

RPMS Behavioral Health System Outpatient Services

Documentation Recommendations

I. Referral/Screening

Type of Visit: INFORMATION/CONTACT VISIT
Type of Contact: OUTPATIENT or SCHOOL or JAIL, etc.
Activity Code: 11-SCREENING (patient present)
44-SCREENING (patient not present)
Document: POV
Case Status: CASE OPEN

II. Assessment/Initial Visit

Type of Visit: REGULAR
Activity Code: 12-ASSESSMENT
Type of Contact: OUTPATIENT or SCHOOL or JAIL, etc.
Document: POV, Patient Education, Medications, Health Factors, GAF, Staging Tool,
Summary of Intake
*Personal History Factors need to be entered, if any
**Case Staffing – assign to a Designated Provider at weekly meeting
**Within three visits with assigned provider, create an initial treatment plan

III. On-going Treatment

A. INDIVIDUAL COUNSELING SESSION

Type of Visit: INFO/CONTACT- No Patient Education/Medications
BRIEF VISIT-Medications
REGULAR VISIT-Patient Education, Medications, or Health Factors
Activity: 13-INDIVIDUAL COUNSELING
Document: POV, Case Notes

B. GROUP SESSION

Type of Contact: OUTPATIENT
Type of Visit: GROUP VISIT
Activity: 91-GROUP COUNSELING
Other codes as appropriate
Document: POV, Case Notes
*Need to use same POV descriptions to identify the type of group

C. CASE MANAGEMENT

Type of Visit: INFORMATION/CONTACT

Activity: 22-CASE MANAGEMENT (PATIENT PRESENT)

31-CASE MANAGEMENT (PATIENT NOT PRESENT)

D. NO-SHOWS

Type of Visit: BRIEF VISIT

Activity: 31-CASE MANAGEMENT (PATIENT NOT PRESENT)

Document: POV, Case Notes

* If Case Management, Patient Not Present isn't a billable service, consider using the No Show Visit Type.

E. MEDICATION MANAGEMENT

Type of Visit: REGULAR

Activity: 16 – MEDICATION MANAGEMENT (PATIENT PRESENT)

26 – MEDICATION MANAGEMENT (PATIENT NOT PRESENT)

Document: POV, Case Notes, Rx Notes, Patient Education (BH-MEDS)

F. CRISIS INTERVENTION

Type of Visit: REGULAR

Activity: 48 – CRISIS INTERVENTION (PATIENT PRESENT)

49 – CRISIS INTERVENTION (PATIENT NOT PRESENT)

Document: POV, Case Notes, Rx Notes

* Treatment plans are documented on the Treatment Plan tab or menu option. An individual encounter form should also be completed to document the treatment planning activity. Follow local standards and policies on timeframes for establishing and reviewing treatment plans.

IV. Discharge/Final Visit

Type of Visit: REGULAR

Activity Code: 19 - DISCHARGE PLANNING (PATIENT PRESENT)

28 - DISCHARGE PLANNING (PATIENT NOT PRESENT)

Document: POV, Patient Education, Medications, Health Factors, GAF, Staging Tool, Placement Disposition, CD Data

Case Status: CLOSED

* Resolve/close out treatment plan; close out Case Status

**Remove designated providers from patient information

V. Administrative Documentation

Type of entry: ADMINISTRATIVE ENTRY
Activity Codes: Any other than Patient Services
Document: Administrative Problem Codes (95-99), Comments

VI. Prevention Activity Documentation (Use BHS v3.0, SDE Option on DE menu)

Type of entry: AN, ADD NON-PATIENT RECORD
Activity Codes: 37 - Preventive Services
97 - Health Promotion
Document: POV, Prevention Activity, Target Audience

Reports Management

I. Patient Listings

- A. DP - Designated Provider List
- B. PPL - Placements by Site/Patient
- C. REV & TPR - Print list of treatment plans needing review/resolved
- D. TCD - Tally of Cases Opened/Admitted/Closed

II. Records Retrieval

- A. GEN - General Retrieval Records

III. Workload Reports

- A. GRS1 – Activity Report
- B. ACT – Activity Record Counts
- C. FACT – Frequency of Activities

IV. Problem Reports

- A. FPRB -Frequency of Problems by Problem Code Groupings
- B. ABU- Abuse Report (Age & Sex)
- C. SSR – Standard Aggregated Suicide Report

Manager Utilities Settings

Export Utilities

CHK - Check records before exporting

GEN - Generate monthly exports

Local Service Sites

ELSS - Add any local service sites where services are provided

Personal History Factors

EPHX - Add any personal history factors, as needed