Department of Health and Human Services
Office of Inspector General
Office of Audit Services

December 2024 | A-09-22-02002

Indiana Made at Least $56 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism

REPORT HIGHLIGHTS

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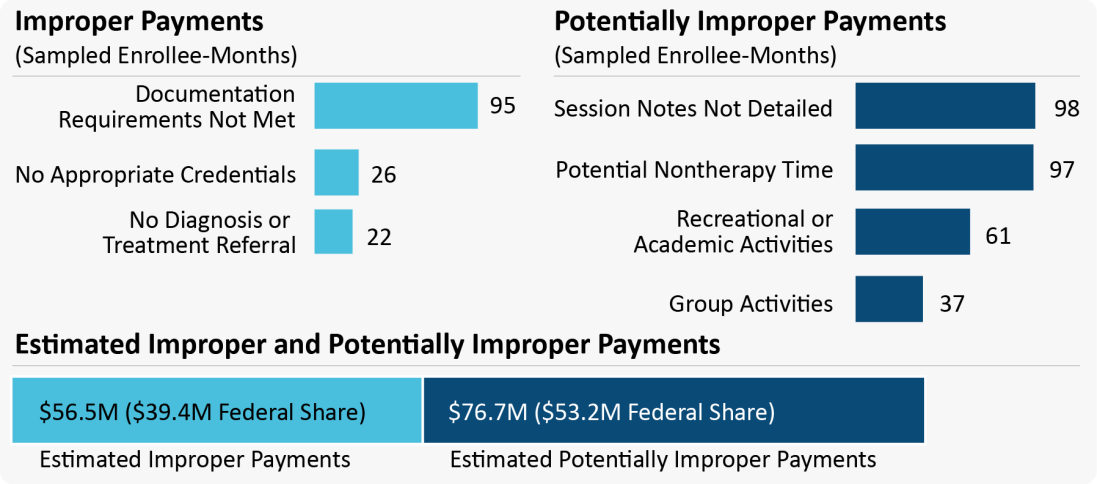
Why OIG Did This Audit

- 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.
- In the past several years, Federal and State agencies have identified questionable billing patterns by some ABA providers and payments to providers for unallowable ABA services.
- Indiana's fee-for-service (FFS) Medicaid payments for ABA in 2017 were $14.4 million, and by 2020 these payments had increased to $101.8 million—the second highest in the Nation.
- This audit examined whether Indiana's FFS Medicaid payments for ABA for 2019 and 2020 complied with Federal and State requirements.

What OIG Found

Indiana'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 several recommendations to Indiana, including that Indiana refund $39.4 million to the Federal Government, provide additional guidance to ABA facilities for documenting ABA, and periodically perform a statewide postpayment review of Medicaid ABA payments to educate providers on requirements. The full recommendations are in the report.

Indiana did not indicate concurrence or nonconcurrence with our recommendations but detailed steps it has taken and plans to take in response to our recommendations.

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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] Indiana's fee-for-service (FFS) Medicaid payments for ABA in calendar year (CY) 2017 were $14.4 million, and by CY 2020 these payments had increased to $101.8 million—the second highest in the Nation.[3] Therefore, we conducted this audit of the Indiana Family and Social Services Administration's (State agency's) FFS Medicaid payments for ABA for CYs 2019 and 2020 (audit period).

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.

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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.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/CIB-07-07-14_30.pdf. Accessed on Nov. 21, 2023.

[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. 29, 2024. 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. 29, 2024. 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. 29, 2024.

[3] In CY 2023, FFS payments had increased to $210.7 million.

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, Indiana's FMAP ranged from 65.84 percent to 72.04 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).

Indiana's Medicaid Program

In Indiana, the State agency's Office of Medicaid Policy and Planning administers the Medicaid program. Medicaid services are incorporated under the umbrella of the Indiana Health Coverage Programs (IHCP).[4] Health care benefits, including ABA, are administered through two delivery systems: FFS and managed care.

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

[4] Other programs and services covered under IHCP include Medicare savings programs and emergency-only services.

Indiana's Medicaid Coverage of Applied Behavior Analysis

The State agency began covering ABA for the treatment of autism on February 6, 2016. The requirements for coverage of ABA are in the Indiana Administrative Code (IAC). In addition, the State agency issued guidance to ABA providers, which included IHCP bulletins, the IHCP provider reference module, and an informal online training course titled "Behavioral Health and ABA Documentation Guidelines."[5, 6] According to the terms of the provider agreement filed with the State agency, providers are bound by State agency guidance (e.g., bulletins and provider reference modules).

Medicaid covers ABA provided to enrollees 20 years of age or younger who were diagnosed with autism by a qualified provider (405 IAC § 5-22-12(b)).[7] For the diagnostic evaluation of an enrollee, the State agency requires that the qualified provider use a standardized test or the most recent version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and include a recommended treatment referral for ABA.[8] To be eligible to provide ABA in Indiana, a provider must be certified by the Behavior Analyst Certification Board (the Board) or be a health services provider in psychology (HSPP).[9] The Board certifies three types of providers: registered behavior technicians (RBTs), Board certified assistant behavior analysts (BCaBAs, which we refer to as "assistant behavior

Requirements for Board Certified ABA Provider Types

1. **Registered Behavior Technician (RBT)**
   - Background check
   - 18 years of age or older
   - High school diploma
   - 40 hours of training
   - Pass RBT exam
2. **Board Certified Assistant Behavior Analyst (BCaBA)**
   - Bachelor-level degree in any field of study
   - 180 hours of behavior analysis coursework
   - 500–1,000 hours of supervised experience
   - Pass BCaBA exam
3. **Board Certified Behavior Analyst (BCBA)**
   - Graduate-level degree in an ABA-related field
   - Pass BCBA exam

[5] The provider reference module is billing and reimbursement guidance for providers conducting business with IHCP.

[6] IHCP, "Behavioral Health and ABA Documentation Guidelines," February 2019. Available online at https://provider.indianamedicaid.com/ihcp/providertraining/BehavioralHealth/story_html5.html. Accessed on Jan. 25, 2024.

[7] For purposes of performing a diagnostic evaluation, a qualified provider is any of the following: a licensed physician, a licensed health service provider in psychology (HSPP), a licensed pediatrician, a licensed psychiatrist, or other behavioral health specialist with training and experience in the diagnosis and treatment of autism.

[8] Effective Mar. 1, 2019, through Indiana Register Final Rule Legislative Services Agency Document #18-249(F), 405 IAC section 5-22-12(a) was amended to include that when completing a diagnostic evaluation, a qualified provider must use the most recent version of the American Psychiatric Association's DSM at the time of the evaluation and include a recommended treatment referral for ABA. Before Mar. 1, 2019, the State agency required the use of a standardized assessment tool.

[9] 405 IAC § 5-22-12(c).

analysts"), and Board certified behavior analysts (BCBAs).[10] Requirements for the three ABA provider types are shown on the previous page.

The State agency permits only BCBAs to be enrolled as Medicaid providers. They can practice independently or be employed by a facility that specializes in ABA for children with autism (ABA facility). ABA facilities also employ RBTs and assistant behavior analysts.

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 and referral) (405 IAC § 5-22-12(f)). The supporting documentation must include an individual treatment plan (ITP) developed by an HSPP or a BCBA (405 IAC § 5-22-12(e)). Prior authorizations for ABA generally cover a 6-month period (405 IAC § 5-22-12(g)). The State agency contracts with an outside health care technology organization to review requests for prior authorizations.

Providers' Use of Procedure Codes for Billing Applied Behavior Analysis

Effective January 1, 2019 (the start of our audit period), the State agency directed providers to use Current Procedural Terminology (CPT®)[11, 12] codes to bill for ABA assessment and treatment services.[13] Each of these CPT codes is billed in 15-minute increments (i.e., 1 unit) of service provided to an enrollee.[14]

CPT code 97153 is the most commonly billed code for ABA in Indiana, accounting for 86 percent of ABA payments covered by our audit. This code is generally billed by an ABA facility for an

[10] Both RBTs and assistant behavior analysts may practice only under the supervision of an HSPP or a BCBA. The Board certifies two levels of BCBAs: a master's degree level and a doctorate degree level. The doctorate degree level is differentiated by a "D" (i.e., BCBA-D). In this report, we refer to both levels as "BCBAs."

[11] *CPT copyright 2018–2019 American Medical Association. All rights reserved.*

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[13] IHCP Bulletin, BT201867, Dec. 31, 2018.

[14] An ABA payment is generally 40 percent of the amount that the ABA provider billed for the specific CPT code. During our audit period, payments to ABA facilities for CPT code 97153 ranged from $32 per hour (4 units) to $160 per hour. For CPT code 97155, payments to ABA facilities ranged from $48 to $256 per hour. Before 2019, ABA payments were based on a fee schedule.

RBT's time providing one-to-one treatment typically performed with an individual child; it is sometimes billed for up to 8 hours of treatment per day. CPT code 97155 is the second most commonly billed code for ABA, accounting for 11 percent of ABA payments covered by our audit. This code is generally billed by an ABA facility for a BCBA's time providing one-to-one treatment that includes a protocol modification.

The State agency permits CPT codes 97153 and 97155 to be billed concurrently during the same period for treatment that an RBT provides and for treatment that a BCBA provides to modify the treatment protocol.[15] For example, if an RBT provides ABA from 8:00 a.m. to 12:00 p.m. and a BCBA comes to work with the RBT to administer a protocol modification from 9:00 a.m. to 11:00 a.m., the facility may bill 4 hours of CPT code 97153 for the RBT's time and 2 hours of CPT code 97155 for the BCBA's time.

Figure 1 shows the most commonly billed CPT codes for ABA in Indiana, along with the minimum credential required for the type of provider performing each service and a description of the service.

Figure 1: Most Commonly Billed Current Procedural Terminology Codes for Applied Behavior Analysis in Indiana

CPT Code	Provider*	Service Description
97151	BCBA	Behavior identification assessment
97152	RBT	Behavior identification supporting assessment
97153	RBT	Adaptive behavior treatment by protocol
97154	RBT	Group adaptive behavior treatment by protocol
97155	BCBA	Adaptive behavior treatment with protocol modification
97156	BCBA	Family adaptive behavior treatment guidance

*Minimum credential required for service

HOW WE CONDUCTED THIS AUDIT

Our audit covered the State agency's FFS Medicaid payments of $151.1 million ($104.5 million Federal share) for 436,661 claim lines for ABA, which we grouped into 18,296 enrollee-months

[15] IHCP Banner Page, BR201915, Apr. 9, 2019.

with dates of service from January 1, 2019, through December 31, 2020.[16] Our audit included only enrollee-months with payments totaling more than $2,500.[17] We selected a stratified random sample of 100 enrollee-months with ABA payments totaling $967,294 ($672,024 Federal share).[18]

The 100 enrollee-months in our sample consisted of 41 unique ABA facilities and 96 unique enrollees. Total payments for each sampled enrollee-month ranged from $2,643 to $28,240. 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 and treatment referral for ABA, (3) the ITP, and (4) 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 that the diagnosing provider used a standardized test or the most recent version of the DSM and included a treatment referral for ABA, (3) the ITP was developed by an HSPP or BCBA, and (4) 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 conduct medical review to determine whether ABA was medically necessary. We shared our findings for the sampled enrollee-months with the State agency.[19]

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.

[16] 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.

[17] Enrollee-months with payments totaling $2,500 or less accounted for 5 percent of total ABA payments.

[18] There were 958 claims and 2,341 claim lines associated with the 100 sampled enrollee-months.

[19] The State agency confirmed our determinations that certain diagnostic evaluations did not meet State diagnostic evaluation and treatment referral requirements for ABA.

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.[20] For 17 of 100 sampled enrollee-months, the State agency made payments of $2,860 for at least 1 claim line that complied with the requirements.[21] However, for 97 of the 100 sampled enrollee-months, the State agency made payments of $433,472 for at least 1 claim line that did not comply with the requirements. Specifically, we found the following deficiencies:[22]

- Session notes describing the ABA provided did not meet documentation requirements (e.g., session notes did not support the CPT codes paid) (95 sampled enrollee-months).[23]

- ABA was provided by staff who did not have the appropriate credentials (26 sampled enrollee-months).

- ABA was provided to children who did not receive the required diagnostic evaluations or treatment referrals for ABA (22 sampled enrollee-months).

On the basis of our sample results, we estimated that the State agency made improper payments of at least $56.5 million ($39.4 million Federal share).[24, 25]

[20] Each sampled enrollee-month had claim lines that we determined to be allowable, unallowable, or potentially unallowable. When a claim line could be considered unallowable for one reason and potentially unallowable for a different reason, we considered the claim unallowable to avoid double-counting.

[21] These 17 sampled enrollee-months had from 1 to 3 claim lines for either an assessment or parent training that we determined to be allowable. The total payment amount per sampled enrollee-month that complied with requirements ranged from $40 to $474.

[22] The number of sampled enrollee-months with deficiencies is greater than 97 because 42 sampled enrollee-months had more than 1 deficiency.

[23] For 1 sampled enrollee-month, the ABA facility stated that the enrollee had private primary insurance that should have paid for ABA. When the primary insurer denied the claims, the ABA facility billed Medicaid in error. According to ABA facility personnel, after researching the issue, the facility canceled all Medicaid ABA claims that were part of our sampled enrollee-month. Therefore, we did not review the supporting documentation for the claim lines and considered all of the ABA payments in the sampled enrollee-month improper.

[24] We estimated that the State agency improperly paid at least $56,577,188 ($39,432,556 Federal share).

[25] 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.

In addition, for all 100 sampled enrollee-months, the State agency made potentially improper ABA payments.[26] Specifically, the documentation supporting the ABA provided was not detailed or the documentation was unreliable:[27]

- Session notes did not fully disclose the extent of services provided or did not include a detailed statement describing the services provided (e.g., the ABA techniques used) and the duration of services provided (98 sampled enrollee-months).

- Session notes included potential nontherapy time (e.g., for meals, breaks, and naps) (97 sampled enrollee-months).

- Session notes referred to recreational or academic activities that may not have been allowable ABA activities (61 sampled enrollee-months).

- Session notes referred to group activities, but payments were made for individual ABA (37 sampled enrollee-months).

We set aside for State agency resolution $530,962 for 71 sampled enrollee-months because documentation was not detailed enough to determine whether payments complied with Federal and State requirements or whether documentation was unreliable.[28] On the basis of our sample results, we estimated that the State agency made $76.7 million ($53.2 million Federal share) of potentially improper ABA payments.[29]

Figure 2 on the following page shows a summary of our findings.

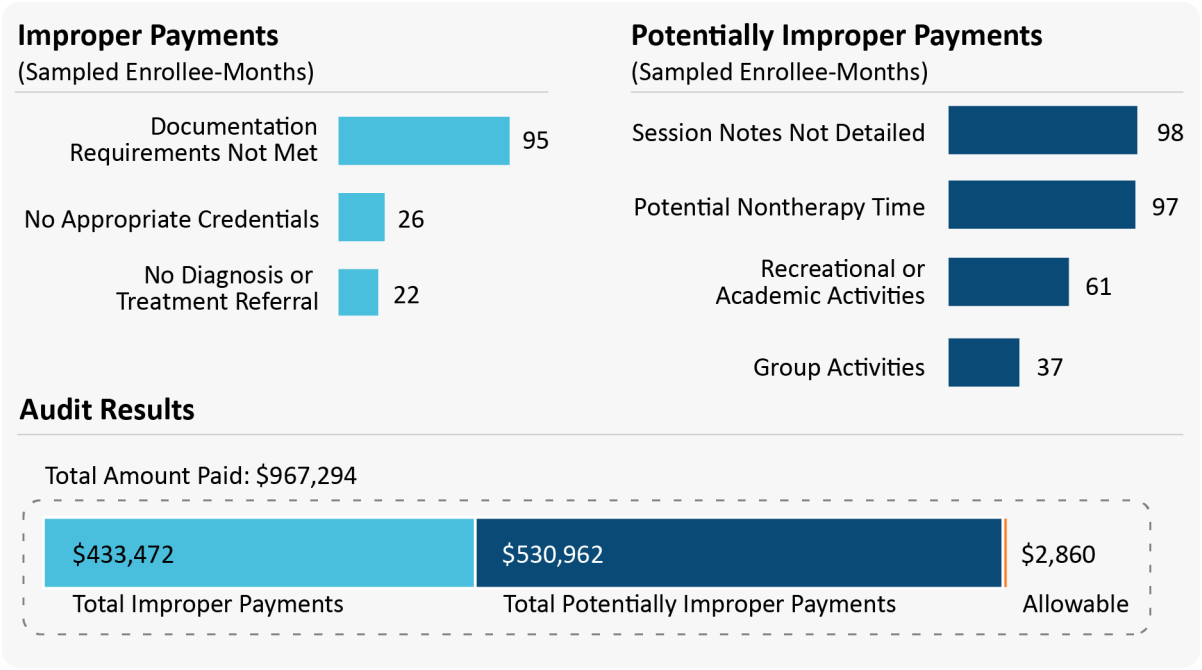
[26] We did not review the session notes for 2 of the 100 sampled enrollee-months: 1 of the enrollee-months was billed to Medicaid in error (see footnote 23), and for the remaining sampled enrollee-month, the ABA facility could not provide session notes. Although we did not review the session notes, we still consider payments for these 2 sampled enrollee-months potentially improper.

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

[28] All 100 sampled enrollee-months had payments that were potentially improper. However, for 29 of these enrollee-months, we determined that all of the payments in the enrollee-month were improper, so we did not include those payments in the amount we set aside.

[29] We estimated that the State agency made potentially improper payments of $76,723,446 ($53,236,026 Federal share).

Figure 2: 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, the State agency did not provide sufficient guidance to ABA facilities for documenting ABA. In addition, the State agency did not perform a statewide postpayment review of payments to ABA facilities to verify that facilities complied with Federal and State requirements related to documentation and provider credentialing.[30] Furthermore, the State agency did not review its prior authorization contractor's procedures for verifying ABA facilities' compliance with State diagnostic evaluation and treatment referral requirements.

THE STATE AGENCY MADE IMPROPER PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS

For 97 of 100 sampled enrollee-months, the State agency made FFS Medicaid payments for ABA: (1) for which session notes did not meet documentation requirements, (2) provided by staff who did not have the appropriate credentials, and (3) provided to children who did not receive the required diagnostic evaluations or treatment referrals for ABA. In total, the State agency improperly paid $433,472 for the sampled enrollee-months (Appendix D). These improper payments occurred because, among other issues: (1) the State agency did not perform a postpayment review of payments to ABA facilities to verify that facilities complied with Federal and State requirements and (2) the State agency's oversight of its prior authorization contractor was not sufficient to ensure that prior authorizations for ABA were approved only for children with required autism diagnostic evaluations and treatment referrals for ABA.

[30] The State agency performed a single audit of one facility's ABA claims in CY 2020.

Federal and State Requirements

States are required to have agreements with providers to keep such records as 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). Federal financial participation is available for covered services furnished only by certified providers (*State Medicaid Manual* § 2497.1).

Medicaid records must be: (1) of sufficient quality to fully disclose and document the extent of services provided to individuals receiving Medicaid assistance and (2) documented at the time the services are provided and before associated claim submission (405 IAC § 1-1.4-2(a)). Records must include the following information and documentation: (1) the identity, including dated signature or initials, and position of the provider employee furnishing the service and (2) a detailed statement describing services furnished, including the duration of services furnished (405 IAC § 1-1.4-2(b)).

The State agency may recover payment from any provider if the provider cannot document services as required by 405 IAC section 1-1.4-2 or the overpayment resulted from an inaccurate description of services or an inaccurate usage of procedure codes (405 IAC § 1-1.4-9(a)). Any provider using an electronic signature must follow the requirements of Indiana Code section 26-2-8-116.[31] Electronic authentication and identification of a signature may be accomplished by an interactive system of security procedures.

The following types of providers may provide ABA: (1) an HSPP; (2) a licensed behavior analyst or BCBA, which includes an assistant behavior analyst; or (3) a credentialed RBT (405 IAC § 5-22-12(c)). ABA provided by an assistant behavior analyst or an RBT must be supervised by a BCBA or an HSPP (405 IAC § 5-22-12(d)). Certain ABA services (such as those billed using CPT codes 97151, 97155, and 97156) must be performed by, at a minimum, a BCBA.

ABA must be available to an individual who is eligible for Medicaid services, has been diagnosed with autism by a qualified provider, and has a completed comprehensive diagnostic evaluation. A qualified provider, when completing such an evaluation, must use the most recent version of the DSM at the time of the evaluation (or before March 1, 2019, a standardized assessment tool) and include a recommended treatment referral for ABA (405 IAC § 5-22-12(a)).

For the purposes of the comprehensive diagnostic evaluation, the State agency defines a qualified provider as: (1) a licensed physician, (2) an HSPP, (3) a licensed pediatrician, (4) a licensed psychiatrist, or (5) other behavioral health specialist with training and experience in the diagnosis and treatment of autism. The State agency clarified that a school psychologist

[31] The State agency confirmed that IHCP Bulletins BT201526 (Apr. 28, 2015) and BT201813 (Apr. 10, 2018) support applying Indiana Code requirements to Medicaid service documentation.

can diagnose only for special education services delivered through the school (Indiana Code § 20-28-1-11). ABA is subject to prior authorization (405 IAC § 5-22-12(f)).

Session Notes Did Not Meet Documentation Requirements

For 95 sampled enrollee-months from 39 ABA facilities, the State agency paid for ABA for which session notes did not meet Federal and State documentation requirements. Specifically, the session notes that the facilities provided did not: (1) support the CPT codes paid (81 sampled enrollee-months), (2) support the number of units of ABA paid (52 sampled enrollee-months), or (3) include valid signatures of providers that furnished ABA (39 sampled enrollee-months). In addition, session notes were missing for 17 sampled enrollee-months.[32]

Session Notes Did Not Support the Current Procedural Terminology Codes Paid

For 81 sampled enrollee-months from 34 ABA facilities, the State agency paid for ABA billed with certain CPT codes (i.e., 97155 and 97156) for which the session notes did not support that the facilities furnished ABA as described in the CPT code. Specifically, CPT code 97155 describes implementing a treatment protocol modification (i.e., a BCBA resolving one or more problems with the treatment protocol while the child is present), and CPT code 97156 describes BCBA-provided guidance to parents to implement treatment protocols (American Medical Association's [AMA's] *2019 CPT Codebook*).

When CPT code 97155 was billed, the session notes did not support that any treatment protocol modification was made. For example, for 2 sampled enrollee-months from one ABA facility, the session notes documented very clearly that no protocol modification was completed, stating: "[p]atient is making adequate progress in all areas no changes warranted" or ". . . no modifications were made at this time."

When CPT code 97156 was billed, some session notes documented parent training; however, some of the notes documented a general discussion between the BCBA and the parent and did not document guidance provided to parents to implement treatment protocols.

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

For 52 sampled enrollee-months from 24 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) units of ABA were paid that exceeded the overall time shown in the session notes, (2) ABA was paid at the same time that a facility documented other services for a child (e.g., speech therapy), (3) documented nap time was included in the units of ABA paid, (4) ABA was paid for services that two RBTs provided the same enrollee during the same timeframe, or (5) electronic notes were signed off before the

[32] The number of sampled enrollee-months with deficiencies is greater than 95 because 65 sampled enrollee-months had more than 1 deficiency.

end of an ABA session or in some cases before a session even started.[33] When electronic session notes are signed before the end of a session, it raises questions about whether the complete session occurred.

For example, for 3 sampled enrollee-months from one ABA facility, units of ABA were billed and paid in excess of the time the session notes supported. For 1 of the 3 sampled enrollee-months, the notes showed that on 1 day the child received ABA from 10:00 a.m. to 4:20 p.m. (25 units); however, the facility billed and was paid for 29 units. In addition, the notes documented that the child took a 45-minute nap (3 units), which was not deducted from the time billed. Therefore, the ABA facility was overpaid by 7 units. The documentation for this sampled enrollee-month showed a problem with billing in excess of the time that the session notes documented for most dates of service. In total, the ABA facility billed 37 excessive units, or 9.25 hours, during the enrollee-month.

Session Notes Did Not Include Valid Signatures of Providers That Furnished Applied Behavior Analysis

For 39 sampled enrollee-months from 14 ABA facilities, the State agency paid for ABA for which the session notes did not include valid signatures of the providers that furnished the services. Specifically, some session notes had no signature, some session notes were signed by someone other than the provider who furnished the service, or electronic signatures did not meet Indiana Code requirements for signatures. If there was not a valid provider signature at the time services were furnished, it raises questions about who authored the session notes and whether the services were provided as documented.

For example, one ABA facility submitted its ABA session notes to us in a spreadsheet format with no provider signatures for any of the ABA that the facility provided. Most of the remaining facilities had one or more session notes that were missing the signature of the provider who furnished ABA. Another ABA facility, for all 9 of its sampled enrollee-months, had session notes that were signed by someone other than the provider who furnished the ABA. Specifically, one BCBA performed BCBA services (billed using CPT codes 97151, 97155, and 97156), but a different BCBA signed the session notes. In many cases, BCBAs signed the notes months after the dates of service and after the facilities had submitted the claims to Medicaid.

In another example, for two ABA facilities that had multiple sampled enrollee-months, when we asked about RBT signatures on session notes, the two facilities stated that the session notes were electronically signed even though none of the session notes had a statement that the signature was provided electronically or had the date and time stamp that is common on electronic signatures. We requested that the facilities provide documentation to show how their electronic signatures met the requirements of Indiana Code section 26-2-8-116. We then requested that the State agency review the documentation each facility submitted. For both

[33] The State agency clarified that any time billed for services provided after session notes were signed are not considered "documented at the time services are provided or rendered."

facilities, the State agency determined that the signatures of the RBTs who furnished the ABA did not meet Indiana Code requirements.

Session Notes Were Missing

For 17 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 were unable to provide session notes.

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 95 sampled enrollee-months occurred because the State agency did not perform a statewide postpayment review of ABA payments to ABA facilities to verify that facilities complied with Federal and State documentation requirements.[34] The State agency's guidance on ABA CPT codes (posted on its website) listed only allowable CPT codes and their definitions; however, the State agency did not provide any additional guidance on the use of CPT code 97155. In addition, a coalition of industry representatives issued guidance that may have led to provider confusion.[35] That guidance stated that CPT code 97155 may be billed when a BCBA observes an RBT delivering treatment to determine whether the treatment protocol is effective, without necessarily implementing a protocol modification as defined by the CPT code description.[36]

Furthermore, the State agency did not provide sufficient guidance to ABA facilities on State signature requirements. Although the IAC states that the signature on session notes must be that of the provider who furnished the service, one facility stated that BCBAs signed all session notes because BCBAs were responsible for services that RBTs provided. However, in conversations with State agency officials, they confirmed that session notes documenting ABA provided by an RBT must be signed by the RBT.

[34] Although the State agency did not perform a statewide postpayment review of FFS ABA payments, the State agency noted that managed care organizations (MCOs) reviewed managed care ABA claims. However, at least one MCO told the State agency that "ABA audits are very hard to review given the issue of documentation." Additionally, one MCO requested that the State agency provide documentation guidance specific to ABA. However, the State agency only reiterated its general documentation requirements and did not provide any clarification.

[35] "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.

[36] Permitting CPT code 97155 to be billed for observation or direction of an RBT without a protocol modification could result in duplicate billing because CPT code 97153 requires the RBT to be "under the direction of" a BCBA.

Applied Behavior Analysis Was Provided by Staff Who Did Not Have Appropriate Credentials

For 26 sampled enrollee-months from 13 ABA facilities, the State agency paid for ABA provided by staff who did not have the appropriate credentials.[37] Specifically, seven ABA facilities permitted behavior technicians, who were not credentialed RBTs, to provide ABA to children (15 sampled enrollee-months), and seven ABA facilities permitted ABA that should have been provided by a BCBA to be provided by an assistant behavior analyst or an RBT (12 sampled enrollee-months).[38] Some ABA facilities stated that noncredentialed technicians were in training with a credentialed RBT; however, the session notes did not document that the technicians were being trained and supervised.

For example, for 8 sampled enrollee-months from an ABA facility, the facility permitted noncredentialed staff to provide ABA. For each sampled enrollee-month, the facility confirmed that its noncredentialed staff obtained their RBT credentials after the dates of service in our sampled enrollee-month, or the facility stated that its noncredentialed staff separated from employment before obtaining RBT credentials. In each case, the notes made no reference to an RBT or a BCBA being present, nor did an RBT or a BCBA countersign the notes to corroborate that noncredentialed staff were being trained and supervised.

The deficiencies we identified for the 26 sampled enrollee-months occurred because the State agency did not perform a statewide postpayment review of ABA payments to verify that only appropriately credentialed staff provided ABA.

Allowing noncredentialed staff without documented supervision to provide ABA may have affected the quality of care that children received.

Applied Behavior Analysis Was Provided to Children Who Did Not Receive Required Diagnostic Evaluations or Treatment Referrals

For 22 sampled enrollee-months from 18 ABA facilities, the State agency paid for ABA provided to children who did not receive a required diagnostic evaluation, the diagnostic evaluation was not performed by a qualified provider, or there was no treatment referral for ABA. Specifically, there was no documentation of a diagnostic evaluation in which a qualified provider used a required assessment tool, the diagnostic evaluation was provided by a school psychologist for purposes of developing an Individualized Education Program (IEP), or the provider did not

[37] One ABA facility with multiple sampled enrollee-months allowed non-RBTs to provide services for each of its sampled enrollee-months; however, the session notes did not specify individual times that staff provided services to enable us to determine the total dollar amount that was improperly paid. Therefore, we considered those payments potentially improper.

[38] The number of ABA facilities with deficiencies is greater than 13 and the number of sampled enrollee-months with deficiencies is greater than 26 because for 1 sampled enrollee-month from 1 facility, behavior technicians (who were not credentialed RBTs) were permitted to provide ABA to children, and ABA that should have been provided by a BCBA was permitted to be provided by an assistant behavior analyst.

include a treatment referral for ABA.[39] The State agency's prior authorization contractor approved prior authorization requests even though the diagnostic evaluations did not meet State requirements or no referrals were included.

For example, for 2 sampled enrollee-months for the same child at an ABA facility, the child did not have a diagnostic evaluation that met the State agency's requirements. Specifically, the documentation that the facility provided did not support an autism diagnosis using a standardized assessment tool.[40] The State agency confirmed that the documentation did not meet the requirement for autism diagnostic evaluations because it did not support that a standardized tool was used. Therefore, we considered the total payments of $21,760 for the sampled enrollee-months improper.[41]

When we requested documentation of a treatment referral for ABA for 1 sampled enrollee-month from another ABA facility, the facility stated that a "[r]eferral was not required by Medicaid when this client began services in August 2016"; however, the State agency had required a referral for ABA since the start of ABA coverage (effective February 6, 2016).[42] Because the child was not referred for ABA, we considered the total payments of $11,068 for the sampled enrollee-month improper.[43]

The deficiencies we identified for the 22 sampled enrollee-months occurred because the State agency's oversight of its prior authorization contractor was not sufficient to ensure that prior authorizations for ABA were approved only for children with required autism diagnostic evaluations and treatment referrals for ABA. Specifically, the State agency never reviewed its contractor's procedures to verify that the contractor was approving prior authorizations in accordance with State diagnostic evaluation and treatment referral requirements for ABA. The State agency relied on its contractor to follow the State agency's general prior authorization guidelines that the State agency documented in the contract.[44] In addition, some ABA facilities were not aware that there were requirements for diagnostic evaluations and treatment referrals. Specifically, some facilities told us they believed that a confirmation of the autism

[39] An IEP is an individualized plan for a child with a disability to receive special education services through the public school system. A child's IEP describes the educational program that has been designed to meet that child's unique needs.

[40] The diagnosis was completed before 405 IAC section 5-22-12(a)(3) was revised, effective Mar. 1, 2019, to require the use of the most recent version of the DSM.

[41] These sampled enrollee-months also included documentation that we determined to be unreliable; for example, two different ITPs had identical signatures that appeared stamped or copied, calling into question the authenticity of the signatures.

[42] IHCP Bulletin, BT201606, Jan. 19, 2016.

[43] There were other findings for this sampled enrollee-month; for example, ABA was provided by uncredentialed staff, and session notes were not signed by the provider that furnished the services.

[44] The State agency's contract was not specific to ABA but covered all services that required prior authorization.

diagnosis was sufficient to meet the requirements, even if the facility did not document an assessment tool or a treatment referral.[45] Finally, some facilities believed that their documentation met requirements because the prior authorizations were approved.

THE STATE AGENCY MADE POTENTIALLY IMPROPER PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS

For all 100 sampled enrollee-months, the State agency made potentially improper FFS Medicaid payments for ABA for which documentation was not detailed or was unreliable. Specifically, session notes: (1) did not have a detailed statement describing the services furnished, (2) included potential nontherapy time, (3) referred to potentially unallowable recreational or academic activities, or (4) referred to group activities rather than to ABA provided to one patient. The State agency paid $530,962 for 71 sampled enrollee-months for which the lack of a detailed statement or specific issues such as the inclusion of nontherapy time made the payments potentially improper (Appendix D).[46] Because we determined that session notes either lacked details or were unreliable, we set aside the $530,962 of potentially improper payments for the State agency to determine whether these payments complied with requirements.

The payments were potentially improper because the State agency did not perform a statewide postpayment review of ABA payments, did not provide sufficient guidance to ABA facilities for documenting ABA, and did not issue guidance to ABA facilities on what it considered billable ABA time.

Federal and State Requirements and Guidance

Medicaid records must fully disclose and document the extent of services provided to individuals receiving Medicaid assistance (the Act § 1902(a)(27) and 405 IAC § 1-1.4-2(a)). In addition, Medicaid records must be documented at the time the services are provided and before associated claim submission (405 IAC § 1-1.4-2(a)). Records must include the following information and documentation: (1) the identity, including dated signature or initials, and position of the provider employee furnishing the service and (2) a detailed statement describing services furnished, including the duration of services furnished (405 IAC § 1-1.4-2(b)). The State agency may recover payment from any provider if the provider cannot document services as required by 405 IAC section 1-1.4-2 or if the overpayment resulted from an inaccurate description of services or an inaccurate usage of procedure codes (405 IAC § 1-1.4-9(a)).

[45] The State agency uses State Form 54727, "Confirmation of Diagnosis," to confirm that an enrollee's disability was determined before the age of 22. This one-page form is used to apply for services under the Division of Disability and Rehabilitative Services. It states the diagnosis and the original date of diagnosis but not how the diagnosis was determined. In addition, the form includes no referral for treatment.

[46] See footnotes 20 and 28.

Coverage shall not be available for services that focus solely on recreational or educational outcomes or are duplicative, such as services provided under an IEP that addresses the same behavioral goals using the same techniques as the ITP (405 IAC § 5-22-12(k)).

CMS and the State agency issued guidance related to cloning session notes (i.e., using notes that appear identical for different visits).[47] Both advised providers to watch for cloned notes because the notes may not reflect the uniqueness of an encounter.

Session Notes Did Not Have a Detailed Statement Describing Services Furnished

For 98 sampled enrollee-months from 40 ABA facilities, session notes did not have a detailed statement describing the services furnished, including their duration.[48] Specifically, session notes did not detail all specific ABA techniques used or provide a clear picture of how those techniques were used or the specific duration of ABA. Because the State agency's requirements do not specify how long session notes should be, we could not conclude whether the notes satisfied State agency requirements to have a detailed statement describing the services furnished. We found that most session notes had only a brief summary of the session along with data collected during the session.[49] In some cases, the summary describing 32 units, or 8 hours, of ABA was as short as three or four sentences. Some session notes included only the data collected and in lieu of a detailed statement had a statement of the child's general disposition (e.g., happy or tired) or what the child ate during the session, or they had only a statement that the child had been diagnosed with autism. Other session notes included only a brief statement on certain activities that the child did well or activities in which the child struggled.

In addition, the State agency's requirements did not specify how to document the duration of the specific ABA services furnished. For example, most session notes or data collected showed only the start and end times of a child's day, the start and end times of a child's morning and afternoon sessions, or the start and end times for the individual RBT who furnished ABA

[47] CMS, Documentation Matters Fact Sheet, "Medicaid Documentation for Behavioral Health Practitioners," 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 Jan. 25, 2024. IHCP, "Behavioral Health and ABA Documentation Guidelines," February 2019. Available online at https://provider.indianamedicaid.com/ihcp/providertraining/BehavioralHealth/story_html5.html. Accessed on Jan. 25, 2024.

[48] For the remaining 2 sampled enrollee-months, we did not review the session notes because: (1) the provider stated that it had billed Medicaid in error (see footnote 23) and (2) the provider did not submit any session notes for the entire sampled enrollee-month.

[49] ABA data collection is the process of recording information on behaviors, including behaviors that ABA is intended to decrease (e.g., aggression, screaming, tantrums, pinching, and self-injury) or to increase (e.g., staying focused on a task, making or responding to requests appropriately, and identifying similar or dissimilar items).

services and did not indicate when the specific services were furnished. (See the next finding, "Session Notes Included Potential Nontherapy Time.")

In addition to the session notes not having a detailed statement, many sampled enrollee-months included text of the notes or signatures that appeared to be cloned (i.e., copied from other ABA session notes). Furthermore, for some sampled enrollee-months, the session notes or ITP showed the wrong child's name in multiple locations. The session notes were not reliable to support: (1) which services children received or the quality of care that they received or (2) whether the RBTs providing ABA were properly supervised. In addition, the presence of another child's name on an ITP indicates that the provider may be inaccurately cutting and pasting information from other ITPs.

For example, for 1 sampled enrollee-month, the ABA facility provided handwritten session notes in which several days' notes and signatures were identical. Each day's session notes were photocopied with spaces left for each day's data (e.g., the number of mands or the number of episodes of aggression).[50] The notes also included a space for the recreational skills that were worked on during the session (e.g., the child played fetch with a dog, played beanbag toss, and played darts). For one date of service, the session notes had blank spaces for the data or skills that were worked on. In addition, the photocopies of the session notes were date-stamped 1 to 2 months before the dates of service. Lastly, we determined that even the signature of the RBT was photocopied because it appeared to be identical on all the notes that had the same format. The BCBA also countersigned the notes, but many of the signatures appeared to be identical.

Session Notes Included Potential Nontherapy Time

For 97 sampled enrollee-months from 40 ABA facilities, session notes did not always support the time billed because the time billed included potential nontherapy time. Specifically, ABA was billed continuously for several hours, or the session notes referred to nontherapy time (e.g., naps) 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., 8:00 a.m. to 4:00 p.m.), the start and end times of the child's morning and afternoon sessions (e.g., 8:00 a.m. to 12:00 p.m. and 12:00 p.m. to 4:00 p.m.), or the start and end times for each individual RBT that furnished services (e.g., 8:00 a.m. to 9:00 a.m., 9:00 a.m. to 11:00 a.m., and 11:00 am to 12:00 p.m.). Even when multiple RBTs furnished services consecutively, the majority of session notes for the sampled enrollee-months documented that ABA time was billed continuously, for as long as 8 hours, without any adjustment to the units of service for potential nontherapy time, such as meals, breaks, or naps.

For example, for 1 sampled enrollee-month, an RBT accompanied a 5-year-old child to school each day, including on a class field trip one day. The ABA facility consistently billed and was paid for 7.5 hours of ABA each day. However, session notes referred to recess and everything

[50] A mand is a child's request for an item or activity.

the child ate during the day, even though the ITP included no goals related to eating and did not document specific ABA provided during recess and lunchtime. For some days, session notes documented that the child had speech or occupational therapy in addition to ABA during the school day. The session notes also documented that some of the RBT's time was clearly limited to observing the child in the classroom or reviewing data and consulting with a BCBA. For 1 day, session notes documented that the BCBA was present and the RBT was not directing the child. Instead, the RBT was reviewing data and consulting with the BCBA while the child took directions from the teacher and a class aide and participated in group activities.

Session Notes Referred to Potentially Unallowable Recreational or Academic Activities

For 61 sampled enrollee-months from 27 ABA facilities, session notes referred to potentially unallowable recreational or academic activities without providing details on the ABA techniques used or their duration. Without those details, the session notes did not support that the sessions included only allowable activities.

For example, for 1 sampled enrollee-month, session notes consisted of only data collected during the 7-hour session for a 19-year-old. The documents that the ABA facility provided included a separate Parent Communication Log that briefly summarized the session. One day's summary stated: "[The child] had a great morning! We struggled [with] getting in the shower, however, [the child] was able to get back on track! He did great handwriting sentences. He played on the tablet and watched [the movie] Smurfs 2." Neither the data nor the communication log specified how much time the child was allowed to participate in these recreational activities (i.e., playing on the tablet and watching the movie). However, the facility was paid for the entire 7-hour day.

Another sampled enrollee-month from a different ABA facility included data collected for a 12-year-old child related to "functional academics," which was not mentioned in the child's ITP. Functional academics included learning science, math concepts, and spelling and doing independent work. Additionally, the data referred to the child taking science and spelling tests.

Furthermore, for some sampled enrollee-months, for those children who attended public school and received special education, some ITPs referenced that the children had IEPs. However, the ITPs and session notes did not specify which services the children received as part of those IEPs. Without those details, we could not determine whether the State agency paid for duplicative ABA (i.e., ABA that addressed the same behavioral goals using the same techniques shown in the ITPs).

Session Notes Referred to Group Activities Rather Than Applied Behavior Analysis Provided to One Patient

For 37 sampled enrollee-months from 20 ABA facilities, session notes referred to group activities, but time was billed and paid as "face-to-face with one patient" (i.e., individual

therapy).[51] The notes did not specify whether the RBT was working face-to-face with one child for the entirety of the services billed or whether a portion of this time was group therapy.

For example, for 1 sampled enrollee-month, session notes had a section in which the RBT documented whether the ABA was provided one-to-one (individual therapy) or to a group. On all but 1 day during the enrollee-month, group activity was documented for some portion of the day. In total, 99 units, or 24.75 hours, of ABA were documented as a group activity but billed as individual therapy. Furthermore, some session notes that documented individual therapy referred to a child following group directions or engaging in playtime with other children, and some session notes that documented group activities referred to lunch.

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 did not perform a statewide postpayment review of ABA payments. In addition, the State agency did not provide guidance to ABA facilities clarifying State requirements that said medical records (i.e., session notes) must be of sufficient quality to fully disclose the extent of services provided and include a detailed statement describing services furnished. In its "Behavioral Health and ABA Documentation Guidelines" online training course, the State agency provided an example of proper notes for a 60-minute psychotherapy session but did not provide an example of proper session notes for documenting ABA.[52] The State agency also did not provide guidance to ABA facilities on what the State agency considers billable ABA time (e.g., whether time billed should include recreational and academic activities, meals, and breaks).

CONCLUSION

The State agency's FFS Medicaid payments for ABA provided to children diagnosed with autism increased significantly from the beginning of ABA coverage in 2016 to our audit period. For our audit period, 97 sampled enrollee-months included ABA payments that did not comply with Federal and State requirements. In addition, 100 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 97 of 100 sampled enrollee-months, the State agency made improper payments for ABA: (1) for which session notes did not meet documentation requirements, (2) provided by staff who did not have the appropriate credentials, and (3) provided to children who did not receive the required diagnostic evaluations or treatment referrals for ABA. In addition, for all

[51] The definition of CPT code 97153 is "[a]daptive behavior treatment by protocol, administered by [RBT] under the direction of a [BCBA], face-to-face with one patient, each 15 minutes."

[52] IHCP, "Behavioral Health and ABA Documentation Guidelines," February 2019, slide 15, "Example." Available online at https://provider.indianamedicaid.com/ihcp/providertraining/BehavioralHealth/story_html5.html. Accessed on Jan. 25, 2024.

100 sampled enrollee-months, the State agency made potentially improper ABA payments for which the documentation supporting the ABA provided was not detailed or the documentation was unreliable. For example, session notes did not have a detailed statement describing the services furnished, or session notes included potential nontherapy time or referred to recreational or academic activities that may not have been allowable ABA activities.

On the basis of our sample results, we estimated that the State agency paid at least $56.5 million ($39.4 million Federal share) for ABA that did not meet Federal and State requirements. Additionally, we estimated that the State agency made $76.7 million ($53.2 million Federal share) of potentially improper ABA payments. In addition, because ABA was provided by noncredentialed staff who may not have been properly supervised and session notes were cloned or otherwise unreliable, children with autism may not have received the quality of ABA they 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 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) State signature requirements, (3) the detail in session notes needed to support ABA provided, and (4) what the State agency considered billable ABA time. In addition, the State agency did not perform a statewide postpayment review of payments to ABA facilities to verify that facilities complied with Federal and State requirements related to documentation and provider credentialing. Furthermore, the State agency's oversight of its prior authorization contractor was not sufficient to ensure that prior authorizations for ABA were approved only for children with required autism diagnostic evaluations and treatment referrals for ABA.

RECOMMENDATIONS

We recommend that the Indiana Family and Social Services Administration:

- refund $39,432,556 (Federal share) to the Federal Government for FFS Medicaid ABA payments that did not comply with Federal and State requirements;

- provide additional guidance to ABA facilities for documenting ABA, including services that must be provided to support the use of CPT codes 97155 and 97156, State signature requirements, the detail in session notes needed to support ABA provided, and what the State agency considers billable ABA time;

- periodically perform a statewide postpayment review of Medicaid ABA payments, including reviewing medical records, to educate providers on requirements and to recover payments that did not comply with Federal and State requirements;

- periodically review its prior authorization contractor's procedures for verifying ABA facilities' compliance with requirements for State diagnostic evaluations and treatment referrals for ABA; and

- exercise reasonable diligence to review and determine whether any of the estimated $53,236,026 (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.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations but detailed steps it has taken and plans to take in response to our recommendations. In addition, the State agency said that it had established a uniform reimbursement rate for ABA effective January 1, 2024. The State agency's comments are included in their entirety as Appendix E.

The State agency responded to our recommendations as follows:

- Regarding our first recommendation, the State agency said it will review the claim lines making up the 100 sampled enrollee-months and, where improper payments exist, will recover the payments from providers in an effort to refund the Federal share.

- Regarding our second recommendation, the State agency said that it has implemented an ABA authorization checklist to instruct providers on appropriate diagnostic testing evaluations, documentation needed to support medical necessity of services, and proper utilization of CPT codes.

- Regarding our third recommendation, the State agency said that it conducted postpayment reviews of ABA payments in 2023 and 2024, including a review of medical records. The State agency also said that it is currently performing postpayment audits of 21 Indiana providers and plans to continue to audit ABA payments annually. Additionally, the State agency said that it plans to develop provider education that will include service delivery requirements for coverage and will highlight reimbursement requirements and documentation standards to substantiate ABA billing.

- Regarding our fourth recommendation, the State agency said that it reviews monthly and quarterly reports submitted by the FFS prior authorization contractor. (The State agency said that it contracted with a new prior authorization contractor effective July 1, 2023.) The State agency also said that it performs monthly random case audits, which include periodic ABA case audits. Finally, the State agency said that its management of the contract includes oversight of contract requirements for prior authorization criteria and that it had leveraged the expertise of the contractor's

reviewers in developing the new ABA utilization management policy to address concerns identified in our audit.

- Regarding our fifth recommendation, the State agency said that it will review a statistically significant sample of the claims representing the $53.2 million Federal share. The State said that if improper payments exist, the State agency will recover the payments from providers and refund the Federal share.

Regarding our first recommendation, although the State agency committed to recover improper payments for the 100 sampled enrollee-months, the State agency did not address the recommended refund of the estimated amount of $39,432,556 (Federal share) for FFS Medicaid ABA payments that did not meet Federal and State requirements. We continue to recommend that the State agency refund this amount to the Federal Government.

Regarding our remaining recommendations, although we have not yet confirmed whether the State agency effectively implemented the recommendations, we are encouraged by the State agency's response and look forward to receiving and reviewing the supporting documentation through our audit resolution process.

OTHER MATTERS

We did not assess the effectiveness or the quality of ABA provided in Indiana; we assessed only whether the State agency's FFS Medicaid ABA payments complied with Federal and State requirements. However, while performing our audit, we identified the following issues that increase the risk of improper payments in Indiana's Medicaid ABA program and may affect the quality of care provided to children with autism: (1) treatment referrals for ABA were outdated, and there was no independent evaluation for continued medical necessity; (2) Medicaid claims for ABA did not provide sufficient detail for utilization review; (3) documentation was insufficient to support that RBTs had required supervision; (4) the State agency did not require background checks of ABA facility staff; and (5) most ABA facilities did not provide parent training.

TREATMENT REFERRALS FOR APPLIED BEHAVIOR ANALYSIS WERE OUTDATED, AND THERE WAS NO INDEPENDENT EVALUATION FOR CONTINUED MEDICAL NECESSITY

The State agency requires prior authorizations for ABA every 6 months (405 IAC §§ 5-22-12(f) and (g)); however, there is no requirement for updated ABA referrals from an independent qualified provider. For many sampled enrollee-months, a child had a treatment referral for ABA several years before the sampled enrollee-month. However, an independent qualified provider did not subsequently evaluate the child to confirm the continued medical necessity of ABA. Instead, continuation of ABA was based solely on the ABA facility's recommendation, which was potentially a conflict of interest that could lead to enrollees not getting the services they need or receiving unnecessary services. Additionally, for some sampled enrollee-months, the ABA facility performed the diagnostic evaluation and referred the child for ABA, which is an

indication that the diagnostic evaluation and treatment referrals were not independent. Additionally, some school-aged children who had been receiving ABA for many years do not appear to have gone to school but rather received ABA full-time (i.e., 6 or more hours per day) based on the initial independent referral for ABA.

For example, for 1 sampled enrollee-month, the date of the autism diagnosis and ABA referral for the child was in January 2014, when the child was 2 years old. Although the supporting documentation included the 2014 referral for ABA (which stated that "ABA therapy be initiated with the maximum allowable time"), there was no additional independent referral as of our sampled enrollee-month (August 2020). During our sampled enrollee-month, the child was 8 years old and receiving ABA 5 days a week, for an average of more than 7 hours of ABA each day. The child's ITP did not mention whether the child attended school but had a standardized statement: "The patient's family [has] taken on responsibility for meeting the educational needs of this patient." Payment for ABA in the sampled enrollee-month totaled $13,416. We determined that this child received ABA starting at the age of 4. Medicaid payments generally increased from year to year, from more than $52,000 in CY 2017 to more than $185,000 in CY 2022 (when the child was 11 years old). Total FFS Medicaid payments for the period totaled $677,448.

MEDICAID CLAIMS FOR APPLIED BEHAVIOR ANALYSIS DID NOT PROVIDE SUFFICIENT DETAIL FOR UTILIZATION REVIEW

The State agency's Medicaid claims data included a field to identify the provider furnishing services. According to State agency officials, that field could include any enrolled ABA provider (i.e., an HSPP or a BCBA) from a facility, and that provider is responsible for ensuring that the ABA provided meets State requirements. There is no requirement that the "furnishing provider" on a claim be the supervising provider for the child. However, we identified instances in which the BCBA shown on a claim as the furnishing provider was not the supervising BCBA. Additionally, the majority of ABA billed was for CPT code 97153, which is a service generally provided by an RBT; however, there was no field that identified the RBT who furnished the service. Because the provider did not always identify the supervising BCBA and there was no field to identify the RBT, the State agency was unable to analyze utilization of ABA.

DOCUMENTATION WAS INSUFFICIENT TO SUPPORT THAT REGISTERED BEHAVIOR TECHNICIANS HAD REQUIRED SUPERVISION

The State agency had no specific supervision requirements for RBTs. However, State agency officials stated that they expected RBTs to stay in compliance with the Board's requirements, including those for supervision of RBTs by, for example, BCBAs. We requested documentation from ABA facilities to support that RBTs were supervised to the extent that the Board required. Not all ABA facilities could provide support to confirm that they provided RBTs the required level of supervision, and some ABA facilities provided support that clearly showed some RBTs did not meet all requirements. Some ABA facilities stated that the burden to meet the Board's requirements was on the RBTs and that the facilities did not keep documentation. Without

documentation to support that RBTs were supervised, the State agency could not evaluate whether RBTs were supervised to the extent the Board requires. In addition, lack of sufficient supervision may have affected the quality of care for the children receiving ABA.

THE STATE AGENCY DID NOT REQUIRE BACKGROUND CHECKS OF APPLIED BEHAVIOR ANALYSIS FACILITY STAFF

The State agency did not require background checks of ABA facility staff (e.g., BCBAs and RBTs). However, after reviewing background checks from those ABA facilities that completed them, we identified some ABA facility staff who had background checks with offenses that could have put children in danger.

For example, one RBT had a conviction for driving under the influence of alcohol within 3 years of the sampled enrollee-month, but the RBT was allowed to transport a child to an outside therapy appointment. A second RBT had a misdemeanor battery charge within 17 months of our sampled enrollee-month. (At the time of the background check, the case was pending.) A third RBT had a felony charge within 4 months of our sampled enrollee-month for causing death when operating a motor vehicle while under the influence of a Schedule I or Schedule II controlled substance.[53] (At the time of the background check, the case was pending.) The specific session notes did not mention that the RBT drove the child, but session notes from our sampled enrollee-month often did not appear to be complete. Each of these three RBTs was from a different ABA facility.

In addition, many RBTs in our sampled enrollee-months had background checks that showed misdemeanor alcohol or drug charges.

MOST APPLIED BEHAVIOR ANALYSIS FACILITIES DID NOT PROVIDE PARENT TRAINING

Most ITPs for ABA mentioned the importance of parental involvement in a child's progress. Even though most ABA facilities requested preapproval for parent training, for most sampled enrollee-months, that training was not provided. Specifically, ABA facilities did not bill parent training for 60 percent of children in our sampled enrollee-months. In addition, as noted in our finding "Session Notes Did Not Support the Current Procedural Terminology Codes Paid," ABA facilities sometimes billed for parent training when none was provided.

[53] A Schedule I controlled substance is a drug with no currently accepted medical use and a high potential for abuse. A Schedule II controlled substance is a drug with a high potential for abuse, with use potentially leading to severe psychological or physical dependence.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the State agency's total FFS Medicaid payments of $151,057,682 ($104,479,383 Federal share) for 436,661 claim lines for ABA, which we grouped into 18,296 enrollee-months with dates of service from January 1, 2019, through December 31, 2020 (audit period).[54] Our audit included only enrollee-months with payments totaling more than $2,500.[55] We selected a stratified random sample of 100 enrollee-months, with ABA payments totaling $967,294 ($672,024 Federal share).

The 100 enrollee-months in our sample consisted of 41 unique ABA facilities and 96 unique enrollees. Total payments for each sampled enrollee-month ranged from $2,643 to $28,240. 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 and treatment referral for ABA, (3) the ITP, and (4) ABA session notes supporting the units of ABA paid.

We did not conduct medical review to determine whether ABA was medically necessary. However, we shared our findings for some of the sampled enrollee-months with the State agency to confirm that the State agency agreed with our determinations that the enrollee-months did not meet Federal or State Medicaid requirements and guidance for ABA.

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 contractor 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 from August 2021 to August 2024.

[54] 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 958 claims and 2,341 claim lines associated with the 100 sampled enrollee-months.

[55] Enrollee-months with payments totaling $2,500 or less accounted for 5 percent of total ABA payments.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance, as well as AMA's *2019 CPT Codebook*;

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

- obtained from the State agency the MMIS's Medicaid FFS data for ABA provided to children 20 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 18,296 enrollee-months, consisting of 436,661 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 that the diagnosing provider used a standardized test or the most recent version of the DSM and included a treatment referral for ABA, (3) the ITP was developed by an HSPP or a BCBA, and (4) 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 our findings for some of the sampled enrollee-months with State agency staff to confirm that the State agency agreed with our determinations for enrollee-months that did not meet Federal and State requirements;

- 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 ABA 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); 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 18,296 enrollee-months, consisting of 436,661 claim lines for ABA provided during our audit period, with total Medicaid payments of $151,057,682.[56] The sampling frame consisted of enrollee-months in which the total paid amount for each enrollee-month was greater than $2,500 for services furnished by providers that were not under investigation by the Office of Inspector General (OIG).[57]

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	Sample Size
1	Enrollee-months with payment amounts from $2,502.00 to $10,160.00	13,801	$87,441,790	50
2	Enrollee-months with payment amounts from $10,160.20 to $47,345.00	4,495	63,615,892	50
Total		**18,296**	**$151,057,682**	**100**

SOURCE OF RANDOM NUMBERS

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

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 we consecutively numbered the items in each stratum in the

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

[57] Enrollee-months in which the total paid amount was less than or equal to $2,500 accounted for 5 percent of the value of the sampling frame.

sampling frame.[58] 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 Federal share of improper FFS Medicaid payments in the sampling frame for ABA provided to children diagnosed with autism. 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.

Furthermore, we used the OIG-OAS statistical software to calculate the point estimate for the total dollar amount and Federal share of potentially improper FFS Medicaid payments in the sampling frame for ABA provided to children diagnosed with autism. In addition, we calculated a two-sided 90-percent confidence interval for this estimate.

[58] Year and month were associated with the end service date (the field "Date_End_Service_Detail") on each claim line 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	13,801	$87,441,790	50	$307,286	48	$150,279
2	4,495	63,615,892	50	660,008	49	283,193
Total	**18,296**	**$151,057,682**	**100**	**$967,294**	**97**	**$433,472**

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	13,801	$60,344,357	50	$214,041	48	$105,058
2	4,495	44,135,026	50	457,983	49	196,661
Total	**18,296**	**$104,479,383**	**100**	**$672,024**	**97**	**$301,719**

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

	Total	Federal Share
Point estimate	$66,939,088	$46,678,052
Lower limit	56,577,188	39,432,556
Upper limit	77,300,988	53,923,549

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	13,801	$87,441,790	50	$307,286	34	$155,760
2	4,495	63,615,892	50	660,008	37	375,202
Total	**18,296**	**$151,057,682**	**100**	**$967,294**	**71**	**$530,962**

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	13,801	$60,344,357	50	$214,041	34	$108,117
2	4,495	44,135,026	50	457,983	37	260,216
Total	**18,296**	**$104,479,383**	**100**	**$672,024**	**71**	**$368,333**

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	$76,723,446	$53,236,026
Lower limit	64,828,107	44,932,952
Upper limit	88,618,784	61,539,100

APPENDIX D: AUDIT RESULTS BY SAMPLED ENROLLEE-MONTH

		Improper Payments			Potentially Improper Payments				Audit Results		
Sample Item Number	Amount Paid	Documentation Requirements Not Met	No Appropriate Credentials	No Diagnosis or Treatment Referral	Session Notes Not Detailed	Potential Nontherapy Time	Recreational or Academic Activities	Group Activities	Allowable	Improper Payments	Potentially Improper Payments
1	$3,162				x	x					$3,162
2	10,069	x			x	x			$40	$506	9,523
3	9,568	x	x		x	x	x			1,920	7,648
4	7,018	x			x	x	x			412	6,607
5	4,158	x			x	x				3,958	200
6	7,523	x		x	x	x	x	x		7,523	
7	9,954	x			x	x	x	x		836	9,118
8	5,201	x			x	x	x	x	41	403	4,758
9	7,048	x		x	x	x	x			7,048	
10	6,974	x			x	x	x			6,974	
11	3,674	x			x	x	x	x		2,772	902
12	5,058	x			x	x				4,818	240
13	3,898	x			x	x				435	3,463
14	7,015	x	x		x	x	x			85	6,930
15	9,721	x	x		x	x		x		360	9,361
16	9,730	x			x	x	x			1,310	8,420
17	4,381	x	x		x	x	x	x		4,381	
18	7,024	x			x	x			200	6,636	188
19	2,703	x	x		x	x	x	x		417	2,286
20	4,648	x			x	x				4,648	
21	7,598	x			x	x	x		392	1,056	6,150
22	4,829	x			x	x				221	4,608
23	6,503	x	x		x	x				488	6,015
24	5,517	x			x	x	x			5,517	
25	4,556	x			x	x				3,796	760

		Improper Payments			Potentially Improper Payments				Audit Results		
Sample Item Number	Amount Paid	Documentation Requirements Not Met	No Appropriate Credentials	No Diagnosis or Treatment Referral	Session Notes Not Detailed	Potential Nontherapy Time	Recreational or Academic Activities	Group Activities	Allowable	Improper Payments	Potentially Improper Payments
26	5,863	x		x	x	x				5,863	
27	7,035	x	x		x	x				3,421	3,614
28	4,496	x		x	x	x				4,496	
29	4,640	x		x	x	x				4,640	
30	2,643	x			x	x	x			2,643	
31	6,044	x			x	x	x	x		1,140	4,904
32	3,385	x		x	x	x	x	x		3,385	
33	5,907	x	x	x	x	x	x			5,907	
34	4,280	x			x	x				4,280	
35	7,986	x	x		x	x	x		474	2,330	5,182
36	8,028	x			x	x				7,628	400
37	8,008	x			x	x				7,688	320
38	2,772				x	x					2,772
39	4,847	x	x		x	x				4,729	119
40	5,080	x	x		x	x	x			672	4,408
41	10,086	x	x	x	x	x	x			10,086	
42	5,958	x			x	x	x	x		1,150	4,808
43	4,293	x	x		x	x	x	x		256	4,037
44	6,588	x		x	x	x	x	x		6,588	
45	4,165	x		x	x	x	x	x		4,165	
46	7,130	x			x	x	x	x		875	6,255
47	8,283	x			x	x	x			1,004	7,279
48	8,942	x			x	x	x			120	8,823
49	8,640	x			x	x		x	100	338	8,202
50	4,660	x			x	x				360	4,300
51	14,586	x		x						14,586	

		Improper Payments			Potentially Improper Payments				Audit Results		
Sample Item Number	Amount Paid	Documentation Requirements Not Met	No Appropriate Credentials	No Diagnosis or Treatment Referral	Session Notes Not Detailed	Potential Nontherapy Time	Recreational or Academic Activities	Group Activities	Allowable	Improper Payments	Potentially Improper Payments
52	16,455	x			x	x			245	1,120	15,090
53	10,170	x			x	x				3,550	6,620
54	10,844	x			x	x		x	100	816	9,928
55	13,800	x		x	x	x	x	x		13,800	
56	14,363	x			x	x				438	13,925
57	10,818	x			x	x	x	x		1,201	9,617
58	14,944	x			x	x	x	x		241	14,703
59	11,390	x			x	x	x	x		550	10,840
60	10,822	x			x	x				207	10,615
61	10,640	x			x	x	x	x	40	1,261	9,339
62	10,790			x	x	x	x			10,790	
63	10,478	x			x	x	x	x	135	665	9,678
64	10,970			x	x	x	x			10,970	
65	14,839	x			x		x			2,477	12,363
66	10,563	x			x	x	x		41	893	9,630
67	12,584	x			x	x				2,110	10,474
68	13,318	x			x	x	x		156	320	12,842
69	16,760	x			x	x	x	x		15,990	770
70	14,700	x		x	x	x	x	x		14,700	
71	17,777	x	x		x	x	x			10,835	6,942
72	10,592	x		x	x	x				10,592	
73	11,223	x			x	x				18	11,206
74	13,180	x		x	x	x	x	x		13,180	
75	13,540	x			x	x	x	x		100	13,440
76	18,903	x			x	x	x	x		11,431	7,471
77	11,240	x	x		x	x				2,556	8,684

		Improper Payments			Potentially Improper Payments				Audit Results		
Sample Item Number	Amount Paid	Documentation Requirements Not Met	No Appropriate Credentials	No Diagnosis or Treatment Referral	Session Notes Not Detailed	Potential Nontherapy Time	Recreational or Academic Activities	Group Activities	Allowable	Improper Payments	Potentially Improper Payments
78	12,740	x			x	x	x		450	1,165	11,125
79	10,785	x		x	x	x				10,785	
80	13,027	x	x	x	x	x				13,027	
81	11,078	x								11,078	
82	15,775	x			x	x	x		165	1,018	14,593
83	28,240	x	x		x	x	x	x		16,001	12,239
84	14,616	x	x		x	x	x	x		6,576	8,040
85	11,912	x			x	x	x	x	52	178	11,682
86	17,646	x	x		x	x	x	x		9,664	7,982
87	11,617	x	x		x	x	x	x		5,285	6,332
88	17,752	x	x		x	x	x			7,404	10,348
89	10,996	x	x		x	x	x			1,688	9,308
90	19,288	x			x	x				2,392	16,896
91	10,856	x			x	x		x		540	10,316
92	10,335	x			x	x	x	x	80	271	9,984
93	11,068	x	x	x	x	x	x			11,068	
94	11,615	x	x		x	x	x			9,209	2,406
95	13,416				x	x					13,416
96	10,411	x	x		x	x	x			3,131	7,280
97	10,168	x		x	x	x	x	x		10,168	
98	11,005	x		x	x	x	x	x		11,005	
99	13,722	x	x		x	x			150	5,304	8,268
100	11,652	x			x	x	x	x		840	10,812
*	**$967,294**	**95**	**26**	**22**	**98**	**97**	**61**	**37**	**$2,860**	**$433,472**	**$530,962**

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

APPENDIX E: STATE AGENCY COMMENTS

Eric Holcomb, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Sept. 11, 2024

Jessica Yun Kim
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Re: Audit Report A-09-22-02002

Dear Ms. Kim,

The Indiana Office of Medicaid Policy and Planning (OMPP) is writing to respond to the Department of Health and Human Services Office of Inspector General (OIG) draft report titled *Indiana Made at Least $56 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed with Autism*. The following represents our response and corrective action plan.

The claims sampled and reviewed in this audit represent dates of service spanning February 2019 through December 2020. Since that time, OMPP has taken meaningful steps to balance the needs of ensuring Medicaid member access to medically necessary Applied Behavior Analysis (ABA) services with curbing unsustainable cost growth. As the report notes, Indiana Medicaid fee-for-service payments for ABA services rapidly increased from 2017 to 2020 and continued to grow in subsequent years. This expenditure growth was driven both by the absence of a set reimbursement rate and increases in utilization. As a result, FSSA established a uniform reimbursement rate effective Jan. 1, 2024. More information on this initiative is available at http://www.in.gov/fssa/applied-behavioral-analysis-therapy.

At the time of the rate-setting exercise, OMPP also recognized a need to ensure utilization management policies to better manage the delivery of ABA services and ensure the appropriateness of care. Throughout 2024, OMPP convened a group of clinical experts to develop updated utilization management and prior authorization policies for ABA services provided under Indiana Medicaid. While many of the issues identified in this audit are specific to clinical documentation and medical record deficiencies, these updated utilization management criteria will also support the specific recommendations and corrective action steps outlined below and will go into effect on or before Jan. 1, 2025.

Additionally, OMPP contracted with a new fee-for-service prior authorization vendor, Acentra Health (formerly known as Kepro), effective July 1, 2023. This new contractual arrangement increases the consistency and quality of prior authorization and utilization management processes across Indiana Medicaid fee-for-service, including ABA services. The OMPP Clinical Operations team engages in robust oversight practices for monitoring the prior authorization vendor performance as described below.

RECOMMENDATIONS

Refund $39,432,556 (Federal share) to the Federal Government for FFS Medicaid ABA payments that did not comply with Federal and State requirements.

OMPP will review in detail the stratified random sample of claims data for the 100 enrollee-months, totaling 2,341 claim lines, and where improper payments exist, OMPP will recover from providers in an effort to refund the federal share.

Provide additional guidance to ABA facilities for documenting ABA, including services that must be provided to support the use of CPT codes 97155 and 97156, State signature requirements, the detail in session notes needed to support ABA provided, and what the State agency considers billable ABA time.

OMPP has implemented an ABA Authorization Checklist to instruct providers on appropriate diagnostic testing evaluations, documentation needed to support the medical necessity of services being requested, and proper utilization of CPT codes and modifiers to delineate the certified or licensed professional rendering the services. This guidance will be reiterated in the broad provider education planned as part of the following recommendation.

Periodically perform a statewide postpayment review of Medicaid ABA payments, including reviewing medical records, to educate providers on requirements and to recover payments that did not comply with Federal and State requirements.

OMPP conducted postpayment reviews of ABA payments in 2023 and 2024, including a review of medical records. Currently 21 Indiana ABA providers are in some stage of postpayment audit. OMPP is committed to ensuring proper payments for ABA services and will continue to audit ABA payments annually.

As OMPP releases new provider utilization management criteria regarding ABA services, provider education will be developed and made public via recorded webinar. This provider education will include service delivery requirements for coverage and also highlight reimbursement requirements and documentation standards to substantiate billing.

Periodically review the fee-for-service prior authorization contractor's procedures for verifying ABA facilities' compliance with requirements for State diagnostic evaluations and treatment referrals for ABA.

OMPP reviews monthly and quarterly reports submitted by the fee-for-service contractor, which include administrative review and appeal outcomes for ABA cases, and performs monthly random case audits, which also includes periodic ABA case audits. These audits evaluate that the clinical review was conducted in a timely manner by qualified staff, case notes contain clear documentation of criteria utilized, the reviewer applied appropriate criteria, and that the case contains medical director notes that are complete, inclusive of secondary decisions on administrative reviews and peer-to-peer reviews.

OMPP management of this contract also includes oversight of contract requirements for prior authorization criteria hierarchy application, turnaround time compliance, and the provision of adequate professional medical and behavioral health professionals with appropriate background and expertise. Additionally, OMPP leveraged the expertise of the fee-for-service prior authorization

contractor's managed care behavioral health physician reviewers in development of the new ABA utilization management policy to address concerns identified in this audit.

Exercise reasonable diligence to review and determine whether any of the estimated $53,236,026 (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.

OMPP will review a statistically significant sample of the identified claims representing $53M in federal share and conduct an audit to determine if improper payments exist. If improper payments exist, OMPP will recover from providers and refund the federal share.

We appreciate the work of your staff on this important audit topic and the opportunity to respond. If you have questions or need additional information, please contact me.

Sincerely,

Cora Steinmetz

Cora Steinmetz
Medicaid Director

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