



# POLARIS PULSE

20 YEARS

An Informational Bulletin Brought To You By Polaris Group

## Polaris Group Hits 20 Year Anniversary in 2008!

Twenty (20) years of proven expertise will be celebrated by Polaris Group in 2008. It is with great pride and enthusiasm that we celebrate this milestone and thank each of our valued clients for their continued support. Twenty years in business, especially with a niche in health care consulting, puts Polaris Group in limited company in the healthcare industry. An entire year of activities is planned for our staff, and clients.



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### 2009 Medicare Premiums Deductibles and Coinsurance

#### Part A Deductible and Coinsurance

A Medicare beneficiary admitted as a hospital inpatient in 2009 will pay a deductible of \$1,068. This is an increase of \$44 from \$1024 in 2008. The Part A deductible is the beneficiary's only cost for up to 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay an additional \$267 per day for days 61 through 90 in 2009, and \$534 per day for "lifetime reserve days" that can be used for hospital stays beyond the 90th day in a benefit period. The corresponding amounts for calendar year 2008 are \$256 and \$512, respectively.

The daily coinsurance for the 21st through 100th day in a skilled nursing facility will be \$133.50 in 2009, up from \$128 in 2008.

#### Part A Premium

Approximately 99 percent of Medicare beneficiaries do not have to pay a premium for Part A services because they have at least 40 quarters of Medicare-covered employment (or are the spouse or widow[er] of such a person). However, other seniors and certain people under age 65 with disabilities who have fewer than 30 quarters of coverage may obtain Part A coverage by paying a monthly premium set according to a statutory formula. This premium will be \$443 per month for 2009, an increase of \$20 from 2008. In addition, seniors with 30 to 39 quarters of coverage, and certain disabled persons with 30 or more quarters of coverage, will pay a premium of \$244 in 2009, compared to \$233 in 2008.

#### Part B Deductible

In 2009, the Part B deductible will be \$135, the same as it was in 2008.

#### Part B Premium

The standard Medicare Part B monthly premium will be \$96.40 in 2009, the same as the Part B premium for 2008. This is the first year since 2000 that there was no increase in the standard premium over the prior year.

As required in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, beginning in 2007 the Part B premium a beneficiary pays each month is based on his or her annual income. Specifically, if a beneficiary's "modified adjusted gross income" is greater than the legislated threshold amounts (\$85,000 in 2009 for a beneficiary filing an individual income tax return or married and filing a separate return, and \$170,000 for a beneficiary filing a joint tax return) the beneficiary is responsible for a larger portion of the estimated total cost of Part B benefit coverage. In addition to the standard 25 percent premium, such beneficiaries now have to pay an income-related monthly adjustment amount. These income-related Part B premiums have been phased-in over three years, beginning in 2007. 2009 is the first year in which affected Part B enrollees will pay the full amount of the income-related premiums. About 5 percent of current Part B enrollees are expected to be subject to the higher premium amounts.

The CMS Fact Sheet containing the Part B Monthly Premium Rate Table for beneficiaries whose modified adjusted gross incomes is greater than the legislated threshold amounts is available at: [www.polaris-group.com/news\\_releases.asp](http://www.polaris-group.com/news_releases.asp)

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#### Reporting Withholding Due to IRS Federal Payment Levy Program (FPLP) on the Remittance Advice

The Taxpayer Relief Act of 1997, Section 1024, requires the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Your Medicare payments could be reduced if the Internal Revenue Service (IRS) needs to collect overdue taxes that you owe.



In July 2000, the Treasury Department's Financial Management Service and the IRS started the Federal Payment Levy Program (FPLP) which is authorized by Internal Revenue Code Section 6331 (h), as prescribed by Section 1024 of the Taxpayer Relief Act of 1997. Through this program, collection of overdue taxes through a continuous levy on certain federal payments is authorized. This includes federal payments made to contractors and vendors, including Medicare providers, doing business with the government.

IRS may reduce federal payments subject to the levy by 15 percent, or the exact amount of tax owed if it is less than 15 percent of the payment. The levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt. Each time the federal payment is levied, the Financial Management Service will send a letter of explanation, including information on which federal payment was levied, and advice on who to contact for resolution.

Effective October 1, 2008, if you owe such taxes to IRS, your Medicare payment may be adjusted accordingly. When such adjustments occur, your Medicare remittance advice will reflect the code of "WU" in the PLB03-1 data field. In addition, a 10 digit toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field. Should this happen to you, note that under current privacy rules and regulations, only the IRS may discuss the tax issue with you.

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#### **Medicare Travel Allowance Fees for Collection of Laboratory Specimens**

CMS issued an emergency update to the Medicare Travel Allowance Fee for Collection of Specimens. The below listed reimbursement rates are effective July 1, 2008.

Medicare Part B covers a specimen collection fee and travel allowance for a laboratory technician to draw a Medicare covered specimen from either a nursing home patient or homebound patient. The travel allowance is intended to cover the estimated travel costs of collecting a specimen and to reflect the technician's salary and travel costs.

The additional allowance can be made only where a specimen collection fee is also payable, i.e., no travel allowance is made where the technician merely performs a messenger service to pick up a specimen drawn by a physician or nursing home personnel. The travel allowance may not be paid to a physician unless the trip to the home, or to the nursing home was solely for the purpose of drawing a specimen. Otherwise travel costs are considered

to be associated with the other purposes of the trip.

The following HCPCS codes are used for travel allowances:

- P9603 - Per Mile Travel Allowance
- P9604 - Flat Rate

#### **Per Mile Travel Allowance (P9603)**

The minimum "per mile travel allowance" is \$1.035. The per mile travel allowance is to be used in situations where the average trip to patients' home/facility is longer than 20 miles round trip, and is to be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip.

The per mile allowance was computed using the Federal mileage rate plus an additional 45 cents a mile to cover the technician's time and travel costs. Contractors have the option of establishing a higher per mile rate in excess of the minimum if local conditions warrant it. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

#### **• Example 1**

A laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be \$62.10 (60 miles x 1.035 cents a mile), plus the specimen collection fee.

#### **• Example 2**

A laboratory technician travels 40 miles from the lab to a Medicare patient's home/facility to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or \$41.40 (40 x 1.035), plus the specimen collection fee.

#### **Flat Rate (P9604)**

CMS will pay a minimum of \$9.55 one way flat rate travel allowance. The flat rate travel allowance is to be used in areas where average trips are less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood drawn at the same address, and for stops at the homes of Medicare and non-Medicare patients. This rate is based on an assumption that a trip is an average of 15 minutes and up to 10 miles one way. It uses the Federal mileage rate and a laboratory technician's time of \$17.66 an hour, including overhead. Contractors have the option of establishing a flat rate in excess of the minimum of



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\$9.55, if local conditions warrant it.

The claimant identifies round trip travel by use of the “LR” modifier.

• **Example 3**

A laboratory technician travels from the laboratory to a single Medicare patient’s facility and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x \$9.55 for a total trip reimbursement of \$19.10, plus the specimen collection fee.

• **Example 4**

A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the specimens are Medicare reimbursed and one is not. The \$9.55 flat rate is multiplied by two to cover the return trip to the laboratory (2 x \$9.55 = \$19.10) and then divided by five (1/5 of \$19.10 = \$3.82). Since one of the patients is non-Medicare, four claims would be submitted for \$3.82 each, plus the specimen collection fee.

**Q & A**

**“Where No Question Goes Unanswered!”**

Q. Is a Skilled Nursing Facility allowed to collect Medicare Coinsurance payments prior to the date of service?

A. A Skilled Nursing Facility (SNF) may not require, request, or accept a deposit or other payment from a Medicare beneficiary as a condition for admission, continued care, or other provision of services, except as follows:

1. A SNF may request and accept payment for a Part A deductible and coinsurance amount on or after the day to which it applies
2. A SNF may request and accept payment for a Part B deductible and coinsurance amount at the time of or after the provision of the services to which it applies
3. A SNF may not request or accept advance payment of Medicare deductible and coinsurance amounts
4. A SNF may require, request, or accept a deposit or other payment for services if it is clear that the services are not covered by Medicare and proper notice is provided.

Source: Medicare Claims Processing Manual, Chapter 1, Section 30.1.1

**TELECONFERENCE TRAININGS**

Polaris Group is pleased to present the following *CEU approved* teleconference trainings  
**Live Teleconference Trainings**

<b>Topic</b>	<b>Date</b>
MDS Fundamentals	10/1
Getting a Handle on ADRs and Denials-Part 1	10/2
Medicare Part A Basics	10/7
Master Section G Coding	10/8
Getting a Handle on ADRs and Denials-Part 2	10/9
Cut Letters and Generic Notices	10/14
Right Coding Sections K, P, & T	10/15
Medicare Doc. and Skilling Criteria	10/21
Sections I, J, O, & W	10/22
CMS F-Tag Review	10/23
Managing Risk—Event Reporting	10/28
Case Management for PPS and Accurate Reimbursement	10/29
Getting a Handle on ADRs and Denials-Part 3	10/30
Survey Process, Preparation & Management	10/30

*Please join us in our Teleconferences .  
For further information regarding these seminars,  
please contact the Seminar Department  
at: 800-275-6252 ext. 233 or register at:  
[www.polaris-group.com](http://www.polaris-group.com)*



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