Washington State Health Care Authority

Behavioral Health Data System

Behavioral Health Supplemental Transaction Data Guide

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Contents

Summary of Changes 6.1-6.2

- Removed Co-Occurring transaction as a requirement for assessment/intakes (pg. 31).
- Updated MRRCT 165.03 Dispatch Time, Level of Acuity, and Time of Arrival language (pgs. 147, 150, and 155).
- Removed MCR transaction 165.02.
- Updated Appendix F with links to 837 Companion Guide and the Encounter Data Reporting Guide (pg. 190).
- Updated DCR Investigation 160.05 table to reflect a “N” for Return to Inpatient/Revocation Authority (pg.33).
- Updated Peak Use code values 2-4 for the Substance Use transaction 036.04 (pg. 171).

Data Guide

Overview

The Washington State healthcare purchasing mechanism, driven by state law and implemented under federal rules, required the integration of both mental health (MH) and substance use disorder (SUD, also known as chemical dependency) into **a behavioral healthcare model**. This behavioral healthcare model was a first step toward a larger integration of behavioral health services with physical healthcare known as Integrated Managed Care (IMC). These innovative changes, in effect since January 1, 2020, are the impetus for a change from fee-for-service to managed care models for SUD treatment services.

The Behavioral Health Data Consolidation (BHDC) project developed and implemented a combined behavioral healthcare model, ultimately incorporating integrated behavioral health data collection, storage, and supporting reporting functions and substance abuse data collection into a database called the Behavioral Health Data System (BHDS).

The BHDS includes data from two legacy systems:

- The Treatment and Assessment Reports Generation Tool (TARGET), covering SUD clients and services
- The Mental Health Consumer Information System (MH-CIS), covering community mental health clients and services

This data guide contains reporting requirements for the Managed Care Organizations (MCOs), and Behavioral Health Administrative Services Organizations (BH-ASOs) to meet the Health Care Authority's Division of Behavioral Health and Recovery's (DBHR) state and federal reporting requirements related to funding.

This data guide enumerates and explains each of the fields in each of the transactions that are submitted directly to HCA. Contractors are also required to submit both Service Encounters through the ProviderOne Medicaid billing system and the behavioral health supplemental transaction. BHDS will join its data with Service Encounter data and other data sources for analysis and reporting.

This data guide, found on the **HCA contractor and provider resources webpage**, does not address ProviderOne encounter data submission; however, that can be found in the **Service Encounter Reporting Instructions (SERI) guide**.

Terminology guide

The terminology used in this data dictionary is within the context of this data system and may differ between the clinical mental health (MH) and SUD definitions. Definitions are defined in the glossary in the context of this guide.

The database that houses submission of data is referred to as the BHDS, which stands for the **Behavioral Health Data System**. Data submissions to BHDS are referred to as **Behavioral Health Supplemental Transactions**.

The Washington Health Care Authority (HCA) division that receives information is referred to as DBHR, which stands for **Division of Behavioral Health and Recovery**.

The organizations submitting the data to DBHR are referred to collectively as **contractors**, meaning the Behavioral Health Administrative Services Organizations (BH-ASOs), and Managed Care Organizations (MCOs) operating in the IMC regions.

The providers or entities providing services directly to clients in the community are referred to as **provider agencies or agency**. These agencies collect and pass data on to contractor for ultimate submission into the BHDS. The people in the community needing and receiving behavioral health services to include SUD and mental health will be referred to as clients.

There are differences between clinical terms in the mental health and SUD field to describe the same item. An example of this is clinical evaluation of the patient for the purposes of forming a diagnosis and plan of

treatment; in the SUD field this is an *assessment*, but in the mental health field it is an *intake evaluation*. All terminology is defined in the glossary.

Document use guide

To find a data element in this data guide, you can **Ctrl + Click** on the element listed under its corresponding transaction in the Table of Contents. You can return to the table of contents by Ctrl + Click on the link in each header.

Navigation

To easily navigate through a PDF document, open the document in its default PDF reader, press **CTRL + F**. A search box will appear; enter your search term and the first match will be highlighted.

Historic code values

This section defines the list of previously accepted code values that are now disabled for use. Each historic code value table identifies the effective start and end date of the code value that is disabled. If a data element is submitted with a code value that is in the historic table, then the effective date in the transaction must be between the start and end date of the code value.

Nationally accepted Health Information Technology (HIT) code crosswalk

The BHDS data guide contains tables that crosswalks available, nationally accepted Health IT vocabulary codes to data elements in the BHDS. The BHDS will NOT accept data elements submitted using these national vocabulary codes. Rather, the HCA DBHR is making available these crosswalks to support BH providers' use of interoperable health information technology systems and tools. We anticipate that BH providers will increasingly use interoperable HIT systems, including certified electronic health records (EHRs). Certified EHRs required use of certain HIT standards to support interoperability. The goal of HCA DBHR making available these crosswalks is to support BH providers who use certified EHRs to re-use data elements captured in their EHRs and more efficiently create required reports.

The crosswalks link certain BHDS data elements to nationally accepted HIT vocabulary codes required by the Federal Government for use in certified EHRs[1]. The HIT vocabulary code sets referenced in the BHDS Guide are listed and described in Appendix H.

Each data element contains the following information:

Content	Information	Example
Data Element Name	Name of data element	ASAM Level Indicated
Effective Date	Date data element became effective for use	4/1/2017
Category/ Section	This is the transaction that the element is submitted in.	
Return to Table of Contents	Link to Table of Contents	
Definition	Defines what data element pertains to	
Code Values	Defines the list of allowed values, with definition if necessary	Code | Value | Definition

[1] https://www.healthit.gov/isa/

Content	Information	Example
Historical Code Values	Defines the list of previously allowed values that are now disabled for use	Code | Value | Start date | End date
Nationally Accepted HIT Code Crosswalk:	Defines the crosswalk to nationally accepted standards as a reference for HIT interoperability	
Data Use	Defines how data is used	This data is collected for the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Episode Data Set (TEDS) block grant or used for program management.
Field Format	Defines the length, character type, and whether it is an identity value, required, allows nulls, or any other special conditions	
Validation	Lists validations that would cause errors in the data	
History	Lists the date and any changes to the data, including any clarifications	mm/dd/yyyy: Decision to change the data element name from “xxxx” to “yyyy.”
Notes	Any notes not covered in other areas	

General considerations of this guide

Reporting organization

The Managed Care Organizations (MCOs) and Behavioral Health-Administrative Services Organizations (BH-ASOs) are required to collect behavioral health supplemental data transactions from their contracted BH providers of mental health and/or substance use disorder services. Each contractor must work with their provider agency to ensure all service encounters (based on services provided to the individual client) are reported through ProviderOne and all related service information is reported as per this BH Data Guide (e.g., service episode transactions, client demographics, etc.).

The following are not required to submit supplemental data as of this guide's publication:

- Fee-for-Service (FFS)
- Indian Health Care Provider (IHCP), except those IHCPs participating in pilot projects to submit directly to BHDS
- Long-term beds
- Hospitals
- ABA providers
- Individual providers

The following are currently required to submit supplemental data:

- BHAs contracted with BH-ASO or MCO to provide BH services
- Freestanding E&Ts
- Non-hospital secure withdrawal management
- Stabilization facilities

Effective dates

Each supplemental data transaction has a data element that identifies a specific date as it relates to the transaction and the client's current treatment event.

Submitters must use the submitter ID that was active during the date reported in the supplemental data transaction. Not all dates in the supplemental data transactions are identified as "effective dates."

If an assessment/intake evaluation has been completed, HCA will link the encounter (line level) submitted for the completed assessment (SUD) or intake evaluation (MH) to the required supplemental transactions due at assessment/intake.

The "effective date" in the supplemental data transactions must be within 45 days of (before or after) the "from date of service" on the completed assessment/intake encounter.

The purpose of the +/- 45-day requirement for linking the completed assessment/intake encounters and supplemental data is to ensure required supplemental data transactions are submitted to BHDS in a timely and consistent manner for BH services. The combined 90-day (+/-45) date perimeter allows for clinical staff to collect and submit the required supplemental data that corresponds to the behavioral health services the client is receiving. HCA's ability to receive timely BH supplemental data and match it to the service encounters is critical for HCA to meet SAMHSA reporting requirements.

A completed assessment/intake is a service, and it is NOT considered treatment. Assessment/intakes are used to formulate the client's treatment plan so that treatment may be provided to meet the client's needs. If an assessment/intake has been completed, the following transactions are required:

- Client demographic
- Client address
- ASAM

- Funding

Once the client receives their first treatment service, the following transactions are required:

- Service episode
- Client profile
- Program ID
- Substance use

If the assessment/intake has been completed (per the encounter) and client did not return to begin treatment, then only report the supplemental data transactions required for the completed assessment/intake.

Client demographic

- The date indicates when the client's demographic information was collected and is associated with the client's current assessment/intake encounter.
- The client demographic transaction is required to be collected and reported at assessment/intake and updated upon change.
- The client demographic transaction is required before the submission of any other transaction (including crisis supplemental data transactions) to BHDS.
- HCA will match the completed assessment/intake to a Client demographic record in BHDS for reporting purposes.

Client address

- The effective date indicates when the client's address was collected and is associated with the client's current assessment/intake encounter.
- The client address transaction is required to be collected and reported at assessment/intake and updated upon change.
- HCA will match the completed assessment/intake to a Client address record in BHDS for reporting purposes.

ASAM (based on assessment date)

- Indicates the date the client was provided the assessment; this must be within 45 days of (before or after) the "from date of service" on the completed assessment/intake encounter.
- This transaction is not required for completed MH intakes.
- HCA will match the completed assessment/intake to a ASAM record in BHDS for reporting purposes.

Funding (based on effective date)

- The effective date in the funding transaction does not signify the start date of a client's receipt of benefits; rather, it reflects the funding source used for the assessment or intake.
- This transaction's effective date reflects the funding source used for the assessment/intake. If the client's benefit (funding source) changes during treatment, then an updated funding transaction must be submitted to reflect the change.
- The effective date reported on the funding transaction must be within 45 days of (before or after) the "from date of service" reported on the completed assessment/Intake encounter.
- This transaction is collected by the provider agency and indicates the type of funding being used for the client's services.
- HCA will match the completed assessment/intake to a Funding record in BHDS for reporting purposes.

After the assessment/intake evaluation has taken place and the client begins the suggested treatment plan, the first encounter submitted for the client's MH/SUD treatment indicates acceptance into the treatment modality and the start of treatment. The service episode start date is used in reporting as the client's admission date.

HCA will link the client's first SUD/MH treatment encounter to the required supplemental transactions due at the start of SUD/MH treatment. Encounters submitted after the admission (start or beginning) of treatment will indicate ongoing treatment.

Note:

- **At admission** (start of treatment) = First treatment encounter for the client's current treatment episode.
    - Supplemental data transactions required at admission for SUD include the Service Episode, Client Profile, Program ID and Substance Use Transactions. Transactions required at admission for MH include the Service Episode, Client Profile, and Program ID if enrolled in a program in the program ID table.
    - For SAMHSA-reporting purposes, the service episode transaction service episode start date is used as the admission date. Admission in this context is not derived from the Admission Date submitted on the encounter.
- **At discharge** = The client's treatment has ended at the provider agency.
    - The end date in the service episode transaction is the discharge date. The end date must be reported if the client is no longer receiving treatment at the provider agency.
    - Appendix K provides guidance on closing a service episode (treatment episode).
    - If a program ID transaction was submitted because the client is either in SUD treatment or in a program listed in the program ID table, then an end date in the program ID transaction must be reported when the client completes the program. The program ID start and end dates must be between or equal to the service episode start and end dates.
    - A client can be enrolled in more than one program at a time.
    - The service episode end date (discharge date) is required when the client completes or ends treatment at the provider agency.

Service episode (based on begin date)

- The date the client began receiving SUD/MH treatment services at the provider agency is indicated.
- This transaction is required for all clients receiving SUD or MH outpatient treatment.
- A service episode is not required for crisis events; refer to the Summary of Transactions for crisis service requirements.

Client profile (based on effective date)

- The date the information was collected and is associated with the client's current treatment service episode at the provider agency is indicated.
- Client profile is required to be collected and reported at admission (start of treatment), at discharge, and upon change.

Program ID (based on begin date)

- The date the client started treatment in a program listed in the program ID transaction is indicated.
- The program ID transaction is NOT required if the client is enrolled in a program that is not listed in the program ID table. For example, MH outpatient treatment is not a program listed in the program ID table and does not require a program ID transaction. The program ID is required for clients receiving SUD treatment.

Substance use (based on effective date)

- The effective date indicates the data in which information on substance use was collected and associated with the client's current treatment event.
- The substance use transaction shall be collected and reported at admission, at discharge, and upon change.
- This transaction is not required for clients receiving MH treatment.
- The three substances reported at admission into treatment must also be reported at discharge (whether they are still using the substance or not).

Service episodes

The service episode transaction collects treatment milestone data for clients receiving behavioral health services. It is used to meet SAMHSA reporting requirements as well as other outcomes/measures listed in the State Plan.

A service episode is required for all clients receiving SUD treatment, MH outpatient treatment, or is enrolled in a program listed in the program ID table.

A service episode transaction is used to capture the beginning (admission) and end (discharge) of all treatment services (SUD/MH) provided to a client at a behavioral health agency.

For provider agencies providing treatment services to substance use and/or MH clients, an admission (the first treatment encounter or service provided for the condition) is the formal acceptance of a client into treatment at the provider agency. An admission has occurred if the client begins treatment (SUD/MH) at the contracted provider agency. Events such as assessments or intakes are not considered treatment as those services are considered to take place before the admission to treatment.

The service episode transaction can be referred to as an "episode of care" and does not capture every single treatment service provided to the client, but rather the start and end of treatment services at the provider agency for the client's current condition. The service encounters submitted to ProviderOne along with the Program ID supplemental data transaction inform HCA of the individual treatment services a client is receiving between admission and discharge at the contracted provider agency. If a client is discharged (treatment services have ended at the provider agency), and the client returns to the provider agency for treatment, a new service episode must be opened at the first treatment service.

Linking supplemental data to encounter data

HCA will link service encounters, including residential and evaluation and treatment services, to supplemental data transactions using data fields such as the client ID and Billing Provider NPI.

HCA will identify BH encounters using the criteria outlined in the SERI: CPT/HCPC, modifiers and diagnosis codes.

If an assessment/intake evaluation has been completed, HCA will link the encounter submitted for the assessment (SUD) or intake evaluation (MH) to the supplemental transactions required at assessment/intake.

After the assessment/intake evaluation has taken place and the client begins the suggested treatment plan, the initial encounter submitted for the MH/SUD treatment indicates acceptance (admission) into the treatment modality.

The required supplemental data transaction for when a client begins treatment for MH/SUD are described below in the Transaction Definitions/ Summary of Transactions section. Encounters submitted after the beginning of treatment will indicate ongoing treatment.

The treatment modality for either MH or SUD should be reported in the program ID transaction along with the encounter if it is listed in the program ID table. If the program is not listed, do not report the program ID transaction (this would include MH outpatient). A client can be enrolled in more than one program/modality at a

time at a provider agency. When a client completes the program or is no longer receiving treatment for that program/modality the program end date is reported in the program ID transaction along with the end reason.

Upon the ending or completion of the client's treatment plan, the submission for the client's current service episode must include the end date (discharge). This indicates the client is no longer receiving treatment or has completed the episode of treatment at the contracted provider agency.

Data file format

The file specifications are left justified, tab-delimited text files with Windows style row delimiters (Carriage Return/Line Feed CR. LF). The order of elements reported will match the order of elements as prescribed for each transaction in the Transactions and Definitions section of this document. If there are multiple changes to the same record in a file, deletions will be processed first, then they will be processed in the order they appear in the file. Transactions will not process if primary keys are invalid, and/or required elements are left blank.

Transactions will not process without the client demographic transaction successfully processing first. Each transaction will be submitted via MFTP using an account given by HCA.

Key fields

Key fields are unique identifiers for an instance of the transaction. These fields are assigned by the submitter system. For example, the PROGRAM ID KEY field uniquely identifies a client is enrolled in a specific program. A client that is enrolled in the same program two different times would have two different records with two different keys. The key field is used to uniquely identify different instances while avoiding having additional fields such as start date be contained in the primary key. This same concept applies to all fields with key in the field name.

MFTP accounts

On or after March 15, 2023, all submitters must use their MFT accounts.

Each reporting organization will be given two accounts. One is **test** (hca-organizationname-test) and the other is **production** (hca-organizationname). There must be one or two specific individuals accountable for the security of these accounts. These individuals will receive the password reset emails and shall be able to reset passwords for these accounts. These accounts are used to log into the two corresponding MFTP sites (test and prod). Passwords may be updated at the web site (mft.wa.gov or mft-test.wa.gov) or with any MFTP tool to which one is accustomed. Account password resets are to be sent as a service request to HCA service desk by authorized individuals.

Blanks/unknowns/not collected

Please follow any guidance provided in Transactions or Elements regarding the use of "unknown" or leaving fields blank. Even though an element may specify that it is a required element in the summary of transactions it may be listed as optional for a particular treatment.

Add/Change status

- Action code "A" (Add) will only function as an add. If the record already exists in BHDS, the transaction will reject with error code 30405-Duplicate record, transaction not posted.
- Action code "C" (Change) will only function as a change. If the record to change does not exist, BHDS will reject the record with error code 30406- Record to change could not be found, transaction not posted.
- Action code "D" (delete) will continue to function as a delete. If the record does not exist, then BHDS will reject the record with error code 30407- Record to delete could not be found, transaction not posted.

Note: Demographic records may not be deleted directly. *CascadeDelete* or *CascadeMerge* must be used to delete Demographic records. This will also delete child records in other tables to retain the integrity of the system.

Primary Keys cannot be updated. If a primary key was reported incorrectly, the transaction must be deleted and resubmitted with action code A (Add) with the correct information.

Special characters

Please follow any guidance provided in Transactions or Elements regarding the use of special characters. Except when specified, avoid using special characters. BHDS does not allow special characters except Dash (-), Underscore (_), and Period(.).

Appendices

The appendices in this section will contain other information to help understand the data including glossary, error codes, and relationships. A description of each appendix is available on the Appendix page.

Transaction definitions

Summary of transactions

Definition

This section summarizes all the transactions the contractor is required to send to HCA based on the scope of their service delivery.

R = Required, Blank = Not Required

Table heading definitions

Transaction: Name of Behavioral Health Supplemental Transaction

- **Assessment/Intake evaluation**: Transactions required when an Assessment for SUD or Intake Evaluation for MH has been completed.
- **Treatment MH**: Transactions required for clients receiving Mental Health Treatment. These transactions are required when the client begins MH treatment. A MH intake is not considered treatment.
    - *R = Program ID transaction is required for MH treatment if the client is enrolled in a program listed in the program ID table. The program ID transaction is NOT required if the client is enrolled in a program that is not listed in the program ID table. For example, MH outpatient treatment is not a program listed in the program ID table and does not require a program ID transaction.
- **Treatment SUD**: Transactions required for clients receiving Substance Use Disorder Treatment (includes outpatient, intensive outpatient, and all types of residential. These transactions are required when the client begins SUD treatment. An assessment is not considered treatment.
- **Discharge**: These transactions must be updated when the client is discharged, or treatment has ended at the provider agency.
    - *Program End: If the client has completed treatment in the program, they are enrolled in but continues to receive treatment at the provider agency, update the existing program ID transaction with the program end date and end reason. If the client is still receiving treatment services, leave the service episode transaction open until the client's treatment is complete and/or is discharged from the provider agency.
    - *R = Required if the Program ID transaction was reported and the client's enrollment in the program has ended.

Summary of Transactions

Transaction	Assessment/Intake	Treatment		Discharge
		MH	SUD	
Header	R	R	R	
Cascade Delete				
Cascade Merge				
Client Demographic	R			
Client Address	R			
Co-Occurring Disorder				
ASAM Placement	R- For assessments only			
Funding	R			R
Client Profile		R	R	R
Program Identification		*R	R	*R
Service Episode		R	R	R
Substance Use			R	R-For SUD only

Crisis Summary of Transactions

Transaction	DCR	ITA	MCR
Header	R	R	R
Client Demographic	R	R	R
DCR	R	R	
ITA		R	
MCR			R

Header – 000.01

Definition

This transaction is a header and is the first record that goes into the BH supplemental transaction (non 837X12N EDI) batch file. The Header tells what number the batch is, the originator, and the date the file was created.

Transaction ID	000.01	Type	Length	Allow Null
Primary key	Submitter ID	Varchar	20	N
	Batch number	Varchar	5	N
Body	Batch date	Date	CCYYMMDD	N

Rules

- This transaction will not process if the batch date does not have a valid date format or the submitting contractors' ProviderOne ID does not represent a contractor with authority to submit directly to HCA. A blank batch number will generate an error.
- Batch number in header must match batch number in the file name.
- Must submit sequential batch numbers.
- Batch numbers are generated by the contractor.

Validation

Sequential batch number will be validated for integrity and blanks.

Notes

This transaction is required as the first record of each supplemental transaction (non 837X12N EDI) batch file and all batches must be submitted for processing in Batch Number order. There is no action code in this transaction.

Example

000.01<tab>105021301<tab>00001<tab>20160930

Cascade Merge – 130.04

Definition

This transaction will void a Client ID and bar its use in the future. A Client ID is voided when the contractor has established two different identifiers for a single person. The provider agency must identify the Client ID to be voided and identify the Client ID to reference in its place.

Transaction ID	130.04	Type	Length	Allow Null
Primary key	Submitter ID	Varchar	20	N
	Client ID to void	Varchar	20	N
Body	Client ID to keep	Varchar	20	N

Rules

- This transaction will not process if the Client ID TO VOID or CLIENT ID TO KEEP is not valid.
- It will also not process if the Client IDs have been previously voided, or the Client IDs are equal.
- Reports for the voided ID will be displayed under the new ID (the CLIENT ID TO KEEP).

Notes

- There is no action code in this transaction.
- This transaction will void the CLIENT ID TO VOID; the merge will update records to the new CLIENT ID TO KEEP.

Example

130.04<tab> 105021301<tab>Client ID 20chars<tab>Client ID 20chars

Cascade Delete – 131.04

Definition

This transaction allows for the mass deletion of non-encounter records for a given client. This is referred to as a "Full Cascade Delete." Deletes will always delete the record unless the record does not exist, in which case an error message will be returned.

Full Cascade Delete

This type of delete will remove all non-encounter information about a client. Once processed, the Client ID will be voided and not available for future processing. The contractors' administrator may delegate his/her authority to authorize Full Cascade Deletes to someone who maintains their information system.

Transaction ID	131.04	Type	Length	Allow Null
Primary key	Submitter ID	Varchar	20	N
	Client ID (ID to be deleted)	Varchar	20	N

Rules

- The transaction will not process if the Client ID is not valid, or the Client ID has already been voided.

Validation

- Validate that the contractor submitting a Cascade Delete transaction is applied for clients in all BHDS tables.
- Will return an error if the primary key combination is not found in the client demographics table.
- Verify client ID to be deleted was not already voided.

Notes

- There is no action code in this transaction.
- There is no body in this transaction.
- Full Cascade Delete no longer requires prior DBHR approval.

Example

131.04<tab>105021301<tab> Client ID 20chars

Client Demographics – 020.09

View details of transaction

Definition

This is the transaction for full demographic data using the Client Unique ID (CUID). The CUID is used by DBHR to link that person's records across various systems.

Transaction ID	020.09	Type	Length	Allow Null
Action code	"A" Add "C" Change	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Effective date	Date	CCYYMMDD	N
Body	First name	Varchar	35	N
	Middle name	Varchar	25	Y
	Last name	Varchar	60	N
	Alternate last name	Varchar	60	Y
	Social security #	Varchar	9	Y
	Birthdate	Date	CCYYMMDD	N
	Gender	Varchar	2	N
	Hispanic origin	Varchar	3	N
	Primary language	Varchar	3	N
	Race(s)	Varchar	18	N
	Sexual orientation	Varchar	2	N
	Source tracking ID	Varchar	40	Y
	Provider NPI	VARCHAR	10	N

Rules

- The Client demographic transaction is required before the submission of any other transaction to BHDS and must be updated upon change.
- The client demographic transaction is required to be collected and reported at assessment/intake and updated upon change. It is understood that the values in data elements Gender, Hispanic Origin, Primary Language, Race, and Sexual Orientation may change based on what the client reports to each provider agency and the changes will be passed to the BHDS without the provider agency identified.
- The effective date reported on the client demographic transaction must be within 45 days of (before or after) the "from date of service" reported on the completed Assessment/Intake encounter.
- The "Provider NPI" is a required field and must be the same Billing Provider NPI submitted in Loop 2010AA, NM1*85 segment on the corresponding encounter data as it links BHDS and encounter data services.
- The Primary Language is required effective April 04, 2025. If a client demographic transaction is submitted with an effective date >= 04/04/2025 it will reject.

Example

020.09<tab>A<tab>105021301<tab>Client ID 20chars <tab>20160401<tab>JOHN<tab>D<tab> DOE <tab>DOES <tab>1234567890<tab>20000101<tab>02<tab>999<tab>444<tab>999<tab>09<tab> SourceTrackingID 40chars

Client Address – 022.04

View details of transaction

Definition

Client's physical residential address (i.e., where Client lives).

Transaction ID	022.04	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Effective date	Date	CCYYMMDD	N
Body	Address line 1	Varchar	120	N
	Address line 2	Varchar	120	Y
	City	Varchar	50	Y
	County	Varchar	5	Y
	State	Varchar	2	N
	Zip code	Varchar	10	Y
	Facility flag	Varchar	1	N
	Source tracking ID	Varchar	40	Y
	Provider NPI	Varchar	10	N

Rules

- Client address is required to be collected and reported at assessment/intake and updated upon change.
- The effective date reported on the client address transaction must be within 45 days of (before or after) the "from date of service" reported on the completed Assessment/Intake encounter.
- The "Provider NPI" is a required field and must be the same Billing Provider NPI submitted in Loop 2010AA, NM1*85 segment on the corresponding encounter data as it is used to link BHDS and encounter data services.
- The client's address of residency is most preferred.
- If a client's address of residency is not available, then submit the client's mailing address; if mailing is not available, report address elements available; at a minimum report county, city, and state or zip.
- If a client is homeless or unable to provide an address of residency or mailing address, report what is available, including city, county, and state or zip code. In the case of residence in a tent in the woods, report the closest city, county, and state or zip code (or the closest by proximity), but do not report provider agency as the closest proximity.
- Follow detailed instructions for Address Line 1 outlined in Address Line 1 data element.
- If the client is staying at a facility, submit the facility address with the facility flag as Y.
- If the client's address of residency is not in U.S., then all body elements are optional (can be left blank),

except “STATE” must be reported as “OT” for Other.

Example

022.04<tab>A<tab>105021301<tab>Client ID 20chars<tab>20160401<tab>Addr Line 1 120chars<tab>Addr Line 2 120chars<tab>Lacey<tab>53067<tab>WA<tab>Zip 10char<tab>SourceTrackingID 40chars

Client Profile – 035.10

View details of transaction

Definition

Additional client characteristics are required for all clients receiving treatment services at the provider agency.

Transaction ID	035.10	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Provider Agency NPI	Varchar	10	N
	Profile Record Key	Varchar	40	N
Body	Effective Date	Date	CCYYMMDD	N
	Education	Varchar	2	N
	Employment	Varchar	2	N
	Marital status	Varchar	2	N
	Parenting (required for substance use disorder, optional mental health)	Varchar	1	Y
	Pregnant (required for substance use disorder, optional mental health)	Varchar	1	Y
	Smoking status	Varchar	2	N
	Residence	Varchar	2	N
	School attendance	Varchar	1	N
	Self help count (required for substance use disorder, optional mental health)	Varchar	2	N
	Used needle recently (required for substance use disorder, optional mental health)	Varchar	1	N
	Needle use ever (required for substance use disorder, optional mental health)	Varchar	2	N
	Military status	Varchar	2	N
	SMI/SED status	Varchar	2	N
	Source tracking ID	Varchar	40	Y

Rules

- Client profile is required to be collected and reported at admission, at discharge and upon change.

Example

035.10<tab>A<tab>105021301<tab>Client ID 20chars <tab>1234567890 <tab>ProfileRecordKey 40chars <tab>20160401<tab>97<tab>97<tab>97<tab>Y<tab>Y<tab>2<tab>97<tab>Y<tab>97<tab>Y<tab>4<tab>97<tab>

Service Episode – 170.06

View details of transaction

Definition

The service episode transaction collects treatment milestone data for clients receiving behavioral health services. A service episode transaction is used to capture the beginning (admission) and end (discharge) of all treatment services (SUD/MH) provided to a client at a contracted behavioral health agency.

The service episode transaction is used to meet SAMHSA reporting requirements as well as other outcomes/measures listed in the State Plan.

Transaction ID	170.06	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Provider NPI	Varchar	10	N
	Episode record key	Varchar	40	N
Body	Service episode start date	Date	CCYYMMDD	N
	Service episode end date	Date	CCYYMMDD	Y
	Service episode end reason	Varchar	2	Y
	Service referral source	Varchar	2	N
	Date of last client contact	Date	CCYYMMDD	Y
	Date of first appointment offered	Date	CCYYMMDD	N
	Medication-assisted opioid therapy	Varchar	2	N
	Source tracking ID	Varchar	40	Y

Rules

- Service Episode is required to be collected and reported at admission, at discharge and upon change.
- A service episode is required for all clients receiving SUD treatment, MH outpatient treatment, or is enrolled in a program listed in the program ID table.
- Only one service episode transaction at a time may be open for a client at the provider agency.
- Once the treatment has ended or has been completed at the provider agency, the service episode is closed (end date reported). If the client comes back for services, a new service episode can be opened for that treatment episode.

Notes

SUD: If an Enrollee has not actively participated in treatment, HCA recommends closing the service episode after more than 45 days of no contact.

MH: If an Enrollee has not actively participated in treatment, HCA recommends closing the service episode after more than 90 days of no contact.

See Appendix K: Closing Service Episode of Care Guidance

Example

170.06<tab>A<tab>105021301<tab>Client ID 20chars<tab>1234567890<tab>Episode Record Key 40chars<tab>20160501<tab>20160601<tab>02<tab>04<tab>SourceTrackingID 40chars

Program Identification – 060.06

View details of transaction

Definition

The Program Identification transaction indicates the program a client is enrolled as identified in the Program ID element.

Transaction ID	060.06	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Provider NPI	Varchar	10	N
	Program ID key	Varchar	40	N
Body	Program ID	Varchar	3	N
	Program start date	Date	CCYYMMDD	N
	Program end date	Date	CCYYMMDD	Y
	Entry referral source	Varchar	2	Y
	Program end reason	Varchar	2	Y
	Source tracking ID	Varchar	40	Y

Rules

- Program Identification is required to be collected and reported at admission and discharge.
- The program ID transaction is required for all SUD clients and those clients who are enrolled in a program listed in the Program ID table.
- The program ID transaction is NOT required if the client is enrolled in a program that is not listed in the program ID table. For example, MH outpatient treatment is not a program listed in the program ID table and does not require a program ID transaction.
- This transaction will not prevent a client from being in 2 or more different programs at a provider agency or enrolling in programs simultaneously.
- A client can be accepted/enrolled in more than one program at the same provider agency at a time.
- The program start and end dates must be within the client's associated service episode transaction start and end dates.

Example

060.06<tab> A<tab>105021301<tab>Client ID 20chars<tab> 1234567890<tab>ProgramIDKey 40 Char<tab>20160401<tab>20160501<tab>97<tab>97<tab>SourceTrackingID 40chars

Co-Occurring Disorder – 121.05

View details of transaction

Definition

Co-Occurring Disorder and screening assessment/intake.

Transaction ID	121.05	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Provider NP	Varchar	10	N
	Gain-ss date	Date	CCYYMMDD	N
	Screen assessment indicator	Varchar	1	N
Body	Co-occurring disorder screening (IDS) (required, based on value in Screening Assessment Indicator)	Varchar	2	Y
	Co-occurring disorder screening (EDS) (required, based on value in Screening Assessment Indicator)	Varchar	2	Y
	Co-occurring disorder screening (SDS) (required, based on value in Screening Assessment Indicator)	Varchar	2	Y
	Co-occurring disorder assessment (required if the client screens high [2 or higher] on **either** the IDS or EDS, and on SDS)	Varchar	2	Y
	Source tracking ID	Varchar	40	Y

Rules

- This transaction will not process if the values for the CO-OCCURRING DISORDER SCREENING (IDS), CO-OCCURRING DISORDER SCREENING (EDS), CO-OCCURRING DISORDER SCREENING (SDS) or CO-OCCURRING DISORDER ASSESSMENT are missing or invalid.
- The Co-occurring disorder assessment is required if the client screens high (2 or higher) on either the IDS or EDS, and on SDS.

Notes:

- The Co-Occurring transaction is no longer required for BHDS reporting.
- If the transaction is reported, it will continue to be validated.

Example

121.05<tab>A<tab>105021301<tab>Client ID 20chars
<tab>1234567890<tab>20160401<tab>B<tab>9<tab>9<tab>9<tab>9<tab>SourceTrackingID 40chars

ASAM Placement – 030.03

View details of transaction

Definition

The American Society of Addiction Medicine (ASAM) criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with SUD and co-occurring conditions. ASAM Level Indicated means the ASAM Level as scored on the ASAM placement criteria.

Transaction ID	030.03	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Provider NPI	Varchar	10	N
	ASAM record key	Varchar	40	N
Body	ASAM assessment date	Date	CCYYMMDD	N
	ASAM level indicated	Varchar	6	N
	Source tracking ID	Varchar	40	Y

Rules

- ASAM Placement is required to be collected and reported at assessment.
- The ASAM assessment date reported on the ASAM placement transaction must be within 45 days of (before or after) the "from date of service" reported on the completed Assessment/Intake encounter.
- Required for all SUD clients, including SUD clients receiving Withdrawal Management Services where an assessment was provided.
- Must collect and report ASAM when there is a level of care change.

Notes

Refer to Service Encounter Reporting Instructions (SERI) for services that may be provided prior to assessment.

Example

030.03<tab>A<tab>105021301<tab> Client ID 20chars<tab>1234567890<tab>ASAMRecordKey 40chars<tab>20160401<tab>OST<tab>

DCR Investigation – 160.05

View details of transaction

Definition

A Designated Crisis Responder (DCR) is the only person who can perform an Involuntary Treatment Act (ITA) investigation that results in a detention or revocation. A crisis worker who is not a DCR can initiate this investigation but for a detention to take place, it is mandated (RCW 71.05 for adults, RCW 71.34 for children 13 and over) that the DCR investigate and make a determination. Therefore, all investigations reported are derived from the investigation resulting from the findings of a DCR. Do not report investigative findings of the crisis worker unless the crisis worker is also a DCR.

The intent of this transaction is to record DCR investigations only. Activities performed by a DCR including crisis intervention, case management, or other activities, while important are not collected by this transaction. Each contractor determines which specific actions come under an investigation. The DBHR recommended criteria for when a DCR activity becomes an 'investigation' is when the decision to investigate has been made and the DCR reads the person his/her rights. The trigger is reading the person his/her rights.

This transaction identifies all investigations by the DCR, even if the DCR is also classified as a crisis worker. An investigation can result in a detention, which is 120 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.

Transaction ID	160.05	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Investigation start date	Date	CCYYMMDD	N
	Investigation start time	Varchar	4 (HHMM)	N
Body	Investigation county code	Varchar	5	N
	Investigation outcome (*code value from table below)	Varchar	2	N
	Detention facility NPI	Varchar	10	Y
	Legal reason for detention/ commitment (*code value from table below)	Varchar	4	N
	Return to inpatient/revocation authority (*code value from table on DCR Investigation Outcome)	Varchar	2	N
	DCR agency NPI	Varchar	20	N
	Investigation referral source	Varchar	2	N
	Investigation end date	Date	CCYYMMDD	N
	Source tracking ID	Varchar	40	Y

Rules

- DCR Investigation is required to be collected and reported ONLY for persons being investigated under the Involuntary Treatment Act.
- This transaction is to be used to provide more information about a crisis service that resulted in an investigation. An associated crisis intervention encounter, per the “Involuntary Treatment Investigation” service modality, is expected to be received in an “837P transaction.”
- There are some code value dependencies based on the Investigation Outcome (required). Please see the DCR Investigation outcome table to clarify those dependencies.

Example

160.05<tab>A<tab>105021301<tab>Client ID 20chars <tab>20160401<tab>20160601 <tab>53067<tab>23<tab>1234567890<tab>Z<tab>9<tab>1234567890<tab>10<tab>20160701<tab>SourceTrackingID 40chars

ITA Hearing – 162.05

View details of transaction

Definition

This transaction documents each hearing under the Involuntary Treatment Act (ITA) 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 commit, revoke, conditionally release, or dismiss.

It is the responsibility of the contractor, where the investigation occurred, to ensure that if they report an investigation resulting in a detention, where a petition for a hearing also occurred for that client, that the associated ITA Hearing is also reported to DBHR. The ITA Hearing transaction should be submitted by the contractor in which the hearing occurred. This may be different than the contractor who reported the ITA Investigation.

This transaction reporting expectation is within 24 hours of the contractor receiving this information due to the importance of this data. This is an exception to the standard contract terms for data reporting timeliness.

Transaction ID	162.05	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Hearing date	Date	CCYYMMDD	N
Body	Hearing outcome	Varchar	2	N
	Detention facility NPI (same as that used in the DCR Investigation transaction)	Varchar	10	Y
	Hearing county	Varchar	5	N
	Source tracking ID	Varchar	40	Y

Rules

- ITA hearing is required to be collected and reported ONLY for persons being investigated under the Involuntary Treatment Act.
- Hearing outcome code value dependencies for the Detention facility NPI are listed in the details of the ITA hearing outcome table.
- Concurrent Transactions: DCR Investigation 160.05

Example

162.05<tab>A<tab>105021301<tab>Client ID 20chars<tab>20160401
<tab>13<tab>1234567890<tab>53067<tab>SourceTrackingID 40chars

Mobile Rapid Response Crisis Team – 165.03

View details of transaction

Definition

This transaction documents supplemental information for Mobile Rapid Response Crisis Team services.

Transaction ID	165.03	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Mobile Rapid Response Type	Varchar	2	N
	Dispatch Date	Date	CCYYMMDD	N
	Dispatch Time	Varchar	4 (HHMM)	N
Body	Mobile Rapid Response Crisis Team Referral Source	Varchar	2	N
	Level of Acuity	Varchar	2	N
	Interpreter Utilized	Varchar	2	N
	Date of Deployment	Date	CCYYMMDD	Y
	Time of Deployment	Varchar	4 (HHMM)	Y
	Date of Arrival	Date	CCYYMMDD	Y
	Time of Arrival	Varchar	4 (HHMM)	Y
	Presenting Problem	Varchar	40	N
	Law Enforcement and Co-Responder Involvement	Varchar	2	N
	Mobile Rapid Response Crisis Team Outcome	Varchar	2	N
	Referral Given	Varchar	40	N
	Event End Date	Date	CCYYMMDD	N
	Event End Time	Varchar	4 (HHMM)	N
	Source Tracking ID	Varchar	40	Y
	MRRCT Agency NPI	Varchar	10	N
	MRRCT Zip Code	Varchar	5	Y

Rules

- BHDS will continue to accept the Mobile Crisis Response transaction 165.02 version until July 09, 2025.
- If the 165.02 version is submitted with an Event Begin Date equal to or greater than July 10, 2025, it will be rejected.

- The MRRCT 165.03 version must be used if the Dispatch Date is equal or greater than July 10, 2025.

Substance Use – 036.04

View details of transaction

Definition

A client history of substance specific information. This transaction captures substances that the client is currently on and does not include any substances the client may have started during treatment. Updates are allowed if inaccurate information is reported or not disclosed initially by the client and discovered at a later date.

Transaction ID	036.04	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Provider NPI	Varchar	10	N
	Program ID	Varchar	3	N
	Effective date	Date	CCYYMMDD	N
Body	Substance (1)	Varchar	2	N
	Age at first use (1)	Varchar	2	N
	Frequency of use (1)	Varchar	2	N
	Peak use (1)	Varchar	2	N
	Method (1)	Varchar	2	N
	Date last used (1)	Date	CCYYMMDD	N
	Substance (2)	Varchar	2	N
	Age at first use (2)	Varchar	2	N
	Frequency of use (2)	Varchar	2	N
	Peak use (2)	Varchar	2	N
	Method (2)	Varchar	2	N
	Date last used (2)	Date	CCYYMMDD	Y
	Substance (3)	Varchar	2	N
	Age at first use (3)	Varchar	2	N
	Frequency of use (3)	Varchar	2	N
	Peak use (3)	Varchar	2	N
	Method (3)	Varchar	2	N
	Date last used (3)	Date	CCYYMMDD	Y
	Source tracking ID	Varchar	40	Y

Rules

- Substance Use is required to be collected and reported at admission, at discharge and is updated upon change for all SUD clients.
- SUD inpatient Provider Agencies are not exempt from reporting.
- The substances must be ranked by relative importance of seriousness of dependency as provided by the client and determined by the clinician. This rank is represented in the order the substances are reported, with (1) having a higher rank of seriousness than (2) or (3).
- The 3 Substances reported at admission into treatment must also be reported at discharge (whether they are still using the substance).
- The following must be included for each substance being reported:
    - AGE AT FIRST USE (report only at admission into SUD treatment)
    - FREQUENCY OF USE
    - PEAK USE
    - METHOD
    - DATE LAST USED
- Substance (1) cannot be reported as “none” (Code value 1).
- If there is no substance 2 or 3, then report “none” (code 1) for SUBSTANCE (2) and/or SUBSTANCE (3) and leave the respective fields AGE AT FIRST USE, FREQUENCY OF USE, PEAK USE, METHOD and DATE LAST USED blank. Substances 2 and 3 can be updated later if the admission substances were inaccurately reported or not disclosed by the client; however, must be reported consistently (admission to discharge).
- If Substance 2 and 3 are reported, all elements are required, except Source Tracking ID.

Example

036.04<tab>A<tab>105021301<tab>1234567890<tab>Client ID 20chars<tab>58<tab>20160401<tab>21<tab>99<tab>6<tab>6<tab>5<tab>20160501<tab>20<tab>99<tab>6<tab>6<tab>5<tab>20160601<tab>19<tab>99<tab>6<tab>6<tab>5<tab>20160701<tab>SourceTrackingID 40chars

Funding – 140.03

View details of transaction

Definition

This transaction documents the type of funding or support the client has and other funding information.

Transaction ID	140.03	Type	Length	Allow Null
Action code	"A" Add "C" Change "D" Delete	Varchar	1	N
Primary key	Submitter ID	Varchar	20	N
	Client ID	Varchar	20	N
	Effective date	Date	CCYYMMDD	N
	Block grant funding	Varchar	2	N
Body	Type of funding	Varchar	2	N
	Source of income	Varchar	2	N
	Source tracking ID	Varchar	40	Y
	Provider NPI	VARCHAR	10	N

Rules

- Funding is required to be collected and reported at assessment/intake, upon change and discharge.
- The effective date in the funding transaction does not signify the start date of a client's receipt of benefits; rather, it reflects the funding source used for the assessment or intake
- This transaction's effective date reflects the funding source used for the assessment/intake. If the client's benefit (funding source) changes during treatment, then an updated funding transaction must be submitted to reflect that change.
- The effective date reported on the funding transaction must be within 45 days of (before or after) the "from date of service" reported on the completed Assessment/Intake encounter.
- The "Provider NPI" is a required field and must be the same Billing Provider NPI submitted in Loop 2010AA, NM1*85 segment on the corresponding encounter data as it is used to link BHDS and encounter data services.
- The funding transaction is collected and reported by the contracted provider agency.

Example

140.03<tab>A<tab>105021301<tab>Client ID 20chars<tab>CCYYMMDD
<tab>3<tab>3<tab>3<tab>SourceTrackingID 40chars

Data element definitions

Data element definitions are classified into sections.

Identifiers

Submitter ID

Section: Identifier

Definition

The unique identifier assigned to each contractor by ProviderOne. It is the same identifier used for sending 837 encounters to ProviderOne.

Code values not applicable

Rules

- The submitter ID is the 7-digit ProviderOne ID plus the 2-digit location code.

Frequency

- Collected for each record as identifying record information.

Data use

- Identifiers are collected at each transaction as a primary key to differentiate transactions by contractor.

Validation

- Unique by contractor.
- 30201 Inactive Submitter ID for the date in transaction. Transaction not posted. Must use current/active Submitter ID.

Notes

- Submitter ID applies to all contractors.

Client ID

Section: Identifier

Definition

A unique identifier is assigned to each client. The Client ID used in 837 encounter data file submissions to ProviderOne must also be used in the corresponding supplemental data transactions.

Code values not applicable

Rules

- Required for all clients.
- For MCOs: The ProviderOne Client ID submitted on the encounter must also be submitted on the supplemental data transactions. This is the same ProviderOne Client ID used in LOOP_2010BA_NM1_09 on the encounter.
- For BH-ASOs: The ASO unique consumer Client ID submitted on the encounter must also be submitted on the supplemental data transaction. This is the same ASO unique consumer client ID submitted in LOOP_2000B_SBR_03 on the encounter.
- A non-Medicaid Client ID (Unique consumer Client ID) must be unique to the Submitter, regardless of the location identifier.

Frequency

- Collected for each record as identifying record information for a client.

Data use

- Identifiers are collected at each transaction as a primary key to differentiate transactions by clients.
- Used for cascade delete and cascade merge.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Unique by client, by contractor.

Provider NPI

Section: Identifier

Definition

Indicates the billing provider National Provider Identifier (NPI) as obtained through federal registration via ProviderOne. Always submit the Billing Provider NPI unless specifically noted that the servicing (rendering) provider NPI is needed.

Code values not applicable

Rules

- Provider NPI = Billing provider NPI Loop 2010AA, NM1*85 segment.
- The Provider NPI field on BHDS transactions must match the billing provider NPI submitted on ProviderOne encounters in Loop 2010AA, NM1*85 Segment.
- If the servicing provider NPI is required in the BHDS transaction, this is the same NPI that's submitted on ProviderOne encounters in Loop 2310B, NM1*82 segment.
- Will be used to obtain the facility code in ProviderOne (2420c Loop – Service Facility Location Name) – Refer to Appendix for Instructions for submitting Site ID in P1.

Frequency

- The Provider NPI is collected when transactions need to be joined to ProviderOne data for reporting purposes.

Data use

- Provider NPI is used to join BHDS data with ProviderOne encounter data.

Validation

- Must be valid in ProviderOne.

Batch Number

Section: Header

Definition

A sequential number assigned to the batch file by the submitting contractor.

Code values not applicable

Rules

- When the batch number exceeds 99999, the submitting contractor will reset the batch number to 00001.
- Needs to be filled with leading zeros.

Frequency

- Submitted for each transaction as the header to differentiate submissions by contractor.

Data use

- Batch number is for identifying unique batches by contractor.

Validation

- Cannot be blank.
- Required for each submission.
- Must be in sequential order.

Batch Date

Section: Header

Definition

Date a batch file of transactions was created by a submitting contractor.

Frequency

- Submitted for each transaction as the header to differentiate submissions by contractor.

Data use

- Batch identification.

Validation

- Cannot be blank.
- Required for each batch.
- Must be valid date.

Notes

- Batch Number and Batch Date will be the same throughout a single submission.

Cascade Merge

Client ID to Keep

Section: Cascade Merge

Definition

A string of characters that uniquely identifies the referenced client within the system overseen by the contractor and used only in the cascade merge transaction. This Client ID will replace all instances of the “Client ID to Void” within the BHDS system.

Code values not applicable

Rules

- Required for a cascade merge.

Frequency

- Collected for each record as identifying record information for a client.

Data use

- Used for cascade merge.

Validation

- Checks whether ID has been previously voided.

Client ID to Void

Section: Cascade Merge

Definition:

A string of characters that uniquely identifies the referenced client within the system overseen by the MCO and used only in the cascade merge transaction. This will be replaced by the “Client ID to Keep” in all instances of the Client ID within the BHDS system. It will be permanently voided and disallowed for all future transactions.

Code values not applicable

Rules

- Required for a cascade merge.

Frequency

- Collected for each record as identifying record information for a client.

Data use

- Used for cascade merge.

Validation

- Checks whether ID has been previously voided.

Source Tracking ID

Section: All Transactions

Definition

This field is found in all transactions and indicates the record ID from the source system for subcontractors to reconcile data to their systems. This is a field and was added at the request of the contractor.

Code values not applicable

Rules

- Does not allow special characters except Dash (-), Underscore (_), and Period(.).

Frequency

- Collected for each record as identifying record information for a record in the subcontractor's source system.

Data use

- Reconcile data to subcontractors' systems.

Validation

- No validation exists in this element.

Client Demographics 020.09

First name

Section: Client Demographics

Definition

Indicates the first/informal names of a client as provided by the contractor. Consistency is important, as the last name and first names are both used as elements to uniquely identify the person across the system.

Code values not applicable

Rules

- Required for all clients.

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Required field.

Middle Name

Section: Client Demographics

Definition

Indicates the full middle name of the client. Use the full middle name if available, otherwise use the middle initial.

Code values not applicable

Rules

- If no middle name or initial is available, leave blank.

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- None.

Last Name

Section: Client Demographics

Definition

Indicates the surname/family/last name of a client as provided by a contractor. Consistency is important here, because the last name and first names are both used as elements to uniquely identify the person across the system.

Code values not applicable

Rules

- Required for all clients.
- Both apostrophes and hyphens are allowed.

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Required field.

Alternate Last Name

Section: Client Demographics

Definition:

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

Code values not applicable

Rules

- Collect if client has an alternate last name for all clients.
- If client has multiple alternate last names, choose one.
- If client has no alternate last name leave blank, do not enter “same as above”, “none”, “N/A”, etc.
- Both apostrophes and hyphens are allowed.

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) – Treatment Episode Data Set (TEDS) Reporting.

Validation

- None.

Social Security Number

Section: Client Demographics

Definition:

A number assigned by the Social Security Administration that identifies a client.

Code values not applicable

Rules

- Collect for all clients when possible.
- Leave blank if unknown or refused.
- Must be a valid Social Security Number.

Frequency

- Whenever possible or upon change

Data use

- Identify the client.
- De-duplication of clients – identifying clients who have the same name but are different people.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Does not allow obvious invalid number such as:
  - 9 digits of the same number.
  - 9 sequential ascending or descending numbers.
- Must be 9 characters in length.

Birthdate

Section: Client Demographics

Definition

Indicates the date of birth (DOB) of the client.

Code values not applicable

Rules

- If DOB is not available, enter 29991231.

Data use

- Used to derive the client's age.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Cannot be blank.
- Required for client demographics transaction.
- Must be valid date, not in the future, or if not available enter 29991231.

Gender

Section: Client Demographics

Definition

Indicates a person's self-identified gender.

Code values:

Code	Value	Definition
1	Female	
2	Male	
4	Transgender	Gender identity differs from the sex they were assigned at birth
5	Intersex	Person born with characteristics of both
7	Transgender female	Designated male at birth but identifies as female: Code as male
8	Transgender male	Designated female at birth but identifies as male: Code as female
97	Unknown	Unknown
98	Refused	Person refused to answer

Historical code values

None.

Nationally accepted HIT code crosswalk

Value	SNOMED CT®	SNOMED Comment	HL7 Version 3	HL7 Comment
Female	446141000124107	Female		
Male	446151000124109	Male		
Transgender				
Intersex				
Transgender female	407376001	Male-to-Female (MTF)/Transgender Female/Trans Woman.		
Transgender male	407377005	Female-to-Male (FTM)/Transgender Male/Trans Man.		
Unknown				
Refused			ASKU	Choose not to disclose

Rules

- Only one option allowed.
- Required for all clients.

Data use

- Community Mental Health Services Block Grant (MHBG).

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Cannot be blank.
- Required for client demographics transaction.
- Must be valid code.

Notes

- In a more limited list that only includes male, female, or unknown, transgender male would be coded as female, and transgender female would be coded as male.

Hispanic Origin

Section: Client Demographics

Definition

Indicates the Hispanic origin the client associates with (e.g., Mexican, Puerto Rican, Cuban, Central American, or South American, or other Spanish origin or descent, regardless of race). Hispanic denotes a place of origin or cultural affiliation rather than a race (i.e., a person can be both white and Hispanic or black and Hispanic and so on).

Code values

Code	Value
709	Cuban
000	Hispanic - Specific Origin Unknown
722	Mexican
998	Not of Hispanic Origin
799	Other Specific Hispanic (e.g., Chilean, Salvadoran, Uruguayan)
727	Puerto Rican
999	Unknown

Historical code values

None.

Nationally accepted HIT code crosswalk:

Value	CDC/PHIN	CDC Comment
Cuban	2182-4	Cuban
Hispanic - Specific Origin Unknown	2135-2	Hispanic or Latino
Mexican	2148-5	Mexican
Not of Hispanic Origin	2186-5	Not Hispanic or Latino
Other Specific Hispanic (e.g., Chilean, Salvadoran, Uruguayan)	Specific Hispanic codes	
Puerto Rican	2180-8	Puerto Rican
Unknown		

Rules

- Only one option allowed.
- Required for all clients.

Data use

- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Cannot be blank.
- Required for client demographics transaction.
- Must be valid code.

Primary Language

Section: Client Demographics

Definition

Indicates the primary speaking language of the client as used in the home, even if that language is English.

Code values

See Appendix G.

Rules

- Only one option allowed.
- Required for all clients.
- Submit “eng” if the primary speaking language of the client is English.

Data use

- Community Mental Health Services Block Grant (MHBG).

Validation

- Must be valid code.
- The Primary Language is required effective April 04, 2025. If a client demographic transaction is submitted with an effective date >= 04/04/2025 it will reject.

Notes

- Source for ProviderOne language list.
- Primary language is contained in Appendix G.

Race(s)

Section: Client Demographics

Definition

Indicates the race(s) the client identifies as. Race categories are based on the US Department of Health and Human Services implementation collection standards for race and ethnicity with the addition of 3 categories: Cambodian, Laotian, and Middle Eastern.

Code values

Code	Value
021	American Indian/ Alaskan Native
031	Asian Indian
040	Black or African American
604	Cambodian
605	Chinese
608	Filipino
660	Guamanian or Chamorro
032	Native Hawaiian
611	Japanese
010	White
612	Korean
613	Laotian
801	Middle Eastern
034	Other Asian
033	Other Pacific Islander
050	Other Race
999	Not Provided

Historical code values

None.

Nationally accepted HIT code crosswalk

Value	CDC/PHIN	CDC Comment	OMB	OMB Comment
American Indian/ Alaskan Native	1735-0 1002-5 1004-1	Alaskan Native – 1735-0 American Indian/ Alaskan Native – 1002-5 American Indian – 1004-1	1002-5	American Indian/ Alaskan Native

Value	CDC/PHIN	CDC Comment	OMB	OMB Comment
Asian Indian	2029-7	Asian Indian	2028-9	Asian
Black or African American	2058-6	African American	2054-5	Black or African American
Cambodian	2033-9	Cambodian	2028-9	Asian
Chinese	2034-7	Chinese	2028-9	Asian
Filipino	2036-2	Filipino	2076-08	Native Hawaiian or other Pacific Islander
Guamanian or Chamorro	2086-7	Guamanian or Chamorro	2076-08	Native Hawaiian or other Pacific Islander
Native Hawaiian	2079-2 2076-8	Native Hawaiian – 2079-2 Native Hawaiian or other Pacific Islander – 2076-8	2076-08	Native Hawaiian or other Pacific Islander
Japanese	2039-6	Japanese	2028-9	Asian
White	2106-3	White	2106-3	White
Korean	2040-4	Korean	2028-9	Asian
Laotian	2041-2	Laotian	2028-9	Asian
Middle Eastern	2118-8	Middle Eastern or North African		
Other Asian	2028-9	Asian	2028-9	Asian
Other Pacific Islander	2500-7 2076-8	Other Pacific Islander – 2500-7 Native Hawaiian or other Pacific Islander – 2076-8	2076-08	Native Hawaiian or other Pacific Islander
Other Race	2131-1	Other Race		
Unknown				

Rules

- Select one or more categories, if a person selects more than 1 code, enter each one in sequence.
- If client does not identify with any of the listed races, then code “050” for Other Race.
- If information is not available or unknown, then code “999”.
- Data submitted must be a multiple of 3 and up to 6 race codes can be submitted.

Data use

- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) – Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code(s).

Sexual Orientation

Section: Client Demographics

Definition

Indicates a client's voluntarily stated sexual orientation.

Code values

Code	Value	Definition
1	Heterosexual	Attraction to persons of the opposite sex
3	Gay/Lesbian/Queer/Homosexual	Attraction to persons of the same sex.
4	Bisexual	Term for women and men whose sexual/affectional identity is oriented to members of both the same and opposite sex.
5	Questioning	Term generally used for adolescents who may be in the process of becoming more comfortable with their sexual orientation identification. Usually describes a youth who may be exploring identifying as gay/lesbian in a culture that generally assumes identification as heterosexual.
9	Choosing not to disclose	Use when an individual is uncomfortable or unwilling to disclose their sexual orientation.

Historical code values

None.

Rules

- Only one option allowed.
- Required for all clients.
- Do not collect for individuals under age 13, instead report 9-Choosing not to disclose.
- If an assessment occurs and age is 13 and over, 9- Choosing not to disclose is an acceptable response.

Data use

- Community Mental Health Services Block Grant (MHBG)
- Substance Abuse Prevention and Treatment Block Grant (SABG) – Treatment Episode Data Set (TEDS) Reporting

Validation

- Cannot be blank.
- Must be valid code.

Client Address 022.04

Address line 1

Section: Client Address

Definition

Indicates the street address where the client currently resides.

Code values not applicable

Rules

- Required for all clients.
- Use US Postal Addressing Standards for the address.
- If unknown, write “unknown” in this field (ADDRESS LINE 1). Do not put unknown in any of the other Address fields, leave them blank.
- If address of residency is not available, then submit the client’s mailing address; if mailing is not available, report address elements available; at a minimum, report county and city.
- If the client is homeless or unable to provide a physical street address, report what is available, and must include the city, county and state or zip code. In the case of residence in a tent in the woods, report the closest city, county, and state or zip code (or the closest by proximity), but do not report provider agency as the closest proximity.

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) – Treatment Episode Data Set (TEDS) Reporting.
- Reports for legislature.
- Program evaluation.

Validation

- None.

Address Line 2

Section: Client Address

Definition

Indicates the continuation of the street address where the client currently resides.

Code values not applicable

Rules

- Use US Postal Addressing Standards for the address.
- If unknown, write “unknown” in the (ADDRESS LINE 1) field. Do not put unknown in any of the other Address fields including this one, rather keep the rest of the Address fields blank.
- If address of residency is not available, then submit the client’s mailing address; if mailing is not available, report address elements available; at a minimum report county and city.
- If the client is homeless or unable to provide a physical street address, report what is available, and must include the city, county and state or zip code. In the case of residence in a tent in the woods, report the closest city, county, and state or zip code (or the closest by proximity), but do not report provider agency as the closest proximity.

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.
- Reports for legislature.
- Program evaluation.

Validation

- None.

City

Section: Client Address

Definition

Indicates the client's current city of residence.

Code values not applicable

Rules

- If a client is homeless or unable to provide a physical street address, report what is available, and must include city, county and state or zip code. In the case of residence in a tent in the woods, report closest city, county, and state or zip code (or the closest by proximity), but do not report provider agency as the closest proximity.

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.
- Reports for legislature.
- Program evaluation.

Validation

- None.

County

Section: Client Address

Definition

Indicates the county where the client currently resides.

Code values

Code	Value
53001	Adams
53003	Asotin
53005	Benton
53007	Chelan
53009	Clallam
53011	Clark
53013	Columbia
53015	Cowlitz
53017	Douglas
53019	Ferry
53021	Franklin
53023	Garfield
53025	Grant
53027	Grays Harbor
53029	Island
53031	Jefferson
53033	King
53035	Kitsap
53037	Kittitas
53039	Klickitat
53041	Lewis
53043	Lincoln
53045	Mason
53047	Okanogan
53049	Pacific
53051	Pend Oreille
53053	Pierce
53055	San Juan
53057	Skagit
53059	Skamania
53061	Snohomish
53063	Spokane
53065	Stevens
53067	Thurston
53069	Wahkiakum
53071	Walla Walla
53073	Whatcom
53075	Whitman
53077	Yakima
40050	Unknown or out of state

Historical code values

None.

Rules

- If a client is homeless or unable to provide a physical street address, report what is available, and must include city, county, and state or zip code. In the case of residence in a tent in the woods, report closest city, county, and state or zip code (or the closest by proximity), but do not report provider agency as the closest proximity.

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.
- Reports for legislature.
- Program evaluation.

Validation

- Must be a valid code.
- If the client is from out of state, must use code value 40050 for county.

State

Section: Client Address

Definition

Indicates the US postal service standard two-letter abbreviation of the state where the client currently resides.

Code values

Code	Value
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
District of Columbia	DC
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Military Address	AA
Minnesota	MN
Mississippi	MS
Missouri	MO

Code	Value
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Puerto Rico	PR
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
Wisconsin	WI
Wyoming	WY
West Virginia	WV
Unknown	XX

Code	Value
Other Country	OT

Historical code values

None.

Rules

- Use US Postal Addressing Standards for the address.
- Required for all clients.
- If the client's address of residency is not available, then submit the client's mailing address; if mailing is not available, report address elements available; at a minimum report county and city.
- If the client is homeless or unable to provide a street address, report what is available, including the city, state, or zip code. In the case of residence in a tent in the woods, report the closest city, state, or zip code (or the closest by proximity), but do not report provider agency as the closest proximity.
- For addresses from other countries select OT and other address field elements can be left blank.

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be a valid code.

Zip Code

Section: Client Address

Definition

Indicates the client's zip code of the area of residency.

Code values not applicable

Rules

- Use US Postal Addressing Standards for the address.
- If the client is homeless or unable to provide a street address, report what is available, including the city, state, or zip code. In the case of residence in a tent in the woods, report the closest city, state, or zip code (or the closest by proximity).

Data use

- Identify the client.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be a valid 5-digit zip code.

Facility Flag

Section: Client Address

Definition

This element is a flag to denote if the client is staying at a facility, submit the facility address with the facility flag as Y.

Code values

Code	Value
Y	Yes
N	No

Historical code values

None.

Rules

- Only use if the client does not have a home address to denote that the address is a facility.

Data use

- Identify the facility.
- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG).

Validation

- None.

Client Profile 035.10

Profile Record Key

Section: Client profile

Definition

This is the primary key for the profile record. This is created uniquely by client and by provider agency.

Code values not applicable

Rules

- Required for all clients.

Validation

- Does not allow special characters except Dash (-), Underscore (_), and Period(.).

Education

Section: Client Profile

Definition

Indicates the client's highest level of education achieved.

Code values

Code	Value
1	No formal schooling
2	Nursery school, pre-school, head start
3	Kindergarten, less than one school grade
4	Grade 1
5	Grade 2
6	Grade 3
7	Grade 4
8	Grade 5
9	Grade 6
10	Grade 7
11	Grade 8
12	Grade 9
13	Grade 10
14	Grade 11
15	Grade 12
16	High School Diploma or GED
17	1st Year of College/University (Freshman)
18	2nd Year of College/University (Sophomore) or Associate Degree
19	3rd Year of College/University (Junior)
20	4th Year of College (Senior)
21	Bachelor's Degree
22	Graduate or professional school - includes Master's and Doctoral degrees, medical school, law school, etc.
23	Vocational School – includes business, technical, secretarial, trade, or correspondence courses, which provide specialized training for skilled employment.
97	Unknown

Nationally accepted HIT code crosswalk

Value	LOINC® Answer ID	LOINC Comment
No formal schooling	LA15606-9	Never attended/kindergarten only
Nursery school, pre-school, head start	LA19748-5	
Kindergarten, less than one school grade	LA15606-9	Never attended/kindergarten only
Grade 1	LA15607-7	Grade 1
Grade 2	LA15608-5	Grade 2
Grade 3	LA15609-3	Grade 3
Grade 4	LA15610-1	Grade 4
Grade 5	LA15611-9	Grade 5
Grade 6	LA15612-7	Grade 6
Grade 7	LA15613-5	Grade 7
Grade 8	LA15614-3	Grade 8
Grade 9	LA15615-0	Grade 9
Grade 10	LA15616-8	Grade 10
Grade 11	LA15617-6	Grade 11
Grade 12	LA15618-4	12th grade, no diploma
High school diploma or GED	LA15564-0 LA15619-2	High school graduate - LA15564-0 GED or equivalent - LA15619-2
1st Year of College/University (Freshman)	LA15620-0	Some college, no degree
2nd Year of College/University (Sophomore) or associate degree	LA15622-6 LA15620-0	Associate degree: academic program - LA15622-6 Some college, no degree LA15620-0
3rd Year of College/University (Junior)	LA15620-0	Some college, no degree
4th Year of College (Senior)	LA15620-0	Some college, no degree
Bachelor's Degree	LA12460-4	Bachelor's degree (e.g., BA, AB, BS)
Graduate or professional school - includes master's and Doctoral degrees, medical school, law school, etc.	LA12461-2 LA15625-9 LA15626-7	Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) - LA12461-2 Professional school degree (example: MD, DDS, DVM, JD) - LA15625-9 Doctoral degree (example: PhD, EdD) - LA15626-7

Vocational School – includes business, technical, secretarial, trade, or correspondence courses, which provide specialized training for skilled employment	LA15621-8	Associate degree: occupational, technical, or vocational program
Unknown	LA12688-0	Don't know

LOINC answer list

Rules

- Only one option allowed.
- Required for all clients.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.

Notes

- If the client is in the 11th grade, then the highest level of education achieved is 10th grade.
- If the client has completed the 12th grade but did not receive a high school diploma or GED, then the highest level achieved (completed) is code value 15 (12th grade).

Employment

Section: Client Profile

Definition

Indicates the client's current employment or primary daily activity as per Washington Administrative Code 458-20-267. If the client engages in multiple employment or daily activities, report the highest level of employment or activity.

Code values

Code	Value	Definition
01	Full time – works at least 35 hours per week; includes members of the Armed Forces, and clients in full-time Supported Employment	
02	Part time– works less than 35 hours per week; includes clients in part- time Supported Employment	
03	Unemployed – defined as actively looking for work or laid off from job (and awaiting to be recalled) in the past 30 days	
05	Employed – full time/part time – full time or part time status cannot be ascertained	

Use the appropriate valid code for the specified classification of a person who is 'Not in the Labor Force,' defined as not employed and not actively looking for work during the past 30 days (i.e., people not interested to work or people who have been discouraged to look for work).

Code	Value	Definition
14	Homemaker	
24	Student	
34	Retired	
44	Disabled	
64	Other reported classification	E.g., volunteers
74	Sheltered/non-competitive employment	
84	Not in the labor force-classification not specified	
96	Not applicable	
97	Unknown	
98	Not collected	

Historical code values

None.

Rules

- Required for all clients.
- "Highest level of employment or activity" corresponds to the value code (i.e., code 01, FULL TIME is a higher level than code 02, PART TIME).

- Only use Code 98 (NOT COLLECTED) if unable to collect because crisis phone service or pre-intake service was provided.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.
- Community Mental Health Services Block Grant (MHBG).
- State reporting.

Validation

- Must be valid code.

Marital Status

Section: Client Profile

Definition

Indicates the current marital status of the client.

Code values

Code	Value	Definition
1	Single or never married	Includes clients who are single or whose only marriage was annulled
2	Now married or committed relationship	Includes married couples, those living together as married, living with partners, or cohabiting
3	Separated	Includes married clients legally separated or otherwise absent from spouse because of marital discord
4	Divorced	Includes clients who are not in a relationship and whose last relationship was a marriage dissolved by judicial declaration
5	Widowed	Includes clients who are not in a relationship and whose last relationship was a marriage and their spouse died.
97	Unknown	Unknown

Historical code values

None.

Nationally accepted HIT code crosswalk

Value	LOINC® Answer ID	LOINC Comment
Single or never married	LA47-6	Never Married
Now married or committed relationship	LA48-4	Married
Separated	LA4288-2	Separated
Divorced	LA51-8	Divorced
Widowed	LA49-2	Widowed
Unknown	LA12688-0	Don’t know

LOINC social connection and isolation panel

Rules

- Only one option allowed.
- Required for all clients.
- Must be a valid code.

Parenting

Section: Client Profile

Definition

Indicates whether a client has dependent children. Dependent children are defined as less than 18 years of age. “Parenting” indicates some form or level of custodial or child support responsibility (i.e., part-time custody or when there is not custody, but parent pays child support).

Code values

Code	Value	Definition
Y	Yes	Client has some level of custodial or child support responsibility
N	No	Client does not have some level of custodial or child support responsibility
U	Unknown	Unknown
R	Refused to answer	Refused to answer

Historical code values

None.

Rules

- Only one option allowed.
- Currently required for female substance use disorder clients only, optional for all other clients. However, per DBHR, parenting is not female-specific and thus this rule is subject to change.

Validation

- Must be valid code.

Pregnant

Section: Client Profile

Definition

Indicates whether a client is pregnant.

Code values

Code	Value
Y	Yes
N	No
U	Unknown
R	Refused to answer

Historical code values:

None.

Nationally accepted HIT code crosswalk

Value	LOINC® Answer ID	LOINC Comment
Yes	LA15173-0	Pregnant
No	LA26683-5	Not pregnant
Unknown	LA4489-6	Unknown
Refused to answer		

LOINC pregnancy status

Rules

- Only one option allowed.
- Required for female substance use disorder clients only.
- Optional for mental health clients.

Data use

- Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.

Smoking Status

Section: Client Profile

Definition

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

Code values

Code	Value
1	Current smoker
2	Former smoker
3	Never smoked
97	Unknown
98	Refused to answer

Historical code values

None.

Nationally accepted HIT code crosswalk

Value	LOINC® Answer ID	LOINC Comment
Current smoker	LA18976-3 LA18977-1	Current every day smoker - LA18976-3 Current some day smoker - LA18977-1
Former smoker	LA15920-4	Former smoker
Never smoked	LA18978-9	Never smoker
Unknown	LA18980-5	Unknown if ever smoked
Refused to answer		

LOINC tobacco smoking status

Rules

- Only one option allowed.
- Required for all clients.

Validation

- Must be valid code.

Residence

Section: Client profile

Definition

Indicates client's primary residence over the last 30 days preceding date of collection.

Code values

Code	Value	Definition
1	Homeless without housing	Individual primarily resides “on the street” or in a homeless shelter.
2	Foster home/ foster care	Individual resides in a foster home. A foster home is a home that is licensed by a county or State department to provide foster care to children, adolescents, and/or adults. This includes therapeutic foster care facilities. Therapeutic foster care is a service that provides treatment for troubled children within private homes of trained families.
3	Residential care	Individual resides in a residential care facility. This level of care may include a group home, therapeutic group home, board and care, residential treatment, rehabilitation center, or agency-operated residential care facilities.
4	Crisis residence	A time-limited residential (24 hours/day) stabilization program that delivers services for acute symptom reduction and restores clients to a pre-crisis level of functioning.
5	Institutional setting	Individual resides in an institutional care facility with care provided on a 24 hour, 7 days a week basis. This level of care may include skilled nursing/ intermediate care facility, nursing homes, institute of mental disease (IMD), inpatient psychiatric hospital, psychiatric health facility, veterans’ affairs hospital, or state hospital.
6	Jail/correctional facility	Individual resides in a jail and/or correctional facility with care provided on a 24 hour, 7 days a week basis. This includes a jail, correctional facility, detention centers, and prison.
7	Private residence	For adults only: this category reflects the living arrangement of adult clients where “independent”/” dependent” status is unknown. Otherwise, use “independent living”/” dependent living” as appropriate.
8	Independent living	For adults only: this category describes adult clients living independently in a private residence and capable of self-care. It includes clients who live independently with case management support or with supported housing supports. This category also includes clients who are largely independent and choose to live with others for reasons not related to mental illness. They may live with friends, spouse, or other family members. The reasons for shared housing could include personal choice related to culture and/or financial considerations.
9	Dependent living	For adults only: this category describes adult clients living in a house, apartment, or other similar dwellings and are heavily dependent on others for daily living assistance

Code	Value	Definition
10	Private residence	For children only – use this code for all children living in a private residence regardless of living arrangement.
11	Other residential status	
12	Homeless with housing	Individual does not have a fixed regular nighttime residence and typically stays ("couch surfs") at the home of family or friends.
97	Unknown	

Historical code values

None.

Rules

- Only one option allowed.
- Required for all clients.
- Use "Unknown" if a particular situation does not fit in one of the categories.
- Codes for "PRIVATE RESIDENCE – adult only", "DEPENDENT LIVING", and "INDEPENDENT LIVING" should be used for adult clients only (age 18 and over).
- Children / Adults who live in family foster homes and therapeutic foster homes should use "FOSTER HOME/FOSTER CARE" and NOT "PRIVATE RESIDENCE".
- Indicates where the client was for the majority of the time in the preceding 30 days. It is optional to report this element on a more frequent basis to capture a change in residence.

Validation

- Must be valid code.

School Attendance

Section: Client profile

Definition

Indicates if the client has attended any form of school within the last 3 months.

Code values

Code	Value	Definition
Y	Yes	Client has attended school at any time in the past 3 months
N	No	Client has not attended school at any time in the past 3 months
U	Unknown	Unknown
R	Refused to answer	Refused to answer

Historical code values

None.

Rules

- Only one option allowed.
- Required for all clients.

Validation

- Must be valid code.

Self-Help Count

Section: Client profile

Definition

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

Code values

Code	Value
1	No attendance
2	Less than once a week
3	About once a week
4	2 to 3 times per week
5	At least 4 times a week
97	Unknown
6	Not collected

Historical code values

None.

Rules

- Only one option allowed.
- Required for substance use disorder, optional for mental health clients.
- For admission records, the reference period is specific to the 30 days prior to admission.
- For discharge records, the reference period is specific to the 30 days prior to discharge.

Data use

- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.

Used Needle Recently

Section: Client profile

Definition

Indicates if the client has injected illicit or unprescribed drugs in the last 30 days.

Code values

Code	Value
Y	Yes
N	No
U	Unknown
R	Refused to answer

Historical code values

None.

Rules

- Only one option allowed.
- Required for substance use clients, optional for mental health.

Validation

- Must be valid code.

Needle Use Ever

Section: Client profile

Definition

Indicates if the client has ever used needles to inject illicit or unprescribed drugs.

Code values

Code	Value
1	Continuously
2	Intermittently
3	Rarely
4	Never
97	Unknown
98	Refused to answer

Historical code values

None.

Rules

- Only one option allowed.
- Required field for all substance use disorder clients, optional for mental health clients.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG).
- Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.

Military Status

Section: Client profile

Definition

Indicates if the client has ever served as an active member in the U.S. military.

Code values

Code	Value
1	Yes
2	No
3	Refuse
4	Unknown

Historical code values

None.

Rules

- Only one option allowed.
- Required for all clients.
- Report code 1 (Yes) regardless of length of service or if the client was dishonorably discharged.

Data use

- Community Mental Health Services Block Grant (MHBG).
- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.

SMI/SED Status

Section: Client profile

Definition

Indicates whether the client has serious mental illness (SMI) or serious emotional disturbance (SED) using the state definition. Use the most recent available status at the end of the reporting period.

Serious Mental Illness (SMI): Pursuant to section 1912(c) of the Public Health Service Act, adults with serious mental illness SMI are persons: (1) age 18 and over and (2) who currently have, or at any time during the past year had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. (3) That has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. Federal Register Volume 58 No. 96 published Thursday May 20, 1993, pages 29422 through 29425.

Serious Emotional Disturbance (SED): Pursuant to section 1912(c) of the Public Health Service Act "children with a serious emotional disturbance" are persons: (1) from birth up to age 18 and (2) who currently have, or at any time during the last year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425.

Note: The above definitions are the current Federal definitions. HCA expects that contractors and their providers will use the appropriate DSM 5, DC:0-5 and/or ICD 10 diagnostic coding conventions.

Code values

Code	Value	Definition
1	SMI	
2	SED	
3	At risk for SED	Optional
4	Not SMI or SED	
97	Unknown	Individual client value is unknown
98	Not collected	Field is not collected

Rules

- Community-based and state hospital or other inpatient populations
- Required for all clients.
- Use code 4 (Not SMI or SED) if the client has not been found eligible for SMI or SED services.
- Use code 97 (Unknown) for a client undergoing evaluation for SMI or SED eligibility pending any decision.

Data use

- SAMHSA MH-CLD Field Number C-08.

Validation

- May not contain NULL/BLANK values.
- When the client's age is 17 years or younger, code 1 cannot be used.

- When the client's age is 18 years or older, code 2 and 3 cannot be used. Exception: codes 2 or 3 may be used for young adults, 18-21 years old, who are protected under the IDEA and continue to receive mental health services from the state's children mental health system.
- When MHBG Funded Services = 1, SMI/SED Status (C-08) must either = 1 or 2.

Service Episode 170.06

Episode Record Key

Section: Service episode

Definition

This field is used to uniquely identify a client's service episode transaction. This field allows contractors to correctly identify and update the client's current service episode transaction.

Code values not applicable

Rules

- Required for all clients.
- Must be unique for each transaction. Only one service episode can be open per client/provider agency.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.
- Does not allow special characters except Dash (-), Underscore (_), and Period(.).

Service Episode Start Date

Section: Service episode

Definition

Indicates the date the client began receiving SUD/MH treatment at the provider agency. The service episode start date is considered the client's admission date.

Code values not applicable

Rules

- This is client and provider-agency specific.
- Required for clients receiving substance use disorder, mental health outpatient treatment, or clients who are enrolled in a special program.
- A client cannot have more than one service episode open at the provider agency at one time.
- The start date must match the from date of service on the clients first treatment encounter at the provider agency, along with the Client ID, and Provider NPI.

Frequency

- Collected on date of first treatment service.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid date.

Service Episode End Date

Section: Service episode

Definition

Indicates the date the client stopped receiving SUD/MH treatment at the provider agency. The service episode end date is considered the discharge date.

Code values not applicable

Rules

- Required for all clients when an episode of care is closed or ends at the provider agency

Frequency

- Collected at discharge or end of treatment at the provider agency.

Validation

- Must be valid date.
- A valid service episode end reason must be submitted if this value is reported.
- A valid Date of Last Contact must be submitted if this value is reported.
- All corresponding Program ID transactions the client was enrolled in at the provider agency must also have a Program ID end date/end reason.

Service Episode End Reason

Section: Service episode

Definition

Indicates the primary reason the client is being discharged from treatment at the provider agency.

Code values

Code	Value	Definition
01	Treatment completed	All parts of the treatment plan or program were completed.
02	Dropout	Client chose not to complete treatment program, with or without specific advice to continue treatment. Includes clients who drop out of treatment for unknown reasons, clients with whom contact is lost, clients who fail to return from leave ("AWOL"), and clients who have not received treatment for some time and are discharged for administrative purposes.
03	Terminated by facility	Treatment terminated by action of facility, generally because of client non-compliance with treatment or violation of rules, laws, policy, or procedures.
04	Transferred client showed	Client was transferred to another treatment program, provider, or facility for continuation of treatment.
05	Incarcerated	Clients whose course of treatment is terminated because the client has been subject to jail, prison, or house confinement, or has been released by or to the courts.
06	Death by suicide	Death by suicide
07	Death not by suicide	Death not by suicide
08	Other	Client transferred or discontinued treatment because of change in life circumstances. Examples: change of residence, illness, or hospitalization, "aging out" of children's services, completion of MH assessment or evaluation that did not result to referral for a treatment service.
09	Lost to contact	Client who has received outpatient services and the provider agency is unable to contact.
10	Administrative closure	No client activity >= 45 days (SUD) or >=90 days (MH). Primarily used for opened service episodes and program identification transactions with begin dates prior to 20200101.
14	Transferred client no show	Transferred to another treatment program or facility but client is no show. Client was transferred to another treatment program, provider, or facility, and it is known that client did not report for treatment.
24	Transferred to non SSA or SMH facility	Transferred to another treatment program or facility that is not in the SSA or SMHA reporting system for example, client is transferred to a Medicaid facility that is not mandated to report client data to the state substance abuse/behavioral health agency. The receiving facility is outside the purview of the Substance Use Agency (SSA) or State Mental Health Agencies (SMHA).

Code	Value	Definition
34	Discharge from SH	Discharged from the State hospital to an acute medical facility for medical services.
97	Unknown	Individual client value is unknown.

Historical code values

Code	Value	Effective start date	Effective end date
98	Not Collected	2020-01-01	2022-09-05
96	Not Applicable	2020-01-01	2024-06-26

Rules

- Only one option allowed.
- Required for all clients when an end date is reported in the service episode transaction.
- “Lost to Contact” is used for clients who did not get back to the provider agency and are not able to be contacted.
- “Left against advice, including dropout” is a termination of treatment initiated by the client, without the Provider Agency’s concurrence.
- “Terminated by facility” is a termination of treatment services that is initiated by the provider agency in response to a client’s continued violation of the provider agency’s established rules or in response to a client’s inability to continue participating in treatment (i.e., medical reasons, transfer of job, etc.).

Frequency

- Collected and report when client is discharged.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.
- Date of Last Contact and End Date must be reported if an End Reason is reported in the Service Episode transaction.

Service Referral Source

Section: Service episode

Definition

Indicates the client's primary referral source to treatment.

Code values

Code	Value	Definition
1	Individual (includes self-referral)	Includes the client, a family member, friend, or any other individual who would not be included in any of the following categories include self-referral due to pending driving while intoxicated/driving under the influence (DWI/DUI).
2	Alcohol/drug abuse provider	Any program, clinic, or other health care provider whose principal objective is treating clients with substance abuse problems, or a program whose activities are related to alcohol or other drug abuse prevention, education, or treatment.
4	Other health care provider	A physician, psychiatrist, or other licensed health care professional; or general hospital, psychiatric hospital, mental health program, or nursing home.
6	School (educational)	A school principal, counselor, or teacher; or a student assistance program (SAP), the school system, or an educational agency.
7	Employer/Employee Assistance Program (EAP)	A supervisor or an employee counselor.
8	Court/Criminal Justice/ DUI/DWI	Any police official, judge, prosecutor, probation officer, or other person affiliated with a federal, state, or county judicial system. Includes referral by a court for DWI/DUI, clients referred in lieu of or for deferred prosecution, or during pretrial release, or before or after official adjudication. Includes clients on pre-parole, pre-release, work or home furlough, or Treatment Alternatives for Safe Communities (TASC). Client need not be officially designated as "on parole." Includes clients referred through civil commitment.
9	Other community referral	Community or religious organization or any federal, state, or local agency that provides aid in the areas of poverty relief, unemployment, shelter, or social welfare. This category also includes defense attorneys and self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
97	Unknown	Individual client value is unknown

Historical code values

Code	Value	Effective start date	Effective end date
3	Mental health provider	2016-01-01	2020-06-30
5	Self help group	2016-01-01	2020-06-30

Rules

- Only one option allowed.
- Required for all clients.
- Choose the primary referral source to the service episode.

Frequency

- Reported when an episode of care is opened (at admission) for a client by the provider agency.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.
- May not be Null or Blank.

Notes

- Codes 3 and 5 have been merged with code 4.
- Both Referral Source tables in Program Identification and Service Episode contain the same values.

Date of Last Contact

Section: Service episode

Definition

The date of last contact the provider agency has with the client. Any contact with a response is considered a last contact.

Code values not applicable

Rules

- If a Service Episode End Date/end reason has been reported, then a date of last contact is required.

Validation

- The record must have a valid date.
- MM must be 01 through 12.
- DD must be 01 through 31.

Source: **Treatment and Assessment Report Generation Tool** (page F-4)

Date of First-Offered Appointment

Section: Service episode

Definition

Records the date of the first appointment for face-to-face service offered by the provider agency for a client (or clients designee) related to this specific treatment episode.

Code values not applicable

Rules

- Examples include the date of the first orientation group or assessment for the client or the admission /intake session.
- Required for all clients.

Validation

- The record must have a valid date.
- Must not contain Null/Blank values.
- MM must be 01 through 12.
- DD must be 01 through 31.

Source: **Treatment and Assessment Report Generation Tool** (page F-4).

Medication-Assisted Opioid Therapy

Section: Service episode

Definition

This field identifies whether the use of opioid medications such as methadone, buprenorphine, and/or naltrexone (for example) is part of the client's treatment plan.

Code values

Code	Value	Definition
1	Yes	
2	No	
3	Not applicable	
7	Unknown	Individual client value is unknown
8	Not collected	Organization does not collect this field

Rules

- Substance abuse reporting: If the client is not in treatment for an opioid problem (codes 05 Heroin, 06 Non-prescription methadone, or 07 Other opiates and synthetics) in one of the Substance Abuse Problem fields, this field may be coded 3 Not applicable. This is not mandatory because it is possible that the client is being treated with opioid therapy for a substance abuse problem not among the maximum of three that can be listed.
- Mental health reporting: Reporting of this information on a mental health record is allowed only for clients with co-occurring mental health and substance abuse problems.

Data use

- SAMHSA TEDS Field Number MDS 19 (admission).

Validation

- May not contain NULL/BLANK values.

Program Identification 060.06

Program ID key

Section: Program identification

Definition

Unique identifier for the Program ID transaction.

Code values not applicable

Rules

- Required for all substance use disorder clients, and for MH clients who are in a program with a Program ID. This transaction is not required for clients receiving MH outpatient treatment as MH outpatient is not a program listed in the Program ID table.
- Must be unique for each transaction. A client can be enrolled in one or more programs listed in the Program ID table at a time. The Program ID key allows contractors/subcontractors to identify/update the correct Program ID transaction.
- A client who is enrolled in the same program two different times should have two different records with two different keys. The key field is used to uniquely identify different instances while avoiding having additional fields such as start date be contained in the primary key.

Validation

- Does not allow special characters except Dash (-), Underscore (_), and Period(.).

Program ID

Section: Program identification

Definition

Indicates the program in which a client is enrolled.

Code values

Code	Value
1	PACT Program for Assertive Community Treatment: The Program for Assertive Community Treatment (PACT) is an evidence-based practice for people with the most severe and persistent mental illnesses, with active symptoms and impairments, and who have not benefited from traditional outpatient programs. PACT is a person-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for reducing psychiatric hospitalizations, facilitating community living, and enhancing recovery. PACT teams are either “full teams” serving up to 100 individuals, or “half-teams” serving up to 50 individuals.
2	Chemical Dependency Disposition Alternative Committable (CDDA COMM): This program is pertaining to mental health and chemical dependency treatment for juvenile offenders. Committable youth to participate in CDDA as a sentencing option for juvenile offenders. The goal is to reduce recidivism by providing a treatment option for chemically dependent or substance abusing youth. The Chemical Dependency Disposition Alternative (CDDA) is an alternative sentence for juvenile offenders who may need chemical dependency treatment. A juvenile offender is eligible for a CDDA if subject to a standard-range disposition of local sanctions or 13 to 36 weeks of confinement and has not committed an A-minus or B-plus offense, other than a first time B-plus drug offense. In these cases, the court may order a chemical dependency evaluation to determine if the youth is chemically dependent. If the court determines that a CDDA is appropriate, the court must impose a disposition and suspend that disposition with a condition that the juvenile undergo outpatient or inpatient chemical dependency treatment. Inpatient treatment for this purpose must not exceed 90 days. The court may also impose conditions of community supervision and other sanctions as part of the CDDA.
3	Chemical Dependency Disposition Alternative locally sanctioned (CDDA LS): This program is pertaining to mental health and chemical dependency treatment for juvenile offenders. Locally sanctioned youth to participate in CDDA as a sentencing option for juvenile offenders. The goal is to reduce recidivism by providing a local supervision option for chemically dependent or substance abusing youth. The Chemical Dependency Disposition Alternative (CDDA) is an alternative sentence for juvenile offenders who may need chemical dependency treatment. A juvenile offender is eligible for a CDDA if subject to a standard-range disposition of local sanctions or 13 to 36 weeks of confinement and has not committed an A-minus or B-plus offense, other than a first time B-plus drug offense. In these cases, the court may order a chemical dependency evaluation to determine if the youth is chemically dependent. If the court determines that a CDDA is appropriate, the court must impose a disposition and suspend that disposition with a condition that the juvenile undergo outpatient or inpatient chemical dependency treatment. Inpatient treatment for this purpose must not exceed 90 days. The court may also impose conditions of community supervision and other sanctions as part of the CDDA.
11	Jail Services: Jail-based transitional mental health services for incarcerated individuals. State funds only. Includes services to individuals who have been referred by jail staff. These individuals are

Code	Value
	incarcerated and have been diagnosed with a mental illness or identified as in need of mental health services. Services can include transition services to persons with mental illness to expedite and facilitate their return to the community. Services include referrals for intake of persons who are not enrolled in community mental health services but who meet priority groups as defined in RCW 71.24. The Contractor must conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.
12	Jail Services - SUD: Jail-based transitional substance use disorder treatment services for incarcerated individuals. State funds only. Includes services to individuals who have been referred by jail staff. These individuals are incarcerated and have been diagnosed with a substance use disorder or identified as in need of substance use disorder treatment services. Services can include transition services to persons with substance use disorders to expedite and facilitate their return to the community. Services include referrals for intake of persons who are not enrolled in community substance use disorder treatment services but who meet priority groups as defined in RCW 71.24. The Contractor must conduct intake assessments for these persons, and, when appropriate, provide transition services prior to their release from jail.
19	Functional Family Therapy: A phasic program where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and the family. The phases are engagement, motivation, assessment, behavior change, and generalization.
20	Illness Self-Management/Illness Management & Recovery: Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with a mental illness strategy for: collaborating actively in their treatment with professionals; reducing their risk of relapses and re-hospitalizations; reducing severity and distress related to symptoms; and improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psychoeducation about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self- management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.
21	Integrated Dual Disorders Treatment: Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.
23	Multi-systemic Therapy: Multi-systemic therapy (MST) views the individual as nestled within a complex network of interconnected systems (family, school, peers). The goal is to facilitate change in this natural

Code	Value
	environment to promote individual change. The caregiver is viewed as the key to long-term outcomes
25	Supported Housing: Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation. Supported housing is a specific program model in which a consumer lives in a house, apartment, or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities, criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization and service availability.
26	Therapeutic Foster Care: Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than that given to traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed.
28	Wraparound with Intensive Services (WISe): A range of service components that are individualized, intensive, coordinated, comprehensive, culturally competent, home and community-based services for children and youth who have a mental disorder that is causing severe disruptions in behavior interfering with their functioning in family, school, or with peers requiring: • The involvement of the mental health system and other child-serving systems (i.e., Juvenile justice, child- protection/welfare, special education, developmental disabilities), • Intensive care collaboration; and • Ongoing intervention to stabilize the child and family to prevent more restrictive or institutional placement. WISe team members demonstrate a high level of flexibility and accessibility in accommodating families by working evenings and weekends, and by responding to crises 24 hours a day, seven days a week. The service array includes intensive care coordination, home and community-based services, and mobile crisis outreach services based on the individual's need and the cross-system care plan* developed by the Child and Family Team (CFT). Care is integrated in a way that ensures youth are served in the most natural, least restrictive environment. The intended outcomes are individualized but usually include increased safety, stabilization, and community integration to ensure that youth and families can live successfully in their homes and communities. *Cross System Care Plan: An individualized, comprehensive plan created by a CFT that reflects treatment services and supports relating to all systems or agents with whom the child is involved

Code	Value
	and who are participating on the CFT. This plan does not supplant but may supplement the official treatment plan that each system maintains in the client record.
30	Supported Employment Program: Services that support individuals with behavioral health issues, who desire to be employed in the community. Services follow the principles of the SAMHSA evidence-based practice also known as Individual Placement and Support. • Competitive employment is the goal. • Supported employment is integrated with treatment. • Eligibility is based on the individual's choice; people are not excluded because of their symptoms or current substance usage. • Attention to the individual's job preferences. • Benefits counseling is important. • Rapid job search after the individual expresses their desire to work. Job development through the development of employer relationships. Time-unlimited support.
34	CJTA(DC): Substance Use Disorder treatment funded through the Criminal Justice Treatment Account (CJTA) and Drug Court (DC). (RCW 70.96A, RCW 70.96A.055: Drug Courts, RCW 2.28.170; Drug Courts) Drug court funding is provided to the following counties: Clallam; Cowlitz; King; Kitsap; Pierce; Skagit; Spokane; and Thurston/Mason. The Contractor must ensure the provision of SUD treatment and support services in accordance with RCW 70.96A and RCW 2.28.170.
35	CJTA (NDC): Criminal Justice Treatment Account Non-Drug Court
36	Diversion Program: To improve the state's forensic mental health system, a prosecutor uses their discretion to dismiss a non-felony charge without prejudice if the issue of competency is raised. The client/defendant is referred for a mental health, substance abuse, or developmental disability assessment to determine the appropriate service needs of the client/defendant. The intent is to divert misdemeanor and low-level felony defendants from incarceration and hospitalization, into needed behavioral health treatment. Note: Active only for King, Benton/Franklin, and Spokane as of 12/21/2020.
38	New Journeys: New Journeys is an evidence- based, multi-disciplinary Coordinated Specialty Care (CSC) model for youth and young adults, ages 15-40, who are experiencing first episode psychosis (FEP). This early intervention approach offers real hope for clinical and functional recovery. Core interventions of CSC model include: • Coordinated team approach providing intensive outpatient services in the home, community, or office • Assertive community outreach and education • Screening of referrals and differential diagnosis of FEP • Behavioral health intake evaluations and assessments • Therapeutic psychoeducation • Individual treatment services-psychotherapy (such as Cognitive Behavioral Therapy for Psychosis, Motivational Interviewing, and Individual Resiliency Training) • Supported Employment/Education (SEE)

Code	Value
	• Family psychoeducation • Psychiatry/medication management • Case management • Peer Support • Primary care coordination Other New Journey services such as psychoeducational group and/or multifamily groups. • Interpreter Services New Journeys Admission Criteria: • Age range: 15-40 years old • Diagnosis: Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, Delusional Disorder or Other Specified Schizophrenia Spectrum and Other Psychotic Disorders. Duration of illness/Onset of Illness: • Greater than or equal to (>) 1 week • Less than or equal to (<) 2 years • IQ over 70 • Symptoms are not known to be caused by mood disorder with psychotic features, pervasive developmental disorder and/or autism spectrum disorder, psychotic disorder due to another medical condition, substance/medication induced psychotic disorder.
39	BEST: The Becoming Employed Starts Today (BEST) project is designed to transform service delivery through promoting sustainable access to evidence-based Supported Employment. BEST provides consumers with meaningful choice and control of employment and support services. BEST utilizes Peer Counselors, reduces unemployment, and supports the recovery and resiliency of individuals with serious mental illness including co-occurring disorders. The Department of Social and Health Services (DSHS) secured the $3.9 million federal grant from the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Mental Health Services. The grant will provide services to 450 people over five years. North Central MCO and its provider Grant Mental Health and Columbia River Mental Health in Clark County are implementing the (BEST) project. Individuals with behavioral health issues, who desire to be employed, can access an approach to vocational rehabilitation known as Supported Employment (SE). This evidence-based practice adopted by SAMHSA assists individuals to obtain competitive work in the community and provides the supports necessary to ensure their success in the workplace.
42	Peer Bridger Program – Hospital & Community: This program ID is used to enroll individuals who are receiving peer bridger services. These services are provided under the BHASO contract and can be provided in the state hospitals or local inpatient settings.
43	Peer Respite: This program ID is associated with the Governor's Plan to transition individuals out of the state hospitals or divert individuals from entering inpatient settings. See HB1394 (2019)
44	Intensive Residential Teams: This program ID is associated with the Governor's Plan to transition individuals out of the state

Code	Value
	hospitals or divert individuals from entering inpatient settings. It is intended to provide intensive services to individuals enrolled in ALTSA adult family homes or assisted living facilities.
45	Intensive Behavioral Health Facilities: This program ID is associated with the Governor's Plan to transition individuals out of the state hospitals or divert individuals from entering inpatient settings. See HB1394 (2019)
51	Substance Use Disorder – Outpatient: Individual and group treatment services of varying duration and intensity according to a prescribed plan. ASAM Level 1: less than 9 hours per week (adults) less than 6 hours per week (adolescents) for recovery or motivational enhancement therapies/strategies.
52	Substance Use Disorder – Intensive Outpatient: Intensive Outpatient: A concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families. ASAM level 2.1: 9 or more hours per week (adults) 6 or more hours per week (adolescents) to treat multidimensional instability.
54	Substance Use Disorder – Intensive Inpatient: A 24-hour care concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families. ASAM level 3.3-3.7: Hours of treatment service to be defined by program and individual treatment plan to treat multidimensional instability.
55	Substance Use Disorder – Long Term Residential: A program of treatment with personal care services for chronically impaired alcoholics and addicts with impaired self-maintenance capabilities. These patients need personal guidance to maintain abstinence and good health. ASAM level 3.1: 24-hour structured program with available personnel; at least 5 of clinical services/week (WAC 246-341-1114 defines services as a minimum of 2 hours each week individual or group counseling and minimum of 2 hours each week education regarding alcohol, other drug, and addiction).
56	Substance Use Disorder – Recovery House: A program of care and treatment with social, vocational, and recreational activities to aid in patient adjustment to abstinence and to aid in job training, employment, or other types of community activities. (WAC 246-341-1114 defines Recovery House services as 4 hours of individual, group counseling and education per week).
57	Substance Use Disorder – Withdrawal Management (aka Detox): Chemical dependency detoxification services are provided to an individual to assist in the process of withdrawal from psychoactive substances in a safe and effective manner, in accordance with American Society of Addiction Medicine Criteria level Withdrawal Management (WM)-3.2-3.7.
58	Substance Use Disorder – Opiate Substitution: Services include the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. These programs must also meet outpatient treatment service requirements.
59	Substance Use Disorder – Housing Support Services: Provide housing support services for women who are pregnant, postpartum, or parenting, and for their children, in drug and alcohol-free residences for up to 18 months. Housing support services are classified as support services rather than treatment.

Historical code values

Code	Value	Effective start date	Effective end date
10	Children's Evidenced Based Pilot:	2016-01-01	2022-08-11
29	Housing and Recovery through Peer Services (HARPS)	2016-01-01	2025-07-09
31	Ticket to Work	2016-01-01	2023-01-20
32	TANF Supported Employment	2016-01-01	2023-01-20
37	Roads to Community Living (RCL)	2016-01-01	2023-01-20
40	1115 Waiver Supportive Housing	2016-01-01	2019-12-31
41	1115 Waiver Supportive Employment	2017-04-01	2019-12-31

Rules

- Required for substance use disorder and mental health clients who are enrolled in a program listed.
- Code values 2, 3, 12, 21, 34, 35, 51, 52, 54, 55, 56, 57, 58, and 59 capture service modalities for substance use clients.
- A client can be enrolled in more than one program at a time.
- All program ID transactions submitted to BHDS must be within the corresponding Service Episode Start and End Dates.

Validation

- Must be valid code.

Program Start Date

Section: Program identification

Definition

The date the client began receiving services under the submitted Program ID and at the provider agency on the transaction.

Code values not applicable

Rules

- Required for substance use disorder and mental health clients who are enrolled in a program listed in the Program ID table.
- A client can be enrolled in more than one program at a provider agency at the same time but must be within the service episode start/end dates.
- Program ID must exist to have a program start date.
- The program start date must match the first “from date of service” on the submitted encounter for the applicable program, along with the submitter ID, Client ID, and Provider NPI.

Frequency

- Collected on date of program start.

Validation

- Must be valid date.

Program End Date

Section: Program identification

Definition

The date the client's treatment services ended for the program designated by the Program ID at the provider agency.

Code values not applicable

Rules

- Required for substance use disorder and mental health clients who are enrolled in a program in the Program ID table.

Frequency

- Collected and reported when client has completed or ended treatment in the program at the provider agency.

Validation

- Must be valid date.
- Program End Reason must also be reported.
- Program End Date must be <= Service Episode End Date\

Entry Referral Source

Section: Program identification

Definition

Indicates the client's primary referral source to a specific treatment modality.

Code values

Code	Value	Definition
1	Individual (includes self- referral)	Includes the client, a family member, friend, or any other individual who would not be included in any of the following categories include self-referral due to pending driving while intoxicated/driving under the influence (DWI/DUI).
2	Alcohol/drug abuse provider	Any program, clinic, or other health care provider whose principal objective is treating clients with substance abuse problems, or a program whose activities are related to alcohol or other drug abuse prevention, education, or treatment.
4	Other health care provider	A physician, psychiatrist, or other licensed health care professional; or general hospital, psychiatric hospital, mental health program, or nursing home.
6	School (Educational)	A school principal, counselor, or teacher; or a student assistance program (SAP), the school system, or an educational agency.
7	Employer/Employee Assistance Program (EAP)	A supervisor or an employee counselor.
8	Court/Criminal Justice/DUI/DWI	Any police official, judge, prosecutor, probation officer, or other person affiliated with a federal, state, or county judicial system. Includes referral by a court for DWI/DUI, clients referred in lieu of or for deferred prosecution, or during pretrial release, or before or after official adjudication. Includes clients on pre-parole, pre-release, work or home furlough, or Treatment Alternatives for Safe Communities (TASC). Client need not be officially designated as "on parole." Includes clients referred through civil commitment.
9	Other community referral	Community or religious organization or any federal, state, or local agency that provides aid in the areas of poverty relief, unemployment, shelter, or social welfare. This category also includes defense attorneys and self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
97	Unknown	Individual client value is unknown.

Historical code values

Code	Value	Effective start date	Effective end date
3	Mental health provider	2016-01-01	2020-06-30
5	Self help group	2016-01-01	2020-06-30

Rules

- Only one option allowed.
- Collect whenever possible, otherwise mark as unknown.
- Choose the primary referral source into the special program.

Frequency

- Collected on entry into a program listed in the program ID table.

Validation

- Must be valid code.

Notes

- Codes 3 and 5 have been merged with code 4.
- Both Referral Source tables in Program Identification and Service Episode contain the same values.

Program End Reason

Section: Program identification

Definition

Indicates the primary reason the client is being discharged from the program.

Code values

Code	Value	Definition
1	Treatment completed	
2	Left against advice, including dropout	Termination of treatment initiated by the client, without the Provider Agency's concurrence.
3	Terminated by facility	Termination of treatment services that is initiated by the provider agency in response to a client's continued violation of the provider agency's established rules or in response to a client's inability to continue participating in treatment (i.e., medical reasons, transfer of job, etc.).
4	Transferred to another SA treatment or mental health program	
5	Incarcerated	
6	Death by suicide	
7	Death not by suicide	
8	Other	
9	Lost to contact	Used for outpatient clients who did not get back to the provider agency and are not able to be contacted.
10	Administrative closure	No client activity >= 45 days (SUD) or >=90 days (MH).

Historical code values

None.

Rules

- Only one option allowed.
- Choose the primary end reason on exit of the program.

Frequency

- Collected at program end.

Validation

- Must be valid code.

Co-Occurring Disorder 121.05

GAIN-SS date

Section: Co-occurring disorder

Definition

Date a screening or assessment (or both) was completed.

Code values not applicable

Rules

- Co-Occurring disorder transaction is no longer required as of 1/1/2026.

Data use

Validation

- Must be valid date if submitted.

Screen Assessment Indicator

Section: Co-occurring disorder

Definition

An indicator used to identify if a Co-occurring Disorder transaction is used to report Global Assessment of Individual Needs-Short Screener (GAIN-SS) screening scores, a follow-up assessment, or both.

Code values

Code	Value
A	Co-Occurring Disorder Quadrant Assessment
S	GAIN-SS Screening
B	Both

Rules

- Only one option allowed.
- Co-Occurring disorder transaction is no longer required as of 1/1/2026.

Data use

Validation

- Must be valid code if submitted.

Co-Occurring Disorder Screening (IDS)

Section: Co-occurring disorder

Definition

The IDS score is one of three produced upon completion of the co-occurring disorders screening process. The IDS score is one of three scores from the outcome of a screening using GAIN-SS tool.

Code values

Code	Value
0	IDS Score of 0
1	IDS Score of 1
2	IDS Score of 2
3	IDS Score of 3
4	IDS Score of 4
5	IDS Score of 5
8	Refused
9	Unable to complete

Historical code values

None.

Rules

- When reporting the outcome of a completed screening, a value between 0 (zero) and 5 must be provided for the IDS score.
- Use 8 to indicate the client refuses to participate in the specific scale.
- Use 9 to indicate the client is unable to complete the specific scale.
- Co-Occurring disorder transaction is no longer required as of 1/1/2026.

Data use

Validation

- Must be valid code if reported.

Co-Occurring Disorder Screening (EDS)

Section: Co-occurring disorder

Definition

The EDS Score is one of three produced upon completion of the co-occurring disorders screening process. The EDS score is one of three scores from the outcome of a screening using GAIN-SS tool.

Code values

Code	Value
0	EDS Score of 0
1	EDS Score of 1
2	EDS Score of 2
3	EDS Score of 3
4	EDS Score of 4
5	EDS Score of 5
8	Refused
9	Unable to complete

Historical code Values

None.

Rules

- When reporting the outcome of a completed screening, a value between 0 (zero) and 5 must be provided for the EDS score.
- Use 8 to indicate the client refuses to participate in the specific scale.
- Use 9 to indicate the client is unable to complete the specific scale.
- Co-Occurring disorder transaction is no longer required as of 1/1/2026.

Data Use

Validation

- Must be valid code if reported.

Co-Occurring Disorder Screening (SDS)

Section: Co-occurring disorder

Definition

The SDS Score is one of three produced upon completion of the co-occurring disorders screening process. The SDS score is one of three scores from the outcome of a screening using GAIN-SS tool.

Code values

Code	Value
0	SDS Score of 0
1	SDS Score of 1
2	SDS Score of 2
3	SDS Score of 3
4	SDS Score of 4
5	SDS Score of 5
8	Refused
9	Unable to complete

Historical code values

None.

Rules

- When reporting the outcome of a completed screening, a value between 0 (zero) and 5 must be provided for the SDS score.
- Use 8 to indicate the client refuses to participate in the specific scale.
- Use 9 to indicate the client is unable to complete the specific scale.
- Co-Occurring disorder transaction is no longer required as of 1/1/2026.

Data use

Validation

- Must be valid code if reported.

Co-Occurring Disorder Quadrant Placement

Section: Co-occurring disorder

Definition

Quadrant placement is based on clinical judgment of clients screened who have indications of a co-occurring mental illness and substance use based on GAIN-SS screening results.

Code values

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

Historical code values

None.

Rules

- Only one option allowed.
- Co-Occurring disorder transaction is no longer required as of 1/1/2026.

Frequency

- Required at intake/assessment for all clients only if the client screens high (2 or higher) on either the IDS or EDS, and on SDS.
- Collected and reported as outline by each contractor's PIHP contract

Data use

- State reporting.

Validation

- Must be valid code if reported.

ASAM placement 030.03

ASAM Record Key

Section: ASAM placement

Definition

A unique value for the ASAM placement transaction.

Code values not applicable

Rules

- Required transaction for all SUD clients.

Data use

- This creates a unique record in the ASAM table for when there is a subsequent evaluation from the same provider agency.

Validation

- Does not allow special characters except Dash (-), Underscore (_), and Period(.).
- Does not allow blanks, nulls, or spaces.

ASAM Assessment Date

Section: ASAM placement

Definition

Date the assessment was completed.

Code values not applicable

Rules

- Required for all substance use disorder clients.
- The Assessment Date must be within (+/- 45 days) of the from service date reported on the completed assessment encounter in ProviderOne.

Validation

- Must be valid date.

ASAM Level Indicated

Section: ASAM placement

Definition

Clinician placement of client ASAM level.

Code values

Code	Adolescent	Adult	Definition
0			Place holder for people who are truly not at any risk.
0.5	Early Intervention	Early Intervention	Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder.
1	Outpatient Services	Outpatient Services	Less than 9 hours of services/week (adult); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.
1-WM	This service is generally connected to additional adolescent focused youth services and is not a stand- alone level of care.	Ambulatory WM without Extended On- Site Monitoring	Level of Withdrawal Management (WM) for Adults. Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery.
2-WM	This service is generally connected to additional adolescent focused youth services and is not a stand- alone level of care.	Ambulatory WM with Extended On-Site Monitoring	Level of Withdrawal Management (WM) for Adults. Moderate withdrawal with all day withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal management.
2.1	Intensive Outpatient Services	Intensive Outpatient Services	9 or more hours of services/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability.
2.5	Partial Hospitalization Services	Partial Hospitalization Services	20 or more hours of services/week for multidimensional instability not requiring 24-hour care.
3.1	Clinically Managed Low-Intensity Residential Services	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours clinical services/week.
3.2-WM	This service is generally connected to additional adolescent focused youth services and is not a stand-alone level of care.	Clinically Managed Residential WM	Level of Withdrawal Management (WM) for Adults. Moderate withdrawal, but needs 24-hour support to complete withdrawal management and

Code	Adolescent	Adult	Definition
			increase likelihood of continuing treatment or recovery.
3.3	This level of care not designated for adolescent populations.	Clinically Managed Population Specific High Intensity Residential Services	24-hour care with trained counselor to stabilize multidimensional imminent danger. Less intensive milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community.
3.5	Clinically Managed Medium-Intensity Residential Services	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.
3.7	Medically Monitored High- Intensity Inpatient Services	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimension 1, 2, or 3. 16 hour/day counselor availability.
3.7-WM	This service is generally connected to additional adolescent focused youth services and is not a stand- alone level of care.	Medically Monitored Inpatient WM	Level of Withdrawal Management (WM) for Adults. Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring.
4	Medically Managed Intensive Inpatient Services	Medically Managed Intensive Inpatient Services	24-hour nursing care daily physician care for severe, unstable problems in Dimension 1, 2, or 3. Counseling available to engage patient in treatment.
4-WM	This service is generally connected to additional adolescent focused youth services and is not a stand- alone level of care.	Medically Managed Intensive WM	Level of Withdrawal Management (WM) for Adults. Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.
OTP	Some OTPs not specified for adolescent populations.	Opioid Treatment Program (Level 1)	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid disorder.

Historical code values

None.

Rules

- Only one option allowed.
- Required for substance use disorder clients.

Validation

- Must be valid code.

DCR Investigation 160.05

Investigation Start Date

Section: DCR investigation

Definition

Indicates the date the individual was advised of their rights under RCW 71.05/71.34.

Code values not applicable

Rules

- Only collected for persons being investigated under the Involuntary Treatment Act
- An individual can have only one investigation start date during a single encounter.

Frequency

- Only collected for persons being investigated under the Involuntary Treatment Act.

Validation

- Must be valid date.

Investigation Start Time

Section: DCR investigation

Definition

Time of day an investigation started. This is used to separate multiple investigations for the same person on the same day.

Code values not applicable

Rules

- Only collected for persons being investigated under the Involuntary Treatment Act. Submit investigation start time anytime an Investigation Start Date is submitted.

Validation

- Must be submitted in 24-hour clock format.

Investigation County Code

Section: DCR investigation

Definition

Indicates the county in which a person was investigated under the Involuntary Treatment Act.

Code values

Code	Value
53001	Adams
53003	Asotin
53005	Benton
53007	Chelan
53009	Clallam
53011	Clark
53013	Columbia
53015	Cowlitz
53017	Douglas
53019	Ferry
53021	Franklin
53023	Garfield
53025	Grant
53027	Grays Harbor
53029	Island
53031	Jefferson
53033	King
53035	Kitsap
53037	Kittitas
53039	Klickitat
53041	Lewis
53043	Lincoln
53045	Mason
53047	Okanogan
53049	Pacific
53051	Pend Oreille
53053	Pierce
53055	San Juan
53057	Skagit
53059	Skamania
53061	Snohomish
53063	Spokane
53065	Stevens
53067	Thurston
53069	Wahkiakum
53071	Walla Walla
53073	Whatcom
53075	Whitman
53077	Yakima

Historical code values

None.

Rules

- Only one option allowed.
- Only collected for persons being investigated under the Involuntary Treatment Act.

Validation

- Must be valid code.

Investigation Outcome

Section: DCR investigation

Definition

Indicates the outcome of a DCR investigation.

Code values

Investigation outcome* CODE	meaning	Legal reason for Detention/ Commitment* (up to 4 characters)	Return to Inpatient/ Revocation Authority*	Inpatient NPI
1	Initial Detention - ITA MH Detention to Mental Health facility under the Involuntary Treatment Act, RCW 71.05 (72-hour initial detentions before January 1, 2021; 120-hour initial detentions starting January 1, 2021, and after).	A-D at least one required	9	Required
2	Referred to voluntary Outpatient mental health services.	Z	9	Blank/Null
3	Referred to voluntary Inpatient mental health services.	Z	9	Blank/Null
4	Returned to Inpatient facility/filed revocation petition.	A-D or X at least one required	1 or 2 Required	Required
5	Filed petition recommending LRA extension.	A-D or X at least one required	9	Blank/Null
6	Referred to non-mental health community resources.	Z	9	Blank/Null
7	Initial Detention - ITA SUD Detention to Substance Use Disorder facility under the Involuntary Treatment Act, RCW 71.05 (72- hour initial detentions before January 1, 2021; 120-hour initial detentions starting January 1, 2021, and after).	A-D at least one required	9	Required
9	Other	Z	9	Blank/Null
10	Referred to acute detox.	Z	9	Blank/Null
11	Referred to sub-acute detox.	Z	9	Blank/Null
12	Referred to sobering unit.	Z	9	Blank/Null
13	Referred to crisis triage	Z	9	Blank/Null
14	Referred to SUD intensive outpatient program.	Z	9	Blank/Null
15	Referred to SUD inpatient program.	Z	9	Blank/Null

Investigation outcome* CODE	meaning	Legal reason for Detention/ Commitment* (up to 4 characters)	Return to Inpatient/ Revocation Authority*	Inpatient NPI
16	Referred to SUD residential program.	Z	9	Blank/Null
17	No detention – E&T provisional acceptance did not occur within statutory timeframes	Z	9	Blank/Null
18	No detention – Unresolved medical issues	Z	9	Blank/Null
19	Non-emergent detention petition filed	Z	9	Blank/Null
20	Did not require Mental Health or Substance Use Disorder services	Z	9	Blank/Null
22	Petition filed for outpatient evaluation	A-D or X at least one required	9	Blank/Null
23	Filed petition recommending AOT extension	Z	9	Blank/Null
24	No detention – Secure Withdrawal Management and Stabilization provisional acceptance did not occur within statutory timeframes	Z	9	Blank/Null

Historical Code Values:

Code	Value	Effective start date	Effective end date
21	Referred for hold (under RCW 71.05 on April 1, 2018)	2009-10-01	2021-12-02

Rules

- Only one option allowed.
- 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 (code 2, 3, or code 10 – 16)
- Only collected for persons being investigated under the Involuntary Treatment Act
- The contractor may change outcome of detention if the outcome of detention is for another AOT (assisted outpatient treatment) – if outcome changes, the contractor will send an update record.

Validation

- Must be valid code.

Detention Facility NPI

Section: DCR investigation

Definition

This field is found in the following transactions and indicates the NPI for the facility where a detention occurs:

- DCR investigation
- ITA hearing

Code values not applicable

Rules

- Required if the client is detained, referred to voluntary inpatient, or returned to inpatient facility.
- If the investigation outcome is code value 1,4 or 7 then Detention Facility NPI is required.
- Only collected for persons being investigated under the Involuntary Treatment Act.

Validation

- Must be valid 10-digit NPI.

Legal Reason for Detention/Commitment

Section: DCR investigation

Definition

Indicates the reason for detention/commitment.

Code values

Code	Value	Definition
A	Dangerous to Self	
B	Dangerous to Others	
C	Gravely Disabled	
D	Dangerous to property	
X	Revoked for reasons other than above	
Z	NA- person was not involuntarily detained under ITA	

Historical code values

None.

Rules

- Up to four options may be submitted per detention.
- Only collected for persons being investigated under the Involuntary Treatment Act

Validation

- Must be valid code.

Return to Inpatient/Revocation Authority

Section: DCR investigation

Definition

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

Code values

Code	Value	Definition
1	DCR 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 minors.	
9	N/A	

Historical code values

None.

Rules

- Only one option allowed.
- Only collected for persons being investigated under the Involuntary Treatment Act

Validation

- Must be valid code.

Notes

- This element is specific to returning a client under less restrictive alternative (LRA) to inpatient treatment and the filing of a revocation petition. It distinguishes legal criteria used for a person on LRA being returned to inpatient treatment. Use code "9" for all cases where the person is placed on LRA or not committed.

DCR Agency NPI

Section: DCR investigation

Definition

- Indicates the NPI for the Agency that employs the DCR that provides ITA investigation services.
- If the DCR is employed by multiple agencies, then report only one of the agencies.
- If the DCR is does not have NPI then report SUBMITTER ID.

Code values not applicable

Rules

- Only one option allowed.
- Only collected for persons being investigated under the Involuntary Treatment Act

Validation

- Must be valid 10-digit NPI.

Investigation Referral Source

Section: DCR investigation

Definition

Indicates the source of the referral for an ITA investigation.

Code values

Code	Value
1	Family: Spouse, parent, child, sibling
2	Hospital
3	Professional: Physician, Behavioral Health Treatment Provider, Child/Adult Protective Services
4	Care Facility: Assisted Living, adult family homes, nursing homes, behavioral health residential setting, rehabilitation facility
5	Legal Representative: The person with legal responsibility over/for the individual
6	School: Primary, secondary, or post-secondary school
7	Social Service Provider
8	Law Enforcement
9	Community: landlord, business, neighbors
10	Other
11	Referral from MCR to DCR

Historical code values

None.

Rules

- Only one option allowed.
- Only collected for persons being investigated under the Involuntary Treatment Act.

Validation

- Must be valid code.

Notes

- Referral from mobile crisis response to designated crisis responder (MCR to DCR): This selection refers the individual from a lower level of care to that of a higher level of care, normally due to the inability of the MCR service provider to reduce feelings of anxiety, ensure safety need, transfer to a crisis stabilization or crisis triage facility, or otherwise provide services needed to provide an appropriate intervention of care for the individual.

Investigation End Date

Section: DCR investigation

Definition

Indicates the date the DCR secured provisional acceptance from an E&T provider or made the determination not to detain an individual under RCW 71.05/71.34.

Code values not applicable

Rules

- The Investigation Start Date cannot be greater than the Investigation End Date.
- Only collected for persons being investigated under the Involuntary Treatment Act

Validation

- Must be valid date.

ITA Hearing 162.05

Hearing Date

Section: ITA hearing

Definition

Indicates the date of an Involuntary Treatment Act court hearing.

Code values not applicable

Rules

- Only reported for clients who receive an Involuntary Treatment Act hearing.

Data use

- Gun background check.

Validation

- Must be valid date.

Hearing Outcome

Section: ITA hearing

Definition

Indicates the outcome of an Involuntary Treatment Act court hearing. Indicates the type of commitment, if any, because of a court order.

Code values

Code	Value	Definition	Facility NPI
0	Dismissed	Dismissal by a court order	
1	14 Day MH Subsequent Commitment	Court order for up to 14 days treatment MH Inpatient	Required
2	90 Day MH Subsequent Commitment	Court order for up to 90 days treatment MH Inpatient	Required
3	180 Day MH Subsequent Commitment	Court order for up to 180 days treatment MH Inpatient	Required
4	90 Day MH LRA	Court order for 90 days of MH Less Restrictive Treatment	
5	180 Day MH LRA	Court order for 180 days of MH Less Restrictive Treatment	
6	Agreed to Voluntary Treatment	Person agrees to voluntary treatment	
7	Revoke MH LRA	Court order revocation of a MH LRA court order	Required
8	Reinstate MH LRA	Discharge of person on the original or modified MH LRA order	
9	5 Day Commitment under Joel's Law	Court order for 120 hours Treatment from a Joel's law petition	Required
10	Dismissal of petition filed under Joel's Law	Court order dismissing a Joel's law petition	
14	14 Day SUD Subsequent Commitment	After 4/1/18 court order for up to 14 days treatment SUD Treatment	Required
19	90 Day SUD LRA	Court order for 90 days of less restrictive alternative SUD treatment	
23	90 Day MH LRA Extension	Court ordered extension of a MH LRA order for up to 90 days of MH Less Restrictive Treatment	
24	180 Day MH LRA Extension	Court ordered extension of a MH LRA order for up to 180 days of MH Less Restrictive Treatment	
27	90 Day SUD LRA Extension	Court ordered extension of a SUD LRA order for up to 90 days of SUD less restrictive alternative treatment	
28	180 Day SUD LRA Extension	Court order extension for 180 days of SUD less restrictive Alternative treatment	

Code	Value	Definition	Facility NPI
30	14 Day MH LRA	Court order for 14 days of MH Less Restrictive Treatment	
31	365 Day MH LRA	Court order for 365 days of MH Less Restrictive Treatment	
32	18-month MH AOT Order	Court order for up to 18 months of Assisted Outpatient MH Treatment	
33	Revoke MH AOT	Court order revocation of MH AOT order	Required
34	Reinstate MH AOT	Discharge of person on the original or modified MH AOT order	
35	Revoke SUD LRA	After 4/1/18 court order revocation of a SUD LRA order	Required
36	Reinstate SUD LRA	Discharge of person on the original or modified SUD LRA order	
37	14 Day SUD LRA	Court order for up to 14 days of less restrictive alternative SUD treatment	
38	18-month SUD AOT Order	Court order for 18 months of Assisted Outpatient SUD Treatment	
39	Revoke SUD AOT	Court order revocation of SUD AOT order	Required
40	Reinstate SUD AOT	Discharge of person on the original or modified SUD AOT order	

Historical code values

Code	Value	Effective start date	Effective end date
11	Order for outpatient evaluation within 72 hours for Assisted Outpatient Treatment	4/1/2016	9/13/2021
12	90 Day Assisted Outpatient Treatment Order	4/1/2016	02/08/2023
13	365 Day Assisted Outpatient Treatment Order	4/1/2016	4/1/2018
15	90 Day SUD Subsequent Commitment	4/1/2018	02/08/2023
16	180 Day SUD Subsequent Commitment	4/1/2018	02/08/2023
17	90 Day SUD revocation	4/1/2018	02/08/2023
18	180 Day SUD revocation	4/1/2018	02/08/2023
20	180 Day SUD LRA	4/1/2018	02/08/2023
21	90 Day MH Subsequent Commitment	7/29/2021	02/08/2023
22	180 Day MH Subsequent Commitment	7/29/2021	02/08/2023
25	90 Day SUD Subsequent Commitment	7/29/2021	02/08/2023
26	180 Day SUD Subsequent Commitment	7/29/2021	02/08/2023
29	180 Day Assisted Outpatient Treatment Order	9/16/2021	02/08/2023

Rules

- Only one option allowed.
- Only reported for clients who receive an Involuntary Treatment Act hearing.

Data use

- Gun background check.

Validation

- Must be valid code.

Detention Facility NPI

Section: ITA hearing

Definition

This field is found in the following transactions and indicates the NPI for the facility where a detention occurs:

- DCR investigation
- ITA hearing

Code values not applicable

Rules

- Only one option allowed.
- Required if the client is detained, referred to voluntary inpatient, or returned to inpatient facility.
- If the hearing outcome is code value 1, 2, 3, 7, 9, 14, 15, 16, 17, 18, 21, 22, 25, or 26 then Detention Facility NPI is required.
- Only collected for persons being investigated under the Involuntary Treatment Act.

Validation

- Must be valid code.

Hearing County Code

Section: ITA hearing

Definition

Indicates the county where a court hearing was held under the Involuntary Treatment Act.

Code values

Code	Value
53001	Adams
53003	Asotin
53005	Benton
53007	Chelan
53009	Clallam
53011	Clark
53013	Columbia
53015	Cowlitz
53017	Douglas
53019	Ferry
53021	Franklin
53023	Garfield
53025	Grant
53027	Grays Harbor
53029	Island
53031	Jefferson
53033	King
53035	Kitsap
53037	Kittitas
53039	Klickitat
53041	Lewis
53043	Lincoln
53045	Mason
53047	Okanogan
53049	Pacific
53051	Pend Oreille
53053	Pierce
53055	San Juan
53057	Skagit
53059	Skamania
53061	Snohomish
53063	Spokane
53065	Stevens
53067	Thurston
53069	Wahkiakum
53071	Walla Walla
53073	Whatcom
53075	Whitman
53077	Yakima

Rules

- Only one option allowed.
- Only collected for persons being investigated under the Involuntary Treatment Act.

Data use

- Gun background check.

Validation

- Must be valid code.

Mobile Rapid Response Crisis Team Services 165.03

Mobile Rapid Response Crisis Team

Section: Mobile Rapid Response Crisis Team

Definition:

Mobile Crisis Response are community services provided to individuals experiencing, or are at imminent risk of experiencing, a behavioral health (BH) crisis. The goals of these services are engagement, symptom reduction, and stabilization.

Mobile Rapid Response Crisis Team is intended to:

- De-escalate crisis situations.
- Relieve the immediate distress of individuals experiencing a crisis.
- Reduce the risk of individuals in a crisis doing harm to themselves or others; and
- Promote timely access to appropriate services for those who require ongoing mental health or Co-occurring mental health and substance abuse services.

Only submit this transaction if it is a Mobile Rapid Response Crisis Team service. Ensure that DCR services are reported separately via the DCR transaction. For staff who provide both MRRCT and DCR services ensure that when transitioning from MRRCT to DCR services the MRRCT transaction is completed and a DCR transaction is started.

General submission guidelines

Item	Action
A referral comes in	Provider uses "Crisis Intervention" encounter code H2011 UB modifier, with the HA or HB modifier, to denote a crisis referral was received- triggers the 165.03
Services occur	• MHP or MHCP encounters H2011 w/ HA or HB, other possible modifiers are FQ and XE. • Many combinations of services can occur here and be a part of mobile crisis response. • Could be phone work, in person, etc., could be working directly with the client or with collaterals, as well as care coordination, etc.
Post initial H2011, additional peer services may occur	H0038 w/ HA or HB modifier – Note that a person cannot receive two services at the same time. Thus, a peer may be the second person on the H2011 encounter, as a two-person outreach. Once the H2011 interaction with the client and/or their supports is completed, **THEN** peer services could occur and be encountered.
Disposition	165.03 MRRCT transaction captures disposition, inclusive of "unable to locate client". There is a 1:1 relationship between the Crisis Intervention H2011 with the UB modifier, and with HA or HB modifier encounter and a MRRCT transaction. The crisis "event" could occur over several days and "ends" when there is a clear disposition. There are 9 current options for disposition.
Post Disposition	If new information is received that prompts another response, then a Crisis Intervention Service- H2011 UB modifier, with HA or HB, is encountered and the above starts all over again.

Notes:

- A crisis “event” in this context identifies the services provided to a client between the MRRCT Dispatch Date and Event End date. The H2011 UB with an HA/HB modifier indicates a referral was received and triggers the collections of the MRRCT transaction in BHDS. A client may receive several crisis services between the start and end of a crisis event. Once there is a clear disposition the MRRCT Event End date must be populated and that ends the crisis “event”. All required data elements within the MRRCT transaction must be collected during the event.
- Date and Time fields must be reported in sequential order, as shown below, so they can be used to calculate in route time for endorsed MRRCT and CBCT responses in rural areas.:
  1. Dispatch Date & Dispatch Time
  2. Date of Deployment & Time of Deployment
  3. Date of Arrival & Time of Arrival
  4. Event End Date & Event End Time

Mobile Rapid Response Crisis Team 165.03

Mobile Rapid Response Type

Section: Mobile Rapid Response Crisis Team

Definition

Mobile Rapid Response Crisis Team services are most effective when provided in-person. An in-person response should be offered initially and provided whenever requested. This can be identified by submitting 01 - Mobile Crisis Response (In person).

A Mobile Rapid Response Crisis Team Response Type of 02 should only be selected if only telehealth services were provided during the entire crisis event.

Only submit this transaction if it is a mobile rapid response crisis team service.

Code values

Code	Value
01	Mobile Crisis Response (In person)
02	Mobile Crisis provided via Telemedicine (includes audio/video and audio only)

Rules

- Only one option allowed.

Validation

- Must be valid code.

Notes:

- Only use MRRCT Type 02 if no in person services were provided in the crisis event.

Dispatch Date

Section: Mobile Rapid Response Crisis Team

Definition:

The date the dispatch (referral) is made to the Mobile Rapid Response Crisis Team.

Code Values Not Applicable

Rules:

- The Dispatch Date must match the From Service Date on the encounter where procedure code is H2011 UB with an HA or HB modifier.

Frequency:

Data Use:

Validation:

- Must be valid date.
- Cannot be a future date.
- Required field.
- Dispatch Date must be equal to or before the Date of Deployment, Date of Arrival, and Event End Date.

History:

Notes:

- Dispatch date is the date when the MRRCT received the referral for the client.

Dispatch Time

Section: Mobile Rapid Response Crisis Team

Definition:

Time of day the mobile rapid response crisis team receives the dispatch (referral) from the referral source.

Dispatch Time should be the specific time the dispatch (referral) was completed and should not be rounded to the nearest quarter hour.

Code Values Not Applicable

Rules:

- Submit time values using a 24-hour clock.
- Time of Arrival and Dispatch Time may match when the in-person MRRCT response actually begins at the same time the dispatch (referral) is received (i.e. the individual in crisis presents in person to the location of the MRRCT).

Frequency:

Data Use:

Validation:

- Must be valid time.
- Required field.
- Dispatch Time must be equal to or before the Time of Deployment, Time of Arrival, and Event End Time.

History:

Notes:

- Dispatch date/time is the date/time when the MRRCT received the referral for the client.

Mobile Rapid Response Crisis Team Referral Source

Section: Mobile Rapid Response Crisis Team

Definition:

Indicates the source of the referral for an MRRCT.

Code Values:

Code	Value	Definition
1	Family or Friend	Examples: Spouse, parent, child, sibling, friend.
2	Hospital	Examples: Emergency Department, inpatient medical floor, ICU.
3	Professional	Medical or behavioral health providers. Examples: Physicians, Behavioral Health Treatment Providers.
4	Care Facility	Examples: Assisted Living Facilities, Adult Family Homes, Nursing Homes, Behavioral Health Residential Setting, Rehabilitation Facilities, daycare/childcare facility.
5	Legal Representative	The person with legal responsibility over/for the individual.
6	School	Examples: Pre-K through 12th, HeadStart, colleges, universities, and trade schools.
7	Social Service Provider	Examples: Department of Social and Health Services, Housing providers, Adult Protective Services, Department of Children Youth and Families, Developmental Disability Administration, other social service agencies.
8	Law Enforcement	Includes law enforcement co-responders
9	Community Member	Examples: Landlord, business, neighbors
10	Self-Referral	
12	Designated Crisis Responder	
13	EMS, Fire, Other first responders	
14	Juvenile Corrections	
15	Adult Corrections	
97	Other	

Historical Code Values:

Code	Value	Effective Start Date	Effective End Date
11	Crisis Call Center Referral	01/01/2016	07/10/2025

Rules:

- Only one option allowed.

Frequency:

Data Use:

Validation:

- Must be valid code.

History:

Notes:

- If the referral source was a crisis call center (i.e. 988, the regional crisis line, or team directly) then report the source that contacted the crisis call center.

Level of Acuity

Section: Mobile Rapid Response Crisis Team

Definition:

The level of acuity defines the timeframe in which an MRRCT needs to respond to an individual in crisis once a referral for MRRCT services occurs.

Code Values:

Code	Value	Definition
1	Urgent	Urgent crises are moderate to serious risk and require a 24-hour response.
2	Emergent	An emergent crisis is an extreme risk and requires a 2-hour response time.
4	Behavioral Health Emergency	A significant behavioral health crisis that requires an immediate in-person response within 1 hour due to the level of risk or lack of means for safety planning. Endorsed teams must meet statutory response times to receive supplemental performance payments.

Historical Code Values:

Code	Value	Effective Start Date	Effective End Date
3	Routine/Follow-up	01/01/2020	07/10/2025

Rules:

- Only one option allowed.

Frequency:

Data Use:

Validation:

- Must be valid code.

History:

Notes:

Interpreter Utilized

Section: Mobile Rapid Response Crisis Team

Definition:

Defines whether a professional interpreter was utilized during the event. Includes in-person, telephonic or HIPPA compliant video interpretation services. The selected code should be based on the use of an interpreter during any service encounter following an initial referral. These services could be provided for up to a 72-hour period following the referral.

Code Values:

Code	Value	Definition
1	Yes	An interpreter was utilized to communicate with the individual in crisis.
2	No	No interpreter was utilized at the encounter.
Y	Yes	An interpreter was utilized to communicate with the individual in crisis.
N	No	No interpreter was utilized at the encounter.

Rules:

- Only one option allowed.
- Required field.

Frequency:

Data Use:

Validation:

- Must be valid code.

History:

Notes:

Date of Deployment

Section: Mobile Rapid Response Crisis Team

Definition:

Date the Mobile Rapid Response Crisis Team was deployed following the initial dispatch (referral). This date will be used to calculate in route time for endorsed MRRCT and CBCT responses in rural areas. Time/Date of Deployment in this context is the act of the MRRCT leaving from a location to another to respond to a request for mobile crisis intervention.

Rules:

- Required field for MRRCT Type = 01.
- Can be Null for MRRCT Type = 02.

Frequency:

Data Use:

Validation:

- Must be valid date.
- Cannot be a future date.
- Cannot be a date before (but can be equal to) the Dispatch date.
- Date of Deployment must be equal to or before the Date of Arrival, and Event End Date.

History:

Notes:

Time of Deployment

Section: Mobile Rapid Response Crisis Team

Definition:

Time of day the Mobile Rapid Response Crisis Team was deployed following the initial dispatch (referral). This time will be used to calculate in route time for endorsed MRRCT and CBCT responses in rural areas. Time/Date of Deployment in this context is the act of the MRRCT leaving from a location to another to respond to a request for mobile crisis intervention.

Code Values Not Applicable:

Rules:

- Submit time values using a 24-hour clock (HHMM).
- Required field IF MRRCT Type = 01.
- Allows NULL IF MRRCT Type = 02.

Frequency:

Data Use:

Validation:

- Cannot be a time before (but can be equal to) the Dispatch Time.
- Time of Deployment must be equal to or before the Time of Arrival and Event End Time.

History:

Notes:

Date of Arrival

Section: Mobile Rapid Response Crisis Team

Definition:

The date the Mobile Rapid Response Crisis Team arrived on the scene and contacted the client or collaterals following the initial dispatch (referral). This date will be used to calculate response time for urban and suburban responses by endorsed MRRCTs and CBCTs.

Rules:

- Required field.
- If MRRCT Type = 02, then Date of Arrival can be NULL
- If MRRCT Type = 01, then Date of Arrival must be a valid date.

Frequency:

Data Use:

Validation:

- Must be valid date.
- Cannot be a future date.
- Date of Arrival must be equal to or before the Event End Date.
- Cannot be a date before (but can be equal to) Dispatch Date and Date of Deployment.

History:

Notes:

- Scene in this context is the location where the MRRCT arranged to meet the client.
- If the client is not at the scene where client was previously reported to be located, still report the Date/Time of Arrival the MRRCT arranged to meet the client and was unable to following the initial dispatch (referral).

Time of Arrival

Section: Mobile Rapid Response Crisis Team

Definition:

Time of day the Mobile Rapid Response Crisis Team arrived on the scene following the initial dispatch (referral). This time will be used to calculate response time for urban and suburban responses by endorsed MRRCTs and CBCTs.

Arrival Time and Dispatch Time may match when the in-person MRRCT response actually begins at the same time the dispatch (referral) is completed (i.e. the individual in crisis presents in person to the location of the MRRCT).

Time of Arrival should be the specific time the MRRCT arrived on scene and should not be rounded to the nearest quarter hour.

Code Values Not Applicable

Rules:

- Submit time values using a 24-hour clock.
- If MRRCT Type = 02, then Time of Arrival can be NULL
- If MRRCT Type = 01, then Time of Arrival must be a valid time.

Frequency:

Data Use:

Validation:

- Must be valid time.
- Time of Arrival cannot be a time before (but can equal to) the Dispatch Time or Time of Deployment.
- Time of Arrival must be equal to or before the Event End Time.

History:

Notes:

- Scene in this context is the location where the MRRCT arranged to meet the client.
- If the client is not at the scene where client was previously reported to be located, still report the Date/Time of Arrival the MRRCT arranged to meet the client and was unable to following the initial dispatch (referral).

Presenting Problem

Section: Mobile Rapid Response Crisis Team

Definition:

The nature of the behavioral health crisis determined by the MRRCT provider during the initial dispatch (referral) and first intervention.

Code Values:

Code	Value	Definition
04	Suicidality	
05	Harm/Risk of Harm to Self	
06	Harm/Risk of Harm to Others	
07	Harm/Risk of Harm from Others	
08	Anxiety	
09	Disruptive Behavior	
10	Depression	
11	Mood Dysregulation	
12	Family Conflict	
13	Trauma	Current or past psychological trauma.
14	Peer Difficulties	
15	School Problems	
16	Psychosis	
17	Eating Disturbance	
18	Intellectual/Developmental Delays	
19	Identity Discovery	Related to support around gender expression, sexuality, race, ethnicity, etc.
20	Loneliness	
21	Intimate relationship problems	
22	Bereavement	
23	Critical Incident	Natural disaster, school violence, other significant incident affecting a group of people in a local or regional area.
24	Substance use	
25	Substance intoxication	
26	Substance withdrawal	
27	Neurocognitive symptoms	TBI, dementia, acute delirium.

Code	Value	Definition
28	Chronic physical symptoms	Chronic pain, chronic medical condition. These symptoms may be contributing to psychological distress.
29	Socioeconomic challenges	Lack of adequate food, lack of safe shelter, income loss.
97	Other	Examples: Undiagnosed, Behavioral Issue(s)

Historical Code Values:

Code	Value	Effective Start Date	Effective End Date
1	Mental Health	07/01/2020	07/10/2025
2	Substance Use Disorder	07/01/2020	07/10/2025
3	Co-Occurring (Mental Health and Substance Use Disorder)	07/01/2020	07/10/2025

Rules:

- Select all that apply.

Frequency:

Data Use:

Validation:

- Must be valid code(s).

History:

Notes:

Law Enforcement and Co-responder Involvement

Section: Mobile Rapid Response Crisis Team

Definition:

Law enforcement or other first responders were present at the scene with or without the presence of behavioral health or other co-responder during any service prior to the final disposition of the crisis event.

Code Values:

Code	Value	Definition
3	Law Enforcement Only	Law enforcement was present without co-responder.
4	Law Enforcement with BH co-responder	Law enforcement with BH co-responder present.
5	Law Enforcement with non-BH co-responder	Law enforcement with non-behavioral health co-responder present. Example: LE paired with an EMT.
6	Fire/EMS	Fire/EMS were present at the scene.
7	No Law Enforcement and/or law enforcement based co-responder	

Historical Code Values:

Code	Value	Effective Start Date	Effective End Date
1	Yes	01/01/2020	07/10/2025
2	No	01/01/2020	07/10/2025
Y	Yes	01/01/2020	07/10/2025
N	No	01/01/2020	07/10/2025

Rules:

- One option allowed.

Frequency:

Data Use:

Validation:

- Must be valid code.

History:

Notes:

Mobile Rapid Response Crisis Team Outcome

Section: Mobile Rapid Response Crisis Team

Definition:

The outcome(s) of the MRRCT event. This should be the final disposition, following the initial dispatch (referral) and any subsequent crisis services provided within 72 hours of the initial dispatch (referral). Note that many crisis events may have a disposition and outcome in less than 72 hours. For example, some dispatches (referrals) may have an outcome following a single in person intervention, but some may include planned follow-up by the MRRCT during the 72 hours following the initial dispatch (referral) and intervention.

Code Values:

Code	Value	Definition
2	MRRCT service completed, no follow-up recommended	MRRCT service completed, no follow-up recommended.
3	MRRCT service completed, follow up recommended	Referral given for independent follow-up.
6	Law Enforcement	Case referred to law enforcement.
7	DCR for ITA evaluation/investigation	Case referred to DCR.
8	Unable to locate individual or individual not available.	MRRCT unable to meet with the individual because they left the location, or they are unavailable for some other reason.
9	Voluntary placement at a shelter or other safe location	MRRCT verified admission to a shelter or other safe location. May include voluntary transport provided by MRRC or other support team to the facility.
10	Assisted with transport to needed services (pharmacy, food bank)	MRRCT verified transportation was provided to the location of needed services. May include voluntary transport provided by MRRC or other support team to the service location, for example a pharmacy or food bank.
11	Assisted with scheduling a next day appointment.	The MRRCT assisted the help seeker with scheduling a next day appointment.
12	Assisted with scheduling follow-up care.	The MRRCT assisted the help seeker with scheduling follow-up care.
13	Individual declined or terminated MRRCT services.	Individual declined or terminated MRRC services.
14	In-home stabilization referral	Used when referring to in-home stabilization services following the initial 72-hour crisis phase, including under the Mobile Response and Stabilization Services (MRSS) model for children, youth, and families.
15	Voluntary placement at a BH crisis facility	MRRCT verified admission to a BH crisis facility (ie. 23-hr crisis relief center, crisis stabilization unit, peer respite facility). May include voluntary transport provided by MRRCT or other support team to the facility.

Code	Value	Definition
16	Voluntary transfer to community hospital (includes ED)	MRRCT verified admission to a community hospital. May include voluntary transport provided by MRRC or other support team to the facility, including a hospital emergency department.
97	Other	Other outcomes not covered.

Historical Code Values:

Code	Value	Effective Start Date	Effective End Date
1	Routine Follow-up completed	01/01/2020	07/10/2025
4	Transport to crisis triage/stabilization	01/01/2020	07/10/2025
5	Transport to community hospital (includes ER)	01/01/2020	07/10/2025

Rules:

- Only one option allowed.
- Required field.

Frequency:

Data Use:

Validation:

- Must be valid code.

History:

Notes:

Referral Given

Section: Mobile Rapid Response Crisis Team

Definition:

Specific referrals given to the client throughout the crisis event for independent follow up (exclude services for which the individual was directly transported e.g., crisis relief center, crisis stabilization unit, E&T, etc., which should be entered in MRRCT Outcome).

Code Values:

Code	Value	Definition
01	Outpatient Substance Use Disorder and/or Mental Health services	Examples: Outpatient facility, Detox service, Community behavioral health organization
02	Non-Behavioral Health Community Services	Examples: Medical Clinic, Primary Care Provider
03	Forensic Projects for Assistance in Transition from Homelessness (F-PATH)	
04	Forensic Housing and Recovery through Peer Services (F-HARPS)	
05	Traditional HARPS	
06	Traditional PATH	
07	Other housing resources	
08	Adult Protective Services	
09	EBT/ABD (Food/Cash Benefits)	
10	Educational Assistance	
11	Employment Assistance	
12	Home and Community Services	
13	Job Training	
14	Medical Insurance Services	Example: Insurance Care Coordinator, MCO Case Manager
15	Dental Care	
16	SSI/SSDI	
17	Veteran's Administration (VA) Benefits	
18	Voluntary Inpatient Behavioral Health Services	
19	Alternative Housing Supports	Examples: Shelter, Drop-in Center
20	Food Bank	
21	No Referrals Given	
22	Peer Respite	

Code	Value	Definition
23	Recovery Navigator	
24	WISe	Wraparound with intensive services includes Multi-Systemic Therapy (MST)
25	TAY	Transitional Age Youth Program age 15-24 (includes TAY-CORE and TAY-WISe) TAY independent housing
26	School Based Mental Health Services	Includes school-based SUD services, ESD or True North
27	Department of Children Youth and Families	CPS, any other DCYF programs, Social Worker, Foster care system, child welfare.
28	Developmental Disabilities Administration	
29	Parenting Support	Examples: parenting class, parent support group, COPE
30	Youth at Risk Information – Juvenile Justice	

Rules:

- Select all that apply.

Frequency:

Data Use:

Validation:

- Must be valid code.
- If code value "(21) No Referral Given" is submitted, do not submit any other value.

History:

Notes:

- At a minimum, report the Referral Given at time of disposition.

Event End Date

Section: Mobile Rapid Response Crisis Team

Definition:

Indicates the date the crisis event was resolved and an outcome (disposition) provided by the MRRCT, concluding the crisis event.

Code Values Not Applicable

Rules:

- Required field.

Frequency:

Data Use:

Validation:

- Must be valid date.
- Cannot be a date before (but can equal to) the Dispatch Date, Deployment Date, or Arrival Date.
- Cannot be a future date.

History:

Notes:

- For staff who provide both MRRCT and DCR services ensure that when transitioning from MRRCT to DCR services the MRRCT transaction is completed and a DCR transaction is started.

Event End Time

Section: Mobile Rapid Response Crisis Team

Definition:

Time of day the crisis was resolved, and an outcome (disposition) provided by the MRRCT, concluding the crisis event.

Code Values Not Applicable

Rules:

- Submit time values using a 24-hour clock (HHMM).

Frequency:

Data Use:

Validation:

- Must be valid time.
- Required field.
- Event End Time must be equal to or greater than Dispatch Time, Time of Deployment, and Time of Arrival.
- It cannot be before the Dispatch Time, Deployment Time or Arrival Time.

History:

Notes:

MRRCT Agency NPI

Section: Mobile Rapid Response Crisis Team

Definition:

Indicates the billing provider NPI for the Agency that employs the MRRCT.

Rules:

- The billing provider NPI on the MRRCT transaction must match the billing provider NPI on the corresponding encounter submitted with procedure code H2011 with a UB and either an HA or HB modifier for the client.

Data Use:

Validation:

- Must be valid 10 digit billing provider NPI.
- No blank or null values.

History

Notes:

MRRCT Zip Code

Section: Mobile Rapid Response Crisis Team

Definition:

Indicates the location of the client at the time the first in person services occurred, via the Zip code, following the initial dispatch .

Code Values not applicable:

Rules:

- Only one option allowed.
- If MRRCT Type is 02, Zip code can be Null.
- If MRRCT Type is 01, zip code is required.

Validation:

- Must be valid 5 digit Zip code.

History:

Notes:

Substance Use 036.04

Substance (1, 2, 3)

Section: Substance use

Definition

Indicates the specific substance(s), or substance category(s), the client is being seen for.

Code values

Code	Value
1	None
2	Alcohol
3	Cocaine/Crack
4	Marijuana/Hashish
5	Heroin
6	Other Opiates and Synthetics
7	PCP-phencyclidine
8	Other Hallucinogens
9	Methamphetamine
10	Other Amphetamines
11	Other Stimulants
12	Benzodiazepine
13	Other non-Benzodiazepine Tranquilizers
14	Barbiturates
15	Other Non-Barbiturate Sedatives or Hypnotics
16	Inhalants
17	Over the Counter
18	Oxycodone
19	Hydromorphone
20	MDMA (ecstasy, Molly, etc.)
21	Other
22	Fentanyl

Historical code values

- None.

Rules

- Required field for all clients receiving substance use disorder services.

- A Substance (except for “None”) cannot be selected more than once.
- Substance (1) cannot be reported as “none” (Code value 1).
- The substances must be ranked by relative importance of seriousness of dependency as provided by the client and determined by the clinician. This rank is represented in the order the substances are reported, with (1) having a higher rank of seriousness than (2) or (3).
- The 3 Substances reported at admission into treatment must also be reported at discharge (whether they are still using the substance), along with any corrections or updates made during the treatment process.
- The following must be included for each substance being reported:
    - AGE AT FIRST USE (REPORT ONLY AT ADMISSION INTO SUD TREATMENT)
    - FREQUENCY OF USE
    - PEAK USE
    - METHOD
    - DATE LAST USED
- If there is no substance 2 or 3, then report “none” (code 1) for SUBSTANCE (2) AND/OR SUBSTANCE (3**)** and leave the respective fields AGE AT FIRST USE, FREQUENCY OF USE, PEAK USE, METHOD and DATE LAST USED blank. Substances 2 and 3 can be updated later if the admission substances were inaccurately reported or not disclosed by the client; however, must be reported consistently (admission to discharge) along with any corrections or updates made during the treatment process.
- If Substance 2 and 3 are reported, all elements are required, except Source Tracking ID.

Frequency

- Substance Use is required to be collected and reported at admission, at discharge and is updated upon change for all SUD clients.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) reporting.

Validation

- Must be valid code.

Age At First Use (1, 2, 3)

Section: Substance Use

Definition

Indicates the age at which the client first used the specific substance.

Code values

Code	Value
0	Client born with a substance use disorder resulting from in-utero exposure
1-98	Age at First Use, in years
99	Not applicable

Historical code values

None.

Rules

- Only reported for substance use disorder clients.
- Required if any substance other than "None" is reported in the SUBSTANCE element.
- Must be less than or equal to client's age when reported.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.

Frequency of Use (1, 2, 3)

Section: Substance use

Definition

Indicates the frequency that the client used a specific substance in the last 30 days.

Code values

Code	Value
1	No Use in The Past Month
2	1-3 Times in Past Month
3	4-12 Times in Past Month
4	13 or More Times in Past Month
5	Daily
6	Not Applicable
7	Not Available

Historical code values

- None.

Rules

- Only reported for substance use disorder clients.
- Required if any substance other than "None" is reported in the SUBSTANCE element.

Data use

- Substance Abuse Prevention and Treatment Block Grant (SABG) - Treatment Episode Data Set (TEDS) Reporting.

Validation

- Must be valid code.

Peak Use (1, 2, 3)

Section: Substance use

Definition

Indicates the highest monthly use pattern in the twelve months preceding admission.

Code values

Code	Value
1	No Use
2	1-3 Times per Month
3	4-12 Times per Month
4	13 or More Times per Month
5	Daily
6	Not Applicable

Historical code values

- None.

Rules

- Only reported for substance use disorder clients.
- Required if any substance other than "None" is reported in the SUBSTANCE element.

Validation

- Must be valid code.

Method (1, 2, 3)

Section: Substance use

Definition

Indicates the most common method the client uses to administer a specific substance.

Code values

Code	Value
1	Inhalation
2	Injection
3	Oral
4	Other
5	Smoking

Historical code values

- None.

Rules

- Only reported for substance use disorder clients.
- Required if any substance other than "None" is reported in the SUBSTANCE element.

Validation

- Must be valid code.

Date of Last Use (1, 2, 3)

Section: Substance use

Definition

Indicates the date the client last used the specific substance.

Code values not applicable

Rules

- Only reported for substance use disorder clients.
- Required if any substance other than "None" is reported in the SUBSTANCE element.
- Must be less than or equal to the date on which it is reported.
- Date last used must be greater than the client's birthdate or age at first use.

Validation

- Must be valid date.

Funding 140.03

Block Grant-Funded Services

Section: Funding

Definition

This field specifies if any of the services and supports clients received were paid for by the SAMHSA Mental Health Block Grant (MHBG) or Substance Abuse Block Grant (SABG).

Code values

Code	Value	Definition
1	Yes	MHBG used to pay for services and supports
3	Yes	SABG used to pay for services and supports
5	None	Block Grant funding does not apply
6	Yes	SABG Covid Enhancement
7	Yes	SABG ARPA (American Rescue Plan Act of 2021)
8	Yes	MHBG Covid Enhancement
9	Yes	MHBG ARPA (American Rescue Plan Act of 2021)
97	Unknown	Individual client value is unknown.

Historical code values

Code	Value	Effective start date	Effective end date
2	MHBG funds were not used	2019-11-01	2022-03-10
4	SABG funds were not used	2019-11-01	2022-03-10
98	Not Collected	2019-11-01	2022-09-05

Rules

- If the client is receiving services funded by both SABG and MHBG then two separate transactions need to be sent to reflect that. One transaction reflecting the SUD services and one for the MH funded services.

Frequency

- Report for all clients.

Data use

- SAMHSA MH-CLD Field Number O-04.

Validation

- May not be null or blank.

Type of Funding Support

Section: Funding

Definition

This field specifies type of funding support for clients.

Code values

Code	Value	Definition
01	Medicaid only	
02	Medicaid and non- Medicaid sources	
03	Non-Medicaid only	
97	Unknown	Individual client value is unknown.

Historical code values

Code	Value	Effective start date	Effective end date
98	Not Collected	2019-11-01	2022-09-05

Rules

- Required data element.
- Must be updated to reflect the current funding support for the client if it changes during treatment.

Data use

- SAMHSA MH-CLD Field Number O-03.

Validation

- May not be null or blank.
- Valid value from table; leading zero is required.

Source of Income/Financial Support

Section: Funding

Definition

Identifies the client's principal source of financial support. For children under 18, this field indicates the parents' primary source of income/support.

Code values

Code	Value	Definition
1	Wages/Salary	
2	Public Assistance	
3	Retirement/Pension	
4	Disability	
20	Other	
21	None	
97	Unknown	Individual client value is unknown.

Historical code values

Code	Value	Effective start date	Effective end date
98	Not Collected	2019-11-01	2022-09-05

Rules

- For minors (younger than 18 years old), report the primary parental source of income/support.

Data use

- SAMHSA TEDS Field Number SUDS 9 (admission).

Validation

- May not be null or blank.

Appendix A: Document History

This is a summary of the changes made to the document.

- Date: effective date of comments/status
- Change Type: proposed change, publish, approve dates, revisions, and drafts
- Description: detailed description or published details
- Name: primary owner of changes

Data Guide version 6.0

Date	Change type	Description	Name
12/23/2025	Approved publish	Version 6.2 Approved 12/23/2025 Published 01/01/2026	Leslie Carey
11/24/2025	Proposed changes 6.1– 6.2	Removed MCR 165.02 transaction, removed requirement for Co-occurring 121.05 transaction, updated language throughout the data guide.	Leslie Carey
06/30/2025	Approved publish	Version 6.1 Approved: 07/09/2025 Published: 07/09/2025	Leslie Carey
05/28/2025	Proposed changes 6.0 – 6.1	Added new MRRCT 165.03 transaction, updated language throughout guide, inactive program ID 29	Leslie Carey
12/31/2024	Approved publish	Version 6.0 Approved: 01/01/2025 Published: 01/10/2025	Leslie Carey
11/26/2024	Proposed changes 5.9 – 6.0	Updated Program ID table with ID (12), updated language throughout the guide.	Leslie Carey

Data Guide version 5.0

Date	Change type	Description	Name
July 19, 2024	Approved publish	Version 5.9 Approved: 07/05/2024 Published: 07/19/2024	Leslie Carey
June 24, 2024	Proposed changes 5.8 to 5.9	Updated versions of client demographic, client address and funding transactions to include the provider NPI. Also removed MCR 24-hour rule and updated funding effective date language.	Leslie Carey
April 12, 2024	Approved publish	Version 5.8	Leslie Carey

Date	Change type	Description	Name
		Approved: 4/11/2024 Published: 4/12/2024	
March 25, 2024	Proposed changes 5.7-5.8	Corrected client profile primary key, summary of transactions and updated service episode end reason table.	Leslie Carey
December 29, 2023	Approved/Publish	Version 5.7 Approved: 12/08/2023 Published: 12/28/2023	Leslie Carey
November 27, 2023	Proposed changes 5.6 to 5.7	Updated language throughout data guide: Primarily service episode, program ID, and additional language for linking supplemental data to encounters	Leslie Carey
July 14, 2023	Approved/Publish	Version 5.6 Approved: June 26, 2023 Published: July 13, 2023	Leslie Carey
June 26, 2023	Proposed changes 5.5 to 5.6	Updated language throughout data guide: Effective date section, submission instructions, funding transaction, historic code value, and service episode.	Leslie Carey
April 07, 2023	Approved/Publish	Version 5.5 Approved: March 31, 2023 Published: April 07, 2023	Leslie Carey
March 31, 2023	Proposed changes 5.3 to 5.4	• Added ABA providers to the list of excluded reporting organizations • Updated all instances of SFT to MFT • Removed all 90-day update requirement language • Updated Appendix G language	Leslie Carey
January 17, 2023	Approved/Publish	Version 5.4 Approved: January 13, 2023 Published: January 17, 2023	Leslie Carey
November 28, 2022	Proposed changes 5.3 to 5.4	Updated ITA hearing outcome table, inactive program ID code values, removed time of dispatch rules in MCR transaction, removed request for service requirement in client demographics and client address.	Leslie Carey
September 30, 2022	Approved/Publish	Version 5.3 Approved: September 28, 2022 Publish: September 30, 2022	Leslie Carey
August 29, 2022	Proposed changes 5.2 to 5.3	Updated historic code value table to include code value 98 for all funding transaction elements and the service episode end reason. Updated error	Leslie Carey

Date	Change type	Description	Name
		codes and placed code value 10 in the historic table for the Program ID.	
July 07, 2022	Approved/ Publish	Version 5.2 Approved: July 07, 2022 Publish: July 07, 2022	Leslie Carey
May 23, 2022	Proposed Changes 5.1 to 5.2	Added clarifying language, added fentanyl to substance 1,2.3 in substance use transaction and added missing states to client address transaction.	Leslie Carey
April 14, 2022	Approved/ Publish	Version 5.1 Approved: 4/14/2022 Publish: 4/15/2022	Leslie Carey
March 21, 2022	Proposed Changes 5.0 to 5.1	• Updated Funding transaction 140.01 to 140.03 with block grant element in primary key. • Updated MCR transaction 165.01 to 165.02 with additional required data elements.	Leslie Carey
September 30, 2021	Approved/Publish	Version 5.0 Approved: 9/29/2021 Publish: 9/30/2021	Leslie Carey
August 30, 2021	Proposed Changes 4.2 to 5.0	Decommissioned Authorization Transaction effective June 1, 2021.	Leslie Carey
February 05, 2021	Approved/ Publish	Version: 4.2 Approved: 2/05/2021 Publish: 2/05/2021	Leslie Carey
January 11, 2021	Proposed Changes 4.1 to 4.2	Received feedback on Data Guide 4.1 Change Summary 4.1-4.2	Leslie Carey
July 15, 2020	Approved/Publish	Version: 4.1 Approved: 7/16/2020 Publish:7/16/2020	Leslie Carey
June 29, 2020	Proposed Changes 4.0 to 3.1	Received feedback on Data Guide 4.0 Change Summary 4.0-4.1	MCOs/BHOs/ASOs

Data Guide Version 4.0

Date	Change type	Description	Name
June 15, 2020	Approved/Publish	Version: 4.0 Approved: 6/15/2020 Publish: 6/15/2020	Michael Barabe
April 1, 2020	Proposed Changes 3.1 to 4.0	Adds new Mobile Crisis Response (MCR) transaction and program.	MCOs/BHOs/ASOs

Data Guide Version 3.1

Date	Change type	Description	Name
April 1, 2020	Approved/Publish	Version: 3.1 Approved: 4/1/2020 Publish: 4/1/2020	Huong Nguyen
January 22, 2020	Proposed Changes 3.0 to 3.1	Received feedback/questions on draft through 4/1/2020 from organizations – Change Summary 3.0-3.1	MCOs/BHOs/ASOs

Data Guide Version 3.0

Date	Change type	Description	Name
August 30, 2019	Approved/ Publish	Version: 3.0 Approved: 1/30/2018 Publish: 2/1/2018	Huong Nguyen
July 9, 2019	Proposed Changes 2.2 to 3.0	Received feedback on draft through 7/9/2019 from organizations – Change Summary 2.2 -3.0 Located here: **hca.wa.gov/assets/program/bhds-data-guide- summary.pdf**	MCOs/BHOs/ASOs

Data Guide Version 2.0

Date	Change type	Description	Name
January 30, 2018	Approved/ Publish	Version: 2.2 Approved: 1/30/2018 Publish: 2/1/2018	Huong Nguyen
February 23, 2017	Approved/ Publish	Version: 2.1 Approved: 1/30/2018 Publish: 2/1/2018	Huong Nguyen
November 18, 2016	Approved/ Publish	Version: 2.0 Approved: 1/30/2018 Publish: 2/1/2018	Huong Nguyen

Appendix B: Error Codes

This is a list of error codes generated from the system.

Error Code Directory

Error code	Description
21913	Incorrect number of fields for the transaction type
23306	Error: ID to Keep has been previously voided.
30039	Error: Invalid Legal Reason for Detention/Commitment or too many codes. Transaction not posted.
30197	Client ID to void may not be the same as the Client Id to keep. Transaction not posted
30198	Client ID to keep may not be blank. Transaction not posted.
30199	Valid Client Demographics for Client ID to keep not found. Transaction not posted.
30200	Client ID to void may not be blank. Transaction not posted.
30201	Inactive Submitter ID for the date in transaction. Transaction not posted.
30202	Valid Client Demographics transaction not found. Transaction not posted.
30203	Invalid Provider NPI. Transaction not posted.
30204	First name may not be blank. Transaction not posted.
30205	Last name may not be blank. Transaction not posted.
30206	Invalid SSN. If not blank, must be exactly nine digits without dashes. Transaction not posted.
30207	Invalid birthdate. May not be blank. Transaction not posted.
30208	Invalid Gender code or effective date is outside of active date range for Gender code. Transaction not posted.
30209	Invalid Military status code. Transaction not posted.
30210	Invalid Assessment Date. Transaction not posted.
30211	Invalid ASAM Level code. Transaction not posted.
30212	Invalid Hispanic Origin code. Transaction not posted.
30213	Invalid Language code. Transaction not posted.
30214	There is an invalid race code - it may be due to length such as a missing leading zero.
30215	Invalid Sexual Orientation code.
30216	Invalid Education code. Transaction not posted.
30217	Invalid Employment code. Transaction not posted.
30218	Invalid Marital Status code. Transaction not posted
30219	Invalid Parenting code. Transaction not posted.
30220	Invalid Authorization Decision Date. Transaction not posted.

Error code	Description
30221	Invalid Authorization ID. May not be blank. Transaction not posted.
30222	Invalid Start Date. May not be blank. Transaction not posted.
30223	Invalid End Date. Transaction not posted.
30224	Start Date may not be later than End Date. Transaction not posted.
30225	Invalid Authorization Decision Code. Transaction not posted.
30226	Error: Invalid Effective date. May not be blank or longer than 8 digits. Transaction not posted.
30227	Invalid County code. Transaction not posted.
30228	Invalid State code. Transaction not posted.
30229	Zip Code not numeric. Transaction not posted.
30230	Invalid Zip Code Length. Transaction not posted.
30231	Invalid WA Zip Code. Transaction not posted.
30232	Invalid OR Zip Code. Transaction not posted.
30233	Invalid ID Zip Code. Transaction not posted.
30234	Facility flag error. Flag shall be 'Y' or 'N'
30235	Invalid Address Line 1
30236	Invalid City Name.
30330	Invalid Pregnant code. Transaction not posted.
30331	Invalid Smoking Status code. Transaction not posted.
30332	Invalid Residence code. Transaction not posted.
30333	Invalid School Attendance code. Transaction not posted.
30334	Invalid Self-Help code. Transaction not posted.
30335	Invalid Needle recently used code. Transaction not posted.
30336	Invalid Needle Use Ever code. Transaction not posted.
30337	Invalid GAINS Date. Transaction not posted.
30338	Invalid Screen Assessment Indicator code. Transaction not posted.
30339	Invalid IDS code. Transaction not posted.
30340	Invalid EDS code. Transaction not posted.
30341	Invalid SDS code. Transaction not posted.
30342	Invalid Screen Assessment Score. May not be blank. Transaction not posted.
30343	Missing one or more of IDS, EDS, SDS when required
30344	Missing Assessment Score when required

Error code	Description
30345	Invalid Detention Facility NPI. Transaction not posted.
30346	Invalid DCR Agency NPI. Transaction not posted.
30347	Invalid Start Time. Transaction not posted.
30348	Invalid Investigation Outcome code. Transaction not posted.
30349	Invalid Investigation Referral Source code. May not be null. Transaction not posted.
30350	Invalid Hearing Outcome. Transaction not posted.
30351	Invalid Hearing Date. Transaction not posted.
30352	Invalid Program code. Transaction not posted.
30353	Invalid Episode Record key. May not be blank. Transaction not posted.
30354	Invalid Episode Modality code. Transaction not posted.
30355	Invalid Discharge Reason code. May not be null if Discharge Date is included. Transaction not posted.
30356	Invalid Referral Source code. May not be null. Transaction not posted.
30357	Invalid Substance One code. Transaction not posted.
30358	Invalid Substance Two code. Transaction not posted.
30359	Invalid Substance Three code. Transaction not posted.
30360	Invalid Age at First Use One code. May not be blank. Transaction not posted.
30361	Invalid Age at First Use Two code. May not be blank unless Substance Two equals 1. Transaction not posted.
30362	Invalid Age at First Use Three code. May not be blank unless Substance Three equals 1. Transaction not posted.
30363	Invalid Frequency Use One code. May not be blank. Transaction not posted.
30364	Invalid Frequency Use Two code. May not be blank unless Substance Two equals 1. Transaction not posted.
30365	Invalid Frequency Use Three code. May not be blank unless Substance Three equals 1. Transaction not posted.
30366	Invalid Peak Use One code. May not be blank. Transaction not posted.
30367	Invalid Peak Use Two code. May not be blank unless Substance Two equals 1. Transaction not posted.
30368	Invalid Peak Use Three code. May not be blank unless Substance Three equals 1. Transaction not posted.
30369	Invalid Method Use One code. May not be blank. Transaction not posted.
30370	Invalid Method Use Two code. May not be blank unless Substance Two equals 1. Transaction not posted.

Error code	Description
30371	Invalid Method Use Three code. May not be blank unless Substance Three equals 1. Transaction not posted.
30372	Invalid Last Used One Date. May not be blank. Transaction not posted.
30373	Invalid Last Used Two Date. May not be blank unless Substance Two equals 1. Transaction not posted.
30374	Invalid Last Used Two Date. May not be blank unless Substance Three equals 1. Transaction not posted.
30375	Invalid Batch Date in the header row.
30378	ASAMRecordKey may not be blank. Transaction not posted.
30379	ASAMRecordKey may not contain non-alphanumeric characters. Transaction not posted.
30380	Disallowed characters in SourceTrackingID. Transaction not posted.
30381	Invalid Revocation Authority code. Transaction not posted.
30382	ProgramIDKey may not be blank. Transaction not posted
30383	Disallowed characters in ProgramIDKey. Transaction not posted.
30384	Invalid First offered date in the Service Episode 170.06
30385	Invalid date for Date of Last Contact. Transaction not posted.
30386	Invalid Opiate therapy code in the Service Episode 170.06
30387	Invalid Service Episode End Reason. Transaction not posted
30390	Invalid Funding code. Transaction not posted.
30391	Invalid Income Source Id. Transaction not posted.
30392	Block Grant funding code invalid.
30393	Invalid SMI-SED status code. Transaction not processed.
30394	Invalid characters in the ProfileRecordKey.
30400	Invalid Batch Number. File not processed.
30401	Batch out of sequence. File not processed
30402	Invalid Transaction Code. Transaction not posted.
30403	Expired transaction code. Transaction not posted.
30404	Record unchanged from previously sent record. Only Update Date touched.
30405	Duplicate record, transaction not posted
30406	Record to change could not be found, transaction not posted.
30407	Record to delete could not be found, transaction not posted.

Error code	Description
30500	Invalid Mobile Crisis Response Type (effective 7/10/2025 – Invalid Mobile Rapid Response Crisis Team Response Type)
30501	Invalid Time value in transaction
30502	Invalid Event Start date or Event End date (Effective 7/10/25 Invalid Dispatch Date or Event End date)
30503	Invalid Referral Source
30504	Invalid Interpreter Flag
30505	Invalid Presenting problem code
30506	Invalid Co-Responder code (within parsed string)
30507	Invalid Referral Given code
30508	Invalid MCR (MRRCT) Outcome code
30509	Invalid MCR (MRRCT) Agency NPI
30510	Invalid MCR (MRRCT) Servicing Provider NPI
30511	Invalid Date of Deployment
30512	Invalid Date of Arrival
30513	Invalid Level of Acuity
30520	No record match for delete. Deletion not executed.
30521	Client Demographic transactions may not be directly deleted. Use Cascade Delete or Cascade Merge.
99999	Temp error number place holder

Notes

A blank response means the file was rejected, or an unrecoverable error occurred.

Appendix C: Entity Relationship Diagram (ERD)

View the entity relationship diagram.

Appendix D: Process Flow Chart

This flowchart is meant to provide an overview of the process and not as a requirement or meant to capture every scenario. View the process flow chart.

Appendix E: Submission Instructions

File naming convention for supplemental data submissions submitted on behalf of another entity

Name files correctly by following the file naming standard below. Do not exceed 50 characters:
<Submitter ID>. <Batch Date>. <Batch Number >. <MCO ID>.txt

- <Submitter ID> – The Submitter ID. Entity who is submitting to HCA. (Same as the 7-digit ProviderOne ID plus the 2-digit location code)
- <Batch Date> – The date a batch file of transactions was created
- <Batch Number> – A sequential 5-digit number using leading zeros
- <MCO ID> – The MCO ID that the file is being submitted on behalf of (Same as the 7-digit ProviderOne ID plus the 2-digit location code)

An example of an entity submitting files on behalf of another entity:
205437602.<Batch Date>. <Batch Number>.105010110.txt

File naming convention for supplemental data submissions when not submitting on behalf of another entity

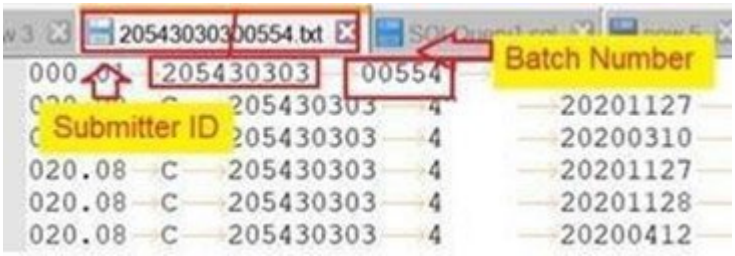
Name files correctly by following the file naming standard below. Do not exceed 50 characters:

- <Submitter ID> – The Submitter ID. Entity who is submitting to HCA. (Same as the 7-digit ProviderOne ID plus the 2-digit location code)
- <Batch Number> – A sequential 5-digit number using leading zeros.

An example of an entity submitting files:
105020603.<Batch Number>.txt

Validation

- The filename and the header (000.01) row must match on the Submitter ID and the batch number.



- In the filename and header row, Submitter must use their active Submitter ID.
- The transaction rows should use the Submitter ID that corresponds to the date of the transaction.

Batch file size limitations

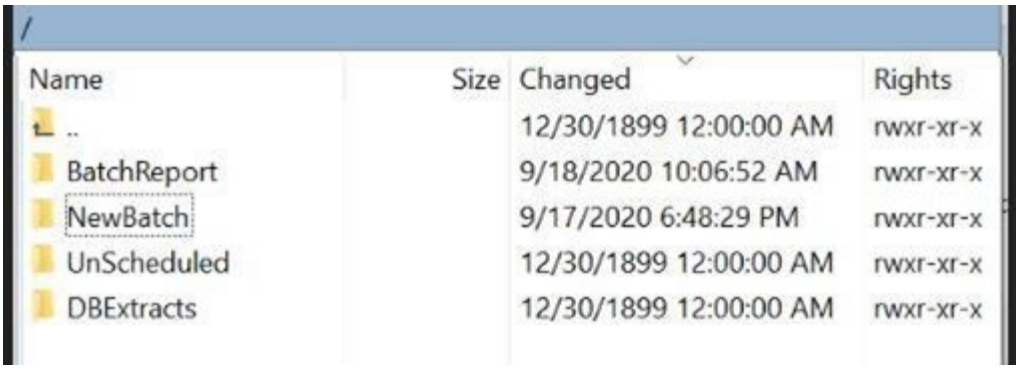
- If the file size is 350Kb then 400 files may be submitted at a time.
- If the file size is 800Kb to 900Kb then please limit the files to 300 at a time.
- Daily scheduled runtime (includes weekends)
- 7:00 AM, 10:00 AM, 1: 00 PM, 4 :00 PM, 7:00 PM.

MFT Upload Instructions

- Each organization will have a login account that is made up of the initials, the type of user (MCO/BH-ASO), and the number “1”. The test accounts have a “-t” in the login name.

- Using Community Health Plan of WA as an example:
    - “hca-communityhealthplanswa” is the Production account.
    - “hca-communityhealthplanswa-test” is the Test account.

The contractor will use their account to log into the MFTP. The MFTP account folders look like this:



Once logged in with the production account the contractor will place the txt files in the production folder corresponding to their account if they are submitting production data. If they are testing, they will use the testing login and place a text file in the test account. Only txt files will be accepted.

The daily (including weekends) processing times are as follows:

- 07:00 AM
- 10:00 AM
- 01:00 PM
- 04:00 PM
- 07:00 PM

If there is an urgent need the contractor should, submit a help ticket to **MMISHelp@hca.wa.gov**.

The job processes the file and produces an error report that gets returned to the contractor with error information regarding which records were processed. Validation of the data will be based on date in the transaction (i.e., Effective Date).

For issues related to MFT access or questions, contact the HCA Service desk at **ServiceDesk@hca.wa.gov**. For all other BHDS or BHDG related questions please contact ProviderOne Help at **MMISHelp@hca.wa.gov**.

Appendix F: Instructions for Submitting DOH License Number on BH Encounters

This is the site-specific Licensed Number assigned by the Department of Health and called the DOH License number. Please refer to the State of Washington 837 Professional and Institutional Encounter Data Companion Guide and Encounter Data Reporting Guide (EDRG) for reporting requirements.

The BH encounter data is joined with BHDS supplemental data transactions for reporting purposes. The DOH license number must be submitted on all BH encounters so HCA can report the site specific location the services occurred at.

Appendix G: Primary Language Code List

Codes submitted should be the first three letters. If there are two codes for a particular language they can be used interchangeably, but preferably the bibliographic version designated as "B" (bibliographic) of the code is used.

Note: It is not mandatory to use all the language codes, and each contractor is able to choose a set of common language codes to use. Once a shorter list for a specific provider is chosen code "und" = undetermined can be used for languages not on the chosen shorter list.

Find the full list at the **International Organization for Standardization website**.

Appendix H: Nationally Accepted HIT Code References

Crosswalk values are added to their corresponding data element.

Standard Development Organizations	Description	Link
LOINC®	LOINC (Logical Observation Identifiers Names and Codes) common terminology for laboratory and clinical observations to send clinical data electronically from laboratories and other data who use the data for clinical care and management purposes.	LOINC
SNOMED CT®	SNOMED CT (Systematized Nomenclature of Medicine-Clinical Terms) is a systematically organized computer processable collection of medical terms providing codes, terms, synonyms, and definitions used in clinical documentation and reporting. SNOMED CT is considered the most comprehensive, multilingual clinical healthcare terminology in the world. SNOMED CT is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information.	SNOMED CT®
CDC/PHIN	CDC PHIN Vocabulary Coding System concepts are used when the public health concepts are not available in the Standard Development Organization (SDO) Vocabulary (e.g., SNOMED CT, LOINC). The CDC/PHIN includes code systems for: • Race & Ethnicity Code System • Race • Ethnicity Hierarchy	CDC PHIN vocabulary CDC PHIN code systems
OMB	OMB (Office of Management and Budget) established codes for race categories.	OMB race categories

Appendix I: Provider Entry Portal (PEP)

The provider entry portal (PEP) is used for non-tribal providers providing services to tribal members. Although the PEP references this data guide, there are additional instructions specified in Provider Entry Portal materials that should be followed for complete transmission. If there are questions or if transactions are not accepted, please contact PEP support.

Appendix J: Criminal Justice Treatment Account (CJTA) (150.01)

Although the CJTA program references this data guide, there are additional transactions specified in CJTA guides that should be followed for complete transmission. Links to CJTA guides will be referenced here when available.

Appendix K: Guidance Attachments

Closing Service Episode of Care Guidance

Purpose: Provide guidance on length of time for an episode to remain open from the last date of contact/visit for an enrollee receiving Behavioral Health Services including Mental Health and Substance Use Disorder.

SUD: If an Enrollee has not actively participated in treatment, HCA recommends closing the service episode after more than 45 days of no contact.

MH: If an Enrollee has not actively participated in treatment, HCA recommends closing the service episode after more than 90 days of no contact.

Before closing: The Contractor has demonstrated reasonable efforts, meaning at least 3 or more attempts to re-engage the Enrollee into services, the Contractor may choose to discharge the Enrollee from services.

Contractors and providers will work internally on policies and procedures regarding discharge guidelines that include outreach to the client before discharging.

BHDS Glossary

1st routine encounter: First non-crisis encounter following the intake/assessment.

Action Code: Action codes are used to modify the data in the database. Actions codes in BHDS are A (add), C (change) and D (delete). More information is provided in the Add/Change Status section of the document.

Admission: For both SUD/MH- An admission is defined as the formal acceptance of a client into substance abuse or mental health treatment program.

Agency: Providers, agencies, or entities providing services directly to clients in the community.

Assessment/Intake Evaluation:

- For SUD: the activities conducted to evaluate an individual to determine if the individual has a substance use disorder and determine placement in accordance with the American Society of Addiction Medicine (ASAM) criteria.
- For MH: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, stabilization services and freestanding evaluation and treatment. The completion of the intake is to determine provisional diagnoses and to establish medical necessity for ongoing treatment.

Behavioral Health Supplemental Transaction: Transactions submitted to the BHDS, aka: non-encounter transactions.

(BHDC) Behavioral Health Data Consolidation: The project effort to integrate both mental health and substance use disorder.

(BHDS) Behavioral Health Data System: This is the process for submission of the client-level data to DBHR.

CDC/PHIN: CDC PHIN Vocabulary Coding System concepts are used when the public health concepts are not available in the Standard Development Organization (SDO) Vocabulary (e.g., SNOMED CT, LOINC).

The CDC/PHIN includes code systems for:

- Race & Ethnicity Code System
- Race
- Ethnicity Hierarchy

Client: Person needing services; person identified in BHDS.

Clinician: Medical professional having direct contact with and responsibility for patients.

Data Element: Field of data.

Date of Request for Service: Date of the request for mental health or substance use services. This will be the date when services are sought or applied for through a telephone call; the date of a walk-in or written request from the individual or, those defined as family; or the date on the receipt of a written EPSDT referral. Although not a clinical intervention or treatment service, request for services is documented for all individuals seeking non-crisis services.

DBHR: Division of Behavioral Health and Recovery

Discharge: Treatment has ended or has been completed and the client is no longer receives services from a particular provider agency for the associated treatment episode.

(EDI) Electronic Data Interchange: The computer-to-computer exchange of business data in standard formats.

EDI 837: The EDI (Electronic Data Interchange) 837 transaction set is the format established to meet HIPAA requirements for the electronic submission of healthcare claim information. The claim information included amounts to the following, for a single care encounter between patient and provider.

EDI X12N (Electronic Data Interchange): A data format based on ASC X12 standards. It is used to exchange specific data between two or more trading partners. Term 'trading partner' may represent organization, group of organizations or some other entity.

GAIN-SS: Global Assessment of Individual Needs-Short Screener

Identifier: Unique key for an entity.

(LOINC) Logical Observation Identifiers Names and Codes: Common terminology for laboratory and clinical observations to send clinical data electronically from laboratories and other data who use the data for clinical care and management purposes.

Contractor Administrator: The head of the organization at the level able to commit the organization and its resources into programs. This does not necessarily mean the CEO, but often is at that level.

(MCOs) Managed Care Organizations: Includes Managed Care Organizations and Behavioral Health- Administrative Service Organizations.

Mental Health: Refers to our cognitive, behavioral, and emotional wellbeing - it is all about how we think, feel, and behave.

MH-CIS: Legacy Mental Health Information System –Mental Health Consumer Information System

Modality: The method of application of a therapeutic agent or treatment regimen. Specific to a substance use level of care.

(OMB) Office of Management and Budget: Established codes for race categories.

On change: Verification with client if information has changed.

Pre-intake: Prior to assessment/intake.

Provider Agency: Sites providing mental health and substance abuse services to clients.

QHH: Qualified Health Home

Quadrant Placement: Quadrant placement was defined using data that is routinely gathered in clinical care or available in administrative data sets (i.e., substance dependence diagnosis, Global Assessment of Functioning scores).

(RCW) Revised Code of Washington: An RCW, or law, is the result of legislation that has been passed by the House and Senate and has been signed by the Governor. The Revised Code of Washington contains all laws that have been adopted in the State of Washington, as well as a history of all laws that have previously existed or been amended.

SAMHSA: Substance Abuse and Mental Health Services Administration

Service Episode: The service episode transaction collects treatment milestone data for clients receiving behavioral health services. It is used to meet SAMHSA reporting requirements as well as other outcomes/measures listed in the State Plan. A service episode is required for all SUD clients, MH outpatient or when a client enrolls in any program listed in the program ID for a single agency/provider. A service episode can be opened for services outside of those requirements.

Service Episode End Date: Indicates the date the client stopped receiving SUD/MH treatment at the provider agency for the associated treatment episode. This is also referred to as the “discharge date”.

Service Episode Start Date: Indicates the date the client began receiving SUD/MH treatment at the provider agency for the associated treatment episode. This is also referred to as the “Admission Date”.

(SNOMED/SNOMED CT) Systematized Nomenclature of Medicine--Clinical Terms: A systematically organized computer processable collection of medical terms providing codes, terms, synonyms, and definitions used in clinical documentation and reporting. SNOMED CT is the most comprehensive, multilingual clinical healthcare terminology in the world.

SNOMED CT is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information.

SUD: Substance Use Disorder

TARGET: Legacy SUD System, Treatment and Assessment Reports Generation Tool

Transaction: A set of submitted data or date table. In the context of this guide, it is the set of data denoted with a number (020.27 – Client Demographics).

(WAC) Washington Administrative Code:
Regulations of executive branch agencies are issued by authority of statutes. Like legislation and the Constitution, regulations are a source of primary law in Washington State. The WAC codifies the regulations and arranges them by subject or agency.

Withdrawal Management Services:
Professional services to people in the process of screening, assessing, preparing, planning, and monitoring of withdrawal symptoms.