ATTUNOVA BY THE COMPLIANCE CONSORTIUM

CLINICAL DOCUMENTATION GUIDANCE MANUAL

DOCUMENTATION DOMAIN SPINE

Public Edition

Document	TCC-CDGM-SPINE-01-P
Version	1.0 — LOCKED
Locked	2026-09-01
Author	D. Derek Jones, PhD, CFE, ICA Fellow
Standing	Controlling structural specification. The Federal Core and every state module of the Clinical Documentation Guidance Manual are built to answer this document and no other.

1. WHAT THIS DOCUMENT IS

This is the structural specification behind the Clinical Documentation Guidance Manual. It defines eleven documentation domains and, within each, a numbered set of questions. Every product in the line answers these questions and only these questions.

The Federal Core answers all eleven domains once, at the federal baseline, across four service lines. Each state module answers the same eleven domains again for one jurisdiction, across the payer contexts in force there. Because the questions do not change, two modules for different states remain readable side by side, and a requirement is answered in one place rather than scattered across a reference book.

We publish this specification for a plain reason. A documentation manual is worth buying only if you know what it undertakes to answer. This document says so in full, before you order anything. It also lets an organization use the question set on its own — as an internal audit instrument, as a gap analysis against existing policy, or as a structure for questions put to a payer or an EHR vendor. That use is welcome.

What this document does not contain is the answers. Those are the manual, and each one is verified against primary authority, cited, and dated.

2. HOW A DOMAIN IS READ

Each domain below carries five fixed parts. Scope states what the domain governs. Exclusions state what it does not, so that a requirement is answered once and in one place. Questions are the numbered response set. Expected authority names the bodies of law and policy a verification pass must reach before an answer is written. The finding records what the domain exists to prevent, drawn from audit experience rather than from the regulations, and it travels with the domain into every module.

A question is answered for a given service line within a given payer context. An answer that is not supported by a citation to primary authority, with an effective date, is not an answer and does not ship.

3. SERVICE LINES

The Federal Core answers every domain against each of the following. Where a domain question does not apply to a service line, the response status is recorded rather than the question omitted.

Code	*Service line*	*Scope*
SL-PSY	Psychiatry	Outpatient psychiatric evaluation, medication management, and psychotherapy rendered by licensed behavioral health practitioners.
SL-SUD	Substance Use Disorder Treatment (OBOT)	Office-based outpatient treatment, including buprenorphine prescribing outside an opioid treatment program.
SL-OTP	Opioid Treatment Program	Services rendered under an OTP certification, including methadone and program-dispensed buprenorphine.
SL-CCB	CCBHC	Services rendered by a Certified Community Behavioral Health Clinic under the certification criteria and its payment methodology.

4. PAYER CONTEXTS

The federal baseline is answered once and is not repeated in state modules. State modules answer the remaining contexts as they apply in that jurisdiction.

Code	*Payer context*	*Treatment*
PC-FED	Federal baseline	The federal floor. Answered once in the Federal Core; not re-answered in state modules.
PC-MCD	State Medicaid (fee-for-service)	The state plan and its published provider guidance.
PC-MMC	Managed Medicaid	Answered per contracted MCO as a delta against PC-MCD, never as a standalone treatment.
PC-MA	Medicare Advantage	Answered per plan, nationally scoped. Risk adjustment and chart review govern; state law generally does not.
PC-PPS	CCBHC payment methodology	PPS-1 or PPS-2 as applicable to the state's demonstration or grant track.

Two boundaries are set here and are not renegotiated per module. Managed Medicaid is answered as a delta against the state fee-for-service answer, never as a standalone treatment of all eleven domains; a state with five contracted plans yields a delta table, not five manuals. Medicare Advantage is not a state-specific context: its requirements arise from plan policy and risk adjustment rather than from state law, and it is answered nationally with a plan matrix.

5. RESPONSE STATUS VOCABULARY

Every answer carries exactly one status. The vocabulary is closed. It exists so that a module can be largely deltas without becoming ambiguous, and so that an absence of published authority is recorded as a dated finding rather than passed over in silence.

Status	*Meaning and drafting obligation*
ADOPTS_FEDERAL	The jurisdiction or payer applies the federal answer without modification. No further text required; the Federal Core answer governs.
MORE_RESTRICTIVE	The jurisdiction or payer imposes a requirement above the federal floor. Full answer text required.
DIFFERS	The requirement is structurally different rather than simply stricter. Full answer text required.
SILENT	No published authority located. Requires a statement of what was searched and the date searched.
NOT_APPLICABLE	The domain question does not apply to this service line in this payer context. Requires a one-line reason.

Where a state or payer requirement conflicts with the federal answer, the more restrictive requirement governs and the module says so at the point of conflict.

6. THE ELEVEN DOCUMENTATION DOMAINS

D01. WHO MAY RENDER, AND SUPERVISION

Scope. The identity, licensure, and credentialing of the rendering practitioner, and the documentation that establishes supervision where the practitioner is a trainee, an unlicensed associate, or a practitioner billing under another's identifier.

Exclusions. Employment status, contracting, and credentialing with the payer as an administrative matter.

Questions.

- D01.1 Which license types, credential levels, and registrations may render this service?
- D01.2 For each unlicensed, associate, or trainee category, what level of supervision is required — general, direct, or personal presence?
- D01.3 What must the supervising practitioner's documentation contain, and where in the record must it appear?
- D01.4 What must the supervisee's own note contain to attribute the service correctly?
- D01.5 Is countersignature required, by whom, and within what timeframe?
- D01.6 Are trainee-rendered services separately billable, and under whose identifier?
- D01.7 What distinguishes teaching-physician rules, incident-to billing, and clinical supervision of unlicensed behavioral health trainees in this context?

Expected authority. 42 CFR Part 415 (teaching physician); Medicare Benefit Policy Manual Ch. 15 (incident-to); 42 CFR Part 8 (OTP staffing); state practice acts and behavioral health agency licensing rules.

Finding. This domain carries the highest refund exposure of the eleven. Teaching physician rules, incident-to billing, and clinical supervision of unlicensed behavioral health trainees are three distinct frameworks, and organizations routinely collapse them into a single attestation box. They are answered separately here because they are separate in law.

D02. SERVICE DEFINITION AND BILLABILITY

Scope. What the service is as a matter of governing authority, and what must have occurred for it to be billable at all.

Exclusions. Code selection, which is D11, and the note's contents, which are D03.

Questions.

- D02.1 How is the service defined by the governing authority?
- D02.2 What are the minimum components that must be present for the service to have occurred?
- D02.3 What activities are excluded — clinically valuable but not constituting the billable service?
- D02.4 What place-of-service and setting restrictions apply?
- D02.5 What frequency, duration, or annual limits apply before prior authorization is required?

D02.6 May this service be billed on the same date as the core services of each other service line, and what documentation supports the separation?

D02.7 What is bundled into the service and therefore not separately billable?

Expected authority. State plan service definitions; SAMHSA 42 CFR Part 8 program requirements; CCBHC certification criteria; payer provider manuals.

Finding. Same-day billing across service lines is the question most often answered wrong in integrated settings. It is answered as a grid rather than as prose, because prose is where the exceptions get lost.

D03. REQUIRED NOTE ELEMENTS

Scope. The contents of the encounter record itself.

Exclusions. Assessment and treatment plan documents, which are D05.

Questions.

D03.1 What elements must every note of this service type contain?

D03.2 Which elements are required by federal authority, which by payer policy, and which by accreditation?

D03.3 Is a specific note format or structure prescribed, and if so by whom?

D03.4 What content, if present, creates audit exposure — cloned text, unsupported template language, conclusory statements without support?

D03.5 What is the minimum standard for linking the note to the active treatment plan?

D03.6 What must a group service note contain that an individual note need not?

D03.7 What is a compliant and a non-compliant example of each required element for this service line?

Expected authority. Payer provider manuals; state behavioral health agency documentation rules; accreditation standards; OIG audit findings.

Finding. Prose descriptions of note requirements do not change provider behavior; paired specimens do. Every answer in this domain carries a compliant and a non-compliant example for that reason.

D04. TIME, UNITS, AND ROUNDING

Scope. How the quantity of service is measured and recorded.

Exclusions. The rate paid for the unit, which is a fee schedule matter.

Questions.

D04.1 Is the service time-based, unit-based, encounter-based, or bundled into a periodic episode?

D04.2 What activities may be counted toward the time, and on what date must they occur?

D04.3 What activities may not be counted?

D04.4 What are the threshold times or unit boundaries, and what rounding convention applies?

D04.5 How must time be recorded — start and stop, total minutes, or attested range?

D04.6 How is a service that crosses midnight or spans multiple contacts on one date handled?

D04.7 What is the documentation standard when two practitioners contribute time to one service?

Expected authority. CPT time rules; CMS transmittals; 42 CFR Part 8 weekly bundled episode structure; state unit definitions.

Finding. Opioid treatment programs break the pattern of this domain. The weekly bundled episode is neither time-based nor unit-based in the ordinary sense, and the questions are answered against the episode rather than the encounter.

D05. ASSESSMENT AND TREATMENT PLAN

Scope. The documents that authorize a course of treatment and the cadence at which they must be refreshed.

Exclusions. The individual encounter note, which is D03.

Questions.

D05.1 What assessment must precede the service, performed by whom, and within what timeframe of admission or first contact?

D05.2 What must the treatment plan contain?

D05.3 Who must sign the plan, and is patient or guardian signature required?

D05.4 What is the review cadence, and what events trigger an off-cycle review?

D05.5 What must a plan review document in order to be adequate?

D05.6 What is the consequence for services rendered while the plan or assessment was lapsed?

D05.7 What is required to document discharge, transfer, or unplanned termination?

Expected authority. State plan and behavioral health agency rules; 42 CFR Part 8 for OTP; CCBHC certification criteria; accreditation standards.

Finding. Services rendered under a lapsed plan or assessment drive more recoupment than any other item in this domain, and the question is frequently absent from vendor documentation guidance. It is answered explicitly here, including whether a lapse can be cured after the fact.

D06. MEDICAL NECESSITY

Scope. What the record must show to establish that the service was warranted, at the outset and over time.

Exclusions. Prior authorization mechanics, which are D02.

Questions.

D06.1 What is the applicable medical necessity standard, and what is its source?

D06.2 What must the record show to establish medical necessity for this service?

D06.3 How is continued-service or continued-stay necessity documented over time?

D06.4 What diagnostic specificity is required, and how must the diagnosis link to the service billed?

D06.5 What is the documentation standard when the service is preventive, screening, or early intervention rather than treatment?

D06.6 What are the most frequent medical-necessity denial rationales for this service line, and what documentation defeats each?

D06.7 How is medical necessity documented for a service that continues at a stable level for an extended period?

Expected authority. State plan medical necessity definitions; ASAM criteria where adopted; payer clinical policy; MA plan coverage policy.

Finding. Documentation for the long-stable patient is the weakest point in behavioral health records, and it is where auditors look first in maintenance populations. A note that reads the same as the note from eighteen months earlier establishes very little.

D07. TELEHEALTH AND AUDIO-ONLY

Scope. Delivery of the service other than in person, and the documentation particular to that modality.

Exclusions. Technology and platform security, which is a HIPAA Security Rule matter outside this manual.

Questions.

D07.1 Which services may be delivered by two-way audio-video, and which by audio only?

D07.2 What originating-site and distant-site requirements apply?

D07.3 What modality and consent elements must appear in the note?

D07.4 What patient-location and practitioner-location documentation is required?

D07.5 What differs for buprenorphine initiation and for OTP services delivered remotely?

D07.6 What flexibilities are time-limited, and what are their stated expiration dates?

D07.7 What in-person examination requirement, if any, attaches before or during remote treatment?

Expected authority. 42 CFR Part 8 as amended 2024; DEA telemedicine rules; CMS telehealth list; state telemedicine statutes and Medicaid policy.

Finding. Every answer in this domain carries expiration risk. Each is recorded with an explicit sunset date where one exists, and this is the first domain re-verified at each annual update.

D08. SIGNATURE, AUTHENTICATION, TIMELINESS, AND AMENDMENTS

Scope. How a record is finalized, and how it may be changed afterward.

Exclusions. Retention, which is D10.

Questions.

D08.1 What constitutes a valid signature, and what additional requirements attach to electronic signature?

D08.2 Within what timeframe must a note be signed or closed?

D08.3 What is the standard for a late entry, and how must it be identified?

D08.4 How must an amendment, correction, or deletion be made and displayed in the record?

D08.5 What audit-trail and metadata requirements attach to the electronic record?

D08.6 How is an unsigned or unlocked note treated when identified during an audit?

D08.7 What is the standard for a scribe or delegated documentation entry?

Expected authority. Medicare Program Integrity Manual Ch. 3; state record-keeping rules; accreditation standards; EHR certification criteria.

Finding. The amendment rules are how a well-intentioned correction becomes a fraud allegation. This domain is answered in mechanics rather than principles, because the mechanics are what the audit trail preserves.

D09. CONSENT, RELEASE OF INFORMATION, AND 42 CFR PART 2

Scope. The authority to create, hold, and disclose the record, with particular attention to substance use disorder records.

Exclusions. Consent to treatment as a clinical matter.

Questions.

D09.1 Which records are Part 2 records, and what makes a program a Part 2 program?

D09.2 What consent elements are required for disclosure, and how do they differ from a HIPAA authorization?

D09.3 What redisclosure notice must accompany a disclosure, and in what form?

D09.4 What documentation of consent must be present in the record itself?

D09.5 What governs disclosure to payers, to care coordination partners, and in response to subpoena or court order?

D09.6 What consent rules apply to minors, and how is the determination documented?

D09.7 How is the record segmented when a single organization holds both Part 2 and non-Part 2 records?

Expected authority. 42 CFR Part 2 as aligned with HIPAA; 45 CFR Parts 160 and 164; state minor consent statutes; state health information privacy law.

Finding. Segmentation is the question integrated organizations actually face when a single entity holds both Part 2 and non-Part 2 records, and it is usually missing from documentation guidance altogether.

D10. RETENTION, SELF-AUDIT, AND AUDIT RESPONSE

Scope. What happens to the record after the encounter, and what the organization must be able to produce and demonstrate.

Exclusions. Litigation strategy and legal representation.

Questions.

- D10.1 How long must records be retained, and from what triggering date?
- D10.2 What format and accessibility standards apply to retained records?
- D10.3 What self-audit, monitoring, or internal review is required or expected of the organization?
- D10.4 What must be produced on a records request, and within what timeframe?
- D10.5 What is the process and documentation for a self-identified overpayment, and what is the repayment deadline?
- D10.6 What documentation supports an appeal of an adverse audit finding, and at what level?
- D10.7 What must the organization retain to evidence that it trained its workforce on these requirements?

Expected authority. 42 CFR 401.305 (60-day overpayment rule); state retention statutes; payer contract audit provisions; OIG compliance program guidance.

Finding. The final question closes the loop back to workforce training. Retention and audit response are where a compliance program is judged as a program rather than as a collection of individual records.

D11. CODE SETS AND PAYER OVERLAY

Scope. The translation between the service as documented and the claim as submitted.

Exclusions. Rates and fee schedule amounts, which belong in the state module appendices.

Questions.

- D11.1 Which code sets govern this service, and what is the current version and effective date of each?
- D11.2 What are the core codes for this service line, and what documentation supports each?
- D11.3 Which modifiers apply, and who in the organization is responsible for applying them?
- D11.4 What are the annual update cycles, and what are the mandatory review trigger dates?
- D11.5 Where does payer policy diverge from the federal or CPT definition of the code?
- D11.6 What is the crosswalk between the service as documented and the code as billed?
- D11.7 Which codes on this list require prior authorization in this payer context?

Expected authority. CPT; HCPCS Level II; ICD-10-CM; CMS quarterly updates; payer fee schedules and provider manuals.

Finding. Review trigger dates are recorded as data rather than as prose. The October 1 ICD-10-CM cycle and the January 1 CPT cycle are standing review obligations for every module built to this specification.

7. CHANGE CONTROL

This specification is locked at version 1.0 as of 2026-09-01. The following changes are version events and require a version increment, a dated change record, and a re-issue of every module in circulation.

- Adding, removing, or renumbering a domain.
- Adding, removing, or renumbering a question within a domain.
- Changing the meaning of a status in the closed vocabulary of Section 5.
- Adding or removing a service line or a payer context.

The following are not version events and may be made without incrementing this document: correcting an expected-authority citation, clarifying a finding, and correcting typographical error.

Two review triggers are standing obligations of every module built to this specification: the October 1 ICD-10-CM annual cycle and the January 1 CPT annual cycle. A module that has not been reviewed against the most recent of these is out of date on its face and is not delivered under a current effective date.

8. THE MANUAL BUILT TO THIS SPECIFICATION

The Clinical Documentation Guidance Manual — Federal Core answers all eleven domains at the federal baseline across psychiatry, substance use disorder treatment including buprenorphine, opioid treatment programs, and CCBHC. State modules answer the same eleven domains for one jurisdiction across state Medicaid, managed Medicaid, and Medicare Advantage, and are produced on order. Washington is the first.

Licensed annually with update rights, because the requirements this specification organizes do not sit still.

The Compliance Consortium LLC · DrDJ@TheComplianceConsortium.org · attunovahq.com