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July 2025 | A-06-23-01002

Wisconsin Made at Least $18.5 Million in Improper Fee-For-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism

REPORT HIGHLIGHTS

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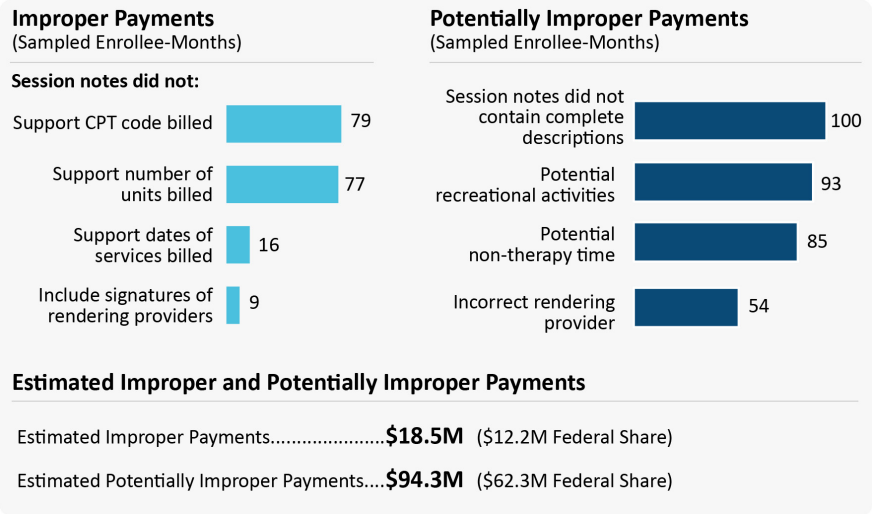
Wisconsin Made at Least $18.5 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism

Why OIG Did This Audit

- Early treatment for autism is important because proper care can reduce children's difficulties while helping them build on their strengths and learn new skills. Although there are other treatments, applied behavior analysis (ABA) is a commonly used therapy for managing autism symptoms.
- Wisconsin's fee-for-service (FFS) Medicaid payments for ABA in 2018 totaled $39.9 million, and by 2022, these payments had increased to $53.7 million.
- This audit examined whether Wisconsin's FFS Medicaid payments for ABA for 2021 and 2022 complied with Federal and State requirements.

What OIG Found

Wisconsin's payments for ABA did not fully comply with Federal and State requirements. All 100 sampled enrollee-months included payments for 1 or more claim lines that were improper or potentially improper.



What OIG Recommends

We made six recommendations to Wisconsin, including that it refund $12.2 million to the Federal Government, provide additional guidance to ABA facilities for documenting ABA, and periodically perform a statewide post payment review of Medicaid ABA payments to educate providers on requirements. The full recommendations are in the report.

Wisconsin partially concurred with our first recommendation, concurred with our remaining recommendations, and detailed steps it plans to address our recommendations.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

Autism spectrum disorder (autism) is a condition related to brain development that is characterized by some degree of difficulty with social interaction and communication, as well as by limited and repetitive patterns of behavior. The symptoms and severity of autism vary widely among those who have the condition. Early treatment for autism is important because proper care can reduce children's difficulties while helping them build on their strengths and learn new skills. Although there are other treatments for autism, applied behavior analysis (ABA) is a commonly used therapy for managing autism symptoms, usually centered on improving social and communication skills.

In July 2014, the Centers for Medicare & Medicaid Services (CMS) issued a bulletin to clarify that State Medicaid programs must cover diagnosis and treatment, which may include ABA, for children with autism.[1] In the past several years, Federal and State agencies have identified questionable billing patterns (e.g., billing for excessive units of service) by some ABA providers, as well as Federal and State payments to providers for unallowable services.[2] Wisconsin's fee-for-service (FFS) Medicaid payments for ABA in calendar year (CY) 2018 were $39.9 million, and by CY 2022, these payments had increased to $53.7 million.[3] Therefore, we conducted this audit of the Wisconsin Department of Health Services' (State agency's) FFS Medicaid payments for ABA for CYs 2021 and 2022 (audit period). The Office of Inspector General (OIG) is conducting a series of audits to determine whether Medicaid payments for ABA provided to children diagnosed with autism complied with Federal and State requirements.[4]

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[1] CMS, Center for Medicaid and CHIP Services Informational Bulletin, "Clarification of Medicaid Coverage of Services to Children with Autism," July 7, 2014. Available online at https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-07-14.pdf. Accessed on Mar. 3, 2025.

[2] See, for example, the Department of Defense (DOD), Office of Inspector General (OIG), *The Defense Health Agency Improperly Paid for Autism-Related Services to Selected Companies in the TRICARE South Region* (DODIG-2017-064), Mar. 10, 2017. Available online at https://media.defense.gov/2017/Dec/19/2001858335/-1/-1/1/DODIG-2017-064.PDF. Accessed on Feb. 28, 2025. DOD-OIG, *TRICARE North Region Payments for Applied Behavior Analysis Services for the Treatment of Autism Spectrum Disorder* (DODIG-2018-084), Mar. 14, 2018. Available online at https://media.defense.gov/2018/Mar/22/2001893494/-1/-1/1/DODIG-2018-084.PDF. Accessed on Feb. 28, 2025. State of Nevada Performance Audit, *Delivery of Treatment Services for Children With Autism, 2020,* (LA22-04), Jan. 6, 2021. Available online at https://www.leg.state.nv.us/Division/audit/Full/BE2022/LA22-04%20Delivery%20of%20Treatment%20Services%20for%20Children%20With%20Autism.pdf. Accessed on Feb. 28, 2025.

[3] In CY 2023, FFS payments had increased to $82.3 million.

[4] OIG, *Indiana Made at Least $56 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism* (A-09-22-02002), issued Dec. 16, 2024.

OBJECTIVE

Our objective was to determine whether the State agency's FFS Medicaid payments for ABA provided to children diagnosed with autism complied with Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance expenditures (called Federal financial participation, or the Federal share) based on the Federal medical assistance percentage (FMAP), which varies depending on the State. (During our audit period, Wisconsin's FMAP ranged from 65.57 percent to 66.30 percent.) To claim the Federal share, States report their Medicaid expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

Wisconsin's Medicaid Program

In Wisconsin, the State agency's Division of Medicaid Services administers the Medicaid program. Medicaid services are incorporated under the umbrella of the ForwardHealth programs. Behavioral treatment benefits, including ABA services, are administered through FFS.

Applied Behavior Analysis

ABA is a therapeutic approach for managing autism symptoms, usually centered on improving social and communication skills. ABA can be provided individually to one child or in a group setting. ABA is often provided at a facility but can be provided in a child's home or school or in the community. Examples of ABA techniques are shown in the box to the right.

Examples of ABA Techniques

Mand Training
Uses prompting and reinforcement to help a child communicate

Discrete Trial Training
Breaks skills into small units to teach one by one

Natural Environment Training
Targets skill development in a less structured environment

Modeling
Presents an example of a desired behavior for the child to imitate

Wisconsin's Medicaid Coverage of Applied Behavior Analysis

The State agency began covering ABA for treatment of autism on January 1, 2016. The State agency's minimum requirements for Medicaid coverage are stated in the Wisconsin administrative code; however, the administrative code does not contain criteria specific to ABA therapy. The State agency has the right and responsibility to publish provider handbooks, bulletins, and periodic updates to inform providers of changes in State or Federal law, policy, reimbursement rates and formulas, departmental interpretation, and procedural directives (DHS 108.02(4)). The State agency published the *Behavioral Treatment Policy Handbook* to inform providers of ABA coverage policies.[5] In addition, the State agency notifies providers of any ForwardHealth policy updates through its online portal or via email.

Requirements for ABA Provider Types in Wisconsin

1 Behavioral Treatment Technician

- High school diploma or General Educational Development (GED) certificate and 40 hours of training or
- registered behavior technician certification.

2 Behavioral Treatment Therapist

- Board-certified assistant behavior analyst certification, or
- master's degree with at least 400 hours of supervised experience, or
- bachelor's degree and at least 2,000 hours of training and supervised experience.

3 Focused Treatment Therapist

- Board-certified assistant behavior analyst certification, or
- master's degree with at least 400 hours of training and supervised experience, or
- bachelor's degree and at least 2,000 hours of training and supervised experience, or
- registered behavior technician certification and at least 2,000 hours of training and supervised experience.

4 Behavioral Treatment Licensed Supervisor

- Licensed as a behavior analyst and at least 4,000 hours of experience as a supervisor and Entity Type 1 National Provider Identifier (NPI),* or
- licensed as a psychiatrist, psychologist, behavior analyst, clinical social worker, professional counselor, or marriage and family therapist and at least 4,000 hours of experience as a supervisor, a certificate of Early Start Denver Model, and Entity Type 1 NPI.

5 Focused Treatment Licensed Supervisor

- Licensed as a psychiatrist, psychologist, behavior analyst, clinical social worker, professional counselor, or marriage and family therapist;
- act within the scope of his or her training and experience; and
- at least 2,000 hours of supervised experience.

*NPI - Entity Type 1 is for individual health care providers.

To be eligible to provide ABA in Wisconsin, a Behavioral or Focused Treatment Licensed Supervisor (licensed supervisor) must have a license issued by the Wisconsin Department of Safety and Professional Services (DSPS). However, the behavioral treatment technician (technician) and behavioral or focused treatment therapist (therapist) do

[5] *Behavioral Treatment Policy Handbook,* available online at Online Handbook Display (wi.gov). Accessed on Oct. 16, 2024.

not need to be licensed. Requirements for the five ABA provider types are shown in the box on the previous page.[6]

The State agency requires all licensed supervisors, therapists, and technicians who provide behavioral treatment to ForwardHealth enrollees to be enrolled in Medicaid as behavioral treatment providers.[7] A licensed supervisor may practice independently or be employed by a facility that specializes in ABA for children with autism (ABA facility). ABA facilities also employ technicians and therapists.

To receive Medicaid payments for ABA, an ABA provider must submit to the State agency a prior authorization request along with supporting documentation (e.g., the diagnostic evaluation, initial assessment, and age-normed testing results).[8] The supporting documentation is required to determine medical necessity for the prior authorization request. The supporting documentation must include a plan of care (POC) developed by a licensed supervisor and must indicate the treatment approach that will be used. Initial prior authorizations for ABA should be submitted for no more than 6 months; the authorization granted may be shorter or longer depending on the demonstration of medical necessity (*Behavioral Treatment Policy Handbook,* Topic # 19038). A prior authorization amendment request may be submitted to request an extension of services for up to a total of 12 months under the initial prior authorization (*Behavioral Treatment Policy Handbook,* Topic # 19039). The State agency performs the review of the request for prior authorizations and approves the provider's request for either comprehensive or focused ABA treatment (*Behavioral Treatment Policy Handbook,* Topic # 450, 451, 19059).

Levels of Applied Behavior Analysis Treatment

There are two different levels of ABA treatment under the Wisconsin behavioral treatment benefit: comprehensive and focused.

Comprehensive treatment covers high-intensity, early-intervention, comprehensive behavioral treatment typically lasting for a year or more. The aim of comprehensive treatment is for the enrollee to acquire a broad base of skills (e.g., communication, social-emotional development, adaptive functioning) with an emphasis on "closing the developmental gap" between the enrollee and same-age peers in the primary deficit areas associated with autism. The broad

[6] Overview of provider specialties with the requirements and certifications can be found at https://www.forwardhealth.wi.gov/kw/pdf/2015-55.pdf and https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Certification/EnrollmentCriteria.aspx?topic=2. Accessed on Oct. 16, 2024.

[7] Wisconsin State plan, Attachment 3.1-A Supplement 1, page 4.ee; Attachment 3.1-B Supplement 1, page 3.ee.

[8] For enrollees under the age of 6, providers are required to either submit a diagnostic evaluation or an attestation that the enrollee has been diagnosed with autism by a qualified professional (*Behavioral Treatment Policy Handbook,* Topic # 20477).

scope of goals and focus on early developmental impacts are the defining features of this treatment (*Behavioral Treatment Policy Handbook,* Topic # 18997).[9]

Focused treatment covers time-limited, lower-intensity treatment that focuses on specific behaviors or deficits. The aim of focused behavioral treatment is to reduce challenging behaviors of the enrollee, develop replacement behaviors, and develop discrete skills that enhance personal independence. A narrow scope of goals and a 12-month timeline for goal mastery are the defining features of focused treatment, in contrast to the broad scope of goals with comprehensive treatment (*Behavioral Treatment Policy Handbook,* Topic # 19017).[10]

Behavioral treatment licensed supervisors, behavioral treatment therapists, and behavioral treatment technicians may provide both comprehensive and focused treatment. Focused-treatment licensed supervisors and focused-treatment therapists may provide focused treatment only.[11]

Providers' Use of Procedure Codes for Billing Applied Behavior Analysis

Effective January 1, 2019, the State agency required providers to use Current Procedural Terminology (CPT®) codes and modifiers to bill for ABA assessment and treatment services (*ForwardHealth Update*, No. 2018-46).[12, 13] Each of these CPT codes is billed in 15-minute increments (i.e., 1 unit) of service provided to an enrollee. In Wisconsin, providers are required to include a modifier with the procedure code to indicate the type of treatment that was provided. ForwardHealth recognizes modifier TG for comprehensive-treatment claims and modifier TF for focused-treatment claims.

CPT code 97153 is the most commonly billed code for ABA in Wisconsin, accounting for 72 percent of ABA payments covered by our audit. This code is generally billed by an ABA facility

[9] Wisconsin State plan, Attachment 3.1-A Supplement 1, page 4.dd; Attachment 3.1-B Supplement 1, page 3.dd.

[10] *Id.*

[11] *Id.*

[12] *CPT copyright 2020 American Medical Association. All rights reserved.*

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for a technician's time providing one-to-one treatment performed with an individual child; it is sometimes billed for up to 7 hours of treatment per day.

CPT code 97153 with modifier TF receives a different payment rate based on the type of provider rendering the service. For example, CPT code 97153 TF rendered by a technician pays less than if it was rendered by a licensed supervisor. However, the payment rate for CPT code 97153 with modifier TG does not differ depending on the type of the rendering provider. Figure 1 shows the payment rates for CPT code 97153 based on the provider type.

Figure 1: Payment Rates for 97153 Based on Provider Type

Procedure Code	Rendering Provider Type	Modifier	Rate 2021	Rate 2022
97153	Any level of provider	TG	$9.53	$10.96
	LS	TF	$33.15	$38.12
	TT	TF	$16.67	$19.17
	BT	TF and 52	$9.53	$10.96

LS: Licensed Supervisor
TT: Treatment Therapist
BT: Behavioral Technician
TG: Comprehensive level of service
TF: Focused level of service
52: Reduced services

CPT code 97155 is the second most commonly billed code for ABA in Wisconsin, accounting for 22 percent of ABA payments covered by our audit. This code is generally billed by an ABA facility for a licensed supervisor or treatment therapist's time providing one-to-one treatment that includes protocol modification.

The State agency does not permit CPT codes 97153 and 97155 to be billed concurrently (*Behavioral Treatment Policy Handbook*, Topic # 18959). For example, if a technician provides ABA from 8:00 a.m. to 12:00 p.m. and a licensed supervisor comes to work with the technician to administer a protocol modification from 9:00 to 11:00 a.m., the facility may bill 2 hours of CPT code 97153 for the technician's time and 2 hours of CPT code 97155 for the licensed supervisor's time.

Figure 2 on the next page shows the billed CPT codes for ABA in Wisconsin, along with the providers who may perform each service and a description of the service.

Figure 2: Billed CPT Codes for Applied Behavior Analysis in Wisconsin

CPT Code	Rendering Provider Type	Service Description
97151	LS	Behavior identification assessment
97152	LS or TT	Behavior identification supporting assessment
97153	Any level of provider	Adaptive behavior treatment by protocol
97155	LS or TT	Adaptive behavior treatment with protocol modification
97156	LS	Family adaptive behavior treatment guidance
97156AM	LS or TT	Family adaptive behavior treatment guidance (Team meeting)

LS: Licensed Supervisor **TT:** Treatment Therapist

HOW WE CONDUCTED THIS AUDIT

Our audit covered the State agency's FFS Medicaid payments of $121.1 million ($80.7 million Federal share) for 1,110,716 claim lines for ABA, which we grouped into 36,345 enrollee-months with dates of service from January 1, 2021, through December 31, 2022.[14] Our audit included only enrollee-months with Federal share amounts greater than or equal to $500. We selected a stratified random sample of 100 enrollee-months, with ABA payments totaling $389,997 ($258,035 Federal share).[15]

The 100 enrollee-months in our sample consisted of 22 unique ABA facilities and 98 unique enrollees. Total payments for each sampled enrollee-month ranged from $807 to $8,549. We requested the following supporting medical record documentation from ABA facilities for each sampled enrollee-month: (1) the approved prior authorization, (2) the diagnostic evaluation that contains a recommendation for ABA, (3) the prescription for ABA, (4) the POC, and (5) the ABA session notes supporting the units of ABA paid.

We reviewed the documentation to determine whether (1) the prior authorization was approved and covered the sampled enrollee-month, (2) the documentation from the diagnostic evaluation confirmed a diagnosis of autism and included a recommendation for ABA, (3) the prescription covered the sampled enrollee-month, (4) the POC was developed and covered the

[14] An enrollee-month consisted of all FFS Medicaid claim lines for ABA for an individual enrollee for which the end date of each claim line fell within the month. A claim line consisted of a specific ABA service (e.g., a service billed with CPT code 97153), generally for a specific date of service. Each claim line was paid individually. An enrollee-month could have had allowable and unallowable claim lines.

[15] There were 871 claims and 3,553 claim lines associated with the 100 sampled enrollee-months.

sampled enrollee-month, and (5) the session notes included required elements (such as the name of the child and the duration of ABA) and supported the units of ABA paid.

We did not use a medical reviewer to determine whether ABA was medically necessary. We shared documentation for some of the sampled enrollee-months that contained claim lines that were improper or potentially improper payments with the State agency and asked the State agency to provide input on whether the session notes supported the CPT code that was paid. We also held multiple meetings with the State agency to discuss what type of support it would expect to see in the session notes.

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 describes our audit scope and methodology, Appendix B describes our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D shows our audit results by sampled enrollee-month.

FINDINGS

The State agency's FFS Medicaid payments for ABA provided to children diagnosed with autism did not fully comply with Federal and State requirements. Specifically, all 100 sampled enrollee-months included payments for 1 or more claim lines that were improper or potentially improper.[16] For 71 of 100 sampled enrollee-months, the State agency made payments of $9,351 (Federal share) for at least 1 claim line that complied with the requirements.[17] However, for 96 of the 100 sampled enrollee-months, the State agency made payments of $46,997 (Federal share) for at least 1 claim line that did not comply with documentation requirements. For these sampled items, we identified session notes that did not:[18]

- support the CPT code billed (79 sampled enrollee-months),
- support the number of units billed (77 sampled enrollee-months),

[16] Each sampled enrollee-month had claim lines that we determined to be allowable, unallowable, or potentially unallowable.

[17] Seventy of the seventy-one sampled enrollee-months included claim lines for either an assessment, parent guidance, or team meeting that we determined to be allowable. One sampled enrollee-month included claim lines for adaptive behavior treatment protocol that we determined to be partially allowable.

[18] The number of sampled enrollee-months with deficiencies is greater than 100 because 70 sampled enrollee-months had more than 1 error.

- support the dates of service billed (16 sampled enrollee-months), or

- include signatures of rendering providers (9 sampled enrollee-months).[19]

On the basis of our sample results, we estimated that the State agency made improper payments of at least $18.5 million ($12.2 million Federal share).[20, 21]

In addition, for all 100 sampled enrollee-months, the State agency made potentially improper ABA payments. We identified the following issues with the supporting documentation for these sampled enrollee-months:[22]

- Session notes did not contain a full description of services provided or did not include the goals addressed or data collected (100 sampled enrollee-months).

- Session notes referred to recreational activities that may not have been allowable ABA activities (93 sampled enrollee-months).

- Session notes included potential nontherapy time (e.g., lunch, naps, travel time) (85 sampled enrollee-months).

- Sessions were billed with an incorrect rendering provider (54 sampled enrollee-months).

We set aside for State agency resolution $201,688 (Federal share) for the 100 sampled enrollee-months because documentation was not complete enough to support that payments complied with Federal and State requirements or whether documentation was reliable. Based on our sample results, we estimated that the State agency made approximately $94.3 million ($62.3 million Federal share) of potentially improper ABA payments.[23]

Figure 3 on the next page shows a summary of our findings.

[19] The sampled enrollee-months are made up of all FFS Medicaid ABA payments for claims (and all associated claim lines) with dates of service through the end of the month.

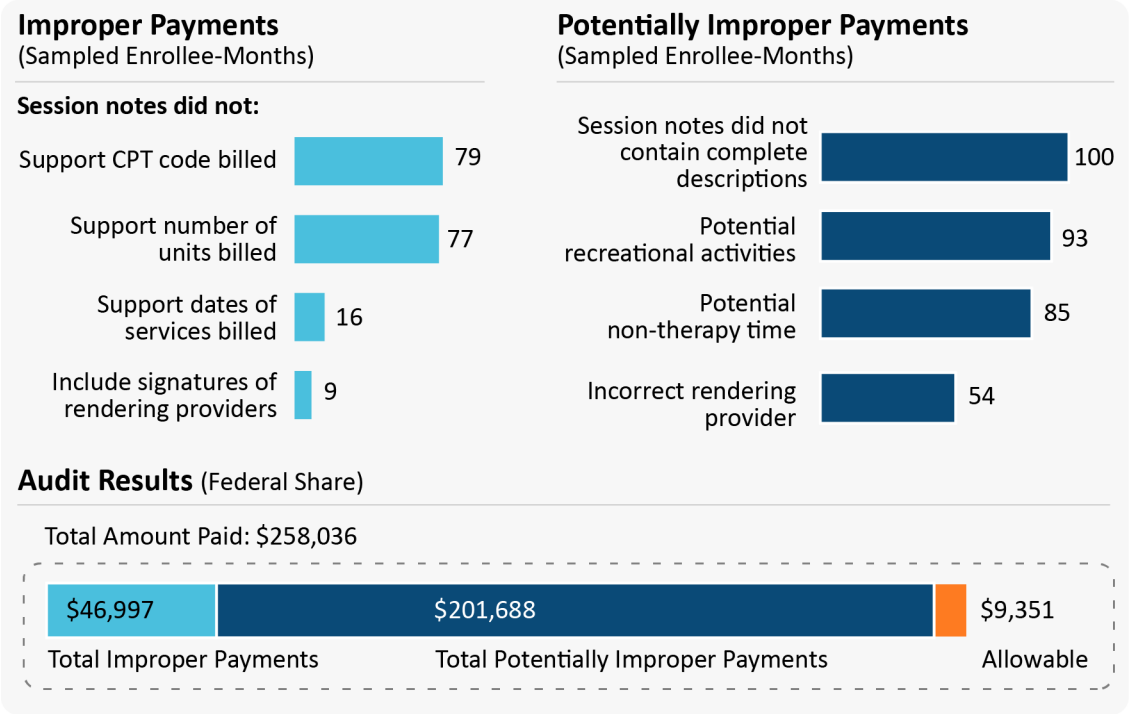
[20] The actual estimated amount was $18,547,493 ($12,287,252 Federal share).

[21] To be conservative, we recommend recovery of improper payments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual improper payment total 95 percent of the time.

[22] The number of sampled enrollee-months with deficiencies is greater than 100 because 98 sampled enrollee-months had more than 1 error.

[23] The actual estimated amount was $94,270,389 ($62,334,835 Federal share).

Figure 3: Summary of Our Findings



The State agency made improper and potentially improper payments because it did not provide effective oversight of FFS Medicaid ABA payments. Specifically, since the program began in 2016, the State agency had not performed a statewide postpayment review of payments to ABA facilities to verify that facilities complied with Federal and State requirements related to documentation. Performing periodic postpayment reviews and sharing the results with providers as part of ongoing education may have prevented the State agency from making improper or potentially improper payments. In addition, the State agency did not provide sufficient guidance to ABA providers for documenting ABA services.

THE STATE AGENCY MADE IMPROPER PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS

For 96 of the 100 sampled enrollee-months, the State agency made FFS Medicaid payments for ABA services that did not meet documentation requirements. Specifically, the facilities did not provide session notes that (1) supported the CPT codes paid, (2) supported the number of units of ABA paid, (3) supported the dates of service that were paid (i.e., notes for these days were missing), or (4) included the rendering provider's signature. In total, the State agency improperly paid $47,015 for the sampled enrollee-months (Appendix D). These improper payments occurred because the State agency did not (1) require providers to document how they resolved issues with, or made changes to, the existing treatment protocol or POC when providing one-to-one treatment that included modification to that protocol and (2) perform a postpayment review of payments to ABA facilities to verify that facilities complied with Federal and State documentation requirements.

Federal and State Requirements

States are required to have agreements with providers to keep records that are necessary to fully disclose the extent of the services provided (the Act § 1902(a)(27)). Expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met (*State Medicaid Manual* § 2497.1). A provider must prepare and maintain truthful, accurate, complete, legible, and concise documentation and medical and financial records for specific services rendered to a recipient by a certified provider (DHS 106.02(9)).

The State agency may reject payment for a service that ordinarily would be covered if the service fails to meet program requirements. Non-reimbursable services include services that fail to comply with program policies or State and Federal statutes, rules, and regulations (DHS 107.02(2)(a)).

Covered services under Wisconsin Medicaid are not reimbursable unless the documentation and medical-record-keeping requirements are met (DHS 106.02(9)(f)). The provider's documentation must include, among other things, an accurate, complete, and legible description of each service provided, and the quantity, level, and supply of service provided (DHS 106.02(9)(a)).

CPT code 97155 covers services for which a licensed supervisor or treatment therapist resolves issues with, or makes changes to, the existing treatment protocol or POC to improve outcomes. This service may include simultaneous direction of a technician, guardian, or caregiver, or a combination of these, who is one-to-one with an enrollee (*Behavioral Treatment Handbook,* Topic # 18980). CPT code 97156 covers face-to-face instruction to guardian(s) or caregiver(s) with or without the enrollee present, focusing on identifying problem behaviors and deficits following the POC, to reduce maladaptive behaviors, skill deficits, or both (*Behavioral Treatment Handbook,* Topic # 18999). CPT code 97151 covers clinical assessment activities used to identify target behaviors and to develop a POC (*Behavioral Treatment Handbook*, Topic # 18979).

The State agency requires certain documentation for behavioral treatment CPT codes. Required documentation for all CPT codes includes the duration of the session (i.e., time in and time out), the names of staff and caregiver(s) present, the place of service, and the rendering provider's signature. The State agency required additional documentation for each CPT code specific to the type of service, as shown in Figure 4 on the next page.

Figure 4: Additional Documentation Requirements for CPT Codes

CPT Code	Additional Documentation Required
97151	Assessment report and Plan of Care
97153	Goals addressed during the session and data collected
97155	Goals addressed during the session and data collected
97156	Potential treatment targets identified or discussed, and training, demonstration, observation, or feedback provided
97156AM	Potential treatment targets identified or discussed

Furthermore, for CPT code 97155, the *Behavioral Treatment Policy Handbook* instructed providers not to bill separately for CPT code 97153 during simultaneous direction of a technician (Topic # 18959).

Session Notes Did Not Support the State Agency's Payments for Current Procedural Terminology Codes

For 79 sampled enrollee-months from 19 ABA facilities, the State agency paid for ABA billed with certain CPT codes (i.e., 97155 and 97156) for which session notes did not support that the facilities rendered ABA as described in the CPT code.

Of the 95 sampled enrollee-months that included a claim line billed with CPT code 97155, 75 sampled enrollee-months included session notes that did not indicate that any issues were resolved or that changes were made to the treatment protocol or POC. For example, one session note stated that the child "participated in social group during session and discrete trial was not conducted – no modifications needed at this time" and indicated that no direction was given to a technician. Another session note stated that the licensed supervisor observed no barriers to progress, the child "increased success with all programming targets" and had "high compliance for completion," and that the next steps would be to "continue with current targets."

Of the 70 sampled enrollee-months that included a claim line billed with CPT code 97156, 8 sampled enrollee-months included at least 1 session note that documented a general discussion between the licensed supervisor or treatment therapist and the guardian(s) or caregiver(s) and did not document any guidance provided to implement treatment protocols. Additionally, some session notes indicated that there was not a guardian(s) or caregiver(s) present during the discussion as required.

Of the 48 sampled enrollee-months that included a claim line billed with CPT code 97151, 4 sampled enrollee-months included session notes that did not document that the licensed supervisor identified target behaviors and developed a POC. For example, some session notes stated that the licensed supervisor "read an article" or made "schedule changes" with no further details to indicate that the activity was related to clinical assessment activities.

Session Notes Did Not Support the Number of Units of Applied Behavior Analysis Paid

For 77 sampled enrollee-months from 18 ABA facilities, the State agency paid the facilities for more units of ABA than the number of units supported by the session notes. Specifically, one or more of the following deficiencies occurred at each facility: (1) the signature on electronic notes was time-stamped prior to the ABA session end time indicated on the session notes, (2) units of ABA were paid that exceeded the overall time shown in the session notes, or (3) ABA was paid for sessions that overlapped during the same timeframe with other sessions.

For 53 sampled enrollee-months from 5 ABA facilities, ABA providers signed session notes more than 8 minutes prior to the end of the session time.[24] For example, the session notes for one sampled enrollee-month reflected that the provider signed 8 of the 17 session notes before the end of the ABA session end time. The session notes were signed between 10 and 39 minutes before the session end time, resulting in 14 units of ABA therapy paid to the provider without assurance that services were being provided.

For 31 sampled enrollee-months from 10 ABA facilities, units of ABA were billed and paid in excess of the time the session notes supported. For example, one session note showed that on 1 day the child received ABA from 12:30 to 2:30 (8 units); however, the facility billed and was paid for 10 units. A session note for a different child stated that the session was canceled, yet the session was still billed and paid.

For 17 sampled enrollee-months from 11 ABA facilities, the State agency paid for units of 97153 that occurred concurrently with paid units of 97155. For example, for one date of service, a 97153 session note indicated that the session occurred from 12:30 to 2:30 (8 units). However, another session note indicated that a 97155 session occurred from 2:00 to 2:30 (2 units). Thus, the sessions would have occurred concurrently for two units. The provider was paid for two units of 97155 and eight units of 97153 but should have been paid for only six units of 97153.

Session Notes Did Not Support Dates of Service Paid

For 16 sampled enrollee-months from 11 ABA facilities, the State agency paid for ABA provided on 1 or more dates of service for which the facilities could not locate the session notes.

[24] The American Medical Association guidance states that a unit of time is attained when the mid-point is passed. ABA CPT codes are billed in 15-minute increments; therefore, one unit is attained when 8 or more minutes are accumulated. The State agency agreed that any time billed after a session note was signed and did not reach the mid-point would not be payable.

Session Notes Did Not Include Signatures of Providers Who Rendered Applied Behavior Analysis

For nine sampled enrollee-months from seven ABA facilities, the State agency paid for ABA for which the session notes did not include signatures of the providers who rendered the services. If there was not a provider signature at the time services were rendered, it is not possible to confirm the author of the session notes or that the service was provided as documented.

The State Agency Did Not Perform a Statewide Postpayment Review of Applied Behavior Analysis Payments and Did Not Provide Sufficient Guidance to Providers

The documentation deficiencies we identified for the 96 sampled enrollee-months occurred because the State agency had not performed a statewide postpayment review of ABA payments to ABA facilities to verify that the facilities complied with Federal and State requirements since the program began in 2016. Performing periodic postpayment reviews and sharing the results with providers as part of ongoing education may have prevented the State agency from making improper or potentially improper payments. [25] According to State agency officials, the State agency has not conducted a postpayment review of ABA claims because of a Wisconsin Supreme Court ruling in 2020 that altered the State agency's ability to recoup overpayments from postpayment reviews.[26]

In addition, the State agency did not provide adequate guidance to providers. The State agency's guidance on ABA CPT codes (listed in its handbook) contained the allowable CPT codes and their definitions, as well as additional guidance related to protocol modification (*Behavioral Treatment Policy Handbook*, Topic # 18980). The guidance stated that for both comprehensive and focused treatment, services are covered for which the licensed supervisor or treatment therapist resolves issues with, or otherwise makes changes to, the existing treatment protocol or POC to improve outcomes. However, the State agency did not provide guidance on how to document the resolution of issues or changes made to the existing treatment protocol or POC. Additionally, a coalition of industry representatives issued guidance that may have led to provider confusion about when to bill CPT code 97155.[27] The issued guidance stated that CPT code 97155 may be billed when a licensed supervisor observes a technician delivering treatment to determine whether the treatment protocol is effective, without necessarily implementing a protocol modification as defined by the CPT code description. Because of the

[25] The purpose of a statewide postpayment review would be to educate providers on correct billing requirements to avoid future errors, not to recoup overpayments for prior claims.

[26] *Kathleen Papa and Professional Homecare Providers, Inc., v. Wisconsin Department of Health Services, 2020 WI 66.*

[27] "Supplemental Guidance on Interpreting and Applying the 2019 CPT Codes for Adaptive Behavior Services," issued in January 2019 by The Steering Committee for the ABA Services Workgroup, with representatives from the Association for Behavior Analysis International, the Association of Professional Behavior Analysts, Autism Speaks, and the Behavior Analyst Certification Board and its CPT consultant.

State agency's lack of guidance to providers about how to document a 97155 session, providers' session notes did not support that any issues were resolved, or changes were made to existing protocols or POC.

THE STATE AGENCY MADE POTENTIALLY IMPROPER PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS

For all 100 sampled enrollee-months, the State agency made potentially improper ABA payments for which documentation was not complete or was unreliable. Most session notes had only a summary of the session along with data collected documentation.[28] Specifically, session notes (1) potentially did not include a complete description of each service provided, (2) referred to potentially unallowable recreational activities, or (3) included potential nontherapy time. In addition, claims contained the incorrect rendering provider. In total, the State agency made potentially improper payments of $201,688 for sampled enrollee-months (Appendix D).

The State agency made potentially improper payments because it had not performed a statewide postpayment review of ABA payments. Performing periodic postpayment reviews and providing ongoing provider education may have prevented the State agency from making potentially improper payments. Additionally, the State agency did not provide sufficient guidance to ABA facilities for documenting sessions, and did not issue guidance to ABA facilities on what it considered billable ABA time.

Federal and State Requirements and Guidance

States are required to have agreements with providers to keep such records as are necessary to fully disclose the extent of the services provided to individuals and provide those documents to the State agency or HHS (SSA § 1902(a)(27)). Expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met (*State Medicaid Manual* § 2497.1). A provider must prepare and maintain truthful, accurate, complete, legible, and concise documentation and medical and financial records for specific services rendered to a recipient by a certified provider (DHS 106.02(9)).

The State agency may reject payment for a service that ordinarily would be covered if the service fails to meet program requirements. Non-reimbursable services include services that fail to comply with program policies or State and Federal statutes, rules, and regulations, for instance, sterilizations performed without following proper informed consent procedures or controlled substances prescribed or dispensed illegally (DHS 107.02(2)(a)).

[28] ABA data collection is the process of recording information regarding behaviors. These behaviors can include negative behaviors that ABA therapy is trying to decrease (e.g., aggression, screaming, tantrums, pinching, and self-injury) or positive behaviors that ABA therapy is trying to increase (e.g., staying focused on a task, making or responding to requests appropriately, and identifying similar or dissimilar items).

Covered services under Wisconsin Medicaid are not reimbursable unless the documentation and medical record-keeping requirements are met (DHS 106.02(9)(f)). The provider's documentation must include, among other things, an accurate, complete, and legible description of each service provided, and the quantity, level, and supply of services provided (DHS 106.02(9)(a)).

Records for 97153 sessions must include, at minimum, the following information and documentation:

- the session time in and time out,
- the names of staff and caregiver(s) present,
- the place of service,
- the goals addressed during the session and data collected, and
- the rendering provider's signature (*Behavioral Treatment Policy Handbook*, Topic # 18959).

Coverage is not available for services that are primarily recreation-oriented or fail to comply with program policies, or State and Federal statutes, rules, and regulations (DHS 107.02(2)(a) and *Behavior Treatment Policy Handbook*, Topic # 19020).

CMS issued guidance related to cloning of session notes (i.e., notes that appear to be identical for different visits).[29] The guidance advised providers to watch for cloned notes because the notes may not reflect the uniqueness of an encounter.

Only licensed supervisors may submit and be reimbursed for claims submitted to ForwardHealth for behavioral treatment services, including group behavioral treatment. When submitting claims for behavioral treatment services, providers are required to indicate the licensed supervisor overseeing the enrollee's POC as the billing provider and indicate the licensed supervisor, treatment therapist, or treatment technician who rendered the service to the enrollee as the rendering provider. Each detail line on the claim requires a rendering provider number. Licensed supervisors other than the one indicated on the enrollee's POC may temporarily render services for the enrollee to accommodate a leave of absence (for example, due to illness), but the licensed supervisor indicated on the enrollee's POC should still be indicated as the billing provider (*Behavior Treatment Policy Handbook*, Topic # 19637).

[29] CMS Documentation Matters Fact Sheet, *Medicaid Documentation for Behavioral Health Practitioners*, issued Dec. 1, 2015. Available online at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/docmatters-behavioralhealth-factsheet.pdf. Accessed on Nov. 21, 2024.

Session Notes Potentially Did Not Contain a Complete Description of Services Provided, the Goals Addressed, or Data Collected

For 100 sampled enrollee-months from 22 ABA facilities, session notes potentially did not have a complete description of the services rendered, including their duration. Specifically, session notes potentially did not contain a complete description of the specific ABA techniques used or provide a clear picture of how those techniques were used or the specific duration of the ABA. Because the State agency's requirements do not specify how detailed session notes should be, we could not conclude whether the notes satisfied State agency requirements that providers prepare accurate, complete, and concise documentation for services rendered. We found that most session notes had only a brief summary of the session along with data collected during the session. Some session notes did not include data collected and included only a brief statement on a child's activities. For example, one session note did not contain any data collected and stated only that the child "had a very good day and played well with all of his friends. He did very well during our table times and is making very good progress with his day of the week program. Overall he had a very good afternoon." Also, for seven sampled enrollee-months from five ABA facilities, the session notes contained identical language for multiple days.

For the 100 sampled enrollee-months reviewed, for at least some claim lines, the session notes did not include documentation of the duration of the specific ABA services rendered. For example, session notes showed only the start and end times of a child's day, or the start and end times of a child's morning and afternoon sessions and did not indicate when the specific services were rendered. (See finding "Session Notes Included Potential Nontherapy Time.") Furthermore, for 97153 sessions that occurred concurrently with 97155, the notes for the 97153 sessions typically included notes for time before or after the concurrent session occurred, and thus we were unable to determine which portion of the notes were for the paid portion of the 97153 sessions.

In addition, seven sampled enrollee-months included notes that appeared to be cloned (i.e., copied from other ABA session notes). The session notes were not reliable to support which services children received or the quality of the care that they received. For seven sampled enrollee-months from five ABA facilities, session notes for multiple days were identical. For example, for one of the seven sampled enrollee-months, the session notes (e.g., the number of mands or the number of episodes of aggression) were copied from previous session notes and pasted electronically.[30] The notes also included the same recreational skills that were worked on during the previous sessions (e.g., the child played Barbie with the technician).

Session Notes Referred to Potentially Unallowable Recreational Activities

For 93 sampled enrollee-months from 19 ABA facilities, session notes referred to recreational activities but did not include details or information about the ABA techniques utilized during

[30] A mand is a request for something wanted or needed, or a request to end something undesirable.

the activities. Without those details, the session notes potentially did not support that the activities were therapeutic and not primarily recreation oriented. For 25 sampled enrollee-months from 1 ABA facility, the session notes contained information related to recreational activities. For example, for 1 of the 25 sampled enrollee-months, the session notes indicated only that the child spent time playing basketball, playing with dinosaurs, using an iPad, playing outside in a sandbox, swinging, and blowing bubbles.

Session Notes Included Potential Nontherapy Time

For 85 sampled enrollee-months from 20 ABA facilities, session notes may not always support the time billed because it included potential nontherapy time. Specifically, ABA was billed continuously for several hours, or the session notes referred to nontherapy time (e.g., naps or lunch) that was included in the time billed. Most session notes or data collected included either the start and end times of the child's day (e.g., 9:00 to 4:00), the start and end times of the child's morning and afternoon sessions (e.g., 9:00 to 1:30 and 1:30 to 4:00), or the start and end times for each technician who rendered services (e.g., 9:00 to 9:30, 9:30 to 11:30, and 11:30 to 1:30). Even when multiple technicians rendered services consecutively, the majority of session notes for the sampled enrollee-months documented that ABA time was billed continuously without any adjustment to the units of service for potential nontherapy times, such as meals, breaks, or naps.

Specifically, 23 sampled enrollee-months from 1 ABA facility contained session notes on the child taking a nap or time eating. For example, for 1 of the 23 sampled enrollee-months, the session notes indicated that the child spent time taking a nap; however, the session notes did not indicate when the nap began and when it ended. The ABA facility billed and was paid for the total number of billed hours, which included nap time that occurred during the session.

Claims Contained an Incorrect Rendering Provider

For 54 sampled enrollee-months from 14 ABA facilities, the rendering provider listed in the session notes was different from the rendering provider listed on the claim. Focused adaptive behavior treatment by protocol may be rendered by any level of behavioral treatment provider; however, reimbursement is based on the type of the rendering provider (technician, therapist, or licensed supervisor). For four sampled enrollee-months with focused treatment, the session notes reviewed did not support that the service was provided by the rendering provider indicated on the claim submitted to Medicaid. The rendering provider on the claims for the sampled enrollee-months was generally the licensed supervisor or therapist, who received a higher reimbursement per unit than the technician who rendered the service. According to State agency officials, this may have occurred if the enrollee had commercial insurance in addition to Medicaid coverage. Wisconsin requires Medicaid claims to be submitted the same way they were submitted to commercial insurance, and some commercial insurance requires the licensed supervisor to be listed as the rendering provider, regardless of who provided the

service. After a review of the sampled enrollee-months with incorrect rendering providers, we determined that not all enrollees had commercial insurance.

The State Agency Did Not Perform a Statewide Postpayment Review of Applied Behavior Analysis Payments and Did Not Provide Clear Guidance to Facilities

The State agency made potentially improper payments because it had not performed periodic postpayment reviews and shared the results with providers as part of ongoing education since the program began in 2016. Performing routine postpayment reviews may have prevented the State agency from making improper or potentially improper payments. In addition, the State agency did not provide guidance to ABA facilities clarifying State requirements that medical records (i.e., session notes) must be of sufficient quality to fully disclose the extent of services provided, including a detailed statement describing services rendered, and guidance on what it considers billable ABA time (e.g., whether time billed should include recreational activities, meals, and breaks). The State agency also did not provide guidance to ABA facilities indicating that the provider who rendered the services should be listed on the claims submitted for Medicaid reimbursement. Additionally, the State agency does not have a procedure in place to determine the level of provider who rendered the service for 97153-focused treatments to ensure proper payment.

Furthermore, according to State agency officials, the State agency has not conducted a postpayment review of ABA claims because of a Wisconsin Supreme Court ruling in 2020 that altered the State agency's ability to recoup payments for claims identified during postpayment reviews that failed to meet the documentation requirements for services provided.

CONCLUSION

For our audit period, 96 of the 100 sampled enrollee-months included ABA payments that did not comply with Federal and State requirements. In addition, all 100 of the sampled enrollee-months included potentially improper ABA payments. The issues that led to potentially improper payments could have had a significant effect on the quality of care provided to children with autism.

For 96 of the sampled enrollee-months, the State agency made the following types of improper payments for ABA: (1) CPT codes paid were not supported by session notes, (2) the number of units of ABA paid were not supported, (3) session notes were missing, or (4) session notes were missing provider signatures. In addition, for all 100 sampled enrollee-months, the State agency made potentially improper ABA payments for which documentation supporting the ABA provided was not detailed or documentation was unreliable. For example, session notes were potentially not complete in describing the services rendered, referred to recreational activities

that may not have been allowable ABA activities, and included potential nontherapy time, and claims had an incorrect rendering provider.

On the basis of our sample results, we estimated that the State agency paid at least $18.5 million ($12.2 million Federal share) for ABA that did not meet Federal and State requirements. Additionally, we estimated that the State agency made approximately $94.3 million ($62.3 million Federal share) of potentially improper ABA payments. In addition, cloned or otherwise unreliable session notes are an indication that children with autism may not have received the type of ABA needed.

The State agency made improper and potentially improper payments because it did not provide effective oversight of FFS Medicaid ABA payments. Specifically, the State agency did not require providers to document how they resolved issues or what changes were made during 97155 CPT code services. It also did not provide sufficient guidance to ABA facilities for documenting ABA, including guidance on (1) services that must be provided to support the use of certain CPT codes, (2) completeness of session notes needed to support ABA provided, (3) what the State agency considered billable ABA time, and (4) State signature requirements. In addition, the State agency did not have a procedure in place to ensure that claims for 97153 CPT code-focused treatments were paid based on the rendering provider.

Furthermore, since the program began in 2016, the State agency had not performed a statewide postpayment review of payments to ABA facilities to verify that facilities complied with Federal and State requirements related to documentation and claim requirements. According to State agency officials, the State agency has not conducted a postpayment review of ABA claims because of a Wisconsin Supreme Court ruling in 2020 that altered the State agency's ability to recoup payments identified during postpayment reviews for services provided that failed to meet the documentation requirements.

RECOMMENDATIONS

We recommend that the Wisconsin Department of Health Services:

- refund $12,287,252 (Federal share) to the Federal Government for FFS Medicaid ABA payments that did not comply with Federal and State requirements;

- exercise reasonable diligence to review and determine whether any of the estimated $62,334,835 (Federal share) in potentially improper ABA payments complied with Federal and State requirements and refund the Federal share of any improper payment amount to the Federal Government;

- update guidance for CPT code 97155 to require documentation on how issues were resolved or what changes were made to the treatment protocol or POC;

- provide additional guidance to ABA facilities about how to document ABA, including the information needed in session notes to support ABA provided and billable ABA time, and State signature requirements;

- develop a procedure to verify the provider who rendered the 97153-focused treatment service and pay the claim based on the rendering provider's specialty level; and

- periodically conduct a statewide postpayment review of Medicaid ABA payments, including reviewing session notes, and provide training in areas where errors were identified by postpayment reviews.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency partially concurred with our first recommendation and concurred with our other five recommendations. Regarding our first recommendation, the State agency agreed with our finding regarding session notes that did not (1) support the number of units of ABA paid, (2) support the dates of service that were paid, and (3) include the rendering provider's signature. However, the State agency did not agree with the part of our finding regarding session notes that did not support payments for CPT code 97155.

Regarding our first and second recommendations, the State agency indicated that it will conduct postpayment audits. It stated that if improper payments exist, it will recover them within the restrictions set forth by Wisconsin's Supreme Court and work with CMS regarding the return of Federal funds upon CMS's request. Additionally, it stated that it would evaluate initiating prepayment audits and explore the ability to create regulatory authority to support postpayment audit operations.

Regarding our third and fourth recommendations, the State agency stated that it would reevaluate and update the *Behavioral Treatment Policy Handbook* and associated guidance. It stated that it will also conduct training and technical assistance to providers on policy changes.

Regarding our fifth recommendation, the State agency stated that it will evaluate the appropriateness of reviewing claims for CPT code 97153 prior to payment. The State agency also stated that it will conduct training and technical assistance to providers on this topic.

Regarding our sixth recommendation, the State agency stated that it will conduct postpayment audits and evaluate initiating prepayment audits.

The State agency's comments are included in their entirety as Appendix E.

We maintain that our first recommendation is valid. The State agency did not provide any specifics explaining the nature of the disagreement with the finding related to the first recommendation. We appreciate the actions that the State agency indicated that it plans to take to address each of our recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the State agency's total FFS Medicaid payments of $121,154,533 ($80,768,369 Federal share) for 1,110,716 claim lines for ABA, which we grouped into 36,345 enrollee-months with dates of service from January 1, 2021, through December 31, 2022 (audit period).[31] Our audit included only enrollee-months for which the Federal share payments totaled $500.00 or more.[32] We selected a stratified random sample of 100 enrollee-months, with ABA payments totaling $389,997 ($258,035 Federal share).

The 100 enrollee-months in our sample consisted of 22 unique ABA facilities and 98 unique enrollees. Total payments for each sampled enrollee-month ranged from $807 to $8,549. We requested the following supporting medical record documentation from ABA facilities for each sampled enrollee-month: (1) the approved prior authorization, (2) the diagnostic evaluation, (3) prescription for ABA, (4) the POC, and (5) ABA session notes supporting the units of ABA paid.

We did not conduct a medical review to determine whether ABA was medically necessary. However, we shared documentation for some of the sampled enrollee-months that contained claim lines that were improper or potentially improper payments with the State agency and asked the State agency to provide input on whether the session notes supported the CPT code that was paid.[33] We also held multiple meetings with the State agency to discuss what type of support it would expect to see in the providers' session notes.

We did not assess the State agency's overall internal control structure. Rather, we limited our audit of internal controls to those applicable to our objective. Specifically, we reviewed the State agency's policies, procedures, and system edits related to ABA payments and the State agency's oversight of its prior authorization and the ABA facilities.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the Medicaid Management Information System (MMIS) FFS claim data that the State agency provided for our audit period. We also established reasonable assurance of the completeness of the claim data by tracing a nonstatistical sample of aggregate claim data amounts to supporting documentation used to report amounts on the State agency's Form CMS-64.

We conducted our audit work from April 2023 through April 2025.

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[31] An enrollee-month consisted of all FFS Medicaid claim lines for ABA for an individual enrollee for which the end date of each claim line fell within the month. There were 871 claims and 3,553 claim lines in the 100 sampled enrollee-months.

[32] Enrollee-months with Federal share payments totaling less than $500 accounted for 3 percent of total ABA payments.

[33] *CPT copyright 2020 American Medical Association. All rights reserved.*

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;

- interviewed State agency staff to gain an understanding of (1) Medicaid ABA billing requirements, (2) the prior authorization review process, (3) the types of guidance that the State agency posted on its official State Medicaid website related to billing for ABA, and (4) the State agency's oversight activities related to its ABA facilities and payments;

- obtained from the State agency the MMIS's Medicaid FFS data for ABA provided to enrollees 21 years of age and younger with dates of service during our audit period;

- reconciled the MMIS's ABA data with the State agency's Form CMS-64;

- created a sampling frame that contained 36,345 enrollee-months, consisting of 1,110,716 claim lines for Medicaid ABA provided during our audit period, and selected a stratified random sample of 100 enrollee-months for review (Appendix B);

- requested supporting documentation from ABA facilities for each sampled enrollee-month and reviewed the documentation to determine whether (1) the prior authorization was approved and covered the sampled enrollee-month, (2) the diagnostic evaluation confirmed a diagnosis of autism and included a referral for ABA, (3) the prescription was active, (4) the POC was developed, and (5) the session notes included required elements (such as the name of the child and the duration of ABA) and supported the units of ABA paid;

- shared documentation for some of the sampled enrollee-months that contained claim lines that were improper or potentially improper payments with the State agency and asked the State agency to provide input on whether the session notes supported the CPT code that was paid, and also held multiple meetings with the State agency to discuss what type of support it would expect to see in the session notes;

- summarized our audit results for payments for each sampled enrollee-month into 3 categories: allowable payments, improper payments, and potentially improper payments (Appendix D);

- estimated the amounts of the improper and potentially improper payments in the sampling frame (Appendix C);

- estimated the Federal shares of the improper and potentially improper payment amounts in the sampling frame (Appendix C);

- interviewed providers to gain an understanding of what guidance the State agency provided and its understanding of billing for CPT code 97155 and what is covered and paid by Medicaid; and

- discussed the results of our audit with State agency officials.

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

SAMPLING FRAME

The sampling frame was an Excel spreadsheet that contained 36,345 enrollee-months, consisting of 1,110,716 claim lines for ABA provided during our audit period, with total Medicaid payments of $121,154,533 ($80,768,369 Federal share).[34] The sampling frame consisted of enrollee-months in which the total Federal share amount for each enrollee-month was greater than or equal to $500 for services rendered by providers who were not under investigation by OIG.[35]

SAMPLE UNIT

The sample unit was an enrollee-month.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample, consisting of two strata (Table 1).

Table 1: Strata for Our Sample

Stratum	Description	Frame Size	Value of Frame (Federal Amount)	Sample Size
1	Enrollee-months with Federal payment amounts from $500.00 to $2,686.22	24,814	$37,741,249	50
2	Enrollee-months with Federal payment amounts from $2,686.28 to $13,712.50	11,531	43,027,120	50
Total		**36,345**	**$80,768,369**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

[34] An enrollee-month contained all ABA claim lines for an enrollee during a month in which the end service date of the claim line (the field "Last_Date_of_Service") fell within the month. The date range of the claim line (from "First_Date_of_Service" to "Last_Date_of_Service") may have been longer than 1 day.

[35] Enrollee-months in which the total Federal share paid amount was less than $500 accounted for 3 percent of the value of the sampling frame.

METHOD OF SELECTING SAMPLE ITEMS

We sorted in ascending order the items in each stratum by enrollee (the field "CLM_RECIP_ID"), year, and month, and then consecutively numbered the items in each stratum in the sampling frame.[36] After generating random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the total dollar amount and the Federal share of FFS Medicaid payments, for ABA provided to children diagnosed with autism, that did not comply with Federal and State requirements in the sampling frame. To be conservative, we recommend recovery of improper payments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

We also used the OIG-OAS statistical software to calculate the point estimate for the total dollar amount and the Federal share of FFS Medicaid payments, for ABA provided to children diagnosed with autism, that were potentially improper in our sampling frame. We also calculated a two-sided 90-percent confidence interval for these estimates.

[36] The year and month were associated with the end service date (the field "Date_End_Service_Detail") on the claim lines in the sample unit.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results for Enrollee-Months With Improper Applied Behavior Analysis Payments (Total Payments)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Enrollee-Months With Improper ABA Payments	Value of Enrollee-Months With Improper ABA Payments
1	24,814	$56,702,567	50	$116,561	46	$20,947
2	11,531	64,451,966	50	273,436	50	49,722
Total	**36,345**	**$121,154,433**	**100**	**$389,997**	**96**	**$70,670**

Table 3: Sample Results for Enrollee-Months With Improper Applied Behavior Analysis Payments (Federal Share)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Enrollee-Months With Improper ABA Payments	Value of Enrollee-Months With Improper ABA Payments
1	24,814	$37,741,249	50	$77,217	46	$13,861
2	11,531	43,027,120	50	180,818	50	33,136
Total	**36,345**	**$80,768,369**	**100**	**$258,035**	**96**	**$46,997**

Table 4: Estimated Values of Improper Payments in the Sampling Frame *(Limits Calculated at the 90-Percent Confidence Level)*

	Total	Federal Share
Point estimate	$21,862,803	$14,520,693
Lower limit	18,547,493	12,287,252
Upper limit	25,178,113	16,754,134

Table 5: Sample Results for Enrollee-Months With Potentially Improper Applied Behavior Analysis Payments (Total Payments)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Enrollee-Months With Potentially Improper ABA Payments	Value of Enrollee-Months With Potentially Improper ABA Payments
1	24,814	$56,702,567	50	$116,561	50	$89,905
2	11,531	64,451,966	50	273,436	50	215,299
Total	**36,345**	**$121,154,433**	**100**	**$389,997**	**100**	**$305,204**

Table 6: Sample Results for Enrollee-Months With Potentially Improper Applied Behavior Analysis Payments (Federal Share)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Enrollee-Months With Potentially Improper ABA Payments	Value of Enrollee-Months With Potentially Improper ABA Payments
1	24,814	$37,741,249	50	$77,217	50	$59,556
2	11,531	43,027,120	50	180,818	50	142,132
Total	**36,345**	**$80,768,369**	**100**	**$258,035**	**100**	**$201,688**

Table 7: Estimated Values of Potentially Improper Payments in the Sampling Frame *(Limits Calculated at the 90-Percent Confidence Level)*

	Total	Federal Share
Point estimate	$94,270,389	$62,334,835
Lower limit	88,056,458	58,242,210
Upper limit	100,484,321	66,427,459

APPENDIX D: AUDIT RESULTS BY SAMPLED ENROLLEE-MONTH

		Improper Payments				Potentially Improper Payments				Audit Results		
Sample Item Number	Amount Paid (Federal Share)	Session Notes Did Not Support the CPT Code Paid	Session Notes Did Not Support the Number of Units Paid	Session Notes Did Not Support Dates of Service Paid	Session Notes Did Not Include Renderer Signature	Session notes Did Not Contain a Complete Description of Services Provided	Potential Recreational Activities	Potential Nontherapy Time	Incorrect Rendering Provider	Allowable (Federal Share)	Improper Payments (Federal Share)	Potentially Improper Payments (Federal Share)
1	1,402	X				X	X	X	X		$545	$857
2	1,116	X				X	X	X	X		150	967
3	1,814	X	X			X	X		X		476	1,338
4	831					X	X	X	X	$191		640
5	2,043	X		X	X	X	X	X			511	1,532
6	1,690	X	X			X	X	X	X		1,215	476
7	2,291	X	X			X	X	X		59	171	2,062
8	1,401			X		X	X	X		59	100	1,242
9	1,499	X	X	X		X	X	X			275	1,224
10	1,494	X	X			X	X	X	X		537	957
11	2,368	X				X	X	X		113	84	2,171
12	1,888	X	X			X	X			221	543	1,125
13	2,207	X	X	X		X	X	X	X		245	1,962
14	875	X	X			X	X	X	X	30	146	699
15	1,366	X	X			X	X	X		29	120	1,217
16	1,032	X				X	X	X		113	241	678
17	1,249	X	X			X	X	X	X	258	419	572
18	1,047					X	X	X	X			1,047
19	701		X			X	X	X	X		50	651
20	1,975	X	X			X	X	X	X		885	1,090
21	602					X	X		X	59		543
22	2,151	X	X			X	X			59	85	2,007
23	674	X	X			X	X		X		127	547
24	834				X	X	X	X	X		59	775
25	917	X	X			X	X	X	X	57	715	145
26	2,323	X	X			X	X		X	326	708	1,289

		Improper Payments				Potentially Improper Payments				Audit Results		
Sample Item Number	Amount Paid (Federal Share)	Session Notes Did Not Support the CPT Code Paid	Session Notes Did Not Support the Number of Units Paid	Session Notes Did Not Support Dates of Service Paid	Session Notes Did Not Include Renderer Signature	Session notes Did Not Contain a Complete Description of Services Provided	Potential Recreational Activities	Potential Nontherapy Time	Incorrect Rendering Provider	Allowable (Federal Share)	Improper Payments (Federal Share)	Potentially Improper Payments (Federal Share)
27	2,106		X			X	X	X	X	122	353	1,631
28	2,113	X	X			X	X	X	X	59	400	1,653
29	1,322	X	X	X		X	X	X			339	983
30	2,266	X	X			X	X	X	X	365	96	1,806
31	2,395	X	X			X	X	X		126	439	1,830
32	1,623					X	X					1,623
33	1,718	X	X	X		X	X	X		111	174	1,434
34	2,659	X	X			X	X	X	X	17	170	2,472
35	1,757	X		X		X		X			86	1,670
36	1,981	X				X	X	X		136	139	1,705
37	880		X			X	X	X	X	94	46	739
38	2,293		X			X	X	X	X	19	14	2,259
39	960	X	X			X	X	X	X	173	424	363
40	894	X				X	X			28	357	509
41	586	X	X			X	X			131	245	210
42	1,089		X			X	X	X	X		29	1,060
43	1,182		X			X	X	X		34	7	1,141
44	2,676		X			X	X	X	X	312	160	2,203
45	533	X	X			X	X	X	X	31	321	181
46	2,146	X		X		X	X	X		120	407	1,620
47	1,053	X	X			X	X	X			35	1,018
48	2,411		X	X		X	X	X	X		535	1,876
49	837	X	X			X	X	X	X		363	474
50	1,949	X	X			X	X	X	X	348	317	1,285
51	2,732	X	X			X	X	X	X	59	822	1,851
52	3,840	X	X			X	X	X		147	1,294	2,400
53	2,720	X	X			X	X	X	X		755	1,965
54	3,334	X				X	X	X		59	361	2,914

		Improper Payments				Potentially Improper Payments				Audit Results		
Sample Item Number	Amount Paid (Federal Share)	Session Notes Did Not Support the CPT Code Paid	Session Notes Did Not Support the Number of Units Paid	Session Notes Did Not Support Dates of Service Paid	Session Notes Did Not Include Renderer Signature	Session notes Did Not Contain a Complete Description of Services Provided	Potential Recreational Activities	Potential Nontherapy Time	Incorrect Rendering Provider	Allowable (Federal Share)	Improper Payments (Federal Share)	Potentially Improper Payments (Federal Share)
55	3,745	X	X			X	X	X		98	111	3,536
56	3,337	X	X			X	X	X	X	59	213	3,065
57	3,085	X	X			X	X	X		59	407	2,619
58	3,794	X	X			X	X	X	X	101	854	2,839
59	3,083	X	X		X	X		X	X	199	760	2,124
60	3,598	X	X			X	X	X		217	992	2,388
61	4,527	X	X			X	X	X		176	564	3,787
62	3,283	X	X	X		X	X	X	X	44	1,416	1,822
63	3,426	X	X		X	X	X	X	X	15	1,108	2,303
64	3,048		X	X		X	X		X	118	275	2,655
65	3,061	X				X	X	X			782	2,279
66	3,128	X	X			X	X	X	X	234	416	2,478
67	4,808	X	X	X		X	X	X	X	59	1,605	3,145
68	2,878		X			X	X	X		41	45	2,792
69	4,669	X	X	X	X	X				59	365	4,245
70	3,130	X	X			X	X	X	X	88	2,910	131
71	3,662		X		X	X	X	X			106	3,556
72	3,364	X	X			X	X	X		131	271	2,962
73	2,722	X			X	X	X	X	X	15	260	2,447
74	3,106	X	X			X			X	59	290	2,758
75	2,718	X	X		X	X	X	X	X	17	433	2,268
76	3,546	X	X			X	X	X	X	51	943	2,552
77	4,077	X				X	X	X		212	1,244	2,621
78	3,445		X			X	X	X		276	94	3,074
79	5,668	X	X	X		X	X	X		398	1,278	3,992
80	2,833	X	X			X	X	X	X	113	386	2,334
81	3,551	X	X			X	X	X	X		496	3,055
82	4,041	X	X	X		X	X	X		147	597	3,296

		Improper Payments				Potentially Improper Payments				Audit Results		
Sample Item Number	Amount Paid (Federal Share)	Session Notes Did Not Support the CPT Code Paid	Session Notes Did Not Support the Number of Units Paid	Session Notes Did Not Support Dates of Service Paid	Session Notes Did Not Include Renderer Signature	Session notes Did Not Contain a Complete Description of Services Provided	Potential Recreational Activities	Potential Nontherapy Time	Incorrect Rendering Provider	Allowable (Federal Share)	Improper Payments (Federal Share)	Potentially Improper Payments (Federal Share)
83	3,003	X				X	X	X		68	195	2,740
84	3,141		X			X	X	X		321	36	2,784
85	4,364	X	X			X	X	X		62	57	4,245
86	3,120	X	X			X	X	X	X	466	656	1,999
87	3,490	X	X			X	X	X		221	396	2,872
88	3,912	X	X			X	X	X		68	41	3,802
89	3,184	X				X	X	X	X		279	2,906
90	4,614	X	X			X	X	X		178	469	3,966
91	4,166		X			X	X		X	283	87	3,796
92	4,566	X	X			X		X	X		2,814	1,753
93	4,841	X	X			X	X	X			1,048	3,793
94	3,082	X				X	X	X	X		279	2,803
95	4,135	X	X			X			X	63	161	3,911
96	3,445	X	X			X				273	949	2,223
97	4,499	X	X		X	X	X	X		94	1,633	2,772
98	4,006		X	X		X	X	X		136	203	3,667
99	2,801	X	X			X	X	X	X	63	1,102	1,637
100	4,492	X				X	X	X			281	4,211
*****	**$258,035**	**79**	**77**	**16**	**9**	**100**	**93**	**85**	**54**	**$9,351**	**$46,997**	**$201,688**

[*] The differences between the payment totals and the sum of the payment amounts for the individual sample items are due to rounding.

APPENDIX E: STATE AGENCY COMMENTS

Tony Evers
Governor

Kirsten L. Johnson
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES

1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
Fax: 608-266-1096
TTY: 711

June 3, 2025

Patricia Wheeler
Regional Inspector General for Audit Services
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: Audit Report A-06-23-01002

Dear Patricia Wheeler,

The Wisconsin Department of Health Services (DHS) is writing to respond to the Department of Health and Human Services, Office of Inspector General (HHS OIG) draft report titled *Wisconsin Made at Least $18.5 Million in Improper Fee-For-Service Medicaid Payments for Applied Behavioral Analysis Provided to Children with Autism*. The following represents our response and corrective action plan.

Wisconsin Medicaid covers Applied Behavior Analysis (ABA) treatment for individuals diagnosed with Autism Spectrum Disorder (ASD) through the Behavioral Treatment benefit. The claims sampled and reviewed in this audit come from Wisconsin's Behavioral Treatment benefit and represent dates of service spanning January 2021 through December 2022. As the report notes, Wisconsin Medicaid fee-for-service payments for ABA services rapidly increased from 2018 to 2022 and continued to grow in subsequent years. This expenditure growth could be the result of benefit policy changes, rate increases, as well as increased utilization of services.

DHS OIG had previously recognized a need for post-payment audits and designed processes to begin auditing activity within the Behavioral Treatment benefit. Audit activity was temporarily paused at the onset of the HHS OIG audit to prevent overlapping efforts, and these audit processes will now resume. DHS OIG and DMS have established quarterly meetings with the ABA provider associations with focus on trainings for conducting self-audits as well as ongoing communication and visibility of changes to the benefit. While many of the issues identified in the HHS OIG audit are specific to sufficient documentation and medical record deficiencies, these ongoing practices will also support the specific recommendations and corrective action steps outlined below.

RECOMMENDATIONS

Refund $12,287,252 (Federal share) to the Federal Government for FFS Medicaid ABA payments that did not comply with Federal and State requirements.

Response: Partial Nonconcurrence.

DHS disagrees with the primary inappropriate payment finding with respect to Wisconsin Medicaid providers' use of CPT code 97155. DHS agrees with the inappropriate payment findings with respect to session notes not supporting billed units, session notes not supporting dates of services paid, and session notes not including signatures of rendering providers. If improper payments exist, DHS will recover them from providers and work with CMS regarding the return of federal funds upon their request.

Corrective Action Plan: DHS OIG will conduct post-payment audits. Where improper payments exist as identified by DHS OIG, the state agency will recover inappropriate payments from providers within the restrictions set forth by Wisconsin's Supreme Court in *Papa v. Wisconsin Dep't of Health Servs.*, 2020 WI 66, 393 Wis. 2d 1, 946 N.W.2d 17, which led to a permanent injunction issued by the Waukesha County Circuit Court on November 24, 2020 (2015CV002403). DHS OIG will also evaluate initiating pre-payment audits through the Payment Integrity Review program in order to prevent future inappropriate payments. Lastly, DHS will explore the ability to create Wisconsin Administrative Code and related regulatory authority to support DHS OIG post-payment audit operations.

Exercise reasonable diligence to review and determine whether any of the estimated $62,334,835 (Federal share) in potentially improper ABA payments complied with Federal and State requirements and refund the Federal share of any improper payment amount to the Federal Government.

Response: Concurrence.

DHS agrees that audits and evaluations of HHS OIG's potential inappropriate findings are warranted. If improper payments exist, DHS will recover from providers and work with CMS regarding the return of federal funds upon their request.

Corrective Action Plan: DHS OIG will conduct post-payment audits. Where improper payments exist, DHS OIG will recover inappropriate payments from providers within the restrictions set forth by Wisconsin's Supreme Court in *Papa v. Wisconsin Dep't of Health Servs.*, 2020 WI 66, 393 Wis. 2d 1, 946 N.W.2d 17, which led to a permanent injunction issued by the Waukesha County Circuit Court on November 24, 2020 (2015CV002403). DHS OIG will also evaluate initiating pre-payment audits through the Payment Integrity Review program in order to prevent future inappropriate payments. Lastly, DHS will explore the ability to create Wisconsin Administrative code and related regulatory authority to support DHS OIG post-payment audit operations.

Update guidance for CPT code 97155 to require documentation on how issues were resolved or what changes were made to the treatment protocol or POC.

Response: Concurrence.
DHS agrees that policy enhancements and clarifications are necessary with respect to covered service definitions and documentation requirements for CPT code 97155.

Corrective Action Plan: DHS will re-evaluate and update Behavioral Treatment handbook policy and associated guidance, including reimbursement structures, to support providers in being appropriately reimbursed for evaluation and modification of individualized treatment and ensure correct coding requirements are met. Provider training and technical assistance on policy changes will be conducted.

Provide additional guidance to ABA facilities about how to document ABA, including the information needed in session notes to support ABA provided and billable ABA time, and State signature requirements.

Response: Concurrence.

Corrective Action Plan: DHS will re-evaluate and update Behavioral Treatment handbook policy and associated guidance with respect to documentation requirements. DHS will conduct training and technical assistance to providers on policy changes.

Develop a procedure to verify the provider that rendered the 97153-focused treatment service and pay the claim based on the rendering provider's specialty level.

Response: Concurrence.

Corrective Action Plan: DHS OIG will evaluate the appropriateness of leveraging the Payment Integrity Review program to review claims for 97153 prior to payment. DHS will conduct training and technical assistance to providers on this topic.

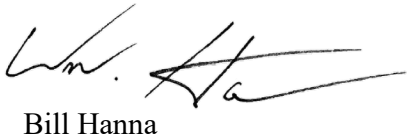
Periodically conduct a statewide post payment review of Medicaid ABA payments, including reviewing session notes, and provide training in areas where errors were identified by post payment reviews.

Response: Concurrence.

Corrective Action Plan: DHS OIG will conduct post-payment audits. DHS OIG will also evaluate initiating pre-payment audits through the Payment Integrity Review program in order to prevent future inappropriate payments and provide targeted technical assistance to providers.

We thank you for the opportunity to respond. If you have questions or need additional information, do not hesitate to contact us.

Sincerely,



Bill Hanna
Medicaid Director

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U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov