Beaumont Transplant Clinic Directory

Beaumont Hospital, Royal Oak Medical Office Building
3535 West 13 Mile Road, Suite 644
Royal Oak, MI 48073
248-551-1033
The clinic is open Monday-Friday 8 a.m. to 4:30 p.m.

Transplant Financial Coordinator

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Transplant Financial Representative

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some insurances may not cover renal transplantation at Beaumont.

It is essential for the success of the kidney transplant to be able to afford medical care and the prescriptions required to prevent rejection after the transplant. The transplant financial coordinator and transplant social worker will work together to assist you in identifying financial resources available to you.

You will be receiving a great deal of new information and you may have many questions and concerns. This booklet will be helpful in answering many of your financial questions related to kidney transplantation, and you should keep it for future reference. It is not meant to answer all of your questions, but we hope it will clarify many of your health insurance benefits and transplant costs.

Financial considerations

The transplant financial coordinator will work with you to explain insurance benefits and assist you with financial issues related to your transplant. We encourage you to write down your questions so that they may be addressed before your transplant. The transplant financial coordinator will review the information in this booklet regarding the financial costs associated with kidney transplantation to help you begin financial planning for transplant.

You will need to know how much your insurance company will pay for both the kidney transplant and for the medications after transplant. It is unlikely that one single source will cover these costs. Often it is necessary to draw on savings accounts, investments, federal and private assistance options, and possibly fund raising.

Know what you have

Know what medical coverage and resources you already have. Health insurance, Medicare and Medicaid all provide coverage. Know the extent of your coverage and exactly what is and what is not covered.

Who pays what?

Commercial insurance benefits

Commercial insurance is obtained through a work sponsored policy or an individually purchased policy. Obtain a copy of your policy's benefit statement and gather the following information:

General benefits:

- Is there a mail order option for prescriptions?
- If I must pay for medicines up front how long does it take to get reimbursed?
- Am I required to get pre-authorization for any services and/or medications?
- If I am covered under two insurance policies, which policy is primary and which pays first?
- Will my insurance pay for travel expenses to and from Beaumont?

Most insurance companies will cover kidney transplantation, however, it is essential that you check with your insurance carrier to verify that coverage.

Ask your insurance company about these benefits specific to transplant:

- Do I have benefits for a kidney transplant at Beaumont?
- Does the policy require pre-authorization for a transplant?
- Are all diagnoses covered for the kidney transplant?
- Do I have a pre-existing condition that excludes me from coverage?
- Does my insurance only pay for transplant at a specific transplant center? What is my co-pay if I choose to go out of network?
- Are organ procurement charges covered? Is there a limit?
- Are living donor expenses covered? At what percent?
- Do I have a separate transplant lifetime maximum

benefit? What is the maximum benefit? If so, are prescription medications included in this maximum amount?

- Is there coverage for transportation and lodging? If so, how much?
- Is transplant case management a requirement? Who will manage my care and what is their role?
- Is there a time limit placed on the coverage for medications (Medicare currently covers 80 percent of the immunosuppressant medication costs for the first three years after transplant)?

Ask the same questions of your secondary insurance if you have more than one policy. If you do not clearly understand your benefits after reviewing your policy handbook and the above questions, ask your insurance company representative or your transplant finance coordinator. It is essential that you understand your coverage before transplant.

Medicare

Medicare covers heart, lung, kidney, pancreas and liver organ transplants for adults. In order for Medicare to cover any transplant services, your transplant center must be Medicare certified. If a center is a non-approved Medicare facility or if Medicare certification is lost, the center cannot bill Medicare for payment of the transplant. If your transplant is done in a non-Medicare approved transplant center, it could affect your ability to have immunosuppressant medications paid under Medicare Part B. Beaumont is Medicare certified for adult kidney and adult liver transplant services.

Patients have to meet certain requirements to be eligible

for Medicare coverage. People with certain medical conditions, such as end stage renal disease (ESRD), are eligible to apply for Medicare. Other qualifying conditions are age and disability. If you have Medicare solely because of ESRD, your Medicare benefits will end 36 months after the month of your kidney transplant.

HOSPITAL: When your primary insurer is Medicare, Medicare Part A covers hospital inpatient expenses. It will pay the hospital bill, less the amount of the inpatient deductible.

PHYSICIAN: When your primary coverage is Medicare, Medicare Part B covers physician visits and outpatient expenses. You must pay monthly premiums to have Medicare Part B. The charges you receive from your physician during your transplant hospitalization are paid at 80 percent. Outpatient clinic visits, doctor's appointments, lab work and outpatient procedures are also paid at 80 percent. You are responsible for an annual deductible and the 20 percent co-pay.

MEDICATION: Patients transplanted at Medicare approved facilities and who have Medicare Part A at the time of transplant are eligible for Medicare Part B for immunosuppressant coverage. When Medicare is your primary coverage, Medicare Part B will provide 80 percent payment for your anti-rejection medications if your Medicare entitlement is based on age, end stage kidney disease or disability.

Medicare Part D prescription drug coverage is offered by private companies approved by Medicare. There are monthly premiums, deductibles and co-pays associated with the Medicare Part D plans. These out-of-pocket cost vary with the individual plans. Your cost will also vary

depending on which drugs you are prescribed, and the plan you select. In certain cases, if you have limited income and resources, you may be eligible for assistance with paying for your prescription drug cost.

If you are new to Medicare, you may apply for Medicare prescription drug plans:

– three months before to up to three months after you are first eligible for Medicare (if you are eligible based on end stage kidney disease)

– three months before and up to three months after your 65th birthday (if you are eligible for Medicare based on age)

– three months before to up to three months after your 25th month of cash disability benefits (if you are eligible for Medicare based on disability)

Your prescription drug coverage starts when your Medicare coverage begins. General enrollment for the Medicare prescription drug program may vary from year to year. Contact Medicare directly for the current year's open enrollment dates. The start period would be January 1 of the new year.

A more detailed explanation of the Medicare benefit is located in the government publication "Medicare and YOU" or contact Medicare directly at 800-MEDICARE (800-633-4227).

It is important to note that Medicare Part A and Part B both have deductibles and/or co-payments. There is a monthly premium for Medicare Part B. Since the patient is responsible for all premiums, deductibles and co-pays, patients often purchase Medicare Supplemental Contracts, also called Medi-Gap policies. Generally the supplemental

policy follows Medicare guidelines and will pay the deductibles and co-payments which Medicare does not cover. Getting a Medicare supplement is an individual choice and the responsibility of the Medicare patient. You may call Medicare or your local insurance provider for additional information.

Determination of Medicare's primary and secondary status

If you have insurance in addition to Medicare, there are specific rules that determine which is primary and which is secondary. The chart below shows those with and without a Group Employee Health Plan (GEHP)

	CAPD	HEMODIALYSIS	NO DIALYSIS
GEHP+ MEDICARE	GEHP primary when CAPD starts. Becomes secondary after the 31st month after the start of CAPD. (Medicare is then primary).	GEHP primary when hemodialysis starts. Becomes secondary after the 34th month after the start of hemodialysis. (Medicare is then primary)	GEHP primary at the time of transplant. Becomes secondary after the 31st month after transplant. (Medicare is then primary)
MEDICARE WITHOUT GEHP	Medicare is primary at the effective date of coverage.	Medicare is primary at the effective date of coverage.	Medicare is primary at the effective date of coverage.

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If you are covered by two insurance policies, one is primary and pays your expenses first, and the other pays secondary. If you have private insurance from a current job as well as Medicare, Medicare is secondary. If you have private insurance that is a retirement benefit, Medicare is primary. Medicare is always primary to Medicaid.

Medicaid

Medicaid covers both kidney and liver transplants. Patients with Medicaid will have either a straight fee for service coverage, or they can be assigned to a Medicaid HMO. Speak with the transplant financial coordinator/ representative about which Medicaid HMO plans are currently contracted with Beaumont for kidney transplant.

HOSPITAL: Medicaid provides coverage for hospitalization, doctor's visits and laboratory work for kidney transplant patients.

OUTPATIENT SERVICES: With approval, Medicaid will cover all medically necessary services to prepare a patient for a kidney transplant.

PHYSICIAN: If Medicaid covers your transplant, your policy will also cover any physician charges.

MEDICATION: Medicaid will pay for prescription medications, including your immunosuppressant medications. You may be required to pay a co-payment. Your pharmacist may be required to obtain prior authorization on selected medications. Over the counter vitamins and supplements may not be covered under your plan. Medicaid is re-evaluated every six months and is provided based on financial need and/or continuing disability. Therefore, you should not count on this coverage for long-term medications.

COORDINATION OF BENEFITS: If you have both Medicare and Medicaid, Medicare will pay first and your Medicaid will pick up deductibles and co-pays that Medicare did not fully cover.

If you have both commercial insurance and Medicaid, your commercial insurer will pay first

General information

Since every case is unique, we cannot determine your actual cost for the entire kidney transplant process. The costs include the pre-transplant evaluation, clinic visits, laboratory work and other testing while on the transplant waiting list, the inpatient hospital stay, and post-transplant

clinic visits, laboratory work and long term follow-up.

PRE-TRANSPLANT EVALUATION AND LISTING: The cost of being evaluated for a kidney transplant includes physicians' fees, blood tests, and other tests such as X-rays, ultrasounds, and cardiac tests. These services are covered by most insurance carriers.

If you have a family member or friend who may be a potential donor, their testing to determine if they are a suitable match and healthy candidate would be billed under your insurance (or Medicare). Potential donors are not responsible for any medical bills incurred for their donor evaluation, surgery or follow-up after surgery (except for out-of-pocket expenses).

INPATIENT STAY: Inpatient costs include the transplant surgery, the average hospital stay, the kidney acquisition charge, medications, and other miscellaneous charges incurred during your hospital stay. This does not reflect out-of-pocket expenses, anesthesia and professional fees.

Out of pocket expenses may include:

Post transplant follow-up

Post transplant costs include clinic visits, lab and radiology charges, medications and other related procedures.

CLINIC VISITS: Depending on your insurance, you may require referrals for your office visit. You may be responsible for paying a percentage of your office visit charges. Ask your insurance carrier about your responsibility for your clinic visits.

LABORATORY AND RADIOLOGY CHARGES: Some insurance companies require referrals for these services. Obtain these referrals before coming in for these procedures.

MEDICATIONS: Some insurance companies and prescriptions plans may pay for all medications. Other providers may have limited or partial coverage, and may even dictate where you can have your prescriptions filled. Providers may have preferred pharmacies or mail order programs.

Following transplant surgery, your physician will prescribe several medications to prevent your body from rejecting your new kidney. These medications are expensive, so you must begin planning for this expense prior to your surgery.

If you have Medicare as your primary insurance, Medicare will pay up to 80 percent of the costs of the anti-rejection medications for three years after transplant. If you do not have secondary coverage that pays for the Medicare co-pays and deductibles, the remaining 20 percent will be your out-of-pocket responsibility. After that three year period, your other prescription coverage should cover the cost of these medications (minus any co-pays and deductibles that you may have). **If you do not have**

additional prescription coverage, you will have to pay for these medications out-of-pocket.

Your Medicare coverage for anti-rejection medications will continue if you meet the following qualifying factors:

- 65 years of age or older; or
- You have a qualifying disability registered with Medicare; you have active Medicare Part A coverage at the time of transplant; and active Medicare Part B is your primary coverage at the time you purchase your medication.

In addition to the immunosuppressant (anti-rejection) medications, you will be on a number of other medications, based on your individual case. Medicare

Part B does not cover these medications. If you do not have any prescription coverage, shop around for the best prices on these medications.

Resources

There are agencies which provide funding to transplant patients in need. If you require assistance, ask the transplant social worker to assist you with finding an agency that meets your individual needs.

Some pharmaceutical (medication manufacturer) companies offer programs to assist those who are unable to afford their medications. Your transplant financial coordinator/assistant can help you apply for these programs if you qualify based on your financial status.

Conclusion

It is important that you are familiar with your coverage under your individual insurance policy. All policies are different, so you cannot rely on word of mouth information, (i.e. your neighbor's Blue Cross/Blue Shield coverage may be different from yours even though it is with the same company). You must read your insurance policy information and follow-up with a call to your employer and/or insurance company to clarify any questions you may have. Write down the full name of the person with whom you speak.

Key points to remember:

- Find out as much as you can about your individual insurance policy.
- Bring your insurance cards with you to each visit.
- Plan early for how you will pay for expenses not covered by you health insurance.
- Do not change or cancel your health insurance without discussing it with the transplant financial coordinator/ representative.
- If you are enrolled in an HMO, secure referrals for the office visits, lab work or treatments before your appointment.
- Notify the transplant financial coordinator about any changes in your insurance, loss of insurance coverage or financial hardships.

Notes and questions