Clinical Documentation Processes

The Centers for Medicare & Medicaid Services (CMS) use a risk adjustment system to account for medical expenses and care coordination costs for beneficiaries with special needs. As part of that system, CMS requires providers to support all diagnoses billed with “substantive documentation” in the provider’s medical record. Commonwealth Care Alliance and CMS may audit providers at any point for compliance with documentation standards.

The definition of “substantive documentation” is that each diagnosis billed must be supported by three items in the medical record:

1. An evaluation for each diagnosis
   - Assessment of relevant symptoms and physical examination findings at time of visit

2. A status for each diagnosis For example:
   - Stable, progressing or worsening, improving
   - Not responding to treatment or intervention

3. A treatment plan for each diagnosis
   - Observation or monitoring for exacerbation, responses to treatment, etc.
   - Referrals to specialists or services (e.g. cardiologist or PT)
   - Continuations or changes to any related medications

Coding Compliance

Commonwealth Care Alliance encourages providers to code to the most appropriate level of specificity as a general standard of practice (CPT, ICD10). Commonwealth Care Alliance and/or CMS may audit the provider at any point for over-coding and/or similar billing practices related to Fraud, Waste, and Abuse.

Educational Resources

Providers are encouraged to contact Commonwealth Care Alliance Provider Relations at (800) 341-8478 to request education about coding and documentation compliance.

Behavioral Health Screening Compliance

In collaboration with EOHHS, Commonwealth Care Alliance requires all of it contracted primary care providers (PCPs) to screen and assess each member for behavioral health needs. The early identification of behavioral health needs can lead to successful referrals, intervention and integrated treatment in a timely manner.

The EOHHS-approved behavioral health screening tool and how to evaluate results can be found in Section 18 Forms in this Provider Manual; how to make a behavioral health specialty care referral can be found in Section14, Provider Credentialing, subsection Role of the Credentialed Primary Care Provider, in this Provider Manual;

CCA recommends the use of the PHQ-9 Depression Assessment Tool, to assess patients for depression. The tool is a diagnostic measure to assess for Major Depression s well as other depressive disorders. The PHQ-9 can be administered
repeatedly to reflect improvement or worsening of symptoms.

CCA recommends the use of the CAGE-AID Screening Tool to assess the use of alcohol and other drug abuse and dependence. The tool is not diagnostic but can identify the existence of alcohol or other drug problems.

In addition CCA recommends that providers conduct a Mental Status exam to further evaluate for other behavioral health symptoms.
Medicare Risk Adjustment: General Guidelines and Recommendations

General Medicare Risk Adjustment Guidelines

In order for the findings and coding of clinical encounters to be accepted by CMS for risk adjustment purposes, a clinical encounter must be in the form of a face-to-face visit by a physician or advanced practice clinician (such as an NP, PA, LICSW, OT, or PT). Moreover, all active diagnoses must be documented during a face-to-face encounter at least once per calendar year in order for the diagnoses to count for risk adjustment purposes.

Annual Assessment Process

Commonwealth Care Alliance encourages providers to adopt the practice of an annual comprehensive assessment to ensure that all active conditions are reviewed at least once during the calendar year. The process of reviewing active conditions may be tied to an annual wellness exam or an annual physical exam.

The documentation and coding compliance practices and general risk adjustment guidelines described above should be adhered to in documenting and coding the findings of an annual comprehensive assessment visit.

Collaboration with Contracted Providers

Commonwealth Care Alliance requires providers monitor the quality, access, and cost-effectiveness of their services and identify and address opportunities for improvement on an ongoing basis. Providers may be required to submit clinical data to Commonwealth Care Alliance, if requested.