplant.

Most people who are eligible for Medicare due to ESRD have Original Medicare. People with ESRD usually cannot have a Medicare Advantage plan. There are a few exceptions. Someone with ESRD might be able to join a Medicare Advantage plan if there is a Special Needs Plan in their area that accepts ESRD patients. Also, someone who has ESRD might also be in a Medicare Advantage plan if they were in this plan before having ESRD.

Coordination of Benefits

Medicare coordinates differently with employer insurance for people with ESRD than it does for people who have Medicare due to age or disability. For people who have Medicare due to ESRD there is what is called a 30-month coordination period. The 30-month coordination period is the first 30 months that someone with ESRD Medicare has Medicare. During this coordination period, their employer insurance is primary. This includes any type of employer insurance, including COBRA and retiree insurance. Even if your client does not sign up for Medicare when they become eligible, the 30-

month coordination period begins when they first qualify for Medicare.

After the 30-month coordination period, Medicare will pay primary for all Medicare covered services and your client's employer insurance, if they have insurance from their employer, will pay second.

Some people who feel that they are adequately covered by their employer health plan may delay enrollment in Medicare in order to avoid having to pay the monthly Part B premium. For people who choose to do this, they should delay enrollment in both Part A and Part B when they become eligible so that they do not incur a penalty later. If they only enroll in Part A and take Part B later, they will have to pay a penalty. It is best for people in this situation to enroll right before their 30-month coordination period ends so that they can avoid having any gaps in coverage. If someone waits until after their 30-month coordination period to enroll in Medicare, they will have to wait until the General Enrollment Period to enroll. The General Enrollment Period is January through March of each year. If someone enrolls during this period, their coverage will begin July 1 of that year. This could lead to someone having gaps in their coverage if they do not enroll during their 30-month coordination period.

It is important to note that in order for Part B to cover someone's immunosuppressive drugs after a

transplant, they must have had Part A when they got the transplant. If they did not have Part A when they got the transplant, their immunosuppressive drugs should be covered under Part D if they are enrolled in it.

Termination of Medicare

If someone has Medicare due to ESRD and their condition improves, their Medicare coverage may end. If your client no longer needs dialysis their Medicare coverage will end 12 months after the month in which they had their last dialysis treatment. If your client had a successful kidney transplant their Medicare will end 36 months after the transplant. A kidney transplant is considered successful if it lasts for 36 months without rejection. If someone starts getting dialysis or has a kidney transplant within 12 months of stopping dialysis, their Medicare will continue. It will also continue for someone who starts getting dialysis or has another kidney transplant within 36 months of having a transplant.

If an individual's Medicare coverage due to ESRD ends and then they qualify for this coverage again, they will not have to wait for their Medicare coverage to start. Their Medicare will begin the first of the month they start dialysis again, or the first of the month they have a kidney transplant. They will also have another 30-month coordination period where their employer will pay first and Medicare pays second.

Medicare Word Search

The following words can be found in the word search puzzle.
The words can be backwards, diagonal, vertical or horizontal.

BENEFIT	H	E	X	T	M	C	U	I	O	I	Y	H	C	M	J
CLAIM	P	M	N	J	Q	J	T	G	L	P	U	H	O	D	A
COPAY	D	E	D	U	C	T	I	B	L	E	T	S	H	I	U
COVERAGE GAP	I	D	T	V	O	V	H	N	E	T	W	O	R	K	J
DEDUCTIBLE	A	I	Y	N	V	M	A	E	Q	N	O	H	U	E	L
ENROLLMENT	C	G	T	I	E	R	A	C	I	D	E	M	B	T	I
EXCEPTION	I	A	V	J	R	M	U	X	T	X	N	F	S	O	C
GENERIC	D	P	F	R	A	C	L	A	I	M	Z	P	I	H	S
MAXIMUS	E	F	X	G	G	T	N	L	Q	M	E	W	I	T	K
MEDICAID	M	E	X	C	E	P	T	I	O	N	U	K	N	Q	A
MEDICARE	E	P	Q	O	G	N	G	N	D	R	C	S	L	R	K
MEDIGAP	N	O	I	T	A	R	E	D	I	S	N	O	C	E	R
NETWORK	T	A	T	K	P	M	O	R	W	B	B	E	P	U	K
OPT OUT	N	Q	M	G	I	W	M	U	I	M	E	R	P	A	G
PREMIUM	W	X	F	O	N	I	M	Q	Z	C	I	C	K	V	Y
RECONSIDERATION															
SHIP															
SPEND DOWN															
TIER															

Dear Hannah

I received a call from a client who said Original Medicare won't cover their stay in a skilled nursing facility (SNF). What do they need to do to get Medicare to cover their SNF care?

- Samuel (SHIP Counselor)

A skilled nursing facility is a facility that provides post-hospital extended care services, at a lower level of care than provided in a hospital. Your clients must follow certain rules in order for Medicare to cover their skilled nursing facility stay. There are four requirements for Medicare coverage of SNFs.

The first requirement is that they have to need skilled nursing care seven days a week or skilled therapy services at least five days a week. Skilled nursing services are services that can only be done by skilled nursing personnel such as licensed practical nurses and registered nurses. Skilled therapy services are physical therapy, occupational therapy or speech/language pathology services received from a licensed therapist. Even if people with chronic medical conditions are not expected to improve, care can still be considered skilled if is necessary to keep them from getting worse. This is called maintenance care.

An individual also has to receive care at a skilled nursing facility that is Medicare-certified in order for Medicare to cover their care. They can find and compare SNFs in their area by going to www.medicare.gov and selecting on "facilities and doctors" on the left hand side of the page.

Medicare will not cover a person's stay at a skilled nursing facility unless they have Part A before they are discharged from the hospital. There are cases where someone has Part A when they enter a SNF, but not when they were discharged from the hospital. For example, if someone enrolled in Medicare after being discharged from the hospital and before entering the SNF. Although this person has Part A when entering the skilled nursing facility, they did not have it before being discharged from the hospital. In this situation, Medicare will not pay for their care at the skilled nursing facility.

The last requirement is often the most confusing. This has to do with what is often referred to as a qualifying hospital stay. People

only qualify to get Medicare-covered skilled nursing facility care if they have had three consecutive inpatient hospital days in the 30 days prior to admission in a Medicare-certified skilled nursing facility. The three necessary days include the day that someone was admitted as an inpatient. The day they are discharged does not count as part of their qualifying hospital stay.

People sometimes think they are an inpatient when they are actually receiving outpatient services. Even if someone is in the hospital for three days, but are considered an outpatient for part of the time, these days do not count toward their qualifying hospital stay. This means Medicare will not cover their SNF care. People can be considered an outpatient even if they stay overnight in the hospital. This is a common situation when people are kept in the hospital under observation stays. According to Medicare, observation stays are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the Emergency Department (ED) or another area of the hospital. Observation stays are usually 48 hours or less, but they can sometimes last longer. It is extremely important that your clients ask their doctors what their status in the hospital is. In order to be considered an inpatient, a doctor must have written an official order admitting them to the hospital.

When people meet these four requirements, Original Medicare pays the full cost of their first 20 days of care in a skilled nursing facility each benefit period. In 2011, the daily copay after the first 20 days is \$141.50 in a benefit period for Original Medicare. A benefit period begins the day you start getting inpatient care and ends when you've been out of the hospital or skilled nursing facility for 60 days in a row.

All the best,
Hannah