Mental Health Division
Consumer Information System
(MHD-CIS)
2003 Data Dictionary

VERSION 3.2

Initial Version 3.0 Publication 10/16/2003
Republished as V3.1 on 12/31/2003
Second Republication as V3.2 on 3/31/2004

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This Data Dictionary documents transactions submitted by the Regional Support Networks to the Mental Health Division's Consumer Information System.

From the fall of 2002 through spring of 2003, the Information System Data Evaluation Committee (ISDEC) formed a small workgroup with a cross section of RSNs represented. This group was formed to address the MHD-CIS Data Dictionary changes required to become compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. A similar workgroup was formed in the fall of 2003 to enhance data consistency statewide and to support future actuarial studies. The Chairperson of the Performance Indicator (PI) workgroup participated in or reviewed the small workgroup's efforts to ensure PI concerns or requirements were met as well. In the spring of 2004 the current version was republished at ISDEC request to provide more clarification and documentation related to HIPAA and the transactions used to apply HIPAA updates. This republication does not change contract requirements

SUMMARY OF MAJOR CHANGES

Transaction 076.01 Community Hospital Authorization: Phased out of service. Inpatient data to be obtained from MAA reporting.

Transaction 075.01 Community Hospital Payment Summary: Phased out of service. RSNs will not pay hospitals directly

Transaction 070.04 E&T Inpatient Service: Replaced by HIPAA 837I. May need to be used if some Inpatient Service Reporting is not allowable under HIPAA.

Transaction 120.03 Outpatient Service: Phased out of service and replaced by HIPAA 837P. Data Element, Provider Type added to 120.03 and 837P transactions to support future actuarial studies. (For collection beginning in March 2004 if HIPAA transactions are not used.)

Transaction 120.04: Created and used by MHD for applying HIPAA 837P transaction updates to the MHD-CIS databases.

These new transactions are compliant with HIPAA regulations. However Trading Partner Agreements between the RSNs and MHD may be used to limit the amount of data required or define technical interface specifications. Trading Partner Agreements are an appendix to this Data Dictionary and are subject to further ISDEC recommended refinement and revision on technical specifications necessary to meet RSN contract and HIPAA requirements.

Reporting Expectations

Reporting RSNs shall provide to the MHD all data described in the Data Dictionary and HIPAA Trading Partner Agreements for the Mental Health Division Consumer Information System (MHD-CIS), or any successor, incorporated herein by reference. Data shall be submitted within 60 days of the close of each calendar month. Upon the receipt of the data, the MHD will generate an error report. The error report will identify errors and warnings (missing or questionable data values). The reporting RSN shall remedy all data errors within 30 calendar days of the receipt of an error report. The MHD will also monitor the quality of the data throughout the fiscal year. All transactions will be final 180 days after the close of the submission month. Once transactions are final, the reporting RSN shall be liable for any costs associated with additional data processing.

For data related to the provision of inpatient services, the conditions in the above paragraph apply, except that this data is not final until 18 months after the close of the submission month.

Comply with HIPAA implementation requirements and standards (e.g., data collection, submission, privacy, and security).

Implement changes made to the MHD data dictionary as required. The initial version of the Data Dictionary must be implemented by 10/16/03 to meet federal HIPAA regulations. For subsequent versions, the reporting RSN shall have 120 days from the date of published changes to modify their data system to reflect the changes.

Ensure that the MHD receives requested information in a manner that will allow for a timely response to inquiries from CMS, the legislature, and other parties about system operations. Such data shall be provided in a time frame developed with the MHD at the time of the request and that takes into consideration the needs of the inquiring party.

Implementation Schedule

A phased implementation to meet HIPAA requirements was necessary depending on each RSN's ability to send the transaction and MHD's ability to receive and process it. MHD was able to accept these Data Dictionary transactions (except as noted) as of 10/16/2003.

The 120.03 Outpatient Service has been phased out but will remain active through March 2004 to allow for historical updates (services prior to HIPAA). A 120.04 version of the transaction (which is basically transparent to the RSNs) was created to allow MHD to extract data from the new HIPAA 837P. The 070.04 E&T Inpatient Transaction should be replaced by the HIPAA 837I but will remain in service in case there are Inpatient Facilities that can not report under HIPAA. MHD will extract data from the 837P and 837I HIPAA transactions and then use MHD-CIS transactions to maintain existing MHD SQL tables.

With a new requirement for Provider Type to be used for actuarial studies, the 120.03 transaction will accept a new data element (warning if missing) effective 1/1/2004. Collection of this data may be done earlier but isn't expected until March 2004 with HIPAA reporting.

2003 Data Dictionary Changes

Transaction Change Summary

Transaction	ID	Comments
Cascade Delete	131.02	Minimum internal change – to reflect new and removed transactions. Since change is internal to MHD, RSNs may continue to use transaction id 131.01
Cascade Merge	130.02	No change
Case Manager	100.01	No change.
CDMHP Investigation	160.02	No change.
Clear Month of Service	077.02	New: This version allows the removal of inpatient and/or outpatient services for a given month based on Provider ID as well as the RSN ID. RSNs may continue to use transaction id 077.01 at their option.
Community Hospital Authorization	076.01	**Phased out** of use for services authorized after October 16, 2003. RSNs have elected to not report Community Hospital Authorizations. Inpatient Encounter information is to be taken from MAA billing.
Community Hospital Payment Summary	075.01	**Phased out** of use after October 16, 2003. This transaction was for RSNs that paid Community Hospitals directly. This is no longer a business practice.
Consumer Demographics	020.05	No changes.
Consumer Periodics	035.05 035.06	No change Under HIPAA diagnosis definitions are modified Minimal change. Diagnosis is now optional in this transaction.
Consumer's Case Manager	011.01	No change.
E&T Inpatient Service	070.04	**Replaced as appropriate** by HIPAA Compliant 837I. – MHD extracts data from the 837I and executes this transaction to maintain current MHD SQL tables. Under HIPAA, diagnosis definitions are modified.
HIPAA 837 Institutional (E&T Inpatient Service)	837I	**New HIPAA Standard Transaction** replacing 070.04 Trading Partner Agreements to identify minimum data
HIPAA 837 Professional (Outpatient Service)	837P	**New HIPAA Standard Transaction** using new 120.04 Trading Partner Agreements to identify minimum data.
Header	000.01	No change.
ITA Hearing	162.02	No change.
Outpatient Service	120.03	**Phased out** and replaced by HIPAA Compliant 837P. Data Element for Provider Type has been added pending use of 837P. Effective 1/1/2004 to 3/31/2004
Outpatient Service	120.04	NEW: (Not available to RSNs) MHD extracts data from the 837P and executes this transaction to maintain current MHD SQL tables.

MHD-CIS Data Dictionary Transactions

Status: Production	**Version:** 1	**ID:** 10018

Transaction: Cascade Delete (Full/Partial)

Effective Date: 1/1/2000

Definition:
This transaction allows for the mass deletion of records for a given consumer. There are two types of cascade delete. The first will eliminate all information previously reported. This is referred to as a "Full Cascade Delete". The second type will delete that information which pertains to a specific agency. This is referred to as a "Partial Cascade Delete".

Full Cascade Delete: This type of delete will remove all information about a consumer. Once processed, the Consumer ID will be voided and not available for future processing. This type of delete requires the authorization of the RSN Administrator and the MHD Chief of Information Services. The RSN Administrator may delegate his/her authority to authorize Full Cascade Deletes to someone who maintains their information system. The authorization must be presented to the MHD Chief of Information Services. This authorization must contain the reason for the deletes, the number of deletes that will be processed, a timeframe when the delete transactions will be submitted, and a contact for coordinating the actual processing of these delete transactions. Upon approval by the MHD Chief of Information Services, the RSN will be contacted and a time frame will be coordinated for the actual processing of this transaction.

Partial Cascade Delete: This type of delete will not require prior authorization. It is limited to a single agency as identified by the Reporting Unit ID. Partial delete will delete a specific consumer's records for the following transactions: 1) Consumer's Case Manager 2) Inpatient Service and 3) Outpatient Service.

NOTE: There is no action code in this transaction!

Transaction ID: Value "131.02"

Primary Key: Reporting Unit ID *(RSN ID)*
Consumer ID *(The ID to be deleted)*

Body: Reporting Unit ID *(Leave blank or null for a Full Cascade Delete; enter the Agency ID for a Partial Cascade Delete)*

Edits:

Message Number	Message
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23306	Soft Error: Consumer ID for Contractor has been previously voided. Transaction not posted.

Status: Production	**Version:** 1.01	**ID:** 10015

Transaction: Cascade Merge

Effective Date: 1/1/1998

Definition:
This transaction will void a Consumer ID and bar its use in the future. A Consumer ID is voided when the Contractor has established two different identifiers for a single person. The Contractor must identify the Consumer ID to be voided and also identify the Consumer ID to reference in its place.

NOTE: There is no action code in this transaction!

Transaction ID: Value "130.02"

Primary Key: Reporting Unit ID *(RSN)*
Consumer ID *(The ID to be voided)*
Body: (Referenced) Consumer ID *(Required - The ID for future reference)*

Edits:

Message Number	Message
22007	Error: Referenced Consumer ID cannot be blank or null. Transaction not posted.
23008	Error: Primary Key Fields cannot be bland or null. Transaction not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
23306	Soft Error: Consumer ID for Contractor has been previously voided. Transaction not posted.
23307	Soft Error: Referenced Consumer ID for Contractor has been previously voided. Transaction not posted.
23313	Error: CID and Referenced CID are equal. Transaction not posted.

Status: Production	Version: 1.01	ID: 10003

Transaction: Case Manager

Effective Date: 1/1/2000

Definition:
This transaction allows the Regional Support Networks (RSN) to describe how an authorized person accessing the Case Manager Locator System (CMLS) can contact them by telephone when making an inquiry on a person who received a documented outpatient service within the most recent 12 months. The purpose is to provide a telephone number that is answered 24 hours a day, 7 days a week, by someone who can authenticate the caller and place them in contact with either a case manager or a clinician who has information about a specific consumer. The password is used by the RSN to authenticate the caller and is used by the RSN as a safeguard to prevent unauthorized release of information. This information is used to support the Case Manager Locator System (CMLS). This transaction may be linked to any number of consumers identified by an RSN. *(See Consumer Case Manager Transaction for more details on how to link this transaction to a specific consumer.)*

Minimum Requirements: Each RSN will maintain one Case Manager transaction for each agency providing outpatient services within the most recent 12 months. Each RSN will also maintain a default Case Manager transaction to contact the RSN within any 24-hour day. The "Case Manager ID" for these default records will be "-AGENCY". The word agency must be in all upper case and be prefixed with a hyphen.

Transaction ID: Value "100.01"

Action Code: Value:
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Agency providing Case Management)*
Case Manager ID *(Unique ID assigned by the Agency or RSN - see minimum requirements above for default value.)*

Body: Case Manager Phone *(Primary - enter 10 digits including Area Code then extension or other)*
Case Manager Comment *(Primary)*
Case Manager Phone *(Secondary)*
Case Manager Comment *(Secondary)*
Case Manager Password

Notes: Two sets of telephone numbers and comments are allowed. When the telephone numbers and comments are displayed on the Case Manager Locator System screen, the primary telephone number is aligned with the primary comment; the secondary telephone number is aligned with the secondary comment. The telephone numbers should include the

area code. If no area code is given, then someone using the Case Manager Locator System may not be able to contact the RSN if they trying to call from outside the RSN's area code.

Edits:

Message Number	Message
23003	Error: Reporting Unit ID%s unknown. Transaction not posted.
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23038	Error: Case Manager Primary Phone cannot be blank or null. Transaction not posted.
23039	Error: Case Manager Password cannot be blank or null. Transaction not posted.
23100	Soft Error: No Case Manager row found for RUID %s and CaseManagerID%s. Delete not posted.
30037	Warning: Invalid primary phone number - Need full 10 digits including Area Code.

Note % signs above replaced by actual ID values when message sent.

Status: Production	**Version:** 2	**ID:** 10007

Transaction: CDMHP Investigation

Effective Date: 1/1/2000

Definition:
A designated Community Mental Health Professional (CDMHP) is the only person who can perform an ITA investigation that results in a detention and revocation. A crisis worker who is not a CDMHP can initiate this investigation but in order for a detention to take place, it is mandated (RCW 71.05 for adults, RCW 71.34 for children 13 and over) that the CDMHP investigate and make a determination. Therefore, all investigations reported are derived from the investigation resulting from the findings of a CDMHP. Do not report investigative findings of the crisis worker unless the crisis worker is also a CDMHP.
The intent of this transaction is to record CDMHP investigations only. Activities performed by a CDMHP including crisis intervention, case management, or other activities, while important are not collected by this transaction. Each RSN determines which specific actions come under an investigation. The MHD recommended criteria for when a CDMHP activity becomes an 'investigation' is when the decision to investigate has been made and the CDMHP reads the person his/her rights. The trigger is reading the person his/her rights.
This transaction identifies all investigations by the CDMHP, even if the CDMHP is also classified as a crisis worker. An investigation can result in: a detention, which is 72 hours; a return to inpatient facility with a revocation of a court ordered less restrictive alternative (LRA) petition filed; a filing of a petition recommending an LRA extension; a referral for voluntary in-patient or outpatient mental health services, a referral to other community resources; or no

action based on mental health needs. When Code 5 is used for Investigation Outcome, the Legal Reasons for Detention/Commitment should be codes A-D and not Z.

Transaction ID: Value "160.02"

Action Code: Value
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Contractor or RSN)*
Consumer ID
Investigation Date
Investigation Start Time

Body: Investigation County
Investigation Outcome
Reporting Unit ID *(State Hospital, Community Hospital or Freestanding Evaluation and Treatment Center where consumer was placed for inpatient services. Leave blank or null if not placed for inpatient services.)*
Legal Reason for Detention/Commitment
Return to Inpatient/Revocation Authority

Note: This transaction is not used to report "crisis services". These services are reported by using the "HIPAA 837P Outpatient Service" transaction.
If the Legal Reasons for Detention/Commitment contain contradictory code values (e.g. AZ) the "Z" will be discarded and a warning will be produced in the exception report.

Edits:

Message Number	Message
22172	Warning: Time is invalid. Time should be HHMM and between 0000 and 2399
23098	Soft Error: Record does not exist. Delete rejected.
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23010	Error: Date is out of range or invalid. Transaction not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23154	Error: RUID not valid for Inpatient facility. Transaction not posted.
23155	Error: Invalid Return to Inpatient/Revocation Authority Code.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
30001	Error: Investigation Outcome required. Transaction not processed.
30038	Error: Invalid Investigation County Code. Transaction not processed.
30039	Error: Invalid Legal Reason for Detention/Commitment. Transaction not posted.

Status: Production	**Version:** 1	**ID:** 200137

Transaction: Clear Month of Service

Effective Date: 1/1/2002

Definition:
This transaction is used to remove all outpatient/inpatient service transactions for a given RSN and month of service. Use this transaction when you intend to resubmit all inpatient or outpatient services for a given month. Please consult with MHD IS staff before submitting this transaction. Special processing will be required to deal with data from HIPAA transactions, which can be reset to initial values but not deleted.

Transaction ID: Value: "077.01"

Primary Key: Reporting Unit ID *(for the RSN)*
Month of Service *(CCYYMM)*

Body: Type of Service Transaction
"O" = All OP Service transactions **<including all integrated data items>** from 837P HIPAA transactions. <Refer to Transaction: Outpatient Service (120.03 and 120.04).>
"ET" = All E&T Service transactions **<including all integrated data items from>** 837I transactions. <Refer to Transaction: E&T Inpatient Service (070.04)>.
"CHA" = All Community Hospital Authorizations: For removing old transactions with Month of Service dates prior to HIPAA implementation
"CHB" = All Community Hospital Payment Summary. For removing old transactions with Month of Service dates prior to HIPAA implementation

Edits:

Message Number	Message
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
30015	Error: Month of Service is invalid date format. Transaction not processed.

Status: Production	Version: 2	ID: 200137

Transaction: Clear Month of Service (V2)

Effective Date: 3/16/2004

Definition:
This transaction is used to remove all outpatient/inpatient service transactions for a given RSN and month of service. **When a specific provider's RUID is given, the transaction will remove all outpatient/inpatient services for that RSN's specific provider and month of service only.**
Removal of specific provider records is restricted to outpatient ('O') and E&T services ('ET'). Use this transaction when you intend to resubmit all inpatient or outpatient services for a given month. Please consult with MHD IS staff before submitting this transaction. Special processing will be required to deal with data from HIPAA transactions, which may be voided but not deleted.

Transaction ID: Value: "077.02"

Primary Key: Reporting Unit ID *(for the RSN)*
Month of Service *(CCYYMM)*

Body:

RUID (provider id)
When all the RSN's services indicated by Type of Service Transaction are to be removed, omit RUID and use a tab to skip

Type of Service Transaction
"O" = All OP Service transactions <**including all integrated data items>** from 837P HIPAA transactions. <Refer to Transaction: Outpatient Service (120.04).>
"ET" = All E&T Service transactions <**including all integrated data items from>** 837I transactions. <Refer to Transaction: E&T Inpatient Service (070.04)>.
"CHA" = All Community Hospital Authorizations: For removing old transactions with Month of Service dates prior to HIPAA implementation
"CHB" = All Community Hospital Payment Summary. For removing old transactions with Month of Service dates prior to HIPAA implementation

Edits:

Message Number	Message
23089	Error: RUID not in Contractor service area. Transaction not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.

30015	Error: Month of Service is invalid date format. Transaction not processed.
30049	Error: Invalid RUID for transaction. Transaction not posted.
30050	Error: Type of Service is blank. Transaction not posted
30051	Error: Type of Service is invalid. Transaction not posted

Status: Phased Out	**Version:** 2	**ID:** 200136

Transaction: Community Hospital Authorization (076.01)

Effective Date: 10/17/2003 **To be phased out of service except for historical data corrections.**

Definition:
Used only to make corrections to data submitted prior to HIPAA implementation. See the previous 2002 MHD-CIS Data Dictionary for data and format requirements.

Status: Phased Out	**Version:** 2	**ID:** 200106

Transaction: Community Hospital Payment Summary (075.01)

Effective Date: 10/17/2003 **To be phased out of service except for historical data corrections.**

Definition:
Used only to make corrections to data submitted prior to HIPAA implementation. See the previous 2002 MHD-CIS Data Dictionary for data and format requirements.

Status: Production	Version: 1.03	ID: 10006

Transaction: Consumer Demographics

Effective Date: 1/1/2002

Definition:
The information contained in this record is used to identify a person. Most information stored in the MHD-CIS is aggregated by identifying unique person records. This transaction allows for establishing in the MHD-CIS a unique identifier, the "Consumer ID", for a person by the Regional Support Network and to provide limited information that describes the person - such as name, birth date, SSN, etc. This transaction must be successfully processed before any other transaction referencing the "Consumer ID" will be accepted.

Transaction ID: Value: "020.05"

Action Code: Value:
"A" Add
"C" Change

Primary Key: Reporting Unit ID *(Contractor or RSN)*
Consumer ID

Body: Surname
Given Names
Gender
Date of Birth
Race
Ethnicity
Hispanic Origin
Preferred Language
Social Security Number
Sexual Orientation

Edits:

Message Number	Message
22000	Warning: Social Security Number is blank.
22001	Warning: Social Security Number is not valid. Set to blank.
22120	Warning: Date of Birth is not valid, should be 8 digits in format CCYYMMDD.
22121	Warning: Date of Birth is blank or null.
22130	Warning: Gender is invalid, set to 3 - Unknown.
22131	Warning: Gender is blank or null, set to 3 - Unknown.
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23023	Error: Given Name is blank or null. Transaction not posted.
23024	Error: Surname is blank or null. Transaction not posted.

23025	Error: Ethnicity Code is not valid. Transaction not posted.
23026	Error: Ethnicity Code is null or blank. Transaction not posted.
23027	Error: Hispanic Origin code is not valid. Transaction not posted.
23028	Error: Hispanic Origin code is null or blank. Transaction not posted.
23029	Error: Language code is not valid. Transaction not posted.
23032	Error: Language code is null or blank. Transaction not posted.
23035	Error: Sexual Orientation Code is invalid. Transaction not posted.
23036	Error: Sexual Orientation Code is blank. Transaction not posted.
23096	Soft Error: Consumer ID for RSN ID has been voided. Add/Change not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
24725	Warning: Ethnicity Code submitted is no longer in use. Please correct and submit again.
30040	Error: Date of Birth can not be beyond current date. Transaction not posted.

Status: Production	**Version:** 1.02	**ID:** 10012

Transaction: Consumer Periodics

Effective Date: 1/1/2002

Definition:
Consumer Periodics are collected at intake, and reported at least every 3 months, or on change. Please note that a warning message will be posted for outpatient service transactions where there does not exist a Consumer Periodics within the last 3 months of service.

Transaction ID: Value "035.05" and "035.06"
Transaction 035.05 requires a Principle Diagnosis.
Transaction 035.06 makes Diagnosis optional.

Action Code: Value
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Contractor or RSN)*
Consumer ID
Month of Periodic *(CCYYMM) (Please note that the day is not included)*

Body: Employment Status
Education
Grade Level
Living Situation

County of Residence
Priority Code
Diagnosis - Four occurrences - use ICD9 format
(May tab over for optional entries)
Impairment Kind
Annual Gross Income
Number of Dependents
GAF - *(Global Assessment of Functioning)*
CGAS - *(Children Global Assessment Scale)*
DC03 - *(Assessment for Children 5 years of age or younger)*

Edits:

Message Number	Message
22192	Warning: Impairment Kind codes field is blank or null. Set to Z (None).
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23010	Error: Date is out of range or invalid. Transaction not posted.
23033	Error: County code is invalid. Transaction not posted.
23081	Error: Date is outside dictionary requirements. Transaction not posted.
23092	Error: Contractor ID provided not valid. Transaction not posted
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
30013	Soft Error: Consumer Periodics transaction does not exist. Delete rejected.
30014	Error: GAF, CGAS and/or DC03 contain invalid values. Transaction not posted.
30018	Error: Non Numeric Gross Income. (Money field and Nulls are allowed) Transaction not posted.
30019	Error: Non Numeric Number of Dependents. Transaction not posted.
30020	Error: One or more Impairment Kind code is invalid. Transaction not posted.
30021	Warning: Priority Code is blank or null. Set to 'O'.
30022	Error: Invalid Priority Code. Transaction not posted.
30023	Warning: Living Situation blank or null. Set to '99' = Unknown.
30024	Error: Invalid Living Situation Code. Transaction not posted.
30025	Warning: Grade is blank or null. Set to '99' = Unknown.
30026	Error: Invalid Grade. Transaction not posted.
30027	Warning: Education is blank or null. Set to '9' = Unknown
30028	Error: Invalid Education code. Transaction not posted.
30029	Warning: Employment is blank or null. Set to '9' = Unknown.
30030	Error: Invalid Employment code. Transaction not posted.
30031	Error: CID has been merged or deleted. Transaction not posted.
30034	Warning: Should have at least one non-zero assessment: GAF, CGAS, or DC03.
30045	Error: Diagnosis is missing. (Applies to 035.05 transaction only)
30046	Error: Diagnosis is invalid.

Status: Production	**Version:** 1.01	**ID:** 10005

Transaction: Consumer's Case Manager

Effective Date: 1/1/2000

Definition:
Each consumer identified by a Regional Support Network (RSN) may be assigned to a "Case Manager" for use within the Case Manager Locator System (CMLS). This transaction associates the "Case Manager" with the "Consumer Demographic" transaction. Each consumer identified by a "Consumer Demographic" record may reference one and only one "Case Manager" record; however, each "Case Manager" record may be referenced by many "Consumer Demographic" records.
Note: If a consumer has on file, with MHD/CIS, any outpatient services within the past 12 months, then the demographic information will be made available through CMLS. If no Case Manager has been assigned to that consumer by this transaction, then CMLS will try to locate the default Case Manager for the agency that provided the most recent outpatient service. In the event there is no default Case Manager record documented for that agency, then CMLS will use the default Case Manager for the RSN.

Transaction ID: Value: "011.01"

Action Code: Value:
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Contractor ID or RSN ID)*
Consumer ID

Body: Case Manager ID *(Unique ID assigned by the RSN or Agency - must first be recorded with Case Manager transaction)*
Reporting Unit ID *(Agency providing Case Management)*

Edits:

Message Number	Message
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23011	Error: No Consumer Case Manager data found for RUID %s, CID %s. Delete not posted
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
23314	Error: Case Manager transaction not found for CaseMgrID and CaseMgrRUID. Transaction not posted.

Note % signs above replaced by actual ID values when message sent.

Status: Phased Out Replaced by HIPAA 837I	Version: 2	ID: 10009

Transaction: E&T Inpatient Service (070.04)

Effective Date: 10/16/2003
Replaced by HIPAA 837I except for historical data corrections and circumstances where an Inpatient Facility is not allowed to report using HIPAA transactions. (Not applicable to current E&T's) Also used by MHD to maintain existing SQL Tables by extraction of corresponding data from submitted HIPAA 837I Transactions. See the following data field conversion/map for HIPAA usage. Note the change in definition of diagnosis under HIPAA. See the HIPAA 837I Implementation Guide for HIPAA Data Definitions

Definition:
This transaction identifies a consumer's stay in an Evaluation and Treatment Facility.

(See following Data Field Conversion map for HIPAA 837I transaction data extraction)

Transaction ID: Value: "070.04"

Action Code: Value

"A" Add
"C" Change
"D" Delete

Primary Key:

Reporting Unit ID (RSN ID or Contractor ID
Consumer ID
Reporting Unit ID (Freestanding Evaluation and Treatment Center
Admission Date

Body:

Discharge Date
Legal Status
Diagnoses (Principle Diagnosis)
Diagnoses (Other Diagnosis1)
Diagnoses (Admitting Diagnosis)
Diagnoses (Other Diagnosis2)

Edits:

Message Number	Message
23008	Error: Primary key fields cannot be blank or null. Transaction not posted
23010	Error: Date is out of range or invalid. Transaction not posted.

23048	Error: Discharge Date is equal or greater than Admission Date. Transaction not posted.
23053	Error: Reporting Unit is not valid for Community Hospital or E&T. Transaction not posted.
23056	Error: Admission or Discharge date is beyond current date. Transaction not posted
23071	Soft Error: No Inpatient Service data found for transaction.
23072	Error: Contractor not permitted to alter transaction for this RUID, CID.
23081	Error: Date is outside dictionary requirements. Transaction not posted.
23088	Error: CID is voided. Transaction not posted.
23109	. Error: Admission Date is prior to Jan 1, 1997. Transaction not posted.
23152	Error: Diagnosis null or blank. Transaction not posted.
23156	Error: Invalid Legal Status codes. Transaction not posted.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
30006	Soft Error: Date(s) are more than 6 months old.
30007	Error: A valid Diagnosis is required.

HIPAA 837I data field conversion/map to Native Transaction 70.04 (E&T Inpatient) data requirements

2002 Data Dictionary Data Name	837 Loop	837 Segment	Industry Name or Alias	Value/Comment
Batch Number	ISA	ISA13	Interchange Control Number	9 character Leading zero-last five digits sequential starting at 1 and reset after 99999
Action Code	<2300>	CLM05-3	Claim Frequency Type Code	Values 1,7,or 8 - Converted from A,C,D by MHD
RSN or Contractor ID	GS	GS02	Application Senders Code	3 digit RUID of the RSN
Consumer ID	<2000B>	SBR03	Reference Identification - Subscriber Primary Identifier	RSN Unique Consumer ID, Not the PIC Code
RUID (of Provider)	<2010AA>	REF02	Billing Provider Additional Identified	3-4 digit RUID of the E&T Provider
Admission Date	<2300>	DPT03	Date Time Period	DPT01 = 435 & DPT02 = DT the first eight characters are the CCYYMMDD Admission Date
Discharge Date	<2300>	DPT03	Date Time Period	DPT01 = 434 & DPT02 = RD8 then characters 10-17 are the CCYYMMDD Discharge Date Note first eight characters should match Admission Date
Legal Status	<2300>	CL102	Admission Source Code (UB92)	Use code "8" for Involuntary and code "2" for voluntary
Diagnoses Primary ICD9	<2300>	HI 01-2	Industry Code (ICD9)	If HI01-1 = BK , This is Principal Diagnosis
Diagnoses - Other	<2300>	HI 01-2	Industry Code (ICD9)	If HI01-1 = BF, This is Other Diagnosis

Diagnosis1				
Diagnoses Admitting	<2300>	HI 02-2	Industry Code (ICD9)	If HI02-1 = BJ, This is Admitting Diagnosis
Diagnoses Other Diagnosis2	<2300>	HI 02-2	Industry Code (ICD9)	If HI02-1 = BF, This is Other Diagnosis

Status: Production	**Version:** 1.01	**ID:** 10001

Transaction: Header

Effective Date: 1/1/2000

Definition:
This transaction is an identifier and is the first record that goes in a non HIPAA batch file. The Header tells what number the batch is, the originator, and the date sent.

Transaction ID: Value: "000.01"

Body:
Batch Date
Submitting Reporting Unit ID
Batch Number

Note: This transaction is required as the first record of each non HIPAA batch and all batches are processed in Batch Number order.

Edits:

Message Number	Message
23300	SAID %s is not a valid reporting unit ID.
23301	Batch number %s does not exist for SAID %s.

Note % signs above replaced by actual ID values when message sent.

Status: Production	Version: 1	ID: 10017

Transaction: ITA Hearing

Effective Date: 1/1/2000

Definition:
This transaction documents each hearing under the Involuntary Treatment Act filed in a specific county. This excludes filings at a State Hospital. If multiple hearings are held for the same person on the same day, record the decision of the court for the most recent hearing. If no decision is made at a hearing and the case is continued to another day, do not record the result of that hearing. Record only those hearings where a court makes a decision such as to detain, revoke, conditionally release, or dismiss.

Transaction ID: Value "162.02"

Action Code: Value
"A" Add
"C" Change
"D" Delete

Primary Key: Reporting Unit ID *(Contractor or RSN)*
Consumer ID
Hearing Date

Body: Hearing Outcome
Reporting Unit ID *(Community/State Hospital or Evaluation and Treatment Center number where the consumer was ordered to inpatient; otherwise leave blank or null)*
Hearing County

Edits:

Message Number	Message
23003	Error: Reporting Unit ID %s unknown. Transaction not posted.
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23010	Error: Date is out of range or invalid. Transaction not posted
23098	Soft Error: Record does not exist. Delete rejected.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
30003	Error: Hearing Outcome Code is invalid. Transaction not processed.
30004	Error: Invalid Hearing County Code. Transaction not processed.
30005	Error: Invalid RUID for Eval and Treatment Ctr or Hospital. Transaction not processed.

Note % signs above replaced by actual ID values when message sent.

References:

REVOCATION - ***Outpatient Treatment or Care - Conditional Release - Procedures for Revocation*** - As provided in RCW 71.05.340(3) - " If the hospital or facility designated to provide outpatient care, the designated county mental health professional or the secretary determines that a conditionally released person is failing to adhere to the terms and conditions of his or her release, or that substantial deterioration in the person's functioning has occurred, then, upon notification by the hospital or facility designated to provide outpatient care, or on his or her own motion, the designated county mental health professional or the secretary may order that the conditionally released person be apprehended and taken into custody and temporarily detained in an evaluation and treatment facility in or near the county in which he or she is receiving outpatient treatment until such time, not exceeding five days, as a hearing can be scheduled to determine whether or not the person should be returned to the hospital or facility from which he or she had been conditionally released. "

PETITION - ***Petition for Initial Detention*** - As provided in RCW 71.05.160 - " Any facility receiving a person pursuant to RCW 71.05.150 shall require a petition for initial detention stating the circumstances under which the person's condition was made known and stating that such officer or person has evidence, as a result of his personal observation or investigation, that the actions of the person for which application is made constitute a likelihood of serious harm to himself or others, or that he is gravely disabled, and stating the specific facts known to him as a result of his personal observation or investigation, upon which he bases the belief that such person should be detained for the purposes and under the authority of this chapter. "

Petition for Involuntary Treatment or Alternative Treatment - As provided in RCW 71.05.240 - " If a petition is filed for fourteen day involuntary treatment or ninety days of less restrictive alternative treatment, the court shall hold a probable cause hearing within seventy-two hours of the initial detention of such person as determined in RCW 71.05.180, as now or hereafter amended. "

Petition for Additional Confinement - As provided in RCW 71.05.290 - " At any time during a person's fourteen day intensive treatment period, the professional person in charge of a treatment facility or his professional designee or the designated county mental health professional may petition the superior court for an order requiring such person to undergo an additional period of treatment."

Petition for Release - As provided in RCW 71.05.480 - " Nothing contained in this chapter shall prohibit the patient from petitioning by writ of habeas corpus for release."

DETENTION - ***Detention of Mentally Disordered Persons for Evaluation and Treatment*** - As provided in RCW 71.05.150 - " When a mental health professional designated by the county receives information alleging that a person, as a result of a mental disorder, presents a likelihood of serious harm to others or himself, or is gravely disabled, such mental health professional, after investigation and evaluation of the specific facts alleged, and of the reliability and credibility of the person or persons, if any, providing information to initiate detention, may, if satisfied that the allegations are true and that the person will not voluntarily seek appropriate treatment, file a petition for initial detention. "

Detention Period for Evaluation and Treatment - As provided in RCW 71.05.180 - " If the evaluation and treatment facility admits the person, it may detain him for evaluation and treatment for a period not to exceed seventy-two hours from the time of acceptance as set forth in RCW 71.05.170. The computation of such seventy-two hour period shall exclude Saturday, Sundays, and holidays. "

COMMITMENT ORDER - ***Definitions*** - As provided in RCW 71.05.020(5) - " 'Judicial Commitment' means a commitment by a court pursuant to the provisions of this chapter. " (i.e., dangerous to self, others, or gravely disabled).

INVESTIGATION - (The only reference to "investigation" in RCW 71.05 is found in RCW71.05.150 - see ***Detention*** above).

Status: Phased Out Replaced by HIPAA 837P	**Version:** 2	**ID:** 10013

Transaction: Outpatient Service (120.03)

Effective Date: 10/16/2003 through 3/31/2004 (Date of Service)
Phased out of service except for historical data corrections.
Used only to make corrections to data submitted prior to HIPAA implementation.

Definition:

This transaction documents outpatient services for a specific consumer. Note: The way MHD receives information on residential services is through the RSN reporting system which is why they are reported by the Outpatient Service Transaction.

Transaction ID: Value: "120.03"

Action Code: Value:
"A" = Add
"C" = Change
"D" = Delete

Primary Key:

Reporting Unit ID
(RSN/PHP ID) .

Reporting Unit ID
(Subcontractor or agency that provided service)

Claim Submit Identifier

In anticipation of HIPAA this identifier became one of the primary keys. It is used to identify a specific contact and claim made by a subcontractor to a Regional Support Network. Either the RSN or contractor determines it at time of claim submittal. It is the responsibility of the RSN to maintain accurate records to track any claim submitted back to their electronic documents and paper medical records kept on the consumer identified within this transaction.

The HIPAA 837P Implementation Guide specifies characters beyond 20 are not required and aren't returned by an 837 receiving system. However with HIPAA allowing multiple services per claim this element alone would not uniquely identify a specific service encounter. As a result the MHD-CIS database key was expanded to 68 characters. Although only 20 characters are expected in this transaction, MHD's implementation of the Claim Submit Identifier is to accept up to 68 characters.

Body:

Consumer ID

The RSN is responsible for uniquely identifying a consumer by the RSN Consumer ID.

Service Date

(CCYYMMDD)

Health Care Service Location

Note: Data Values changed as of October 17 2003

CPT Code

Note: As of October 2003 valid HCPCS codes may be entered in this field

Minutes of Service

EPSDT Indicator

A "Y" value implies an official referral form from the physician has to be in the clinical record; OR, documentation that a child was referred for a complete health screening. It must be related to a referral in to or out of the system for EPSDT service

Person Identification Code *(Hint PIC - Enter only if known.)*

(PIC code used to authorize service. This code is optional and is used by MHD to link Eligibility Records to this service event. It is used to determine Title XIX eligibility and to determine the Program, Match and Medical code on file at time of service.)

Provider Type

Required for actuarial studies to denote the specific type of provider involved with services.

Edits:

Message Number	Message
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23076	Error: Health Care Service Location code is not valid. Transaction not posted.
23077	Error: Health Care Service Location code is blank or null. Transaction not posted.
23081	Error: Date is outside dictionary requirements. Transaction not posted.
23089	Error: RUID not in Contractor service area. Transaction not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
24728	Warning: Cannot delete outpatient service record because it was not found
24729	Warning: Service Record is more than six months old. May not be counted in RSN totals.
24730	Error: Service Date is invalid or post dated.
24732	Error: CPT or HCPCS Code cannot be blank or null. Transaction not processed
24733	Error: Invalid CPT or HCPCS Code. Transaction not processed
30002	Error: Minutes of Service contains unusual value (must be between 0 and 1440). Transaction not posted.
30017	Warning: EPSDT contains invalid value. Set to 'N'.
30036	Warning: Missing Consumer Periodic report within last 3 months.
30047	Warning: Service Provider Type Code is blank (after 3/1/04)
30048	Error: Service Provider Type Code is Invalid. Transaction not posted

Status: MHD IT Internal Derived from HIPAA 837P	Version: 3	ID: 10013

Transaction: Outpatient Service (120.04)

Effective Date: 3/31/2004

Definition:

HIPAA 837 Professional transactions are used to report outpatient encounters. In order to maintain existing SQL Tables, MHD extracts corresponding data from submitted HIPAA 837P Transactions to create this transaction as an interface to MHD-CIS. This transaction is in MHD-CIS native format similar to transaction 120.03 but it is not available to the RSNs. The only time RSNs will see the transaction is as part of Batch or Error reports from the MHD-CIS system to denote the transaction was derived from a HIPAA 837P See the following data field conversion/map for HIPAA usage. MHD translates the 837P into this transaction used by MHD

Native Transaction Format	**837P HIPAA Equivalent** (See following Data Field Conversion map)
Transaction ID: Value: "120.04"	HIPAA: 873P
Action Code: Value: "A" = Add "C" = Change "D" = Delete	HIPAA: <2300> CLM05-3 HIPAA:GS02
Primary Key:	
Reporting Unit ID *(RSN/PHP ID) Compliant with HIPAA until Fed Ids are available.*	HIPAA:GS02
Reporting Unit ID *(Subcontractor or agency that provided service) Compliant with HIPAA until Fed Ids are available.*	HIPAA:<2010AA>REF02
Claim Submit Identifier *(See HIPAA 837P Guide pg 171 and 473)*	HIPAA:<2300> CLM01 +HIPAA <2400> REF02
The 837P Implementation Guide specifies Claim Submit Identifier as a unique identifier for a claim. In order to identify a specific encounter within a claim it is also necessary to use a Line Item Control Number from the HIPAA service detail level. The two HIPAA data items are combined in this transaction.	
Body:	
Consumer ID *(Compliant with HIPAA until universal IDs are available.)* The RSN is responsible for uniquely identifying a consumer by the RSN Consumer ID.	HIPAA:<2000B> SBR03

Service Date HIPAA: <2400> DPT03
(CCYYMMDD)

Health Care Service Location HIPAA:<2400> SV105
Required by HIPAA *(See HIPAA 837P Implementation Guide pgs 173;404*
Note: Data Values changed as of October 17 2003

CPT Code or HCPCS Code HIPAA:<2400> SV101-2

Minutes of Service HIPAA:<2400> SC104
(See HIPAA Transaction 837 pg 403)

EPSDT Indicator HIPAA:<2400> SV111
(See HIPAA Transaction 837 pg 406.)

Person Identification Code HIPAA:<2010BA> NM109
(Hint PIC - Enter only if known.)
(PIC code used to authorize service. This code is optional and is used by MHD to link Eligibility Records to this service event. It is used to determine Title XIX eligibility and to determine the Program, Match and Medical code on file at time of service.)

Provider Type
(See HIPAA Transaction 837 pg 488.) Required for actuarial studies to denote the specific type of provider involved with services.

Diagnoses – up to 4 Occurrences
(See HIPAA

Principle Diagnosis	*HIPAA <2300> HI 01-2 where HI01-1 = BK*
Additional Diagnosis2	*HIPAA <2300> HI 02-2 where HI02-1 = BF*
Additional Diagnosis3	*HIPAA <2300> HI 03-2 where HI03-1 = BF*
Additional Diagnosis4	*HIPAA <2300> HI 04-2 where HI04-1 = BF*

Edits:

Message Number	Message
23008	Error: Primary key fields cannot be blank or null. Transaction not posted.
23076	Error: Health Care Service Location code is not valid. Transaction not posted.
23077	Error: Health Care Service Location code is blank or null. Transaction not posted.
23081	Error: Date is outside dictionary requirements. Transaction not posted.
23089	Error: RUID not in Contractor service area. Transaction not posted.
23107	Error: RSN or Contractor ID not valid. Transaction not posted.
23305	Error: Consumer Demographic transaction not found for Contractor ID, CID. Transaction not posted.
24728	Warning: Cannot delete outpatient service record because it was not found

24729	Warning: Service Record is more than six months old. May not be counted in RSN totals.
24730	Error: Service Date is invalid or post dated.
24732	Error: CPT or HCPCS Code cannot be blank or null. Transaction not processed
24733	Error: Invalid CPT or HCPCS Code. Transaction not processed
30002	Error: Minutes of Service contains unusual value (must be between 0 and 1440). Transaction not posted.
30007	Error: A valid Diagnosis is required. Transaction not posted.
30017	Warning: EPSDT contains invalid value. Set to 'N'.
30036	Warning: Missing Consumer Periodic report within last 3 months.
30048	Error: Service Provider Type Code is Invalid. Transaction not posted

HIPAA 837P data field conversion/map to MHD-CIS Transaction 120.04 (Outpatient Service) data requirements

2002 Data Dictionary Data Name	837 Loop	837 Segment	Industry Name or Alias	Value/Comment
Batch Number	ISA	ISA13	Interchange Control Number	9 character leading zeros- last five digits sequential starting at 1 and reset after 99999
Action Code	<2300>	CLM05-3	Claim Frequency Type Code	Values 1,7,or 8
CONID (RUID of RSN)	GS	GS02	Application Senders Code	3 digit RUID of the RSN
RUID (of Provider)	<2010AA>	REF02	Billing Provider Additional Identified	3-4 digit RUID of the Provider
Claim Submit Identifier	<2300> <2400>	CLM01 REF02	Claim Number +Line Item Control Number	68 Character Unique Number
Consumer ID	<2000B>	SBR03	Reference Identification - Subscriber Primary Identifier	RSN Unique Consumer ID, Not the PIC Code

Service Date	<2400>	DPT03	Service Date	CCYYMMDD
Health Care Service Location	<2400>	SV105	Place of Service Code - Health Care Service Location	
CPT Code (and HCPCS)	<2400>	SV101-2	Product Service ID – Procedure Code	CPT or HCPCS code
Minutes of Service	<2400>	SV104	Quantity - Minutes	Values from 0 to 1440
EPSDT	<2400>	SV111	Response Code – EPSDT Indicator	Any value except "Y " is treated as "N"
Person Identification Code	<2010BA>	NM109	Identification Code – Subscriber Primary Identifier	Use PIC if Medicaid and known else "Unknown"
Provider Type	<2400>	NTE02	Line Note Text	Use "ADD" for NTE01 Values 1=RN/ LPN, 2=ARNP 3=Psychiatrist/MD, 4=MA/Ph.D 5=Below Masters Degree 6=Peer Counselor 7=Mental Health Specialist 8=Not Applicable
Diagnoses (Principle)	<2300>	HI 01-2	Industry Code (ICD9)	If HI01-1 = BK , This is Principal Diagnosis
Diagnoses (Additional)	<2300>	HI 02-2	Industry Code (ICD9)	If HI02-1 = BF, This is Additional Diagnosis2
Diagnoses (Additional)	<2300>	HI 03-2	Industry Code (ICD9)	If HI03-1 = BF, This is Additional Diagnosis3
Diagnoses (Additional)	<2300>	HI 04-2	Industry Code (ICD9)	If HI04-1 = BF, This is Additional Diagnosis4

2003 Data Dictionary Changes

Data Element Change Summary

Standard Transaction Data Element	Type of Change				Summary of Change Some of these data elements are shown as discarded in standard transactions but may still be seen in the HIPAA Transactions
	HIPAA	Sharpen Focus	Discard Element	Add Element	
Admission Date	X				HIPAA 837I <2300> DPT03
Amount Paid by Medicare	X		X		Phased out of service with the Community Payment Summary Transaction
Authorization Number	X		X		To be phased out of service with the Community Hospital Authorization Transaction
Claim Submit Identifier	X				HIPAA 837P <2300> CLM01 and <2400>REF increased max length
CPT Code/HCPCS	X				HIPAA 837P <2400>SV101-2
Date Paid	X		X		Phased out of service with the Community Payment Summary Transaction
Diagnosis	X	X			HIPAA 837P, 837I AND optionally used in Consumer Periodics as predominant diagnosis within reporting period.
Discharge Date	X				HIPAA 837I <2300>DPT03
Discharge Disposition	X		X		Phased out of service with the Community Hospital Authorization Transaction.
DRG Code	X		X		Phased out of service with the Community Hospital Authorization Transaction.
EPSDT Indicator	X				HIPAA 837P<2400> SV111
Health Care Service Location	X				HIPAA 837P<2400> SV105
Legal Status	X				HIPAA 837I<2300> CL102 (code 8 for involuntary)
Minutes of Service	X				HIPAA 837P<2400> SV104
Person Identifier Code	X				HIPAA 837P<2010BA> NM109
Provider Number	X		X		Phased out of service with the Community Payment Summary Transaction
Provider Type	X			X	New element added to the Outpatient Service Transaction and to the HIPAA 837P<2400>NTE02
Reimbursement Amount	X		X		Phased out of service with the Community Payment Summary Transaction

RSN at Discharge	X		X		Phased out of service with the Community Hospital Authorization Transaction.
Service Date	X				HIPAA 837P<2400>DPT03
Total Claim Charge	X		X		Phased out of service with the Community Payment Summary Transaction
Total Recipient Payment	X		X		Phased out of service with the Community Payment Summary Transaction
Total Third Party Payment Amount	X		X		Phased out of service with the Community Payment Summary Transaction

MHD CIS Data Definitions

Data Definitions are listed alphabetically below. Those that have been replaced or impacted by HIPAA have been annotated and their definition will not be reproduced here. For HIPAA specific data definitions, refer to the appropriate HIPAA Transaction Implementation Guides.

Sub Object	Status	Version	ID
Action Code	Production	1.01	101001
Admission Date Replaced by HIPAA	HIPAA Definition	1.02	101039
Amount Paid by Medicare Replaced by HIPAA	HIPAA Definition	1	200118
Annual Gross Income	Production	1	200123
Authorization Number Replaced by HIPAA	HIPAA Definition	1.02	101083
Batch Date	Production	1.01	101003
Batch Number	Production	1.01	101004
Case Manager Comment	Production	1.01	101005
Case Manager ID	Production	1.01	101006
Case Manager Password	Production	1.01	101007
Case Manager Phone	Production	1.01	101008
CGAS	Production	1	200145
Claim Submit Identifier Replaced by HIPAA	HIPAA Definition	1	200140
Consumer ID	Production	1.02	101010
County Code	Production	1.01	101011
County of Residence	Production	1.02	200130

CPT Code Replaced by HIPAA	HIPAA Definition	1	200142
Date of Birth	Production	1.01	101014
Date Paid	HIPAA Definition	1	200110
DC03	Production	1	200147
Diagnosis Replaced by HIPAA except for Consumer Periodics where diagnosis is now optional	Production and HIPAA Definition	1	200131
Discharge Date Replaced by HIPAA	HIPAA Definition	1.02	101050
Discharge Disposition	Phased Out	1	200148
DRG Code	Phased Out	1	200143
Education	Production	1.02	101051
Employment Status	Production	1.02	101053
EPSDT Indicator Replaced by HIPAA	HIPAA Definition	1	200146
Ethnicity	Production	1.02	101017
GAF Score	Production	1	200135
Gender	Production	1.01	101019
Given Names	Production	1.01	101020
Grade Level	Production	1	200128
Health Care Service Location Replaced by HIPAA	HIPAA Definition	1	200126
Hearing County	Production	1	101077
Hearing Date	Production	1	101076
Hearing Outcome	Production	1	101078
Hispanic Origin	Production	1.01	101021

Impairment Kind	Production	1.02	101022
Investigation County	Production	1.01	101058
Investigation Date	Production	1.01	101059
Investigation Outcome	Production	1.01	101060
Investigation Start Time	Production	1.01	101061
Legal Reasons for Detention/Commitment	Production	1	101088
Legal Status Replaced by HIPAA	HIPAA Definition	1.02	101062
Living Situation	Production	1	200129
Minutes of Service Replaced by HIPAA	HIPAA Definition	1.01	101063
Month of Periodic	Production	1	200141
Month of Service	Production	1	200138
Number of Dependents	Production	1	200124
Person Identifier Code Replaced by HIPAA	HIPAA Definition	1.01	101018
Preferred Language	Production	1.02	101024
Priority Code	Production	1.02	101026
Provider Number Replaced by HIPAA	HIPAA Definition	1	200109
Provider Type	Production - New	1	101089
Race	Production	1	200144
Reimbursement Amount Replaced by HIPAA	HIPAA Definition	1	200116
Reporting Unit ID	Production	1.02	101027
Return to Inpatient/Revocation Authority	Production	1	101087
RSN at Discharge	Phased Out	1.01	200149

Service Date Replaced by HIPAA	HIPAA Definition	1.01	101067
Sexual Orientation	Production	1.01	101068
Social Security Number	Production	1.01	101033
Surname	Production	1.01	101071
Total Claim Charge Replaced by HIPAA	HIPAA Definition	1	200113
Total Recipient Payment Replaced by HIPAA	HIPAA Definition	1	200115
Total Third Party Payment Amount Replaced by HIPAA	HIPAA Definition	1	200114
Transaction ID	Production	1.02	101073
Type of Service Transaction	Production	1	200139

Status: Production	**Version:** 1.01	**ID:** 101001

DD: Action Code

Effective Date: 1/1/2000

Definition:
Most batch transactions sent to the Mental Health Division/Consumer Information System contain a code, which indicates that a given action takes place. Actions allowed on a given transaction are defined below.

Note: The Action Code is used in most transactions. The exceptions are listed below. These exceptions should not have a "Tab" inserted in the transaction to delineate the location of an Action Code.

1. Cascade Merge
2. Cascade Delete (Full/Partial)
3. Header

Maximum character length: 1

Code	Definition
A	Add a Record. If the record already exists as defined by the transaction's primary

	key, then replace the existing information with the new information contained in the body.
C	Change a Record. If the record does not already exist based on the transaction's primary key, then add a new record to the file.
D	Delete. If the record as identified by the transaction's primary key does not exists, then inform the Contractor that the MHD-CIS has no record to delete.

Status: Production	**Version:** 1.02	**ID:** 101039

DD: Admission Date

Effective Date: 1/1/2002

Definition:
Date a person was admitted to a facility. For HIPAA Definition see pages 167-170 of the 837 Institutional Guide 004010X096 For HIPAA reporting see Trading Partner Agreements

Maximum character length: 8

Format: CCYYMMDD

Where used: ; ET Inpatient Service (being phased out of service)
HIPAA 837I

Status: Production	**Version:** 1	**ID:** 200123

DD: Annual Gross Income

Effective Date: 1/1/2002

Definition:
Average annual family income. Family defined as members who normally share living environment who share income. Does not include income of group home members, other shelter members or inpatient roommates. Use the information available or best estimation in determining this element. If the person is on SSI, or is eligible for Washington State medical assistance, assume that the person is below the Federal Poverty level. For inpatients this represents the income of family of residence. For foster children report the child's annual income (benefit). This is to be reported annually or if changed. Change represents an amount

that would change the designated poverty level of the consumer or change to the sliding fee scales used by RSNs.

Format: This is a money field allowing $, commas and a period. Null values allowed if amount not reported.

Where used: Consumer Periodics

Status: Production	**Version:** 1.01	**ID:** 101003

DD: Batch Date

Effective Date: 1/1/1998

Definition:
Date a batch file of transactions was created by a submitting agency.

Maximum character length: 8

Format: CCYYMMDD

Where used: Header

Status: Production	**Version:** 1.01	**ID:** 101004

DD: Batch Number

Effective Date: 1/1/1998

Definition:
A sequential number assigned to the batch file by the submitting agency. When the batch number exceeds 99999 the submitting agency will reset the batch number to 00001.

Note: HIPAA transaction submission uses different batch numbering than standard transactions. On the HIPAA 837 the Transaction Batch Number is ISA13. Since the ISA13 field is nine digits, additional leading zeros should be entered. Only the last five digits entered in the ISA 13 will be used. For example, HIPAA Batch two would be entered as '000000002'

Maximum character length: 5 (Fill with leading zeros).

Where used: Header

Status: Production	Version: 1.01	ID: 101005

DD: Case Manager Comment

Effective Date: 1/1/2000

Definition:
Free-form field for commenting on the phone numbers (e.g. daytime, nighttime, beeper, etc.) or for entering other case manager information.

This information is stored at the State for the purpose of supporting the Case Manager Locator System.

Maximum character length: 255 Variable Length

Note: Problems have been detected with posting long comments. At this time, please keep comments short while this problem is being resolved.

Where used: Case Manager

Status: Production	Version: 1.01	ID: 101006

DD: Case Manager ID

Effective Date: 1/1/1998

Definition:
A code established by a Contractor to uniquely identify the case manager or case management team for a given consumer. A case management team may consist of one or more case management staff who shares responsibility for the care of a consumer. Case Manager ID can be established only by the Contractor through the RSN/PHP.

Maximum character length: 10 Variable Length

Where used: Case Manager
Consumer's Case Manager

Status: Production	Version: 1.01	ID: 101007

DD: Case Manager Password

Effective Date: 1/1/1998

Definition:
A keyword that identifies that the requester has authority to inquire about a consumer. The password is updated in accordance with the RSN's Policy on Security of Consumer Information. This password is used in the Case Manager Locator System (CMLS) on the MHD-CIS Intranet.

Maximum character length: 30 Variable Length

Where used: Case Manager

Status: Production	Version: 1.01	ID: 101008

DD: Case Manager Phone

Effective Date: 1/1/1998

Definition:
The phone number where the appointed case manager can be reached. It is important that the area code be included so that someone calling from outside a given RSN's area can reach the appropriate contact point. The recommended format is the full ten (10) digit phone number including the area code then any extension if known. This telephone number will be displayed in the Case Management Locator System exactly as entered.

Maximum character length: Minimum 10 - 20 Variable Length

Where used: Case Manager

Status: Production	**Version:** 1	**ID:** 200145

DD: CGAS

Effective Date: 1/1/2002

Definition:
Global Assessment Scale for Children 6 to 17 Years of Age. Specified Time Period: 1 month Rate the subject's most impaired level of general functioning for the specified time period by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (e.g. 35, 58, 62). Rate actual functioning regardless of treatment or prognosis. Use code 000 for inadequate information

Maximum character length: 3 - (left zero fill)

The examples of behavior provided are only illustrative and are not required for a particular rating.

Code	Definition
91-100	Superior functioning in all areas (at home, at school, and with peers); involved in a wide range of activities and has many interests (e.g. has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc): likeable, confident; "everyday" worries never get out of hand; doing well in school; no symptoms.
81-90	Good functioning in all areas; secure in family, school, and with peers; there may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam, occasionally 'blowups" with siblings parents, or peers).
71-80	No more than slight impairment in functioning at home, at school; or with peers; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g. parental separations, deaths, birth of a sib), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.
61-70	Some difficulty in a single area, but generally functioning pretty well (e.g. sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.
51-60	Variable functioning with sporadic difficulties or symptoms in several but not all-social areas; disturbance would be apparent to those who encounter the child in a

	dysfunctional setting or time but not to those who see the child in other settings.
41-50	Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.
31-40	Major impairment in functioning in several areas and unable to function in one of these areas, e.g. disturbed at home, at school, with peers or in society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent: such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).
21-20	Unable to function in almost all areas, e.g., stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).
11-20	Needs considerable supervision to prevent hurting others or self (e.g. frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, e.g. severe abnormalities in verbal and gestured communication, marked social aloofness, stupor, etc.
01-10	Needs Constant supervision (24-hr care) due to severely aggressive or destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.

Where used: Consumer Periodics

Status: Production	**Version:** 1	**ID:** 200140

DD: Claim Submit Identifier

Effective Date: 1/1/2002

Definition:
An identifier when used in combination with the Reporting Unit ID will be unique to a given outpatient/inpatient service transaction as stated in the transaction definition. It must uniquely identify an individual service within the RSN. For outpatient service transactions, the agency providing the service may create this unique identifier. For HIPAA Definition see the discussion

below and pages 170-179 of the 837 Professional Guide 004010X098. For HIPAA reporting see Trading Partner Agreements

Maximum character length: 68.

When initially implemented for a non HIPAA Outpatient Service transaction on 1/1/2002 the maximum length was set as 20. This was based on HIPAA Implementation Guide suggestion and a one claim per encounter reporting expectation. The HIPAA Implementation Guides however allows multiple services per claim. Since multiple services are allowed per claim, the Claim Submit Identifier (CSI) alone on a HIPAA transaction is insufficient to uniquely identify the service encounter. On the HIPAA 837P, the Claim Submit Identifier (CSI) used at the 2300 CLM level is the CSI for the total claim. (See page 171 of the 837P Implementation Guide.) The Claim Submit Identifier for the service itself is the Reference Identification at the 2400 level, which is the Line Item Control Number. (See page 473 of the 837P Implementation Guide.) Merging of these two fields was necessary to produce a unique identifier.

Where used: Outpatient Service (being phased out of service)
HIPAA 837P

Status: Production	**Version:** 1.02	**ID:** 101010

DD: Consumer ID

Effective Date: 1/1/2002

Definition:
The identifier established by a Contractor, which uniquely identifies a consumer. Once a Consumer ID has been submitted to the MHD-CIS, it is never deleted. Use this ID on all transactions that require the identification of a consumer.

Maximum character length: 20 Variable Length

Note: A Consumer ID is established in the MHD-CIS by submitting a Consumer Demographic transaction.

Where used: Consumer Demographics
Cascade Delete (Full/Partial)
Cascade Merge
CDMHP Investigation
Consumer Periodics
Consumer's Case Manager
ITA Hearing

Status: Production	**Version:** 1.01	**ID:** 101011

DD: County Code

Effective Date: 1/1/1998

Definition:
A code ranging from '01' through '40'. Codes '01' through '39' identify the 39 counties in alphabetical order. Code '40' represents an unknown county.

Maximum character length: 2 (left zero fill).

Code	Definition	Code	Definition
01	Adams	21	Lewis
02	Asotin	22	Lincoln
03	Benton	23	Mason
04	Chelan	24	Okanogan
05	Clallam	25	Pacific
06	Clark	26	Pend Oreille
07	Columbia	27	Pierce
08	Cowlitz	28	San Juan
09	Douglas	29	Skagit
10	Ferry	30	Skamania
11	Franklin	31	Snohomish
12	Garfield	32	Spokane
13	Grant	33	Stevens
14	Grays Harbor	34	Thurston
15	Island	35	Wahkiakum
16	Jefferson	36	Walla Walla
17	King	37	Whatcom
18	Kitsap	38	Whitman

19	Kittitas	39	Yakima
20	Klickitat	40	Unknown or out of state

Where used: Consumer Periodics (County of Residence)
CDMHP Investigations (Investigation County)
ITA Hearing (Hearing County)

Status: Production	**Version:** 1.02	**ID:** 200130

DD: County of Residence

Effective Date: 1/1/2002

Definition:
A code indicating the county where a person lives (or unknown). Do not change if the consumer is placed in an institutional setting,

Maximum character length: 2 (left zero fill).

Note: See County Code for values.

Where used: Consumer Periodics

Status: Production	**Version:** 1	**ID:** 200142

DD: CPT Code

Effective Date: 1/1/2002

Definition:
Current Procedural Terminology (CPT) codes found in the current CPT (2004 and beyond) manual as published by the American Medical Association. For HIPAA Definition see pages 400-407 of the 837 Institutional Guide 004010X096 and pages 55-57 of the 837P Addenda 004010X098A1 For HIPAA reporting see Trading Partner Agreements. Known as Procedure Code under HIPAA. See also Health Care Financing Administration Common Procedure Coding System HCPCS Codes.

Prior to HIPAA, the National Association of State Mental Health Program Directors (NASMHPD) proposed a new set of CPT Codes for specific Mental Health Procedures. Pending assignment (or disapproval) of NASMHPD proposed CPT codes, the MHD Research unit provided a set of NASMHPD temporary codes be used for reporting under the Outpatient Service Transaction 120.03. These codes may not be used in HIPAA Transactions and will not be supported after the 120.03 Outpatient Service Transaction is phased out of service no later than March of 2004. These codes and rollups were published in the MHD-CIS 2002 Data Dictionary and are currently available from the MHD Research Unit under separate cover.

Maximum character length: 5.

Where used: Outpatient Service
HIPAA 837 Professional and HIPAA 837 Institutional

Status: Production	**Version:** 1.01	**ID:** 101014

DD: Date of Birth

Effective Date: 1/1/1998

Definition:
The date a person was reported born.

Submit the date in the format CCYYMMDD. November 26, 1933 would be submitted on the batch transaction as 19331126.

Maximum character length: 8

Format: CCYYMMDD

Note: When a birth date is post (or greater than) a service date or the date is invalid, then all statistics related to these types of birth dates are usually attributed to the adult population.

Where used: Consumer Demographics

Status: Production	**Version:** 1	**ID:** 200147

DD: DC03

Effective Date: 1/1/2002

Definition:
Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) is a product of eight years of work by ZERO TO THREE'S

multidisciplinary Diagnostic Classification Task Force. The task was to develop the first comprehensive guide to assessment, diagnosis and treatment planning for mental health problems in children, from infants to toddlers. (See http://www.zerotothree.org)
Zero to 100 scale describes the child's level of functioning. Complements DSM-IV. Original Source: Zero to Three/ National Center for Clinical Infant Programs, 1994 Current Codes available from the Washington Institute for Mental Illness Research & Training (WIMIRT). Use code 000 for inadequate information.

Note: MHD will also use the DC03 for 4 and 5-year-old children. CGAS is used for 6-17 year olds

Maximum character length: 3 (left zero fill)

Where used: Consumer Periodics

Status: Production	**Version:** 1	**ID:** 200131

DD: Diagnosis

Effective Date: 1/1/2004

Definition:
Medical diagnosis in ICD-9CM format

In the Consumer Periodics Transaction, Diagnosis is optional. Up to four diagnosis (ICD9 codes) may be entered. It represents the predominant mental health diagnosis for the period, which is a different business use than a specific encounter diagnosis as reported on a HIPAA 837 transaction.

For HIPAA Definition see pages 265-270 of the 837 Professional Guide 004010X098 or pages 227-229 of the 837 Institutional Guide 004010X096 and page 19 of the 004010X096A1 Addenda. For HIPAA reporting see Trading Partner Agreements. **Maximum character length:** 3 to 6 (Or tabbed over if not reported)

Note: ICD-9CM may be coded as three digits with no period. Editing for valid codes will be on the first three digits only. Note page 265 of the Professional Guide under Note 2 reads: "Do not transmit the decimal point in the diagnosis codes. The decimal point is assumed."

Where used: Consumer Periodics
ET Inpatient Service
HIPAA 837 Institutional
HIPAA 837 Professional

Status: Production	Version: 1.02	ID: 101050

DD: Discharge Date

Effective Date: 1/1/2002

Definition:
Date a person was released from a facility.

For HIPAA Definition see pages 167-168 of the 837 Institutional Guide 004010X096. Discharge Date is assumed to be characters 10-17 of loop 2300 Statement Dates where DPT01 = 435 and DPT02 = RD8. For HIPAA reporting see Trading Partner Agreements

Maximum character length: 8

Format: CCYYMMDD

Where used: ET Inpatient Service
HIPAA 837Institutional

Status: Production	Version: 1.02	ID: 101051

DD: Education

Effective Date: 1/1/2002

Definition:
Describes if a consumer is in a formal educational program. This includes home schooling.

Maximum character length: 1

Code	Definition
1	Full time education: (1-12 grade: 20+ hours a week; kindergarten and greater than 12th grade: 12+ hours a week)
2	Part time education: (1-12: less than 20 hours a week, K and greater than 12th grade: less than 12 hours a week)
8	Not in educational program.
9	Unknown.

Where used: Consumer Periodics

Status: Production	**Version:** 1.02	**ID:** 101053

DD: Employment Status

Effective Date: 1/1/2002

Definition:
Employment status of the consumer during the Consumer Periodic time frame.

Guidelines:

This field is required to be reported as part of Consumer Periodics. This status may be recorded as "Unknown/Missing" if the service rendered is one-time, classified as Emergency/Crisis, or an assessment of the employment could not be determined during the time period reported. MHD does not expect employment records for children under 16. However, if reported code 8 or code 9 could be used.

Maximum character length: 1

Code	Definition
1	Employment Full-time: (35 hours or more paid employment per week).
3	Employment Part-time: (Less than 35 hours paid employment per week).
4	Supported Employment: (SE programs use a team approach for treatment, with employment specialists carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. Frequently coordinated with Vocational Rehabilitation benefits.
5	Employed sheltered workshops, onsite at SE or other treatment agency offices.
6	Volunteer work: (1 or more hours per week volunteer work).
7	Retired.
8	Not Employed.
9	Unknown/Missing.

Where used: Consumer Periodics

Status: Production	Version: 1	ID: 200146

DD: EPSDT Indicator

Effective Date: 1/1/2002

Definition:
A code indicating a Yes or No condition or response. This code is used to flag a service or referral (into or out of an agency) that is related to an EPSDT *(Early and Periodic Screen for Diagnosis and Treatment of children)* screening; a "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement. This code is required if Medicaid services are the result of an EPSDT screening referral for children (under 21 years of age). For HIPAA Definition see page 406 SV111of the 837 Institutional Guide 004010X096. For HIPAA reporting see Trading Partner Agreements

Maximum character length: 1

Where used:Outpatient Service
HIPAA 837P

Status: Production	Version: 1.02	ID: 101017

DD: Ethnicity

Effective Date: 1/1/2002

Definition:
Taken from the Year 2000 census survey form as published by the Bureau of Census. Select one or more races to indicate what this person considers himself/herself to be.

If a person selects more than one code, enter each one in sequence. For example the selection of 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. If the information is not available or unknown, then code as 999. Do not use code '999' with any other code combinations.

For reporting purposes, multi ethnicity coding will be combined into a single category. This is to prevent counting the same client multiple times.

Maximum character length: Variable Length of 3 or multiple of 3 characters

Code	Definition
010	White
021	American Indian or Alaska Native
031	Asian Indian

032	Native Hawaiian
033	Other Pacific Islander
034	Other Asian
040	Black, African American, or Negro
050	Some other race
605	Chinese
608	Filipino
611	Japanese
612	Korean
619	Vietnamese
660	Guamanian or Chamorro
655	Samoan
999	Not reported/Unknown

Where used: Consumer Demographics

Status: Production	**Version:** 1	**ID:** 200135

DD: GAF Score

Effective Date: 1/1/2002

Definition:
Global Assessment of Functioning. Use code 000 for inadequate information.

Maximum character length: 3 - (left zero fill)

Use Axis V codes from DSM-IV.

Where used: Consumer Periodics

Status: Production	**Version:** 1.01	**ID:** 101019

DD: Gender

Effective Date: 7/1/1998

Definition:
A code indicating either Male or Female. Indicate the gender of male or female.

Maximum character length: 1

Code	Definition
1	Female
2	Male
3	Unknown

Note: The value "3" for "Unknown" should be avoided. In statistical reports that look at gender as "Male" and "Female" exclusively, the "Unknown" ***may be*** included with the "Male" population.

Where used: Consumer Demographics

Status: Production	**Version:** 1.01	**ID:** 101020

DD: Given Names

Effective Date: 1/1/1998

Definition:
The given/first/informal names of a consumer as provided by a Reporting Unit. (May include Title.)

In general, follow the rules of the appropriate culture when determining which name is the surname and which the given name. Consistency is important here, because the last name and given names are both used as elements to uniquely identify the person across the system.

The given name as recorded on significant documentation can be used to resolve contradictions. Use reasonable judgment to determine the best choice.

Maximum character length: 40 Variable Length

Where used: Consumer Demographics

Status: Production	Version: 1	ID: 200128

DD: Grade Level

Effective Date: 1/1/2002

Definition:
Identifies the highest-grade level completed by the consumer.

Maximum character length: 2 - (left zero fill)

Code	Definition
00	Preschool/kindergarten
01 - 12	List the specific grade completed, (Use 12 for GED)
13	Some College
14	2 year degree (AA, AS)
16	4 year degree (BA, BS)
18	Post-graduate education
99	Unknown, Never attended, or below pre-school

Where used: Consumer Periodics

Status: Production	Version: 1	ID: 200126

DD: Health Care Service Location (Pre HIPAA)

Effective Date: 1/1/2002 through 10/17/2003

HIPAA Alias: Place of Service Code

Definition:
The following is the initial code set proposed by HIPAA and implemented in 2002. They do not cover all options that were discussed in the joint PI/ISDEC meetings *(spring/summer 2001)* and there are some workgroup recommendations on use of potentially redundant codes. The recommendations include using codes 53 instead of code 11 and code 19 instead of code 80. Codes 11 and 80 will be merged for reporting purposes if they are entered in the MHD-CIS. Codes 21 and 51 are not expected to be used in an outpatient situation. Code 56 is expected.

NOTE: These Codes are outdated. Outpatient Service transactions with Date of Service prior to 10/17/03 are edited against these values. See the Post HIPAA codes for transactions with Date of Service after 10/17/03.

Maximum character length: 2

Place of Service Code(s)	Place of Service Name	Place of Service Description
11	Office *(Mental Health Outpatient Facility)*	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, E&T, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
19	School	Location, other than a hospital or other facility, where the patient receives care in a school.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care	A facility which provides room, board and other personal

	Facility	assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center *(Mental Health Outpatient Facility)*	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
80	School	Location, other than a hospital or other facility, where the patient receives care in a school.
99	Other Unlisted Facility	Other service facilities not identified above including 'on the street'.

Where used:

Outpatient Services (Date of Service prior to 10/17/03)

Status: Production	**Version:** 2	**ID:** 200126

DD: Health Care Service Location

Effective Date: 10/18/2003

HIPAA Alias: Place of Service Code

Definition:
Codes used on professional claims/encounters to specify the entity where the service(s) were rendered. **NOTE:** HIPAA 837P and Outpatient Service transactions with Date of Service after 10/17/03 should use these codes. Refer to. http://www.cms.hhs.gov/states/posdata.pdf for current code values

Maximum character length: 2

Where used: Outpatient Services (Date of Service prior to 10/17/03)
HIPAA 837

Since Health Care Service Location Codes are subject to change, the codes available from the HHS web site will take precedence over any codes published in this Data Dictionary.

The reference to codes following HIPAA Implementation in October 2003 that were on this page has been removed

Refer to. http://www.cms.hhs.gov/states/posdata.pdf for current code values

Status: Production	Version: 1	ID: 200143

DD: HCPCS Code

Effective Date: 10/17/2003

Definition:
Health Care Financing Administration Common Procedure Coding (HCPCS). Current Health Care Procedural Terminology codes found in the current HCPCS (2004 and beyond) manual as published by the American Medical Association. For HIPAA Definition see pages 400-407 of the 837 Institutional Guide 004010X096 and pages 55-57 of the 837P Addenda 004010X098A1 For HIPAA reporting see Trading Partner Agreements. Known as Procedure Code under HIPAA. See also Common Procedure Terminology (CPT) Codes.

As of HIPAA Implementation on 10/17/04 the OutPatient Service Transaction 120.03 was modified to also accept HCPCS codes in place of CPT Codes.

Maximum character length: 5.

Where used: Outpatient Service
HIPAA 837 Professional and HIPAA 837 Institutional

Status: Production	Version: 1	ID: 101077

DD: Hearing County

Effective Date: 1/1/2000

Definition:
The county where a court hearing was held.

Maximum character length: 2

See County Code for code values. County code "40" for "Unknown" will be rejected.

Where Used: ITA Hearing

Status: Production	Version: 1	ID: 101076

DD: Hearing Date

Effective Date: 1/1/2000

Definition:
The date of a court hearing.

Maximum character length: 8

Format: (CCYYMMDD)

Where used: ITA Hearing

Status: Production	Version: 1	ID: 101078

DD: Hearing Outcome

Effective Date: 1/1/2000

Definition:
Code representing the number of days committed as a result of a court order.

Note: No distinction is made between initial commitments/LRA and extensions. If the court orders another time period, round up to nearest time period.

Special Note for Codes 7 and 8: These are court-hearing outcomes based on petitions for revocation filed by the CDMHP. The CDMHP can return a person to inpatient status then file a petition for court determination. The court can revoke the LRA (Code 7) which substantiates the CDMHP's action and returns the person to inpatient for the remainder of their time. The court may also return the person to the community on a less restricted alternative (Code 8) with the same or amended conditions.

Maximum character length: 1

Code	Definition
0	Dismissed
1	14 Day Commitment
2	90 Day Commitment or extension
3	180 Day Commitment or extension
4	90 Day LRA or LRA extension

5	180 Day LRA or LRA extension
6	Agreed to Voluntary Treatment
7	Revoke LRA
8	Reinstate LRA

Where used: ITA Hearing

Status: Production	**Version:** 1.01	**ID:** 101021

DD: Hispanic Origin

Effective Date: 1/1/1998

Definition:
A person of Mexican, Puerto Rican, Cuban, Central American or South American, or other Spanish origin or descent, regardless of race. The code is for primary self-reported Hispanic type. Roll-up code "000" may only be used with ITA and Crisis one-time services.

Use the code that describes the person's identification with Hispanic culture, origin or descent, in addition to the race/ethnicity recorded under Race/Ethnicity. If the RSN/PHP has conflicting views from their providers, the RSN/PHP will submit the most recent reported.

Every person should have an entry for both Ethnicity and Hispanic Origin codes.

Maximum character length: 3 - (left zero fill)

Code	Definition
000	General Hispanic
709	Cuban
722	Mexican/Mexican-American/Chicano
727	Puerto Rican
799	Other Spanish/Hispanic
998	Not Spanish/Hispanic
999	Unknown

Where used: Consumer Demographics

Status: Production	**Version:** 1.02	**ID:** 101022

DD: Impairment Kind

Effective Date: 1/1/2002

Definition:
The set of codes that identifies an individual's disability, in addition to the mental disorder for which they are being treated. **The disability should have a major impact on the person and their ability to function in the community and to procure food, clothing, and a safe place to live.** Multiple categories can be selected to describe the individual's impairment(s). Enter up to three applicable disability codes.

Maximum character length: 3 - Use up to 3 codes listed below (Variable Length).

Code	Definition
A	Development or intelligence; i.e., mental retardation or developmental disorder, organic brain syndrome.
C	Physical (unable to walk without assistance, unable to care for self, chronic illness).
D	Alcohol or drug dependence; i.e., dependence on alcohol or drugs which negatively affects the individual's ability to maintain a stable living arrangement, unable to remain in competitive employment, unable to provide adequate care for dependents, legal problems related to substance abuse.
E	Vision Impairments (does not include wearing glasses).
F	Hearing Impairments.
G	Other communication difficulties (speech and language, language comprehension. Does not include non-native speakers).
X	Other - Medical or physical disabilities not listed above.
Y	Unknown.
Z	None.

Where used: Consumer Periodics

Status: Production	Version: 1.01	ID: 101058

DD: Investigation County

Effective Date: 1/1/2000

Definition:
A code to indicate the county in which a person was investigated under the Involuntary Treatment Act.

Maximum character length: 2 (left zero fill). See County Code for values

Where used: CDMHP Investigation

Status: Production	Version: 1.01	ID: 101059

DD: Investigation Date

Effective Date: 1/1/2000

Definition:
Date of an investigation under the Involuntary Treatment Act.

Maximum character length: 8

Format: CCYYMMDD

Where used: CDMHP Investigation

Status: Production	Version: 1.01	ID: 101060

DD: Investigation Outcome

Effective Date: 1/1/2000

Definition:
A code indicating the outcome to a person investigated.

Maximum character length: 1

Code	Definition
1	Detention (72 hours as identified under the Involuntary Treatment Act, RCW 71.05).
2	Referred to voluntary Outpatient mental health services.

3	Referred to voluntary Inpatient mental health services.
4	Returned to Inpatient facility/filed revocation petition.
5	Filed petition-recommending LRA extension
6	Referred to non-mental health community resources.
9	Other.

Note: Code "1" if the person was informed of their rights and involuntarily detained. A person may have been informed of their rights and may have decided to be treated voluntarily. In this case, document this as code "2" or "3" for referral to a facility for either voluntary inpatient or outpatient mental health services.

Where used: CDMHP Investigation

Status: Production	**Version:** 1.01	**ID:** 101061

DD: Investigation Start Time

Effective Date: 1/1/2000

Definition:
Time of day an investigation was started.

Maximum character length: 4

Format: HHMM

Note: This field is used to separate multiple investigations for the same person on the same day. It may be left blank if there is only one investigation, or the Contractor may specify any value up to 4 characters in length to uniquely identify multiple investigations on the same day. It is recommended that a time value be submitted using a 24-hour clock. If multiple investigations are reported for the same person on the same day and no start time is stated, then the new investigation will overwrite any old investigation without a start time.

Where used: CDMHP Investigation

Status: Production	Version: 1	ID: 101088

DD: Legal Reasons for Detention/Commitment

Effective Date: 1/1/2000

Definition:
Identifies the basic reason for detaining a person for 72 hours or committing a person to inpatient treatment or a less restrictive alternative (LRA) under the Involuntary Treatment Act, RCW 71.05 for adults and RCW 71.34 for children 13 and over (Children under 13 may not be detained through the ITA process). If more than one reason applies, select all that apply.

Note: Up to 4 codes may be recorded if a detention took place.

Maximum character length: 4

Code	Definition
A	Dangerous to self
B	Dangerous to others
C	Gravely disabled
D	Dangerous to property
Z	NA-person was not involuntarily detained under ITA

Where used: CDMHP Investigation

Status: Production	Version: 1.02	ID: 101062

DD: Legal Status

Effective Date: 1/1/2002

Definition:
A code indicating the legal status of a person upon entering a facility. If a person changes the legal status during the admission, use only the status at time of admission.

Maximum character length: 1

Format	Definition
V	Voluntary
I	Involuntary (Committed via ITA or courts)

Where used: ET Inpatient Service
HIPAA 837I a.k.a. Admission Type Code - See TPA for valid values

Status: Production	**Version:** 1	**ID:** 200129

DD: Living Situation

Effective Date: 1/1/2002

Definition:
Identifies the environment in which the client lives. Although reported on a 90-day cycle, the living situation for the last 30 days (where the consumer was the majority of the time) is the information to be reported.

Maximum character length: 2

Code	Definition
10	Private Residence without support: Individual lives in a house, apartment, trailer, boat, hotel, dorm, or barrack, Single Room Occupancy (SRO) and does not require routine or planned support to maintain his/her independence in the living situation. Includes children living with parents.
20	Private Residence receiving support: Individual lives in a house, apartment, trailer, boat, hotel, dorm, or barrack, Single Room Occupancy (SRO) and receives planned support to maintain independence in his/her private residence. This may include individualized services to promote recovery, manage crises, perform activities of daily living, and/or manage symptoms. Support services are delivered in the person's home environment. The person providing the support services may include a family member or a friend living with the client or a person/organization periodically visiting the home.
30	Foster Home: Individual resides in a Foster Home. A Foster Home is a home that is licensed by a County Department to provide foster care to children and adolescents. This

	includes Therapeutic Foster Care Facilities and adults in AFH.
40	24-Hour Residential Care: Individual resides in a residential care facility with care provided on a 24-hour, 7 day a week basis. Includes aggregate care and CCF facilities. This level of care may include a Group Home, Therapeutic Group Home, Board and Care, Crisis Residential, Residential Treatment, or Rehabilitation Center, or Residential Care/Treatment Facility and chemical dependency residential programs.
50	Institutional Setting: Individual resides in an institutional care facility with care provided on a 24-hour, 7 day a week basis. This level of care may include a Skilled Nursing/Intermediate Care Facility, Institute of Mental Disease (IMD), Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), Veterans Affairs Hospital, DD Facility, or State Hospital.
60	Jail/Juvenile Correction Facility: Individual resides in a Jail and/or Correctional facility with care provided on a 24-hour, 7 day a week basis. This level of care may include a Jail, Correctional Facility, Prison, Youth Authority Facility, Juvenile Hall, Boot Camp, or Boys Ranch.
70	Homeless/Shelter: A person has no permanent place of residence where a lease or mortgage agreement between the individual and the owner exists. A person is considered homeless if he/she lacks a fixed, regular, and adequate nighttime residence and/or his/her primary nighttime residency is: A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, B) an institution that provides a temporary residence for individuals intended to be institutionalized, or C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street).
80	Other
99	Unknown: Information on an individual's residence is not available.

Where used: Consumer Periodics

Status: Production	Version: 1.01	ID: 101063

DD: Minutes of Service

Effective Date: 1/1/1998

Definition:
The number of minutes a specific service was provided...

Maximum character length: 4 Variable Length

Where used: Outpatient Service
HIPAA 837 <2400>Professional Service SV104 Quantity

Status: Production	Version: 1	ID: 200141

DD: Month of Periodic

Effective Date: 1/1/2002

Definition:
The year and month of the periodic information as reported by the clinician. Format: CCYYMM

Maximum character length: 6.

Where used: Consumer Periodics

Status: Production	Version: 1	ID: 200138

DD: Month of Service

Effective Date: 1/1/2002

Definition:
The year and month of service. Format: CCYYMM

Maximum character length: 6.

Where used: Clear Month of Service

Status: Production	Version: 1	ID: 200124

DD: Number of Dependents

Effective Date: 1/1/2002

Definition:
List number of individuals, in addition to the consumer, who rely on the annual family income. Family defined as members who normally share residence and who share income. Does not include group home members, other shelter members or inpatient roommates. For inpatients this represents the number of dependents in the family of residence. For foster children report dependent of 1.

Example: A family of father, mother, two natural children and one foster child. a) Foster Child is client; number of dependents is '1'. b) Mother is client, Number of Dependents is '4'; Self = 1, husband = 1, two natural children = 2 for a total of 4.

Maximum character length: 2

Where used: Consumer Periodics

Status: Production/HIPAA	Version: 1.01	ID: 101018

DD: Person Identifier Code

Active Date: 1/1/2002

Definition:

A Personal Identifier Code (PIC) used by Division of Income Assistance to identify consumers eligible for state funded financial assistance as determined by the Division of Income Assistance. Also used by the Medical Assistance Administration to identify consumers eligible for Medical Assistance. There are two formats for this code. They are LLLLLIIYYMMDDT (First five characters of Last Name, First Initial, Middle Initial, Year, Month, Day of birth, Tie Breaker) or IIMMDDYYLLLLLT (First Initial, Middle Initial, Month, Day, Year of Birth, First five characters of Last Name, Tie Breaker). Enter the PIC exactly as it is shown on the Medical ID Card.

Maximum character length: 14

Format: LLLLLIIYYMMDDT or IIMMDDYYLLLLLT

The following are General Guidelines on how the PIC is formatted:

If the last name has five characters or more, enter the first five;
If the last name is hyphenated, enter the hyphen **IF** the hyphen comes before the first five characters or is the fifth character;

If the last name has less than five characters, space fill to make up five characters.
If there is no middle initial, enter as a hyphen (-).
If there is an apostrophe (') in the name, enter the apostrophe **IF** it is included on the Medical ID Card.

Examples: For purposes of these examples, "T" is being used as the tie breaker character. The tie breaker character is a variable character assigned by the caseworker. Note that all the examples use the second format listed above, but the same principles apply to either format.

John E. Wellington, born November 8, 1963 is entered as JE110863WELLIT.

Jane A. Doe, (**only three characters in LAST NAME**), born October 23, 1940 is entered as JA102340DOE__T. The two underscore marks represent blank spaces. **Do NOT put in the underscore marks; these should be BLANK SPACES.**

Stephen Doe (**only three characters in last name; *no middle initial***), born January 1, 1955, is entered as S-010155DOE__T. **Note that if there is no middle initial, it should be entered as a hyphen (-)**

Jerry A. Doe-Johnson (**three characters before the hyphenated last name**), born July 1, 1945, is entered as JA070145DOE-JT.

Judith Doe-Johnson (**no middle initial, three characters before the hyphenated last name**), born August 31, 1948, is entered as J-083148DOE-JT.

James E. Johnson-Doe, (**more than five characters before the hyphenated last name**) born April 3, 1967, is entered as JE040367JOHNST.

Jacob F. O'Brien (**apostrophe showing on the Medical ID Card**), born November 5, 1980, is entered as JF110580O'BRIT.

Jacob F. O'Brien (***NO* apostrophe showing on the Medical ID Card**), born November 5, 1980, is entered as JF110580OBRIET.

Note: The PIC can change at any time.

Where used: Outpatient Services
HIPAA 837P and 837I in loop 2010BA

Status: Production	**Version:** 1.02	**ID:** 101024

DD: Preferred Language

Effective Date: 1/1/2002

Definition:
This code identifies the language in which a person prefers to receive services.

Maximum character length: 2 (left zero fill).

Codes	Definition	Codes	Definition
00	Language Unknown	17	Hungarian
01	Japanese	18	Russian
02	Korean	19	Romanian
03	Spanish	20	Polish
04	Vietnamese	21	Greek
05	Laotian	22	Tigrigna
06	Cambodian	23	Amharic
07	Mandarin	24	Finnish
08	Hmong	25	Farsi
09	Samoan	26	Czech
10	Ilocano	27	Mien
11	Tagalog	28	Yakama
12	French	29	Salish
13	English	30	Puyallup
14	German	31	Thai
15	American Sign Language	99	Other Language
16	Cantonese		

Where used: Consumer Demographics

Status: Production	**Version:** 1.02	**ID:** 101026

DD: Priority Code

Effective Date: 1/1/2002

Definition:
Refer to RCW 71.24.025. An indicator of the relative seriousness duration and intensity of the presenting mental disorder of a particular person as well as distinguishing whether the consumer is a member of a targeted group as established by legislative mandate. Priority code is expected for crisis services. Providers may not have enough information about an individual to make a 'chronic' determination, but the provider should have enough information to make a seriously disturbed or seriously emotionally disturbed rating. However if a crisis worker can not determine a priority of chronic or serious, the priority code should be reported as acute. If a person is determined by the RSN at their sole discretion to be at risk, code them as 'A' acute, otherwise code 'O' for other. See WAC 388-0865-0150 for definitions of adult and child. Currently a child is one who has not reached his/her eighteenth birthday unless Medicaid eligible in which case a child is one who has not reached his/her twenty first birthday. Adults and Children conditional definitions are included below:

Maximum character length: 1

CODE	DEFINITION
A	Acutely Mentally Ill- a condition limited to a short-term severe crisis episode of a mental disorder, grave disability, or presenting a likelihood of serious harm. Not to be coded if the individual meets criteria for "chronic", "serious", or "seriously emotionally disturbed".
C	Chronically Mentally Ill Adult- an adult who has a mental disorder and meets at least one of the following criteria: -2 or more inpatient hospitalizations with the last 2 years, -continuous psychiatric hospitalization or residential treatment longer for more than 6 months out the preceding year, -because of mental disorder for more than 1 year, unable to engage in gainful activity. Gainful activity is based on Public Law related to SSI and SSDI regulations for earned income. For WA State this translates to a monetary amount. Refer to SSA Publication No. 05-11015 February 2001
D	Seriously Disturbed person- a person who has a mental disorder that causes major impairment in several areas of daily living. If the person is a child, this is a sufficient criterion. If they are an adult they must meet this or at least one of the following criteria :

	-is gravely disabled or presents a likelihood of serious harm to themselves or others, or to property; -has been on conditional release, or under a less restrictive alternative order at some time during the preceding two years; -has continuing suicidal preoccupation or attempts.
E	Severely emotionally disturbed child- is a child who has a mental disorder which is clearly interfering with their functioning in family, school or with peers, and meets one of the following criteria: -has undergone involuntary treatment or out of home placement related to a mental disorder within the last two years; -is currently served by juvenile justice, child-protection/welfare, special education, or developmental disabilities; -is at risk of escalating maladjustment due to: -chronic family dysfunction involving a mentally ill or inadequate caretaker; -changes in custodial adult; -going to, residing in, or returning from out of home placement; -subject to repeated physical abuse or neglect; -drug or alcohol abuse; -homelessness.
O	Other- Does not meet the criteria for Acutely mentally ill, Chronically mentally ill, Seriously disturbed, or Severely Emotionally Disturbed.

Where used: Consumer Periodics

Status: Production	Version: 1	ID: 101089

DD: Provider Type

Effective Date: 1/1/2004

Definition:
Identifies the professional level of a specific outpatient service provider. If a provider works as a counselor and a Mental Health Specialist, use code 7 only when that provider is providing a special population evaluation. Otherwise, they are to be listed by their credentials as shown below.

Maximum character length: 1

Code	Definition
1	RN/LPN
2	ARNP
3	Psychiatrist/MD
4	MA/Ph.D.
5	Below Masters Degree
6	Peer Counselor
7	Mental Health Specialist
8	Not Applicable

Where used: Outpatient Services
and as HIPAA 837P <2400>NTE02 (where NTE01 = ADD)

Status: Production	**Version:** 1	**ID:** 200144

DD: Race

Effective Date: 1/1/2002

Definition:
Code indicating the racial or ethnic background of a person as initially defined for reporting under HIPAA regulations on the HIPAA 834 Plan Enrollment form. Since the 834 Transaction is not currently used in the MHD/RSN transaction environment this data element is retained in the MHD Consumer Demographics transaction as a place holder for potential future use. If not entered on a Consumer Demographics Transaction (blank), the value will be calculated from the reported Ethnicity and Hispanic Origin

NOTE: The data elements Ethnicity and Hispanic Origin will continue being used to satisfy the other federal (reporting, funding and managed care) requirements until such time as there is a clarification from the competing federal authorities.

Maximum character length: 1 (leave blank if not reported)

Codes	Definition
7	Not Provided
A	Asian or Pacific Islander
B	Black
C	Caucasian
H	Hispanic
I	American Indian or Alaskan Native
N	Black (Non-Hispanic)
O	White (Non-Hispanic)

Where used: Consumer Demographics

Status: Production	Version: 1.02	ID: 101027

DD: Reporting Unit ID aka RSN RUID

Effective Date: 1/1/2002

Definition:
Unique identifier assigned to each unit reporting data on the MHD CIS System.

Maximum character length: 3-4 (left zero fill).

Note: There are Reporting Unit IDs (RUID) and also RSN identifiers which are a two digit text equivalent. This code is assigned by MHD to identify Reporting Unit. Since this list may change as Reporting Units are added or deleted over time, codes are kept on the MHD Intranet. For a complete list of centers or to establish a new ID, see instructions on the MHD Intranet. RSN IDs as of Dictionary publication are shown in the following table. Also note both values, RSN RUID and RSN ID are used in HIPAA 837 transactions.

RSN RUID	RSN ID	RSN Name
410	SP	Spokane RSN
411	KI	King RSN
412	NS	North Sound RSN
413	GC	Greater Columbia RSN
414	NC	North Central RSN
415	NE	Northeast RSN
416	PE	Peninsula RSN
417	CO	Southwest (Cowlitz) RSN
418	TM	Thurston / Mason RSN
419	PI	Pierce RSN
420	GH	Grays Harbor RSN
424	CL	Clark RSN
425	CD	Chelan / Douglas RSN
426	TI	Timberlands RSN

Where used: Header
Clear Month of Service

Cascade Delete (Full/Partial)
Cascade Merge
Case Manager
CDMHP Investigation
Consumer Demographics
Consumer Periodics
Consumer's Case Manager
HIPAA 837I and 837P
ITA Hearing

Status: Production	**Version:** 1	**ID:** 101087

DD: Return to Inpatient/Revocation Authority

Effective Date: 1/1/2000

Definition:
Identifies the basic reason for revoking a person. See RCW 71.05.340(3)(a) & (b).

Note: This element is specific to returning a consumer under LRA to inpatient treatment and the filing of a revocation petition. It distinguishes legal criteria used for person on LRA being returned to inpatient treatment. Use code "9" for all cases where the person is placed on LRA or not committed.

Maximum character length: 1

Codes	Definition
1	CDMHP determined detention during course of investigation per RCW 71.05.340(3)(a).
2	Outpatient provider requested revocation per RCW 71.05.340(3)(b) or RCW 71.34 for kids.
9	N/A.

Where used: CDMHP Investigation

Status: Production	Version: 1.01	ID: 101067

DD: Service Date

Effective Date: 1/1/1998

Definition:
Date a service was provided.

Maximum character length: 8

Format: CCYYMMDD

Where used:
Outpatient Service
HIPAA 837P as <2400> Service Date

Status: Production	Version: 1.01	ID: 101068

DD: Sexual Orientation

Effective Date: 1/1/1998

Definition:
A code that describes a person's voluntarily stated sexual orientation. This code should not be inferred by the clinician. The person should collect the information during assessment, on discharge or upon notification. Do not collect this information from individuals under 13 years of age.

Maximum character length: 1

Code	Definition
1	The person states they are heterosexual.
2	The person states they are gay, lesbian, or bisexual.
9	Unknown/Not voluntarily given by person.

Where used: Consumer Demographics

Status: Production	Version: 1.01	ID: 101033

DD: Social Security Number

Effective Date: 1/1/2000

Definition:
A number assigned by the Social Security Administration which uniquely identifies a person.

Maximum character length: 9

SSN Citing for Federal Regulations:
The collection of SSN is allowed under the following Federal regulations:

42CFR433.138

HCFA State Medical Manual (All Parts)(Pub. 45) SMM15 15802 - Use and Verification of Social Security Number (SSN)

The attempt should be made to collect the SSN whenever possible. The SSN however, may not always available for mental health consumers.

Where used: Consumer Demographics

Status: Production	Version: 1.01	ID: 101071

DD: Surname

Effective Date: 1/1/1998

Definition:
The surname/family/last name of a consumer as provided by an RSN/PHP. In general, follow the rules of the appropriate culture when determining which name is the surname. Consistency is important here because the last name will be used as one element to uniquely identify the person across our system.

Maximum character length: 30 Variable Length

Where used: Consumer Demographics

Status: Production	**Version:** 1.02	**ID:** 101073

DD: Transaction ID

Effective Date: 1/1/2002

Definition:
A code to indicate the type of transaction record to be processed in a batch file.

Maximum character length: 6

Transaction ID	Transaction Title
131.02	Cascade Delete (Full/Partial)
130.02	Cascade Merge
100.01	Case Manager
160.02	CDMHP Investigation
077.02	Clear Month of Service
076.01	Community Hospital Authorization - May be used until HIPAA transaction implementation. Once phased out of service this transaction would only be used for historical data updates.
075.01	Community Hospital Payment Summary - May be used until HIPAA transaction implementation. Once phased out of service this transaction would only be used for historical data updates.
020.04	Consumer Demographics
035.06	Consumer Periodics
011.01	Consumer's Case Manager
000.01	Header
070.04	ET Inpatient Service - Used until phased out and replaced by HIPAA transactions. Once phased out of service this transaction would only be used for pre-HIPAA historical data updates.
162.02	ITA Hearing
120.03	Outpatient Service - Used until phased out and replaced by HIPAA transaction. Once phased out of service this transaction would only be used for pre-HIPAA historical data updates.

120.04	Outpatient Service transaction extracted from HIPAA837P transactions for update of the MHD-CIS SQL databases. Transparent to RSNs except on MHD-CIS transaction reports to indicate the HIPAA 837P source.

Where used: Transactions identified in the previous table.

Status: Production	**Version:** 1	**ID:** 200139

DD: Type of Service Transaction

Effective Date: 1/1/2002

Definition:
Identifies the type of service transactions that are to be removed based on a given month and year.

Maximum character length: 3.

Code	Description
O	OP Services Transactions
ET	E&T Services Transactions
CHA	Community Hospital Authorization Transactions (historical-now phased out
CHB	Community Hospital Payment Summary Transactions (historical-now phased out

Where used: Clear Month of Service

MHD-CIS HIPAA Transactions

Federal Standards – HIPAA Implementation Guides

The National Electronic Data Interchange (ANSI ASC X12N) Transaction Set Implementation Guides for HIPAA has complete specifications for the full HIPAA Transactions which are quite robust in content. The Transaction Guides and their Addendum are the official source for transaction specifications and data definitions. The CIS-MHD Data Dictionary will not attempt to duplicate the information in those guides, rather refer to appropriate sections by the page numbers.

These implementation guides provide standardized data requirements and content for all users of the HIPAA transactions. The purpose of the implementation guide is to expedite the goal of achieving a totally electronic data interchange health encounter/claims processing and payment environment. This implementation guides provides a definitive statement of what data translators must be able to handle. The implementation guides also specify limits and guidance to what a provider (submitter) can place in a transaction. The implementation guides are intended to be compliant with the data standards set out by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its associated rules.

Trading Partner Agreements

It is appropriate and prudent for data exchange partners to have trading partner agreements that go with the standard Implementation Guides. This is because there are 2 levels of scrutiny that all electronic transactions must go through.

First is standards compliance. These requirements MUST be completely described in the Implementation Guides for the standards, and NOT modified by specific trading partners.

Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system? Since this will vary from site to site (e.g., payer to payer), additional documentation which gives information regarding the processing, or adjudication, will prove helpful to each site's trading partners (e.g., providers), and will simplify implementation.

It is important that these trading partner agreements NOT:

- Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide
- Add any additional data elements or segments to this Implementation Guide
- Utilize any code or data values, which are not valid in this Implementation Guide
- Change the meaning or intent of this Implementation Guide

These types of companion documents should exist solely for the purpose of clarification, and should not be required for acceptance of a transaction as valid.

Transaction Detail

Two standard MHD/CIS transactions are being replaced by HIPAA Transactions.

Sub Object	Status	Version	ID
HIPAA 837I replacing ET Inpatient Service	New	1	20001
HIPAA 837P replacing Outpatient Service	New	1	20002

Status: Production	Version: 1	ID: 20001

HIPAA Transaction: 837 Institutional (E&T)

Definition:
This transaction identifies a consumer's stay in an Evaluation and Treatment Facility

Effective Date: 10/17/2003

HIPAA FORMAT – See HIPAA Health Care Claim: Institutional 837 ASC X12N 837 (004010X096), its successors and subsequent HIPAA Transaction Guide Addenda.

- Interchange Control Header
- Functional Group Header
- Transaction Set Header
- Beginning of Hierarchical Transaction
- Transmission Type Identification
    - <1000A> Submitter Name
    - <1000A> Submitter EDI Contact Information
    - <1000B> Receiver Name
        - <2000A> Billing/Pay-To Provider Hierarchical Level
        - <2010AA> Billing Provider Name
        - <2010AA> Billing Provider Address
        - <2010AA> Billing Provider City/State/ZIP
        - <2010AA> Billing Provider Secondary Identification
        - <2010AA> Billing Provider Contact Information
            - <2000B> Subscriber Hierarchical Level
            - <2000B> Subscriber Information
            - <2010BA> Subscriber Name
            - <2010BA> Subscriber Address
            - <2010BA> Subscriber City/State/ZIP Code
            - <2010BA> Subscriber Demographic Information
            - <2010BC> Payer Name
                - <2300> Claim Level Information
                - <2300> Discharge Hour
                - <2300> Statement Dates
                - <2300> Admission Date/Hour
                - <2300> Institutional Claim Code
                - <2300> Principal, Admitting, E-Code, And Patient Reason For Visit Diagnosis Information
                - <2300> Other Diagnosis Information
                - <2310A> Attending Physician Name
                - <2400> Service Line
                - <2400> Institutional Service Line
- Transaction Set Trailer
- Functional Group Trailer
- Interchange Control Trailer

HIPAA TRANSACTION CONTENT – See HIPAA **Health** Care Claim: Institutional 837 ASC X12N 837 (004010X096) or its successor, 837 ADDENDA, and MHD/RSN Trading Partner Agreements.

Note: For the purposes of reporting E&T Inpatient Services not all portions of the HIPAA Transaction will be needed. MHD must be able to accept and process a full transaction however many "loops" (HIPAA term for or specific sets of data) will not be acted upon by MHD and therefore are not necessary to use.

See Appendix A: Trading Partner Agreements

Status: Production	**Version:** 1	**ID:** 20002

HIPAA Transaction: 837 Professional (Outpatient Services)

Definition:
This transaction documents outpatient services for a specific consumer.

Effective Date: 10/17/2003

HIPAA FORMAT – See HIPAA Health Care Claim: Professional 837 ASC X12N 837 (004010X098) its successors and subsequent HIPAA Transaction Guide Addenda.

- Interchange Control Header
- Functional Group Header
- Transaction Set Header
- Beginning of Hierarchical Transaction
- Transmission Type Identification
  - <1000A> Submitter Name
  - <1000A> Submitter EDI Contact Information
  - <1000B> Receiver Name
    - <2000A> Billing/Pay-To Provider Hierarchical Level
    - <2010AA> Billing Provider Name
    - <2010AA> Billing Provider Address
    - <2010AA> Billing Provider City/State/ZIP
    - <2010AA> Billing Provider Secondary Identification
    - <2010AA> Billing Provider Contact Information
      - <2000B> Subscriber Hierarchical Level
      - <2010BA> Subscriber Name
      - <2010BB> Payer Name
        - <2300> Claim Level Information
        - <2300> Prior Authorization or Referral Number
        - <2300> Medical Record Number
        - <2300> Health Diagnosis Code

    - <2400> Service Line
    - <2400> Professional Service
    - <2400> Date - Service Date
    - <2400> Line Item Control Number
    - <2400> Line Note
- Transaction Set Trailer
- Functional Group Trailer
- Interchange Control Trailer

HIPAA TRANSACTION CONTENT – See HIPAA Health Care Claim: Professional 837 ASC X12N 837 (004010X098) or its successor, 837 ADDENDA, and MHD/RSN Trading Partner Agreements.

For the purposes of reporting Outpatient Services not all portions of the HIPAA Transaction will be needed. MHD must be able to accept and process a full transaction however many "loops" (HIPAA term for or specific sets of data) will not be acted upon by MHD and therefore are not necessary to use.

See Appendix A: Trading Partner Agreements

MHD-CIS Native and HIPAA Transaction Submission

MHD will support a computer server site where RSN's may submit each of the transactions described in this Data Dictionary. The site has a number of folders where transaction batches may be placed and error and batch reports may be picked up.

The Data Dictionary is definition rather than procedure oriented. Details on transaction submission requirements, file and folder naming conventions, encryption/security protocols, batch numbering conventions, and other process oriented information are contained in the Trading Partner Agreement Appendix.