Policy & Procedure

POLICY: #442– Documentation and Authentication of Services and Billing

SECTION: Service Provision

MAINTAINED BY: QI Director

APPLIES TO:
- ☐ OnPoint Board of Directors
- ☒ OnPoint Staff
- ☒ Contracted Providers
- ☐ Other: _____

Approved By: _____
Chief Executive Officer

Approved By: _____
Medical Director (if applicable)

First Effective: 03/1999
Last Revised: 01/2026

PURPOSE

To ensure that complete, accurate, and timely documentation occurs for services provided, it is expected that staff and provider agencies follow established time frames for documentation and billing.

DEFINITIONS

Direct services – services that are provided face-to-face with or without the client present, depending on the service and billing code. Telehealth video and audio only may be considered direct service in some instances.

Indirect services – services that include discussions with other professionals or agencies involved in the case, consultation with family members, phone calls, etc.

POLICY

A) All OnPoint, direct hire and contract provider staff, are responsible for the timely and accurate ongoing documentation of services provided. Documentation must:
   1. demonstrate medical necessity,
   2. be legible, including signature and credentials,
   3. include date of service and start and stop times, as appropriate,
   4. include what service was provided and how the individual responded to that service,
   5. explain what goals, objectives, and interventions are being worked on, refer to the IPOS,
   6. include whether the individual is making progress toward the goal addressed during the contact,
   7. support continued need and clinical justification for services,
   8. NOT include copy and paste (also called cloning or copy forward of clinical information), with the exception of physician and Advanced Practice Providers (APP) who utilize a transcription service, or use of information from an OnPoint approved clinically assisted note taking program or other AI approved tool.
   9. be completed and signed timely by the person who provided the service,
   10. support the foundation for coding, reporting, and billing of the service.

B) Direct services will be documented within the Electronic Health Record (EHR) by all OnPoint staff and authorized contract provider agencies.

C) Indirect services are documented within the EHR on a contact/non-billable/miscellaneous note.

D) When a service note is signed, the author is attesting to the accuracy of the service time and content of the note. If a proxy is used for entries into the EHR, the proxy assures accuracy of information that is entered on behalf of the author, and the author authenticates by signature.

E) If an OnPoint approved clinical assisted note taking program or other approved AI tool is used to

generate the documentation, the documentation will be reviewed by the service delivery provider for accuracy and corrected as needed. The signature of the provider indicates the note accurately reflects the service provided.

F) Transcription for the psychiatrists and APPs is expected to be returned for review and signature within 24 hours of the service being provided. The psychiatrists and APP are expected to review and sign on the next workday.

G) If a contract provider has an EHR other than CRANE they may use their agency's EHR for documentation. However, the Contract Provider shall allow designated OnPoint staff access to an audit account in its EHR for the purpose of monitoring service documentation. Contract Providers who document in their own EHR shall submit supporting documentation with invoices/claims.

H) The following times must be adhered to. If unforeseen circumstances arise that do not allow meeting the standards set below, a plan for timely completion must be developed with the OnPoint supervisor.

I) Documentation is not "complete" until all required signatures are obtained.

Document	When to Complete	Time Frame to Complete Documentation	Billing Information/Date
Initial Biopsychosocial (BPS) Assessment	New client to agency	No later than 3 business days after the date the client was seen for the Initial BPS.	Date individual was seen for assessment appointment. If assessment takes more than one session to complete, bill for date completed.
Updated BPS Assessment	• An Updated BPS should be done when there is a change in need, level of care, and/or services at a time outside of the annual BPS/IPOS workflow. • Carrying forward of medical and/or psychiatric history only may be appropriate, as long as additional information from the current year is included, as well. • An IPOS Addendum must be used to update the IPOS, or a new IPOS completed, if the Updated BPS necessitates changes to the service plan. • Should ONLY be used AFTER an initial or annual IPOS has been completed. • Must be completed if more than 90 calendar days have passed since the Initial BPS. • If the annual BPS is due within 90 calendar days, complete the annual BPS instead of an update. • An updated Assessment DOES NOT change the due date of annual paperwork.	• Within 7 business days after the assessment appointment	• Date individual was seen to gather updated information. Report actual direct service time. If assessment update takes more than one session to complete, bill for date completed.

Document	When to Complete	Time Frame to Complete Documentation	Billing Information/Date
Annual BPS Assessment	• At least once per year, but no more than 365 days from the Initial BPS or most recent Annual BPS • BPS must include a thorough review of all information in the previous assessment. Updates to the new assessment must be made, where appropriate. • Carrying forward medical and/or psychiatric history only may be appropriate, provided any information from the current year is also included.	• Within 7 business days of the appointment	• Bill for date individual was seen to review assessment. Report direct time with individual. • If assessment completion requires multiple sessions, bill for date completed. • If previous information is used to populate the annual BPS and individual is not seen specifically to complete the assessment, this is not a billable service.
Other Assessment	• Initially when referral is made (i.e. OT, Speech, ASAM-C, etc.) • Within 365 days of last assessment • Some assessments may be completed more frequently, as authorized • Some assessments require a physician prescription, per the Medicaid Provider Manual or commercial insurance	• Within 7 business days of the appointment	• Date individual was seen to gather/update information. Report direct service time. • If assessment update takes more than one session to complete, bill for date completed. • Report actual direct service time if not an encounter code, i.e., ABA Behavioral Follow-up Assessment.
Individual Plan of Service (IPOS)	<u>New Clients:</u> • An initial ("preliminary") IPOS shall be developed within 7 business days of the start of services (at time of assessment) or, if an individual is hospitalized for less than 7 days, before discharge or release. • A preliminary IPOS is only effective for up to 30 days, with potential for up to two (2) 30-day extensions. • A comprehensive IPOS must be completed prior to initial IPOS expiration or within 90 days of BPS to avoid a lapse in service. <u>Existing Clients:</u> • An annual IPOS must be completed within 90 days of the BPS and prior to expiration of the current IPOS to avoid any lapse in service. • An IPOS must be reviewed and updated at least annually and is effective for no more than 365 days.	• Preliminary IPOS: within 7 business days of appointment. • Client/guardian signature must be obtained immediately as IPOS is not valid without signature. Efforts to obtain client/guardian signature must be documented in the record and continue until signature is obtained. • A copy of the written IPOS must be given to clients within 15 business days of the person-centered planning meeting which develops/amends the IPOS and be reflected in the record.	Date that staff and individual completed the IPOS. Report direct start and stop service time.

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Periodic Reviews	• BC-OPC and receiving psychotherapy – every 90 days from IPOS or last Periodic Review. • ACT – at least quarterly following IPOS and/or at consumer request. • Formal periodic reviews must occur at the frequency determined by the individual during the person-centered planning process. • Periodic reviews for those with guardians must include both the individual and guardian. • IPOS must be reviewed and revised upon reassessment of functional need (at least every 12 months), which can be initiated by request of the individual or when needs change significantly. • Individuals, their guardians, and authorized representatives may request an IPOS review at any time.	• Within 3 business days of date due • Obtaining client/guardian signature is to be done immediately.	• Bill for date of service or date completed. • If periodic review is completed using information and knowledge gathered throughout the review period without the individual present, the service is not billable.
Crisis Note	At time of crisis service.	Within 24 hours of contact	Bill for date and time spent directly with individual.
Pre-Screens	At time of preadmission screening.	Within 48 hours of contact	Bill for date and time spent directly with individual
Service Notes (OnPoint)	Whenever a face-to-face ongoing appointment occurs (not assessments, etc.)	Within 2 business days of contact.	Bill for date and time spent directly with individual. Appointment status must be changed from “Scheduled” to “kept” (with correct start/stop times), Cancelled, or No Show.
Residential Service Notes/Logs (Provider Agency)	Whenever a face-to-face service is provided.	• Within 48 hours of service delivery, including signature. • If logs are entered by a proxy, direct care staff must complete original notes at time of service. • Documentation must be electronically submitted prior to or at the time of claim submission; all services for the previous fiscal year must be entered by October 31. See Policy 713 for detail.	Bill for the direct time with the individual. Reference Policy 301 for more detail.

Document	When to Complete	Time Frame to Complete Documentation	Billing Information/Date
CLS, Respite, Skill Building Service Notes (Provider)	Whenever a face-to-face service is provided.	• Within 2 business days of date of service, including signature. • If logs are entered by a proxy, original notes must be completed by direct care staff at time of service. • Documentation must be electronically submitted prior to or at the time of claim submission; all services for the previous fiscal year must be entered by October 31. See Policy 713 for detail.	• Bill for the direct face-to-face time with the individual. • Documentation must include start and stop time for each service, as appropriate. • Provider shall have 60 days to resubmit any denied claims after notification through the EHR of denied claims.
Indirect/Non-billable Notes	Whenever an indirect service is provided.	Within 2 business days of contact	Date of contact and start/stop time must be documented, though time is not billable.
Notices of Adverse Benefit Determination (NABD)	Adequate Notice: provided when a requested service is denied or limited, an authorization decision is not made within the required 14-day timeframe (72 hours for expedited requests), or for denial of payment for a claim	Within 14 days of standard requests for service authorization (72 hours for expedited requests), or at time of action for denial of payment for a claim	Not billable See Policy #1103 Grievance and Appeals of Supports-Service
	Advance Notice: provided for the imminent suspension, reduction, or termination of any previously authorized/currently provided service(s).	At least 10 days prior to the proposed effective date of the changes	
Psychiatric Evaluation	At the time of first appointment with the psychiatrist.	• Completed immediately following the service. • Transcription is to be entered into record within 2 business days of appointment and reviewed/signed by physician within 7 business days.	• Bill for the direct time with the individual and medical decision making. • Documentation must include date and start and stop time as per code.
Updated Psychiatric Evaluation	As medically necessary or clinically appropriate or as part of a post-hospitalization discharge	• Completed immediately following the service. • Transcription is to be entered into record within 2 business days of appointment and reviewed/signed by	• Bill for the direct time with the individual. • Documentation must include date and start and stop time as per code.

Document	When to Complete	Time Frame to Complete Documentation	Billing Information/Date
		physician within 7 business days.	
Medication Reviews	• When ongoing services are provided by the psychiatrist or APP. • Medication Reviews must be completed at least every 90 days.	• Completed immediately following providing the service. • Transcription is to be entered into record within 2 business days of appointment and reviewed/signed by provider within 7 business days.	• Bill for the direct time with the individual. • Documentation must include date and start and stop time as per code.
Transfer Document (Internal Referral Form)	When there is a transfer from one primary staff to another.	Prior to any service being billed by new staff.	Not billable
Discharge Summary	Whenever ALL OnPoint services are being discontinued and after an Advance/Adequate Notice has been sent and 14 calendar days have transpired.	Discharge Summary to be completed within 14 calendar days of the discharge date, which should be 14 calendar days after Advance/Adequate Notice was sent.	Not billable

REFERENCE(S)
List relevant references and source document(s) of policies here (one reference per row)

ATTACHMENT(S)
List associated attachments, forms, job aids, and instructional guides here (one attachment per row)