

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**WISCONSIN PHYSICIANS SERVICE  
NEEDS ENHANCED GUIDANCE AND  
PROVIDER EDUCATION RELATED TO  
PHLEBOTOMY TRAVEL ALLOWANCES**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Gloria L. Jarmon  
Deputy Inspector General  
for Audit Services

September 2019  
A-06-17-04005

# *Office of Inspector General*

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## Report in Brief

Date: September 2019  
Report No. A-06-17-04005

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Review

Medicare pays a specimen collection fee when it is medically necessary for a clinical laboratory technician to draw a specimen to perform a clinical diagnostic laboratory test. When a technician travels to a nursing facility or homebound patient and a specimen collection fee is payable, the Social Security Act provides for payment of a travel allowance. Prior work found that travel allowances were at risk of being overpaid.

For this review, we focused on travel allowance payments for clinical diagnostic laboratory tests made by one Medicare administrative contractor (MAC), Wisconsin Physicians Service (WPS), because it was one of the largest payers of travel allowances in the Nation from January 1, 2015, through December 31, 2016 (audit period).

The objective of our review was to determine whether payments made by WPS to providers for travel allowances for clinical diagnostic laboratory tests complied with Medicare requirements.

### How OIG Did This Review

Our review covered 268,621 claim lines totaling \$7 million paid by WPS for Medicare Part B travel allowances during our audit period.

## Wisconsin Physicians Service Needs Enhanced Guidance and Provider Education Related to Phlebotomy Travel Allowances

### What OIG Found

Payments made by WPS to providers for travel allowances for clinical diagnostic laboratory tests did not always comply with Medicare requirements. Specifically, 76 of the 109 claim lines in our stratified random sample that were reviewed complied with Medicare requirements, but 33 claim lines did not (some lines had multiple deficiencies). WPS made payments to providers for (1) claims with incorrectly calculated prorated mileage, (2) claims using the incorrect clinical laboratory fee schedule rate, and (3) claims without sufficient documentation to support payment. On the basis of our sample results, we estimated that WPS paid providers \$353,755 in travel allowances for clinical laboratory services that were not in accordance with Medicare requirements.

### What OIG Recommends and WPS Comments

We recommend that WPS (1) work with the Centers for Medicare & Medicaid Services to clarify guidance to providers, which could have resulted in savings totaling an estimated \$353,755 during our audit period; (2) educate providers on how to correctly calculate the prorated mileage for phlebotomy travel allowance payments; (3) educate providers on their responsibility to bring any previously paid claims to their MAC's attention if they were paid using the wrong rate; and (4) educate providers on their responsibility to maintain adequate documentation to support payment for phlebotomy travel allowance payments.

In written comments on our draft report, WPS did not indicate concurrence or nonconcurrence with our recommendations. However, it agreed to implement our recommendations. WPS expects to have additional provider education developed and published by September 30, 2019.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

Medicare pays a specimen collection fee when it is medically necessary for a clinical laboratory technician to draw a specimen for a clinical diagnostic laboratory test.<sup>1</sup> In addition, when a technician travels to a nursing facility or homebound patient and a specimen collection fee is payable, the Act provides for payment of a travel allowance “to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample.”<sup>2</sup> Prior Office of Inspector General (OIG) work found that travel allowances have been overpaid when clinical laboratories claimed travel mileage in excess of the actual miles traveled.<sup>3</sup>

For this review, we focused on travel allowance payments for clinical diagnostic laboratory tests made by one Medicare administrative contractor (MAC), Wisconsin Physicians Service (WPS), because it was one of the largest payers of travel allowances in the Nation from January 1, 2015, through December 31, 2016.<sup>4</sup>

### OBJECTIVE

The objective of our review was to determine whether payments made by WPS to providers for travel allowances for clinical diagnostic laboratory tests complied with Medicare requirements.

### BACKGROUND

#### Medicare Program

Title XVIII of the Act established the Medicare program, which provides health insurance coverage for people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part B provides supplementary medical insurance for medical and other

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<sup>1</sup> Section 1833(h)(3)(A) of the Social Security Act (the Act), 42 U.S.C. § 1395l(h)(3)(A). See also chapter 16, section 60.1.2, of the Medicare Claims Processing Manual (the Manual), Rev. 3425, 12-18-15.

<sup>2</sup> The Act § 1833(h)(3)(B).

<sup>3</sup> Office of Investigations settlements, and *Professional Clinical Laboratory, Inc., Generally Did Not Comply With Medicare Requirements For Billing Phlebotomy Travel Allowances* (A-06-16-02002), October 2018. Available online at <https://oig.hhs.gov/oas/reports/region6/61602002.asp>.

<sup>4</sup> OIG is performing another audit of Medicare travel allowance payments for clinical diagnostic laboratory tests made by another MAC.

health services, including laboratory services. CMS contracts with MACs to process and pay Medicare Part B claims submitted by clinical laboratories.

## **Federal Regulations**

A travel allowance to collect a sample from a nursing facility or homebound patient may only be claimed by a clinical laboratory when a specimen collection fee is also payable.<sup>5</sup> A specimen collection fee is payable for specimens extracted by a laboratory technician, such as a blood sample drawn through venipuncture or a urine sample drawn by catheterization. No fee is allowed for samples where the cost of collection is minimal, such as throat cultures, blood draws by capillary puncture, or urine collection absent catheterization. The travel allowance is based on the actual distance traveled to each nursing facility or residence on a route until the blood, urine, and micro draws or pickups (collectively called specimens)<sup>6</sup> are dropped off at a clinical laboratory, a reference laboratory,<sup>7</sup> or other drop location (referred to as a trip throughout this report). According to the Manual, chapter 16, section 60.2:

- The allowance cannot be claimed if the technician does not draw the sample but merely performs a messenger service to pick up a blood or urine specimen drawn by a physician or nursing facility personnel.<sup>8</sup>
- At no time is the clinical laboratory allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

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<sup>5</sup> The Act § 1833(h)(3).

<sup>6</sup> A micro is collected and will be tested by the clinical laboratory's microbiology department, such as culture swabs, stool specimens, etc. A draw is either a blood sample taken by venipuncture or a urine sample by catheterization. A pickup is simply transporting a sample not drawn or collected by the laboratory technician. A specimen collection fee is not payable for pickup services.

<sup>7</sup> A reference laboratory is defined as a clinical laboratory that receives a specimen from another clinical laboratory and performs one or more tests on such specimen.

<sup>8</sup> We had several discussions with CMS during our review, and they acknowledge that the guidance is conflicting at times. While the allowance cannot be claimed if the technician merely picks up a specimen drawn by a physician or nursing facility personnel, CMS officials clarified during our discussions with them that the patients with pickups are to be included in the prorated mileage calculation.

- Carriers<sup>9</sup> must prorate travel allowance amounts claimed by providers by the number of patients (including Medicare and non-Medicare patients) from whom specimen draws or pickups were made on the same trip.<sup>10</sup>

### **Phlebotomy Travel Allowance Calculation**

There are two Healthcare Common Procedure Coding System (HCPCS)<sup>11</sup> codes used for travel allowances: P9603 and P9604. P9603 is used when the average round trip to a patient's home or nursing facility is longer than 20 miles, paid on a mileage per trip basis. P9604 is used when the average round trip is less than 20 miles, paid on a flat rate per trip basis. We reviewed only P9603 because prior OIG work found errors when calculating the prorated mileage travel allowance.

Under either code, when one trip is made for specimen draws or pickups from multiple patients (i.e., at a nursing facility), the travel payment component is prorated based on the number of patients on that trip for both Medicare and non-Medicare patients.<sup>12</sup> All draws and pickups are prorated on the day of the pickup, and the prorated travel allowance is billed on behalf of each Medicare patient.

The prorated mileage for P9603 is calculated as follows:

- The numerator is the sum of all miles driven by a laboratory technician to all nursing facilities or homebound patients for a single trip to collect all specimens.<sup>13</sup>
- The denominator is the total number of Medicare and non-Medicare patients with specimen draws and pickups on a trip.

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<sup>9</sup> Carriers predated MACs as entities that processed and paid Medicare Part B claims.

<sup>10</sup> A CMS Recurring Update Notification states that "the travel payment component is prorated based on the number of specimens collected on the trip, for both Medicare and non-Medicare patients . . . ." CMS acknowledged during our review that the guidance is conflicting on whether to prorate based on the number of "patients" or "specimens." CMS stated that "the policy is intended to determine Medicare's portion of the travel allowance by dividing by the total number of patients (Medicare and non-Medicare)." CMS also stated it would work to clarify the guidance.

<sup>11</sup> HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services to ensure that these claims are processed in an orderly and consistent manner.

<sup>12</sup> The Manual, chapter 16, § 60.2.

<sup>13</sup> Per discussions with CMS, specimens include blood, urine, and micro draws or pickups.



The result is the prorated travel allowance mileage per patient. To calculate the total Medicare travel allowance, the prorated mileage is then multiplied by a per mile reimbursement rate set by CMS each year. The reimbursement rates are announced through change request transmittals from CMS, which during our audit period were sometimes released after the start of a new calendar year but were retroactive to January 1.<sup>14</sup> Providers are responsible for ensuring their claims are multiplied by the correct reimbursement rate; they should bring any previously paid claims to their contractors' attention if paid using an incorrect rate.

## **Wisconsin Physicians Service**

A MAC is a private healthcare insurer to which CMS has awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims for Medicare fee-for-service beneficiaries. WPS is the MAC for Jurisdiction 5 and processes Parts A and B claims for Iowa, Kansas, Missouri, and Nebraska. WPS is also responsible for Jurisdiction 8, which includes Parts A and B for Indiana and Michigan. We limited our review to WPS Jurisdiction 5.

## **HOW WE CONDUCTED THIS REVIEW**

Our review covered 268,621 claim lines<sup>15</sup> totaling \$7 million paid by WPS for Medicare Part B travel allowances between January 1, 2015, and December 31, 2016. Each claim line represented a Medicare travel allowance. We selected a stratified random sample of 120 claim lines that were each part of a trip.

We obtained documentation from 6 providers with claim lines in our sample, which accounted for 109 of the 120 claim lines. The remaining 11 claim lines came from 3 providers that were no longer in operation and could not be contacted, so we were unable to review these claim lines.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimated overpayments.

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<sup>14</sup> Calendar year 2014 rates were released on March 14, 2014 (Change Request 8641); calendar year 2015 rates were released on January 23, 2015 (Change Request 9066); calendar year 2016 rates were released on December 31, 2015 (Change Request 9485).

<sup>15</sup> Our review included only HCPCS code P9603.

## FINDINGS

Payments made by WPS to providers for travel allowances for clinical diagnostic laboratory tests did not always comply with Medicare requirements. Specifically, 76 of the 109 claim lines in our stratified random sample that were reviewed complied with Medicare requirements, but 33 claim lines did not (some lines had multiple deficiencies). We found errors related to prorated mileage, payment rates, and inadequate documentation. On the basis of our sample results, we estimated that WPS paid providers \$353,755 in travel allowances for clinical laboratory services that were not in accordance with Medicare requirements.

### DOCUMENTATION DID NOT SUPPORT PRORATED MILES

Although the Manual states that at no time will the clinical laboratory be allowed to bill for more miles than are reasonable<sup>16</sup> or for miles not actually traveled by the laboratory technician,<sup>17</sup> we found that WPS paid providers for incorrectly calculated prorated mileage.

We found that payments for 18 of the 109 claim lines<sup>18</sup> in our sample were incorrectly paid due to incorrect prorated mileage. Specifically:

- Fourteen claim lines used the wrong number of patients when calculating the prorated mileage.
- Six claim lines used incorrect total miles when calculating the prorated mileage. Some of the errors included mileage from the laboratory technician's house to the laboratory before collecting specimens,<sup>19</sup> or mileage to locations without any specimens collected. For example, one laboratory technician drove 17 extra miles to a nursing home without collecting any specimens and included these miles in the prorated mileage calculation.

CMS's policy is intended to determine Medicare's portion of the travel allowance by dividing the total number of patients (Medicare and non-Medicare) from whom specimens were collected on a trip, but we found that several providers in our sample calculated the prorated mileage using the number of blood draws on a trip, not the number of patients with specimens collected. Although providers were calculating the prorated mileage using the wrong method

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<sup>16</sup> Per our discussions with WPS and CMS, mileage to a location without any specimens collected should not be included when calculating the prorated mileage.

<sup>17</sup> The Manual, chapter 16, § 60.2.

<sup>18</sup> Two claim lines used the wrong number of patients and incorrect total miles when calculating the prorated mileage.

<sup>19</sup> If the laboratory technician began the route at their house and went directly to the first specimen collection location, we included those miles, but if the laboratory technician traveled to the laboratory before collecting any specimens, we began the mileage when the laboratory technician left the laboratory.

(number of blood draws), many claim lines in our sample did not contain errors because the number of blood draws was the same as the number of patients. Additionally, some providers reported the wrong number of patients when completing paperwork upon returning to the laboratory.

Incorrect mileage totals occurred because the providers did not always confirm that there were specimens to be collected at each location prior to arrival, or because the laboratory technician included miles from their home to the laboratory before collecting any specimens.

Many of these errors occurred because WPS did not provide sufficient oversight or guidance to the providers on how to correctly calculate the prorated mileage.

### **DIFFERENCE DUE TO CHANGE IN FEE SCHEDULE**

Payment for the travel allowance is made based on the clinical laboratory fee schedule. The CMS Change Requests<sup>20</sup> revising the payment rate for travel allowances were released annually (sometimes several weeks after the start of the year), with an effective date of January 1 of each year. Claims for travel allowances paid using the incorrect payment rate were not automatically adjusted. Providers should bring any previously paid claims to their contractors' attention if they were paid using the incorrect rate.

We found that 15 of the 109 claim lines in our sample were not multiplied by the correct payment rate. These errors occurred because providers did not resubmit claims to be retroactively adjusted after updated payment rates issued by CMS were published. WPS did not provide sufficient guidance to providers to resubmit any claims that used the incorrect rate.

### **NO DOCUMENTATION TO SUPPORT SPECIMEN COLLECTION**

Payments to Medicare providers should not be made unless the provider has furnished information necessary to the MAC to determine the amount owed to the provider.<sup>21</sup> The Manual states that the travel allowance should be prorated by dividing the mileage by the total number of patients from whom specimen draws or pickups were made in the same trip.

For four claim lines in our sample, the providers did not provide us with sufficient documentation. Without adequate documentation, we were unable to determine whether the correct prorated mileage was submitted to WPS and paid. The providers with insufficient documentation did not give a reason for not providing sufficient documentation.

WPS did not provide sufficient oversight to ensure that providers maintained adequate documentation to support payment.

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<sup>20</sup> Change Requests 8641, 9066, 9485.

<sup>21</sup> The Act § 1833(e).

## **RECOMMENDATIONS**

We recommend that Wisconsin Physicians Service:

- work with CMS to clarify guidance to providers, which could have resulted in savings totaling an estimated \$353,755 during our audit period;
- educate providers on how to correctly calculate the prorated mileage for phlebotomy travel allowance payments;
- educate providers on their responsibility to bring any previously paid claims to their MAC's attention if they were paid using the wrong rate; and
- educate providers on their responsibility to maintain adequate documentation to support payment for phlebotomy travel allowance payments.

## **WISCONSIN PHYSICIANS SERVICE COMMENTS**

In written comments on our draft report, WPS did not indicate concurrence or nonconcurrence with our recommendations. However, it agreed to implement our recommendations. WPS expects to have additional provider education developed and published by September 30, 2019.

WPS's comments appear in their entirety as Appendix D.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our review covered 268,621 claim lines of Medicare Part B travel allowances, totaling \$7,016,729, paid by WPS during our audit period, January 1, 2015, through December 31, 2016. We reviewed only P9603 because prior OIG work found errors when calculating the prorated mileage travel allowance. The claim data were obtained from the CMS National Claims History file on the OIG Data Warehouse. We selected a stratified random sample of 120 travel allowance claim lines to review.

We did not perform an overall assessment of WPS's internal control structure. Rather, we reviewed only the internal controls that related directly to our objective. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We performed our audit work from October 2017 through August 2018.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS officials to gain a better understanding of Medicare requirements for travel allowances and to obtain their interpretation of the Medicare regulations related to travel allowances;
- interviewed WPS officials to gain an understanding of their policies and procedures related to how they process and pay for travel allowances;
- obtained data from CMS's National Claims History file of WPS's travel allowance claims (HCPSC code P9603) and extracted from CMS's National Claims History file a sampling frame of 268,621 Medicare Part B travel allowance claim lines, totaling \$7,016,729, paid by WPS from January 1, 2015, through December 31, 2016;
- selected a statistical sample of 120 phlebotomy travel allowance claim lines for review;
- sent a letter to each provider that we could contact associated with 109 claim lines in our sample to request documentation (e.g., mileage logs, requisition orders) to support each claim line in our sample (the remaining 11 claim lines came from 3 providers that were no longer in operation and could not be contacted, so we were unable to review these claim lines);

- evaluated the documentation obtained from WPS providers that we could contact for each sample claim line to determine how many miles were traveled and how many patients were serviced during each trip;
- calculated what the travel allowance should have been for 109 sample claim lines according to Medicare requirements and compared with the actual amount paid and noted any differences;
- estimated the overpayment of all claim lines in the sample frame during the audit period;
- discussed the results of our audit with each provider that supplied documentation; and
- discussed the results of our audit with WPS officials.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimated overpayments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### POPULATION AND SAMPLING FRAME

The population consisted of Medicare Part B travel allowances \$5 or greater that were paid by WPS for HCPCS code P9603 from January 1, 2015, through December 31, 2016. The file containing this population (i.e., the sampling frame) consisted of 268,621 Medicare Part B travel allowance claim lines, totaling \$7,016,728.88.

### SAMPLE UNIT

The sample unit was a Medicare travel allowance claim line.

### SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified sample consisting of four strata. The strata were divided based upon the Medicare payment amount for the travel allowance claim line.

Stratum	Number of Claim Lines	Stratum Boundaries	Value
1	183,277	\$5 to \$16.70	\$1,615,906.96
2	53,103	\$16.71 to \$58.55	1,541,091.54
3	21,632	\$58.70 to \$130.20	1,935,384.08
4	10,609	\$130.21 to \$302.82	1,924,346.30
<b>Total</b>	<b>268,621</b>		<b>\$7,016,728.88</b>

We selected a sample of 120 travel allowance claim lines, 30 lines from each stratum.

### SOURCE OF RANDOM NUMBERS

Random numbers were generated by the Region VI statistical specialist using the HHS-OIG Office of Audit Services (OAS) RAT-STATS 2010 Version 4 statistical software package.

### METHOD OF SELECTING SAMPLE UNITS

We sequentially numbered the claim lines within each stratum. Stratum 1 was numbered 1 to 183,277; stratum 2 was numbered 1 to 53,103; stratum 3 was numbered 1 to 21,632; stratum 4 was numbered 1 to 10,609. After generating 30 random numbers for each stratum, we selected the corresponding claim lines in each stratum.

### ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of unallowable Medicare payments for travel allowances.

## APPENDIX C: SAMPLE RESULTS AND ESTIMATES<sup>22</sup>

### Sample Details and Results

Stratum	Sampling Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Travel Allowances	Value of Unallowable Travel Allowances
1	183,277	\$1,615,906.96	30	\$209.64	12	\$10.62
2	53,103	1,541,091.54	30	692.22	12	41.34
3	21,632	1,935,384.08	30	2,779.11	6	209.88
4	10,609	1,924,346.30	30	5,290.91	3	182.00
<b>Total</b>	<b>268,621</b>	<b>\$7,016,728.88</b>	<b>120</b>	<b>\$8,971.88</b>	<b>33</b>	<b>\$443.84</b>

### Estimated Value of Phlebotomy Travel Allowance Overpayments (Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$353,755
Lower limit	150,067
Upper limit	557,442

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<sup>22</sup> This estimate applies to providers we were able to contact. We could not contact three providers that were no longer in operation. The 11 claim lines for these 3 providers were treated as non-errors.



## APPENDIX D: WISCONSIN PHYSICIANS SERVICE COMMENTS



Wisconsin Physicians Service Insurance Corporation  
A CMS Medicare Contractor  
1717 W. Broadway | P.O. Box 1787 | Madison, WI 53701-1787

August 13, 2019

Ms. Patricia Wheeler  
Office of Audit Services, Region VI  
1100 Commerce Street, Room 632  
Dallas, TX 75242

RE: Office of Inspector General (OIG) Draft Report- A-06-17-04005

Dear Ms. Wheeler,

This letter is in response to the OIG draft report titled *Wisconsin Physicians Service Needs Enhanced Guidance and Provider Education Related to Phlebotomy Travel Allowances*.

The OIG objective was to determine whether payments made by WPS to providers for travel allowances for clinical diagnostic laboratory tests complied with Medicare requirements.

The OIG concluded payments made by WPS to providers for travel allowances for clinical diagnostic laboratory tests did not always comply with Medicare requirements. Specifically, 76 of the 109 claim lines in the stratified random sample that were reviewed complied with Medicare requirements, but 33 claim lines did not (some lines had multiple deficiencies). The OIG found errors related to prorated mileage, payment rates, and inadequate documentation. The sample results estimated that WPS paid providers \$353,755 in travel allowances for clinical laboratory services that were not in accordance with Medicare requirements.

OIG Recommendations to WPS and WPS responses to Recommendations:

- *work with CMS to clarify guidance to providers, which could have resulted in savings totaling an estimated \$353,755 during our audit period;*
- *educate providers on how to correctly calculate the prorated mileage for phlebotomy travel allowance payments;*
- *educate providers on their responsibility to bring any previously paid claims to their MAC's attention if they were paid using the wrong rate; and*
- *educate providers on their responsibility to maintain adequate documentation to support payment for phlebotomy travel allowance payments*

WPS Response to the OIG Recommendations:



- *work with CMS to clarify guidance to providers, which could have resulted in savings totaling an estimated \$353,755 during our audit period;*

WPS Response:

Prior to and during development of our education WPS GHA Provider Outreach and Education (POE) staff will work with CMS, as needed, to clarify any guidance.

- *educate providers on how to correctly calculate the prorated mileage for phlebotomy travel allowance payments;*

WPS Response:

WPS GHA POE staff will develop education that includes how to correctly calculate the prorated mileage for phlebotomy travel allowance payments. Additionally, WPS GHA will perform data analysis on HCPCS P9603 and P9604 in Jurisdiction 5.

- *educate providers on their responsibility to bring any previously paid claims to their MAC's attention if they were paid using the wrong rate; and*

WPS Response:

WPS GHA POE staff will develop education that advises providers of their responsibility to bring any previously paid claims to their MAC's attention if they were paid using the wrong rate.

- *educate providers on their responsibility to maintain adequate documentation to support payment for phlebotomy travel allowance payments*

WPS Response:

WPS GHA POE staff will develop education that advises providers of their responsibility to maintain adequate documentation to support payment for phlebotomy travel allowance payments.

WPS is expecting to have the education developed and published by September 30, 2019. The education will be published on our WPS GHA portal ([www.wpsgha.com](http://www.wpsgha.com)) and communicated via the WPS GHA eNews (electronic mailing list).

If you have any questions or need additional information, please contact me at 402-995-0443.

Sincerely,

Mark DeFoil  
Director, Contract Administration

cc: Ronda Jones, CMS  
Wanda Jones, CMS  
Robert Bernal, CMS  
Linda Tran, CMS  
Matthew Odom, OIG