Table of Contents

Transaction: ASAM Placement 2
Transaction: Authorization Request 12
Transaction: Batch Footer 24
Transaction: Batch Header 25
Transaction: CALOCUS 26
Transaction: Case Manager Contact Information 40
Transaction: Case Manager Link 44
Transaction: Children's Functional Assessment Rating Scale 47
Transaction: Client Demographics 51
Transaction: Conditions at Assessment 74
Transaction: Co-Occurring Disorders Assessment 87
Transaction: Co-Occurring Disorders Screening 89
Transaction: CPT Service Detail 93
Transaction: Crisis Diversion Services 112
Transaction: Diagnosis ICD-10-CM 118
Transaction: Disability 122
Transaction: Dynamic Client Data 127
Transaction: HIPAA Health Care Claims 837 Professional 142
Transaction: Income Category 143
Transaction: Key Dates 146
Transaction: LOCUS 150
Transaction: Medicaid Coverage 162
Transaction: MHRM Summary 170
Transaction: Mobile Crisis Team Intervention 174
Transaction: Notice of Exit 181
Transaction: Problem Severity Summary 195
Transaction: PSS-I Symptoms 200
Transaction: PSS-I Trauma History 206
Transaction: Program Referral 214
Transaction: Residential Absence 224
Transaction: Residential Arrangement 229
Transaction: Residential Facility 237
Transaction: SED Functional Criteria 241
Transaction: SMI Functional Criteria 250
Transaction: Staff Person 255
Transaction: Staff Qualifications 263
Transaction: Substance Use 269
Transaction: Vulnerability Assessment Transaction 301
Transaction: Universal Attributes and Definitions 313

Transaction: ASAM Placement

Definition:
Use this transaction to report the ASAM (American Society of Addiction Medicine) placement level recommended by a qualified clinician who has assessed a client using The ASAM Criteria, Third Edition.

Required for:
SUD outpatient benefits
SUD residential
SUD detox
SUD OST
SUD assessment only

Procedure:
- When an authorization is in UA status, the Event Date must equal the authorization assessment date.
- Once an authorization goes to AA status, another ASAM Placement transaction may be submitted with a later event date.

Frequency:
Assessment
Intake
On change to planned level [not required to submit changes that are only to a dimension level for someone in on-going treatment]
Continuation of benefits
On exit

Transaction ID: 170.02

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	Y
Case ID	Text	10		Y
Event Date	Date (YYYYMMDD)	8		Y
Level Planned	Text	6	Y	Y
Dimension 1 ASAM Level	Text	6	Y	Y
Dimension 2 ASAM Level	Text	6	Y	Y
Dimension 3 ASAM Level	Text	6	Y	Y
Dimension 4 ASAM Level	Text	6	Y	Y
Dimension 5 ASAM Level	Text	6	Y	Y
Dimension 6 ASAM Level	Text	6	Y	Y
King County ID	Number	10		Y

History:
Significant changes were made to this transaction effective 6/15/2017:

- Revised the “Level” attribute name to “Level Planned” and modified the definition to clarify that this reflects the planned treatment. The basic meaning for this attribute have not changed from the from the 4/1/2016 data dictionary.
- Revised the list of ASAM Level Planned codes and levels to only include levels that are funded by the BHO.
- Replaced the ‘Risk Rating’ attributes for Dimensions 1 through 6 with new ‘ASAM Level’ attributes for Dimensions 1 through 6.
- Revised the list of ASAM Levels that may be submitted for Dimension 1 (Acute intoxication and withdrawal potential) to only allow code 0 for adolescents, and to only allow code 0 or “Withdrawal management” ASAM Levels for adults.
- Added OTP as an outpatient treatment level that may be submitted for Dimensions 2 through 6 and removed the “OST Indicator” attribute.
- Added documentation at the end of the transaction to describe the logic and data BHRD will use to derive an overall “ASAM Level Indicated” value from the submitted provider data for an individual on the event date and submit that value to the state.

Attribute: Level Planned

Transaction:
ASAM Placement

Definition:
Indicates the level of care that the clinician recommends for the client as a treatment placement at this time.

Procedure:
- Only levels that are eligible for BHO-funded services may be submitted.
- The Level Planned from an assessment will be used to validate the level(s) of care associated with the program code for an SUD authorization request with that assessment date. Levels accepted for each program code can be found in the sp_program_asam table in the BHO database.

Required Documentation:
Documentation of the planned ASAM level must be provided in agency records.

Type: Text (6)

Valid Codes	Definition	Program
0	No further ASAM placement level recommended.	
0.5	Early Intervention Services that explore and address any problems or risk factors that appears to be related to substance use and addictive behavior, and to help the individual recognize the harmful consequences of high-risk substance use and/or addictive behavior. Such individuals may not appear to meet the diagnostic criteria for a substance use disorder, but require early intervention for education and further assessment.	S02: Recovery Support OST: Opiate Substitution Treatment
1	Outpatient Encompasses organized outpatient treatment services which may deliver addiction, mental health treatment, or general health care personnel, including addiction –credentialed physicians, provide professionally directed screening, evaluation, treatment and ongoing recovery and disease management. This service is provided in regularly scheduled sessions of fewer than 9 contact hours for adults and fewer than six hours for adolescents per week.	S01: OP/IOP OST: Opiate Substitution Treatment
2.1	Intensive Outpatient Needs for psychiatric and medical services are addressed through consultation and referral arrangements. This service is provided in 9-19 hours of structured counseling and education about addiction-related and mental health problems per week.	S01: OP/IOP OST: Opiate Substitution Treatment

Valid Codes	Definition	Program
3.1	Clinically Managed Low Intensity Residential Services Directed towards applying recovery skills, relapse prevention, emotional coping strategies, promoting personal responsibility, and reintegration back into work, education, and family life while living in a 24-hour structured environment. This also includes at least 5 hours of professional addiction services per week. Often, consumers enter this level of care upon completion of or with ongoing treatment in other levels of service.	SRS: SUD Residential Treatment
3.3	Clinically Managed Population-Specific High Intensity Residential Services Consumers enter this level of service when the effects of substance use or other addictive disorder or a co-occurring disorder resulting in cognitive impairment on the individual's life are so significant and the resulting level of impairment is so great that outpatient motivational and/or relapse prevention strategies are not feasible or effective. Programming and staffing address more severe medical, emotional, cognitive, and behavioral problems. Case management provides a "wrap-around" service.	SRS: SUD Residential Treatment
3.5	Clinically Managed High Intensity Residential Services Assist individuals whose substance use is currently so out of control that they need 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. Treatment is specific to maintaining abstinence from substance use, arrest other addictive and antisocial behaviors, and effect change in participants' lifestyles, attitudes, and values. Preventing relapse while vigorously promoting personal responsibility and positive character change in an intense therapeutic community.	SRS: SUD Residential Treatment
3.7WM	Medically Monitored Inpatient Withdrawal Management Unlike Level 3.2-WM, this level provides 24-hour medically supervised withdrawal management services.	DTX: Detox

Attribute: Dimension 1-6 ASAM Level

Transaction:
ASAM Placement

Required Documentation:
- Documentation of the clinician's assessment on each dimension must be provided in agency records.
- During chart reviews, BHRD will only review documentation for its description of the clinical work and its support for the submitted "ASAM Level Planned" and the assessed level for each dimension.
- BHRD will not review documentation for the 'ASAM level indicated' value that BHRD will submit to the state after deriving a level from the individual dimension data and client age data.

Type: Text (6)

Dimension 1 ASAM Level

Definition:
Acute Intoxication and/or Withdrawal Potential

Procedure:
Withdrawal management codes will not be accepted for adolescents under 19 on the assessment date. Submit code 0 on Dimension 1.

Valid Codes	Adolescent	Adult	Definition
0			Place holder for people who are truly not at any risk
1-WM	This service is generally connected to additional adolescent focused youth services and is not a stand-alone level of care.	Ambulatory WM without Extended On-Site Monitoring	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery
2-WM	This service is generally connected to additional adolescent focused youth services and is not a stand-alone level of care.	Ambulatory WM with Extended On-Site Monitoring	Moderate withdrawal with all day withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal management

Valid Codes	Adolescent	Adult	Definition
3.2-WM	This service is generally connected to additional adolescent focused youth services and is not a stand-alone level of care.	Clinically Managed Residential WM	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery
3.7-WM	This service is generally connected to additional adolescent focused youth services and is not a stand-alone level of care.	Medically Monitored Inpatient WM	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring
4-WM	This service is generally connected to additional adolescent focused youth services and is not a stand-alone level of care.	Medically Managed Intensive WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability

Dimension 2 ASAM Level

Definition:
Biomedical Conditions and Complications

Dimension 3 ASAM Level

Definition:
Emotional, Behavioral, or Cognitive Conditions and Complications

Dimension 4 ASAM Level

Definition:
Readiness to Change

Dimension 5 ASAM Level

Definition:
Relapse, Continued Use or Continued Problem Potential

Dimension 6 ASAM Level

Definition:
Recovery/Living Environment

Common code list used for all Dimensions 2-6

Valid Codes	Adolescent	Adult	Definition
0			Place holder for people who are truly not at any risk
0.5	Early Intervention	Early Intervention	Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder
1	Outpatient Services	Outpatient Services	Less than 9 hours of services/week (adult); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies
2.1	Intensive Outpatient Services	Intensive Outpatient Services	9 or more hours of services/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
2.5	Partial Hospitalization Services	Partial Hospitalization Services	20 or more hours of services/week for multidimensional instability not requiring 24-hour care
3.1	Clinically Managed Low-Intensity Residential Services	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours clinical services/week
3.3	This level of care not designated for adolescent populations	Clinically Managed Population Specific High Intensity Residential Services	24-hour care with trained counselor to stabilize multidimensional imminent danger. Less intensive milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community
3.5	Clinically Managed Medium-Intensity Residential Services	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
3.7	Medically Monitored High-Intensity Inpatient Services	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimension 1, 2, or 3. 16 hour/day counselor ability

Valid Codes	Adolescent	Adult	Definition
4	Medically Managed Intensive Inpatient Services	Medically Managed Intensive Inpatient Services	24-hour nursing care daily physician care for severe, unstable problems in Dimension 1, 2, or 3. Counseling available to engage patient in treatment
OTP	Some OTPs not specified for adolescent populations.	Opioid Treatment Program (LEVEL 1)	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid disorder

Additional information on ASAM levels, dimensions and how BHRD will derive a summary 'ASAM Level Indicated' to submit to DBHR using the ASAM level of care data that providers report for each dimension:

1. Only the 'withdrawal management' levels and '0' (No ASAM placement level) may be used for Dimension 1, and that is the only dimension for which they may be submitted.

2. In using logic to derive an 'ASAM Level Indicated', the three residential/inpatient withdrawal management levels will rank above any treatment level, but any treatment level (1 – 4 or OTP/1) will rank above the two withdrawal management levels that are ambulatory.

3. The explicit 'withdrawal management' levels as placement levels do not apply to adolescents (under 19 on assessment date) because they do not exist as stand-alone levels of care with adolescents. BHRD IS will reject any WM level if submitted as the 'Level Planned' level for someone under 19 on the assessment date OR as the level for Dimension 1.

4. BHRD will identify the 'ASAM level indicated' by the assessment of an individual's ASAM level on each dimension using this logic:

    a. For adults (19 or older on the assessment/ASAM date):

        i. If the ASAM level for Dimension 1 indicates one of the three highest Withdrawal Management levels (3.2, 3.7, 4), that is the 'ASAM Level Indicated'.

        ii. Otherwise, the ASAM Level Indicated is the highest level (largest number) indicated on any of the other five dimensions. For the purpose of this ordering, "OTP (Level 1)" will be treated as 2.2. See the table below.

        iii. For adolescents (under 19 on the ASAM date): the ASAM Level Indicated is the highest level (largest number) indicated on any of Dimensions 2 through 6. For the purpose of this ordering, "OTP (Level 1)" will be treated as 2.2. See the table below.

5. Additional notes on the 'OST Indicator' that is being dropped, and the 'OTP (LEVEL 1)' code now added for Dimensions 2-6:

   a. BHRD does not need 'OST Indicator' for authorization processes, but simply accepts Levels 0.5, 1, or 2.1 as appropriate when a provider requests an OST authorization.

      Doing this allows the same set of ASAM data to support a simultaneous 'S01' authorization, which is allowed by the BHO (as of June 1, 2017).

   b. BHRD needs to use the state's 'OTP (LEVEL 1)' as an 'ASAM Level' when sending data to the state, and will do that by including 'OTP (Level 1) on the lists for Dimensions 2-6, but treating it as if it is level '2.2' in the treatment ranking. If one or more dimensions have 'OTP' and no other dimension is higher than '2.1', BHRD will send 'OTP', otherwise the highest treatment level treatment will be selected and sent.

State Code List of ASAM Levels, re-sorted to reflect the order that BHRD will use to select the highest level from Dimension 1 through 6 to send "ASAM Level Indicated" to the state:

Code	**Definition**	**Dimensions Submitted for**
4-WM (Level of Withdrawal Management (WM) for Adults	Medically Managed Intensive WM: Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability	1 (adults only)
3.7-WM (Level of Withdrawal Management (WM) for Adults	Medically Monitored Inpatient WM: Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring	1 (adults only)
3.2-WM (Level of Withdrawal Management (WM) for Adults	Clinically Managed Residential WM: Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery	1 (adults only)
4	Medically Managed Intensive Inpatient Services: 24-hour nursing care daily physician care for severe, unstable problems in Dimension 1, 2, or 3. Counseling available to engage patient in treatment	2, 3, 4, 5, 6
3.7	Medically Monitored Intensive Inpatient Services: 24-hour nursing care with physician availability for significant problems in Dimension 1, 2, or 3. 16 hour/day counselor ability	2, 3, 4, 5, 6
3.5	Clinically Managed High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community	2, 3, 4, 5, 6

Code	Definition	Dimensions Submitted for
3.3	Clinically Managed Population Specific High Intensity Residential Services: 24-hour care with trained counselor to stabilize multidimensional imminent danger. Less intensive milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community	2, 3, 4, 5, 6
3.1	Clinically Managed Low-Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours clinical services/week	2, 3, 4, 5, 6
2.5	Partial Hospitalization Services: 20 or more hours of services/week for multidimensional instability not requiring 24-hour care	2, 3, 4, 5, 6
OTP (LEVEL 1)	Opioid treatment program: Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid disorder	2, 3, 4, 5, 6
2.1	Intensive outpatient services: 9 or more hours of services/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	2, 3, 4, 5, 6
1	Outpatient services: Less than 9 hours of services/week (adult); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	2, 3, 4, 5, 6
0.5	Early intervention: Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder	2, 3, 4, 5, 6
2-WM (Level of Withdrawal Management (WM) for Adults	Ambulatory WM with Extended On-Site Monitoring: Moderate withdrawal with all day withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal management	1 (adults only)
1-WM (Level of Withdrawal Management (WM) for Adults	Ambulatory WM without Extended On-Site Monitoring: Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery	1 (adults only)
0	No intervention needed: Place holder for people who are truly not at any risk	2, 3, 4, 5, 6

Transaction: Authorization Request

Definition:
The request from a provider for BHRD to authorize either a benefit or a program for a client; or the report from a provider to BHRD that a client does not meet medical necessity criteria for receiving services.

Required for:
All programs

Procedure:
Authorization request transactions for outpatient and residential benefits that are paid on a case rate basis must be posted by the last day of the calendar month following the assessment date.

Frequency:
On request for services (Medicaid only)
Assessment
On change (outpatient benefit only during first two months)

Transaction ID: 670.02

Action Code:

A	**Add Authorization Request**

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Date of Assessment	Text (YYYYMMDD)	8	
Benefit/Program Requested	Text	3	Y
Benefit Change Code	Text	2	Y
Request Date	Text (YYYYMMDD)	8	
Authorization Number	Text (number)		
Adult or Child Benefit	Text	1	Y
King County ID	Text (number)		

Attribute: Date of Assessment

Transaction:
Authorization Request

Definition:
This is the date that a face-to-face assessment was begun for the purpose of submitting an authorization request for a client.

- For non-residential authorizations, this is the date of assessment.
- For residential authorizations, this is the date the client enters the facility.

Procedure:

- In general, the start date of the authorization is the date of the assessment.
- For benefit change codes 05, 07, submit the date of the new assessment.
- For a client who does not meet medical necessity criteria for the outpatient level of care, submit the date of the assessment or the scheduled date if the assessment did not take place.

Required Documentation:
Providers shall document the beginning and end dates of the assessment in provider records.

Examples:

1. A person was assessed on July 15, 2009. The assessment took two hours and was completed that day. Enter 20090715.

2. A homeless person was identified for services on February 3, 2009. The clinician began interaction with the client on February 17, 2009, and completed the assessment on March 2, 2009. Enter 20090217.

Type: Date (8) YYYYMMDD

Attribute: Benefit/Program Requested

Transaction:
Authorization Request

Definition:
The outpatient (mental health, SUD) or residential (mental health) benefit or BHO-administered program (see Section 04: Crisis Services Level of Care and Section 07: Additional Outpatient Services) requested by a provider for a client assessed against medical necessity and/or program-specific criteria.

Procedure:
- Submit a separate request for each outpatient or residential benefit or BHO-administered program from which a client will receive services.
- When a client does not meet medical necessity criteria for a mental health outpatient benefit, submit "00" (no benefit requested) for benefit code requested. See Example 2
- Each authorized outpatient or residential benefit or BHO-funded program from which a client receives services will have a unique authorization number assigned. (See "Authorization Number" attribute.) This number will link the client and service events with the outpatient or residential benefit or the BHO-funded program under which the service was delivered.
- See the King County Medical Necessity Criteria in:
  - Section 05: Outpatient Services Level of Care, Attachment A for information on outpatient benefit requirements, and
  - Section 08: Residential and Supportive Housing Services Level of Care for information on residential benefit requirements.
- The "Program Overlap Rules" document provides details on which programs can overlap and under what conditions. The "Program Overlap Rules" document is available in the ISAC Notebook.

Examples:
1. Based on an assessment, the provider requests an authorization for an outpatient benefit with a 2X case rate by submitting code "2X1." The authorization is approved by the BHO and is assigned an authorization number.

2. Based on an assessment, the provider determines that a client does not meet medical necessity criteria for the outpatient level of care and submits code "00" for benefit code requested. A "No benefit requested" (00) authorization record is created by BHRD IS and is assigned an authorization number.

3. During an outpatient benefit period, a client decompensates and the DMHPs approve the use of a hospital diversion bed. The provider submits a new authorization request using code 74.

Type: Text (3)

Valid Codes	Definition
Outpatient Level of Care (Mental Health)	
2X1	Outpatient Benefit with 2X case rate
3A1	Outpatient Benefit with 3A case rate
3B1	Outpatient Benefit with 3B case rate
00	No benefit requested. Client did not keep appointment. (Medicaid clients only)
112	Assessment Only (OPB). Client did not meet medical necessity.
Outpatient Level of Care (SUD)	
S01	SUD Outpatient – OP/IOP
S02	SUD Outpatient – Recovery Support Services
SA0	SUD Assessment Only – client did not meet ACS
SA1	SUD Assessment Only – ACS met – Referred elsewhere
Outpatient Level of Care (COD)	
102	**COD Outpatient**
Additional Outpatient Services	
05	Municipal Mental Health Court
06	KC Regional Mental Health Court
09	PES Care Manager (Harborview ED)
25	Specialty Employment Program (SEP)
35	Geriatric Regional Assessment Team
48	FIRST – Pre Release
49	FIRST – Post Release
53	Mental Health Integration Program
57	PACT, Engagement
58	PACT, Enrollment
60	HOST/PATH Outreach
61	HOST – Intensive Case Management/Stabilization
65	Western State Hospital Intensive Community Support Program
66	Expanding Community Services Intensive Community Support and Recovery Program
67	Offender Re-Entry Community Support Program (ORCSP) – Pre Release
68	Offender Re-Entry Community Support Program (ORCSP) – Post Release

Valid Codes	Definition
69	Integrated Dual Disorders Treatment
77	MIST Engagement
78	MIST Enrollment
82	FACT, Engagement
83	FACT, Enrollment
86	Regional Mental Health Court Peer Support
87	Forensic Intensive Supportive Housing
88	Co-Stars
90	Peer Bridger
101	Housing Voucher
103	Re-entry Case Management
104	Re-entry Boundary Spanner
105	Behavioral Treatment
107	MIDD Wraparound
108	Family Treatment Court Wraparound
109	Trauma Informed Care Grant
110	Transitional Recovery Program Mental Health Professional
111	Moral Reconation Therapy – Domestic Violence
113	Transition Support Program
114	HOME Outreach
115	HOME Enrollment
151	Criminal Justice Liaison Program – South East (SE)
152	Criminal Justice Liaison Program – King Co Correctional Facility (KCCF)
153	Criminal Justice Liaison Program – Work and Education Release (WER)
154	Criminal Justice Liaison Program – Community Center for Alternative Programs (CCAP)
DOC	Department of Corrections
OST	SUD Opiate Substitution Treatment
PPW	SUD Pregnant or Parenting Women
S03	Older Adult SUD Treatment

Valid Codes	Definition
Crisis Level of Care	
13	Children's Crisis Outreach Response System (CCORS)
15	CCORS Intensive Stabilization Services
40	Adult Crisis Stabilization (including next day appointment)
74	Adult Inpatient Diversion Bed
75	Crisis Respite Program – DESC
76	Mobile Crisis Team
79	Crisis Diversion Interim Services
80	Crisis Diversion Facility Team
DTX	SUD Detoxification
Residential Level of Care (SUD)	
SRS	SUD Residential – NOT SUBMITTED THROUGH THIS TRANSACTION; Entered by Authorizer through the Inpatient application.
Residential Level of Care (Mental Health)	
71	Adult Long-Term Rehabilitation Benefit
72	Adult Supervised Living Benefit
73	Adult Long-Term Rehabilitation Benefit (Benson Heights)
372	Intensive Supportive Housing
373	Standard Supportive Housing Benefit
374	FIRST Outpatient
Inpatient Level of Care	
IP	Inpatient Benefit – NOT SUBMITTED THROUGH THIS TRANSACTION; Entered by Authorizer through the CCS or Inpatient application.

Attribute: Benefit Change Code

Transaction:
Authorization Request

Definition:
A code that indicates whether the authorization request transaction is for a new authorization or a change to an existing authorization.

Procedure:
Codes ‘61’ or ‘69’ are used to request a provider change from an outpatient benefit (i.e., a tier) to a new outpatient benefit with a different provider. Once the new benefit goes to 'AA' status, the previous benefit is automatically terminated. For the provider change authorization request to process successfully, the existing outpatient benefit must have a status of 'AA' and the assessment date for the new authorization request must be between the start and expire dates of the existing outpatient benefit.

Required Documentation:
The provider shall maintain records documenting the reason for the initial request or a change to an existing authorized outpatient benefit.

Examples:
1. A provider identifies a client as both eligible for and in need of services. The provider submits the first authorization request to provide services to the client. Use Code '01'.

2. A client who had an outpatient benefit that ended two weeks ago is reassessed and determined eligible for and in need of services. The provider submits an initial request for a 3A authorization. Use Code '01'.

3. A provider received an initial authorization for an outpatient benefit with a 2X case rate. Three weeks into providing services, the provider identifies a need for an outpatient benefit with a 3B case rate. Use Code '02'.

4. A provider requests an outpatient benefit for a client who currently has an outpatient benefit with another provider. The client wants to change providers for one of the valid reasons associated with the change codes '61 or '69'. The provider uses either '61' or '69' according to the reason for the provider change. The requesting provider may request whatever outpatient benefit case rate is determined appropriate. It is not necessary to request the same outpatient benefit case rate as the current authorization unless that is determined to be clinically appropriate.

Type: Text (2)

Valid Codes	Definition
00	No benefit was requested (use with programs ‘00’, ‘112, SA0, and SA1).
01	Initial request for authorization.
02	Outpatient benefit case rate change – Request for a change in the outpatient benefit case rate for an existing authorization during the first two calendar months of the benefit. If approved, this code results in a change to the current outpatient benefit case rate, retrospective to the Start Date of the benefit. When this code is submitted after the second calendar month of the benefit, the request will be rejected. If an authorization has been approved (authorization status 'AA'), the request will be rejected.
05	Next benefit – If approved, this code results in the creation of a new full-term outpatient benefit with a start date equal to the calendar day following the expiration date of the existing outpatient benefit. Note: The assessment date must fall within the last thirty days of the existing outpatient benefit.
07	Catastrophic Case Rate Change – Request for change in outpatient case rate change due to permanent, catastrophic change in client. If approved, this code results in the termination of the existing benefit and a new full-term outpatient benefit and case rate beginning the day of the reported assessment.
61	Provider Change (from one tier to another) – No cause provided. Clients may change providers without cause, and for any reason, during the first 30 days of enrollment, and once every 12 months thereafter.
69	Provider Change (from one tier to another) – Other good cause; documented in client file.

Attribute: Request Date

Transaction:
Authorization Request

Definition:
The date the request is submitted by the provider.

Example:
Provider submits an authorization request on June 1, 2008. The request date is 20080601.

Type: Date (8) YYYYMMDD

Attribute: Authorization Number

Transaction:
Authorization Request

Definition:
A unique number assigned by the BHRD information system (IS) to a particular authorized benefit (outpatient or residential) or to an authorization for a BHO-administered program (see Section 04: Crisis Services Level of Care and Section 07: Additional Outpatient and Support Services) or to report that a client does not meet medical necessity criteria for receiving services. The authorization number uniquely identifies the combination of client, authorized benefit/program, and benefit/program start date.

Procedure:
- This attribute is null for initial authorization requests. The authorization number will be assigned by the BHRD IS and returned in the authorization response report.
- The authorization number is required when the provider is submitting a request for next (i.e., continuing) benefits, case rate change, or provider change.
- For persons served under both a benefit (outpatient or residential) and one or more BHO-administered programs, separate authorization numbers will be issued for each benefit/program.

Required Documentation:
Providers shall record the authorization number in the client's records.

Examples:
1. A child is authorized to receive outpatient benefit services with a 2X1 case rate and an authorization number is provided (551234). Each time she receives a service during the benefit period, the provider must submit the authorization number (551234) with the HIPAA 837P transaction.

2. During the outpatient benefit, the child also receives services from the CCORS intensive stabilization services program. The provider of those services submits an authorization request transaction for program 15. The BHRD IS transmits an authorization response with a unique authorization number (559876). Each time services under this program are transmitted in the HIPAA 837P transaction, the authorization number (559876) must be used.

Type: Integer

Attribute: Adult or Child Benefit

Transaction:
Authorization Request

Definition:
This attribute is used to indicate if an adult or child benefit is being requested. This is necessary because youth aged 18 – 20 can be served either way.

Procedure:
- Code this attribute at the time of the assessment for outpatient benefits. Be careful to code this attribute correctly. Once the benefit is approved, this attribute can be changed only during the first two calendar months of the benefit.
- The edit rejects incompatibility between a coded value and the DOB.
- This code is only relevant for mental health and SUD outpatient benefits. For clients under 18 years of age, submit code 5. For clients 18-20 years, submit either code 4 (to request an adult benefit) or code 5 (to request a child benefit). For clients 21 years or older, submit code 4.
- For mental health benefits for clients aged 18-20 years, regardless of the type of benefit requested (child or adult), a GAF Scale score must be submitted, **not** CGAS. (See GAF/CGAS transaction).
- The submitted code cannot be changed through a batch transaction. To change the submitted value during the first two calendar months, contact the Help Desk to request the change.

Required Documentation:
Providers shall maintain a record of the requested benefit type.

Examples:
1. A client is 19 years old. At the time of assessment, it was decided to request authorization for an adult outpatient benefit rather than request service under a child's outpatient benefit (which has different clinical outcome measures). Code 4. Note that a GAF scale score must be submitted for this client because they are 19 years old.

2. A client is 10 years old. Submit code 5.

3. A client is 30 years old. Submit code 4.

4. An authorization request is submitted for a specialty program that is not an outpatient benefit. Submit code 3.

Type: Text (1)

Valid Codes	Definition
~~1~~	~~The child is certified to be served by a team.~~
~~2~~	~~The child is not certified to be served by a team.~~
3	Not applicable. Program requested is not an outpatient benefit.
4	Adult benefit, including 18-20 year olds if applicable.
5	Child benefit, including 18-20 year olds if applicable.

Transaction: Batch Footer

Definition:
This record should appear as the last record in each batch.

Procedure:
- The record count should **not** include the batch header or batch footer records.
- The edit program tests the record count value with the number of separate lines in the batch.

Required for:
Each batch

Frequency:
Every time a batch is submitted to BHRD IS.

Transaction ID: 999.01

Action Codes:
NONE

Attribute	Type	Size	Coded
Batch ID	Text (number)	5	
Date of Submittal	Text (YYYYMMDD)	8	
Source Organization ID	Text	3	Y
Record Count	Text (number)	5	

Transaction: Batch Header

Definition:
This record should appear as the first record in each batch. It identifies the batch ID, date of submission and the provider submitting the batch.

Required for:
Each batch

Frequency:
Every time a batch is submitted to BHRD IS.

Transaction ID: 000.03

Action Codes:
NONE

Attribute	Type	Size	Coded
Batch ID	Text (number)	5	
Date of Submittal	Text	8	
Source Organization ID	Text	3	Y

Transaction: CALOCUS

Definition:
Use this transaction to report the results of an assessment using the CALOCUS instrument.

The application of the case rate criteria requires a formal, face-to-face assessment process that results in an outpatient authorization request from the provider to the King County BHO. Children (ages 3-17) shall be assessed using the CALOCUS instrument. Children aged 18, 19, and 20 shall have the option of being assessed for eligibility for either an adult or child's outpatient benefit, using either the LOCUS or CALOCUS instrument.

Required for:
Mental health case rate benefits
Mental health supportive housing benefits
Mental health residential benefits
Mental health inpatient benefits

Frequency:
Initial assessment
Continuation of benefits
On change
On exit

Transaction ID: 190.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	Y
Case ID	Text	10		Y
Event Date	Date (YYYYMMDD)	8		Y
Dimension I Score	Number	1	Y	Y
Dimension II Score	Number	1	Y	Y
Dimension III Score	Number	1	Y	Y
Dimension IV A Score	Number	1	Y	Y
Dimension IV B Score	Number	1	Y	Y
Dimension V Score	Number	1	Y	Y
Dimension VI Child Sub-Scale Score	Number	1	Y	Y
Dimension VI Caretaker Sub-Scale Score	Number	1	Y	Y
Composite Score	Number	2		Y
Level of Care Requested	Number	1	Y	Y
King County ID	Number	10		Y

Attribute: Dimension I Score

Transaction:
CALOCUS

Definition:
Risk of Harm

This dimension considers a child or adolescent's potential to be harmed by others or cause significant harm to self or others.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Low Risk of Harm
2	Some Risk of Harm
3	Significant Risk of Harm
4	Serious Risk of Harm
5	Extreme Risk of Harm

Attribute: Dimension II Score

Transaction:
CALOCUS

Definition:
Functional Status

This dimension measures changes in the degree to which a child or adolescent is able to fulfill responsibilities for a given developmental level. This may include interactions with others in school, at home and in social situations with peers as well as changes in self-care.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Minimal Functional Impairment
2	Mild Functional Impairment
3	Moderate Functional Impairment
4	Serious Functional Impairment
5	Severe Functional Impairment

Attribute: Dimension III Score

Transaction:
CALOCUS

Definition:
Co-Morbidity: Developmental, Medical, Substance Use and Psychiatric

This dimension measures the coexistence of disorders across four domains (psychiatric, substance use, medical and developmental) but does not consider co-occurring disturbances within each domain.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No Co-morbidity
2	Minor Co-morbidity
3	Significant Co-morbidity
4	Major Co-morbidity
5	Severe Co-morbidity

Attribute: Dimension IV A Score

Transaction:
CALOCUS

Definition:
Recovery Environment – Environmental Stress Sub-Scale

This dimension considers factors in the environment that may contribute to the onset or maintenance of illness or disability, and factors that may support a child or adolescent's efforts to achieve or maintain recovery. Because children and adolescents are more dependent on, and exert less control over, their environment than adults, in the CALOCUS, the recovery environment encompasses the family milieu, as well as the school, medical, social services, juvenile justice, and other components in which the child or adolescent may receive services or be involved on an ongoing basis. Two sub-scales are used to measure this dimension: Environmental Stress and Environmental Support. These two sub-scales are designed to balance the relative contributions of these factors.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Minimally Stressful Environment
2	Mildly Stressful Environment
3	Moderately Stressful Environment
4	Highly Stressful Environment
5	Extremely Stressful Environment

Attribute: Dimension IV B Score

Transaction:
CALOCUS

Definition:
Recovery Environment – Environmental Support Sub-Scale

This dimension considers factors in the environment that may contribute to the onset or maintenance of illness or disability, and factors that may support a child or adolescent's efforts to achieve or maintain recovery. Because children and adolescents are more dependent on, and exert less control over, their environment than adults, in the CALOCUS, the recovery environment encompasses the family milieu, as well as the school, medical, social services, juvenile justice, and other components in which the child or adolescent may receive services or be involved on an ongoing basis. Two sub-scales are used to measure this dimension: Environmental Stress and Environmental Support. These two sub-scales are designed to balance the relative contributions of these factors.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Highly Supportive Environment
2	Supportive Environment
3	Limited Support in Environment
4	Minimally Supportive Environment
5	No Support in Environment

Attribute: Dimension V Score

Transaction:
CALOCUS

Definition:
Resiliency and Treatment History

This section addresses a child 's or youth 's success or failure to make use of treatment and natural supports that foster resilience and help them get back on track developmentally.

Procedure:
Record the clinician’s assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician’s assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Full Resiliency and/or Response to Treatment
2	Significant Resiliency and/or Response to Treatment
3	Moderate or Equivocal Resiliency and/or Response to Treatment
4	Poor Resiliency and/or Response to Treatment
5	Negligible Resiliency and/or Response to Treatment

Attribute: Dimension VI Child Sub-Scale Score

Transaction:
CALOCUS

Definition:
Treatment Acceptance and Engagement
Child or Adolescent Acceptance and Engagement Sub-Scale

The Treatment Acceptance and Engagement dimension measures the child's or adolescent's, as well as the parent and/or primary caretaker's acceptance of and engagement in treatment.

Only the highest of the two sub-scale scores (child or adolescent vs. parent and/or primary caretaker) is added into the composite score. If a child or adolescent is emancipated, the parent and/or primary caretaker sub-scale is not scored.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Optimal
2	Constructive
3	Obstructive
4	Adversarial
5	Inaccessible

Attribute: Dimension VI Caretaker Sub-Scale Score

Transaction:
CALOCUS

Definition:
Treatment Acceptance and Engagement
Parental and/or Primary Caretaker Acceptance and Engagement Sub-Scale

The Treatment Acceptance and Engagement dimension measures the child or adolescent's (as well as the parent and/or primary caretaker's) acceptance of and engagement in treatment.

Only the highest of the two sub-scale scores (child or adolescent vs. parent and/or primary caretaker) is added into the composite score. If a child or adolescent is emancipated, the parent and/or primary caretaker sub-scale is not scored.

Procedure:
Record the clinician’s assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician’s assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Optimal
2	Constructive
3	Obstructive
4	Adversarial
5	Inaccessible

Attribute: Composite Score

Transaction:
CALOCUS

Definition:
Indicates the composite score as defined by the CALOCUS instrument.

Procedure:
Record the composite score as calculated per the instructions of the CALOCUS instrument.

Required Documentation:
Documentation of the composite score calculation must be provided in agency records.

Type: Number

Valid Codes	Definition
1-35	Valid range

Attribute: Level of Care Requested

Transaction:
CALOCUS

Definition:
Indicates the level of care requested by the clinician.

Procedure:
In general, the level of care requested should be consistent with the level derived from the CALOCUS decision tree and/or the Determination Grid. However, exceptions are permitted based upon additional clinical determinations. The rationale for an exception should be documented in the client's file.

Required Documentation:
Documentation of the client's CALOCUS level of care must be provided in agency records.

Type: Numeric

Valid Codes	Definition	Corresponding MH Benefit
0	Level Zero: Does not meet access to care or completed treatment	112 <none>
1	Level One: Recovery Maintenance and Health Management Level One services typically provide follow-up care to mobilize family strengths and reinforce linkages to natural supports. Those appropriate for Level One services either may be substantially recovered from an emotional disorder or other problem or their problems are sufficiently manageable within their families, such that the problems are no longer threatening to expected growth and development.	2X1
2	Level Two: Low Intensity Community Based Services This level of care includes mental health services for children, adolescents, and families living in the community. Level Two services frequently are provided in mental health clinics or clinicians' offices. Services also may be provided within a juvenile justice facility, school, social service agency, or other community setting. Children and adolescents appropriate for Level Two services generally do not require the extensive systems coordination and case management of the higher levels of care, since their families are able to use community supports with minimal assistance. The degree of individualization of services at Level Two also may not be as extensive as at higher levels of care, but continuity of at least one treatment relationship often is essential to maintenance at optimal levels of functioning. Clinicians offering follow-up at Level Two must provide continuing individual and family assessment with the capacity to add needed services as necessary.	3A1

3	Level Three: High Intensity Community Based Services This level of care generally is appropriate for children and adolescents who need more intensive outpatient treatment and who are living either in their families with support, or in alternative families or group facilities in the community. The family's strengths allow many, but not all, of the child's needs to be met through natural supports. Treatment may be needed several times per week, with daily supervision provided by the family or facility staff. Services may be provided in a mental health clinic or clinician's office, but often are provided in other components of the system of care with mental health consultation. Service coordination is essential for maintaining the child or adolescent in the community at Level Three. Medical care from either a pediatrician or family physician should be available in the community.	3B1
4	Level Four: Medically Monitored Community Based Services This level of care refers to services provided to children and adolescents capable of living in the community with support, either in their family, or in placements such as group homes, foster care, homeless or domestic violence shelters, or transitional housing. To be eligible for Level Four services, a child or adolescent's service needs must require the involvement of multiple components within the system of care. For example, an adolescent may require the services of a probation officer, a mental health clinician, a child and adolescent psychiatrist, and a special education teacher to be maintained in the community. These children and adolescents, therefore, need intensive, clinically informed case management to coordinate multi-system and multidisciplinary interventions. Optimally, an individualized service plan is developed by a Wraparound team. Services are delivered more frequently and for more extended periods than at lower levels of care. Services in this level of care include partial hospitalization, intensive day treatment, treatment foster care, and home-based care determined by a Wraparound plan that may involve both support and clinical services brought to the home and various support services for parents/caregivers. Level Four services also may be provided in schools, substance abuse programs, juvenile justice facilities, social services group care facilities, mental health facilities, or in the child or adolescents home.	

5	Level Five: Medically Monitored Residence Based Services This level of care refers to treatment in which the essential element is the maintenance of a milieu in which the therapeutic needs of the child or adolescent and family can be addressed intensively. This level of care traditionally has been provided in non-hospital settings such as residential treatment facilities or therapeutic foster homes. Equivalent services have been provided in juvenile justice facilities and specialized community based residential schools, hospitals with designated step down program units and could be provided in homeless and/or domestic violence shelters or other community settings. It also is possible to provide Level Five services in a child or adolescent's home, if Wraparound planning and resources can provide the needed service intensity in the less restrictive environment. Level Five services include the modification and continuation of a Wraparound plan or, if the youth is new to services the development of a Wraparound team that can determine a program, that will prepare the family for the child or adolescent 's re-integration into their family and community with treatment in lower levels of care. Ideally, the step-down plan represents a modification of the comprehensive Level Five Wraparound plan, providing continuity of care and integrating the child or adolescent's treatment experiences while in more restricted Level 5 services into their return to a more open community setting.	
6	Level Six: Medically Managed Residence Based Services Level Six services are the most restrictive and often, but not necessarily, the most intensive in the level of care continuum. Traditionally, Level Six services have been provided in a secure facility such as a hospital or locked residential program. This level of care also may be provided through intensive application of mental health and medical services in a juvenile detention and/or educational facility, provided that these facilities are able to adhere to medical and psychiatric care standards needed at Level Six. Level Six services also may be provided in community settings, including a child or adolescent's home, if mental health and medical services are organized at the required intensity and security measures are adequate. Although high levels of restrictiveness are typically required for effective intervention at Level Six, every effort to reduce, as feasible, the duration and pervasiveness of restrictiveness is desirable to minimize its negative effects.	

Transaction: Case Manager Contact Information

Definition:
Establishes case manager contact information in the BHRD IS.

Crisis workers use the BHRD IS to locate and contact the case manager responsible for the care of a client.

See also Case Manager Link.

Required for:
All outpatient benefits, Adult Long-Term Rehabilitation (71),
FACT enrollment (83), PACT enrollment (58),
HOST/PATH outreach (60), HOST – Intensive Case Management/Stabilization (61),
Co-Occurring Disorder Integrated Treatment Services (64),
Municipal Jail Transition Services (55), County Jail Transition Services (56),
Western State Hospital Intensive Community Support Program (65),
Expanding Community Services Intensive Community Support and Recovery Program (66),
ORCSP (previously CIAP) – Pre Release (67),
ORCSP (previously CIAP) – Post Release (68),
FIRST – Pre Release (48), FIRST – Post Release (49)

FACT and PACT enrollment providers will report Team Leader contact information.

Frequency:
On assignment
On change

Transaction ID: 100.03

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case Manager ID	Text	10	
Primary Case Manager Phone	Text	10	
Primary Case Manager Comment	Text	50	
Secondary Case Manager Phone	Text	10	
Secondary Case Manager Comment	Text	50	

Attribute: Case Manager ID

Entity:
Case Manager Contact Information

Definition:
This attribute links the Staff Person ID of the case manager with telephone contact numbers in order to provide 24-hour case management and crisis contact services for enrolled consumers.

The Primary Case Manager (case manager, therapist, other clinical staff designated by the provider) is the individual with primary responsibility for implementing a plan for outpatient mental health rehabilitation services to be provided to the client (WAC 388-865-0345).

The Secondary Case Manager can be used by the provider to identify an alternate 24-hour contact person.

Procedure:
- Enter the Staff Person ID of the responsible case manager in this field to identify the staff person who is the case manager /primary care provider.
- Providers have discretion in determining whether the primary and secondary case managers are the same or a different contact person, but must ensure the 24-hour availability of case management information.

Required Documentation:
Provider records shall document the identity of the primary care provider responsible for the coordination of care for a given client. Providers shall update the BHRD IS when there is a change in the identified primary care provider for a given client.

Valid Codes:
This code must be an existing, open Staff Person ID. Up to 10 characters are permitted.

Attribute: Case Manager Phone

Transaction:
Case Manager Contact Information

Definition:
The phone number by which case managers/primary care providers can be reached 24 hours per day, 7 days per week.

Procedure:
- Use the case manager phone to provide the numbers for the case managers listed. The telephone numbers will be used by crisis workers to contact clinicians responsible for the care of client.
- Use the "Case Manager Comment" attribute to provide detailed information for the phone numbers provided.

Example:
The primary case manager's telephone number is (206) 296-5213. Enter 2062965213. Do not use parenthesis, dashes, or spaces.

Type: Text (10)

Valid Codes:
No restrictions. Up to 10 characters are permitted.

Attribute: Case Manager Comment

Transaction:
Case Manager Contact Information

Definition:
A free-form field used to comment on case management team/primary care provider phone numbers.

Procedure:
- Use the primary case manager comment key to provide additional information about contacting the primary care provider who can be contacted by clinical care coordinators.
- Use the secondary case manager comment key to provide additional information about the contact person.

Example:
Comments might include: This is daytime number only; this number is for a beeper; this is the number to use after hours/on weekends, etc.

Type: Text (50)

Valid Codes:
No restrictions. Up to 50 characters are permitted.

Transaction: Case Manager Link

Definition:
This information is used to link individual clients with the case manager/primary care provider or practitioner responsible for implementing client care. A successful 'Case Manager Contact Information' transaction must have processed successfully prior to submitting this 'Case Manager Link ' transaction.

Required for:
Clients in a mental health or SUD outpatient benefit
Clients in select specialty programs (please see the Required Transactions spreadsheet in the ISAC Notebook)

Frequency:
Initial assessment
On change

Procedure:
- If a client is receiving mental health outpatient services and SUD outpatient services from the same agency this transaction will be sent twice (even if it is the same case manager for mental health and SUD).
- If the wrong case manager type is submitted by mistake, the transaction must be deleted and re-sent (because case manager type is part of the key).

Transaction ID: 011.02

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	Y
Case ID	Text	10		Y
Case Manager Type	Text	1	Y	Y
Case Manager ID	Text	10		Y
Case Manager Reporting Unit ID	Text	3	Y	Y

Attribute: Case Manager Type

Transaction:
Case Manager Link

Definition:
Indicates if the case manager or primary care provider is responsible for coordinating the client's mental health treatment or substance use disorder treatment.

Type: Text (1)

Valid Codes	Definition
M	The case manager or primary care provider coordinates the client's mental health treatment.
S	The case manager or primary care provider coordinates the client's SUD treatment.

Attribute: Case Manager ID

Transaction:
Case Manager Link

Definition:
A code established by a provider to link each client with his/her case manager/primary care provider. (See WAC 388-865-0345.)

Required Documentation:
- Enter the Staff Person ID of the responsible case manager in this field to identify the staff person who is the case manager /primary care provider.
- Provider records shall document the name of the primary care provider/case manager responsible for the coordination of care for a given client.
- Client records shall include documentation of the date that the case manager was assigned and terminated (when applicable) from the client's case.
- Providers are responsible for updating the BHRD IS when there is a change in the identified primary care provider for a given client.

Valid Codes:
No restrictions. Up to 10 characters are permitted.

Transaction: Children's Functional Assessment Rating Scale

Definition:
The Children's Functional Assessment Rating Scale (CFARS) is an inventory that is used to assess the level of functioning of children and adolescents in a number of life domains.

Procedure:
- Scores on the CFARS are used to identify focuses for treatment and to determine whether the client achieves desired outcomes.
- The "anchors" below are used to rate the individual.
- Report as the event date the required reporting date (as described under "Frequency"), using the most recent contacts with the client to rate his or her functioning.
- A report will be available in the Reports application that lists all upcoming CFARS reporting dates, as well as all past due CFARS data that have not been submitted and posted successfully to the ea_cfars table. Required data for an authorization will be considered past due unless a complete set of CFARS scores is posted from the provider for the client with an Event Date that is within 30 days of the required reporting date. If, because of a termination, two required reporting dates are within 60 days of each other, a single set of data will meet the requirement as long as the Event Date is no more than 30 days after the first reporting date and no more than 30 days before the second reporting date.

Coding Definitions:
Use the following anchors to rate the client on items A-P on the CFARS Problem Severity Rating Summary:

1 NO PROBLEM
- Functioning is consistently average or better than what is typical for this person's age, sex, and subculture.
- There is no need for treatment.

2 LESS THAN SLIGHT PROBLEM

3 SLIGHT PROBLEM
- Functioning in this range falls short of typical for a person of this age, sex, and subculture most of the time.
- Problems may be intermittent or may persist at a low level.
- Problems have little or no impact on other domains or they are currently controlled by medications.
- The need for treatment is not urgent but may require therapeutic intervention in the future.

4 SLIGHT TO MODERATE PROBLEM

5 MODERATE PROBLEM
- Functioning in this range is clearly marginal or inadequate, not meeting the usual expectations of a typical person of this age, sex, and subculture.
- The dysfunction or problem may persist at a moderate level or become severe on occasion.
- Problems may be related to other domains and do require therapeutic intervention(s).

6 MODERATE TO SEVERE PROBLEM

7 SEVERE PROBLEM
- Functioning in this range is marked by obvious and consistent failures, never meeting expectations of a typical person of this age, sex, and subculture.
- The dysfunction or problem may be chronic.
- Problems almost always extend to other domains and generally interfere with interpersonal or social relationships with others.
- Hospitalization or some other form of external control may be needed in addition to other therapeutic intervention(s).

8 SEVERE TO EXTREME PROBLEM

9 EXTREME PROBLEM
- The highest level of the scale, suggesting the person's problem(s) is creating a situation that is totally out of control, unacceptable, and/or potentially life threatening.
- The need for external control or intervention is immediate.

Required for:
Child Outpatient benefits (2X1, 3A1, 3B1) for which the first month of the benefit is paid with Mental Illness and Drug Dependency (MIDD) funds

Frequency:
For Child Outpatient benefits (2X1, 3A1, 3B1) at:
Authorization start, six months after authorization start, and authorization end. If an authorization is terminated before the original expiration date, the CFARS is required for the termination date.

Transaction ID: 650.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Depression	Text (number)	1	Y
Anxiety	Text (number)	1	Y
Hyperactivity	Text (number)	1	Y
Thought Process	Text (number)	1	Y
Cognitive Performance	Text (number)	1	Y
Medical/Physical	Text (number)	1	Y
Traumatic Stress	Text (number)	1	Y
Substance Use	Text (number)	1	Y
Interpersonal Relationships	Text (number)	1	Y
Behavior in “Home” Setting	Text (number)	1	Y
ADL Functioning	Text (number)	1	Y
Socio-Legal	Text (number)	1	Y
Work or School	Text (number)	1	Y
Danger to Self	Text (number)	1	Y
Danger to Others	Text (number)	1	Y
Security Management Needs	Text (number)	1	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

CFARS Definitions:
Definitions for the subscales of the CFARS can be found in the Children’s Functional Assessment Rating Scale Manual available at: http://outcomes.fmhi.usf.edu/_assets/docs/cfarsmanual.pdf

Required Documentation:
- Completed CFARS must be maintained in provider records for each client required to be assessed with this instrument.
- Providers shall maintain records to identify the clinical staff person by name, degree, and working job title that assessed the client on the CFARS. The individual conducting the assessment can be anyone authorized by provider protocols to do so.

Type: Number

For CFARS "A" through "P":

Valid Codes	Definition
1	No Problem
2	Less than Slight Problem
3	Slight Problem
4	Slight to Moderate Problem
5	Moderate Problem
6	Moderate to Severe Problem
7	Severe Problem
8	Severe to Extreme Problem
9	Extreme Problem

Transaction: Client Demographics

Definition:
General demographic information that describes a person.

Required for:
All programs

Frequency:
Initial assessment
On change

Transaction ID: 020.07

Action Codes:

A	Add
C	Change

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	Y
Case ID	Text	10		Y
Event Date	Date (YYYYMMDD)	8		Y
Surname	Text	30		Y
Alternate Surname	Text	30		N
First Name	Text	30		Y
Middle Name	Text	30		N
Suffix	Text	30		N
Gender	Number	1	Y	Y
Date of Birth	Date (YYYYMMDD)	8		Y
Ethnicity	Text	45	Y	Y
Hispanic Origin	Text	3	Y	Y
Interpreter Required	Number	1	Y	Y
Language Code	Text	2	Y	Y
Sexual Orientation	Number	1	Y	Y
Military Status	Text	2	Y	Y
Family Military Status	Text	2	Y	Y

Attribute	Type	Size	Coded	Required
Social Security Number	Text	9		Y
Marital Status	Number	2	Y	Y
King County ID	Number			C

Attribute: Surname

Transaction:
Client Demographics

Definition:
The surname/family/last name of a client. In general, follow the rules of the appropriate culture when determining which name is the surname.

Procedure:
- This is a required attribute.
- Consistency is important; the last name will be used as one element to uniquely identify the person across our system.
- A null field will generate a fatal error.
- If the surname is unknown, you may enter, "UNKNOWN" (without the quotation marks). However, a reported value of "UNKNOWN" will **not** meet data timeliness requirements for outpatient or residential benefits paid on a case rate basis.
- Only the following characters are allowed: alphabetic characters, hyphens, space (but not as the first character), apostrophe (single quotation mark). No numeric characters are permitted.

Required Documentation:
The client's surname shall be included in his/her clinical record. Providers shall be required to update name changes.

Example:
If the surname is a hyphenated, include both names in the surname field using a hyphen between names. For instance**,** Gilbert-Richards is entered as Gilbert-Richards.

Type: Text (30)

Attribute: Alternate Surname

Transaction:
Client Demographics

Definition:
Indicates any other last name by which the client may have reported.

Procedure:
- This is not a required attribute (if null, an empty field must exist in the submitted batch file).
- If the client has more than one alternate surname, then report the one used most frequently.
- Only the following characters are allowed: alphabetic characters, hyphens, space (but not as the first character), apostrophe (single quotation mark). No numeric characters are permitted.
- Report a null value (blank) to delete an existing value that was entered by mistake or is no longer applicable.

Required Documentation:
The client's alternate surname shall be noted in his/her clinical record.

Example:
If the surname is a hyphenated, include both names in the surname field using a hyphen between names. For instance**,** Gilbert-Richards is entered as Gilbert-Richards.

Type: Text (30)

Attribute: First Name

Transaction:
Client Demographics

Definition:
The first name of a client. In general, follow the rules of the appropriate culture when determining which name is the surname and which is the first name.

Procedure:
- This is a required attribute.
- Consistency in reporting each client's name is important; the last name and first name will be used as elements to uniquely identify the person across our system.
- The first name as recorded on significant documentation can be used to resolve contradictions. Use reasonable judgment to determine the best choice.
- First names may include spaces, apostrophe (single quote) and hyphens. No numeric characters allowed.
- A null field will generate a fatal error.
- If the first name is unknown, you may enter "UNKNOWN" (without the quotation marks). However, a reported value of "UNKNOWN" will **not** meet data timeliness requirements for outpatient or residential benefits paid on a case rate basis.

Required Documentation:
The client's first name shall be included in the client's clinical record. Providers shall update/correct name changes as necessary.

Example:
Submit "Mary Anne" if the client's name is Mary Anne Susan Smith.

Type: Text (30)

Attribute: Middle Name

Transaction:
Client Demographics

Definition:
The middle name of a client. In general, follow the rules of the appropriate culture when determining which name is the middle name.

Procedure:
- This is not a required attribute (if null, an empty field must exist in the submitted batch file).
- If only the middle initial is known, enter the middle initial without a period. If there is no middle name, leave the field blank.
- Middle names may include spaces, apostrophe (single quote) and hyphens. No numeric characters allowed.
- Report a null value (blank) to delete an existing value that was entered by mistake or is no longer applicable.

Required Documentation:
The client's middle name shall be included in the client's clinical record. Providers shall update/correct name changes as necessary.

Examples:
1. Submit "Susan" if the client's name is Mary Anne Susan Smith.

2. Submit "S" if the client's name is Mary Anne S. Smith.

Type: Text (30)

Attribute: Suffix

Transaction:
Client Demographics

Definition:
The suffix for the client's name, if one exists.

Procedure:
- This is not a required attribute (if null, an empty field must exist in the submitted batch file).
- Report the suffix. If abbreviated do not include the period.
- Report a null value (blank) to delete an existing value that was entered by mistake or is no longer applicable.

Required Documentation:
The client's name shall be included in the client's clinical record. Providers shall update/correct name changes as necessary.

Examples:
1. Submit "Sr" if the client's name is John Smith Sr.

2. Submit "III" if the client's name is John Smith III.

Type: Text (30)

Attribute: Gender

Transaction:
Client Demographics

Definition:
A code that indicates the self-identified gender of a client or staff person.

Procedure:
- This is a required attribute.
- Enter the self-identified gender.

Required Documentation:
Provider records must indicate that gender identification was self-identified.

Examples:
1. The client identifies herself as female, born female. Use Code 1.

2. The client identifies herself as female, born male. Use Code 1.

3. The client identifies himself as male. Use Code 2.

4. The client identifies as transgender. Use Code 5.

5. The client identifies as intersex. Use Code 6.

Type: Text (1)

Valid Codes	Definition	State Code (BHRD Use Only)
1	Female	1
2	Male	2
5	Transgender	4
6	Intersex: Person born with characteristics of both	5

Attribute: Date of Birth

Transaction:
Client Demographics

Definition:
The date a person was born.

Procedure:
- This is a required attribute.
- If the exact day or the exact day and exact month are unknown, enter '01' for the day and month.
- If the exact year is unknown, enter '01' for the day and month and enter an approximate year.

Required Documentation:
Providers shall maintain documentation describing the source of information from which the date of birth was established.

Example:
The client provided a driver's license showing a birthdate of February 11, 1937. **Enter 19370211.**

Type: Text (8) YYYYMMDD

Attribute: Ethnicity

Transaction:
Client Demographics

Definition:
This code is used to indicate the client's ethnicities as reported by the client.

Procedure:
- This is a required attribute.
- Enter all the codes that best describe the client's self-reported ethnicities.
- If the information is not available or unknown, then use code 999. Do not use code 999 with any other code combinations.

Every person shall have both at least one Ethnicity code and a Hispanic indicator code (see "Hispanic Origin"). This is a Federal requirement, established by the Bureau of the Census.

Required Documentation:
Vendor records shall document the ethnicities of the client and verify that the client reported this information.

Examples:
1. A client self-identifies as both White and Chinese would be coded as 010605. The first three digits (010) represents the first ethnicity, the second three digits (605) are the next ethnicity and so on.

2. A client self-identifies as Cambodian, code 604.

Type: Text (45)

Valid Codes	Definition	State Code (BHRD Use Only)
010	White / Caucasian	010
021	American Indian or Alaska Native	021
031	Asian Indian	031
032	Native Hawaiian	032
033	Other Pacific Islanders	033
034	Other Asian	034
040	Black, African American	040
050	Some Other Race	050
604	Cambodian	604
605	Chinese	605
608	Filipino	608

Valid Codes	Definition	State Code (BHRD Use Only)
611	Japanese	611
612	Korean	612
613	Laotian	613
618	Thai	034
619	Vietnamese	034
660	Guamanian or Chamorro	660
695	Samoan	033
801	Middle Eastern	801
871	African – Ethnic	040
999	Not Reported / Unknown	999

Attribute: Hispanic Origin

Transaction:
Client Demographics

Definition:
A person of Mexican, Puerto Rican, Cuban, Central American, South American or other Spanish origin or descent, regardless of race.

Procedure:
- This is a required attribute.
- Roll-up code "000" may only be used by crisis services.
- Use the code that describes the person's self-identification with Hispanic culture, origin, or descent, **in addition to** the ethnicities recorded under Ethnicity.

Note: Every person shall have an entry for both Ethnicity and Hispanic indicator.
Required Documentation:

Providers shall document whether or not a client identifies with any Hispanic culture. Records shall document that Hispanic cultural identification was self-identified by the client, or, for children younger than 13 years, by the client's parent or legal caregiver.

Examples:
1. A client self-identifies himself as Puerto Rican. Code 727 for the "Hispanic Origin" attribute. The same client states his ethnic group is African American. Code 040 for the attribute "Ethnicity."

2. A client self-identifies as White/Caucasian, code 010 for the attribute "Ethnicity." When asked if she also identifies with any Hispanic culture, the client states that she does not. Code 998 for the "Hispanic Origin" attribute.

Type: Text (3)

Valid Codes	Definition
000	General Hispanic – May only be used for crisis services
709	Cuban
722	Mexican/Mexican-American/Chicano
727	Puerto Rican
799	Other Spanish/Hispanic
998	Not Spanish/Hispanic
999	Unknown

Attribute: Interpreter Required

Transaction:
Client Demographics

Definition:
This code is used to identify a person who, in the opinion of either the case manager or the client, is functionally monolingual and needs the assistance of an interpreter or staff who speaks his/her language in order to request or receive appropriate mental health services.

Procedure:
- This is a required attribute.
- Enter the code 2 – YES if the person, because of a limited ability to speak English, requires the assistance of an interpreter in order to communicate effectively with regard to the course of their treatment.
- Limited English Proficiency does not include persons who are English speakers but who require assistance in reading.
- For children, if the child is fluent in English but a family member who is in treatment with the child requires the assistance of an interpreter, code this field 2 – YES.

Required Documentation:
When code 2 is used, documentation must indicate that interpretive services are provided to the client or to the client's family member who is also in service and requires interpretive services.

Examples:
1. A client's primary language is Spanish, but she has some ability to speak English. However, when this client is experiencing a mental health crisis, she needs interpretive services in order to communicate effectively. Code 2.

2. A 12-year-old client is proficient in English. His mother is also receiving mental health services and only speaks Korean. Code 2.

3. A client's primary language is Russian. He is receiving residential services from provider staff who speaks Russian. Code 2.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not require an interpreter.
2	Yes – the person requires the assistance of an interpreter.
9	Unknown – the English language proficiency of the person is unknown / unavailable

Attribute: Language Code

Transaction:
Client Demographics

Definition:
This code identifies the language in which a person prefers to receive services. This is usually the language used in the person's home.

Procedure:
- This is a required attribute.
- This is **not** an indicator of fluency in English.
- Use the attribute "Interpreter Required" to describe fluency in English in the context of treatment.

Required Documentation:
Provider records shall document the client's current preferred language.

Type: Text (2)

Valid Codes	Definition	State Code (BHRD Use Only)
00	Language Unknown	99
01	Japanese	01
02	Korean	02
03	Spanish	03
04	Vietnamese	04
05	Laotian	05
06	Cambodian	06
07	Mandarin	07
08	Hmong	08
09	Samoan	09
10	Ilocano	10
11	Tagalog	11
12	French	12
13	English	NULL
14	German	14
15	American Sign Language	15
16	Cantonese	16

Valid Codes	Definition	State Code (BHRD Use Only)
17	Hungarian	17
18	Russian	18
19	Romanian	19
20	Polish	20
21	Greek	21
22	Tigrigna	22
23	Amharic	23
24	Finnish	24
25	Farsi	25
26	Czech	26
27	Mien	27
28	Yakima	28
29	Salish	29
30	Puyallup	30
31	Thai	31
32	Portuguese	99
34	Other Chinese Not Cantonese or Mandarin	34
35	Dutch	35
36	Gujarati	36
37	Indian	37
39	Lakota Sioux	39
40	Malay	40
41	Marathi	41
42	Norwegian	42
50	Tongan	99
51	Arabic	33
52	Bosnian	99
53	Hindi	32
54	Oromo	99

Valid Codes	Definition	State Code (BHRD Use Only)
55	Punjabi	99
56	Somali	99
57	Swahili	99
58	Ukrainian	43
60	Italian	38
81	Other African	99
82	Other Native American	99
83	Other Filipino Dialect	99
85	Other Asian	99
87	Other communication methods (such as lip-reading, fingerspelling, etc.)	99
99	Other Language	99

Attribute: Sexual Orientation

Transaction:
Client Demographics

Definition:
This code describes the client's stated sexual orientation.

Procedure:
- This is a required attribute.
- Note that sexual identification should not be inferred by the clinician. It must be self-reported by the client.
- If a client's sexual identification was previously reported using a discontinued code, then a new value should be submitted when the next benefit is requested.

Required Documentation:
Providers must provide documentation indicating that a client stated his/her sexual orientation. If information is unknown at the time of assessment, but the client's sexual orientation becomes known at a later date, providers are responsible for updating the clinical record and the BHO IS.

Example:
A client states she is a lesbian. Code 3.

Type: Text (1)

Valid Codes	Definition	State Code (BHRD Use Only)
1	Heterosexual Attraction to persons of the opposite sex.	1
3	Gay/Lesbian/Queer/Homosexual Attraction to persons of the same sex.	3
4	Bisexual Term for women and men whose sexual/affectional identity is oriented to members of both the same and opposite sex.	4
5	Questioning Term generally used for adolescents who may be in the process of becoming more comfortable with their sexual orientation identification. Usually describes a youth who may be exploring identifying as gay/lesbian in a culture that generally assumes identification as heterosexual. May also describe an adult.	5

Valid Codes	Definition	State Code (BHRD Use Only)
6	Choosing not to disclose Use when an individual is uncomfortable or unwilling to disclose their sexual orientation.	9
8	Not asked The question was not asked or client did not self-identify. Also, use this code for child under age 13.	9
9	Unknown This information is not available at present.	9

Attribute: Military Status

Transaction:
Client Demographics

Definition:
This code indicates whether the client has served in any branch of the United States military (Army, Navy, Marines, Air Force, Coast Guard), including service in the National Guard or Reserves.

Procedure:
- This is a required attribute.
- At a minimum, the provider should ask all adults who receive services whether they have ever served in the U.S. military. More information may be gathered for clinical or case management reasons but is not required for this attribute.

Required Documentation:
The provider shall document in the clinical file the source of information about the client's military status.

Examples:
1. Client said he was in the Coast Guard forty years ago. Code 01.

2. Client said he had been in the Army Reserves. He was not sure if he had been on active duty or not. Code 01.

3. When asked if he had ever served in the U.S. military, client was uncertain and said he could not remember. Code 09.

Type: Text (2)

Valid Codes	Definition
01	The person served in the U.S. military
02	The person has never served in the U.S. military
08	Not asked – the question was not asked or client refused to answer. Also, use this code for child under age 18.
09	Unknown – this information is not available at present.

Attribute: Family Military Status

Transaction:
Client Demographics

Definition:
This code indicates whether the client is the dependent child (18 or under), spouse, or domestic partner of someone who served in any branch of the United States military (Army, Navy, Marines, Air Force, Coast Guard), including service in the National Guard or Reserves. A minor dependent is the veteran's biological/adopted child under 18, regardless of living situation or guardianship, until such time as they age into adulthood, are legally adopted by someone else, or are granted legal emancipation.

Procedure:
- This is a required attribute.
- At a minimum, the provider should ask each person (or parent/guardian if a young child), who receives services whether the client is the dependent child, spouse, or domestic partner of someone who served in the United States military. More information may be gathered for clinical or case management reasons, but is not required for this attribute.

Required Documentation:
The provider shall document in the clinical file the source of information about the client's family military status.

Examples:
1. Sixteen year-old client said his mother had served in the Army before he was born – Code 01.

2. Thirty-five year-old client said her husband was in the Air Force. She was not sure if he had been on active duty or not – Code 02.

3. The biological father of a 15-year-old client in foster care had served in the Army and suffered serious injury; neither of her foster parents served – Code 01.

Type: Text (2)

Valid Codes	Definition
01	Dependent child of a person who served in the U.S. military.
02	Spouse or domestic partner of a person who served in the U.S. military.
03	Neither the dependent child, nor the spouse or domestic partner of a person who served in the U.S. military.
08	Not asked – the question was not asked or client refused to answer.
09	Unknown – this information is not available at present.

Attribute: Social Security Number

Transaction:
Client Demographics

Definition:
This is the social security number (SSN) assigned to the client.

Procedure:
- This is a required attribute.
- Do not use a parent's SSN for a child or a spouse's SSN. If the client does not have his own SSN, or SSN is unknown, use code 999999999.
- Enter the number with no dashes or spaces.

Required Documentation:
- The provider shall maintain documentation identifying the source of information for the client's SSN.
- If 999999999 is submitted, providers are required to update the BHO IS when SSN information is provided.

Example:
The client verbally provided the number; the client showed his/her social security card; the SSN was shown on a third-party funder's document.

Type: Text (9)

Valid Codes	Definition
	Social Security Number
999999999	Unknown

Attribute: Marital Status

Transaction:
Client Demographics

Definition:
Indicates the current marital status of the client.

Procedure:
- This is a required attribute.
- Report on change.

Required Documentation:
The provider shall document in the clinical file the source of information about the client's marital status.

Type: Numeric

Valid Codes	Definition	State Code (BHRD Use Only)
1	Single or Never married: Includes those who are single or whose only marriage was annulled.	1
2	Now married or Committed Relationship: Includes those married, those living together as married, living with partners, or cohabiting.	2
3	Separated: Includes those married clients legally separated or otherwise absent from spouse because of marital discord.	3
4	Divorced: Includes clients who are not in a relationship and whose last relationship was a marriage dissolved by judicial declaration.	4
5	Widowed: Includes clients who are not in a relationship and whose last relationship was a marriage and their spouse died.	5
99	Unknown	97

Attribute: King County ID

Transaction:
Client Demographics

Definition:
The unique King County identifier assigned to a client after the BHO IS has unduplicated client records across all King County provider agencies.

Procedure:
- This is a required attribute for (C)hange requests. It should be left blank for (A)dd requests.
- This identification number, provided by the BHO IS, uniquely identifies a client served by the King County BHO.

Required Documentation:
This number must be maintained in the client's record.

Type: Integer

Transaction: Conditions at Assessment

Definition:
Describes a condition, circumstance, or risk applicable at the beginning of the benefit.

Procedure:
- The presence of one or more of these conditions may be required to support authorization to a benefit or to support the priority authorization of a non-Medicaid client.
- Submit one transaction for each applicable condition, risk, or circumstance.

Required for:
Outpatient benefit only for all Medicaid-enrolled children and youth and for non-Medicaid authorization to indicate immigrant status for all ages.

Frequency:
Assessment: Assessment date must be within 30 days of the assess date for client's current authorization.

Transaction ID: 617.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Assessment Date	Text (YYYMMDD)	8	
Condition Code	Text	3	Y
King County ID	Text (number)		

Attribute: Condition Code

Transaction:
Conditions at Assessment

Definition:
These codes identify specific conditions and circumstances, risk indicators, medical necessity, and other indicators noted during the assessment that impact eligibility.

Procedure:
- The clinician must document and report every condition or circumstance applicable.
- Submit one transaction for every applicable condition, circumstance, or risk indicator.

Required Documentation:
- Chart notes documenting clinical interviews with the child, primary caretaker and any other significant adult.
- Written referral material from social service evaluations, court documents, or other clinical programs when available at initial evaluation shall also be maintained.
- Attempts at corroboration are desirable and, if they are not completed by the time of the clinical review, attempts at acquiring corroborating documentation shall be noted in the chart.

Example:
A four-year-old girl is referred for therapeutic day care by the University of Washington Teratology Clinic with a written evaluation documenting Fetal Alcohol Syndrome and documenting Inadequate Parenting and Child Neglect. On interview, the child discloses corroborated inappropriate sexual contact with the mother's boyfriend. Enter codes for Fetal Alcohol Syndrome/Effect (103), Inadequate Parenting and Child Neglect (133), and Sexual Abuse (135).

Type: Text (3)

Children's Conditions

Valid Codes	Definition
Children's Conditions – Medical Necessity	
101	Chronic medical condition that may affect psychological functioning: A chronic medical condition, evaluated and diagnosed by a physician, which impacts the child's and his/her family's daily life due to functional limitations, needs for medication and/or rehabilitative activity. This condition shall be limited to any medical condition that does not directly affect the brain and its functioning. It excludes all neurological conditions that affect the function of the brain with direct impact on personality and functioning in the environment. (See 102.) Examples of general medical conditions that may affect psychological functioning are juvenile diabetes and asthma.
102	Neurological Condition Affecting Psychological Functioning: A chronic neurological condition, evaluated and diagnosed by a physician, which impacts the child's and his/her family's daily life due to functional limitations, needs for medication and/or rehabilitative activity. This condition is limited to neurological conditions with a direct physiological effect on brain function with the exception of Fetal Alcohol Syndrome (See 103). The brain lesions directly affect personality and functioning. Examples of neurological conditions that may affect psychological functioning are seizure disorders, particularly temporal lobe seizures, or an intractable headache syndrome.
103	Fetal Alcohol Syndrome/Effect or Fetal Drug Exposure: A chronic static brain injury sustained due to intrauterine exposure of a substance toxic to the fetus which impacted brain development. Compelling evidence of FAS/E or FDE includes a history of alcohol and/or drug use by the patient's birth mother during pregnancy and current symptoms of impulsivity and/or age inappropriate judgment with or without physical stigmata or retardation. To be coded, this condition must have been formally evaluated and diagnosed by a child psychiatrist or any other physician with special interest and experience in evaluating these conditions, or there must be compelling current evidence of symptoms or history of fetal exposure. Mental status examination on assessment must corroborate symptom history for an undiagnosed child and plans for a physician evaluation shall be documented in the chart. Consideration of a differential diagnosis must be evident in the record of the evaluation.
104	Developmental Disorder: Must be a diagnosable (DSM-5 or current version criteria) condition. A Developmental Disability shall be defined as a condition described in the DSM-5 under "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" specifically, diagnoses listed under "Mental Retardation," "Learning Disorders," "Motor Skills Disorder," and "Communications Disorders." It specifically excludes Pervasive Developmental Disorder.

Valid Codes	Definition
105	Learning Disability: Difficulties with academic tasks which have been diagnosed with psychological and/or educational testing and documented by a school system in a Focus of Concern (or similar) process. This condition does not include educational designations of Seriously Behaviorally Disturbed. (See 106.)
106	Seriously Behaviorally Disturbed: The presence of an educational system designation of SBD discerned through a Focus of Concern (or similar) process. The SBD designation is the result of patterns of behavior that disrupt the child's process of learning and may or may not meet criteria for a psychiatric diagnosis.
None – Use Disability	Substance Abuse in a Child: Report using the "Substance Abuse" attribute in the Disability transaction, a substance abuse problem during the 90 days prior to assessment significant enough to meet DSM-5 criteria and reported on the "Diagnosis Axis" and "Diagnosis Code" attributes. A substance use disorder may be cited on assessment when there is compelling evidence or history of a pattern of use which impacts the function of the child. A qualified professional must subsequently confirm this diagnosis. Documentation of such an evaluation, or plans for such an evaluation, shall be evident in the record. A qualified professional shall be defined as a certified chemical dependency professional with training and experience with children and adolescents, a board certified or eligible child and adolescent psychiatrist or a general psychiatrist with training or experience with adolescent psychiatry.
108	Law Breaking Behavior in Child: A child or adolescent with a pattern of behavior that regularly violates the law or a child who has committed a single serious legal offense (or time limited cluster of offenses). This condition refers to behavior that has caused a child or adolescent to be adjudicated by a court as a juvenile offender or behavior which is part of the child's medical or social history that, if found to be fact in a legal hearing, would lead to adjudication.
109	Attachment Difficulties: A child whose current behavior indicates absent, weak or troubled attachments and has a history of disrupted parenting before age five. Examples of disrupted parenting are multiple placements, frequent disruptions in members of the household, or mental or physical disorders in the patient's primary caretaker that diminished availability for parenting. A diagnosis of reactive attachment disorder may be present or strongly suspected for these children when young and the symptoms of this syndrome may persist into late childhood and adolescence though modified as per developmental status.

Valid Codes	Definition
110	Multiple Systems Involvement: Identifies whether the child is involved with one or more formal systems, in addition to mental health, within the preceding 12 months. Involved means the person is or has received services from formal systems. Formal systems can include but are not limited to schools, juvenile rehabilitation, alcohol/substance use disorder treatment, child or adult protective services, child welfare services, developmental disability services, vocational rehabilitation, etc. Schools can count as one system if the client is assessed for a child's outpatient benefit. Involvement with schools does not mean school attendance. It means the ongoing involvement of school counseling, special education systems, etc.
111	Receiving Special Education Services: The child has been determined to be eligible and is receiving services in accordance with the federal Individuals with Disabilities Education Act, and Washington Administrative Code 392.172.
112	None of the conditions are present based upon the intake assessment.

Children's Circumstances

Definition:
These codes identify specific circumstances noted during the assessment.

Procedure:
- Submit one transaction code for every circumstance applicable.
- Some clients will have codes for multiple circumstances. Some circumstance definitions preclude use of another.

Required Documentation:
- Documentation of clinical interview with child, primary caretaker and any other significant adult.
- Written referral material from social service evaluations, court documents or other clinical programs when available at initial evaluation.
- Attempts at corroboration are desirable and if not completed by the time of clinical review, attempts at acquiring corroborating documentation shall be noted in the chart.

Example:
A five-year-old boy witnessed the shooting death of his mother by his father (code 137, 138). This occurred as the culmination of a long-standing pattern of fighting in which the father had physically assaulted the aunt and mother (code 131, 136). The father had a diagnosis of alcoholism and when drunk regularly beat the patient (code 134, 143). The mother, who was the primary caretaker of the child most hours of the day, was mentally retarded and had a pattern of leaving the child alone while she was off with a friend (code 133, 146).

Valid Codes	Definition
Children's Circumstances – Medical Necessity	
131	Family Discord: A circumstance in which there is a significant pattern of discord in the family to which the child is exposed or in which he/she is a participant. A significant pattern identified for this circumstance is a pattern of arguing, verbal and mild physical altercations, traumatic disruptions in the household, property damage or disagreements sufficient to interfere with the primary functions of the family to nurture children and provide mutual support for adults. Serious parent/child conflict is included. Such patterns must be persistent and must involve at least two individuals. As such this definition excludes the case of an oppositional and defiant youth who is the sole disruptive force in an otherwise well-functioning family. The definition does not exclude but may not necessarily include domestic violence. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.

Valid Codes	Definition
132	Out-of-Home Placement: A circumstance in which the child or adolescent has had a significant disruption in his/her living situation due to being placed outside his/her home. A significant disruption is defined as at least one out of home placement greater than one week in the year prior to assessment. The placement outside of the child or adolescent's home must be due to the parent's or guardian's inability to care for the child or meet his/her needs. This may include cases where the primary problem is due to dysfunctional parents as well as cases where the primary problem is with the child who has overwhelmed otherwise competent parents. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information Compare this definition to the "Out of Home Placements" in the Outcome Count transaction.
133	Inadequate Parenting/Child Neglect: A circumstance in which there is a persistent pattern involving inadequate care for the child or adolescent. Inadequacy as defined for these circumstances may be due to the parents or guardians having poor skills or inadequate knowledge of raising a child, or it may be due to the parents being preoccupied with their own difficulties. The care and supervision of the identified child/adolescent needs to be sufficiently poor as to compromise his/her health and welfare. The parents could be providing adequate care for another child in the family while their care for the patient may be grossly inadequate due to the child's special needs or special vulnerability. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
134	Physical Abuse: A circumstance in which there has been physical abuse to the child to such a degree that a professional is legally bound to report the circumstances to DSHS Child Protective Services. Physical abuse is defined for this circumstance as an act of physical restraint, assault or threat of assault, or any other form of physical intrusion onto the body of a child or adolescent which is hostile in intent, disrespectful of the child's physical integrity, and/or grossly insensitive to the child's developmental need for privacy, sense of safety, and physical integrity. Such acts must be performed by an individual sufficiently older and/or larger as to create an adverse power differential for the child. This definition excludes such acts as can be characterized as sexual. (See 135.) Use code based on history or disclosure obtained at assessment and documented in the record. The documentation may include any referral information.

Valid Codes	Definition
135	Sexual Abuse: A circumstance in which there has been sexual abuse to the child to such a degree that a professional is legally bound to report the circumstances to DSHS Child Protective Services. The circumstance of sexual abuse is defined as existing when the child or adolescent is the victim of inappropriate sexual interest by an adult or an individual sufficiently older or more powerful to preclude legal consent. In the case of adolescents, this age and power differential is such that the child is unable to exercise control or consent over the interaction. This attention may be an overt physical sexual act such as would meet legal definitions for rape or molestation. It may also be a pattern of sexual harassment or inappropriate sexualized attention. In addition to inappropriate sexual interest, sexual abuse according to this definition includes inappropriate exposure to adult sexuality such as witnessing the sex acts of family members or being exposed to pornography. This definition presumes that when sexual abuse is present it either creates in the child a sense of threat to physical or psychological integrity, or is inconsistent with the child's psychosexual developmental status. Use code based on history or disclosure obtained at assessment and documented in the record. The documentation may include any referral information.
136	Domestic Violence: A circumstance in which there is an act or pattern of physical violence or threats of violence between members of the child's household which have led to (or could lead to) bodily harm. This definition excludes acts or threats of violence specifically aimed at the child. Such acts or threats are coded as physical abuse (134) and may coincide with domestic violence. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
137	Child Witness to Violence or Traumatic Death: A circumstance in which a child or adolescent has been a direct witness to an act of violence in the community (not indirectly such as in a movie or on television). This may include both willful acts of violence between individuals, or accidental violence which may or may not have led to death but has involved severe bodily harm. This circumstance is not coded when the acts of violence are witnessed in the home as part of a pattern of domestic violence between household members (136) but may be coded if the child was a witness to a traumatic death in the home. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.

Valid Codes	Definition
138	Death of a Parent: A circumstance in which the child has suffered the death of a parent. Death of a parent is broadly defined to include the death of the "psychological parent" or an adult who has functioned as a primary caretaker with whom the child has a parental bond. Examples of psychological parents might be a grandmother or aunt functioning as a parent, a long-term foster parent, or a stepparent. The death of a parent shall be documented in the record based on history as derived from the assessment and referral material. The significance of the loss of a presumed psychological parent who has died will be made and documented in the record as part of the assessment. Use code based on assessment and referral data.
139	Troubled Sibling: A circumstance in which there is a sibling in the identified client's family who is significantly troubled. Significantly troubled is defined as requiring a disproportionate amount of the family's time and resources so as to impact on the daily life of the identified client. The sibling may be affected with mental health, substance use disorder, medical problems, or may have a developmental disability or juvenile justice problems. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
140	Suicidal Behavior in a Parent: A circumstance in which the child has had a significant exposure to the suicidal behavior of a parent. Significant exposure is defined as requiring one of two circumstances: (1) The child's parent has made a suicide attempt or parasuicide in the past year; or (2) The suicidal behavior was in the more distant past but after the birth of the child and the behavior was repetitive, serious and affected the parent's ability to parent the child. Parasuicide is defined as an act of self-harm, which may or may not be intended to cause death, but which yields observable damage to body tissues. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
141	Divorce/Separation of Parents: A circumstance in which the parents have moved from living together to living separately during the child's lifetime. The separation may or may not involve parental abandonment or conflict regarding child custody issues. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.

Valid Codes	Definition
142	Health Problems in Parents: A circumstance in which the parent has a chronic health problem diagnosed by a nurse practitioner or physician requiring ongoing treatment or management. For this circumstance to be cited, the health problem of the parent must be sufficient to cause or threaten significant disruption in the overall functioning of the parent and in his/her capacity to attend to parental duties. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
143	Substance Abuse in Parents: A circumstance in which a parent has a substance use disorder diagnosed by a chemical dependency professional or physician requiring ongoing treatment or management. For this circumstance to be cited, the substance use disorder of the parent must be sufficient to cause or threaten significant disruption in the overall functioning of the parent and in their capacity to attend to their parental duties. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
144	Parents Involvement in Criminal Justice System: A circumstance in which the parent has a criminal justice problem characterized by having been convicted of a crime and subject to a legal consequence or the parent is significantly involved in responding to charges of crimes as to be required to expend significant amounts of time and resources. For this circumstance to be cited, the criminal justice problem of the parent must be sufficient to cause or threaten significant disruption in their overall functioning and in their capacity to attend to their parental duties. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
145	Mental Illness in Parents: A circumstance in which the parent has a chronic mental health problem diagnosed by a psychiatrist or qualified mental health specialist requiring ongoing treatment or management. For this circumstance to be cited, the mental health problem of the parent must be sufficient to cause or threaten significant disruption in their overall functioning and in their capacity to attend to their parental duties. Use code based on history obtained at assessment and document in the record. The documentation may include any referral information.

Valid Codes	Definition
146	Cognitive Impairment in Parents: A circumstance in which the parent has a cognitive impairment diagnosed by psychological testing and/or medical/psychiatric or advanced nurse practitioner evaluation which requires ongoing management and support services. For this circumstance to be cited, the cognitive impairment of the parent must be sufficient to cause significant incapacity in their overall functioning and in her/his capacity to attend to parental duties. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
147	Child's Parent(s) Teens: The circumstance of either parent being 18 or younger at the time the child was born. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
148	Teen Parenthood or Pregnancy: A circumstance in which an adolescent client is a teen parent, has been pregnant but aborted, or gave up the child for adoption. Teen parenthood and adolescent pregnancy are defined by the client becoming pregnant at age 18 or younger or, in the case of males, fathered a child at age 18 or younger. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
149	Harassment or Abuse by Peers: A circumstance in which a child or adolescent suffers a persistent pattern of abuse by peers. Harassment and abuse by peers is defined as a pattern of peer relationships in which a child or adolescent client is selected for harassment, physical or verbal abuse, derision and torment by more than one peer and that the child demonstrates no, or inadequate, coping skills to address the abuse. The child may or may not have actively participated in the set up for ill treatment by peers. The child may or may not have effective parental or adult support in dealing with such problems. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
150	Cultural or Sexual Minority Status Where Context Creates Risks: A circumstance in which the fact of cultural or sexual minority status creates risk to emotional wellbeing due to the social context which condones or provokes racial, cultural, or sexual minority-based harassment and intolerance. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.

Valid Codes	Definition
151	Multiple Moves: A circumstance in which the child makes a move in primary residence, with or without his/her family, more than three times in the year preceding the assessment. Use code based on history obtained at assessment and document in the record. The documentation may include any referral information.
402	Homelessness, Children: A circumstance in which a child, with or without their family, sustains at least one episode of homelessness during past year. To be homeless one must have no identified place of residence and must have been in that status for longer than one week. If the child is homeless without his/her family, the child is unable to return to a parental home or the home of a previous guardian. An identified place of residence for a child or adolescent is the parental home, a placement sanctioned by the parents informally such as with a relative or close family friend, or a placement ordered by the court in a formal placement process. Inability to return to a parental home or previous placement must be due to: (1) the absence of such a home; (2) the fact that the child has actively been forced out of the parental home or previous placement and is unwelcome there; or (3) the court has intervened to prevent the return of the child to an unsafe previous home. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information. See also "Other Indicators." Homelessness, Adults: See Residential Arrangement transaction.

Risk Indicators

Definition:
These codes (currently only one) identify specific risk indicators noted during the assessment. These codes designate that a non-Medicaid person qualifies for enrollment in the MHP due to an acute need of service.

Procedure:
- Submit one transaction code for each applicable risk indicator.
- Document and report every condition applicable to the client.

Required documentation:
- Chart notes documenting clinical interview with client, primary caretaker, and any other significant adult.
- Written referral material from social service evaluations, court documents, or other clinical programs when available at initial evaluation.
- Attempts at corroboration are desirable and if not completed by a time of clinical review, attempts at acquiring corroborating documentation will be noted in the chart.

Example:
A seven-year-old girl has disclosed to her care worker that she has been sexually abused. This was reported to CPS and evaluated by that agency which found that the allegations were substantiated. Prosecution of the stepfather is pending (code 201).

Valid Codes	Definition
Risk Indicators – Acute Need of Services	
314	Refugee or Immigrant – Adult, Children of Refugee or Immigrant – Child. This code is used to indicate that the client is in acute need of services because of this status as defined under the non-Medicaid policy. See Section 05: Outpatient Services Level of Care. No time restrictions apply. This code replaces code 304 – Refugee or Immigrant in the past calendar year.

Transaction: Co-Occurring Disorders Assessment

Definition:
The Co-occurring disorders assessment quadrant value.

Required for:
Outpatient, Residential: When the individual scores a 2 or higher on either of the first two scales (Internal Disorder Screen and External Disorder Screen) and a 2 or higher on the third (Substance Disorder Screen). See the "Co-Occurring Disorders Screening" transaction for more information.

Frequency:
See COD Screening frequency requirements.

Transaction ID: 791.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Quadrant	Text	1	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

Attribute: Co-occurring Disorders Quadrant

Transaction:
Co-occurring Disorders Assessment

Procedure:
- The COD assessment is a quadrant assignment only.
- The COD assessment is required for clients 13 and over.
- When reporting an assessment, a value must be submitted.

Required Documentation:
Justification for all quadrants must be provided in agency records. Documentation must include the date the quadrant was assigned; the name, title, and credentials of the clinician who assigned the quadrant; and a justification for the quadrant.

Type: Character (1)

Valid Codes	Definition
1	Less severe mental health disorder/Less severe substance use disorder
2	More severe mental health disorder/Less severe substance use disorder
3	Less severe mental health disorder/More severe substance use disorder
4	More severe mental health disorder/More severe substance use disorder
9	No Co-occurring treatment need

Transaction: Co-Occurring Disorders Screening

Definition:
Identifies the outcome of a screening using *GAIN Short Screen* (GAIN-SS) tool.

Required for:
Outpatient, Residential, Crisis

Frequency:
Initial assessment
Crisis episode – only if not completed (by any provider) in the previous 12 months.

Transaction ID: 790.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
IDS Score	Text	1	Y
EDS Score	Text	1	Y
SDS Score	Text	1	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

Attribute: IDS Score

Transaction:
Co-Occurring Disorders Screening

Definition:
The Internal Disorder Screener (IDS) is designed to identify people experiencing internalizing disorders such as depression, anxiety, suicidal ideation, and acute/post-traumatic stress disorders.

Type: Text (1)

Valid Codes	Definition
0-5	Score in the range from 0 to 5
8	Refused
9	Not Completed

Attribute: EDS Score

Transaction:
Co-Occurring Disorders Screening

Definition:
The External Disorder Screener (EDS) is designed to identify persons experiencing externalizing disorders such as attention deficit, hyperactivity, conduct disorder, aggression/violence, and other externalizing behavioral problems.

Type: Text (1)

Valid Codes	Definition
0-5	Score in the range from 0 to 5
8	Refused
9	Not Completed

Attribute: SDS Score

Transaction:
Co-Occurring Disorders Screening

Definition:
The Substance Disorder Screener (SDS) is designed to identify persons abusing or dependent upon alcohol or other drugs.

Procedure:
- The screening is required for clients 13 and over.
- The screening tool should be scored on self-report only. (If the client is in denial, this will mean a low screening score, even when the client is obviously intoxicated.)
- Only report screenings conducted by your agency.
- The IDS, EDS, and SDS score can have a range of 0-5, 8 or 9.
- When reporting the outcome of a screening, a value in each of the scores must be provided. The range for a screening that is completed is between 0 and 5 in each scale (i.e., IDS, EDS, SDS).
- Use 8 to indicate the client refuses to participate in the specific scale.
- Use 9 to indicate client is unable to complete the specific scale.

Required Documentation:
Providers must document the source of scores. Documentation must include: the date the screening was done and the name, title, and credentials of the clinician who conducted the screening.

Type: Text (1)

Valid Codes	Definition
0-5	Score in the range from 0 to 5
8	Refused
9	Not Completed

Transaction: CPT Service Detail

Definition:
Detailed client service episode records. Since October 16, 2003, this transaction is only used as part of Batch or Extraction error reports from the BHRD IS to denote the data were derived from a HIPAA 837P transaction. The fields are listed here to assist with understanding how HIPAA transactions are translated into legacy transactions for processing into the BHRD database and how errors are reported to providers in Batch Error reports or Extraction reports.

Required for:
Outpatient, Residential, Crisis
The transaction is not accepted for program 101.

Procedure:
A Change transaction can be used to update the following fields:
Service Modifier, Service Minutes, Service Location, EPSDT Indicator, Staff person ID, and EPB Codes.

Required Documentation:
All services provided to a client must be documented in the clinical record with the date, type, location, and duration of the service episode and the name of the clinician providing the service.

Collection Frequency:
On event

Transaction ID: 120.07

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Service Transaction ID	Text	15	
Event Date	Text (YYYYMMDD)	8	
CPT Code	Text	5	Y
Service Modifier	Text	8	Y
Minutes of Service	Text (number)	4	
Service Location	Text	2	Y

Attribute	Type	Size	Coded
EPSDT Indicator	Text	1	
Staff Person Provider ID	Text	10	Y
Staff Person King County ID	Text	10	
Authorization Number	Text (number)		
King County ID	Text (number)		
Address Line 1	Text	55	N
Address Line 2	Text	55	N
City	Text	30	N
State	Text	2	Y
Zip	Text	15	N
Claim ID	Text	38	N
Primary Service ID	Text	17	N
EBP Code	Text	23	Y
DBHR Agency Number	Text	6	Y

Attribute: Event Date

Transaction:
CPT Service Detail

Definition:
The date an episode of service was provided.

Required Documentation:
Providers shall document the date of all service episodes provided.

Type: Date (8) YYYYMMDD

Attribute: Service Transaction ID

Transaction:
CPT Service Detail

Definition:
A number or identifier that uniquely identifies each discrete service event among all service transactions reported by the provider.

Procedure:
This ID is used to uniquely identify the service record being reported and is generated at the provider level.

Example:
A client receives two out of facility case management services on the same day. Each service is reported with a unique service transaction identifier to differentiate the two transactions.

Type: Character (15)

Attribute: CPT Code

Transaction:
CPT Service Detail

Definition:
A Current Procedural Terminology (CPT) or Healthcare Common Procedures Code Set (HCPCS) code that identifies a service delivered to a client.

Procedure:
- All services provided to, or for, a client must be reported.
- Only CPT/HCPCS codes found in the DBHR Service Encounter Reporting Instructions that are available at https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information will be accepted unless additional codes are specified by BHRD in the KCBHO Service Encounter Reporting Instructions contained in Attachment E.
- CPT codes are identified and defined by the American Medical Association (AMA). HCPCS codes are maintained and distributed by the Center for Medicare and Medicaid Services (CMS). Changes may be made to the DBHR and/or KCBHO Service Encounter Reporting Instructions as a result of changes made to the CPT codes by the AMA or to the HCPCS codes by CMS.

Required Documentation:
Providers shall maintain documentation in the client's record that supports the service codes submitted.

Attribute: Service Modifier

Transaction:
CPT Service Detail

Definition:
A code that indicates a service provided was changed or clarified by some specific circumstance. Modifiers are used in association with Current Procedural Terminology (CPT) and Healthcare Common Procedures Code Set (HCPCS) codes.

Known as Procedure Modifier under HIPAA.

Procedure:
- Enter up to four modifier codes per service encounter.
- Leave the attribute blank if no modifiers are required.
- The CPT (or HCPCS) code/modifier combination must follow the DBHR Service Encounter Reporting Instructions, which are available at https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information, and/or the BHRD-specific KCBHO Service Encounter Reporting Instructions contained in Attachment E.
- Only modifiers found in the DBHR Service Encounter Reporting Instructions or Attachment E will be accepted.

Examples:
1. HCPCS code H0046 is defined as 'Mental health services, not otherwise specified.' This code in combination with the MHD defined modifier 'UB' identifies an encounter as a 'Request for Service.' Use modifier 'UB' in conjunction with code H0046 to report 'Request for Services' encounters. (See the MHD Service Encounter Reporting Instructions, Request for Services section.)

2. After an intake with a six-year-old girl whose problems include conflicts with other students, the clinician obtains a release of information and contacts her teacher to gain understanding of the girl's school difficulties. Use modifier "UK" in conjunction with code H2015 to report the time spent in collaborative work with the teacher. (See Attachment E, Collateral Contact section.)

Type: Character (8)

Attribute: Minutes of Service

Transaction:
CPT Service Detail

Definition:
The number of minutes for a specific Service Event.

Procedure:
- Report the actual minutes (**not** units) unless the service is *per diem*.
- The minutes reported for a service encounter must be between 5 and 1440.
- For per diem services, submit one for minutes of service.

Required Documentation:
Providers shall document the actual number of minutes for each service event (duration) in clinical records.

Type: Number (4)

Attribute: Service Location

Transaction:
CPT Service Detail

Definition:
Codes used on professional claims/encounters to specify the place where the service was rendered. HIPAA 837P transactions should use the current code values specified at:

http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Procedure:
Report one location code for each discrete service event.

Type: Character (2)

Attribute: EPSDT Indicator

Transaction:
CPT Service Detail

Definition:
This attribute is used to indicate whether a service: (a) resulted from an Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) screening by a medical provider, or (b) resulted in a referral to a medical provider for an EPSDT screening. EPSDT screenings are required for children (under 21 years of age) who have Medicaid coverage.

Procedure:
Report a "Y" if this specific service resulted from or led to an EPSDT referral. Otherwise, report "N."

Examples:
1. As a result of an EPSDT screening, a physician refers a six-year-old boy to a mental health center for assessment of mental health treatment needs. The clinician requests an outpatient benefit after the assessment and meets regularly with the boy and/or his father. Submit the assessment service with a "Y" for EPSDT Indicator. Submit subsequent services with "N" for EPSDT Indicator.

2. During an intake for a 12-year-old-girl, the clinician learns that she has not had a physical checkup in three years and refers her to her primary care doctor for an EPSDT screening. Submit the service that led to the referral with a "Y" for EPSDT Indicator. Submit subsequent services with "N" for EPSDT Indicator.

Type: Character (1)

Attribute: Staff Person Provider ID

Transaction:
CPT Service Detail

Definition:
This uniquely identifies the agency of the staff person providing the service. This attribute normally is the Reporting Unit ID of the client.

Procedure:
- Where a provider holding an authorization for a benefit has contracted with a second agency to provide services, the authorized provider is responsible for reporting service data, including the second agency staff person providing the service. Use this attribute to report the second agency ID and second agency staff ID.
- For purposes of Interpreter Services, providers using a contracted service bureau may create a single staff ID to represent all bureau staff.

Required Documentation:
All services provided to a client must be documented in the clinical record with the date, type, location, and duration of the service episode and the name of the clinician providing the service.

Example:
CPC has an authorized client. CPC has contracted with Central Area to provide specific services using Central Area staff. Report the Central Area ID (019) in the Staff Person Provider ID field, and the Central Area staff ID in the Staff ID field.

Type: Text (10)

Attribute: Staff Person King County ID

Transaction:
CPT Service Detail

Definition:
This is the King County ID (KCID) for the staff person within an agency who is providing and reporting a service to a client. For services which involve one or more staff persons, the client's primary case manager is the identified staff person, unless the purpose of the service is psychiatric or ARNP consultation. In that instance, the psychiatrist (first) or the ARNP (second) is the identified staff person.

Procedure:
- If the primary case manager is not present, the most senior staff person (determined by education and experience) who is present for the entire service event is the identified staff person.
- For services provided by a consultant or supervisor (e.g., special population consultation), report the KCID of the consultant and not the KCID of the case manager receiving the consultation.
- For consultation modalities where the specialist is a member of the reporting provider staff, the provider must submit the KCID of the consultant.
- When the specialist is either a member of another network provider staff or a mental health specialist on sub-contract with the provider, the provider may report either the provider ID and staff KCID of the specialist, or a staff KCID of "999" indicating that this is a qualified specialist and not a member of the reporting provider staff, or a staff KCID of "998" indicating that this is a special population MH Specialist with one of the special population qualifications listed under the Staff Qualifications transaction.
    - Staff qualifications must be appropriate to the submitted CPT code/modifier(s) combination, as specified in the State MHD Service Encounter Reporting Instructions and/or KCBHO Service Encounter Reporting Instructions. To crosswalk BHRD staff qualifications to the state's instructions, see the "Mapping-to-State's Provider Type" column in the table for the Qualifications attribute in the Staff Qualifications transaction.

Required Documentation:
All services provided to a client must be documented in the clinical record with the date, type, location (in/out), and duration of the service episode and the name of the clinician providing the service, including the provider staff ID, or the outside specialist's name and staff ID (999).

Type: Text (10)

Attribute: Address Line 1

Transaction:
CPT Service Detail

Definition:
Free-form text for the first line of client's mailing address.

Procedure:
- This is a required data element.
- If a client is homeless or client's mailing address is unknown, report the address of agency's office where the letter should be sent.
- This address will be used to send required notification letters to clients.

Required Documentation:
The client's mailing address must be maintained in his/her clinical record.

Type: Text (55)

Attribute: Address Line 2

Transaction:
CPT Service Detail

Definition:
Free-form text for the second line of client's mailing address.

Procedure:
This is an optional data element. It is required only if the mailing address has a second address line.

Required Documentation:
The client's mailing address must be maintained in his/her clinical record.

Type: Text (55)

Attribute: City

Transaction:
CPT Service Detail

Definition:
Free-form text for the city.

Procedure:
This is a required data element.

Required Documentation:
The client's mailing address must be maintained in his/her clinical record.

Type: Text (30)

Attribute: State

Transaction:
CPT Service Detail

Definition:
Official USPS state abbreviation.

Procedure:
This is a required data element.

Required Documentation:
The client's mailing address must be maintained in his/her clinical record.

Type: Text (2)

Attribute: Zip code

Transaction:
CPT Service Detail

Definition:
The five- or nine-digit code for the zip code for the person's latest mailing address.

Procedure:
This is a required data element.

Required Documentation:
The client’s mailing address must be maintained in his/her clinical record.

Type: Text (15)

Attribute: Claim ID

Transaction:
CPT Service Detail

Definition:
The submitter's claim identifier from the 837P.

Procedure:
All services submitted under one Claim ID are considered part of the same encounter if you have identified your system as submitting "one encounter per claim."

Type: Text (38)

Attribute: Primary Service ID

Transaction:
CPT Service Detail

Definition:
References the Service ID of the service for which an add-on CPT code has been submitted.

Procedure:
This is a required data element if you have identified your system as submitting “multiple encounters per claim” and you submit a service that is an add-on CPT code.

Type: Text (17)

Attribute: EBP Code

Transaction:
CPT Service Detail

Definition:
Evidenced based practice code.

Procedure:
This is a pipe-delimited list of valid evidenced based practice codes as outlined in the "Evidence Based Practice – Children's Mental Health" section of the "Service Encounter Reporting Instructions for BHOs" (https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information).

Type: Text (23)

Transaction: Crisis Diversion Services

Definition:
Program specific information for the Crisis Diversion Facility (CDF)

Procedure:
- Required for all Crisis Diversion Facility authorizations.
- Each Crisis Diversion Facility authorization should have one Crisis Diversion Services record.

Required Documentation:
- Documentation of an interview with the person, referral source, or other informant.
- Attempts at corroboration are desirable and attempts at acquiring corroborating documentation shall be noted in the provider records.

Required for:
Crisis Diversion Facility **(80)**

Frequency:
Each time a person arrives at the Crisis Diversion Facility for services.

Transaction ID: 860.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Authorization Number	Text (number)		
Diversion Type	Text	1	Y
Primary Presenting Condition	Text	2	Y
Arrival DateTime	Text (YYYYMMDDHHMM)	12	
Exit DateTime	Text (YYYYMMDDHHMM)	12	
Service Level	Text	3	Y
King County ID	Text (number)		

Attribute: Diversion Type

Transaction:
Crisis Diversion Services

Definition:
The Diversion Type is designed to identify the type of facility from which the crisis diversion diverted the person.

Type: Text (1)

Valid Codes	Definition
H	Hospital
J	Jail
N	Neither

Attribute: Primary Presenting Condition

Transaction:
Crisis Diversion Services

Definition:
The Primary Presenting Condition describes the perceived current state of the person, at the beginning of a crisis episode, that is a contributing factor to the circumstances leading to the intervention.

Type: Text (2)

Valid Codes	Definition
SA	Substance Abuse
MH	Mental Health
BT	Both

Attribute: Arrival DateTime

Transaction:
Crisis Diversion Services

Definition:
Indicates the beginning date and time (to the minute) when the individual entered the facility.

Procedure:
- Submit the time in a 24-hour clock format.
- Arrival Start DateTime must be the same day as the Authorization Request Date of Assessment.
- Arrival Start DateTime must precede the Exit DateTime.

Type: DateTime (12) YYYYMMDDHHMM

Attribute: Exit DateTime

Transaction:
Crisis Diversion Services

Definition:
Indicates the date and time (to the minute) at which program services concluded for the individual.

Procedure:
- Submit the time in a 24-hour clock format.
- Exit DateTime must be the same day as the Notice of Exit Event Date (end of the authorization).

Type: DateTime (12) YYYYMMDDHHMM

Attribute: Service Level

Transaction:
Crisis Diversion Services

Definition:
Indicates the intensity of services which the individual received.

Type: Text (3)

Valid Codes	Definition
NAF	Not Appropriate for Facility – individual arrived at facility, did not meet eligibility criteria, provider referred/transferred individual to another service system, agency, or facility
SRL	Stabilization/Referral/Linkage – individual served at facility, provider stabilized/referred/transferred individual to another service system, agency, or facility
ACB	Assigned to a CDF bed

Transaction: Diagnosis ICD-10-CM

Definition:
Identifies a person's diagnosis.

Required for:
Crisis, Outpatient, Residential, Inpatient

Procedure:
Authorization is in 'UA' status

When an authorization is in 'UA' status, the BHRD system selects the client diagnosis records (regardless of authorization number) submitted on the earliest event date between the authorization's assessment date and 92 days into the future. Only diagnosis records submitted by the agency requesting the authorization are considered.

Authorization is in 'AA' status

Once an authorization reaches 'AA' status, the set of diagnoses with the most recent event date on the system is considered applicable. For a given event date, the set of diagnoses should be a complete set of all applicable diagnoses on that date. Resubmit all applicable diagnoses if a diagnosis transaction is submitted for an event date different from the previous event date and previous diagnoses still apply.

Do not delete a diagnostic code unless it was submitted in error. The BHRD IS maintains a historical record of all diagnoses for each client.

Frequency:
Initial Assessment
On change to the diagnosis

Transaction ID: 870.01

Action Codes:

A	Add
C	Change (Primary Focus Indicator only)
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Diagnosis Code	Text	8	Y
Event Date	Text (YYYYMMDD)	8	
Primary Focus Indicator	Text	2	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

Attribute: Diagnosis Code

Transaction:
Diagnosis ICD-10-CM

Definition:
The Diagnosis Code Attribute is used to identify mental, behavioral and neurodevelopmental disorders.

Procedure:
- There is no limit on the number of diagnosis codes that can be submitted.
- Primary Focus Indicator is the only field that can be changed for a diagnosis record that has been submitted and posted. If you are changing the primary focus indicator on an existing diagnosis from '00' (not primary) to '01' (primary) you must first change the existing primary ('01') to '00' (not primary).
- Diagnoses failing one or more of the following edits will be rejected:
  - For all clients age six years old and above, only ICD-10-CM codes can be submitted.
  - For all clients six years old and above, "The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition" (DSM-5) diagnostic criteria should be used in the provider medical record and in consultations with BHRD staff.
  - For children under six years old the provider may use a DC:0-5 diagnosis instead of the DSM-5 diagnosis. Use the tables that follow to crosswalk DC:0-5 codes to ICD-10-CM codes.
- Agencies must identify the clinician assigning the diagnosis in the face-to-face service record reported to the system and must maintain documentation identifying that clinical staff person by name and title.
- The individual making the diagnosis can be anyone authorized by the agency to determine diagnosis.

Required Documentation:
Justification for all diagnoses must be provided in agency records. Documentation must include the date each diagnosis was assigned; the name, title and credentials of the clinician who assigned the diagnosis; and a justification for the diagnosis.

Type: Text (8)
Enter the ICD-10-CM diagnosis code. **Include the period**.

Valid Values:
All ICD-10-CM diagnosis codes.

Covered Diagnoses:
Refer to the most recent Access to Care Standards (ACS) document published by the Division of Behavioral Health and Recovery (https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/access-care-standards-acs-and-icd-information). The most recent version can also be found in the ISAC Notebook.

Attribute: Primary Focus Indicator

Transaction:
Diagnosis ICD-10-CM

Definition:
The Primary Focus Indicator is used to identify whether or not the diagnosis is the primary focus of treatment.

Procedure:
- At least one diagnosis must be marked as the primary focus of treatment.
- Up to two diagnoses can be identified as the primary focus of treatment. If two diagnoses are identified as the primary focus of treatment, one of them must be a SUD diagnosis (ICD-10 code range F10-F19).
- If the primary focus of treatment changes during an outpatient or residential benefit, the change does not need to be submitted until diagnostic data is next required.

Documentation:
See Diagnosis Code.

Examples:
1. An adult client is diagnosed with major depression and mental retardation. The current treatment plan addresses problems due to the major depression. Code major depression as the primary focus of treatment.

2. A child has an attention-deficit hyperactivity disorder and a social phobia. The treatment plan focuses primarily on the ADHD. Code the ADHD as the primary focus of treatment.

Valid Codes	Definition
01	Primary focus of treatment.
00	Not primary focus of treatment.

Transaction: Disability

Definition:
Describes disabilities other than the disability of mental illness.

Required for:
All outpatient or residential benefits paid on a case rate basis, all programs

Procedure:
Multiple unique "impairment kind" codes may be submitted for the same KCID/event date. There is no 'C' (change) action code available if you wish to change the "Impairment Kind." If "Impairment Kind" for a previously submitted disability transaction must be changed, submit a 'D' (delete) followed by an 'A' (Add). "Substance Abuse" can be changed using action code "C."

Frequency:
Assessment
On change

Transaction ID: 050.03

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Impairment Kind	Text	10	Y
Substance Abuse	Text	1	Y
King County ID	Text (number)		

Attribute: Impairment Kind

Transaction:
Disability

Definition:
The set of codes that identifies a person's disability, other mental health diagnosis, or conditions. To determine when a problem area should be identified as a disability, the general criteria are that disabilities should have a major impact on the person and his/her ability to function in the community. Examples of community functioning are the ability to procure food, clothing, and a safe place to live without assistance.

Procedure:
- Whenever any disability code is submitted, resubmit all currently applicable disability codes.
- Enter up to three applicable disability codes in a single transaction. This is the maximum number of two character codes that can be juxtaposed in a single 'Impairment Kind' field. If codes are concatenated, they are split out into separate rows in the database.
- Do not use codes 10 or 99 in conjunction with any other codes.
- This is a state-required field.

Required Documentation:
- For each coded disability, provider shall document the rationale for determining the existence of a disability. If this is not available, state why in the client's record.
- If code 80 is used (other disabilities not listed), provider records must identify the disability.
- For each coded disability, documentation shall include the date of onset, the impact on the client's functioning, identification of other systems providing services to the client, information about collaborative service planning and provision and impact of other disabilities on the client's mental health.

Examples:
1. A client reported having an auditory disability during an earlier assessment. This was reported in a transaction. Six months later the client acquired a medical disability. Submit codes 33 and 44 with the date of onset of the medical disability.

2. During the initial assessment, documentation is provided verifying that a client is mentally retarded and has a visual disability. Report codes 24 and 31 with the assessment date.

3. A client is diagnosed with congestive heart failure and HIV. Report Code 44 once only.

Type: VarChar (10)

Valid Codes	Definition
10	None – No disability. Do not use in conjunction with any other impairment kind codes (Normally multiple impairment codes can be entered in this field).
Limits development of intelligence	
20	Developmental – ITA ONLY
23	Developmental Disability – Physical A physical impairment or loss of function attributable to the brain or CNS (e.g. cerebral palsy), manifested before age 22, which is likely to continue indefinitely and results in substantial limitation in three or more specified areas of functioning and requiring specific and lifelong or extended care. See Public Law 95-602 (1978).
24	Developmental Disability – Mental A disability attributable to an intellectual impairment (not a mental illness) as evidenced by a diagnosis of mental retardation, or an IQ of approximately 70 or below, or inclusion for services in the Department of Developmental Disabilities. This disability must be manifested before age 22, is likely to continue indefinitely, and results in substantial limitation in three or more specified areas of functioning, requiring specific and lifelong or extended care. See Public Law 95-602 (1978).
Sensory or communication	
30	Sensory or communication – ITA ONLY
31	Visual disability
32	Deaf: A hearing impairment of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, manual communication and gestures. In general, an individual with a loss exceeding 80 decibels in the conversational range is considered to be deaf.
33	Hard of hearing: A hearing impairment resulting in a functional loss, but not to the extent the individual must depend primarily upon visual or tactile communication. The hearing loss should be a significant factor in the symptoms of the mental illness, (e.g., increasing anxiety, suspiciousness, or isolation); in the person's level of functioning; or in the provision of treatment.
34	Other communication difficulties (speech and language, language comprehension). (Does not include non-native speakers.)
Other	
43	Medically compromised: A person considered to be "medically compromised homebound" has a chronic medical condition, physical or psychiatric, which causes significant disability such that the individual is (1) unable to leave home, or (2) if leaving home is possible, this occurs infrequently, is usually for the purpose of receiving medical care, and requires considerable effort, supervision, or assistance. Because of this difficulty or inability to leave home, the medically compromised homebound individual is unable to utilize services if provided only in a clinic.

Valid Codes	Definition
44	Medical or physical disabilities including chronic illness not listed above. Do not submit duplicates of this code, regardless of the number of conditions that the code defines.
45	Neurological disabilities not listed above
50	Mobility
80	Other disabilities not listed above

Attribute: Substance Abuse

Transaction:
Disability

Definition:
This attribute codes a client's abuse or dependence on drugs and/or alcohol.

Procedure:
- **Drug** refers to an individual who currently or within the past year has abused or had a dependence on drugs.
- **Alcohol** refers to an individual who currently or within the past year has abused or had a dependence on alcohol.
- **Drug and Alcohol** refers to an individual who currently or within the past year has abused or had a dependence on both drugs and alcohol.

Note: Time frame for definitions above was changed from 90 days to past year starting 1/1/2002.

Required Documentation:
Providers must document the source of information used to determine the appropriate code. Examples of sources of information: the client reported; the client's chemical dependency professional reported; the client's parole officer reported; the hospital record indicated; the clinician observed.

Examples:
1. During the assessment for services, a client stated she became clean and sober from alcohol two months ago. The clinician has obtained no information that conflicts with this report. Code 2 until one year after the client last used.

2. A client reports to his case manager that he has an occasional social drink. The case manager has observed no impact of alcohol on the client's life in general or related to treatment. Code 8.

Type: Character (1)

Valid Codes	Definition
1	Drug
2	Alcohol
3	Drug and alcohol
6	Client denies – clinician suspects abuse or dependence
7	Drug or alcohol abuse or dependence – IN REMISSION for a year or more.
8	No history of abuse or dependence

Transaction: Dynamic Client Data

Definition:
A collection of client related data elements that can change over time.

Required for:
Mental health and SUD outpatient benefits
Mental health and SUD residential benefits

Frequency:
Initial assessment
On change

Procedure:
Report this set of data when any of the data elements change. Because the data is reported as a set the current value of all elements should be reported as of the event date.

Transaction ID: 180.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	
Case ID	Text	10		
Event Date	Date (YYYYMMDD)	8		
Employment Status	Text	2	Y	Y
Education Status	Text	2	Y	Y
Grade Level	Text	2	Y	Y
Pregnant	Number	1	Y	Y
Birthdate of Youngest Child	Date (YYYYMMDD)	8		N
Smoking Status	Number	2	Y	Y
Self Help Count	Text	2	Y	SUD
Used Needle Recently	Number	1	Y	SUD
Needle Use	Number	2	Y	SUD
SUD_ROI_Granted	Number	1	Y	SUD
King County ID	Number	10		Y

Attribute: Event Date

Definition:
On assessment, the event date is the date of assessment as reported in the authorization request.

On change, the event date is the date of the actual change, or where not known exactly, the best available estimate.

Procedure:
Whenever a change occurs for any of the attributes, submit a transaction with the event date of the changed attributes, the new code for the changed attributes, and the previously reported codes for the other attributes. All attributes will be stored in a single record with the single event date, and only the attribute(s) with new value(s) will be considered to have changed.

Attribute: Employment Status

Transaction:
Dynamic Client Data

Definition:
A code that describes the client's status with respect to paid work.

Procedure:
- Where a client meets more than one definition below, report the lowest numbered King County ("valid code") that applies.
- On assessment, report the date of the assessment.
- On change, report the actual date of the change. Where unknown, report the best estimate and document in the file.
- If the change is due to the new employment status code, the event date is the date when the client's employment status using the new set of codes is re-evaluated.
- This is used for State and BHRD outcome measures and for the BHRD "Employment Increase" Recovery Incentive measure.

Required Documentation:
Provider records shall document all employment including the source of information used to code this attribute.

Examples:
1. During an assessment, the client reports she holds two part-time jobs, one for 25 hours a week as a nursing assistant and the second for 15 hours a week as a teacher's aide. Report the client as employed competitively full-time (Code 21), since the total hours of employment exceed 35 hours.

2. A client attends college and has a 15-hour a week work-study job. Report as employed competitively less than 20 hours a week (Code 23).

3. An unemployed client is referred to a supported employment program and begins receiving job placement services. Report as not employed but actively looking for work (Code 25). Two months later, she obtains a 20-hour a week competitive job and continues to receive supported employment services. Report as employed competitively 20-34 hours a week (Code 22).

4. An unemployed client begins receiving DVR services and begins receiving job placement services. Report as not employed but actively looking for work (Code 25). Two months later, he obtains a 20 hour a week job and continues to receive employment supports through DVR. Report as employed competitively 20-34 hours a week (Code 22).

5. A client works 20 hours a week in a three-month transitional employment job associated with a clubhouse. Report as employed in a non-competitive job (Code 24).

6. A client accompanies her elderly neighbor to the store each week to help with shopping, but is not interested in finding paid employment. Report as not in labor force (Code 26).

7. A client volunteers weekly at a local food bank. Report as not in labor force (Code 26).

Type: Text (2)

Valid Codes	**Definition**	**State Code (BHRD Use Only)**
21	Employed Competitively Full-time: 35 hours or more paid employment per week	01
22	Employed Competitively Part-time: 20-34 hours paid employment per week	02
23	Employed Competitively Part-time: Less than 20 hours paid employment per week	02
24	Employed in a non-competitive job (1 or more hours per week). Position is considered non-competitive if it meets any one or more of the following criteria: Position is in a “sheltered” or protected setting in which the typical performance expectations of mainstream jobs do not apply. Applications for position are deemed eligible based solely upon an individual’s diagnosis of a mental illness or of a developmental or other disability, rather than on specific job qualifications related to the duties and responsibilities of the position. Position is limited to specific group/type of individuals (i.e., consumers receiving services at a particular agency) and not available to anyone who meets identified job qualifications. Co-workers/peers are primarily mental health consumers or individuals with a common disability. Salary is less than minimum wage	74

Valid Codes	Definition	State Code (BHRD Use Only)
25	Not employed: Actively looking for work may consist of any of the following activities: Participating in a supported employment, or certified clubhouse employment, program Contacting: An employer directly or having a job interview A public or private employment agency Friends or relatives A school or university employment center Sending out resumes or filling out applications Placing or answering advertisement Checking union or professional registers Some other means of active job search	03
60	Not in Labor Force: Homemaker	14
61	Not in Labor Force: Student	24
62	Not in Labor Force: Retired	34
63	Not in Labor Force: Disabled	44
64	Not in Labor Force: Other reported classification (e.g. volunteer)	64
99	Unknown	97

Attribute: Education Status

Transaction:
Dynamic Client Data

Definition:
A code that describes the client's involvement in formal learning activities.

Procedure:
- On assessment, report the date of the assessment.
- On change, report the actual date of the change. Where unknown, report the best estimate and document in the file.

Required Documentation:
Provider records shall document education status including the source of information used to code this attribute.

Examples:
1. A youth attends high school 15 hours a week to complete classes required to graduate. He also does volunteer work at a nursery because he wants to eventually work for a landscaping firm. Submit Code 41.

2. A child is taught at home by his mother under a formal plan for home schooling. Submit Code 21.

3. A youth has graduated from high school and attends vo-tech school 15 hours a week. Submit Code 21.

4. A youth attends high school 10 hours a week to finish two classes needed to graduate and works 20 hours a week. Submit Code 41.

5. A 35-year-old woman returns to college 10 hours a week to finish an accounting degree. Submit Code 41.

6. A youth is suspended for one week from attending high school full-time. No change is required: Code 21 still applies.

7. A youth is expelled from one high school and plans to apply to attend another, but is not yet enrolled. Submit Code 97.

Type: Text (2)

Valid Codes	Definition	State Code (School Attendance) BHRD Use Only
21	Full-time education: (1-12 grade: 20+ hours per week; kindergarten and >12 grade: 12+ hours per week). A person is considered enrolled in school during scheduled vacations or term breaks that follow a period of enrollment as defined above.	Y
41	Part-time education: (1-12 grade: less than 20 hours per week; kindergarten and >12 grade: less than 12 hours per week). A person is considered enrolled in school during scheduled vacations or term breaks that follow a period of enrollment as defined above.	Y
97	Not in educational activities	N

Attribute: Grade Level

Transaction:
Dynamic Client Data

Definition:
Identifies the highest grade level completed by the client.

Type: Character (2)

Code	Definition	State Code (Education) BHRD Use Only
01	Grade 1	4
02	Grade 2	5
03	Grade 3	6
04	Grade 4	7
05	Grade 5	8
06	Grade 6	9
07	Grade 7	10
08	Grade 8	11
09	Grade 9	12
10	Grade 10	13
11	Grade 11	14
12	High School Diploma or GED	16
14	2 years of college or Associate Degree	18
16	Bachelor’s Degree	21
17	1 year of college	17
18	Post-graduate education	22
19	3 years of college	19
20	4 years of college	20
23	Vocational	23
30	Nursery school, pre-school, head start	2
31	Kindergarten	3
32	Grade 12 (no diploma or GED)	15
90	Never attended or below preschool	1
99	Unknown	97

Attribute: Pregnant

Transaction:
Dynamic Client Data

Definition:
Indicates if the client is pregnant.

Procedure:
Report 'No' (code 1) if the client is male.

Type: Number

Code	Definition
1	No
2	Yes
3	Unknown

Attribute: Birthdate of Youngest Child

Transaction:
Dynamic Client Data

Definition:
The birthdate of the client's youngest child.

Procedure:
- If the exact day or the exact day and exact month are unknown, enter '01' for the day and month.
- If the exact year is unknown, enter '01' for the day and month and enter an approximate year.
- Submit a null value if the client has no children.

Required Documentation:
Providers shall maintain documentation describing the source of information.

Examples:
The client said his youngest daughter was born April 18, 2014. **Enter 20140418.**

Type: Text (8) YYYYMMDD

Attribute: Smoking Status

Transaction:
Dynamic Client Data

Definition:
Indicates a client's smoking status. In this case, vaping is not considered a form of smoking.

Type: Number (2)

Valid Codes	Definition	State Code (BHRD Use Only)
1	Current smoker	1
2	Former smoker	2
3	Never smoker	3
99	Unknown	97

Attribute: Self Help Count

Transaction:
Dynamic Client Data

Definition:
Indicates the average number of times in a week the client has attended a self-help program in the thirty days preceding the date of collection. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from Substance Use Disorder and dependence.

Procedure:
Required for SUD clients; optional for mental health clients.

Type: Character (2)

Valid Codes	Definition	State Code (BHRD Use Only)
1	No attendance	1
2	Less than once a week	2
3	About once a week	3
4	2 to 3 times per week	4
5	At least 4 times a week	5
99	Unknown	97

Attribute: Used Needle Recently

Transaction:
Dynamic Client Data

Definition:
Indicates if the client has injected unprescribed drugs in the last 30 days.

Procedure:
Required for SUD clients; optional for mental health clients.

Type: Number

Code	Definition	State Code (BHRD Use Only)
1	No	Y
2	Yes	N
3	Unknown	U

Attribute: Needle Use

Transaction:
Dynamic Client Data

Definition:
Indicates if the client has ever used needles to inject unprescribed drugs in their lifetime.

Procedure:
- Required for SUD clients; optional for mental health clients.
- Report the code that best describes the highest level of use the individual reports.

Type: Number

Valid Codes	Definition	State Code (BHRD Use Only)
1	Continuously	1
2	Intermittently	2
3	Rarely	3
4	Never	4
99	Unknown	97

Attribute: SUD_ROI_Granted

Transaction:
Dynamic Client Data

Definition:
Indicates if a SUD client has signed the "CONSENT FOR SUBSTANCE USE DISORDER CLIENT LOOKUP" form giving their consent to share information across the BHO provider network for purposes of care coordination. In practice, this means that BHO network providers will see summary information for the client in the Extended Client Lookup System (ECLS). SUD-specific transaction data submitted by other agencies (for example, Substance Use) will not be viewable.

Procedure:
- Required for clients receiving substance use disorder treatment or assessed for a substance use disorder (whether the authorization is for an assessment only of for treatment to be provided).
- Submit a null value for mental health clients. Note that a null value will not override an existing 'Yes'.

Type: Number

Code	Definition
1	No
2	Yes

Transaction: HIPAA Health Care Claims 837 Professional

Definition:
In 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law. It requires, among other things, that the U.S. Department of Health and Human Services establish national standards for electronic health care transactions and code sets (Transactions Rule).

The Transactions Rule requires BHRD and all other covered entities to use standard HIPAA transactions for electronic exchange of data that are covered under HIPAA. This requires BHRD to receive and providers to send service data using the HIPAA Health Care Claims 837 Professional (837P) transaction.

The HIPAA 837P replaced the existing CPT Service Detail transaction on October 16, 2003. Data from the HIPAA 837P transaction is translated into the legacy CPT Service Detail to be processed and posted to the BHRD IS. See the CPT Service Detail transaction.

Required for:
Outpatient, Residential, Crisis

Collection Frequency:
On event

Transaction Format:
For complete description of the HIPAA 837 Professional transaction's data elements and segments, refer to the following documents:

- X12N Health Care Claim: 837 Professional Implementation Guide, version ASC X12N 837 (005010X222A1) published June 2010. This document is available electronically at www.wpc-edi.com.

For additional site-specific transaction processing information, refer to the following document:

- BHRD and KCMHP Providers Trading Partner Agreement (Section 15: Attachments C and D)

Transaction: Income Category

Definition:
Describes a person's income and family size.

Required for:
Outpatient, Residential

Frequency:
Assessment
On change

Transaction ID: 060.04

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Annual Income	Text (number)	6	
Family Size	Text (number)	2	
King County ID	Text (number)		

Attribute: Annual Income

Transaction:
Income Category

Definition:
This identifies the income of the family reported in the "Family Size" attribute.

Procedure:
- Report the total annual household income at authorization start.
- Report on change when the change is large enough to cause the client to be over or under the Federal Poverty level (for their family size).
- Annual Income is linked with Family Size to assist in eligibility determination.
- This will be used to determine whether a client's income level is at or above the federal poverty level.
- Federal poverty level guidelines are updated every year.
- Foster children always have an income of 0 and a family size of one.

Required Documentation:
- Providers shall document the client's total family income in the client record.
- Documentation must include the number of individuals reported who meet the definition of family members in the "Family Size" attribute and the source of information about the client's household income (e.g., income tax returns, client/family member self report).

Type: Integer

Attribute: Family Size

Transaction:
Income Category

Definition:
The actual number of related individuals living in the household who are dependent on the household income. Use information as reported by the client.

Procedure:
- For an adult client, members of a household who can be counted are the Medicaid client, his/her elderly or disabled parent, dependent children under the age of 18, spouses.
- Do not count siblings or children over the age of 18 unless the children are disabled.
- For the purpose of this attribute, elderly means a person aged 60 and older. See "Impairment Kind" attribute for definitions of disabled.
- If the client is a child, members of a household who can be counted are the Medicaid client, his/her parents (married or unmarried), stepparents (if not divorced from the parent), adoptive parents, and siblings under the age of 18.
- Foster children always have a family size of one.
- This transaction is used 1) to calculate whether or not the client's income is at or above the federal poverty definition; and 2) to determine a person's eligibility (self-pay) for services when not covered by Medicaid. Self-pay status is greater than 200% of the federal poverty level for adults and 300% of the federal poverty level for children. A self-pay client is not eligible for MHP services.
- If the family size is unknown, enter the value 99 for family size. Where the family size is unknown, the client will be treated as exceeding any qualifying income levels for purposes of determining non-Medicaid eligibility.

Required Documentation:
A description of "family" for each client must be documented in the client's record.

Examples:
1. If the client lives alone, report as one.

2. If the client shares his/her household with three other people who meet the criteria above, report four.

3. If the client shares his/her household with three people who do meet the criteria above and two people who **do not** meet these criteria, report four.

Type: Number (2)

Transaction: Key Dates

Definition:
Use this transaction to report three key dates required for all mental health and SUD outpatient benefits:

Request for Services Date
First Intake Appointment Offered Date
First Routine Appointment Offered Date

Required for:
All Medicaid clients who request services
Many non-Medicaid clients who request services (see Section 05: Outpatient Services Level of Care for details)
Not required for Continuation of Benefits authorizations or where there is less than a 90 day gap between two outpatient benefits.

Frequency:
Initial assessment

Transaction ID: 200.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	Y
Case ID	Text	10		Y
Authorization Number	Number	8		Y
Request for Services Date	Date (YYYYMMDD)	8		Y
First Intake Appointment Offered Date	Date (YYYYMMDD)	8		Y*
First Routine Appointment Offered Date	Date (YYYYMMDD)	8		Y*
King County ID	Number	10		Y

* Not required under some circumstances. See explanation in attribute description.

Attribute: Request for Services Date

Transaction:
Key Dates

Definition:
A request for services is the point in time when a person legally authorized to sign the consent for treatment seeks care by scheduling an appointment for an intake for routine behavioral health services through a telephone call, walk-in, written request, or the receipt of a written Early Periodic Screening, Diagnosis, and Treatment (EPSDT) referral. An EPSDT referral is only a request for service when an individual or the person legally authorized to sign for consent for treatment for that individual has confirmed that he or she is requesting service.

Procedure:
- Report the date that services were requested based upon the definition above.
- This is a required attribute.

Required Documentation:
Documentation of the request for services must be provided in agency records.

Type: Date (YYYYMMDD)

Attribute: First Intake Appointment Offered Date

Transaction:
Key Dates

Definition:
An intake appointment within 10 working days of the request for services shall be offered to all persons covered by Medicaid and to all persons not covered by Medicaid who meet financial eligibility and are First Priority. When resources are available for persons not covered by Medicaid who are Second Priority, this timeline also applies. See Section 05: Outpatient Services Level of Care for more details.

Procedure:
- Report the first offered intake appointment date. The date should be reported even if the client declined the appointment or accepted it but did not show up.
- This is a required attribute if an intake appointment was offered. This attribute can be null if no intake appointment was offered or if the offer has not yet been made. If the offer occurs after the initial submission of this transaction, another submittal should occur with an action code of "C" (change).

Required Documentation:
Documentation of the first offered intake appointment date must be provided in agency records.

Type: Date (YYYYMMDD)

Attribute: First Routine Appointment Offered Date

Transaction:
Key Dates

Definition:
- The first routine appointment must be offered to occur within 28 calendar days of request for service.
- The first routine appointment must be offered regardless of whether or not the requested outpatient benefit has been granted.
- The first routine appointment may be provided prior to the completion of the intake.
- Please reference Section 05: Outpatient Services Level of Care for additional details.

Procedure:
- Report the first routine appointment offered date. The date should be reported even if the client declined the appointment or accepted it but did not show up.
- This is a required attribute if a routine appointment was offered. This attribute can be null if no routine appointment was offered or if the offer has not yet been made. If the offer occurs after the initial submission of this transaction, another submittal should occur with an action code of "C" (change).

Required Documentation:
Documentation of the first routine appointment offered date must be provided in agency records.

Type: Date (YYYYMMDD)

Transaction: LOCUS

Definition:
Use this transaction to report the results of an assessment using the LOCUS instrument.

The application of the case rate criteria requires a formal, face-to-face assessment process that results in an outpatient authorization request from the provider to the King County BHO. Adults (age 21 and older) shall be assessed using the LOCUS instrument. Children aged 18, 19, and 20 shall have the option of being assessed for eligibility for either an adult or child's outpatient benefit, using either the LOCUS or CALOCUS instrument.

Required for:
Mental health case rate benefits
Mental health supportive housing benefits
Mental health residential benefits
Mental health inpatient benefits

Frequency:
Initial assessment
Provider (vendor) change
Continuation of benefits
On change
On exit

Transaction ID: 160.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	Y
Case ID	Text	10		Y
Event Date	Date (YYYYMMDD)	8		Y
Dimension I Score	Number	1	Y	Y
Dimension II Score	Number	1	Y	Y
Dimension III Score	Number	1	Y	Y
Dimension IV A Score	Number	1	Y	Y
Dimension IV B Score	Number	1	Y	Y
Dimension V Score	Number	1	Y	Y

Attribute	Type	Size	Coded	Required
Dimension VI Score	Number	1	Y	Y
Composite Score	Number	2		Y
Level of Care Requested	Number	1	Y	Y
King County ID	Number	10		Y

Attribute: Dimension I Score

Transaction:
LOCUS

Definition:
Risk of Harm

This dimension of the assessment considers a person's potential to cause significant harm to self or others.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Minimal Risk of Harm
2	Low Risk of Harm
3	Moderate Risk of Harm
4	Serious Risk of Harm
5	Extreme Risk of Harm

Attribute: Dimension II Score

Transaction:
LOCUS

Definition:
Functional Status

This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Minimal Impairment
2	Mild Impairment
3	Moderate Impairment
4	Serious Impairment
5	Severe Impairment

Attribute: Dimension III Score

Transaction:
LOCUS

Definition:
Medical, Addictive, and Psychiatric Co-Morbidity

This dimension measures potential complications in the course of illness related to co-existing medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No Co-morbidity
2	Minor Co-morbidity
3	Significant Co-morbidity
4	Major Co-morbidity
5	Severe Co-morbidity

Attribute: Dimension IV A Score

Transaction:
LOCUS

Definition:
Recovery Environment – Level of Stress

This dimension considers factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a person's efforts to achieve or maintain mental health and/or abstinence.

Stressful circumstances may originate from multiple sources and include interpersonal conflict or torment, life transitions, losses, worries relating to health and safety, and ability to maintain role responsibilities.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Low Stress Environment
2	Mildly Stressful Environment
3	Moderately Stressful Environment
4	Highly Stressful Environment
5	Extremely Stressful Environment

Attribute: Dimension IV B Score

Transaction:
LOCUS

Definition:
Recovery Environment – Level of Support

This dimension considers factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a person's efforts to achieve or maintain mental health and/or abstinence.

Supportive elements in the environment are resources which enable persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Highly Supportive Environment
2	Supportive Environment
3	Limited Support in Environment
4	Minimal Support in Environment
5	No Support in Environment

Attribute: Dimension V Score

Transaction:
LOCUS

Definition:
Treatment and Recovery History

This dimension of the assessment recognizes that a person's past experience provides some indication of how that person is likely to respond to similar circumstances in the future.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Fully Responsive to Treatment and Recovery Management
2	Significant Response to Treatment and Recovery Management
3	Moderate or Equivocal Response to Treatment and Recovery Management
4	Poor Response to Treatment and Recovery Management
5	Negligible Response to Treatment

Attribute: Dimension VI Score

Transaction:
LOCUS

Definition:
Engagement and Recovery Status

This dimension of the assessment considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process.

Procedure:
Record the clinician's assessment of the client in this dimension.

Required Documentation:
Documentation of the clinician's assessment must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Optimal Engagement and Recovery
2	Positive Engagement and Recovery
3	Limited Engagement and Recovery
4	Minimal Engagement and Recovery
5	Unengaged and Stuck

Attribute: Composite Score

Transaction:
LOCUS

Definition:
Indicates the composite score as defined by the LOCUS instrument.

Procedure:
Record the composite score as calculated per the instructions of the LOCUS instrument.

Required Documentation:
Documentation of the composite score calculation must be provided in agency records.

Type: Number

Valid Codes	Definition
1-35	Valid range

Attribute: Level of Care Requested

Transaction:
LOCUS

Definition:
Indicates the level of care requested by the clinician.

Procedure:
In general, the level of care requested should be consistent with the level derived from the LOCUS decision tree and/or the Determination Grid. However, exceptions are permitted based upon additional clinical determinations. The rationale for an exception should be documented in the client's file.

Required Documentation:
Documentation of the client's LOCUS level of care must be provided in agency records.

Type: Numeric

Valid Codes	Definition	Corresponding MH Benefit
0	LEVEL ZERO: Does not meet access to care or completed treatment	112 <none>
1	LEVEL ONE – Recovery Maintenance and Health Management This level of care provides treatment to clients who are living either independently or with minimal support in the community, and who have achieved significant recovery from past episodes of illness. Treatment and service needs do not require supervision or frequent contact.	2X1
2	LEVEL TWO – Low Intensity Community Based Services This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs.	3A1
3	LEVEL THREE – High Intensity Community Based Services This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic-based programs.	3B1

Valid Codes	Definition	Corresponding MH Benefit
4	LEVEL FOUR– Medically Monitored Non-Residential Services This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings but whose treatment needs require intensive management by a multidisciplinary treatment team. Services which would be included in this level of care have traditionally been described as partial hospital programs and as assertive community treatment programs.	
5	LEVEL FIVE – Medically Monitored Residential Services This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, freestanding residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level.	
6	LEVEL SIX – Medically Managed Residential Services This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but in some cases, could be provided in freestanding non-hospital settings.	

Transaction: Medicaid Coverage

Definition:
Describes the coverage available to the client for mental health services as of the date reported in the event date.

Procedure:
This transaction must be submitted for all outpatient and residential benefits paid on a case rate basis. See individual attributes for unknown or not applicable codes.

During an authorization's pre-approval period the BHRD IS determines if a discrepancy exists between ProviderOne's data (as stored in the BHRD IS) and agency-submitted data regarding the client's Medicaid coverage on the authorization's start date. (An authorization is not approved until any such discrepancy is rectified).

To perform this evaluation, the BHRD IS uses the agency-submitted Medicaid transaction with the most recent event date, where the event date is less than or equal to the authorization's start date. Data conflicts with another agency's submission for the same individual on the same event date can be avoided by using the authorization's assessment date (rather than the first of the month). If your event date is equal to the start date of your authorization and you receive the error "Data Conflicts With Existing Data" you can see what agency your data is conflicting with using ECLS –> Person Summary –>Income Cov. In this case, pick an event date one day or more prior to your authorization's start date that does not conflict with another agency's submission.

Required for:
Outpatient, Residential

Frequency:
Initial Assessment
On change

Transaction ID: 140.07

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
CSO Identifier	Text	2	Y
Medicare Indicator	Text	1	Y
Private Pay Indicator	Text	1	Y
Third-Party Coverage Indicator	Text	1	Y
ProviderOne ID	Text	11	
KCID	Text (number)	10	

Attribute: CSO Identifier

Transaction:
Medicaid Coverage

Definition:
This attribute identifies the location of the Community Service Office (CSO) where the client is Medicaid-enrolled and eligible under federal Medicaid (Title XIX) for Mental Health benefits in King County MHP.

Procedure:
- Providers shall determine Medicaid status and CSO as part of the assessment process and in each subsequent month during the authorized outpatient or residential benefit period.
- The *CSO Identifier* field cannot be left blank.
- A note about CSO 95:
  CSO 95 is used *only* when the ProviderOne Portal shows BHO (other than King County) coverage for the client. If the client is a foster child and lives out of King County and has coverage under a different BHO, use CSO 95. If the client is an adult and is in a protected address program and lives in King County and ProviderOne shows Thurston-Mason BHO (Central Medicaid CSO), use CSO 95.

Required Documentation:
- Providers must document the source used to verify a client's Medicaid eligibility.
- If an electronic database was used to confirm eligibility, providers shall maintain receipt of confirmations or printouts.

Examples:
1. At the time of assessment, the client provided her ProviderOne services card to the clinician. The clinician used the ProviderOne Portal to look up the client. The clinician found a "King County Regional Support Network" entry in the "Managed Care" section with a date range that covers the assessment date. Enter 91.

2. A foster parent provides documentation of foster care. Enter 95.

3. A clinician has documentation that a Medicaid client is in a confidential address program. Enter 95.

Type: Text (1)

Valid Codes	Definition
90	T-XIX enrolled – Not a King County CSO. Not eligible under Medicaid.
91	T-XIX enrolled – King County CSO. Eligible under Medicaid.
95	T-XIX enrolled – Central Medicaid CSO (CSO #76) – Includes D Coupon children and those in a confidential address program. Eligible under Medicaid.
96	T-XIX enrolled – Ticket to Work clients who present with an SO8 coupon from Okanogan County.
97	T-XIX enrolled – Client is Medicaid eligible in Salish BHO or North Sound BHO. Use this code only if you will be providing an SUD benefit to the client; mental health benefits are not covered in the inter-BHO agreement.
99	Not enrolled in T-XIX. Not eligible under Medicaid.

Attribute: Medicare Indicator

Transaction:
Medicaid Coverage

Definition:
Indicates whether a client is covered by Medicare.

Procedure:
- These codes are in addition to Medicaid coverage.
- This field cannot be left blank.

Required Documentation:
Providers shall maintain documentation that identifies sources of mental health treatment funding. Examples of documentation include fee agreements, copies of Medicare health insurance cards, insurance verification documents.

Example:
A client's mental health services are funded in part by Medicaid and in part by Medicare. Submit codes indicating both Medicaid and Medicare coverage.

Type: Text (1)

Valid Codes	Definition
0	No Medicare coverage – client is not covered by Medicare
1	Medicare Hospitalization Coverage – client is covered by Medicare (Part A)
2	Medicare Full Coverage (Part A and B)
3	Medicare Part B Coverage ONLY
4	Medicare Part C *

*Medicare Part C is managed Medicare, sometimes called Medicare Advantage.

It is NOT the Medicare prescription drug coverage, which is Medicare Part D.

Attribute: Private Pay Indicator

Transaction:
Medicaid Coverage

Definition:
This code indicates whether a client is billed for private payment.

Procedure:
- This code includes cases where a client is making co-payments or is on a sliding fee scale.
- This field cannot be blank.

Required Documentation:
Providers shall maintain documentation that identifies sources of mental health treatment funding.

Type: Text (1)

Valid Codes	Definition
0	No private pay – client is not billed for payment from their private funds.
1	Private Pay – client is billed for payment from their private funds.

Attribute: Third-Party Coverage Indicator

Transaction:
Medicaid Coverage

Definition:
This code indicates whether the person has one or more sources of third-party coverage for mental health services. Third-party coverage includes all sources of funding for services provided to the client including grants and private insurance. For the purposes of this element, third-party coverage excludes coverage reported as Medicaid or Medicare.

Required Documentation:
Providers shall maintain documentation that identifies sources of mental health treatment funding. Examples of documentation include fee agreements, copies of Medicare health insurance cards, insurance verification documents.

Type: Text (1)

Valid Codes	Definition
0	No third-party coverage
1	Third-party coverage – Client has one or more sources of third-party coverage

Attribute: ProviderOne Client ID Number

Transaction:
Medicaid Coverage

Definition:
A ProviderOne Client ID Number used by DSHS to confirm eligibility for clients and bill claims in ProviderOne. It is a system assigned, static, 9-digit numeric identifier followed by the letters “WA” (lower case will fail). ProviderOne Client ID does not change and will follow a client for life. The ProviderOne client ID number will be printed on the client’s plastic “Services Card” that will replace the paper Medical Assistance ID.

This field should be left blank for the CSO code '99'. All other CSO codes require a valid ProviderOne ID, even though the client may not currently be covered or may be covered in a different county.

Transaction: MHRM Summary

Definition:
A summary of an individual's responses on the "Mental Health Recovery Measure" (MHRM) questionnaire, which reflects the individual's view of his/her current recovery process.

Required for: All adults reporting at least one traumatic event on the trauma history that is used for screening for trauma under the "Trauma-Informed Care Grant"

OR

All adults screened for trauma under the "Trauma-Informed Care Grant"

Frequency:
On trauma screening
Every six months after trauma screening
On discharge or grant end, if earlier

Procedure:
MHRM Summary will be rejected if there is no PSS-I Trauma History record for the RUID/Case ID with an Event Date that is on or before the MHRM Summary Event Date.

Transaction ID: 840.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
MHRM Total	Text (number)	3	
MHRM Missing	Text (number)	2	
King County ID	Text (number)		

Attribute: Event Date

Definition:
The date on which the person filled out the MHRM questionnaire.

Attribute: MHRM Total

Transaction:
MHRM Summary

Definition:
A number that totals the values of all responses to the Mental Health Recovery Measure questionnaire.

Procedure:
- Use the following values for the responses given, and sum the values from items 1 through 30: Strongly Disagree = 0; Disagree = 1; Not Sure = 2; Agree = 3; Strongly Agree = 4.
- See the Mental Health Recovery Measure questionnaire for instructions on answering the questionnaire, and for the exact wording of each item.
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Count as “2” (Not Sure) any items that remain unanswered.
- Minimum value allowed is “0”; maximum is “120.”
- NULLS are not allowed.

Attribute: MHRM Missing

Transaction:
MHRM Summary

Definition:
The number of uncompleted items 1 through 30 on the Mental Health Recovery Measure questionnaire.

Procedure:
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Minimum value allowed is “0”; maximum is “30.”
- NULLS are not allowed.

Transaction: Mobile Crisis Team Intervention

Definition:
Program specific information for the Mobile Crisis Team (MCT).

Required for:
Mobile Crisis Team (76)

Frequency:
Every crisis episode

Procedure:
Required for all crisis episodes to which the MCT responds with an outreach.

Required Documentation:
- Documentation of an interview with the person, referral source, or other informant.
- Attempts at corroboration are desirable and attempts at acquiring corroborating documentation shall be noted in the provider records.

Transaction ID: 850.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Authorization Number	Text (number)		
Diversion Type	Text	1	Y
Primary Presenting Condition	Text	2	Y
Episode Start Date/Time	Text (YYYYMMDDHHMM)	12	
Episode End Date/Time	Text (YYYYMMDDHHMM)	12	
Homeless Indicator	Text	1	
Zip Code	Text (number)	5	
King County ID	Text (number)		

Attribute: Diversion Type

Transaction:
Mobile Crisis Team Intervention

Definition:
The Diversion Type is designed to identify the type of facility from which the crisis intervention diverted the person.

Type: Text (1)

Valid Codes	Definition
H	Hospital
J	Jail
N	Neither

Attribute: Primary Presenting Condition

Transaction:
Mobile Crisis Team Intervention

Definition:
The Primary Presenting Condition describes the perceived current state of the person at the beginning of a crisis episode that is a contributing factor to the circumstances leading to the intervention.

Type: Text (2)

Valid Codes	Definition
SA	Substance Abuse
MH	Mental Health
BT	Both

Attribute: Episode Start Date/Time

Transaction:
Mobile Crisis Team Intervention

Definition:
Indicates the beginning date and time (to the minute) when the MCT received the referral of this crisis event.

Procedure:
- Submit the time in a 24-hour clock format.
- The date of the Episode Start Date/Time must be the same as the authorization's assessment date.

Type: Date/Time (12)
YYYYMMDDHHMM

Attribute: Episode End Date/Time

Transaction:
Mobile Crisis Team Intervention

Definition:
Indicates the conclusion date and time (to the minute) at which the MCT is finished with the person and any immediate associated consultation.

Procedure:
- Submit the time in a 24-hour clock format.
- The date of the Episode End Date/Time must be on or before the authorization's end date.

Type: Date/Time (12) YYYYMMDDHHMM

Attribute: Homeless Indicator

Transaction:
Mobile Crisis Team Intervention

Definition:
This code is used to indicate the person's homeless status as reported by the person, referral source, or other informant.

Type: Text (1)

Valid Codes	Definition
N	No
Y	Yes
U	Unknown

Attribute: Zip Code

Transaction:
Mobile Crisis Team Intervention

Definition:
The five-digit postal code, used by the United States Postal Service, for the person's latest mailing address.

Procedure:
Submit the Zip Code for the location of the crisis episode if the person’s Zip Code is unknown. Do not use 99999 or 77777.

Type: Text (number) (5)

Transaction: Notice of Exit

Definition:
A request by the provider to the MHP to cancel or terminate a benefit or a program authorization, or notice from the provider to the MHP that a benefit/program will not be renewed.

Procedure:
- The following benefits and programs always require a notice of exit when they end:
  - Long-term Rehabilitation (LTR – code 71) and Supervised Living (SL – code 72) benefits
  - All MHP-administered programs.
- Notice of exit transactions are required when a client exits from an outpatient benefit unless another outpatient level of care benefit (codes 2X1, 3A1, 3B1) is authorized within 90 days.
- Notice of exit transactions are required when a client exits from a Standard Supportive Housing benefit (373) unless another benefit with the same benefit/program code is authorized within 90 days.
- Notice of Exit transactions are required even if a benefit is terminated automatically by the system based on a provider change and changes reported by the provider (for example, to county of residence or income).
- BHRD will submit disposition data to the state MHD based on Notice of Exit data. Data will only be submitted to the MHD when a client has not had an open outpatient or residential authorization for 90 days.
- BHRD will send a letter to inform the client that his or her services have ended when there is a termination of an authorization for any of these benefits or programs: 2X1, 3A1, 3B1, 65, 66, 71, 372, or 373. A letter will also be sent when there is a cancellation of an authorization for these same benefits/programs after the authorization letter has been sent to the client. The reason given in the letter will be based on the reported Reason for Termination/Cancellation.

Required for:
All benefits/programs except 00
See the “Benefits/Programs for which Notice of Exit must be reported” table below.

Frequency:
Exit from a benefit or program.

Transaction ID: 613.01

Action Codes:

A	Add
C	Change

Field	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Authorization Number	Text (number)		
Exit Code	Text	2	Y
Reason for Termination/Cancellation	Text	2	Y
King County ID	Text (number)		

Programs/Benefits for which Notice of Exit must be reported

Program Code	Definition	Defined Length*	TM: use 09 CX: use 11	Manual Review Required
Outpatient Level of Care (Mental Health)				
2X1	Outpatient Benefit with 2X case rate	X		
3A1	Outpatient Benefit with 3A case rate	X		
3B1	Outpatient Benefit with 3B case rate	X		
00	No benefit requested. Client does not meet medical necessity criteria for receiving services.			
112	Assessment Only (OPB). Client did not meet medical necessity.			
Outpatient Level of Care (SUD)				
S01	SUD Outpatient – OP/IOP	X		
S02	SUD Outpatient – Recovery Support Services	X		
SA0	SUD Assessment Only – client did not meet ACS			
SA1	SUD Assessment Only – ACS met – Referred elsewhere			
Additional Outpatient Services				
06	Regional Mental Health Court			
09	PES Care Manager (Harborview ED)			
25	Specialty Employment Program (SEP)		X	
35	Geriatric Regional Assessment Team		X	
48	FIRST – Pre Release			X
49	FIRST – Post Release			X

Program Code	Definition	Defined Length*	TM: use 09 CX: use 11	Manual Review Required
53	Mental Health Integration Project	X		
57	PACT, Engagement			
58	PACT, Enrollment			
60	HOST/PATH Outreach		X	
61	HOST Intensive Case Management/Stabilization			
64	Co-Occurring Disorder Integrated Treatment Services	X		
65	Western State Hospital Intensive Community Support Program			
66	Expanding Community Services Intensive Community Support and Recovery Program			
67	ORCSP (previously CIAP) – Pre Release			X
68	ORCSP (previously CIAP) – Post Release			X
69	Integrated Dual Disorders Treatment	X		X
77	MIST Engagement			
78	MIST Enrollment			
82	FACT, Engagement		X	X
83	FACT, Enrollment			X
86	Regional MHC Peer Support			
87	Forensic Intensive Supportive Housing			X
88	Co-Stars			X
101	Housing Voucher	X		
103	Re-entry Case Management	X		
104	Re-entry Boundary Spanner			
105	Behavioral Treatment			
107	MIDD Wraparound			
108	Family Treatment Court Wraparound			
109	Trauma Informed Care Grant			
111	Moral Reconation Therapy-Domestic Violence			
113	Transition Support Program			

Program Code	Definition	Defined Length*	TM: use 09 CX: use 11	Manual Review Required
151	Criminal Justice Liaison Program – South East (SE)	X		
152	Criminal Justice Liaison Program – King County Correctional Facility (KCCF)	X		
153	Criminal Justice Liaison Program – Work and Education Release (WER)	X		
154	Criminal Justice Liaison Program – Community Center for Alternative Programs (CCAP)	X		
OST	SUD Opiate Substitution Treatment			
PPW	SUD Pregnant or Parenting Women			
S03	Older Adult SUD Treatment			
Crisis Level of Care				
09	PES Care Manager (Harborview ED)			
13	Children's Crisis Outreach Response System (CCORS)		X	
15	CCORS Intensive Stabilization Services		X	
40	Adult Crisis Stabilization (including next day appointment)		X	
74	Adult Inpatient Diversion Bed		X	
75	Crisis Respite Program – DESC		X	
76	Mobile Crisis Team		X	
79	Crisis Diversion Interim Services			
80	Crisis Diversion Facility Team			
DTX	SUD Detoxification			
Residential Level of Care (SUD)				
SRS	SUD Residential {NOT SUBMITTED THROUGH THIS TRANSACTION; Entered by Authorizer through the Inpatient application.}			

Program Code	Definition	Defined Length*	TM: use 09 CX: use 11	Manual Review Required
Residential Level of Care (Mental Health)				
71	Adult Long-Term Rehabilitation Benefit			
72	Adult Supervised Living Benefit			
73	Adult Long-Term Rehabilitation Benefit (Benson Heights)			
373	Standard Supportive Housing Benefit	X		
Inpatient Level of Care				
IP	Inpatient Benefit (NOT SUBMITTED THROUGH THIS TRANSACTION; Entered by Authorizer through the CCS or Inpatient application.)			

* An “X” in the “Defined Length” column means that when a benefit or program authorization is created, an expiration date is set. No “X” means that the expiration date remains NULL (blank) until the authorization is terminated.

** An “X” in the “TM: use 09, CX: use 11” column means that the only Exit Reason accepted to terminate the program authorization is code “09” and the only Exit Reason accepted to cancel the authorization is code “11.” “09” or “11” will only be accepted for programs that have an “X” in this column.

*** An “X” in the “Manual Review Required” column means that a termination or cancellation request goes through a manual review process before being approved.

Attribute: Event Date

Transaction:
Notice of Exit

Definition:
For terminations, this is the effective date of the termination. For cancellations, this is the date the provider learned that the cancellation was needed. For expirations, this is the date that the provider decided not to request a renewal of the authorization (applies only to benefits or programs that have a pre-determined expiration date).

Required Documentation:
Documentation supporting the reason and the effective date.

Procedure:
- For an event resulting in termination of a benefit or program, report the date of the event.
- When a benefit will expire without renewal, the date reported should be within 90 days following the benefit expiration date.

Termination Rules:
All programs and benefits
- If the termination date is within 30 days from today (a future date), a warning is issued.
- If the termination date is more than 30 days in the future, the transaction will fail.
- An agency can submit one termination change transaction. Subsequent requests should be submitted even though they will fail. Submit a help desk ticket requesting the change.

Programs and benefits with a pre-determined expiration date
In ECLS the expiration date is populated at the time the authorization request processes.
- The termination date must be less than the pre-determined expiration date.
- A change to a termination date must be made within 180 days after the expiration date.

Programs and benefits without a pre-determined expiration date
In ECLS the expiration date is null (blank) at the time the authorization request processes.
- A change to a termination date must be within 180 days of the existing termination date.

Examples:
1. Submit 20080303 when a client dies on March 3, 2008 regardless of when case manager learns of it.

2. A client tells her case manager on May 2, 2008, that she is moving to Boise on May 10. Submit May 10, 2008 in the format 20080510.

3. At the end of a “2X1” outpatient benefit authorization with an expiration date of June 2, 2008, the client is unsure if she wants to continue receiving services. She makes a plan with her therapist to contact him by the end of July with a decision. Three weeks later, on June 23, she calls the therapist and indicates that she does not think she needs further services. Submit June 23, 2008 in the format 20080623.

Type: Date (8) YYYYMMDD

Attribute: Authorization Number

Transaction:
Notice of Exit

Definition:
This is the authorization number for the benefit or program that is ending or has ended.

Type: Integer

Attribute: Exit Code

Transaction:
Notice of Exit

Definition:
This code indicates cancellation, initial termination, non-renewal, or a change to a previously terminated authorization date or reason.

All case-rate benefits and some non-case rate benefits have a pre-set expiration date. That is, when these authorizations are first processed, the expiration date has a value. Whether an authorization has a pre-set expiration date or not has an impact on which Exit Code to use in the Notice of Exit transaction.

Refer to the “Defined Length” column in the “Benefits/Programs for which Notice of Exit must be reported” table.

1. Cancellation:
   Elimination of an authorization. The authorization status code is changed from 'AA' to 'CX' and the authorization status reason is set to the submitted exit reason. These are excluded from most BHRD reports and from processes for submitting data to the state MHD.

   For outpatient and residential benefits paid on a case rate basis, all payments made under the benefit are recouped.

2. Termination:
   Code '2' is valid only for authorizations currently in 'AA' status. On termination, the authorization status code is changed from 'AA' to 'TM', the authorization status is set to the submitted exit reason, and the authorization termination date is changed from the pre-set expiration date (if any) to the submitted event date. If the authorization has a pre-set expiration date, then the authorization is considered "terminated" if it ends before the pre-set expiration date. The termination date submitted must be less than the preset date. See exit code '3' for an alternative approach.

   For outpatient and residential benefits paid on a case rate basis, no payments are made for the months following the termination date.

3. Expiration with no renewal:
   This exit code is valid only for benefits or programs that have a pre-set expiration date. The authorization status code for expired authorizations remains 'AA'.

   For benefits or programs that have a pre-defined length, a Notice of Exit is required if the provider does not submit another authorization request for the same benefit or program within 90 days after the expiration date. The authorization status reason is set to the submitted exit reason. All “Outpatient Level of Care” benefit codes shown in “Benefits/Programs for which Notice of Exit must be reported” are part of a single “outpatient benefit” so that a change from 3A1 to 2X1 does **not** require a Notice of Exit.

4. Use when submitting a notice of exit for authorizations where the expiration date is already populated and the authorization status is 'TM'. Use this code:

- To change a previously submitted Notice of Exit termination date or exit reason.
- To submit a required notice of exit when the BHRD IS has automatically terminated an authorization (e.g. a provider change).

Required Documentation:
Providers shall maintain documentation supporting the reason and the effective date.

Procedure:
- Change requests for cancelled authorizations will be rejected.
- See Reason for Termination/Cancellation/Non-Renewal Procedure for Reasons that cannot be changed.
- Submitting a new event date with code “04” for a terminated non-case-rate authorization requests, but does not make, a change to the expiration date in the master authorization table. Instead, the new date will be stored in the ma_notice_of_exit table and the request to change the expiration date will be processed manually. IS staff will review the request and change the expiration date to the newly submitted event date if the change complies with the restrictions on overlapping authorizations and other business rules.
- All tiers and some programs have a preset expiration date. Others do not. Which exit code to use may depend on whether or not the benefit/program has a preset expire date.

Type: Text (2)

Valid Codes	Definition
01	Provider requests cancellation. Authorization status is set to "CX.”
02	Use for benefits/program WITH a pre-set expiration date when provider requests termination prior to the preset expire date. Use for programs/benefits WITHOUT a preset expiration date the first time provider requests termination. Authorization status is set to "TM.”
03	Benefit or program authorization has expired and no new authorization request for the same benefit or program is planned within 90 days of the expiration date. Authorization status remains "AA.”
04	Provider requests change to a previously submitted exit reason or termination date or when the provider is submitting the required notice of exit for an automatically-terminated authorization (authorization status TM) by the BHRD IS (e.g.: provider change). Authorization status remains "TM.”

Attribute: Reason for Termination/Cancellation/Non-Renewal

Transaction:
Notice of Exit

Definition:
This is the reason for the cancellation, termination, or expiration of the program authorization or benefit.

Required Documentation:
Documentation must support the reason and the event (exit) date reported.

Procedure:
- If accepted as the exit reason, this code will be stored as the "status reason" in the master authorization table.
- Requests to change the following status reason will not be accepted: MC Medicaid coverage is not verified.
- Providers must submit a more informative code for authorizations that are assigned a status reason of "01" (Out of County) by the IS based on residential arrangement or Medicaid coverage data that the provider submitted. The provider must submit an exit reason that indicates whether: treatment was completed (code 31), a referral was made to another BHO (code 15) or to another system/facility/provider (code 16 or 17), or no referral was made (code 04).
- When an authorization is terminated or cancelled by the IS, the "status reason" in the master authorization table will not be changed by the provider-submitted exit reason. The exit reason will be stored in the ma_notice_of_exit table with the authorization number and Exit Code.

Examples:
See the "Benefits/Programs for which Notice of Exit must be reported" table at the beginning of this transaction for guidance on which programs may be terminated with a "09" code.

1. An adult is authorized to receive SEP (Specialty Employment Program – code 25) services starting May 1, 20010. Her services end July 15, 2011. At that time, the provider submits a notice of exit transaction with an Event Date of 20110715 and with code "09" as the Reason for Termination. This transaction will end the authorization: the status code will be changed to "TM" and the expiration date will be set to July 15, 2011.

2. An adult in prison is authorized to the pre-release FIRST program (code 48). He completes his sentence and leaves prison on January 2, 2008. On January 3, 2008, he begins a post-release FIRST program. The provider submits a notice of exit transaction with code 20 as the Reason for Termination and an Event Date of January 2, 2008. The authorization expire (end) date, which was NULL, is changed to January 2, 2008, the status code is changed to "TM" and the status reason code is changed to "20."

3. An adult is authorized to a 3B outpatient benefit (code 3B1) starting February 1, 2007. The benefit expires on January 31, 2008. The client begins a new 3A (code 3A1) outpatient benefit on March 26, 2008. The provider need not submit a notice of exit transaction for the 3B benefit which ended on January 31, 2008.

4. An adult is authorized to a 3B outpatient benefit (code 3B1) starting February 1, 2007. The benefit expires on January 31, 2008. The client begins a Standard Supportive Housing benefit on March 26, 2008. The provider must submit a notice of exit transaction for the 3B benefit, and submits a transaction with code 20 (Changing program type or provider) as the Reason for Non-Renewal.

5. An adult is authorized to a 3B outpatient benefit (code 3B1) starting February 1, 2007. Because of on-going problems with his living situation, he is assessed and approved for a Standard Supportive Housing benefit to begin January 6, 2008. The outpatient benefit provider submits a Notice of Exit transaction with an Event Date of January 5, 2008 and code 20 for Reason for Termination. The original expiration date is changed from January 31, 2008 to January 5, 2008.

Type: Text (2)

Valid Codes	Definition	Exit Type**	Additional Usage Information	State Code (BHRD Use Only)
01	Moved out of County	C, T, E		
02	Client died	C, T, E		7 6: If EO indicates death by suicide.
04	Client moved to another county – no referral/transfer to another BHO	C, T, E		8
05	Client who did not have Medicaid at start of benefit does not now meet Non-Medicaid financial eligibility requirements (e.g., third-party payor, income too high)	C, T, E		8
06	Client who had Medicaid at start of benefit lost Medicaid and is not eligible for Non-Medicaid funding	C, T, E	For termination this only applies to outpatient or residential benefits paid on a case rate basis – for other program authorizations or benefits losing Medicaid is NOT a reason to terminate.	8

Valid Codes	Definition	Exit Type**	Additional Usage Information	State Code (BHRD Use Only)
07	Client who had Medicaid at start of benefit lost Medicaid and is eligible for Non-Medicaid funding	C, T, E	For termination this only applies to outpatient and residential benefits paid on a case rate basis – for other program authorizations or benefits losing Medicaid is NOT a reason to terminate. This should be sent whether or not the provider plans to request a new OPB authorization with Non-Medicaid funding unless a more basic reason, like "31 Client completed treatment" also applies, in which case the other reason should be reported. BHRD programming will determine whether a new program authorization is started within 90 days, and will not send data to MHD if it is.	8
NO CODE SUB-MITTED	Client received an intake but did not meet medical necessity	NA	An "MN" status reason code is assigned by the IS if "00" is the only program requested and there is an intake service submitted. This only applies to Medicaid.	N/A
09	Discharge from crisis or other specified program.	T	See the "Benefits/Programs for which Notice of Exit must be reported" table for the programs that can use this reason.	N/A
11	Cancelled by provider	C	This code will only be accepted for programs with an "X" in the "09 and 11 only" column in the Program table above.	N/A
12	Client enrolled in PACE	C, T, E		8
13	Client has been in hospital for 30 days and discharge is not occurring within an additional 60 days. Includes Children's Long-term Inpatient facilities	C, T, E		4
14	Client has been in prison, jail, Juvenile Rehabilitation Administration facilities, or juvenile detention for 30 days	C, T, E		5

Valid Codes	Definition	Exit Type**	Additional Usage Information	State Code (BHRD Use Only)
	and release is not occurring within an additional 30 days. [For MIO-CTP – use 42 if it applies]			
NO CODE SUB-MITTED	Client transferred to different MH agency within KCBHO	T	A "VC" (Vendor change) status reason code is assigned by the IS when an outpatient benefit is terminated because another provider has submitted an outpatient benefit authorization request.	8
15	Client desires/has been referred/transferred to another BHO for services	C, T, E	Report this when a referral or transfer to another BHO is made in conjunction with an out of county move.	4
16	Client referred to primary care to manage MH needs	C, T, E		8
17	Client-desires/has been referred/transferred to another (non-BHO, non-primary care) service system, agency or facility	C, T, E		8
20	Client changing program type or provider	C, T, E	This code is needed to explain a program or provider termination date for those programs where a more informative reason than "discharge" (code 09) is required.	4
21	Provider is unable to provide services to client for other reason	C*,T*,E	This code should only be used if no other specific code applies.	8
22	No qualifying service provided	C*	This code should only be used if no other specific code applies.	N/A
23	Data error in authorization request	C		N/A
31	Client completed treatment, no longer meets continued stay criteria, meets	C, T, E		1

Valid Codes	Definition	Exit Type**	Additional Usage Information	State Code (BHRD Use Only)
	discharge criteria, opted in (MHC only), or graduated			
32	Client's whereabouts unknown (lost to contact)	C*,T*,E		9
33	Client exited from program due to violating program rules, or revoked for non-compliance with court conditions	T, E	This code will only be accepted for Housing Voucher program.	N/A
34	No longer eligible: Not competent or Charges dismissed – MHC only	T		N/A
35	Client refused services or declined to participate in program. Clinician must talk with client to use this code. If client is simply not attending treatment and can't be reached, use code 32.	C*,T*,E		8
37	Not clinically eligible – MHC only	T		N/A
42	Returned to prison – FIRST only	T		5
43	Completed sentence and declined further service – MIO – CTP only	T		8
44	Released by oversight committee and/or program – FIRST only	T		8

** C – cancellation; T – termination; E – expiration without renewal

* BHRD manual clinical review required for termination or cancellation for case-rate benefits.

Transaction: Problem Severity Summary

Definition:
The Problem Severity Summary (PSS) is an inventory that is used to assess the level of functioning of adults in a number of life domains.

Procedure:
- Scores on the PSS are used to identify focuses for treatment and to determine whether the client achieves desired outcomes.
- Use the anchors below to rate the individual. Each item is listed as a separate attribute in subsequent pages.
- Report as the event date the required reporting date (as described under "Frequency"), using the most recent contacts with the client to rate his or her functioning.
- A report will be available in the Reports application that lists all upcoming PSS reporting dates, as well as all past due PSS data that have not been submitted and posted successfully to the ea_pss table. Required data for an authorization will be considered past due unless a complete set of PSS scores is posted from the provider for the client with an Event Date that is within 30 days of the required reporting date. If, because of a termination, two required reporting dates are within 60 days of each other, a single set of data will meet the requirement as long as the Event Date is no more than 30 days after the first reporting date and no more than 30 days before the second reporting date.

Coding Definitions:
Use the following anchors to rate the client on items A-N in the Problem Severity Summary:

0 – ABOVE AVERAGE: AREA OF STRENGTH RELATIVE TO AVERAGE PERSON.
- Functioning in the particular domain is consistently better than that which is typical for age, sex, and subculture.
- Never below typical expectations of the "average person."

1 – AVERAGE: FUNCTIONS AS WELL AS MOST PEOPLE.
- Functions in the domain as well as most people of the same sex, age, and subculture.
- Given the same environmental forces, is able to meet usual expectations consistently. "Ordinary."

2 – SLIGHT: LIMITED IMPAIRMENT OR DISRUPTION IN FUNCTIONING.
- Functioning in the domain is managed with some difficulty. Performance is just below "average" expectation.
- Slightly diminished or limited skills.
- Occasional disruption in functioning may create interference with community adaptation. Behaviors are mostly appropriate but may need prompting.
- In terms of socio-legal behavior, actions are not likely to result in arrest but may result in public disturbance/police reprimands (e.g., minor infractions, cigarettes destroying someone's papers or books).
- In terms of rating symptoms in items K-N, may exhibit slight psychiatric symptoms, e.g., some subjective distress and/or mild distortion in thought process.

3 – MARKED: OBVIOUS IMPAIRMENT, INADEQUATE FUNCTIONING.
- Functioning in the domain is poorly managed. Performance is clearly below average.
- Skill deficits are obvious.
- Disturbances in functioning create noticeable disruption in overall community adaptation.
- Appropriate behavior may require significant coaching.
- In terms of socio-legal behavior, actions may result in arrest (e.g., stealing a purse, breaking others' possessions).
- In terms of rating psychiatric symptoms items K-N, symptoms are noticeable, significant subjective distress and/or thought disturbance will be noted.

4 – SEVERE IMPAIRMENT: SIGNIFICANT DISRUPTION/FAILURES IN FUNCTIONING.
- Functioning in the domain is very difficult, generally leads to failure in performance.
- Skill deficits are severe, may threaten client safety or result in unsanitary living conditions.
- Disruption in functioning creates constant interference in community adaptation. Behavior is highly inappropriate; may require active assistance/guidance.
- In terms of socio-legal behavior, person shows little regard for rules or laws (e.g., flagrant violations that are likely to lead to arrest).
- In terms of psychiatric symptoms, items K-N, symptoms are severe (e.g., severe anxiety, depression, subjective distress, dissociation, incapacitating thought disturbances, prominent hallucinations, bizarre delusions, incoherence).

5 – EXTREME IMPAIRMENT: OUT OF CONTROL, UNACCEPTABLE.
- Productive functioning in the domain is inconceivable at time of rating.
- Skills are absent.
- Extreme disruption in functioning makes community adaptation impossible. Behaviors are totally uncontrolled.
- In terms of socio-legal behavior, actions are extremely destructive toward property or people.
- In terms of psychiatric symptoms items K-N, extreme symptoms may include vegetative symptoms, loss of contact with reality, lack of communication, lack of orientation to time, place or person. Symptoms may indicate rapid, uncontrollable decompensation.

Required for:
COD programs (64, 69)
Jail Transition Services programs (55, 56)
FACT (83)
FISH (87);
Adult and Older Adult Outpatient benefits (2X1, 3A1, 3B1) for which the first month of the benefit is paid with Mental Illness and Drug Dependency (MIDD) funds

Frequency:
For COD programs (64, 69) and Jail Transition Services programs (55, 56), at:
Authorization start and end
For FACT (83) and FISH (87) programs at:
Authorization start, each year after authorization start, and authorization end
For Adult and Older Adult Outpatient benefits (2X1, 3A1, 3B1) at:
Authorization start, six months after authorization start, and authorization end. If an authorization is terminated before the original expiration date, the PSS is required for the termination date.

Transaction ID: 640.03

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Dangerous Behavior	Text (number)	1	Y
Socio-legal	Text (number)	1	Y
Negative Social Behavior	Text (number)	1	Y
Self-care	Text (number)	1	Y
Community Living	Text (number)	1	Y
Social Withdrawal	Text (number)	1	Y
Response to Stress	Text (number)	1	Y
Sustained Attention	Text (number)	1	Y
Physical	Text (number)	1	Y
Health Status	Text (number)	1	Y
Depressive Symptoms	Text (number)	1	Y
Anxiety Symptoms	Text (number)	1	Y
Psychotic Symptoms	Text (number)	1	Y
Dissociative Symptoms	Text (number)	1	Y
Cognitive	Text (number)	1	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

PSS Definitions:

A. Dangerous Behavior
Behavior which is, intentionally or unintentionally, dangerous to self or others (e.g., self-injurious, physical harm to others, disease infection of others, setting fires, rape, cruelty to animals, walks into traffic, walks outside without proper clothing for the weather). Can include threatening self-harm or harm to others (e.g., pushing, intimidating).

B. Socio-Legal
Law-breaking behavior that does not present a physical threat to self or others. Behaviors may include breaking or destroying property, prostitution, public intoxication, disturbing the peace, stealing, cheating, fraud, touching or flashing genitals, or urinating in public.

C. Negative Social Behavior
Non-dangerous social behavior that ranges in severity from arguing and annoying social behavior to behavior that interferes with others (e.g., yelling or screaming, talking to self, making noises, refusing to do chores in group living situation). At the most severe, the behaviors are offensive to others (e.g., swearing, staring, or spitting at people).

D. Self-Care
Difficulty performing daily toileting, hygiene and eating.

E. Community Living
Difficulty performing basic household responsibilities that, if not performed, may affect a community living arrangement such as cleaning, cooking, laundering, shopping, managing money, keeping appointments, arranging and using transportation, having difficulty avoiding common household dangers (e.g., leaves stove on).

F. Social Withdrawal
Social behaviors that demonstrate an inhibition from engaging in social contact or active withdrawal from social contact (e.g., mostly autonomous activities, fear of contact, non-response to initiation of contact by others, poor eye contact, extreme shyness).

G. Response to Stress
Managing stressful circumstances in ways that significantly exacerbate psychiatric symptoms or are self-destructive or harmful to others.

H. Sustained Attention
Difficulty sustaining focused attention for long enough time to permit completion of tasks commonly found in normal daily work, school, or vocational training settings.

I. Physical
Impairment in sensory/motor areas such as in seeing, hearing, speaking, walking, using arms and hands, which is not of a temporary nature or that interferes with ability to live in the community. Rate the functional impairment that the physical limitation imposes upon the person, (e.g., interference with ability to live in community).

J. Health Status
Chronic health problems that typically require consistent medical management (e.g., diabetes, hypertension, HIV, COPD, congestive heart failure). Rate the functional impairment that the health condition imposes upon the person, (e.g., interference with ability to live in the community).

K. Depressive Symptoms
Symptoms of depression such as depressed mood, excessive worry/distress, sadness/despair, hopelessness; changes in appetite, sleep, or concentration; somatization, suicide ideation.

L. Anxiety Symptoms
Anxiety including excessive tension, fears, obsessions/compulsions, somatization.

M. Psychotic Symptoms/Thought Disorder
Hallucinations, delusions or strikingly peculiar behavior (e.g., talking to oneself in public). Unusual perceptual experiences, odd beliefs, or magical thinking which influences behavior and is not consistent with a person's cultural norms. May include bizarre thought content or beliefs in extraordinary abilities or powers (e.g. ability to thought broadcast, being controlled by a dead person). May also be characterized by digressive, vague, overelaborate speech or poverty of content of speech. (Do not include dissociative symptoms).

N. Dissociative Symptoms
Disturbance of identify, feelings of unreality, loss of self-identity, intrusive flashbacks, "zoning out", poor grounding in reality, signs of personality splitting (multiple personalities).

O. Cognitive
Does the client exhibit symptoms of memory disturbance, confused, unclear thinking or communication, attention deficits, disorientation in reference to time, place, or person (not associated with Dissociative Disorder or Psychotic symptoms) or is there any indication that the client has a developmental disorder, dementing process or other organic brain disorder?

Required Documentation:
- Completed PSS must be maintained in provider records for each client required to be assessed with this instrument.
- Providers shall maintain records to identify the clinical staff person by name, degree, and working job title who assessed the client on the PSS. The individual conducting the assessment can be anyone authorized by provider protocols to do so.

Type: Number

For PSS, "A" through "N":

Valid Codes	Definition
0	Above average: Area of strength relative to average
1	Average: Functions as well as most people
2	Slight impairment: Limited impairment or disruption in functioning
3	Marked impairment: Obvious impairment, inadequate functioning
4	Severe impairment: Significant disruption/failures in functioning
5	Extreme impairment: Out of control, unacceptable

For PSS "O Cognitive" only, use:

Valid Codes	Definition
1	No
2	Yes

Transaction: PSS-I Symptoms

Definition:
Describes the individual's experience of problems related to traumatic events.

Required for:
All adults screened for trauma under the "Trauma-Informed Care Grant"

Frequency:
On trauma screening
Every six months after trauma screening
On discharge or grant end, if earlier

Procedure:
- This transaction is required for every person screened for trauma history on the trauma screening date and at each six-month anniversary of the initial screening for trauma.
- If no trauma history has been reported, submit the transaction with "0" for each of the following attributes: Problem List Total, Problem List Missing, Interference List Total, and Interference List Missing.
- PSS-I Symptoms will be rejected if there is no PSS-I Trauma History record for the RUID/Case ID with an Event Date that is on or before the PSS-I Symptoms Event Date.

Transaction ID: 830.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Problem List Total	Text (number)	2	
Problem List Missing	Text (number)	2	
Interference List Total	Text (number)	1	
Interference List Missing	Text (number)	1	
King County ID	Text (number)		

Attribute: Event Date

Definition:
The date on which the person reported his or her experience of problems related to a traumatic event.

Attribute: Problem List Total

Transaction:
PSS-I Symptoms

Definition:
The sum of all scores (0-3) on items 1 through 17 of the "PTSD Symptom Scale (PSS)" symptoms (problems and interference) section.

Procedure:
- See the symptom section of the PTSD Symptom Scale (PSS)" form for instructions on reporting values, and for the exact wording of each item.
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Count as "0" any items that remain unanswered.
- Minimum value allowed is "0"; maximum is "51."
- NULLS are not allowed.

Attribute: Problem List Missing

Transaction:
PSS-I Symptoms

Definition:
The number of uncompleted items 1 through 17 of the "PTSD Symptom Scale (PSS)" symptoms (problems and interference) section.

Procedure:
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Minimum value allowed is "0"; maximum is "17."
- NULLS are not allowed.

Attribute: Interference List Total

Transaction:
PSS-I Symptoms

Definition:
The number of areas where an individual answered "yes," indicating interference from post-traumatic problems on the "PTSD Symptom Scale (PSS)" interference section (items 1 through 9).

Procedure:
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Minimum value allowed is "0"; maximum is "9."
- NULLS are not allowed.

Attribute: Interference Missing

Transaction:
PSS-I Symptoms

Definition:
The number of uncompleted items in the “PTSD Symptom Scale (PSS)” interference section (items 1 through 9).

Procedure:
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Minimum value allowed is “0”; maximum is “9.”
- NULLS are not allowed.

Transaction: PSS-I Trauma History

Definition:
Describes the kinds of traumatic events that an individual has experienced or witnessed and their immediate impacts on the individual.

Required for:
All adults screened for trauma under the "Trauma-Informed Care Grant"

Frequency:
On trauma screening
At next six-month anniversary after new trauma experience or new reporting of trauma

Procedure:
If an individual initially reports no traumatic events, but later discloses an earlier traumatic event or experiences a new traumatic event, submit a new set of screening data from the "PTSD Symptom Scale (PSS)" trauma history section at the next six-month anniversary of the original trauma screening.

Transaction ID: 820.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Accident Fire Explosion (01)	Text (number)	1	Y
Natural Disaster (02)	Text (number)	1	Y
Assault by Known Person (03)	Text (number)	1	Y
Assault by Unknown Person (04)	Text (number)	1	Y
Sexual Assault by Known Person (05)	Text (number)	1	Y
Sexual Assault by Unknown Person (06)	Text (number)	1	Y
Combat War Zone (07)	Text (number)	1	Y
Early Sexual Contact (08)	Text (number)	1	Y
Imprisonment (09)	Text (number)	1	Y

Attribute	Type	Size	Coded
Torture (10)	Text (number)	1	Y
Life-threatening Illness (11)	Text (number)	1	Y
Other Trauma (12)	Text (number)	1	Y
Other Trauma Description	Text	100	N
Worst Trauma	Text (number)	2	Y
Treatment Reason	Text (number)	2	Y
Physical Injury to Self	Text (number)	1	Y
Physical Injury to Other	Text (number)	1	Y
Own Life in Danger	Text (number)	1	Y
Other’s Life in Danger	Text (number)	1	Y
Felt Helpless	Text (number)	1	Y
Felt Terrified	Text (number)	1	Y
King County ID	Text (number)		

Attribute: Event Date

Definition:
For the original screening, this is the date on which the trauma history was collected.

For recently experienced or disclosed trauma that is reported at a six-month anniversary of the original screening, use the six-month anniversary date. ("Six-month anniversary" means 6, 12, 18, etc., months after the original screening.)

Example:
A client who reported having had no particularly traumatic experiences when she was originally screened on March 15, 2011, was seriously injured, as was her son, in a car accident in June 2011. Subsequently, she talked with her therapist about her injuries, her fear for her and her son's lives, and her feelings of helplessness and terror as the accident happened. When her therapist asks if it has stirred up any old feelings from earlier experiences, she talks about feeling supported by her mother when she felt scared as a child, but does not report any other traumatic events. At the six-month anniversary, submit a new transaction with a date close to September 15, 2011, that reports "Yes" for "Accident Fire Explosion (1)," "No" for all the other kinds of trauma and "Yes" on each of the attributes about physical, cognitive, and emotional experiences of the accident.

Attributes:
Accident Fire Explosion (01)
Natural Disaster (02)
Assault by Known Person (03)
Assault by Unknown Person (04)
Sexual Assault by Known Person (05)
Sexual Assault by Unknown Person (06)
Combat War Zone (07)
Early Sexual Contact (08)
Imprisonment (09)
Torture (10)
Life-threatening Illness (11)
Other Trauma (12)

Transaction:
PSS-I Trauma History

Definition:
Indicates whether or not the individual has experienced or witnessed different kinds of traumatic events.

Procedure:
- See the "PTSD Symptom Scale (PSS)" trauma history section for instructions on reporting values, and for the exact wording of each item.
- If 2 (Yes) is reported for "Other Trauma," a brief description of it should be submitted for the "Other Trauma Description" attribute.
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- NULLS are not allowed.

Valid Codes	Definition
1	No
2	Yes
9	No answer

Attribute: Other Trauma Description

Transaction:
PSS-I Trauma History

Definition:
Briefly describes the nature of reported trauma that does not fit into any of the first eleven categories of trauma reported in this transaction.

Procedure:
- If 2 (Yes) is reported for "Other Trauma," submit a brief description of the type of other trauma(s) experienced. Transaction will be rejected if this procedure is violated.
- If 1 (No) is reported for "Other Trauma," do not submit a value for this attribute (NULLS are allowed). Transaction will be rejected if this procedure is violated.
- Other traumas reported shall be documented in the clinical record.

Attribute: Worst Trauma

Transaction:
PSS-I Trauma History

Definition:
Indicates which of the kinds of trauma an individual has experienced or witnessed he or she found the most difficult or traumatic.

Procedure:
- Use the numbers for each type of trauma listed on the trauma history checklist (also listed with the Attribute names above) to indicate the kind of traumatic event or situation that the person found most traumatic.
- Where clinically appropriate, encourage the person to identify his or her worst trauma if this item has been missed.
- Transaction will be rejected if Code 1 (No) or Code 9 (No answer) is submitted for the type of trauma indicated as the Worst Trauma. (If the value submitted for the "Natural Disaster" attribute is "9," Worst Trauma cannot be Code 02.)
- NULLS are not allowed.

Type Code	Description
01	Accident Fire Explosion
02	Natural Disaster
03	Assault by Known Person
04	Assault by Unknown Person
05	Sexual Assault by Known Person
06	Sexual Assault by Unknown Person
07	Combat War Zone
08	Early Sexual Contact
09	Imprisonment
10	Torture
11	Life-threatening Illness
12	Other Trauma
99	Not reported

Attribute: Treatment Reason

Transaction:
PSS-I Trauma History

Definition:
Indicates which of the kinds of trauma that an individual has experienced or witnessed is the reason he or she is seeking treatment.

Procedure:
- Use the numbers for each type of trauma listed on the trauma history checklist to indicate the kind of traumatic event or situation for which the person is seeking treatment. (Those numbers are also listed after the Attribute names above.)
- Transaction will be rejected if Code 1 (No) or Code 9 (No answer) is submitted for the type of trauma indicated as the Treatment Reason. (If the value submitted for the "Combat War Zone" attribute is "1," Treatment Reason cannot be Code 07.)
- NULLS are not allowed.

Type Code	Description
00	Not seeking treatment for trauma
01	Accident Fire Explosion
02	Natural Disaster
03	Assault by Known Person
04	Assault by Unknown Person
05	Sexual Assault by Known Person
06	Sexual Assault by Unknown Person
07	Combat War Zone
08	Early Sexual Contact
09	Imprisonment
10	Torture
11	Life-threatening Illness
12	Other Trauma
99	Not reported

Attributes:
Physical Injury to Self
Physical Injury to Other
Own Life in Danger
Other's Life in Danger
Felt Helpless
Felt Terrified

Transaction:
PSS-I Trauma History

Definition:
For any of the traumas reported by the person, indicates whether or not certain physical, cognitive, or emotional experiences were part of the traumatic event(s)

Procedure:
- See the "PTSD Symptom Scale (PSS)" trauma history section for instructions on reporting values, and for the exact wording of each item.
- If no trauma experiences are reported, submit Code 9 for each attribute.
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- NULLS are not allowed.

Valid Codes	Definition
1	No
2	Yes
9	Not reported

Transaction: Program Referral

Definition:
This transaction is used to report client referrals to or from other providers or other service systems.

Procedure:
Submit one transaction for each referral.

Required for:
Outpatient, Crisis

Frequency:
Initial Assessment: referral type '01' (except Continuation of Benefits)
Initial Assessment: referral type '02' (except Continuation of Benefits)
Discharge if applicable: referral type '03'

Transaction ID: 616.02

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Authorization Number	Text (number)		
Event Date	Text (YYYYMMDD)	8	
Referral Type	Text	2	Y
Program type	Text	4	Y
Agency/System	Text	4	Y
Linkage Indicator	Text	2	Y
King County ID	Text (number)		

Attribute: Event Date

Transaction:
Program Referral

Definition:
This is the date of the referral.

Procedure:
- For a referral to or from the reporting mental health provider from or to an external system, report the date the referral was made.
- For screening contact, report the date of the first screening contact by the client.
- The Event Date must fall within the benefit or program authorization period except for screening contact and referral in.

Type: Text (8) YYYYMMDD

Attribute: Referral Type

Transaction:
Program Referral

Definition:
This code identifies the referral as one of: From the provider, To the provider, or Screening Contact.

Procedure:
If the referral transaction is required, then each referral type must be submitted (one transaction for each referral type)

Required Documentation:
All referrals to or from the provider must be maintained in provider records.

Type: Text (2)

Referral Type	Description
01	Screening Contact. This code indicates that the Event Date reported was the date that the client was screened for services. Not required for Continuation of Benefit. Use Program Type and Agency / System codes 9998 Not Applicable
02	Referral into the reporting Agency. Not required for Continuation of Benefit.
03	Referral by (from) the reporting Agency.

Attribute: Program Type

Transaction:
Program Referral

Definition:
This code describes programs or services that are provided by a facility, provider, or system to meet specific needs.

Example: Head Start Program

Procedure:
- This attribute is optional for outpatient benefits and most other programs; use Code 9998.
- This attribute is required for program codes 09 (PES Care Manager), 35 (Geriatric Regional Assessment Team), and 103 (Re-entry Case Management.
- Referrals to a specific BHO-funded program may be reported using the program codes listed under the Benefit/Program attribute of the Authorization Request transaction.
- Report this code for referrals made at the time of discharge from services.
- No report is required at expiration of a benefit where the client will continue services at the same provider agency under a continuation of benefit.
- For a referral to a BHO program, use the Program Code. See Authorization Request.

Required Documentation:
All sources of referral must be maintained in provider records.

Type: Text (4)

Program Type	Description
08	Harborview Emergency Department – ROI on file
110	Mental Health Services – General
111	Mental Health Crisis Services – General
112	Voluntary Inpatient Programs – General
113	Involuntary Inpatient Programs – General
114	Active Outreach by Mental Health Services provider
115	Mental Health Services – Outpatient Screening
116	Mental Health Services – Referral to BHO Outpatient Benefit Provider
117	Mental Health Services – Outpatient Non Network Provider
118	Mental Health Services – Provider Out of State
120	Medical Care – General
121	Emergency Medical Care – General
122	Nursing Home Programs – General

Program Type	Description
130	Legal Services – General
131	Law Enforcement / Police
132	Juvenile Justice Services
133	Legal Services – Mental Health Court
134	Alcohol & Substance Abuse Services – Involuntary
140	Alcohol & Substance Abuse Services – General
141	Alcohol & Substance Abuse Services – Detox
142	Alcohol & Substance Abuse Services – SUDNDA
143	Alcohol & Substance Abuse Services – ADATSA
144	Alcohol & Substance Abuse Services – Sobering
145	Alcohol & Substance Abuse Services – REACH
146	Alcohol & Substance Abuse Services – Inpatient Public
147	Alcohol & Substance Abuse Services – Inpatient Private
148	Alcohol & Substance Abuse Services – Outpatient Public
149	Alcohol & Substance Abuse Services – Outpatient Private
150	Residential/Housing Programs – General (excluding nursing homes)
160	Vocational Services – General
165	Veterans' court services
170	Developmental Disability Services – General
180	Other Social Services – General (may include DSHS Home and Community Services, Aging/Youth Services, and any social services other than mental health)
190	Educational Services – General
198	Other Services – General (any services not listed)
60	HOST – Outreach
61	HOST – Intensive Case Management
9151	Respite Bed Program
9152	Diversion Bed Program
9153	Temporary Housing Services
9154	Shelter Services
9998	Not applicable

Attribute: Agency / System

Transaction:
Program Referral

Definition:
These codes describe any organization or group of organizations that provide programs or services.

Example: Community Psychiatric Clinic, Division of Child and Family Services

Procedure:
- Referrals to a specific agency must be reported using the "Agency ID" in the ECLS "Agency List." Some Agency IDs are included below for convenience.
- Referrals to a system should be reported using the codes below.

Required Documentation:
- This Attribute is always required for a referral to or a referral from a reporting agency. Not required for Screening Contact.
- Provider records must document all referral sources.
- If collaborative or ongoing services are provided by a referral source, include information describing the type of ongoing involvement with the client and include this in the client's Individualized Tailored Care Plan (see Definitions).

Example:
During an outpatient benefit, the provider refers the client to a Primary Care practitioner. Report Agency/System code 1021 – Primary Care Practitioner non-specific, and report Program Type Code 9998 – Not applicable.

Type: Text (4)

Agency/System	Definition	State Code – Referral In Only (BHRD Use Only)
Mental Health System		
1010	Outpatient Network Mental Health Providers – Non-specific	3
1011	Outpatient Non-network Mental Health Providers – Non-specific (including psychiatrists, counselors, treatment centers)	3
1012	Inpatient Mental Health Facilities – Non-specific	3
1013	Designated Mental Health professional	3
1014	Children's Crisis Response Team	3
1015	Geriatric Regional Assessment Team	3
1113	Re-entry Case Management	8

Agency/System	Definition	State Code – Referral In Only (BHRD Use Only)
1114	Co-Occurring Disorder (COD) treatment program/IDDT	4
1125	Center for Community Alternatives Program (CCAP)	8
1126	King County Work and Education Release (WER)	8
Medical System		
1020	Inpatient Medical Facilities – Non-specific	4
1021	Primary Care Practitioners – Non-specific	4
1022	Emergency Rooms – Non-specific	4
1023	Nursing Home	9
1024	Ambulance Services	4
1025	Amerigroup Managed Care Organization (MCO)	4
1026	Community Health Plan of Washington MCO	4
1027	Coordinated Care MCO	4
1028	Molina Healthcare MCO	4
1029	UnitedHealthcare MCO	4
Legal System		
1030	Police – Non-specific	8
1031	Jail – Non-specific	8
1032	Attorneys	8
1033	Jail Probation Officers	8
1034	Court Referral, including less restrictive orders (LROs)	8
1035	Pre-booking Diversion (Harborview Emergency Department)	8
1036	Police booked or cited (Harborview Emergency Department)	8
1037	Regional Mental Health Court	8
1038	Municipal Mental Health Court	8
1039	King County Drug Court	8
1120	Electronic Home Detention	8
1130	KC Superior Court Felony Drop Down (Regional MHC only)	N/A
1131	KC Regional Court Misdemeanors (Regional MHC only)	N/A
1132	City Transfer Cases (Regional MHC only)	N/A

Agency/System	Definition	State Code – Referral In Only (BHRD Use Only)
301	King County Correction Facility (see the ECLS Agency List)	8
302	Regional Justice Center (see the ECLS Agency List)	8
303	Division of Youth Services (see the ECLS Agency List)	8
305	Juvenile Rehabilitation Administration (see the ECLS Agency List)	8
306	Seattle Police Department (see the ECLS Agency List)	8
307	Department of Correction (see the ECLS Agency List)	8
311	South Correctional Entity (SCORE) (see the ECLS Agency List)	8
933	Metro Transit Police (see the ECLS Agency List)	8
934	Sound Transit Police (see the ECLS Agency List)	8
Substance Abuse Facilities		
1040	Substance Abuse System – non-specific	2
1041	Outpatient Substance Abuse Facilities – Public, non-specific	2
1042	Inpatient Substance Abuse Facilities – Public, non-specific	2
1043	Outpatient Substance Abuse Facilities – Private, non-specific	2
1044	Inpatient Substance Abuse Facilities – Private, non-specific	2
1045	Self-help Associations (AA, NA, etc.)	5
490	Seattle Recovery Center (SRC) (see the ECLS Agency List)	2
491	South King County Recovery Center (see the ECLS Agency List)	2
492	Sobering Center (see the ECLS Agency List)	2
~~493~~	~~Cedar Hills Alcohol Treatment (CHAT) (see the ECLS Agency List)~~	
Housing System		
1050	Housing System – Non-specific	9
Developmental Disabilities System		
1060	Developmental Disabilities System – Non-specific	9
Vocational System		
1070	Vocational System – Non-specific	9

Agency/System	Definition	State Code – Referral In Only (BHRD Use Only)
Social Services System		
1110	Social Services System – Non-specific	9
1111	Children's Administration (formerly DCFS)	9
1112	DCHS	9
Educational System		
1080	Educational System – Non-specific	6
Other Systems		
1090	Other Systems – Non-specific	97
1091	Veteran Affairs System – Non-specific	9
1092	Family Support System – Non-specific (including family, friends)	9
1093	Community Support System – Non-specific (including ministry, community support organizations)	9
1094	Self-Referral	1
1095	Wraparound Services	9
1096	Parent Support System/Network	9
1133	Fire – Non-specific	9
9998	Not applicable	97
935	Kent Fire Department (see the ECLS Agency List)	9
BHRD Use Only		
	Specific Agency ID not listed above	9

Attribute: Linkage Indicator

Transaction:
Program Referral

Definition:
This code describes the type and success of the referral.

Procedure:
- Report this code for referrals made by the provider during the benefit or program authorization, and for referrals made at the time of discharge from services.
- For referrals into your agency, or for Screening Contacts, use code 98 – Not applicable.
- Programs 09 (PES Care Manager) and 35 (Geriatric Regional Assessment Team), and 103 (Re-entry Case Management) are required to follow up on referrals and report meaningful codes.

Required Documentation:
All sources of referral must be maintained in provider records.

Type: Text (2)

Valid Codes	Definition
01	Client refused
02	No services available
03	Client accepted; no linkage made
04	Linkage confirmed
07	Pending linkage; client accepted
31	Client did not connect with referral
33	Provider declined referral
35	Follow-up Plan
39	Unable to confirm linkage
98	Not applicable
99	Unknown

Transaction: Residential Absence

Definition:
This transaction is used for reporting a client's temporary absence from a residential facility.

Procedure:
- This transaction is only required when the client is living in a BHO-funded residential facility as reported in the Residential Arrangement entity.
- This transaction must be reported by the provider holding the residential authorization to document temporary leaves from a facility.
- If the client is leaving the facility permanently or moving to another facility, do not use this transaction. Instead, use the Residential Facility transaction to report the change.
- Only absence reason will be updated on Change.
- New absence record (Add) cannot overlap client's existing absence record.

Required for:
LTR, Supervised Living

Frequency:
On Occurrence

Transaction ID: 115.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Absence Start Date	Text (YYYYMMDD)	8	
Absence Last Date	Text (YYYYMMDD)	8	
Absence Reason	Text	2	Y
Facility Code	Text	9	
KCID	Text (number)		

Attribute: Absence Start Date

Transaction:
Residential Absence

Definition:
The start date of client's absence from the facility

Procedure:
- Report the date the client leaves the facility.
- BHRD will stop the reporting of residential per-diem service to the State MHD starting on the Absence Start Date until and including the Absence Last Date.

Required Documentation:
Providers shall document all dates in clinical or personnel records.

Type: Date (8) YYYYMMDD

Attribute: Absence Last Date

Definition:
This is the last date of the client's absence from the facility.

Procedure:
- Absence Last Date is a required field and cannot be null.
- When a client returns from an absence, report the Absence Last Date as the date of the last day where the client was not in the residential facility at midnight. For example, if the client returns to the facility on May 1, 2004 before midnight, then report April 30, 2004 as the Absence Last Date.
- BHRD will resume the reporting of residential per-diem service to the State MHD on the day following the Absence Last Date.

Required Documentation:
Provider shall document all dates in clinical or personnel record.

Type: Date (8) YYYYMMDD

Attribute: Absence Reason

Transaction:
Residential Absence

Definition:
This attribute codes the reason for a client's temporary absence from a facility.

Procedure:
Report the reason for client's absence using the code list below.

Required Documentation:
Providers shall maintain documentation supporting the reason.

Valid Codes	Definition
01	Medical Hospitalization
02	Psychiatric Hospitalization
03	Jail
04	Authorized Leave
05	Unauthorized Leave

Attribute: Facility Code

Transaction:
Residential Absence

Definition:
This attribute codes the exact residential facility where the client currently resides.

Procedure:
Report the Facility Code using the Facility Code list under the Residential Facility transaction.

Transaction: Residential Arrangement

Definition:
This is an outcome measure that describes the residential arrangement of the client.

Required for:
All programs

Frequency:
Initial Assessment
On change

Transaction ID: 110.06

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Start Date	Text (YYYYMMDD)	8	
Residential Arrangement	Text	2	Y
Zip Code	Text	9	
County Code	Text	2	Y
King County ID	Text (number)		

Attribute: Start Date

Transaction:
Residential Arrangement

Definition:
The date a client moved into a residence or the date that the residential arrangement information was obtained from the client or the date that the residential arrangement information was reported using revised codes (see Procedure below).

Procedure:
- For Assessments, report the date that the residential arrangement information was obtained from the client.
- For On Change, report the actual date the client moved residence.
- To update Residential Arrangement data using the new set of codes effective October 1, 2011, report the date on or after October 1, 2011 when the client's residential arrangement status is reviewed and the correct code identified.

Required Documentation:
Provider shall document all dates in clinical or personnel records.

Type: Date (8) YYYYMMDD

Attribute: Residential Arrangement Code

Transaction:
Residential Arrangement

Definition:
This code describes the housing arrangement of the client on the Event Date of the transaction.

Procedure:
- Report the residential arrangement on assessment and on change. On change means when client has a change from one type of housing to another.
- For the initial assessment, use the date the residential arrangement was obtained from the client as the start date.
- When there is a change in residential arrangement, report the actual date the residential arrangement change occurred.
- If a client's residential arrangement is fluctuating
- If a client's residential arrangement is fluctuating frequently among some combination of Homeless, Temporary housing, Jail, Psychiatric Inpatient, Residential Drug/Alcohol treatment, none of which are expected to last longer than 30 days (or 60 for Jail and or 90 for Inpatient Psych/Residential Drug Treatment, respectively), report the code that best describes the majority of time in the last 30 days.
- If there is a change that is expected to last for a while (for example, losing housing and becoming homeless; moving from Residential Care to Permanent Housing – assisted), report the new residential arrangement when the change occurs. That is, do not wait 16 days until "Permanent Housing – assisted" becomes the residential arrangement for the majority of time in the last 30 days.
- Dependent children and youth living with parents should be reported based on the living situation that describes the permanence and adequacy of their parents' living situation (that is, homeless, permanent, temporary or transitional), without regard to "intensive supportive services" that the parent may require. In other words, codes 01, 04, 05, or 06 could apply to a child, but 02 or 03 will not.
- This is an outcome measure.

Required Documentation:
Providers shall document the type of residence a client lives in and any changes of that place of residence.

Examples:
1. A 10-year-old client lives with her mother in a transitional housing site for women coming out of prison. Report 06 for "Transitional Housing.

2. A client receiving services under a Long-Term Residential benefit lives in an agency-operated residential facility, which is also licensed as an Institute for Mental Disease. Report 07 for "Residential Care."

3. A man who has recently been sleeping on the streets, with a few brief stays at his brother's house, is involuntarily hospitalized. Continue to report code 82 for "Homeless," unless he remains in inpatient psychiatric facilities for 90 days.

4. A 16- year-old client lives in a group home operated by another social service agency. Report 07 for "Residential Care"

Type: Text (2)

In the following definitions:

- "Intensive supporting services" includes the mental health and case management services provided by PACT High Intensity Treatment, MPC, ECS, Standard Supportive Housing, and similar programs.
- "Emancipated youth" means a youth sixteen years of age or older, who: is a resident of the state, has the ability to manage his or her financial affairs, and has the ability to manage his or her personal, social, educational, and nonfinancial affairs.

Valid Codes	**Definitions**	**State Code (BHRD Use Only)**
Type of housing		
01	Permanent housing – unassisted: Without intensive supporting services required to maintain housing. A house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO), rented or owned, with an expectation of long-term residency. Includes dependent children living with parents or legal guardians but not in foster care.	8: Adults 10: Children (< 18)
02	Permanent housing – assisted: With intensive supporting services required to maintain housing. A house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO), rented or owned, with an expectation of long-term residency.	9: Adults 10: Children
03	Temporary housing – unassisted: Without intensive supporting services required to maintain housing, and without an expectation of long-term residency.	8: Adults 10: Children
04	Temporary housing –assisted: With intensive supporting services required to maintain housing, and without an expectation of long-term residency.	9: Adults 10: Children
05	Temporary housing – dependent: Living with friends or family temporarily including "couch surfing" and includes emancipated youth.	9: Adults 10: Children
06	Transitional housing: Housing provided as part of participation in a housing readiness program with time-limited housing and supporting services provided with the goal of permanent housing.	11
07	Residential Care: May include a Group Home, Therapeutic Group Home, Board and Care, Residential Treatment, Rehabilitation Center, or Agency-operated residential care facilities.	3

Valid Codes	Definitions	State Code (BHRD Use Only)
08	Skilled Nursing/Nursing/Intermediate Care Facility	5
09	Other institutional setting: A licensed institutional treatment and care facility not covered by other codes, including Institute of Mental Disease (IMD), DD Facility, or Medical Hospital.	5
22	Adult Family Home: Regular neighborhood homes licensed by the state for two to six residents where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision, and varying levels of assistance with care are provided.	9?
25	Residential Drug/Alcohol treatment – treatment for 90 days or more. If the client is in treatment for less than 90 days, use the code for the living arrangement just prior to treatment.	3
26	Foster Care (for children) A Licensed Foster Home to provide foster care to children and adolescents including Therapeutic Foster Care Facilities.	2
61	Jail/Juvenile Correctional Facility – Incarceration for 60 days or more. If the client is incarcerated for less than 60 days, use the code for the living arrangement just prior to incarceration.	6
62	Psychiatric Inpatient Facility – Voluntary or involuntary hospitalization for 90 days or more; includes CLIP programs. Types of facility include Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), Veterans Affairs Hospital, or State Hospital. If the client is hospitalized for less than 90 days, use the code for the living arrangement just prior to hospitalization.	5
82	Homeless – Those persons of all ages who lack a fixed, regular, and adequate nighttime residence including persons whose primary nighttime residence is one of the following: Emergency shelter (e.g., missions, churches) where residence is on a ‘night by night basis’ Living on the streets, in a vehicle, or abandoned building Being discharged/discharged from an institution (e.g., jail, medical or psychiatric hospital) with no arranged residence Temporary living accommodations by a voucher system (e.g., motel vouchers) Living in a public or private place not designed for, or not ordinarily used as, a regular sleeping accommodation for human beings	1

Attribute: Zip code

Transaction:
Residential Arrangement

Definition:
The five-digit code for the zip code for the person's residence at the time of admission or review.

Procedure:
- If a client resides in King County, the zip code **must** be submitted.
- This will be used to identify all clients who reside within the BHRD /MHP service area.
- If a client is homeless, report the zip code where assessment took place. Do not report zip code again unless client has had a change in residential arrangement.
- For clients in a confidential address program, submit either the provider's zip code or BHRD zip code (98104).

Required Documentation:
The client's address and zip code must be maintained in his/her clinical record.

Example:
Client is homeless and received assessment on the corner of Third and James downtown Seattle. Use zip code 98104.

Type: Text (9)

Valid Codes	Definition
Five-digit zip code	Zip Code
77777	Out of County – Unknown

Attribute: County Code

Transaction:
Residential Arrangement

Definition:
A code to identify client's county of residence. Codes '01' through '39' identify the 39 counties in alphabetical order. Code '99' represents unknown county.

Procedure:
- Where a provider requests a benefit for a client with an out of county code, the request requires manual review and approval by the MHP.
- For clients placed in facilities outside of King County (e.g., Western State Hospital or Pioneer Center), a change in county code should be reported when client has been there for 90 days or more.
- This information is used by the state to establish the BHO of responsibility and for the purposes of allocating resources.
- This information is used by King County to determine eligibility for services under the MHP and the BHO.
- For clients in a confidential address program, submit the code for King County.

Type: Text (2)

Valid Codes	Definition
01	Adams
02	Asotin
03	Benton
04	Chelan
05	Clallam
06	Clark
07	Columbia
08	Cowlitz
09	Douglas
10	Ferry
11	Franklin
12	Garfield
13	Grant
14	Grays Harbor
15	Island
16	Jefferson

Valid Codes	Definition
17	King
18	Kitsap
19	Kittitas
20	Klickitat
21	Lewis
22	Lincoln
23	Mason
24	Okanogan
25	Pacific
26	Pend Oreille
27	Pierce
28	San Juan
29	Skagit
30	Skamania
31	Snohomish
32	Spokane
33	Stevens
34	Thurston
35	Wahkiakum
36	Walla Walla
37	Whatcom
38	Whitman
39	Yakima
90	Out of state
98	Out of County – county unknown

Transaction: Residential Facility

Definition:
This is the entity that describes the residential facility where the client lives.

Procedure:
- This transaction is only required when the client is living in a BHO-funded residential facility as reported in the Residential Arrangement entity.
- This transaction must be reported by the provider holding the residential authorization when an authorization request is submitted for a residential program.

Required for:
LTR, Supervised Living

Frequency:
Assessment
On change

Transaction ID: 112.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Start Date	Text (YYYYMMDD)	8	
Exit Date	Text (YYYYMMDD)	8	
Facility Code	Text	9	Y
KCID	Text (number)		

Attribute: Start Date

Transaction:
Residential Facility

Definition:
The date a client moved into a residence.

Procedure:
- For assessments, report the actual start date the client began residence in the facility.
- When a client moves, report the exit date for the former facility (see Exit Date attribute for procedure) and the new start date for the new facility.
- This transaction was implemented January 1, 1998. There are no residential facility data before that date.

Required Documentation:
Providers shall document all dates in clinical or personnel records.

Type: Date (8) YYYYMMDD

Attribute: Exit Date

Transaction:
Residential Facility

Definition:
The date a client moved out of a residence.

Procedure:
When a client leaves the facility, report the exit date as the last day client was at the facility as of midnight.

Required Documentation:
Provider shall document all dates in clinical or personnel record.

Type: Date (8) YYYYMMDD

Attribute: Facility Code

Transaction:
Residential Facility

Definition:
This attribute codes the exact residential facility where the client currently resides.

Procedure:
- Valid codes for each of the residential facilities are noted below.
- When there is a change in residence, report the actual date the residential change occurred and the new location.

Required Documentation:
Providers must document the place and type of residence a client lives in. When a residential change occurs, the records shall reflect that change.

Facility Names and Codes

Valid Codes	Definition
222	Avondale House
219	Benson Heights
164	Spring Manor
165	Cascade Hall
166	Chartley House
167	El Rey
8032	El Rey – SL
123	Firwood
221	Highwest Residence
158	Hilltop Center
169	Keystone Resources
225	Midway Residential (as of 03/04/99)
224	Stillwater
148	Transitional Resources

Transaction: SED Functional Criteria

Definition:
Must be used for a person under the age of 18. May be used for persons of age 18, 19, or 20: persons aged 18, 19, or 20 years old may qualify for services under SED or SMI determinations.

To meet the functional criteria for SED, a person must have, as a result of a covered diagnosis, dysfunction in at least one (1) of the following Capacities or one (1) of the Symptoms. Duration of the dysfunction must be present, or expected to persist, for six (6) months.

The "Assessment Date" must equal the authorization's assess date.

Required for:
Initial authorization requests (benefit change code '01') for case rate benefits. Not required for continuation of benefits or provider changes.

Frequency:
Initial assessment

Transaction ID: 890.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Assessment Date	Text (YYYYMMDD)	8	
Functional: 1: Self Care	Text	1	Y
Functional: 2: Community	Text	1	Y
Functional: 3: Social	Text	1	Y
Functional: 4: Family	Text	1	Y
Functional: 5: School and Work	Text	1	Y
Symptom: 1: Psychotic	Text	1	Y
Symptom: 2: Dangerous	Text	1	Y
Symptom: 3: Trauma	Text	1	Y
King County ID	Text (Number)		

Attribute: Functional: 1: Self Care

Transaction:
SED Functional Criteria

Definition:
Functioning in self-care

Impairment in age-appropriate/developmental age self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and/or nutritional needs.

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Functional: 2: Community

Transaction:
SED Functional Criteria

Definition:
Functioning in community

Inability to maintain safety without assistance; a consistent lack of age-appropriate/developmental age behavioral controls, decision-making, and/or judgment any of which may increase the risk for potential out-of-home placement.

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Functional: 3: Social

Transaction:
SED Functional Criteria

Definition:
Functioning in social relationships

Impairment of social relationships is manifested by the consistent inability to develop and maintain normal relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Functional: 4: Family

Transaction:
SED Functional Criteria

Definition:
Functioning in the family

Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents), disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

- Rarely or minimally seeking comfort in distress
- Limited positive affect and excessive levels of irritability, sadness, or fear
- Disruptions in feeding and sleeping patterns
- Failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
- Willingness to go off with unfamiliar adult with minimal or no hesitation
- Regression of previously learned skills

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Functional: 5: School and Work

Transaction:
SED Functional Criteria

Definition:
Functioning at school/work

Impairment in school/work function is manifested by an inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Symptom: 1: Psychotic

Transaction:
SED Functional Criteria

Definition:
Psychotic symptoms

Symptoms that are characterized by defective or loss of contact with reality, often with hallucinations or delusions.

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Symptom: 2: Dangerous

Transaction:
SED Functional Criteria

Definition:
Danger to self, others, or property as a result of emotional disturbance

The individual is self-destructive (e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property.)

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Symptom: 3: Trauma

Transaction:
SED Functional Criteria

Definition:
Trauma Symptoms

Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience a disruption in their age-expected/developmental age range of emotional and social developmental capacities.

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Transaction: SMI Functional Criteria

Definition:
Must be used for persons age 21 and older. May be used for persons of age 18, 19, or 20: persons aged 18, 19, or 20 years old may qualify for services under SED or SMI determinations.

To meet the functional criteria for SMI, a person must have, as a result of a covered diagnosis, current dysfunction in at least one of the following four (4) domains, as described below. This dysfunction has been present for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months. Six-month minimum timeframe does not apply to all diagnoses per DSM. Examples are acute stress disorder, adjustment disorder, and certain psychotic disorders.

The "Assessment Date" must equal the authorization's assess date.

Required for:
Initial authorization requests (benefit change code ‘01’) for case rate benefits. Not required for continuation of benefits or provider changes.

Frequency:
Initial assessment

Transaction ID: 880.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Assessment Date	Text (YYYYMMDD)	8	
Functional: 1: Self Care	Text	1	Y
Functional: 2: Risk of Harm	Text	1	Y
Functional: 3: School and Work	Text	1	Y
Functional: 4: Risk of Deterioration	Text	1	Y
King County ID	Text (Number)		

Attribute: Functional: 1: Self Care

Transaction:
SMI Functional Criteria

Definition:
Inability to live in an independent or family setting without supervision

Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food, and clothing must be provided or arranged for by others. Unable to attend one or more basic needs of hygiene, grooming, nutrition, medical, and/or dental care. Unwilling to seek necessary medical/dental care for serious medical or dental conditions due to mental health symptoms. Refuses treatment for life threatening illnesses because of behavioral health disorder.

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Functional: 2: Risk of Harm

Transaction:
SMI Functional Criteria

Definition:
A risk of serious harm to self or others

Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized, or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan.

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Functional: 3: School and Work

Transaction:
SMI Functional Criteria

Definition:
Dysfunction in role performance

Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities.

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Attribute: Functional: 4: Risk of Deterioration

Transaction:
SMI Functional Criteria

Definition:
Risk of deterioration

Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors. Care is complicated and requires multiple providers. Also, consumers with past psychiatric history, with gains in functioning that have not solidified or cannot be maintained without treatment and/or supports.

Procedure:
Record whether or not the client meets this specific functional criterion.

Required Documentation:
Documentation of the client's functional assessment must be provided in agency records.

Type: Text (1)

Valid Codes	Definition
1	No – the person does not meet this functional criterion.
2	Yes – the person does meet this functional criterion.

Transaction: Staff Person

Definition:
Information about staff employed by mental health providers.

Procedure:
It is not possible to change the "Start Date" for existing data. If a correction is required, contact the King County Help desk.

Required for:
All staff

Frequency:
On hire
On discharge

Transaction ID: 810.05

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Staff Person ID	Text	10	
Start Date	Text (YYYYMMDD)	8	
End Date	Text (YYYYMMDD)	8	
Surname	Text	30	
Given Name	Text	30	
Gender	Text	1	Y
Language Code	Text	10	Y
King County ID	Text (number)		

Attribute: Staff Person ID

Transaction:
Staff Person

Definition:
The identifier established by a Reporting Unit that uniquely identifies a staff person. A Staff ID submitted by a Reporting Unit should not be identical to a client Case ID submitted by that Reporting Unit. This uniquely identifies the staff person within an agency who is providing and reporting a service to a client. Where a staff person is also a case manager, the staff ID and the case manager ID should be identical.

Required Documentation:
All services provided to a client must be documented in the clinical record with the date, type, location (in/out), and duration of the service episode and the name of the clinician providing the service.

Type: Text (10)

Attribute: Start Date

Transaction:
Staff Person

Definition:
The date an agency staff person began employment.

Required Documentation:
Providers shall document all start and change dates in personnel records.

Type: Date (8) YYYYMMDD

Attribute: End Date

Transaction:
Staff Person

Definition:
This is the date the staff person leaves the agency.

Procedure:
- For the Staff Person transaction, it is the end of the staff person's employment or volunteer work at the agency.
- Transmit a NULL if not applicable.

Required Documentation:
All end dates must be documented in provider records.

Example:
A case manager terminates his employment at an agency. Report the last date of employment.

Type: Date (8) YYYYMMDD

Attribute: Surname

Transaction:
Staff Person

Definition:
The surname/family/last name of a staff person as provided by a Reporting Unit. In general, follow the rules of the appropriate culture when determining which name is the surname.

Procedure:
- Consistency is important; the last name will be used as one element to uniquely identify the person across our system.
- Only the following characters are allowed: alphabetic characters, hyphens, space (but not as the first character), apostrophe (single quotation mark). No numeric characters are permitted.

Type: Text (30)

Attribute: Given Name

Transaction:
Staff Person

Definition:
The given/first/legal names of a staff person as provided by a reporting unit. In general, follow the rules of the appropriate culture when determining which name is the surname and which the given name.

Procedure:
- Consistency in reporting each name is important; the last name and given names will be used as elements to uniquely identify the person across our system.
- The middle name is a required entry. If only the middle initial is known, enter the middle initial. If there is no middle name, leave the field blank.
- The given name as recorded on significant documentation can be used to resolve contradictions. Use reasonable judgment to determine the best choice.
- Given names may include spaces, apostrophe (single quote) and hyphens. No numeric characters are allowed.

Example:
Garry D. Richards, Jr. should be entered as Garry D Jr (dropping the period after the middle initial and the abbreviation).

Type: Text (30)

Attribute: Gender

Transaction:
Staff Person

See description of the Gender attribute in the Client Demographics transaction.

Gender code “9” (“Unknown”) is acceptable.

Attribute: Language Code

Transaction:
Staff Person

Definition:
This code identifies the languages in which a staff person can provide services.

Procedure:
- Enter up to five codes that describe languages in which a staff person can provide services.
- Language code “00” (“Language Unknown”) is not acceptable.

Required Documentation:
Provider records shall document the languages in which a staff person can provide services.

Type: Text (10)

See valid language codes in the Language Code attribute in the Client Demographics transaction.

Transaction: Staff Qualifications

Definition:
Describes the professional qualifications for provider staff.

Required for:
All staff

Procedure:
- Submit on hire and on change.
- Submit at least one transaction for every staff person.
- Submit one transaction for every specialty.

Transaction ID: 660.01

Action Codes:

A	Add
D	Delete

Field	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Staff Person ID	Text	10	
Specialty Area	Text	2	Y

Attribute: Staff Person ID

Transaction:
Staff Qualifications

Definition:
This uniquely identifies the staff person within an agency who is providing and reporting a service to a client. Where a staff person is also a case manager, the staff ID and the case manager ID should be identical. All staff person IDs should already exist in the BHRD system prior to submitting a Staff Qualification transaction. This includes staff id "999," "998," and "990."

For mental health specialists agencies must submit the mental health specialty as well as the educational attainment level. For the special '998' staff ID, submit the educational attainment level that your contracted MH specialists would have (typically 25 or 27).

Procedure:
- The staff ID assigned must remain unique to the staff person and cannot be reassigned.
- When the specialist who delivered a service is either a member of another network provider staff or a mental health specialist on sub-contract with the provider, the provider may report the service with either the staff ID of the specialist, or a staff ID of “999” indicating that this is a qualified specialist and not a member of the reporting provider staff, or a staff ID of “998” indicating that this is a special population MH Specialist with one of the following qualifications, as defined under the *qualifications* attribute
  - African American Ethnic Minority MH Specialist
  - Asian/Pacific Islander Ethnic Minority MH Specialist
  - Hispanic Ethnic Minority MH Specialist
  - Native American Ethnic Minority MH Specialist
  - Sexual Minority MH Specialist
  - Other Ethnic Minority MH Specialist
- Staff ID “990” is designated as a team staff ID for reporting per-diem services and services being delivered by a team.

Required Documentation:
The name of the staff person providing services to a client must be documented in provider records.

Type: Text (10)

Attribute: Specialty Area

Transaction:
Staff Qualifications

Definition:
This codes the professional staff members who meet the requirements for mental health and mental health specialists according to WAC 388-865-0150. See also Section 13: Quality Management.

Procedure:
- Code **each** specialist type for which a clinical staff person qualifies in a separate record.
- If a staff person is a mental health specialist, you must submit at least two codes – one identifying the mental health specialty and one identifying the educational attainment level. The educational attainment level will be submitted to DBHR as the provider type in the encounter data. The mental health specialist qualification will be checked by the BHRD IS system when a special population evaluation is performed.
- This also describes staff educational attainment levels.

Required Documentation:
Providers must document each specialty area for which a staff person is qualified. For mental health professionals, documentation must include evidence supporting WAC 388-865-0150 or BHO/MHP waiver status 388-865-0265. For mental health specialists, documentation must include the type and amount of training the staff person received in each specialty area, supervision information including hours, name and qualifications of supervisor, and span of time supervision was provided. Documentation should include graduation or program completion records for the highest level of educational attainment for each staff person.

Examples:
1. A staff person is qualified both as a geriatric mental health specialist and as an Asian/Pacific Islander Ethnic Minority Health Specialist. Submit two records, one coded 02 and the other 04.

2. A staff person has completed a master degree in counseling and has over two years of experience in mental health care. Code 25.

Type: Text (2)

Valid Codes	Definition	Mapping to State's Provider Type
01	Child Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the BHRD IS.
02	Geriatric Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the BHRD IS.

Valid Codes	Definition	Mapping to State's Provider Type
03	African American Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the BHRD IS.
04	Asian/Pacific Islander Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the BHRD IS.
05	Hispanic Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the BHRD IS.
06	Native American Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the BHRD IS.
07	Disability Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the BHRD IS.
08	Sexual Minority Mental Health Specialist is defined as a mental health professional who: 1. Has completed a minimum of one hundred actual hours of specialized training devoted to a) a broad range of sexual minority issues; and b) effects of culture on mental health. 2. Has the equivalent of one year of full-time direct service with the sexual minority population under the supervision of a mental health professional meeting the criteria of a sexual minority specialist. 3. Can demonstrate cultural competence attained through on-going training or study regarding sexual minority issues totaling 8 to 16 hours per year. (See also 13, Quality Management, Attachment B.)	4 – MA/PhD
09	Other Ethnic Minority Mental Health Specialist	No mapping, but still required by the BHRD IS.
20	Mental Health Professional: A physician assistant working with a supervising psychiatrist as defined in 71.05 and 71.34 RCW.	2 – ARNP/PA
21	Mental Health Professional: A physician or osteopath licensed under chapter 18.71 or 18.57 RCW, who is board eligible in psychiatry. [WAC 388-865-0150]	3 – Psychiatrist/MD
22	Mental Health Professional: A psychologist licensed under chapter 18.83 RCW. [WAC 388-865-0150]	4 – MA/PhD

Valid Codes	Definition	Mapping to State's Provider Type
23	Mental Health Professional: A registered psychiatric nurse licensed under chapter 18.79 RCW with at least two years' experience in the direct treatment of mentally ill persons and who is an ARNP with prescriptive authority. [WAC 388-865-0150]	2 – ARNP
24	Mental Health Professional: A registered psychiatric nurse licensed under chapter 18.79 RCW with at least two years' experience in the direct treatment of mentally ill persons and who is not an ARNP with prescriptive authority. [WAC 338-865-0150]	1 – RN/LPN
25	Mental Health Professional: A person with at least a master's degree in counseling or one of the social services from an accredited college or university and at least two years' experience in the direct treatment of mentally ill persons. [WAC 388-865-0150]	4 – MA/PhD
26	Mental Health Professional: A mental health counselor or marriage and family therapist licensed under chapter 18.225 RCW with at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional, OR a social worker licensed under chapter 18.225.RCW. [WAC 388-865-0150]	4 – MA/PhD
27	Mental Health Professional: A person otherwise qualified to perform the duties of a mental health professional but who does not meet the requirements listed in (a) through (e) of the WAC, where the State has granted an exception to such requirements upon review of a written request by the BHO or MHP involved. [WAC 388-865-0150] [WAC 388-865-0265]	9 – Bachelor Level with Exception/ Waiver
28	Certified Consumer Peer Counselor: a consumer of mental health services who has met the educational, experience and training requirements, has satisfactorily passed the examination, and has been issued a certificate by the State Mental Health Division as specified in WAC 388-865-0107.	6 – DOH Credentialed Certified Peer Counselor
29	Peer Support Specialist: A paraprofessional who is a consumer of mental health services (or a parent of a child receiving mental health services) who receives training, supervision (by a mental health professional), and provides support to peers all according to the King County Standards for Peer Support Services.	14 – Non-DOH Credentialed Certified Peer Counselor
32	Non-Mental Health Professional – RN/LPN	1 – RN/LPN
40	Medical Assistant – Certified	15 – Medical Assistant – Certified
50	Doctor of Pharmacy (PharmD)	16 – PharmD

Valid Codes	Definition	Mapping to State's Provider Type
70	Non-Mental Health Professional – Physician Assistant	2 – ARNP/PA
71	Non-Mental Health Professional – M.D.	3 – Psychiatrist/MD
72	Non-Mental Health Professional – Ph.D.	4 – MA/PhD
73	Non-Mental Health Professional – Master's	4 – MA/PhD
74	Non-Mental Health Professional – Bachelors	5 – Below Master's Degree
75	Non-Mental Health Professional – Associate	5 – Below Master's Degree
76	Non-Mental Health Professional – High School or GED	5 – Below Master's Degree
77	None of the above	12 – Other
80	Chemical Dependency Professional (CDP)	20 – Chemical Dependency Professional
81	Chemical Dependency Professional Trainee (CDPT)	21 – Chemical Dependency Professional Trainee
82	Designated Chemical Dependency Professional	22 – Designated Chemical Dependency Professional

Transaction: Substance Use

Definition:
A client history of substance specific information.

Required for:
SUD outpatient benefits
SUD residential benefits (data submission and entry described in the SUD Residential Authorization Process Manual)
Detox

Frequency:
SUD case rate outpatient benefits
- Initial authorization request
- Every 180 days during a continuous episode of care – A continuous episode of care is the period during which a client remains in an outpatient benefit at the same provider without interruption. This period of time could involve several consecutive authorizations (the second and subsequent requests are submitted as "continuation of benefits").
- On change
- On exit

SUD residential benefits
- On admit
- On discharge
- Every 90 days if stay exceeds 90 days

Detox
Once per episode

Transaction ID: 150.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	Y
Case ID	Text	10		Y
Event Date	Date (YYYYMMDD)	8		Y
Substance 1 Code	**Number**	**2**	**Y**	**Y**
Substance 1 Frequency of Use	Number	1	Y	C

Attribute	Type	Size	Coded	Required
Substance 1 Frequency of Use Uncontrolled Environment	Number	1	Y	C
Substance 1 Peak Frequency	Number	1	Y	C
Substance 1 Method	Number	1	Y	C
Substance 1 Date Last Used	Date (YYYYMMDD)	8		C
Substance 1 First Use Age	Number	2	Y	C
Substance 2 Code	Number	2	Y	Y
Substance 2 Frequency of Use	Number	1	Y	C
Substance 2 Frequency of Use Uncontrolled Environment	Number	1	Y	C
Substance 2 Peak Frequency	Number	1	Y	C
Substance 2 Method	Number	1	Y	C
Substance 2 Date Last Used	Date (YYYYMMDD)	8		C
Substance 2 First Use Age	Number	2	Y	C
Substance 3 Code	Number	2	Y	Y
Substance 3 Frequency of Use	Number	1	Y	C
Substance 3 Frequency of Use Uncontrolled Environment	Number	1	Y	C
Substance 3 Peak Frequency	Number	1	Y	C
Substance 3 Method	Number	1	Y	C
Substance 3 Date Last Used	Date (YYYYMMDD)	8		C
Substance 3 First Use Age	Number	2	Y	C
Substance 4 Code	Number	2	Y	C
Substance 4 Frequency of Use	Number	1	Y	C
Substance 5 Code	Number	2	Y	C
Substance 5 Frequency of Use	Number	1	Y	C
King County ID	Number	10		Y

Attribute: Substance 1 Code

Transaction:
Substance Use

Definition:
Indicates the substance with the number 1 ranking at the beginning of a continuous episode of care. For SUD residential and detox a continuous episode of care is the period between admit and discharge (inclusive). For SUD outpatient benefits a continuous episode of care is the period during which a client remains in an outpatient benefit at the same provider without interruption (this period of time could involve several consecutive authorizations).

Procedure:
- The substance must be ranked by relative importance of seriousness of dependency as provided by the client and determined by the counselor.
- The same top three substances must be reported during a continuous episode of care.
- This is a required attribute.
- Report "None" (code 1) if an assessment was performed and it was determined that the client is not using any substances.
- An authorization for treatment will not be granted if "None" (code 1) is reported.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	None
2	Alcohol
3	Cocaine/Crack
4	Marijuana/Hashish
5	Heroin
6	Other Opiates And Synthetics
7	PCP-phencyclidine
8	Other Hallucinogens
9	Methamphetamine
10	Other Amphetamines
11	Other Stimulants
12	Benzodiazepine
13	Other non-Benzodiazepine Tranquilizers

Valid Codes	Definition
14	Barbiturates
15	Other Non-Barbiturate Sedatives or Hypnotics
16	Inhalants
17	Over-The-Counter
18	Oxycodone
19	Hydromorphone
20	MDMA (ecstasy, Molly, etc.)
21	Other

Attribute: Substance 1 Frequency of Use

Transaction:
Substance Use

Definition:
Indicates the frequency that the client used a specific substance in the last 30 days.

Procedure:
- If the Substance 1 Code is ‘1’ (None) then this attribute must be null. Otherwise, it is required.
- Report for the 30 days prior to the Event Date.
- Report the use for the last 30 days, even if it is “No use” (Code 1) because the person has been in a controlled environment like a jail or treatment facility.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the past month
2	1–3 times in the past month
3	4- 12 times in the past month
4	13 times in the past month
5	Daily

Attribute: Substance 1 Frequency of Use Uncontrolled Environment

Transaction:
Substance Use

Definition:
Indicates the frequency that the client used a specific substance in the last 30 days in which they were in an uncontrolled environment.

Procedure:
- If the Substance 1 Code is '1' (None), then this attribute must be null. Otherwise, it is required.
- If the person has been in an uncontrolled environment (for example, living at home) for the last 30 days, report the same value as reported for "Substance 1 Frequency of Use"
- If the person has been in a controlled environment (for example, in jail) for the last 30 days, report the frequency of use for the 30 days in which they were free to use.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the past month
2	1–3 times in the past month
3	4- 12 times in the past month
4	13 times in the past month
5	Daily

Attribute: Substance 1 Peak Frequency

Transaction:
Substance Use

Definition:
Indicates the highest monthly use pattern in the 12 months preceding the continuous episode of care start date.

Procedure:
If the Substance 1 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the 12 months preceding the episode of care start date
2	1–3 Times Per Month
3	4–12 Times Per Month
4	13 or More Times Per Month
5	Daily

Attribute: Substance 1 Method

Transaction:
Substance Use

Definition:
Indicates the most common method the client uses to administer the substance.

Procedure:
If the Substance 1 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Inhalation
2	Injection
3	Oral
4	Other
5	Smoking

Attribute: Substance 1 Date Last Used

Transaction:
Substance Use

Definition:
Indicates the date that client last used a specific substance.

Procedure:
If the Substance 1 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Date (YYYYMMDD)

Attribute: Substance 1 First Use Age

Transaction:
Substance Use

Definition:
Indicates the age at which the client first used the specific substance.

Procedure:
If the Substance 1 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
0	Client born with a substance use disorder resulting from in-utero exposure
1–98	Age at first use, in years

Attribute: Substance 2 Code

Transaction:
Substance Use

Definition:
Indicates the substance with the number 2 ranking at the beginning of a continuous episode of care.

Procedure:
- The substance must be ranked by relative importance of seriousness of dependency as provided by the client and determined by the counselor.
- The same top three substances must be reported during a continuous episode of care.
- This is a required attribute.
- Report "None" (code 1) if a second substance is not reported at the beginning of a continuous episode of care.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	None
2	Alcohol
3	Cocaine/Crack
4	Marijuana/Hashish
5	Heroin
6	Other Opiates And Synthetics
7	PCP-phencyclidine
8	Other Hallucinogens
9	Methamphetamine
10	Other Amphetamines
11	Other Stimulants
12	Benzodiazepine
13	Other non-Benzodiazepine Tranquilizers
14	Barbiturates
15	Other Non-Barbiturate Sedatives or Hypnotics
16	Inhalants

Valid Codes	Definition
17	Over-The-Counter
18	Oxycodone
19	Hydromorphone
20	MDMA (ecstasy, Molly, etc.)
21	Other

Attribute: Substance 2 Frequency of Use

Transaction:
Substance Use

Definition:
Indicates the frequency that the client used a specific substance in the last 30 days.

Procedure:
- If the Substance 2 Code is '1' (None), then this attribute must be null. Otherwise, it is required.
- Report for the 30 days prior to the Event Date.
- Report the use for the last 30 days, even if it is "No use" (Code 1) because the person has been in a controlled environment like a jail or treatment facility.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the past month
2	1-3 times in the past month
3	4-12 times in the past month
4	13 times in the past month
5	Daily

Attribute: Substance 2 Frequency of Use Uncontrolled Environment

Transaction:
Substance Use

Definition:
Indicates the frequency that the client used a specific substance in the last 30 days in which they were in an uncontrolled environment.

Procedure:
- If the Substance 2 Code is '1' (None), then this attribute must be null. Otherwise, it is required.
- If the person has been in an uncontrolled environment (for example, living at home) for the last 30 days, report the same value as reported for "Substance 2 Frequency of Use"
- If the person has been in a controlled environment (for example, in jail) for the last 30 days, report the frequency of use for the 30 days in which they were free to use.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the past month
2	1-3 times in the past month
3	4-12 times in the past month
4	13 times in the past month
5	Daily

Attribute: Substance 2 Peak Frequency

Transaction:
Substance Use

Definition:
Indicates the highest monthly use pattern in the 12 months preceding the continuous episode of care start date.

Procedure:
If the Substance 2 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the 12 months preceding the episode of care start date
2	1-3 Times Per Month
3	4-12 Times Per Month
4	13 or More Times Per Month
5	Daily

Attribute: Substance 2 Method

Transaction:
Substance Use

Definition:
Indicates the most common method the client uses to administer the substance.

Procedure:
If the Substance 2 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Inhalation
2	Injection
3	Oral
4	Other
5	Smoking

Attribute: Substance 2 Date Last Used

Transaction:
Substance Use

Definition:
Indicates the date that client last used a specific substance.

Procedure:
If the Substance 2 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Date (YYYYMMDD)

Attribute: Substance 2 First Use Age

Transaction:
Substance Use

Definition:
Indicates the age at which the client first used the specific substance.

Procedure:
If the Substance 2 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
0	Client born with a substance use disorder resulting from in-utero exposure
1–98	Age at first use, in years

Attribute: Substance 3 Code

Transaction:
Substance Use

Definition:
Indicates the substance with the number 3 ranking at the beginning of a continuous episode of care.

Procedure:
- The substance must be ranked by relative importance of seriousness of dependency as provided by the client and determined by the counselor.
- The same top three substances must be reported during a continuous episode of care.
- This is a required attribute.
- Report "None" (code 1) if a third substance is not reported at the beginning of a continuous episode of care.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	None
2	Alcohol
3	Cocaine/Crack
4	Marijuana/Hashish
5	Heroin
6	Other Opiates and Synthetics
7	PCP-phencyclidine
8	Other Hallucinogens
9	Methamphetamine
10	Other Amphetamines
11	Other Stimulants
12	Benzodiazepine
13	Other non-Benzodiazepine Tranquilizers
14	Barbiturates
15	Other Non-Barbiturate Sedatives or Hypnotics
16	Inhalants

Valid Codes	Definition
17	Over-The-Counter
18	Oxycodone
19	Hydromorphone
20	MDMA (ecstasy, Molly, etc.)
21	Other

Attribute: Substance 3 Frequency of Use

Transaction:
Substance Use

Definition:
Indicates the frequency that the client used a specific substance in the last 30 days.

Procedure:
- If the Substance 3 Code is '1' (None), then this attribute must be null. Otherwise, it is required.
- Report for the 30 days prior to the Event Date.
- Report the use for the last 30 days, even if it is "No use" (Code 1) because the person has been in a controlled environment like a jail or treatment facility.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the past month
2	1-3 times in the past month
3	4-12 times in the past month
4	13 times in the past month
5	Daily

Attribute: Substance 3 Frequency of Use Uncontrolled Environment

Transaction:
Substance Use

Definition:
Indicates the frequency that the client used a specific substance in the last 30 days in which they were in an uncontrolled environment.

Procedure:
- If the Substance 3 Code is '1' (None), then this attribute must be null. Otherwise, it is required.
- If the person has been in an uncontrolled environment (for example, living at home) for the last 30 days, report the same value as reported for "Substance 3 Frequency of Use"
- If the person has been in a controlled environment (for example, in jail) for the last 30 days, report the frequency of use for the 30 days in which they were free to use.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the past month
2	1-3 times in the past month
3	4-12 times in the past month
4	13 times in the past month
5	Daily

Attribute: Substance 3 Peak Frequency

Transaction:
Substance Use

Definition:
Indicates the highest monthly use pattern in the 12 months preceding the continuous episode of care start date.

Procedure:
If the Substance 3 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the 12 months preceding the episode of care start date
2	1–3 Times Per Month
3	4–12 Times Per Month
4	13 or More Times Per Month
5	Daily

Attribute: Substance 3 Method

Transaction:
Substance Use

Definition:
Indicates the most common method the client uses to administer the substance.

Procedure:
If the Substance 3 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	Inhalation
2	Injection
3	Oral
4	Other
5	Smoking

Attribute: Substance 3 Date Last Used

Transaction:
Substance Use

Definition:
Indicates the date that client last used a specific substance.

Procedure:
If the Substance 3 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Date (YYYYMMDD)

Attribute: Substance 3 First Use Age

Transaction:
Substance Use

Definition:
Indicates the age at which the client first used the specific substance.

Procedure:
If the Substance 3 Code is ‘1’ (None), then this attribute must be null. Otherwise, it is required.

Required Documentation:
Documentation of the client’s substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
0	Client born with a substance use disorder resulting from in-utero exposure
1–98	Age at first use, in years

Attribute: Substance 4 Code

Transaction:
Substance Use

Definition:
Indicates an additional substance that is being used by the client.

Procedure:
- For convenience, this substance has a '4' in its name, but ranking only applies to the top three substances.
- At the start of a continuous episode of care, reporting is only required for the three most clinically important substances. If clinically important use of another substance begins after the start of a continuous episode of care, report that substance with the next required data submission using the appropriate event date, and report the frequency of use (next attribute) for that substance for the 30 days before the event date.
- Once a fourth substance is reported, continue to report on this substance through the duration of the continuous episode of care.
- This is not a required attribute, but it becomes required for subsequent event dates once it is reported.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
2	Alcohol
3	Cocaine/Crack
4	Marijuana/Hashish
5	Heroin
6	Other Opiates And Synthetics
7	PCP-phencyclidine
8	Other Hallucinogens
9	Methamphetamine
10	Other Amphetamines
11	Other Stimulants
12	Benzodiazepine
13	Other non-Benzodiazepine Tranquilizers
14	Barbiturates

Valid Codes	Definition
15	Other Non-Barbiturate Sedatives or Hypnotics
16	Inhalants
17	Over-The-Counter
18	Oxycodone
19	Hydromorphone
20	MDMA (ecstasy, Molly, etc.)
21	Other

Attribute: Substance 4 Frequency of Use

Transaction:
Substance Use

Definition:
Indicates the frequency that the client used a specific substance in the last 30 days.

Procedure:
- This is a required attribute if the Substance 4 Code is not null.
- If a fourth substance is reported after the start of a continuous episode of care, report the frequency of use in the last 30 days for that substance and continue to report on it until the end of the continuous episode of care.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the past month
2	1-3 times in the past month
3	4-12 times in the past month
4	13 times in the past month
5	Daily

Attribute: Substance 5 Code

Transaction:
Substance Use

Definition:
Indicates an additional substance that is being used by the client.

Procedure:
- For convenience, this substance has a '5' in its name, but ranking only applies to the top three substances.
- At the start of a continuous episode of care, reporting is only required for the three most clinically important substances. If clinically important use of another substance begins after the start of a continuous episode of care, report that substance with the next required data submission using the appropriate event date, and report the frequency of use (next attribute) for that substance for the 30 days before the event date.
- Once a fifth substance is reported, continue to report on this substance through the duration of the continuous episode of care.
- This is not a required attribute, but it becomes required for subsequent event dates once it is reported.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
2	Alcohol
3	Cocaine/Crack
4	Marijuana/Hashish
5	Heroin
6	Other Opiates And Synthetics
7	PCP-phencyclidine
8	Other Hallucinogens
9	Methamphetamine
10	Other Amphetamines
11	Other Stimulants
12	Benzodiazepine
13	Other non-Benzodiazepine Tranquilizers

Valid Codes	Definition
14	Barbiturates
15	Other Non-Barbiturate Sedatives or Hypnotics
16	Inhalants
17	Over-The-Counter
18	Oxycodone
19	Hydromorphone
20	MDMA (ecstasy, Molly, etc.)
21	Other

Attribute: Substance 5 Frequency of Use

Transaction:
Substance Use

Definition:
Indicates the frequency that the client used a specific substance in the last 30 days.

Procedure:
- This is a required attribute if the Substance 5 Code is not null.
- If a fifth substance is reported after the start of a continuous episode of care, report the frequency of use in the last 30 days for that substance and continue to report on it until the end of the continuous episode of care.

Required Documentation:
Documentation of the client's substance use must be provided in agency records.

Type: Number

Valid Codes	Definition
1	No use in the past month
2	1–3 times in the past month
3	4–12 times in the past month
4	13 times in the past month
5	Daily

Transaction: Vulnerability Assessment Transaction

Definition:
Describes the results of an assessment of a homeless person's functioning in ten life or risk domains; used to prioritize access to housing and supportive services.

Required for:
Homeless adults who have had a vulnerability assessment completed using the standardized DESC vulnerability assessment tool, and who have given consent for the assessment results to be submitted to BHRD for inclusion in the integrated database that is used to identify high need candidates for housing resources

Frequency:
On referral for shelter or housing. At each 12-month anniversary, if continuing to seek shelter/housing.

Procedure:
All data for this transaction will be submitted by DESC, including vulnerability assessments performed by other agencies**.**

Transaction ID: 680.03

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Survival Rating	Text (number)	1	Y
Basic Needs	Text (number)	1	Y
Indicated Mortality Risks	Text (number)	1	Y
Medical Risks	Text (number)	1	Y
Organization Orientation	Text (number)	1	Y
Mental Health	Text (number)	1	Y
Substance Use	Text (number)	1	Y
Communication	Text (number)	1	Y
Social Behaviors	Text (number)	1	Y

Attribute	Type	Size	Coded
Homelessness	Text (number)	1	Y
Veteran Status	Text	1	Y
Assessor ID	Text	8	Y
King County ID	Text (number)		
ROI Consent Granted	Text	1	Y
Provisional Assessment	Text	1	Y

Attribute: Reporting Unit ID

Transaction:
Vulnerability Assessment Transaction

Procedure:
Always submit DESC Agency ID: 152

Attribute: Case ID

Transaction:
Vulnerability Assessment Transaction

Definition:
The unique client identifier in the DESC information system.

Procedure:
Even if the assessment was done by another agency, submit the DESC Case ID. All clients assessed using the DESC Vulnerability assessment tool and reported to the BHRD IS are identified as DESC clients.

Attribute: Event Date

Transaction:
Vulnerability Assessment Transaction

Definition:
The date the assessment was completed.

Attributes for domains assessed:
Survival Rating
Basic Needs
Indicated Mortality Risks
Medical Risks
Organization Orientation
Mental Health
Substance Use
Communication
Social Behaviors
Homelessness

Transaction:
Vulnerability Assessment Transaction

Definition:
See the DESC Vulnerability Assessment Tool for definitions of, and procedures for scoring, the assessment domains.

Attribute: Assessment Values

Transaction:
Vulnerability Assessment Transaction

Definition:
- Assessment values for the first nine domains are 1 through 5.
- Homelessness values are 1 through 3.

Attribute: Veteran Status

Transaction:
Vulnerability Assessment Transaction

Definition:
Indicates whether or not the client reported being a military veteran.

Attribute: Assessor ID

Transaction:
Vulnerability Assessment Transaction

Definition:
An identifier in the BHRD system of the person who assessed a client using the Vulnerability Assessment Tool.

Procedure:
- For DESC staff, use the KCID assigned to the person in the BHRD system.
- For assessors who are not DESC staff, DESC staff will assign the alphanumeric Assessor ID and report it to the DCHS IT staff. DCHS IT staff will manually update the sud_vul_assessor table**.**

Attribute: King County ID

Transaction:
Vulnerability Assessment Transaction

Procedure:
Each reported client should have a KCID. If the person assessed does not have a KCID, DESC will need to submit a Client Demographics transaction with Agency ID '152' to get a KCID assigned.

Attribute: ROI Consent Granted

Transaction:
Vulnerability Assessment Transaction

Definition:
This attribute indicates if the client has granted consent to release information.

Type: Text (1)

Valid Codes	Definition
1	No – The client has not granted consent to share his/her Vulnerability Assessment data.
2	Yes – The client has granted consent to share his/her Vulnerability Assessment data.

Attribute: Provisional Assessment

Transaction:
Vulnerability Assessment Transaction

Definition:
This attribute indicates if this was a provisional assessment.

Type: Text (1)

Valid Codes	Definition
1	No – This was not a provisional assessment.
2	Yes – This was a provisional assessment.

Transaction: Universal Attributes and Definitions

Attribute: Case ID

Definition:
The identifier established by a Reporting Unit which uniquely identifies a client. A case ID should never be recycled to another client.

Type: Char (10)

Valid Codes:
No restrictions. Up to 10 characters may be used.

Attribute: Event Date

Definition:
The date an event actually occurred or the date an agency learned of the event or change.

Type: Date (8) YYYYMMDD

Summary Table of Event Date Reporting Requirements

Transaction	On assessment	On change or occurrence	On discharge	Master table
Activity Evaluation	Assessment Date	Actual Date	N/A	ep_activity
Authorization Request	Assessment Date	Actual Date	N/A	au_master
Client Demographic	Assessment Date	Actual Date		g_person, g_demographic mp_ethnicity client_master
Conditions at Assessment	Assessment Date	N/A	N/A	ma_cond_ass
Co-occurring Disorders Assessment	N/A	Actual Date	N/A	ea_cod_assessment
Co-occurring Disorders Screening	N/A	Actual Date	N/A	ea_cod_screening
CPT Service Detail (submitted in HIPAA 837P transaction)	N/A	Actual Date	N/A	ea_cpt_service ea_cpt_service_modifier mp_mail_address
Diagnosis	Assessment Date	Actual Date	Actual Date	ea_diag
Disability	Assessment Date	Actual Date	N/A	ep_disability ep_subabuse
Income Category	Assessment Date	Actual Date	N/A	ep_income02
Medicaid Coverage	Assessment Date	Actual Date	N/A	ep_medicaid_cov
Notice of Exit	N/A	N/A	Actual Date	ma_notice_of_exit au_master
Outcome Event	N/A	Actual Date	N/A	ea_outcome_event
Priority	Assessment Date	Actual Date	N/A	mp_priority
PSS	Assessment Date	Actual Date	Actual Date	ea_pss
Program Referral	Actual Date	N/A	Actual Date	ma_screen_cont ma_prgm_ref_in ea_prgm_ref_out
Residential Absence	Actual Date	Actual Date	N/A	ep_resid_absence
Residential Arrangement	Assessment Date	Actual Date	N/A	ep_residence ep_address
Residential Facility	Actual Date	Actual Date	N/A	ep_facility
Staff Person	N/A	Actual Start Date	Actual Discharge Date	g_person, g_demographic client_master ep_staff_dur

Definitions for Summary Table:

Assessment Date:
The date reported in the Authorization Request transaction as the Assessment Date for Benefit Change Code 01 and 05.

Actual Date:
The date the event (e.g., referral, diagnosis, discharge, or change) occurred. This is not the date the change was reported to the clinician. Where unknown, make a best estimate and document the file.

On Discharge:
The date of discharge. For system edits, this date must always be within the benefit period.

NOTE: The computer system or data entry date should not be entered as the event date unless it really is.

Attribute: King County ID

Transaction:
Universal

Definition:
The unique King County identifier assigned to a person by the BHRD IS after the MHP system has unduplicated person records across all data sources.

Procedure:
- This identification number uniquely identifies a client receiving services from the King County MHP, or staff providing services at King County MHP.
- If providers know the client's King County ID, it must be submitted in the authorization request for an outpatient or residential benefit. It is the responsibility of the reporting provider to check the ECLS for the correct King County ID. The KCID is required for all indicated transactions except an initial authorization request and the service detail record for a client not already assigned a KCID.
- This attribute may be null if the provider does not know it for the initial authorization request but must be used in subsequent transactions.

Required Documentation:
The client's KCID must be maintained in the clinical record.

Type: Integer

Attribute: Reporting Unit ID

Required for:
Listed entities

Definition:
A code established by the Mental Health Division to uniquely identify an organization delivering services to a client.

Type: Char (5)