Documentation Practices

In recent years, there has been growing interest in the implementation of Contingency Management (CM) programming by community settings, and this has revealed a **need for documentation practices that protect against accusation of fraud and abuse**. This has been spurred, in part, by a few publicized cases fraudulent or abusive practices undertaken by some community treatment organizations. While such cases do not reflect what would be expected to occur during implementation of CM by the vast majority of those who provide therapeutic services, even a few publicized instances of fraud and abuse increase the need for all in the treatment community to employ effective documentation practices.

In 2021, a national policy group formed in response to passage of the CMS 1115 Waiver Program. The mission of this group was to **formulate risk management safeguards** intended to govern legal and policy issues concerning CM practices in community settings. Among its efforts, this policy group reviewed existing Anti-Kickback and Beneficiary Inducements statutes with consideration for how to help community settings minimize risks of statute violation and resulting penalties. Among their concerns is historical reliance on case-by-case assessment in how these statutes are applied, which raises the prospect of inequity among treatment settings. Specifically, greater-resourced settings are well-positioned to navigate this uncertain legal and regulatory terrain, whereas lesser-resourced settings—which are more apt to be smaller, led by persons of color, and serve rural communities—are in a more disadvantageous position for such navigation. In absence of other federal guidance, this policy group distinguished in a public letter what its members regarded as **permissible vs. not permissible CM practices**:

Permissible as CM Practices	
A	Use of rewards with direct connection* to care coordination and management of targeted clients, to include for participation in community-based services recommended by the licensed health provider
B	Use of rewards via digital health technology (e.g., remote patient monitoring and telehealth)
C	Use of rewards only when the desired health outcome occurs, and for which objective and validated measures consistent with treatment are available (e.g., attendance, abstinent drug tests, and other confirmed behavioral measures)
D	Use of rewards to advance treatment goals, as determined by the licensed health provider, including: (i) adherence to a treatment regimen; (ii) adherence to a drug regimen; (iii) adherence to a follow-up care plan; (iv) management of a disease or condition; (v) improvement in measurable evidence-based health outcomes for the client or targeted client population; or (vi) ensuring client safety
Not Permissible as CM Practices	
A	Use of rewards that result in medically unnecessary or inappropriate items or services reimbursed in whole or in part by a federal health care program
B	Advertisement of the availability of rewards as means either to recruit clients, or to steer clients away from other health care providers
C	Use of rewards for the purpose of increasing fees
D	Use of rewards with inadequate protection against fraud

*A direct connection is that which empowers clients to fully participate in care coordination activities, including appointment attendance, medication self-administration, substance testing results, community reinforcement participation, cognitive behavioral therapy effort, and peer recovery coaching participation.

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Beyond the consensus its members reached about permissible CM practices, the national policy group also outlined a list of **guardrails to be implemented to protect against fraud and abuse**—some of which bear directly on documentation practices. Their full list of guardrails is provided below:

- Research-validated evidence-based practices
- Formal implementation using a written protocol
- Rewards should not exceed $200/month/per patient
- Each patient must have a documented clinical diagnosis
- Each patient's care plan must be documented in the record by a licensed health care professional/clinician
- Individualized care plans should document specific behavioral targets, amounts and schedules
- For each patient, a complete, written accounting of every payment, its purpose, the related behavioral expectation and the patient's actual effort for which the reward has been received
- For example, the documentation should specifically record the appointments expected and attended, each substance test that was expected and whether the result was consistent or inconsistent with the intended medical expectations (i.e., harm reduction, abstinence and/or adherence to any medications that have been prescribed). Gift or monetary incentives and their distribution must be accurately inventoried
- Ongoing attention to and audit-ready processes for backroom functions (e.g., electronic health records, attendance records, established accounting procedures, etc.)
- Clear protections to avoid using incentives for recruitment (e.g., no advertisements) or suggestions of rebates, refunds, or kick-back offers

While intended as provisional until greater clarity is provided by federal entities, these guardrails offer needed **guidance and recommended documentation practices** for community settings seeking to implement CM programming. It is hoped that this:

1) Enables treatment settings to make **informed decisions** about whether to implement CM programming;
2) Prepares setting personnel to **undertake documentation practices** with appropriate rigor (e.g., specifying a setting's CM protocol in writing, documenting individual client efforts to demonstrate a targeted treatment-adherent behavior, keeping auditable records of the distribution of earned rewards as 'payments'); and
3) Fosters both **innovation and collective growth** in the national dissemination of CM to the treatment community.

Finally, it bears mention that guidance on documentation practices **may change rapidly** in the current healthcare environment, as efforts are underway to prompt federal entities like the Office of National Drug Control Policy and Department of Health and Human Services to jointly establish a more definitive set of safeguards and best practices against fraud and abuse. Accordingly, it is strongly recommended that community settings seeking to implement CM **consult with relevant federal and state entities** to ensure compliance with any newly-emerging standards of practice for CM implementation.