What Providers Need to Know About Billing Treatment Sessions

This information was developed by the Wisconsin Department of Health Services (DHS) – Office of the Inspector General (OIG) to help educate providers on federal and state program requirements. Featured topics include the rules and regulations that providers must follow, as well as program guidance, best practices, and helpful resources to support program participation efforts.

Overview

Individualized therapy services **must** be provided under a written plan of care according to Wis. Admin. Code §§ DHS 107.16(3)(a)1., DHS 107.17(3)(a)1., and DHS 107.18(3)(a)1. The plan of care **must** state the type, amount, frequency, duration of the therapy services, and be signed by the prescriber. Any changes **must** be made in writing and signed by the prescriber.

While frequency and duration of therapy treatment services are determined on a case-by-case basis, providers should estimate the length of time needed for the member to realistically achieve their treatment goals. This estimate also should include how many times the member will need to be treated during that timeframe.

Making Adjustments

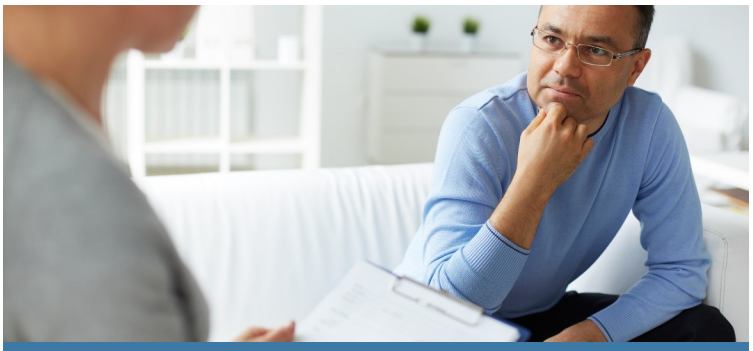
Adjusting the frequency, duration, and/or length of treatment session is allowable under certain circumstances. Please see the two examples below:

Payor Source of Members

According to ForwardHealth Handbook Topic #216, providers **must** offer Wisconsin Medicaid members the same level and quality of care as private pay patients. As a result, providers **may not** adjust the frequency, duration, and/or length of treatment sessions based on the member's payor source.

Status Change of Members

If a member's status changes, providers **may** adjust the frequency, duration, and/or length of treatment sessions based on medical necessity. In such instances, documentation must clearly support why treatment sessions were altered.



PA Requirements

Providers who serve members with an active Prior Authorization (PA) may need to change the frequency, duration, and/or length of therapy treatment sessions. Please refer to the information below to help determine when a new PA may be necessary.

Increase in Frequency

When treatment session frequency is increased or extends beyond the active PA period, providers **must** submit an amendment request that explains the medical necessity for the increase in service, along with the necessary supporting documentation.

Reduction in Frequency or Duration

When treatment session frequency is reduced during an active PA period, a new PA is **not** needed. However, when the duration is reduced during an active PA period, the OIG recommends that providers **submit** an amendment request to end date the PA early.

Changes in Length

A new PA is **not** needed for changes pertaining to the length of treatment sessions.

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Fraud, Waste & Abuse Examples

- A provider reduces a member's length of treatment from hourlong to 30-minute sessions due to a change in pay status from private pay at $100/session to Medicaid reimbursement at $50/session. This is **not** allowable because providers may **not** consider the payment source when offering treatment services.
- A provider continues to treat a member at the same frequency level when the member has plateaued or no functional gains are reasonably expected. Since skilled treatment at the continued frequency is not supported by documents, it is more appropriate to reduce the frequency to a consultative or monitoring level to evaluate further direct service needs.

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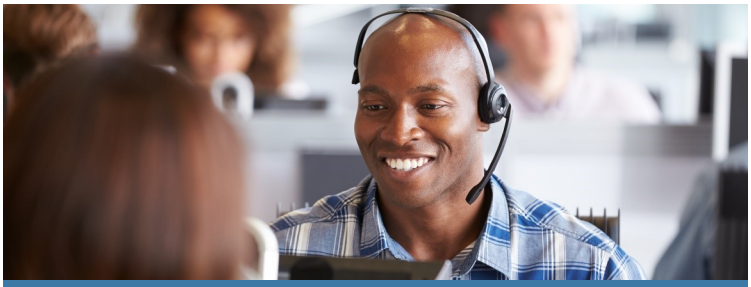

Get Billing Help!

The OIG encourages providers to seek help with billing questions prior to submitting claims by calling Provider Services at 800-947-9627.

Contact Us

- For OIG audit assistance, please contact the staff person listed on your audit letter.
- To report suspected fraud, call 877-865-3432 or visit www.reportfraud.wisconsin.gov.