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Behavioral Health and Recovery Division [BHRD]

# Data Dictionary

*for*

King County Integrated Care Network [KCICN]  
Behavioral Health Administrative Services Organization [BH-ASO]

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## Transaction: ASAM Placement

**Definition:**

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

**Required for:**

- SUD Outpatient Benefits
- SUD Residential
- SUD Detox (Withdrawal Management)
- SUD OST
- SUD Assessment Only
- SUD Secure Detox

**Procedure:**

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

**Frequency:**

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

**Transaction ID:** 170.02

**Action Codes:**

A	Add
C	Change
D	Delete

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

### History:

- Significant changes were made to this transaction effective 6/15/2017:
  - Revised the “Level” attribute name to “Level Planned” and modified the definition to clarify that this reflects the planned treatment. The basic meaning for this attribute has not changed from the from the 4/1/2016 data dictionary.
  - Revised the list of ASAM Level Planned codes and levels to only include levels that are funded by the BH-ASO/KCICN.
  - Replaced the ‘Risk Rating’ attributes for Dimensions 1 through 6 with new ‘ASAM Level’ attributes for Dimensions 1 through 6.
  - Revised the list of ASAM Levels that may be submitted for Dimension 1 (Acute intoxication and withdrawal potential) to only allow code 0 for adolescents, and to only allow code 0 or “Withdrawal management” ASAM Levels for adults.
  - Added OTP as an outpatient treatment level that may be submitted for Dimensions 2 through 6 and removed the “OST Indicator” attribute.
  - Added documentation at the end of the transaction to describe the logic and data BHRD will use to derive an overall “ASAM Level Indicated” value from the submitted provider data for an individual on the event date and submit that value to the state.

**Attribute:** *Level Planned***Transaction:**

ASAM Placement

**Definition:**

Indicates the level of care that the clinician recommends for the client as a treatment placement currently.

**Procedure:**

- Only levels that are eligible for BH-ASO/KCICN-funded services may be submitted.
- The Level Planned from an assessment will be used to validate the level(s) of care associated with the program code for an SUD authorization request with that assessment date. Levels accepted for each program code (stored in the sp\_program\_asam table in the ASO/KCICN database) are listed below.

Program	Level Planned
DTX	3.2WM
DTX	3.7WM
OST	0.5
OST	1
OST	2.1
500/501	0
500/501	1
500/501	2.1
500/501	0.5
SRS	3.1
SRS	3.3
SRS	3.5
SRS	3.7

**Required Documentation:**

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

**Type:** Text (6)

Valid Codes	Definition	Program
0	<i>No further ASAM placement level recommended.</i>	
0.5	<p><i>Early Intervention</i></p> <p>Services that explore and address any problems or risk factors that appears to be related to substance use and addictive behavior, and to help the individual recognize the harmful consequences of high-risk substance use and/or addictive behavior. Such individuals may not appear to meet the diagnostic criteria for a substance use disorder but require early intervention for education and further assessment.</p>	<p><i>S02:</i> Recovery Support</p> <p><i>OST:</i> Opiate Substitution Treatment</p>
1	<p><i>Outpatient</i></p> <p>Encompasses organized outpatient treatment services which may deliver addiction, mental health treatment, or general health care personnel, including addiction –credentialed physicians, provide professionally directed screening, evaluation, treatment and ongoing recovery and disease management. This service is provided in regularly scheduled sessions of fewer than 9 contact hours for adults and fewer than six hours for adolescents per week.</p>	<p><i>S01:</i> OP/IOP</p> <p><i>OST:</i> Opiate Substitution Treatment</p>
2.1	<p><i>Intensive Outpatient</i></p> <p>Needs for psychiatric and medical services are addressed through consultation and referral arrangements. This service is provided in 9-19 hours of structured counseling and education about addiction-related and mental health problems per week.</p>	<p><i>S01:</i> OP/IOP</p> <p><i>OST:</i> Opiate Substitution Treatment</p>
3.1	<p><i>Clinically Managed Low Intensity Residential Services</i></p> <p>Directed towards applying recovery skills, relapse prevention, emotional coping strategies, promoting personal responsibility, and reintegration back into work, education and family life while living in a 24-hour structured environment. This also includes at least 5 hours of professional addiction services per week. Often, consumers enter this level of care upon completion of or with ongoing treatment in other levels of service.</p>	<p><i>SRS:</i> SUD Residential Treatment</p>
3.2WM	<p><i>Clinically Managed Residential Withdrawal Management</i></p> <p><b>Not valid for clients under the age of 19.</b></p> <p>This level emphasizes peer and social support and is intended for patients whose intoxication and/or withdrawal is sufficient to warrant 24-hour support.</p>	<p><i>DTX:</i> <i>Detox</i></p>

Valid Codes	Definition	Program
3.3	<p><i>Clinically Managed Population-Specific High Intensity Residential Services</i></p> <p>Consumers enter this level of service when the effects of substance use or other addictive disorder or a co-occurring disorder resulting in cognitive impairment on the individual's life are so significant and the resulting level of impairment is so great that outpatient motivational and/or relapse prevention strategies are not feasible or effective. Programming and staffing address more severe medical, emotional, cognitive, and behavioral problems. Case management provides a "wrap-around" service.</p>	SRS: SUD Residential Treatment
3.5	<p><i>Clinically Managed High Intensity Residential Services</i></p> <p>Assist individuals whose substance use is currently so out of control that they need 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. Treatment is specific to maintaining abstinence from substance use, arrest other addictive and antisocial behaviors and effect change in participants' lifestyles, attitudes, and values. Preventing relapse while vigorously promoting personal responsibility and positive character change in an intense therapeutic community.</p>	SRS: SUD Residential Treatment
3.7WM	<p><i>Medically Monitored Inpatient Withdrawal Management</i></p> <p><b>Not valid for clients under the age of 19.</b></p> <p>Unlike Level 3.2-WM, this level provides 24-hour medically supervised withdrawal management services.</p>	DTX: Detox

**Attributes:** *Dimension 1 – 6 ASAM Level***Transaction:**

ASAM Placement

**Required Documentation:**

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

**Type:** Text (6)**Dimension 1 ASAM Level****Definition:***Acute Intoxication and/or Withdrawal Potential***Procedure:**

- Withdrawal management codes will not be accepted for adolescents (clients under 19 years of age) on the assessment date. Submit code 0 on Dimension 1.

Valid Codes	Adolescent	Adult	Definition
0			Place holder for people who are truly not at any risk
1-WM	Not valid for adolescents	Ambulatory WM without Extended On-Site Monitoring	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery
2-WM	Not valid for adolescents	Ambulatory WM with Extended On-Site Monitoring	Moderate withdrawal with all day withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal management
3.2-WM	Not valid for adolescents	Clinically Managed Residential WM	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery

Valid Codes	Adolescent	Adult	Definition
3.7-WM	Not valid for adolescents	Medically Monitored Inpatient WM	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring
4-WM	Not valid for adolescents	Medically Managed Intensive WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability

**Dimension 2 ASAM Level****Definition:**

*Biomedical Conditions and Complications*

**Dimension 3 ASAM Level****Definition:**

*Emotional, Behavioral, or Cognitive Conditions and Complications*

**Dimension 4 ASAM Level****Definition:**

*Readiness to Change*

**Dimension 5 ASAM Level****Definition:**

*Relapse, Continued Use or Continued Problem Potential*

**Dimension 6 ASAM Level****Definition:**

*Recovery/Living Environment*

**Common code list used for all Dimensions 2-6**

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

<b>Valid Codes</b>	<b>Adolescent</b>	<b>Adult</b>	<b>Definition</b>
3.7	Medically Monitored High-Intensity Inpatient Services	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimension 1, 2, or 3. 16 hour/day counselor ability
4	Medically Managed Intensive Inpatient Services	Medically Managed Intensive Inpatient Services	24-hour nursing care daily physician care for severe, unstable problems in Dimension 1, 2, or 3. Counseling available to engage patient in treatment
OTP	Some OTPs not specified for adolescent populations	Opioid Treatment Program (LEVEL 1)	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid disorder
9	Not valid for adolescents	WM Services	Unable to Assess (WMS Only)

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

1. Only the ‘withdrawal management’ levels and ‘0’ (No ASAM placement level) may be used for Dimension 1, and that is the only dimension for which they may be submitted.
2. In using logic to derive an ‘ASAM Level Indicated’, the three residential/inpatient withdrawal management levels will rank above any treatment level, but any treatment level (1 – 4 or OTP/1) will rank above the two withdrawal management levels that are ambulatory.
3. The explicit ‘withdrawal management’ levels as placement levels do not apply to adolescents (under 19 on assessment date) because they do not exist as stand-alone levels of care with adolescents
  - a. BHRD IS will reject any WM level if submitted as the ‘Level Planned’ level for someone under 19 on the assessment date OR as the level for Dimension 1.
4. BHRD will identify the ‘ASAM level indicated’ by the assessment of an individual’s ASAM level on each dimension using this logic:
  - a. For adults (19 or older on the assessment/ASAM date):
    - i. If the ASAM level for Dimension 1 indicates one of the three highest Withdrawal Management levels (3.2, 3.7, 4), that is the ‘ASAM Level Indicated’.
    - ii. Otherwise, the ASAM Level Indicated is the highest level (largest number) indicated on any of the other five dimensions. For the purpose of this ordering, “OTP (Level 1)” will be treated as 2.2. See the table below.
    - iii. For adolescents (under 19 on the ASAM date): the ASAM Level Indicated is the highest level (largest number) indicated on any of Dimensions 2 through 6. For the purpose of this ordering, “OTP (Level 1)” will be treated as 2.2. See the table below.
5. Additional notes on the ‘OST Indicator’ that is being dropped, and the ‘OTP (LEVEL 1)’ code now added for Dimensions 2 – 6:
  - a. BHRD does not need ‘OST Indicator’ for authorization processes, but simply accepts Levels 0.5, 1 or 2.1 as appropriate when a provider requests an OST authorization.
    - i. Doing this allows the same set of ASAM data to support a simultaneous SUD outpatient authorization, which is allowed by the BH-ASO/KCICN (as of June 1, 2017).
  - b. BHRD needs to use the state’s ‘OTP (LEVEL 1)’ as an ‘ASAM Level’ when sending data to the state and will do that by including ‘OTP (Level 1)’ on the lists for Dimensions 2-6 but treating it as if it is level ‘2.2’ in the treatment ranking. If one or more dimensions have ‘OTP’ and no other dimension is higher than ‘2.1’, BHRD will send ‘OTP’, otherwise the highest treatment level treatment will be selected and sent.

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

<b>Code</b>	<b>Definition</b>	<b>Dimensions Submitted for</b>
4-WM (Level of Withdrawal Management (WM) for Adults)	Medically Managed Intensive WM: Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability	1 (adults only)
3.7-WM (Level of Withdrawal Management (WM) for Adults)	Medically Monitored Inpatient WM: Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring	1 (adults only)
3.2-WM (Level of Withdrawal Management (WM) for Adults)	Clinically Managed Residential WM: Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery	1 (adults only)
4	Medically Managed Intensive Inpatient Services: 24-hour nursing care daily physician care for severe, unstable problems in Dimension 1, 2, or 3. Counseling available to engage patient in treatment	2, 3, 4, 5, 6
3.7	Medically Monitored Intensive Inpatient Services: 24-hour nursing care with physician availability for significant problems in Dimension 1, 2, or 3. 16 hour/day counselor ability	2, 3, 4, 5, 6
3.5	Clinically Managed High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community	2, 3, 4, 5, 6
3.3	Clinically Managed Population Specific High Intensity Residential Services: 24-hour care with trained counselor to stabilize multidimensional imminent danger. Less intensive milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community	2, 3, 4, 5, 6
3.1	Clinically Managed Low-Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours clinical services/week	2, 3, 4, 5, 6
2.5	Partial Hospitalization Services: 20 or more hours of services/week for multidimensional instability not requiring 24-hour care	2, 3, 4, 5, 6

Code	Definition	Dimensions Submitted for
OTP (LEVEL 1)	Opioid treatment program: Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid disorder	2, 3, 4, 5, 6
2.1	Intensive outpatient services: 9 or more hours of services/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	2, 3, 4, 5, 6
1	Outpatient services: Less than 9 hours of services/week (adult); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	2, 3, 4, 5, 6
0.5	Early intervention: Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder	2, 3, 4, 5, 6
2-WM (Level of Withdrawal Management (WM) for Adults)	Ambulatory WM with Extended On-Site Monitoring: Moderate withdrawal with all day withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal management	1 (adults only)
1-WM (Level of Withdrawal Management (WM) for Adults)	Ambulatory WM without Extended On-Site Monitoring: Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery	1 (adults only)
0	No intervention needed: Place holder for people who are truly not at any risk	2, 3, 4, 5, 6

## Transaction: Authorization Request

### Definition:

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

### Required for:

All programs except for programs 00(No benefit requested.)

### Procedure:

- Authorization request transactions for SUD FFS, MH outpatient, and residential benefits that are paid on a case rate basis must be posted by the last day of the second calendar month following the assessment date. For example, if the assessment date is July 12, 2020, the authorization request must be posted by September 30, 2020.
- PACT clients must be pre-approved for PACT programs 57(PACT Engagement) and 58(PACT Enrollment) on or before assessment date.

### Frequency:

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

**Transaction ID:** 670.02

### Action Codes:

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

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**Attribute:** *Date of Assessment*

**Transaction:**  
Authorization Request

**Definition:**

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

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

**Procedure:**

- In general, the start date of the authorization is the date of the assessment.
- For benefit change codes 02 and 05, submit the date of the new assessment.
- For a client who does not meet medical necessity criteria for the outpatient level of care, submit the date of the assessment (Assessment Only benefits 112, SA0 and SA1).

**Required Documentation:**

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

**Examples:**

1. A person was assessed on January 15, 2020. The assessment took two hours and was completed that day. Enter 20200115.
2. A homeless person was identified for services on February 3, 2020. The clinician began interaction with the client on February 17, 2020, and completed the assessment on March 2, 2020. Enter 20200217.

**Type:** Date (8)  
YYYYMMDD

**Attribute:** *Benefit/Program Requested***Transaction:**

Authorization Request

**Definition:**

The outpatient (mental health, SUD) or residential (mental health) benefit or BH-ASO/KCICN-administered program (see Provider Manual) requested by a provider for a client assessed against medical necessity and/or program-specific criteria. Below is a comprehensive list of programs. Providers may only request programs for which they are eligible to provide services as determined by their contract with King County.

**Procedure:**

- Submit a separate request for each outpatient or residential benefit or BH-ASO/KCICN-administered program from which a client will receive services.
- Each authorized outpatient or residential benefit or BH-ASO/KCICN-funded program from which a client receives services will have a unique authorization number assigned. (See “Authorization Number” attribute.) This number will link the client and service events with the outpatient or residential benefit or the BH-ASO/KCICN-funded program under which the service was delivered.
- Mental Health Outpatient Benefits 400 and 401 are stratified by the KC Population Health Stratification (PHS) tool and assigned a level of care (Low, Medium, or High) based on available data (both agency supplied and external data sources).
- See the King County Medical Necessity Criteria in: Behavioral Health and Recovery Division (BHRD) Provider Manuals: <https://kingcounty.gov/en/dept/dchs/human-social-services/behavioral-health-recovery/provider-resources>
- The “Program Overlap Rules” document provides details on which programs can overlap and under what conditions. The “Program Overlap Rules” document is available in the ISAC Notebook.

**Examples:**

1. Based on an assessment, the provider requests an authorization for a mental health outpatient benefit by submitting code “400.” The authorization is created by BHRD IS and is assigned an authorization number. The level of care (L, M, H) is determined by the PHS tool and reported back to the provider.
2. Based on an assessment, the provider determines that a Medicaid client does not meet medical necessity criteria for the outpatient level of care and submits code “112” for benefit code requested. An “Assessment Only” (112) authorization record is created by BHRD IS and is assigned an authorization number. Based on an assessment, the provider requests an authorization for an SUD outpatient benefit by submitting code “500” (Medicaid) or “501” (Non-Medicaid.) The authorization is created by BHRD IS and is assigned an authorization number.
3. During an outpatient benefit period, a client decompensates and the DCRs approve the use of a hospital diversion bed. The provider submits a new authorization request using code 74.

**Type:** Text (3)

Valid Codes	Definition
<b>Outpatient Level of Care (Mental Health)</b>	
00	No benefit requested. Client did not keep appointment (Medicaid Clients only)
112	Assessment Only (OPB). Client did not meet medical necessity.
400	Mental Health Outpatient Medicaid Funded
401	Mental Health Outpatient MIDD Funded (Non-Medicaid)
450	Mild to Moderate Mental Health Services
<b>Outpatient Level of Care (SUD)</b>	
SA0	SUD Assessment Only - client did not meet ACS
SA1	SUD Assessment Only - ACS met - Referred elsewhere
500	SUD Outpatient –Medicaid
501	SUD Outpatient - MIDD
<b>Additional Outpatient Services</b>	
09	PES Care Manager (Harborview ED)
25	Specialty Employment Program (SEP)
57	PACT, Engagement
58	PACT, Enrollment
60	HOST Outreach
61	HOST Intensive Case Management/Stabilization
66	Expanding Community Services Intensive Community Support & Recovery Program
90	Peer Bridger
91	Familiar Faces Intensive Care Management Team
93	SHARP Enrollment
94	HARPS
95	LINC
103	Re-entry Case Management
107	MIDD Wraparound
108	Family Treatment Court Wraparound
111	Moral Reconciliation Therapy-Domestic Violence
113	Transition Support Program
114	HOME Outreach
115	HOME Enrollment
116	Outreach - Assisted Outpatient Treatment (AOT)
117	Court Ordered - Assisted Outpatient Treatment (AOT)
155	Competency Boundary Spanner
156	Law Enforcement Assisted Diversion (LEAD)
157	Community Outreach and Advocacy Team (COAT)
159	Western State Hospital Peer Bridger Program
S03	Older Adult SUD Treatment
162	ACRS – Promoting Peace and Recovery
163	ACRS - Community Center for Alternative Programs – SUD Services

164	South King County Pretrial Services
172	Vital program - Intensive Care Management Team Medicaid [Harborview ONLY]
177	KCSARC Specialty Services
178	Hero House NW Day Support
179	Housing Outreach Partners
180	New Journeys (First Episode Psychosis)
261	Occupational Therapy
300	WSH Discharge Transition
403	Community Outreach and Advocacy Team - COAT Medicaid
430	PATH
451	Medication for Opioid Use Disorder (MOUD)
460	Hospital Liaisons
462	Peer Pathfinder
520	Health to Housing (HtH) BH Mobile Team
521	Permanent Supportive Housing (PSH) BH Mobile Team
531	Brief Intervention for Substance Use
ADC	Adult Drug Court
AOS	Assisted Outpatient Services Program
BUP	Opioid Buprenorphine Contracts
DOC	Department of Corrections
LOE	(LEAD) Outreach and Engagement
OST	SUD Opiate Substitution Treatment (MAT)
<b>Crisis Level of Care</b>	
13	Children's Crisis Outreach Response System (CCORS)
15	CCORS Intensive Stabilization Services
40	Adult Crisis Stabilization (including next day appointment)
74	Adult Inpatient Diversion Bed
75	Crisis Respite Program – DESC
79	Crisis Diversion Interim Services
80	Crisis Diversion Facility Team
119	Overdose Recovery & Care Access (ORCA)
120	CORS-YA
160	Involuntary Treatment Triage
166	Youth Connection Services YCS
200	Connections - Urgent Care
201	Connections - 23 Hour Observation
202	Connections - Crisis Stabilization Unit
203	Connections - Transitions
276	Mobile Rapid Response Crisis Team (MRRCT)
530	SUD Crisis Services NDA

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DTX	SUD Detoxification
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<b>Residential Level of Care (SUD)</b>	
SRS	SUD Residential {NOT SUBMITTED THROUGH THIS TRANSACTION. Entered by Authorizer through the Inpatient application.}
<b>Residential Level of Care (Mental Health)</b>	
71	Adult Long-Term Rehabilitation Benefit
72	Adult Supervised Living Benefit
73	Adult Long-Term Rehabilitation Benefit (Benson Heights)
121	Intensive Behavioral Health Treatment Facilities [IBHTF]
122	Intensive Residential Treatment (IRT)
123	Intensive Step-Down Phase 1
124	Intensive Step-Down Phase 2
366	Enhanced-Intensive Community Support and Recovery Program (E-ICSRP)
372	Intensive Supportive Housing
373	Standard Supportive Housing Benefit
<b>Inpatient Level of Care</b>	
IP	Inpatient Benefit {NOT SUBMITTED THROUGH THIS TRANSACTION; Entered by Authorizer through the CCS or Inpatient application.}

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**Attribute:** *Benefit Change Code***Transaction:**

Authorization Request

**Definition:**

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

**Procedure:**

- Code '61' is used to request a provider change from an outpatient benefit to a new outpatient benefit with a different provider, within the same treatment focus. Once the new benefit goes to 'AA' status, the previous benefit is automatically terminated. For the provider change authorization request to process successfully, the existing outpatient benefit must have a status of 'AA' and the assessment date for the new authorization request must be between the start and expire dates of the existing outpatient benefit.

**Required Documentation:**

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

**Examples:**

1. A provider identifies a client as both eligible for and in need of services. The provider submits the first authorization request to provide services to the client. Use Code '01'
2. A client who currently has a MIDD funded mental health outpatient benefit that expires within 30 days sees the client for a reassessment and determined eligible for and in need of continued services. The provider submits a continuation of benefit request for a 400 or 401 authorization (as determined by current Medicaid Eligibility). Use Code '05'.
3. A provider requested a 400 benefit for a client who did not have Medicaid on the date of assessment and needs to submit a new authorization request to change it to 401 (Non-Medicaid). Use Code '02'.
4. 4. provider requests an SUD outpatient benefit for a client who currently has a SUD outpatient benefit with the same treatment focus with another provider. Use Code '61' to submit a benefit request for a 500 or 501 authorization.

**Type:** Text (2)

Valid Codes	Definition
00	No benefit was requested (use with programs '00', '112', 'SA0', and 'SA1').
01	Initial request for authorization – First benefit or new benefit after a previous benefit has expired or terminated
02	Outpatient benefit change - Request for a change in the outpatient benefit for an existing authorization during the first two calendar months of the benefit. If approved, this code results in a change to the current outpatient benefit, retrospective to the Start Date of the benefit. When this code is submitted after the second calendar month of the benefit, the request will be rejected. If an authorization has been approved (authorization status 'AA') the request will be rejected.
05	Continuation of Benefit - Request a next benefit for case rate benefits with a predetermined end date (Ex: '401', '373', '374') If approved, this code results in the creation of a new full-term outpatient benefit with a start date equal to the calendar day following the expiration date of the existing outpatient benefit. <b>Note: The assessment date must fall within the last thirty days (including the expiration date) of the existing outpatient benefit.</b>
61	Provider Change (from one benefit to another) - No cause provided. Clients may change providers without cause, and for any reason, at any time. There are no restrictions to how many times this can be done.

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**Attribute:** *Request Date*

**Transaction:**  
Authorization Request

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

**Example:**  
1. Provider submits an authorization request on March 1, 2023. The request date is 20230301.

**Type:** Date (8)  
YYYYMMDD

**Attribute:** *Authorization Number***Transaction:**

Authorization Request

**Definition:**

A unique number assigned by the BHRD information system (IS) to a particular authorized benefit (outpatient or residential) or to an authorization for an BH-ASO/KCICN-administered program or to report that a client does not meet medical necessity criteria for receiving services. The authorization number uniquely identifies the combination of client, authorized benefit/program, and benefit/program start date.

**Procedure:**

- This attribute is null for initial authorization requests (01). The authorization number will be assigned by BHRD IS and returned in the authorization response report.
- The authorization number is required when the provider is submitting a request for continuation of benefits (05), benefit change (02), or provider change (61).
- For persons served under both a benefit (outpatient or residential) and one or more BH-ASO/KCICN-administered programs, separate authorization numbers will be issued for each benefit/program.

**Required Documentation:**

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

**Examples:**

1. A child is authorized to receive outpatient benefit services with a 400 benefit and an authorization number is provided (1123455). Each time she receives a service during the benefit, the provider must submit the authorization number (1123455) with the HIPAA 837P transaction.
2. During the outpatient benefit, the child also receives services from the CCORS intensive stabilization services program. The provider of those services submits an authorization request transaction for program 15. The BHRD IS transmits an authorization response with a unique authorization number (19987665). Each time services under this program are transmitted in the HIPAA 837P transaction, the authorization number (19987665) must be used.

**Type:** Integer

**Attribute:** *Adult or Child Benefit***Transaction:**

Authorization Request

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

Providers shall maintain a record of the requested benefit type.

**Examples:**

1. A client is 10 years old. Submit code 5.
2. A client is 30 years old. Submit code 4.
3. An authorization request is submitted for a specialty program that is not an outpatient (case-rate) benefit. Submit code 3.

**Type:** Text (1)

Valid Codes	Definition
3	Not applicable. Program requested is not an outpatient benefit.
4	Adult benefit, including 18-20 years old if applicable.
5	Child benefit, including 18-20 years old if applicable.

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**Transaction: Batch Header****Definition:**

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

**Required for:**

Each batch

**Frequency:**

Every time a batch is submitted to BHRD IS.

**Transaction ID:** 000.03

**Action Codes:**

NONE

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

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**Transaction: Batch Footer****Definition:**

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

**Procedure:**

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

**Required for:**

Each batch

**Frequency:**

Every time a batch is submitted to BHRD IS.

**Transaction ID:** 999.01

**Action Codes:**

NONE

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

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## Transaction: CALOCUS

**Definition:**

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

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

**Authorization is in 'UA' status**

For Program 401 - Mental Health MIDD (Non-Medicaid), the Composite Score must be at least 14.

The system selects the CALOCUS record (regardless of authorization number) submitted on the earliest event date between the authorization's assessment date and authorization cutoff date.

**Authorization is in 'AA' status**

Once an authorization reaches 'AA' status the record with the most recent Event Date in the system is considered applicable.

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

**Required for:**

- Mental health case rate benefits
- Mental health supportive housing benefits
- Mental health residential benefits
- Mental health inpatient benefits

**Frequency:**

- Initial assessment
- Continuation of benefit
- Medicaid OPB Anniversary
- On change

**Transaction ID:** 190.01**Action Codes:**

A	Add
C	Change
D	Delete

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

**Attribute:** *Dimension I Score***Transaction:**  
CALOCUS**Definition:**  
*Risk of Harm*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Low Risk of Harm
2	Some Risk of Harm
3	Significant Risk of Harm
4	Serious Risk of Harm
5	Extreme Risk of Harm

**Attribute:** *Dimension II Score***Transaction:**  
CALOCUS**Definition:**  
*Functional Status*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Minimal Functional Impairment
2	Mild Functional Impairment
3	Moderate Functional Impairment
4	Serious Functional Impairment
5	Severe Functional Impairment

**Attribute:** *Dimension III Score***Transaction:**  
CALOCUS**Definition:***Co-Morbidity: Developmental, Medical, Substance Use and Psychiatric*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	No Co-morbidity
2	Minor Co-morbidity
3	Significant Co-morbidity
4	Major Co-morbidity
5	Severe Co-morbidity

**Attribute:** *Dimension IV A Score***Transaction:**  
CALOCUS**Definition:**  
*Recovery Environment – Environmental Stress Sub-Scale*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Minimally Stressful Environment
2	Mildly Stressful Environment
3	Moderately Stressful Environment
4	Highly Stressful Environment
5	Extremely Stressful Environment

**Attribute:** *Dimension IV B Score***Transaction:**  
CALOCUS**Definition:**  
*Recovery Environment – Environmental Support Sub-Scale*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Highly Supportive Environment
2	Supportive Environment
3	Limited Support in Environment
4	Minimally Supportive Environment
5	No Support in Environment

**Attribute:** *Dimension V Score***Transaction:**  
CALOCUS**Definition:**  
*Resiliency and Treatment History*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Full Resiliency and/or Response to Treatment
2	Significant Resiliency and/or Response to Treatment
3	Moderate or Equivocal Resiliency and/or Response to Treatment
4	Poor Resiliency and/or Response to Treatment
5	Negligible Resiliency and/or Response to Treatment

**Attribute:** *Dimension VI Child Sub-Scale Score***Transaction:**  
CALOCUS**Definition:***Treatment Acceptance and Engagement  
Child or Adolescent Acceptance and Engagement Sub-Scale*

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

Only the higher of the two sub-scale scores (child or adolescent vs. parent and/or primary caretaker) is added into the composite score, *except when a child or adolescent is emancipated*. In these cases, the parent and/or primary caretaker sub-scale is not tabulated into the composite score.

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Optimal
2	Constructive
3	Obstructive
4	Adversarial
5	Inaccessible

**Attribute:** *Dimension VI Caretaker Sub-Scale Score***Transaction:**  
CALOCUS**Definition:**

Treatment Acceptance and Engagement

Parental and/or Primary Caretaker Acceptance and Engagement Sub-Scale

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

Only the higher of the two sub-scale scores (child or adolescent vs. parent and/or primary caretaker) is added into the composite score, *except when a child or adolescent is emancipated*. In these cases, the parent and/or primary caretaker sub-scale is not tabulated into the composite score.

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- If a child or adolescent is emancipated, use code 8 – Emancipated Child, Not Applicable. Do not add into the composite score.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Optimal
2	Constructive
3	Obstructive
4	Adversarial
5	Inaccessible
8	Emancipated Child, Not Applicable

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**Attribute:** *Composite Score*

**Transaction:**  
CALOCUS

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

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

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

**Type:** Number

Valid Codes	Definition
1 - 35	Valid range

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**Attribute:** *Level of Care Requested*

**Transaction:**  
CALOCUS

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

**Procedure:**  
In general, the level of care requested should be consistent with the level derived from the CALOCUS decision tree and/or the Determination Grid. Starting July 1, 2020, for mental health outpatient benefits (400/401), this attribute is no longer used. Record the level indicated by the corresponding composite score as shown below. This attribute shall be removed in a future Data Dictionary publication.

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

**Type:** Numeric

Valid Codes	Definition	Corresponding MH Benefit
0	Rating not Reported Electronically, Evidence is Maintained in Clinical Record	
1	<p>Level One: Recovery Maintenance and Health Management</p> <p>Level One services typically provide follow-up care to mobilize family strengths and reinforce linkages to natural supports. Those appropriate for Level One services either may be substantially recovered from an emotional disorder or other problem or their problems are sufficiently manageable within their families, such that the problems are no longer threatening to expected growth and development.</p>	400/401 (Comp Score 10-13)
2	<p>Level Two: Low Intensity Community Based Services</p> <p>This level of care includes mental health services for children, adolescents, and families living in the community. Level Two services frequently are provided in mental health clinics or clinicians' offices. Services also may be provided within a juvenile justice facility, school, social service agency, or other community setting. Children and adolescents appropriate for Level Two services generally do not require the extensive systems coordination and case management of the higher levels of care, since their families are able to use community supports with minimal assistance. The degree of individualization of services at Level Two also may not be as extensive as at higher levels of care, but continuity of at least one treatment relationship often is essential to maintenance at optimal levels of functioning. Clinicians offering follow-up at Level Two must provide continuing individual and family assessment with the capacity to add needed services as necessary.</p>	400/401 (Comp Score 14-16)
3	<p>Level Three: High Intensity Community Based Services</p> <p>This level of care generally is appropriate for children and adolescents who need more intensive outpatient treatment and who are living either in their families with support, or in alternative families or group facilities in the community. The family's strengths allow many, but not all, of the child's needs to be met through natural supports. Treatment may be needed several times per week, with daily supervision provided by the family or facility staff. Services may be provided in a mental health clinic or clinician's office, but often are provided in other components of the system of care with mental health consultation. Service coordination is essential for maintaining the child or adolescent in the community at Level Three. Medical care from either a pediatrician or family physician should be available in the community.</p>	400/401 (Comp Score 17+)

4	<p><b>Level Four: Medically Monitored Community Based Services</b></p> <p>This level of care refers to services provided to children and adolescents capable of living in the community with support, either in their family, or in placements such as group homes, foster care, homeless or domestic violence shelters, or transitional housing. To be eligible for Level Four services, a child or adolescent's service needs must require the involvement of multiple components within the system of care. For example, an adolescent may require the services of a probation officer, a mental health clinician, a child and adolescent psychiatrist, and a special education teacher to be maintained in the community. These children and adolescents, therefore, need intensive, clinically informed case management to coordinate multi-system and multidisciplinary interventions. Optimally, an individualized service plan is developed by a Wraparound team.</p> <p>Services are delivered more frequently and for more extended periods than at lower levels of care. Services in this level of care include partial hospitalization, intensive day treatment, treatment foster care, and home-based care determined by a Wraparound plan that may involve both support and clinical services brought to the home and various support services for parents/caregivers. Level Four services also may be provided in schools, substance abuse programs, juvenile justice facilities, social services group care facilities, mental health facilities, or in the child or adolescent's home.</p>	
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5	<p><b>Level Five: Medically Monitored Residence Based Services</b></p> <p>This level of care refers to treatment in which the essential element is the maintenance of a milieu in which the therapeutic needs of the child or adolescent and family can be addressed intensively. This level of care traditionally has been provided in non-hospital settings such as residential treatment facilities or therapeutic foster homes. Equivalent services have been provided in juvenile justice facilities and specialized community based residential schools, hospitals with designated step-down program units and could be provided in homeless and/or domestic violence shelters or other community settings. It also is possible to provide Level Five services in a child or adolescent's home, if Wraparound planning and resources can provide the needed service intensity in the less restrictive environment. Level Five services include the modification and continuation of a Wraparound plan or, if the youth is new to services the development of a Wraparound team that can determine a program, that will prepare the family for the child or adolescent's re-integration into their family and community with treatment in lower levels of care. Ideally, the step-down plan represents a modification of the comprehensive Level Five Wraparound plan, providing continuity of care and integrating the child or adolescent's treatment experiences while in more restricted Level 5 services into their return to a more open community setting.</p>	
6	<p><b>Level Six: Medically Managed Residence Based Services</b></p> <p>Level Six services are the most restrictive and often, but not necessarily, the most intensive in the level of care continuum. Traditionally, Level Six services have been provided in a secure facility such as a hospital or locked residential program. This level of care also may be provided through intensive application of mental health and medical services in a juvenile detention and/or educational facility, provided that these facilities are able to adhere to medical and psychiatric care standards needed at Level Six. Level Six services also may be provided in community settings, including a child or adolescent's home, if mental health and medical services are organized at the required intensity and security measures are adequate. Although high levels of restrictiveness are typically required for effective intervention at Level Six, every effort to reduce, as feasible, the duration and pervasiveness of restrictiveness is desirable to minimize its negative effects.</p>	

## Transaction: Case Manager Contact Information

### Definition:

Establishes case manager contact information in the BHRD IS.

Crisis workers use the BHRD IS to locate and contact the case manager responsible for the care of a client. A successful Staff Person Transaction must have been processed prior to submitting a Case Manager Contact Information transaction.

See also [Case Manager Link](#).

### Required for:

Clients in a mental health or SUD outpatient benefit

Clients in a Long-Term Rehabilitation residential benefit

Clients in select specialty programs (See the Required Transactions spreadsheet in the ISAC Notebook)

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

### Frequency:

On assignment

On change

**Transaction ID:** 100.03

### Action Codes:

A	Add
C	Change
D	Delete

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

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**Attribute:** *Case Manager ID***Entity:**

Case Manager Contact Information

**Definition:**

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

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

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

**Procedure:**

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

**Required Documentation:**

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

**Valid Codes:**

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

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**Attribute:** *Case Manager Phone***Transaction:**

Case Manager Contact Information

**Definition:**

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

**Procedure:**

- Use the case manager phone to provide the numbers for the case managers listed. The telephone numbers will be used by crisis workers to contact clinicians responsible for the care of client.
- Use the “Case Manager Comment” attribute to provide detailed information for the phone numbers provided.
- If submitting a 10-digit phone number, the first 3 digits must represent an area code otherwise the transaction will be rejected with error message 241 – Invalid phone number.

**Example:**

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

**Type:** Text (10)

**Valid Codes:**

No restrictions. Up to 10 characters are permitted.

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**Attribute:** *Case Manager Comment***Transaction:**

Case Manager Contact Information

**Definition:**

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

**Procedure:**

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

**Example:**

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

**Type:** Text (50)

**Valid Codes:**

No restrictions. Up to 50 characters are permitted.

## Transaction: Case Manager Link

### Definition:

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

The 'Case Manager Contact Information' transaction must be successfully processed prior to submitting the 'Case Manager Link' transaction.

### Required for:

- Clients in a mental health or SUD outpatient benefit
- Clients in a Long-Term Rehabilitation residential benefit
- Clients in select specialty programs (please see the Required Transactions spreadsheet in the ISAC Notebook)

### Frequency:

- Initial assessment
- On change

### Procedure:

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

**Transaction ID:** 011.02

### Action Codes:

A	Add
C	Change
D	Delete

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

**Attribute:** *Case Manager Type*

**Transaction:**  
Case Manager Link

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

**Type:** Text (1)

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

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**Attribute:** *Case Manager ID***Transaction:**

Case Manager Link

**Definition:**

A code established by a provider to link each client with his/her case manager/primary care provider.

**Required Documentation:**

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

**Valid Codes:**

No restrictions. Up to 10 characters are permitted.

## Transaction: Client Demographics

### Definition:

General demographic information that describes a person.

### Required for:

All programs

### Frequency:

- Initial assessment
- On change

**Transaction ID:** 020.09

**Effective Date:** February 1, 2022

### Action Codes:

A	Add
C	Change

Attribute	Type	Size	Coded	Required
<b>Reporting Unit ID</b>	Text	3	Y	Y
<b>Case ID</b>	Text	10		Y
<b>Event Date</b>	Date (YYYYMMDD)	8		Y
Surname	Text	30		Y
Alternate Surname	Text	30		N
First Name	Text	30		Y
Middle Name	Text	30		N
Suffix	Text	4		N
Gender	Number	2	Y	Y
Date of Birth	Date (YYYYMMDD)	8		Y
Ethnicity	Text	45	Y	Y
Hispanic Origin	Text	3	Y	Y
Interpreter Required	Number	1	Y	Y
Language Code	Text	3	Y	Y
Sexual Orientation	Number	1	Y	Y
Military Status	Text	2	Y	Y
Family Military Status	Text	2	Y	Y
Social Security Number	Text	9		Y
Marital Status	Number	2	Y	Y
ProviderOne ID	Text (123456789WA)	11		C
King County ID	Number	10		C

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**Attribute:** *Surname***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Example:**

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

**Type:** Text (30)

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**Attribute:** *Alternate Surname***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Example:**

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

**Type:** Text (30)

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---

**Attribute:** *First Name***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Example:**

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

**Type:** Text (30)

**Attribute:** *Middle Name***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Example:**

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

**Type:** Text (30)

**Attribute: Suffix****Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Example:**

1. Submit code "SR" if the client's name is John Smith Sr.
2. Submit code "III" if the client's name is John Smith III.

**Type:** Text (4)

Valid Codes
II
III
IV
V
VI
VII
VIII
JR
SR

**Attribute:** *Gender***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Examples:**

- The client identifies herself as female, born female. Use Code 1.
- The client identifies herself as female, born male. Use Code 1.
- The client identifies himself as male, born male. Use Code 2.
- The client identifies himself as male, born female. Use Code 2.
- The client identifies as transgender. Use Code 5.
- The client identifies as intersex. Use Code 6.
- **The client chooses not to answer. Use Code 98.**

**Type:** Text (2)

Valid Codes	Definition	State Code (BHRD Use Only)
1	Female	1
2	Male	2
5	Transgender	4
6	Intersex: Person born with characteristics of both	5
98	Person refused to answer	98

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**Attribute:** *Date of Birth***Transaction:**

Client Demographics

**Definition:**

The date a person was born.

**Procedure:**

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

**Required Documentation:**

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

**Examples:**

1. The client provided a driver's license showing a birthdate of October 19, 1972. **Enter 19721019.**

**Type:** Text (8)  
YYYYMMDD

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**Attribute:** *Ethnicity***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

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

**Required Documentation:**

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

**Examples:**

1. A client self-identifies as both White and Chinese would be coded as 010605. The first three digits (010) represents the first ethnicity, the second three digits (605) are the next ethnicity and so on.
2. A client self-identifies as Cambodian, code 604.

**Type:** Text (45)

<b>Valid Codes</b>	<b>Definition</b>	<b>State Code (BHRD Use Only)</b>
010	White / Caucasian	010
021	American Indian or Alaska Native	021
031	Asian Indian	031
032	Native Hawaiian	032
033	Other Pacific Islanders	033
034	Other Asian	034
040	Black, African American	040
050	Some Other Race	050
604	Cambodian	604
605	Chinese	605
608	Filipino	608
611	Japanese	611
612	Korean	612
613	Laotian	613
618	Thai	034
619	Vietnamese	034
660	Guamanian or Chamorro	660
695	Samoan	033
801	Middle Eastern	801
871	African - Ethnic	040
999	Not Reported / Unknown	999

**Attribute:** *Hispanic Origin***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

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

**Required Documentation:**

Providers shall document whether a client identifies with any Hispanic culture. Records shall document that Hispanic cultural identification was self-identified by the client, or, for children younger than 13 years, by the client's parent or legal caregiver.

**Examples:**

1. A client self-identifies himself as Puerto Rican. Code 727 for the "Hispanic Origin" attribute. The same client states his ethnic group is African American. Code 040 for the attribute "Ethnicity."
2. A client self-identifies as White/Caucasian, code 010 for the attribute "Ethnicity." When asked if she also identifies with any Hispanic culture, the client states that she does not. Code 998 for the "Hispanic Origin" attribute.

**Type:** Text (3)

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

**Attribute:** *Interpreter required***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Examples:**

1. A client's primary language is Spanish, but she has some ability to speak English. However, when this client is experiencing a mental health crisis, she needs interpretive services to communicate effectively. Code 2.
2. A 12-year-old client is proficient in English. His mother is also receiving mental health services and only speaks Korean. Code 2.
3. A client's primary language is Russian. He's receiving residential services from provider staff who speaks Russian. Code 2.

**Type:** Text (1)

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

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**Attribute:** *Language Code***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

- This is a required attribute.
- Use any code from the iso639-2 language standard list.
- This is **not** an indicator of fluency in English.
- Use the attribute "Interpreter Required" to describe fluency in English in the context of treatment.
- If the primary language cannot be determined or is unknown, use 'und' (Undetermined).

**Required Documentation:**

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

**Type:** Text (3)

*See full list of iso639-2 language codes list at the end of the Data Dictionary (page 300)*

**Attribute:** *Sexual Orientation***Transaction:**

Client Demographics

**Definition:**

This code describes the client's stated sexual orientation.

**Procedure:**

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

**Required Documentation:**

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

**Example:**

1. A client states she is a lesbian. Code 3.

**Type:** Text (1)

Valid Codes	Definition	State Code (BHRD Use Only)
1	Heterosexual - Attraction to persons of the opposite sex.	1
3	Gay/Lesbian/Queer/Homosexual - Attraction to persons of the same sex.	3
4	Bisexual - Term for women and men whose sexual/affectional identity is oriented to members of both the same and opposite sex.	4
5	Questioning - Term generally used for adolescents who may be in the process of becoming more comfortable with their sexual orientation identification. Usually describes a youth who may be exploring identifying as gay/lesbian in a culture that generally assumes identification as heterosexual. May also describe an adult.	5
6	Choosing not to disclose - Use when an individual is uncomfortable or unwilling to disclose their sexual orientation.	9
8	Not asked - The question was not asked or client did not self-identify. Also use this code for child under age 13.	9
9	Unknown - This information is not available at present.	9

**Attribute:** *Military Status***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Example:**

1. Client said he was in the Coast Guard forty years ago. Code 01.
2. Client said he had been in the Army Reserves. He was not sure if he had been on active duty or not. Code 01.
3. When asked if he had ever served in the U.S. military, client was uncertain and said he couldn't remember. Code 09.

**Type:** Text (02)

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

**Attribute:** *Family Military Status***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Examples:**

1. Sixteen-year-old client said his mother had served in the Army before he was born - Code 01.
2. Thirty-five-year-old client said her husband was in the Air Force. She was not sure if he had been on active duty or not - Code 02.
3. The biological father of a 15-year-old client in foster care had served in the Army and suffered serious injury; neither of her foster parents served - Code 01.

**Type:** Text (2)

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

**Attribute:** *Social Security Number***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

- This is a required attribute.
- Do not use a parent's SSN for a child or a spouse's SSN. If the client does not have his own SSN, or the full SSN is unknown, use code 999999999.
- Do not submit a combination of known and unknown, such as 999995712. Use code 999999999.
- Enter the number with no dashes or spaces.

**Required Documentation:**

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

**Example:**

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

**Type:** Text (9)

Valid Codes	Definition
	Social Security Number
999999999	Unknown/Refused

**Attribute:** *Marital Status***Transaction:**

Client Demographics

**Definition:**

Indicates the current marital status of the client.

**Procedure:**

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

**Required Documentation:**

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

**Type:** Numeric

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

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**Attribute:** *ProviderOne ID*

**Transaction:**  
Client Demographics

**Definition:**  
The client's ProviderOne ID

**Procedure:**

- This is a required attribute for Medicaid clients. The ProviderOne ID will be used for client matching and deduplication purposes only, this attribute is not used to determine a client's Medicaid eligibility.

**Required Documentation:**  
The provider shall document in the clinical file the source of information about the client's ProviderOne ID.

**Type:** Text

**Format:** 123456789WA (9 digits followed by 'WA')

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**Attribute:** *King County ID***Transaction:**

Client Demographics

**Definition:**

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

**Procedure:**

- This is a required attribute for (C)hange requests and optional for (A)dd requests.
- If the King County ID (KCID) is supplied as part of an (A)dd request it will be taken into account as part of the client de-duplication process. Note that the resultant KCID may or may not match the KCID supplied in this transaction.
- This identification number, provided by the BHRD IS, uniquely identifies a client served by the King County BH-ASO.

**Required Documentation:**

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

**Type:** Integer

## Transaction: Conditions at Assessment

### Definition:

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

### Procedure:

- The presence of one or more of these conditions may be required to support authorization to a benefit or to support the priority authorization of a non-Medicaid client.
- The presence of one or more chronic health conditions impacts population health stratification where that information is not otherwise known.
- Submit one transaction for each applicable condition, risk, or circumstance.

Required for:

Not required

### Frequency:

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

On Change: For example, reporting chronic health conditions for clients for whom this data isn't already available in the system, Non-Medicaid (MIDD) funded clients in particular.

**Transaction ID:** 617.01

### Action Codes:

A	Add
C	Change
D	Delete

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

**Attribute:** *Condition Code***Transaction:**

Conditions at Assessment

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Example:**

1. During assessment, an adult client indicates that they have been diagnosed with Cardiovascular Disease. Enter code for Cardiovascular Disease (155).
2. An existing Non-Medicaid (MIDD) client suffers from Asthma, but that data is not known to the BHRD IS data system for Population Health Stratification. Submit a Conditions at Assessment transaction with code for Asthma (152).
3. A four-year-old girl is referred for therapeutic day care by the University of Washington Teratology Clinic with a written evaluation documenting Fetal Alcohol Syndrome and documenting Inadequate Parenting and Child Neglect. On interview, the child discloses corroborated inappropriate sexual contact with the mother's boyfriend. Enter codes for Fetal Alcohol Syndrome/Effect (103), Inadequate Parenting and Child Neglect (133), and Sexual Abuse (135).

**Type:** Text (3)

***Chronic Health Conditions, All Ages***

Valid Codes	Definition
<b>Chronic Health Conditions, All Ages – Population Health Stratification</b>	
152	Asthma: A chronic condition that can cause the airways in the lungs to become inflamed and narrow.
153	Diabetes: A chronic disease that occurs when the pancreas is no longer able to make insulin or when the body cannot make good use of insulin it produces. There are three main types of diabetes: Type 1, Type 2 and Gestational
154	Chronic Obstructive Pulmonary Disease (COPD): A group of diseases that cause airflow blockage and breathing-related problems, such as emphysema and chronic bronchitis.
155	Cardiovascular Disease (CVD): Any disease of the heart, vascular disease of the brain, or disease of the blood vessel. In practice, CVD is measured through the presence of one or more of seven specific diagnoses: <ul style="list-style-type: none"> <li>• Atrial fibrillation</li> <li>• Heart failure</li> <li>• Hyperlipidemia (high cholesterol)</li> <li>• Hypertension (high blood pressure)</li> <li>• Ischemic heart disease</li> <li>• Myocardial infarction</li> <li>• Stroke</li> </ul>

***Children's Conditions***

Valid Codes	Definition
<b>Children's Conditions Medical Necessity</b>	
101	Other chronic medical condition that may affect psychological functioning: A chronic medical condition (other than those listed above), evaluated and diagnosed by a physician, which impacts the child's and his/her family's daily life due to functional limitations, needs for medication and/or rehabilitative activity. This condition shall be limited to any medical condition that does not directly affect the brain and its functioning. It excludes all neurological conditions that affect the function of the brain with direct impact on personality and functioning in the environment. (See 102.)
102	<b>Neurological Condition Affecting Psychological Functioning:</b> A chronic neurological condition, evaluated and diagnosed by a physician, which impacts the child's and his/her family's daily life due to functional limitations, needs for medication and/or rehabilitative activity. This condition is limited to neurological conditions with a direct physiological effect on brain function with the exception of Fetal Alcohol Syndrome (See 103). The brain lesions directly affect personality and functioning. Examples of neurological conditions that may affect psychological functioning are seizure disorders, particularly temporal lobe seizures, or an intractable headache syndrome.

Valid Codes	Definition
<b>Children's Conditions Medical Necessity</b>	
103	<p><b>Fetal Alcohol Syndrome/Effect or Fetal Drug Exposure:</b> A chronic static brain injury sustained due to intrauterine exposure of a substance toxic to the fetus which impacted brain development. Compelling evidence of FAS/E or FDE includes a history of alcohol and/or drug use by the patient's birth mother during pregnancy and current symptoms of impulsivity and/or age-inappropriate judgment with or without physical stigmata or retardation.</p> <p>To be coded, this condition must have been formally evaluated and diagnosed by a child psychiatrist or any other physician with special interest and experience in evaluating these conditions, or there must be compelling current evidence of symptoms or history of fetal exposure. Mental status examination on assessment must corroborate symptom history for an undiagnosed child and plans for a physician evaluation shall be documented in the chart.</p> <p>Consideration of a differential diagnosis must be evident in the record of the evaluation.</p>
104	<p><b>Developmental Disorder:</b> Must be a diagnosable (DSM IV, Axis I, II or III criteria) condition. A Developmental Disability shall be defined as a condition described in the DSM IV under "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" specifically, diagnoses listed under "Mental Retardation," "Learning Disorders," "Motor Skills Disorder," and "Communications Disorders." It specifically excludes Pervasive Developmental Disorder.</p> <p>Mental retardation is the Axis II diagnosis specific to child or adolescent developmental disorders. Examples of Axis III conditions which may be cited are failure to thrive and malnourishment syndromes.</p>
105	<p><b>Learning Disability:</b> Difficulties with academic tasks which have been diagnosed with psychological and/or educational testing and documented by a school system in a Focus of Concern (or similar) process.</p> <p>This condition does not include educational designations of Seriously Behaviorally Disturbed. (See 106.)</p>
106	<p><b>Seriously Behaviorally Disturbed:</b> The presence of an educational system designation of SBD discerned through a Focus of Concern (or similar) process. The SBD designation is the result of patterns of behavior that disrupt the child's process of learning and may or may not meet criteria for a psychiatric Axis I or II diagnosis.</p>
None - Use <u>Disability</u>	<p><b>Substance Abuse in a Child:</b> Report using the "Substance Abuse" attribute in the <u>Disability</u> transaction, a substance abuse problem during the 90 days prior to assessment significant enough to meet DSM IV criteria and reported on the "Diagnosis Axis" and "Diagnosis Code" attributes.</p> <p>A substance use disorder may be cited on assessment when there is compelling evidence or history of a pattern of use which impacts the function of the child. A qualified professional must subsequently confirm this diagnosis. Documentation of such an evaluation, or plans for such an evaluation, shall be evident in the record. A qualified professional shall be defined as a certified chemical dependency professional with training and experience with children and adolescents, a board certified or eligible child and adolescent psychiatrist or a general psychiatrist with training or experience with adolescent psychiatry.</p>

Valid Codes	Definition
<b>Children's Conditions Medical Necessity</b>	
108	<p><b>Law Breaking Behavior in Child:</b> A child or adolescent with a pattern of behavior that regularly violates the law or a child who has committed a single serious legal offense (or time limited cluster of offenses).</p> <p>This condition refers to behavior that has caused a child or adolescent to be adjudicated by a court as a juvenile offender or behavior which is part of the child's medical or social history that, if found to be fact in a legal hearing, would lead to adjudication.</p>
109	<p><b>Attachment Difficulties:</b> A child whose current behavior indicates absent, weak or troubled attachments and has a history of disrupted parenting before age five. Examples of disrupted parenting are multiple placements, frequent disruptions in members of the household, or mental or physical disorders in the patient's primary caretaker that diminished availability for parenting.</p> <p>A diagnosis of reactive attachment disorder may be present or strongly suspected for these children when young and the symptoms of this syndrome may persist into late childhood and adolescence though modified as per developmental status.</p>
110	<p><b>Multiple Systems Involvement:</b> Identifies whether the child is involved with one or more formal systems, in addition to mental health, within the preceding 12 months. Involved means the person is or has received services from formal systems. Formal systems can include but are not limited to schools, juvenile rehabilitation, alcohol/substance use disorder treatment, child or adult protective services, child welfare services, developmental disability services, vocational rehabilitation, etc. Schools can count as one system if the client is assessed for a child's outpatient benefit. Involvement with schools does <b>not</b> mean school attendance. It means the ongoing involvement of school counseling, special education systems, etc.</p>
111	<p><b>Receiving Special Education Services:</b> The child has been determined to be eligible and is receiving services in accordance with the federal Individuals with Disabilities Education Act, and Washington Administrative Code 392.172.</p>
112	None of the conditions are present based upon the intake assessment.

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## *Children's Circumstances*

**Definition:**

These codes identify specific circumstances noted during the assessment.

**Procedure:**

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

**Required Documentation:**

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

**Example:**

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

Valid Codes	Definition
<b>Children's Circumstances - Medical Necessity</b>	
131	<p><b>Family Discord:</b> A circumstance in which there is a significant pattern of discord in the family to which the child is exposed or in which he/she is a participant.</p> <p>A significant pattern identified for this circumstance is a pattern of arguing, verbal and mild physical altercations, traumatic disruptions in the household, property damage or disagreements sufficient to interfere with the primary functions of the family to nurture children and provide mutual support for adults. Serious parent/child conflict is included.</p> <p>Such patterns must be persistent and must involve at least two individuals. As such this definition excludes the case of an oppositional and defiant youth who is the sole disruptive force in an otherwise well-functioning family.</p> <p>The definition does not exclude but may not necessarily include domestic violence.</p> <p>Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.</p>
132	<p><b>Out-of-Home Placement:</b> A circumstance in which the child or adolescent has had a significant disruption in his/her living situation due to being placed outside his/her home. A significant disruption is defined as at least one out of home placement greater than one week in the year prior to assessment.</p> <p>The placement outside of the child or adolescent's home must be due to the parent's or guardian's inability to care for the child or meet his/her needs. This may include cases where the primary problem is due to dysfunctional parents as well as cases where the primary problem is with the child who has overwhelmed otherwise competent parents.</p> <p>Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.</p> <p>Compare this definition to the "Out of Home Placements" in the <u>Outcome Count</u> transaction.</p>

Valid Codes	Definition
133	<p><b>Inadequate Parenting/Child Neglect:</b> A circumstance in which there is a persistent pattern involving inadequate care for the child or adolescent.</p> <p>Inadequacy as defined for these circumstances may be due to the parents or guardians having poor skills or inadequate knowledge of raising a child, or it may be due to the parents being preoccupied with their own difficulties. The care and supervision of the identified child/adolescent needs to be sufficiently poor as to compromise his/her health and welfare. The parents could be providing adequate care for another child in the family while their care for the patient may be grossly inadequate due to the child's special needs or special vulnerability.</p> <p>Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.</p>
134	<p><b>Physical Abuse:</b> A circumstance in which there has been physical abuse to the child to such a degree that a professional is legally bound to report the circumstances to DSHS Child Protective Services.</p> <p>Physical abuse is defined for this circumstance as an act of physical restraint, assault or threat of assault, or any other form of physical intrusion onto the body of a child or adolescent which is hostile in intent, disrespectful of the child's physical integrity, and/or grossly insensitive to the child's developmental need for privacy, sense of safety, and physical integrity. Such acts must be performed by an individual sufficiently older and/or larger as to create an adverse power differential for the child.</p> <p>This definition excludes such acts as can be characterized as sexual. (See 135.)</p> <p>Use code based on history or disclosure obtained at assessment and documented in the record. The documentation may include any referral information.</p>

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

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

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

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

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

## Transaction: Co-Occurring Disorders Assessment

### Definition:

The Co-occurring disorders assessment quadrant value.

### Required for:

- As of 12/31/2025 the Co-Occurring Disorders Screening transaction and the Co-Occurring Disorders Assessment transaction are no longer required and will be removed from this Data Dictionary after July 2026.
- Outpatient, Residential: When the individual scores a 2 or higher on either of the first two scales (Internal Disorder Screen and External Disorder Screen) and a 2 or higher on the third (Substance Disorder Screen). See the "Co-Occurring Disorders Screening" transaction for more information.
- If indicated by the Screening, the COD assessment is required for clients 13 years old and over,

### Procedure:

For **A**(dd) and **C**(hange) requests, the submitted authorization must have one of these status codes: AA, PN, TM, UA and WL. The status code is not checked for **D**(elete).

### Frequency:

See COD Screening frequency requirements.

### Transaction ID: 791.01

#### Action Codes:

A	Add
C	Change
D	Delete

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

**Attribute:** *Co-occurring Disorders Quadrant***Transaction:**

Co-occurring Disorders Assessment

**Type:** Character (1)

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

**Procedure:**

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

**Required Documentation:**

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

## Transaction: Co-Occurring Disorders Screening

### Definition:

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

### Required for:

- As of 12/31/2025 the Co-Occurring Disorders Screening transaction and the Co-Occurring Disorders Assessment transaction are no longer required and will be removed from this Data Dictionary after July 2026.
- Outpatient
- Residential
- Crisis
- Clients 13 years or older

### Frequency:

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

### Transaction ID: 790.01

### Action Codes:

A	Add
C	Change
D	Delete

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

**Attribute:** *IDS Score***Transaction:**

Co-Occurring Disorders Screening

**Definition:**

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

**Type:** Text (1)

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

**Attribute:** *EDS Score***Transaction:**

Co-Occurring Disorders Screening

**Definition:**

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

**Type:** Text (1)

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

**Attribute:** *SDS Score***Transaction:**

Co-Occurring Disorders Screening

**Definition:**

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

**Type:** Text (1)

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

**Procedure:**

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

**Required Documentation:**

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

## Transaction: CPT Service Detail

### Definition:

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

**Required for:** Outpatient, Residential, Crisis

The transaction is not accepted for program 101.

### Procedure:

A Change transaction can be used to update the following fields: Service Modifier, Measure Basis, Quantity, Service Location, EPSDT Indicator, Staff NPI, Taxonomy Code, DOH License Number, and EPB Codes.

### Required Documentation:

All services provided to a client must be documented in the clinical record with the date, type, location, and duration of the service episode, the diagnosis(es) treated and the name and credentials of the clinician providing the service.

### Collection Frequency:

On event

**Transaction ID:** 120.07

### Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
<b>Reporting Unit ID</b>	Text	3	Y
<b>Service Transaction ID</b>	Text	15	
<b>Event Date</b>	Text (YYYYMMDD)	8	
CPT Code	Text	5	Y
Service Modifier	Text	8	Y
Minutes of Service <i>(Changes to encounters with event dates prior to 01/01/2019 only)</i>	Text (number)	4	
Service Location	Text	2	Y
EPSDT Indicator	Text	1	
Staff Person Provider ID	Text	3	Y
Staff Person King County ID <i>(Changes to encounters with event dates prior to 01/01/2019 only)</i>	Text	10	
Authorization Number	Text (number)	10	
King County ID	Text (number)	10	
Address Line 1	Text	55	N
Address Line 2	Text	55	N
City	Text	30	N
State	Text	2	Y
Zip	Text	15	N
Claim ID	Text	38	N
Primary Service ID	Text	15	N
EBP Code	Text	23	Y
DBHR Agency Number <i>(Changes to encounters with event dates prior to 07/01/2019 only)</i>	Text	6	Y
Diagnosis 1	Text	8	
Diagnosis 2	Text	8	
Diagnosis 3	Text	8	
Diagnosis 4	Text	8	
DOH License Number	Text	15	
Staff NPI	Text	10	
Staff Taxonomy Code	Text (number)	10	
Measure Basis	Text	2	
Quantity	Text (number)	5	

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**Attribute:**      *Event Date***Transaction:**

CPT Service Detail

**Definition:**

The date an episode of service was provided.

**Required Documentation:**

Providers shall document the date of all service episodes provided.

**Type:** Date (8)

YYYYMMDD

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**Attribute:** *Service Transaction ID***Transaction:**

CPT Service Detail

**Definition:**

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

**Procedure:**

- This ID is used to uniquely identify the service record being reported and is generated at the provider level.
- Any necessary deletions or changes to the original submission must retain the same Service Transaction ID

**Example:**

1. A client receives two out of facility case management services on the same day. Each service is reported with a unique service transaction identifier to differentiate the two transactions.
2. Service ID 1234567 was submitted and successfully posted on 8/15/2019. On 10/1/2019 it was discovered to have the wrong quantity. Submit a 'C' (Change) using the same Service ID 1234567 and corrected quantity.

**Type:** Character (15)

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**Attribute:** *CPT Code***Transaction:**

CPT Service Detail

**Definition:**

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

**Procedure:**

- All services provided to a client must be reported.
- Only CPT/HCPCS codes found in the HCA Service Encounter Reporting Instructions (SERI) are accepted unless additional codes are specified in King Supplemental Service Encounter Reporting Instructions. (Links for both documents can be found in the ISAC Notebook.)
- CPT codes are identified and defined by the American Medical Association (AMA). HCPCS codes are maintained and distributed by the Center for Medicare and Medicaid Services (CMS). Changes may be made to the HCA and/or King Service Encounter Reporting Instructions as a result of changes made to the CPT codes by the AMA or to the HCPCS codes by CMS.

**Required Documentation:**

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

**Attribute:** *Service Modifier***Transaction:**

CPT Service Detail

**Definition:**

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

Known as Procedure Modifier under HIPAA.

**Procedure:**

- Enter up to four modifier codes per service encounter.
- Leave the attribute blank if no modifiers are required.
- The CPT (or HCPCS) code/modifier combination must follow the HCA Service Encounter Reporting Instructions, which are available at <https://www.hca.wa.gov/billers-providers-partners/program-information-providers/service-encounter-reporting-instructions-seri> and/or the BHRD specific King- Service Encounter Reporting Instructions available at <https://kingcounty.gov/en/dept/dchs/human-social-services/behavioral-health-recovery/provider-resources>. Only modifiers found in the HCA Service Encounter Reporting Instructions or KING SERI will be accepted.

**Examples:**

1. HCPCS code H0046 is defined as ‘Mental health services, not otherwise specified.’ This code in combination with the HCA SERI defined modifier ‘UB’ identifies an encounter as a ‘Request for Service.’ Use modifier ‘UB’ in conjunction with code H0046 to report ‘Request for Services’ encounters. (See the HCA Service Encounter Reporting Instructions, Request for Services section.)
2. A service was provided via Skype. Use modifier GT in conjunction with the applicable CPT Code to indicate the use of telemedicine.

**Type:** Character (8)

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**Attribute:** *Minutes of Service***Transaction:**

CPT Service Detail

**Definition:**The number of minutes for a specific Service Event (*Event dates through December 31, 2018 only*)**Procedure:**

- Use of this field is limited to corrections to previously submitted encounters with event dates prior to January 1, 2019. For event dates on and after January 1, 2019, agencies must use Attribute: 'Quantity',
- Report the actual minutes (**not** units) unless the service is *per diem*.
- The minutes reported for a service encounter must be between 5 and 1440.
- For per diem services, submit one for minutes of service.

**Required Documentation:**

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

**Type:** Number (4)

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**Attribute:** *Service Location***Transaction:**

CPT Service Detail

**Definition:**

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

[http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html)

**Procedure:**

- Report one location code for each discrete service event.

**Required Documentation:**

Providers shall document the location of each service event in clinical records.

**Type:** Character (2)

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**Attribute:** *EPSDT Indicator***Transaction:**

CPT Service Detail

**Definition:**

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

**Procedure:**

- Report a “Y” if this specific service resulted from or led to an EPSDT referral. Otherwise, report “N.”

**Examples:**

1. As a result of an EPSDT screening, a physician refers a six-year-old boy to a mental health center for assessment of mental health treatment needs. The clinician requests an outpatient benefit after the assessment and meets regularly with the boy and/or his father. Submit the assessment service with a “Y” for EPSDT Indicator. Submit subsequent services with “N” for EPSDT Indicator.
2. During an intake for a 12-year-old-girl, the clinician learns that she has not had a physical checkup in three years and refers her to her primary care doctor for an EPSDT screening. Submit the service that led to the referral with a “Y” for EPSDT Indicator. Submit subsequent services with “N” for EPSDT Indicator.

**Type:** Character (1)

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**Attribute:** *Staff Person Provider ID***Transaction:**

CPT Service Detail

**Definition:**

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

**Procedure:**

- Where a provider holding an authorization for a benefit has contracted with a second agency to provide services, the authorized provider is responsible for reporting service data, including the second agency staff person providing the service. Use this attribute to report the second agency ID and second agency staff ID.

**Required Documentation:**

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

**Example:**

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

**Type:** Text (10)

**Attribute:** *Staff Person King County ID***Transaction:**

CPT Service Detail

**Definition:**

This is the King County ID (KCID) for the staff person within an agency who is providing and reporting a service to a client (*Event dates through December 31, 2018 only*). For services which involve one or more staff persons, the client's primary case manager is the identified staff person, unless the purpose of the service is psychiatric or ARNP consultation. In that instance, the psychiatrist (first) or the ARNP (second) is the identified staff person.

**Procedure:**

- Use of this field is limited to corrections to previously submitted encounters with event dates prior to January 1, 2019. For event dates on and after January 1, 2019, agencies must use Attribute: 'Staff NPI',
- If the primary case manager is not present, the most senior staff person (determined by education and experience) who is present for the entire service event is the identified staff person.
- For services provided by a consultant or supervisor (e.g., special population consultation), report the KCID of the consultant and not the KCID of the case manager receiving the consultation.
- For consultation modalities where the specialist is a member of the reporting provider staff, the provider must submit the KCID of the consultant.
- When the specialist is either a member of another network provider staff or a mental health specialist on sub-contract with the provider, the provider may report either the provider ID and staff KCID of the specialist, or a staff KCID of "999" indicating that this is a qualified specialist and not a member of the reporting provider staff, or a staff KCID of "998" indicating that this is a special population MH Specialist with one of the special population qualifications listed under the Staff Qualifications transaction.
- Staff qualifications must be appropriate to the submitted CPT code/modifier(s) combination, as specified in the State HCA Service Encounter Reporting Instructions and/or King Service Encounter Reporting Instructions. To crosswalk BHRD staff qualifications to the state's instructions, see the "Mapping-to-State's Provider Type" column in the table for the Qualifications attribute in the Staff Qualifications transaction.

**Required Documentation:**

Providers shall document the author of each service event in clinical records to include a handwritten or electronic signature and credentials.

**Type:** Text (10)

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**Attribute:** *Address Line 1*

**Transaction:**  
CPT Service Detail

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

**Procedure:**

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

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

**Type:** Text (55)

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**Attribute:** *Address Line 2*

**Transaction:**  
CPT Service Detail

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

**Procedure:**

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

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

**Type:** Text (55)

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**Attribute:** *City*

**Transaction:**  
CPT Service Detail

**Definition:**  
Free-form text for the city.

**Procedure:**

- This is a required data element.

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

**Type:** Text (30)

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**Attribute:** *State*

**Transaction:**  
CPT Service Detail

**Definition:**  
Official USPS state abbreviation.

**Procedure:**

- This is a required data element.

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

**Type:** Text (2)

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**Attribute:** *Zip code*

**Transaction:**  
CPT Service Detail

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

**Procedure:**

- This is a required data element.

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

**Type:** Text (15)

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---

**Attribute:** *Claim ID*

**Transaction:**  
CPT Service Detail

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

**Procedure:**

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

**Type:** Text (38)

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**Attribute:** *Primary Service ID*

**Transaction:**  
CPT Service Detail

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

**Procedure:**

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

**Type:** Text (17)

---

---

**Attribute:** *EBP Code***Transaction:**

CPT Service Detail

**Definition:**

Evidenced based practice code.

**Procedure:**

- EBP Codes are outlined in the 2019 Reporting Guide for Research and Evidence-based Practices in Children’s Mental Health. Link: <https://www.hca.wa.gov/assets/program/ebp-reporting-guides.pdf>
- Only one EBP code may be submitted per encounter.
- EBP Codes must be submitted as 860###000. Replace “###” with the applicable three-digit EBP Code.
- EBP codes may only be used with select CPT Codes. See EBP Validation section of the ISAC Notebook.
- EBP Codes may only be used in children’s mental health programs. They cannot be used for adults, or SUD programs.

**Type:** Text (23)

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**Attribute:** *DBHR Agency Number*

**Transaction:**  
CPT Service Detail

**Definition:**  
A unique six-digit number assigned by DBHR to licensed behavioral health agency locations (**through June 30, 2019 only**).

**Procedure:**

- For event dates on and after July 1, 2019, agencies must use Attribute: 'DOH License Number'.
- Report the DBHR Agency Number of the home site of the staff person who performed the service.
- Applies only to event (service) dates through June 30, 2019.

**Type:** Text (6)

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---

**Attribute:** *Diagnosis 1***Transaction:**

CPT Service Detail

**Definition:**

The principal ICD-10 diagnosis code addressed within the service encounter. Where multiple diagnoses are reported within the same encounter, Diagnosis 1 represents the condition that requires the most time, the most decision-making and the most skill.

**Procedure:**

- For MH services, use a diagnosis code in ICD-10 ranges F01-F09 or F20-F99. If a diagnosis cannot be made or is unknown, use F99: Mental disorder, not otherwise specified.
- For SUD services, use a diagnosis code in ICD-10 ranges F10-F19. If a diagnosis cannot be made or is unknown, use Z7141: Alcohol abuse counseling and surveillance, or alcoholic for alcohol related disorders; or Z7151 for Drug abuse counseling and surveillance, of drug abuser for drug related disorders.

**Required Documentation:**

Providers shall document the primary diagnosis treated for each service event in clinical records.

**Type:** Text (8)

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---

**Attribute:** *Diagnosis 2*

**Transaction:**  
CPT Service Detail

**Definition:**  
Secondary ICD-10 diagnosis code addressed within the service encounter.

**Required Documentation:**  
Providers shall document any additional diagnosis treated for each service event in clinical records.

**Type:** Text (8)

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---

**Attribute:** *Diagnosis 3*

**Transaction:**  
CPT Service Detail

**Definition:**  
Tertiary ICD-10 diagnosis code addressed within the service encounter.

**Required Documentation:**  
Providers shall document any additional diagnosis treated for each service event in clinical records.

**Type:** Text (8)

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**Attribute:** *Diagnosis 4*

**Transaction:**  
CPT Service Detail

**Definition:**  
Quaternary ICD-10 diagnosis code addressed within the service encounter.

**Required Documentation:**  
Providers shall document any additional diagnosis treated for each service event in clinical records.

**Type:** Text (8)

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---

**Attribute:** *DOH License Number***Transaction:**

CPT Service Detail

**Definition:**

A unique (typically alpha-numeric) number assigned by the Department of Health (DOH) to licensed behavioral health agency locations.

**Procedure:**

- Report the DOH License Number of the home site of the staff person who performed the service.
- This is a required element starting on July 1, 2019.

**Examples:**

1. Mental Health and SUD outpatient facilities have DOH License numbers that begin with BHA.FS. Providers are encouraged to report the full number (Ex: BHA.FS.12345678), although numerical values only (12345678) are accepted.

**Type:** Text (15)

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**Attribute:** *Staff NPI***Transaction:**

CPT Service Detail

**Definition:**

This is the National Provider Identifier (NPI) for the staff person within an agency who is providing and reporting a service to a client. Any staff reporting services must register with the National Plan & Provider Enumeration System (NPPES) to obtain an NPI number if they do not already have one. Staff must also register their NPI with the Health Care Authority (HCA) by enrolling as a provider in ProviderOne.

**Procedure:**

- If the primary case manager is not present, the most senior staff person (determined by education and experience) who is present for the entire service event is the identified staff person.
- Staff qualifications must be appropriate to the submitted CPT code/modifier(s) combination, as specified in the State HCA Service Encounter Reporting Instructions and/or King Service Encounter Reporting Instructions. To crosswalk BHRD staff qualifications to the state's instructions, see the "Mapping-to-State's Provider Type" column in the table for the Qualifications attribute in the Staff Qualifications transaction.

**Type:** Text (10)

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**Attribute:** *Staff Taxonomy Code***Transaction:**

CPT Service Detail

**Definition:**

This is the Taxonomy Code for the staff person within an agency who is providing and reporting a service to a client. The taxonomy code is used to report the provider type of the staff that performed the service.

**Procedure:**

- Report the taxonomy code that is most appropriate to their highest level of licensure or education for the CPT Code reported.
- Where staff have both mental health and SUD credentials, report the taxonomy appropriate for the treatment focus based on the CPT Code reported (i.e. MH taxonomy for a mental health service, SUD taxonomy for an SUD service).
- Staff qualifications must be appropriate for the Taxonomy Code being reported. To crosswalk BHRD staff qualifications to the state's instructions, see the "CPT Service Taxonomy Code" column in the table for the Qualifications attribute in the Staff Qualifications transaction.

**Type:** Text (10)

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**Attribute:** *Measure Basis***Transaction:**

CPT Service Detail

**Definition:**

The unit of measure as defined by the HCA IMC Service Encounter Reporting Instructions for the CPT Code reported.

**Procedure:**

- CPT Codes are reported as Units (UN).  
As of July 2022, H0001 is no longer reported as Minutes (MJ), instead reported as Units (UN)

**Required Documentation:**

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

**Type:** Number (2)

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**Attribute:** *Quantity***Transaction:**

CPT Service Detail

**Definition:**

The number of units for a specific Service Event.

**Procedure:**

- Report the number of units of service provided based on the HCA IMC Service Encounter Reporting Instructions for the CPT Code reported.
- For per diem services, submit a quantity of one.

**Required Documentation:**

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

**Type:** Number (4)

## Transaction: Crisis Diversion Services

### Definition:

Program specific information for the Crisis Diversion Facility (CDF)

### Procedure:

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

### Required Documentation:

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

### Required for:

Crisis Diversion Facility (80)

### Frequency:

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

### Transaction ID: 860.01

### Action Codes:

A	Add
C	Change
D	Delete

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

**Attribute:** *Diversion Type*

**Transaction:**  
Crisis Diversion Services

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

**Type:** Text (1)

Valid Codes	Definition
H	Hospital
J	Jail
N	Neither

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---

**Attribute:** *Primary Presenting Condition***Transaction:**

Crisis Diversion Services

**Definition:**

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

**Type:** Text (2)

Valid Codes	Definition
SA	Substance Abuse
MH	Mental Health
BT	Both

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**Attribute:** *Arrival Start DateTime***Transaction:**

Crisis Diversion Services

**Definition:**

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

**Procedure:**

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

**Type:** DateTime (12)

YYYYMMDDHHMM

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**Attribute:** *Exit DateTime***Transaction:**

Crisis Diversion Services

**Definition:**

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

**Procedure:**

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

**Type:** DateTime (12)

YYYYMMDDHHMM

**Attribute:** *Service Level***Transaction:**

Crisis Diversion Services

**Definition:**

Indicates the intensity of services which the individual received.

**Type:** Text (3)

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

## Transaction: Crisis Facility

### Definition:

Information specific to services delivered at crisis facilities.

### Required for:

- Program: 200 – Urgent Care
- Program: 201 – 23 Hour Observation
- Program: 202 – Crisis Stabilization Unit
- Program: 119 – Opioid Recovery & Care Access (ORCA)

### Frequency:

- Every authorization for one of the crisis programs above.

**Transaction ID:** 310.02

### Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	Y
Case ID	Text	10		Y
Authorization Number	Text			Y
Mode of Arrival	Text	2	Y	Y
Mode of Arrival Detail	Text	3	Y	C
Mode of Arrival Write In	Text	80		C
Referral Source Type	Text	4	Y	Y
Referral Source Detail	Text	3	Y	C
Referral Source Write In	Text	80		C
Primary Presenting Problem	Text	2	Y	Y
Additional Presenting Problem(s)	Text	10	Y	
Post Overdose	Text	2	Y	Y
Clinical Interventions Delivered	Text	40	Y	Y
Medication Interventions Delivered	Text	10	Y	Y
Behavioral Health Disposition	Text	20	Y	Y
Post Discharge Destination	Text	2	Y	Y
KCID	Text			Y
Voluntary or Involuntary Arrival	Text	2	Y	Y

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Mode of Departure	Text	2	Y	Y
Date/Time of Arrival	Text (YYYYMMDDHHMM)	12		Y
Date/Time First Responders Transferred Care to Crisis Facility	Text (YYYYMMDDHHMM)	12		C
Date/Time of First Service	Text (YYYYMMDDHHMM)	12		
Date/Time DCR Requested	Text (YYYYMMDDHHMM)	12		C
Date/Time of Discharge	Text (YYYYMMDDHHMM)	12		Y

**Attribute:** *Mode of Arrival***Transaction:**

Crisis Facility

**Definition:**

How a client arrives at the crisis facility.

**Procedure:**

- This is a required data element.

**Type:** Text (2)

Valid Codes	Definition	Description
10	Transferred from another program within the same crisis facility	Examples: BH Urgent Care, 23 Hour Observation, Crisis Stabilization Unit
11	Arrived by foot/bicycle/scooter	
12	Arrived by public transportation	
13	Arrived by private vehicle	
14	Arrived by rideshare/taxi	Examples: Uber, Lyft
15	Dropped off by ambulance or fire department/Emergency Medical Services (EMS)/Mobile Integrated Health (MIH)	Examples: AMR, Tri-Med, Renton Fire Department, Seattle Health One, Seattle Health 99
16	Dropped off by law enforcement	Example: Bellevue Police Department
17	Dropped off by mobile crisis program	Examples: MRRCT (Sound/DESC), CCORS/MRSS (YMCA)
18	Dropped off by Emergency Services Patrol (ESP)	
19	Dropped off by co-responder program	Examples: RCR, CARES, TRU
20	Dropped off by other community organization	Examples: case manager, car from community organization, outreach programs, etc.
98	Unknown	Use this code when this information is not known or was not yet collected in a definitive and discrete format.
99	Other mode of arrival	

**Attribute:** *Mode of Arrival Detail***Transaction:**

Crisis Facility

**Definition:**

Specific agency or program which transported a client to a crisis facility if they are dropped off by an ambulance or fire department/EMS/MIH, law enforcement, co-responder program, or mobile crisis program.

**Procedure:**

- This is a required data element if the following codes are submitted for Mode of Arrival:
  - 15 – Dropped off by ambulance or fire department/EMS/MIH
  - 16 – Dropped off by law enforcement
  - 17 – Dropped off by mobile crisis program
  - 19 – Dropped off by co-responder program

**Example:**

- Client is brought to the crisis facility by Seattle Fire Department. Submit code 546.

**Type:** Text (3)

Valid Codes	Definition
<b>Ambulance or Fire/EMS/MIH List</b>	
686	AMR
688	Tri-Med
500	Auburn Fire Department
502	Bellevue Fire Department
504	Black Diamond Fire Department
506	Bothell Fire Department
508	Burien/Normandy Park Fire Department (King County Fire District 2)
510	Eastside Fire and Rescue
512	Enumclaw Fire Department
514	Fall City (King County Fire District 27)
516	Kangley-Palmer (King County Fire District 47)
518	Kent Fire and Life Safety
522	King County Fire District 49/51
524	Kirkland Fire Department
526	Maple Valley Fire and Life Safety
528	Mercer Island Fire Department
530	Mountain View Fire & Rescue
532	North Highline (King County Fire District 11)
534	Pacific Fire Department
536	Port of Seattle Fire Department
538	Puget Sound Regional Fire Authority
540	Redmond Fire Department

542	Renton Fire Department (Fire District 40)
544	SeaTac Fire Department
546	Seattle Fire Department
658	Seattle Fire Health One/Mobile Integrated Health
660	Seattle Fire Health 99/Mobile Integrated Health
548	Skykomish KCFD (King County Fire District 50)
550	Skyway/Bryn Mawr (King County Fire District 20)
552	Shoreline Fire Department
652	Shoreline Fire North King County Mobile Integrated Health
554	Snoqualmie Fire and Rescue
556	Snoqualmie Pass (King County Fire District 51)
558	South King Fire and Rescue
560	Tukwila Fire Department
562	Valley Regional Fire Authority
564	Vashon Island Fire and Rescue
994	Other fire department/EMS/MIH
<b>Law Enforcement List</b>	
568	Algona Police Department
208	Auburn police Department
570	Bellevue Police Department
572	Black Diamond Police Department
574	Bothell Police Department
200	Burien Police Services
575	Carnation Police Department
576	Clyde Hill Police Department
578	Covington Police Department
580	Des Moines Police Department
582	Duvall Police Department
584	Enumclaw Police Department
586	Federal Bureau of Investigation
588	Federal Way Department of Public Safety
590	Issaquah Police Department
592	Kenmore Police Department
204	Kent Police Department
594	King County International Airport Police Department
596	King County Sheriff's Option
598	Kirkland Police Department
600	Lake Forest Park Police Department
602	Maple Valley Police Department
604	Medina Police Department
606	Mercer Island (and Hunts Point) Police Department
933	Metro Transit Police
603	Milton Police Department

608	Mountlake Terrace Police Department
609	Muckleshoot Tribal Police
610	Newcastle Police Department
612	Normandy Park Police Department
616	Pacific Police Department
618	Port of Seattle Police Department
620	Redmond Police Department
206	Renton Police Department
622	Sammamish Police Department
624	SeaTac Police Department
306	Seattle Police Department
626	Seattle University Police Department
628	Shoreline Police Department
630	Snoqualmie (and North Bend) Police Department
632	Sound Transit Police Department
634	Tukwila Police Department
704	University of Washington Police Department
638	US Department of Homeland Security
640	US Department of Veterans Affairs Police
642	US Marshal's Office
644	Washington State Patrol
645	Washington State Department of Corrections
646	Woodinville Police Department
999	Other law enforcement
<b>Co-Responder Program List</b>	
648	Regional Crisis Response (RCR)
650	King County Sheriff Therapeutic Response Unit (TRU)
651	Seattle Police Crisis Response Team
654	Redmond Police THRIVE
656	Port of Seattle Police Crisis Response Team
662	Seattle Community Assisted Response & Engagement (CARE)
712	Bellevue Police/Fire CARES & Community Crisis Assistance Team
666	Eastside Fire CORE Connect
668	Snoqualmie Police Co-Response Program
670	Burien Police/Fire CARES & Community Response Team
706	Puget Sound Regional Fire CARES (outreach and prevention)
708	Valley Regional Fire CARES (outreach and prevention)
998	Other co-responder program
<b>Mobile Crisis Program List</b>	
710	Mobile Rapid Response Crisis Team (MRRCT) – DESC
722	Mobile Rapid Response Crisis Team (MRRCT) – Sound
682	Children's Crisis Outreach Response System (CCORS)/Mobile Response and Stabilization Services (MRSS) – YMCA

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684	Crisis Outreach Response System - Young Adults (CORS-YA) – YMCA
997	Other mobile crisis program

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**Attribute:** *Mode of Arrival Write In*

**Transaction:**  
Crisis Facility

**Definition:**  
Additional write-in option for specific agency, program, or other detail of how a client arrives at the crisis facility, when not included in the coded list for Mode of Arrival Detail.

**Procedure:**

- This field is required if Mode of Arrival is 99 – Other mode of arrival.
- If a client arrives by a mode of arrival that is not listed, select 99 (other mode of arrival) in the Mode of Arrival field and write in how the client arrived in this field.

**Type:** Text (80)

**Attribute:** *Referral Source Type***Transaction:**

Crisis Facility

**Definition:**

How a client was referred to the crisis facility.

**Procedure:**

- This is a required data element.
- Referral source may not be clear in many scenarios, as clients potentially access multiple services or have a circuitous path prior to arriving at a crisis facility. If first responder drop-off, select type of first responder. If walk-in intake, ask which program, service, or person last referred the client to or suggested that they come to this facility for their current concerns. If none, select 'Self.'

**Type:** Text (4)

Valid Codes	Definition	Description
2010	Another program within the same crisis facility	Examples: BH Urgent Care, 23 Hour Observation, Crisis Stabilization Unit
1094	Self	
1092	Family/friend/caregiver	
1035	Law enforcement (referral source for voluntary transport by LE, ambulance, etc.)	Example: Bellevue Police Department referred a client to a crisis facility; police officers may or may not provide the voluntary transport (mode of arrival could be police, ambulance, etc.).
2035	Law enforcement (referral source for involuntary transport by LE, ambulance, etc.)	Example: Bellevue Police Department referred a client to a crisis facility involuntarily; police officers may or may not provide the involuntary transport themselves (mode of arrival could be ambulance, etc.).
2020	DCR evaluation without ITA detention	
1133	Fire department/Emergency Medical Services (EMS)/Mobile Integrated Health (MIH)	Examples: Renton Fire Department, Seattle Health One
2030	Mobile crisis program	Examples: MRRCT (Sound/DESC), CCORS/MRSS (YMCA)
2040	Co-responder program	Examples: RCR, CARES, TRU
2050	ED/Hospital	Examples: Harborview, Fairfax
1010	Outpatient behavioral health provider	Examples: Sound, ACRS
1021	Primary care or other outpatient medical provider	Non-behavioral health medical provider

2070	Crisis line	Examples: 988, Regional Crisis Line
2080	Other crisis facility	Examples: Crisis Care Center, Opioid Recovery and Care Access, Crisis Solutions Center
3000	MH or SUD residential facility	Examples: Keystone, Sea Mar Renacer
3010	Housing/homelessness program	Examples: Shelter, Permanent Supportive Housing, Health Through Housing
3020	School or college	Example: University of Washington
3030	Jail or court	Examples: Regional Justice Center, King County Courthouse
1093	Other community organization or program	Examples: case manager, support organizations, outreach programs like Pioneer Square Client Engagement, City Hall Park Outreach Team, etc.
1090	Other referral source	
1098	Unknown	Use this code when this information is not known or was not yet collected in a definitive and discrete format.

**Attribute:** *Referral Source Detail***Transaction:**

Crisis Facility

**Definition:**

Specific agency or program if a client was referred by fire department/EMS/MIH, law enforcement, co-responder program, mobile crisis program, outpatient behavioral health provider, crisis facility, ED/Hospital, or jail or court.

**Procedure:**

- This is a required data element if the following codes are submitted for Referral Source Type
  - 2030 – Mobile crisis program
  - 2040 – Co-responder program
  - 1133 – Fire department/Emergency Medical Services (EMS)/Mobile Integrated Health (MIH)
  - 1035 – Law enforcement (referral source for voluntary transport by LE, ambulance, etc.)
  - 2035 – Law enforcement (referral source for involuntary transport by LE, ambulance, etc.)
  - 2050 – ED/Hospital
  - 1010 – Outpatient behavioral health provider
  - 2080 – Other crisis facility
  - 3030 – Jail or court

**Type:** Text (3)

Valid Codes	Definition
<b>Fire/EMS/MIH List</b>	
500	Auburn Fire Department
502	Bellevue Fire Department
504	Black Diamond Fire Department
506	Bothell Fire Department
508	Burien/Normandy Park Fire Department (King County Fire District 2)
510	Eastside Fire and Rescue
512	Enumclaw Fire Department
514	Fall City (King County Fire District 27)
516	Kangley-Palmer (King County Fire District 47)
518	Kent Fire and Life Safety
522	King County Fire District 49/51
524	Kirkland Fire Department
526	Maple Valley Fire and Life Safety
528	Mercer Island Fire Department
530	Mountain View Fire & Rescue
532	North Highline (King County Fire District 11)
534	Pacific Fire Department

536	Port of Seattle Fire Department
538	Puget Sound Regional Fire Authority
540	Redmond Fire Department
542	Renton Fire Department (Fire District 40)
544	SeaTac Fire Department
546	Seattle Fire Department
658	Seattle Fire Health One/Mobile Integrated Health
660	Seattle Fire Health 99/Mobile Integrated Health
548	Skykomish KCFD (King County Fire District 50)
550	Skyway/Bryn Mawr (King County Fire District 20)
552	Shoreline Fire Department
652	Shoreline Fire North King County Mobile Integrated Health
554	Snoqualmie Fire and Rescue
556	Snoqualmie Pass (King County Fire District 51)
558	South King Fire and Rescue
560	Tukwila Fire Department
562	Valley Regional Fire Authority
564	Vashon Island Fire and Rescue
994	Other fire department/EMS/MIH
<b>Law Enforcement List</b>	
568	Algona Police Department
208	Auburn Police Department
570	Bellevue Police Department
572	Black Diamond Police Department
574	Bothell Police Department
200	Burien Police Services
575	Carnation Police Department
576	Clyde Hill Police Department
578	Covington Police Department
580	Des Moines Police Department
582	Duvall Police Department
584	Enumclaw Police Department
586	Federal Bureau of Investigation
588	Federal Way Department of Public Safety
590	Issaquah Police Department
592	Kenmore Police Department
204	Kent Police Department
594	King County International Airport Police Department
596	King County Sheriff's Option
598	Kirkland Police Department
600	Lake Forest Park Police Department
602	Maple Valley Police Department
604	Medina Police Department

606	Mercer Island (and Hunts Point) Police Department
933	Metro Transit Police
603	Milton Police Department
608	Mountlake Terrace Police Department
609	Muckleshoot Tribal Police
610	Newcastle Police Department
612	Normandy Park Police Department
616	Pacific Police Department
618	Port of Seattle Police Department
620	Redmond Police Department
206	Renton Police Department
622	Sammamish Police Department
624	SeaTac Police Department
306	Seattle Police Department
626	Seattle University Police Department
628	Shoreline Police Department
630	Snoqualmie (and North Bend) Police Department
632	Sound Transit Police Department
634	Tukwila Police Department
704	University of Washington Police Department
638	US Department of Homeland Security
640	US Department of Veterans Affairs Police
642	US Marshal's Office
644	Washington State Patrol
645	Washington State Department of Corrections
646	Woodinville Police Department
999	Other law enforcement
<b>Co-Responder Program List</b>	
648	Regional Crisis Response (RCR)
650	King County Sheriff Therapeutic Response Unit (TRU)
651	Seattle Police Crisis Response Team
654	Redmond Police THRIVE
656	Port of Seattle Police Crisis Response Team
662	Seattle Community Assisted Response & Engagement (CARE)
712	Bellevue Police/Fire CARES & Community Crisis Assistance Team
666	Eastside Fire CORE Connect
668	Snoqualmie Police Co-Response Program
670	Burien Police/Fire CARES & Community Response Team
706	Puget Sound Regional Fire CARES (outreach and prevention)
708	Valley Regional Fire CARES (outreach and prevention)
998	Other co-responder program
<b>Mobile Crisis Program List</b>	
710	Mobile Rapid Response Crisis Team (MRRCT) – DESC

722	Mobile Rapid Response Crisis Team (MRRCT) – Sound
682	Children’s Crisis Outreach Response System (CCORS)/Mobile Response and Stabilization Services (MRSS) – YMCA
684	Crisis Outreach Response System - Young Adults (CORS-YA) – YMCA
997	Other mobile crisis program
<b>Outpatient Behavioral Health Provider List</b>	
018	Asian Counseling and Referral Service
023	Associated Behavioral Health Care
259	Atlantic Street Center
077	Catholic Community Services of WA
266	Center for Human Services
262	Children’s Home Society of WA DBA Akin
021	Community House Mental Health
024	Consejo Counseling and Referral Services
141	Crisis Connections
152	Downtown Emergency Service Center (DESC)
020	Evergreen Healthcare
811	Evergreen Treatment Services
112	Friends of Youth
026	Harborview Outpatient Mental Health & Addiction Services
037	HealthPoint
912	Hero House NW
038	International Community Health Services (ICHS)
969	Ikron
891	Integrative Counseling Services
884	Intercept Associates
814	Kent Youth & Family Services
898	King County Sexual Assault Resource Center
278	Lutheran Community Services NW
680	MultiCare Auburn (Outpatient)
027	Navos (Outpatient)
147	NeighborCare
892	New Traditions
897	Refugee Women’s Alliance (REWA)
226	Rodgers Behavioral Health
151	Ryther Center
227	Sea Mar Community Health Centers
032	Seattle Indian Health Board
281	Seneca Family of Agencies
033	Sound
721	Southwest Youth & Family Services
019	Therapeutic Health Services
148	Transitional Resources
034	Valley Cities Counseling & Consultation

874	Vashon Youth & Family Services
824	WAPIFASA
952	WCHS Inc
031	YMCA Family Services and Mental Health
035	Youth Eastside Services (YES)
370	UW The Clinic
996	Other BH outpatient provider
<b>Crisis Facility List</b>	
700	Opioid Recovery & Care Access (ORCA)
702	Crisis Solutions Center
703	Central Crisis Care Center
705	East Crisis Care Center
707	North Crisis Care Center
709	South Crisis Care Center
711	Youth Crisis Care Center
992	Other Crisis Facility
<b>Emergency Department/Hospital List</b>	
746	Evergreen Health
607	Fairfax Behavioral Health – Kirkland
361	Fred Hutchinson Cancer Center
756	Kaiser Permanente Washington
362	Kindred Hospital Seattle – First Hill
681	MultiCare Auburn Medical Center
364	MultiCare Covington Medical Center
759	Navos (Hospital)
636	Overlake Medical Center & Clinic
599	Olympic Heritage Behavioral Health
363	Providence Hospital
080	Seattle Children’s Hospital
365	Snoqualmie Valley Health
902	St. Anne Hospital
672	St. Elizabeth Hospital
901	St. Francis Hospital
366	Swedish Ballard
675	Swedish Cherry Hill
657	Swedish First Hill
938	Swedish Health Services
368	Swedish Issaquah
367	Tacoma General Hospital
947	Telecare
614	UW Medicine – Harborview Medical Center
677	UW Medicine – UW Medical Center Montlake
674	UW Medicine – UW Medical Center Northwest

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678	UW Medicine – Valley Medical Center
369	VA Puget Sound Health Care System – Seattle
664	Virginia Mason Medical Center
993	Other hospital
<b>Jail or Court List</b>	
400	King County Courthouse
402	King County Correctional Facility (KCCF)
406	Maleng Regional Justice Center (MRJC)
404	Judge Patricia H. Clark Children and Family Justice Center
408	Regional Mental Health Court
410	Kirkland Jail
412	Issaquah Municipal Court
413	South Correctional Entity Jail (SCORE)
991	Other Jail or Court

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**Attribute:** *Referral Source Write In*

**Transaction:**  
Crisis Facility

**Definition:**  
Additional write-in option for specific agency, program, or other detail of how a client is referred to the crisis facility, when not included in the coded list for Referral Source Detail.

**Procedure:**

- This field is required if Referral Source is 1090 – Other referral source.
- If a client is referred by a source that is not listed, select 1090 (other referral source) in the Referral Source field and write in how the client arrived in this field.

**Type:** Text (80)

**Attribute:** *Primary Presenting Problem***Transaction:**

Crisis Facility

**Definition:**

The main reason for which a person is seeking care at this crisis facility. Presenting problems are mostly symptoms or stressors, not diagnoses.

**Procedure:**

- This is a required data element.
- Collected only at the first authorization for a continuous facility stay. Otherwise, select the first code.
- Select only one code.
- Additional presenting problems can be reported in the attribute below.

**Examples:**

- Client arrives at a Crisis Care Center Behavioral Health Urgent Care with psychosis – new onset as the primary presenting problem. When submitting this transaction for the Behavioral Health Urgent Care authorization, select code 52.
- Client arrives at a Crisis Care Center Behavioral Health Urgent Care with psychosis – new onset as the primary presenting problem. The client is then transferred to a Crisis Stabilization Unit within the same Crisis Care Center. When submitting this transaction for the Crisis Stabilization Unit authorization, select code 01.

**Type:** Text (2)

Valid Codes	Definition
01	Not Applicable – Client transferred from another program within the facility
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
14	Peer difficulties
15	School problems
17	Eating disturbance
18	Intellectual/developmental delays
19	Identity discovery
20	Loneliness

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21	Intimate relationship problems
22	Bereavement
23	Critical incident
24	Substance use
25	Substance intoxication
26	Substance withdrawal
27	Neurocognitive symptoms
28	Chronic physical symptoms
29	Socioeconomic challenges
50	Medical/physical health concerns
51	Psychosis – chronic
52	Psychosis – new onset
53	Mania
54	Unstable living arrangement
98	Unknown
99	Other

**Attribute:** *Additional Presenting Problem(s)***Transaction:**

Crisis Facility

**Definition:**

Additional reasons for which a person is seeking care at this crisis facility. Presenting problems are mostly symptoms or stressors, not diagnoses.

**Procedure:**

- Collected only at the first authorization for a continuous facility stay.
- Primary presenting problem is reported in the attribute above.
- Additional presenting problems only reported if more than one problem from the list applies. Otherwise, leave this attribute empty.
- Select all that apply (up to 5 codes).
- Report multiple codes in one string, with no spaces or special characters.

**Examples:**

- Client arrives at a Crisis Care Center Behavioral Health Urgent Care with psychosis – new onset as the primary presenting problem and family conflict as an additional presenting problem. When submitting this transaction for the Behavioral Health Urgent Care authorization, select code 12.
- Client arrives at a Crisis Care Center Behavioral Health Urgent Care with psychosis – new onset as the primary presenting problem and family conflict as an additional presenting problem. The client is then transferred to a Crisis Stabilization Unit within the same Crisis Care Center. When submitting this transaction for the Crisis Stabilization Unit authorization, leave this attribute empty.
- Client arrives at a Crisis Care Center Behavioral Health Urgent Care with psychosis – new onset as the primary presenting problem and no additional presenting problems. When submitting this transaction for the Behavioral Health Urgent Care authorization, leave this attribute empty.
- Client arrives at a Crisis Care Center Behavioral Health Urgent Care with psychosis – new onset as the primary presenting problem and no additional presenting problems. The client is then transferred to a Crisis Stabilization Unit within the same Crisis Care Center. When submitting this transaction for the Crisis Stabilization Unit authorization, leave this attribute empty.

**Type:** Text (10)

Valid Codes	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

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12	Family conflict
13	Trauma
14	Peer difficulties
15	School problems
17	Eating disturbance
18	Intellectual/developmental delays
19	Identity discovery
20	Loneliness
21	Intimate relationship problems
22	Bereavement
23	Critical incident
24	Substance use
25	Substance intoxication
26	Substance withdrawal
27	Neurocognitive symptoms
28	Chronic physical symptoms
29	Socioeconomic challenges
50	Medical/physical health concerns
51	Psychosis – chronic
52	Psychosis – new onset
53	Mania
54	Unstable living arrangement
99	Other

**Attribute:** *Post Overdose***Transaction:**

Crisis Facility

**Definition:**

Whether the client presented to the crisis facility because of complications due to substance use overdose or immediately following an overdose (generally within 48 hours of overdosing). The number of hours between an overdose and arrival at a crisis facility does need to be strictly interpreted. It is most important to convey whether a substance use overdose was the primary reason for an individual to arrive at a crisis facility.

**Procedure:**

- Collected only at the first authorization for a continuous facility stay. Otherwise, leave this attribute empty.
- Select only one code.

**Type:** Text (2)

Valid Codes	Definition	Description
01	No	The client did not present to the crisis facility because of complications due to substance use overdose or immediately following an overdose (generally within 48 hours of overdosing).
02	Yes	The client did present to the crisis facility because of complications due to substance use overdose or immediately following an overdose (generally within 48 hours of overdosing).
98	Unknown	Use this code when this information is not known or was not yet collected in a definitive and discrete format.

**Attribute:** *Clinical Interventions Delivered***Transaction:**

Crisis Facility

**Definition:**

Treatment, supports, or other clinical interventions delivered as part of a person's crisis care while in this program.

**Procedure:**

- This is a required data element.
- Collected at every authorization for a continuous facility stay.
- Select all that apply (up to twenty codes).
- Report multiple codes in one string, with no spaces or special characters.

**Type:** Text (40)

Valid Codes	Definition	Description
<b>Crisis Stabilization</b>		
10	Used de-escalation techniques	
11	Removed access to means of harm	Refers to actual removal or efforts to coordinate removal of access to means of harm, beyond counseling on the topic. If counseling is conducted as part of safety planning, select code 12 below.
12	Made crisis safety plan	Created a crisis, suicide, or safety plan, as defined by providers. BHRD may introduce standards in the future.
13	Used maximum observation (1:1)	This includes only 1:1 observation, not every 15 minutes.
14	Called Designated Crisis Responder (DCR) for an involuntary treatment evaluation	
<b>SUD</b>		
15	Provided Substance Use Disorder (SUD) counseling (individual or group)	This is not constrained to only counseling provided by an SUD Professional (SUD-P).
16	Initiated or provided withdrawal management	
17	Engaged Substance Use Disorder Professional (SUD-P) on site	Engaged SUD-P at the crisis facility. If coordinated external care, select code 26 below.
<b>Therapeutic Supports</b>		
18	Provided peer support (individual or group)	Beyond basic-level greeting.

19	Engaged in other group therapy session	Groups other than SUD or peer-led. Could be focused on mental health or other skills. If SUD counseling or peer support, select codes 15 or 18 above.
20	Provided therapeutic art, music, or other creative activities	
<b>Seclusion or Restraint</b>		
21	Used physical restraints	
22	Used seclusion	
<b>Physical Health</b>		
23	Managed medical/physical health needs internally at the crisis facility	Stable medical/physical health needs at the outpatient level of care. That is, not at the medical urgent care or emergency department levels of care. Includes both chronic/previous or newly detected conditions. Examples include wound care, minor infections (UTI, upper respiratory, etc.), medication for diabetes, high blood pressure, cholesterol, asthma, etc. This is limited to non-behavioral health needs.
24	Transferred to ED for medical/physical health care and returned within 6 hours	Only for cases where client left for ED without being discharged and returned to the crisis facility. If client did not return to the crisis facility or did not return within 6 hours, document as “Transferred to ED for medical/physical health care” in the Behavioral Health Disposition attribute below. This applies to 23-Hour Observation and ORCA programs.
25	Transferred to ED for medical/physical health care and returned within 6-24 hours	Only for cases where client left for ED/hospital without being discharged and returned to the crisis facility. If client did not return to the crisis facility or did not return within 6-24 hours, document as “Transferred to ED for medical/physical health care” in the Behavioral Health Disposition attribute below. This applies to Crisis Stabilization Unit programs.
<b>Care Coordination</b>		
26	Coordinated care with existing providers	Any provider, including behavioral health or primary care providers (PCPs).
27	Coordinated with family/support system	

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28	Coordinated with housing/homelessness services	
29	Coordinated with probation/parole	
<b>None</b>		
98	Unknown	Use this code when this information is not known or was not yet collected in a definitive and discrete format.
99	None of the above	

**Attribute:** *Medication Interventions Delivered***Transaction:**

Crisis Facility

**Definition:**

Specific medication or medication-related supports delivered as part of a person's crisis care while in this program.

**Procedure:**

- This is a required data element.
- Collected at every authorization for a continuous facility stay.
- Select all that apply (up to five codes).
- Report multiple codes in one string, with no spaces or special characters.

**Type:** Text (10)

Valid Codes	Definition	Description
<b>Psychiatric</b>		
40	Administered psychiatric medication over objection	Example: Intramuscular injection for acute agitation.
41	Provided psychiatric medication on site (for psychiatric reasons)	Only select this code when psychiatric medication is provided for psychiatric reasons; if used for a seizure disorder, for instance, do not select. If psychiatric medication was only administered over objection, only select code 40 above. If specifically providing Clozapine, only select code 42 below.
42	Provided or prescribed Clozapine	Specific psychiatric medication. If only providing Clozapine, only select this code and not also code 41 above.
43	Administered Long-Acting Injectable (LAI) antipsychotic	
44	Prescribed or dispensed psychiatric medications upon discharge	Includes providing a prescription for a new medication as well as refilling a pre-existing prescription upon discharge. Also includes directly dispensing if available at the facility.
<b>Overdose and MOUD</b>		
45	Administered Naloxone on site	Such as Narcan. If prescribed or dispensed, select code 46 below.
46	Prescribed or dispensed Naloxone	Such as Narcan. If directly administered on site, select code 45 above.
47	Administered Long-Acting Injectable (LAI) Buprenorphine	

48	Provided or prescribed Buprenorphine - Medication for Opioid Use Disorder (MOUD)	
49	Provided, dispensed, or prescribed Methadone – Medication for Opioid Use Disorder (MOUD)	
50	Provided or prescribed Naltrexone (oral or Long-Acting Injectable) – Medication for Overdose Protection	Only if Naltrexone provided or prescribed for overdose protection. If providing or prescribing Naltrexone for MAUD, select code 51 below.
<b>MAUD and Tobacco</b>		
51	Provided or prescribed Medication for Alcohol Use Disorder (MAUD)	Includes Naltrexone if provided for AUD and other MAUD.
52	Provided or prescribed tobacco use disorder medication or nicotine replacement	Examples: Nicotine patches, lozenges, others
<b>Physical Health</b>		
53	Provided or prescribed physical health medications	Includes any physical health medications provided or prescribed during a stay, whether it is new or continued from home. Examples: blood pressure medication, diabetes medication. If the physical health medication is for one of the options below (e.g. HIV, lice), only select the respective code below.
54	Provided or prescribed contraception	
55	Provided or prescribed HIV pre-exposure prophylaxis	
56	Provided or prescribed medication for other Sexually Transmitted Infection (STI)	Examples: medication for syphilis, gonorrhea, etc. If HIV pre-exposure prophylaxis, select only code 55 above.
57	Provided or prescribed medication for lice, scabies, or other superficial infection	
<b>None</b>		
98	Unknown	Use this code when this information is not known or was not yet collected in a definitive and discrete format.
99	None of the above	Select if no medication interventions are delivered.

**Attribute:** *Behavioral Health Disposition***Transaction:**

Crisis Facility

**Definition:**

The next steps for a client regarding their crisis or post-crisis care upon leaving this crisis facility.

**Procedure:**

- This is a required data element.
- Collected at every authorization for a continuous facility stay.
- Select all that apply (up to 10 codes).
- Report multiple codes in one string, with no spaces or special characters.

**Type:** Text (20)

Valid Codes	Definition	Description
<b>Admitted or transferred to another facility (higher level of care)</b>		
30	Admitted to involuntary hospitalization	
31	Admitted to voluntary hospitalization	
32	Transferred to 23H Observation Unit (Crisis Relief Center/CRC)	
33	Transferred to Crisis Stabilization Unit (CSU)	
<b>Referred to or appointment made with another service for SUD care</b>		
34	Referred to ORCA	DESC outpatient facility with 24h maximum length of stay, not licensed for withdrawal management. It may initiate medications and support withdrawal symptoms as a potential steppingstone to withdrawal management, similar to a Crisis Care Center. If ORCA instructs clients to return to ORCA for medication, select this code.
35	Referred to withdrawal management/detox facility	DOH-licensed withdrawal management residential treatment facilities, typically with multiday stays, such as Valley Cities Recovery Place. If a client is referred to withdrawal management treatment at a Crisis Stabilization Unit, select code 33 instead.
36	Appointment made with Medication for Opioid Use Disorder (MOUD) provider	MOUD includes Methadone, Buprenorphine, Long-Acting Injectable or otherwise.

37	Referred to other outpatient substance use treatment provider	Other than ORCA and MOUD provider (if either of these, select codes 34 or 36 above).
<b>Referred to another service for further crisis or post-crisis support</b>		
38	Referred to 24/7 Behavioral Health Urgent Care (BHUC)	
39	Referred to post-crisis follow-up services	Includes both BHRD contracted Post-Crisis Follow-Up (PCFU) programs and other post-crisis follow-up services.
40	Referred to outpatient mental health provider	
41	Referred to Next Day Appointment (NDA)	BHRD Next Day Appointment (NDA) program. Appointments are scheduled via the Regional Crisis Line (for mental health NDA) or the Recovery Help Line (for SUD NDA).
42	Referred to Sobering Center	King County facility that offers supports to people recovering from acute intoxication.
43	Referred to Crisis Respite Program	DESC facility that provides temporary shelter and/or residential care for individuals in crisis.
44	Referred to Crisis Solutions Center	DESC Crisis Diversion Facility (CDF) or Crisis Diversion Interim Services (CDIS) facilities, which provide crisis stabilization services.
<b>Medical and other non-BH needs</b>		
45	Transferred to emergency department (ED) for medical/physical health care	Client was discharged from crisis facility. If client left for medical/physical health care for less than 24 hours and returned to crisis facility, select codes 24 or 26 in the Clinical Interventions Delivered attribute above instead. If client was transferred to ED after crisis facility called 911 for emergency medical response, select code 46 below.
46	Transferred to emergency department (ED) after crisis facility called 911 for emergency medical response	If client was transferred to ED for medical/physical health care without the crisis facility calling 911 for emergency medical response, select code 45 above.
47	Referred to housing and/or other social services	
<b>Other</b>		
48	Declined further treatment (left “against medical advice”)	Self-directed discharge, not recommended by team. Includes by client or parent of a minor.
98	Other	Examples: client deceased, elopement.

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99	Unknown	Use this code when this information is not known or was not yet collected in a definitive and discrete format.
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**Attribute:** *Post Discharge Destination***Transaction:**

Crisis Facility

**Definition:**

Where a client goes immediately after leaving this crisis facility. This does not necessarily mean where a client sleeps that night or their housing status.

**Procedure:**

- This is a required data element.
- Collected at every authorization for a continuous facility stay.
- Select only one code.

**Type:** Text (2)

Valid Codes	Definition	Description
<b>Another treatment facility</b>		
10	Another Crisis Care Center program within the same crisis facility	This includes transfers to a Crisis Care Center 23h Observation Unit or Crisis Stabilization Unit. For an E&T that is in the same or an adjacent location, select code 11 below.
11	Psychiatric or Evaluation & Treatment (E&T) facility	Including E&Ts that share a facility with a Crisis Care Center.
12	Emergency department (ED) or medical hospital	
13	Other crisis facility	Examples: Crisis Care Center, ORCA, CSC
14	Mental health residential/treatment facility	Examples: Long-term rehabilitation (e.g. Sound Keystone), supervised living (e.g. Community House Spring Manor), standard supportive housing (e.g. Navos Midway 50+).
15	Substance use disorder (SUD) residential/treatment facility	Examples: Valley Cities Recovery Place – Seattle, Sea Mar Turning Point
<b>Housing/unsheltered</b>		
16	Own residence	Owned or rented home. This includes living somewhat permanently with family or friends/roommates.
17	Family or friends' residence temporarily	Temporarily, transitionally, or informally staying with family or friends (e.g. couch surfing).
18	Housing/homelessness program	Examples: shelter, permanent supportive housing, transitional housing, group home, etc.

19	Street or unsheltered, by client preference	Place not meant for habitation, if the crisis facility successfully connected a person to available housing/homelessness programs but the person chose not to pursue them.
20	Street or unsheltered due to unavailable housing/homelessness programs	Place not meant for habitation, if crisis facility attempted to connect a person to housing/homelessness resources but they were not available.
<b>Other</b>		
21	Jail or detention	
22	Outpatient or community-based mental health/substance use disorder provider	Not a facility. Example: Client leaves with a therapist, in-person warm handoff.
98	Other	Examples: skilled nursing facility, assisted living, hotel, client deceased, etc.
99	Unknown	Use this code when this information is not known or was not yet collected in a definitive and discrete format.

**Attribute:** *Voluntary or Involuntary Arrival***Transaction:**

Crisis Facility

**Definition:**

The way a client arrived at the crisis facility, whether it was voluntarily or involuntarily.

**Procedure:**

- This is a required data element.
- Select only one

**Type:** Text (02)

Valid Codes	Definition	Description
10	Transferred from another program within the same crisis facility	Examples: 23 Hour Observation, Crisis Stabilization Unit
12	Voluntary Arrival	First responder entrance or walk-in
14	Involuntary Transport	Arrived on a law enforcement initiated involuntary transport (IVT)/detention

**Attribute:** *Mode of Departure***Transaction:**

Crisis Facility

**Definition:**

How a client leaves the crisis facility and/or is transported to post-discharge destination. Report as planned upon discharge.

**Procedure:**

- This is a required data element.
- Select only one.

**Type:** Text (02)

Valid Codes	Definition	Description
10	Transferred to another program within the same crisis facility	Examples: 23 Hour Observation, Crisis Stabilization Unit, other co-located services such as E&T.
12	Transported in vehicle operated by crisis facility	Vehicle associated with the crisis facility that is submitting the transaction. Example: CCC owned car/van.
14	Transported by Non-Emergency Medical Transport (NEMT)	Examples: Transport brokered through HopeLink, Access.
16	Transported by ambulance or fire department/Emergency Medical Services (EMS)/Mobile Integrated Health	Examples: AMR, Tri-Med, Renton Fire Department, Seattle Health One, Seattle Health 99.
18	Left by public transportation	Regardless of whether transit pass was provided by crisis facility or person served.
20	Left by rideshare/taxi	Examples: Uber, Lyft, local taxi company. Regardless of whether rideshare/taxi was called by crisis facility or person served.
22	Left by foot/bicycle/scooter	
24	Left by private vehicle	Driven by self or family/friend.
26	Transported by law enforcement	Example: Bellevue Police Department
28	Transported by children/youth mobile crisis program	Refers to Mobile Response Stabilization Services (MRSS)/Children's Crisis Outreach Response System (CCORS)
30	Transported by Emergency Services Patrol (ESP)	Refers to BHRD service offering transport to individuals around an extended downtown Seattle area, either in response to 911 referral or as self-initiated outreach.
32	Transported by co-responder program	Examples: RCR, Seattle CARE, Bellevue CARES, TRU
34	Transported by Post Crisis Follow Up (PCFU) provider	
36	Transported by other community organization or program	Examples: Case manager, car from community organization, outreach programs, etc.
38	Other	Example: Transported by outpatient provider.

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99	Unknown	Person left before a mode of departure was planned (at discharge), without staff knowing more details, and/or “against medical advice” (self-directed discharge).
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**Attribute:** *Date/Time of Arrival*

**Transaction:**  
Crisis Facility

**Definition:**  
The date and time the client arrives in the crisis program.

**Procedure:**

- This is a required data element.

**Type:** Text/Time (12)  
YYYYMMDDHHMM

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**Attribute:** *Date/Time First Responders Transferred Care to Crisis Facility*

**Transaction:**  
Crisis Facility

**Definition:**  
The date and time first responders transferred care/dropped client off at the crisis facility.

**Procedure:**

- This is a required data element if first responder drop-off, ‘Mode of Arrival’ codes:
  - 15 (Dropped off by ambulance or fire/EMS/MIH)
  - 16 (Dropped off by law enforcement)
  - 17 (Dropped off by mobile crisis programs)
  - 19 (Dropped off by co-responder program)

**Type:** Text/Time (12)  
YYYYMMDDHHMM

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**Attribute:** *Date/Time of First Service*

**Transaction:**  
Crisis Facility

**Definition:**

Refers to the date and time when an individual first has a clinical interaction with a licensed behavioral health (BH) provider or clinician following arrival. This field is intended to support measurement of wait time from arrival to first BH clinical contact.

First clinical interactions may include, but are not limited to: peer assessment, crisis stabilization, intake, and/or clinical assessment.

Non-clinical activities (e.g., vitals collection, urine drug screening, administrative tasks, or other medical screening not involving BH clinical engagement) are not included.

**Procedure:**

- This is a required data element unless mode of arrival = 10 (Transferred from another program within the same crisis facility)

**Type:** Text (12)  
YYYYMMDDHHMM

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**Attribute:** *Date/Time DCR Requested*

**Transaction:**  
Crisis Facility

**Definition:**  
Time DCR evaluation was requested.

**Procedure:**

- This is only required if “DCR called” is selected in “Clinical Interventions”
- If this has a value, then “DCR called” is required in “Clinical Interventions”

**Type:** Text (12)  
YYYYMMDDHHMM

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**Attribute:** *Date/Time of Discharge*

**Transaction:**  
Crisis Facility

**Definition:**  
The date and time the client was discharged from the crisis program.

**Procedure:**

- This is a required data element.

**Type:** Text (12)  
YYYYMMDDHHMM

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## Transaction: Diagnosis ICD-10-CM

**Definition:**

Identifies a person's diagnosis.

**Required for:**

Crisis, Outpatient, Residential, Inpatient

**Procedure:**Authorization is in 'UA' status

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

Authorization is in 'AA' status

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

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

**Frequency:**

- Initial Assessment
- Continuation of benefit
- Medicaid OPB Anniversary
- On change to the diagnosis

**Transaction ID:** 870.01

**Action Codes:**

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

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

**Attribute:** *Diagnosis Code***Transaction:**

Diagnosis ICD-10-CM

**Definition:**

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

**Procedure:**

- There is no limit on the number of diagnosis codes that can be submitted.
- Mental health programs require at least one mental health diagnosis (F01-F09, F20-F99)
- SUD programs require at least one substance use diagnosis (F10-F19)
- Primary Focus Indicator is the only field that can be changed for a diagnosis record that has been submitted and posted. If you are changing the primary focus indicator on an existing diagnosis from '00' (not primary) to '01' (primary) you must first change the existing primary ('01') to '00' (not primary).
- Diagnoses failing one or more of the following edits will be rejected:
- **For all clients age six years old and above, only ICD-10-CM codes can be submitted.**
- For all clients six years old and above, "The Diagnostic and Statistical Manual (DSM) of Mental Disorders, Fifth Edition" (DSM-5) diagnostic criteria should be used in the provider medical record and in consultations with BHRD staff.
- For children under six years old the provider may use a DC03 diagnosis instead of the DSM-5 diagnosis. Use the tables that follow to crosswalk DC03 codes to ICD-10-CM codes.
- Agencies must identify the clinician assigning the diagnosis in the face-to-face service record reported to the system and must maintain documentation identifying that clinical staff person by name and title. The individual making the diagnosis can be anyone authorized by the agency to determine diagnosis.

**Required Documentation:**

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

**Type:** Text (8)

Enter the ICD-10-CM diagnosis code. **Include the period.**

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

**Attribute:** *Primary Focus Indicator***Transaction:**

Diagnosis ICD-10-CM

**Definition:**

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

**Procedure:**

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

**Documentation:**

See Diagnosis Code.

**Examples:**

1. An adult client is diagnosed with major depression and mental retardation. The current treatment plan addresses problems due to the major depression. Code major depression as the primary focus of treatment.
2. A child has an attention-deficit hyperactivity disorder and a social phobia. The treatment plan focuses primarily on the ADHD. Code the ADHD as the primary focus of treatment.

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

## Transaction: Disability

### Definition:

Describes disabilities other than the disability of mental illness.

### Required for:

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

### Procedure:

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

### Frequency:

- Assessment
- On change

**Transaction ID:** 050.03

### Action Codes:

A	Add
C	Change
D	Delete

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

**Attribute:** *Impairment Kind***Transaction:**

Disability

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Examples:**

1. A client reported having an auditory disability during an earlier assessment. This was reported in a transaction. Six months later the client acquired a medical disability. Submit codes 33 and 44 with the date of onset of the medical disability.
2. During the initial assessment, documentation is provided verifying that a client is mentally retarded and has a visual disability. Report codes 24 and 31 with the assessment date.
3. A client is diagnosed with congestive heart failure and HIV. Report Code 44 once only.

**Type:** VarChar (10)

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

**Attribute:** *Substance Abuse***Transaction:**

Disability

**Definition:**

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

**Procedure:**

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

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

**Required Documentation:**

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

**Examples:**

1. During the assessment for services, a client stated she became clean and sober from alcohol two months ago. The clinician has obtained no information that conflicts with this report. Code 2 until one year after the client last used.
2. A client reports to his case manager that he has an occasional social drink. The case manager has observed no impact of alcohol on the client's life in general or related to treatment. Code 8.

**Type:** Character (1)

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

## Transaction: Dynamic Client Data

### Definition:

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

### Required for:

Mental health and SUD outpatient benefits  
Mental health and SUD residential benefits

### Frequency:

Initial assessment  
On change

### Procedure:

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

**Transaction ID:** 180.02

**Effective Date:** November 1, 2022

### Action Codes:

A	Add
C	Change
D	Delete

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

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**Attribute:** *Event Date***Definition:**

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

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

**Procedure:**

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

**Attribute:** *Employment Status***Transaction:**

Dynamic Client Data

**Definition:**

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

**Procedure:**

- Where a client meets more than one definition below, report the lowest numbered King County ("valid code") that applies.
- On assessment, report the date of the assessment.
- On change, report the actual date of the change. Where unknown, report the best estimate and document in the file.
- If the change is due to the new employment status code, the event date is the date when the client's employment status using the new set of codes is re-evaluated.

This is used for State and BHRD outcome measures. **Required Documentation:**

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

**Examples:**

1. During an assessment, the client reports she holds two part-time jobs, one for 25 hours a week as a nursing assistant and the second for 15 hours a week as a teacher's aide. Report the client as employed competitively full-time (Code 21), since the total hours of employment exceed 35 hours.
2. A client attends college and has a 15 hour a week work-study job. Report as employed competitively less than 20 hours a week (Code 23).
3. An unemployed client is referred to a supported employment program and begins receiving job placement services. Report as not employed but actively looking for work (Code 25). Two months later, she obtains a 20-hour a week competitive job and continues to receive supported employment services. Report as employed competitively 20-34 hours a week (Code 22).
4. An unemployed client begins receiving DVR services and begins receiving job placement services. Report as not employed but actively looking for work (Code 25). Two months later, he obtains a 20 hour a week job and continues to receive employment supports through DVR. Report as employed competitively 20-34 hours a week (Code 22).
5. A client works 20 hours a week in a three-month transitional employment job associated with a clubhouse. Report as employed in a non-competitive job (Code 24).
6. A client accompanies her elderly neighbor to the store each week to help with shopping, but is not interested in finding paid employment. Report as not in labor force (Code 26).
7. A client volunteers weekly at a local food bank. Report as not in labor force (Code 26).

**Type:** Text (2)

Valid Codes	Definition	State Code (BHRD Use Only)
21	Employed Competitively Full-time: 35 hours or more paid employment per week	01
22	Employed Competitively Part-time: 20-34 hours paid employment per week	02
23	Employed Competitively Part-time: Less than 20 hours paid employment per week	02
24	Employed in a non-competitive job (1 or more hours per week).  Position is considered non-competitive if it meets any one or more of the following criteria: <ul style="list-style-type: none"> <li>• Position is in a “sheltered” or protected setting in which the typical performance expectations of mainstream jobs do not apply.</li> <li>• Applications for position are deemed eligible based solely upon an individual’s diagnosis of a mental illness or of a developmental or other disability, rather than on specific job qualifications related to the duties and responsibilities of the position.</li> <li>• Position is limited to specific group/type of individuals (i.e., consumers receiving services at a particular agency) and not available to anyone who meets identified job qualifications.</li> <li>• Co-workers/peers are primarily mental health consumers or individuals with a common disability.</li> <li>• Salary is less than minimum wage</li> </ul>	74
25	Not employed: Actively looking for work may consist of any of the following activities: <ul style="list-style-type: none"> <li>• Participating in a supported employment, or certified clubhouse employment, program</li> <li>• Contacting: <ul style="list-style-type: none"> <li>○ An employer directly or having a job interview</li> <li>○ A public or private employment agency</li> <li>○ Friends or relatives</li> <li>○ A school or university employment center</li> </ul> </li> <li>• Sending out resumes or filling out applications</li> <li>• Placing or answering advertisement</li> <li>• Checking union or professional registers</li> <li>• Some other means of active job search</li> </ul>	03
60	Not in Labor Force: Homemaker	14
61	Not in Labor Force: Student	24
62	Not in Labor Force: Retired	34
63	Not in Labor Force: Disabled	44
64	Not in Labor Force: Other reported classification (e.g., volunteer)	64
99	Unknown	97

## Attribute: Source of Income/Support

### Transaction:

Dynamic Client Data

### Definition:

Identifies the client's principal source of financial support.

### Procedure:

- Report the primary source of income/support of the client.
- For children younger than 18, report the primary parental source of income/support.

### Required Documentation:

Providers shall document the client's total family income in the client record.

### Examples:

1. A client reports that their principal source of income is from their job. Report Code 1.
2. A client reports they receive Veteran Benefits as their primary source of income. Report code 20.
3. A client reports that they receive some income from a part time job but most of their support comes from SSI or SSDI, report Code 4.
4. A client reports that they do not have any income/support. Report Code 21.
5. A client reports that they receive some public assistance, but their principal source of income is from alimony payments. Report Code 20.
6. A client reports they are in the process of applying for public assistance. Report Code 21. Once they have public assistance report Code 2.

**Type:** Text (2)

Valid Codes	Definition	State Code BHRD Use Only
1	Wages/Salary	1
2	Public Assistance	2
3	Retirement/Pension	3
4	Disability	4
20	Other	20
21	None	21
97	Unknown	97

**Attribute:** *Education Status***Transaction:**

Dynamic Client Data

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Examples:**

1. A youth attends high school 15 hours a week to complete classes required to graduate. He also does volunteer work at a nursery because he wants to eventually work for a landscaping firm. Submit Code 41.
2. A child is taught at home by his mother under a formal plan for home schooling. Submit Code 21.
3. A youth has graduated from high school and attends vo-tech school 15 hours a week. Submit Code 21.
4. A youth attends high school 10 hours a week to finish two classes needed to graduate and works 20 hours a week. Submit Code 41.
5. A 35-year-old woman returns to college 10 hours a week to finish an accounting degree. Submit Code 41.
6. A youth is suspended for one week from attending high school full-time. No change is required: Code 21 still applies.
7. A youth is expelled from one high school and plans to apply to attend another and is not yet enrolled. Submit Code 97.

**Type:** Text (2)

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

**Attribute: Grade Level****Transaction:**

Dynamic Client Data

**Definition:**

Identifies the highest grade level completed by the client.

**Type:** Character (2)

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

**Attribute:** *Pregnant*

**Transaction:**  
Dynamic Client Data

**Definition:**  
Indicates if the client is pregnant.

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

**Type:** Number

Code	Definition
1	No
2	Yes
3	Unknown

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**Attribute:** *Birthdate of Youngest Child***Transaction:**

Dynamic Client Data

**Definition:**

The birthdate of the client's youngest child.

**Procedure:**

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

**Required Documentation:**

Providers shall maintain documentation describing the source of information.

**Examples:**

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

**Type:** Text (8)

YYYYMMDD

**Attribute:** *Smoking Status*

**Transaction:**  
Dynamic Client Data

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

**Type:** Number

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

**Attribute:** *Self Help Count***Transaction:**

Dynamic Client Data

**Definition:**

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

**Procedure:**

- Required for SUD clients, optional for mental health clients.

**Type:** Character (2)

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

**Attribute:** *Used Needle Recently*

**Transaction:**  
Dynamic Client Data

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

**Procedure:**

- Required for SUD clients, optional for mental health clients.

**Type:** Number

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

**Attribute:** *Needle Use*

**Transaction:**  
Dynamic Client Data

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

**Procedure:**

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

**Type:** Number

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

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## Transaction: HIPAA Health Care Claims 837 Professional

**Definition:**

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

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

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

**Required for:**

Outpatient, Residential, Crisis

**Collection Frequency:**

On event

**Transaction Format:**

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

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

## Transaction: Income Category

**Definition:**

Describes a person's income and family size.

**Required for:**

Outpatient, Residential

**Frequency:**

Assessment

Continuation of Benefit

On change

**Transaction ID:** 060.04

**Action Codes:**

A	Add
C	Change
D	Delete

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

**Attribute:** *Annual Income*

**Transaction:**  
Income Category

**Definition:**  
This identifies the income of the family reported in the “Family Size” attribute.

**Procedure:**

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

**Required Documentation:**

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

**Type:** Integer

**Attribute:** *Family Size*

**Transaction:**  
Income Category

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

A description of “family” for each client must be documented in the client’s record.

**Examples:**

1. If the client lives alone, report as one.
2. If the client shares his/her household with three other people who meet the criteria above, report four.
3. If the client shares his/her household with three people who do meet the criteria above and two people who **do not** meet this criteria, report four.

**Type:** Number (2)

## Transaction: Key Dates

### Definition:

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

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

### Required for:

All Medicaid clients who request services  
 Many non-Medicaid clients who request services  
 Not required for Continuation of Benefits or where there is less than a 90-day gap between two outpatient benefits (of the same treatment focus).  
 Not required for Medicaid OPB Anniversary

### Frequency:

Initial assessment

### Procedure:

- For outpatient benefits, all three dates must be reported by the authorization cutoff date

**Transaction ID:** 200.01

### Action Codes:

A	Add
C	Change
D	Delete

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

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

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**Attribute:** *Request for Services Date***Transaction:**

Key Dates

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Type:** Date (YYYYMMDD)

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**Attribute:** *First Intake Appointment Offered Date***Transaction:**

Key Dates

**Definition:**

An intake appointment within 10 working days of the request for services shall be offered to all persons covered by Medicaid and to all persons not covered by Medicaid who meet financial eligibility.

**Procedure:**

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

**Required Documentation:**

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

**Type:** Date (YYYYMMDD)

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**Attribute:** *First Routine Appointment Offered Date***Transaction:**

Key Dates

**Definition:**

- The first routine appointment must be offered to occur within 28 calendar days of request for service.
- The first routine appointment must be offered regardless of whether or not the requested outpatient benefit has been granted.
- The first routine appointment may be provided prior to the completion of the intake.

**Procedure:**

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

**Required Documentation:**

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

**Type:** Date (YYYYMMDD)

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## Transaction: LOCUS

**Definition:**

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

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

Authorization is in 'UA' status

For Program 401 - Mental Health MIDD (Non-Medicaid), the Composite Score must be at least 14.

The system selects the LOCUS record (regardless of authorization number) submitted on the earliest event date between the authorization's assessment date and authorization cutoff date.

Authorization is in 'AA' status

Once an authorization reaches 'AA' status the record with the most recent Event Date on the system is considered applicable.

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

**Required for:**

- Mental health case rate benefits
- Mental health supportive housing benefits
- Mental health residential benefits
- Mental health inpatient benefits

**Frequency:**

- Initial assessment
- Continuation of benefits
- Medicaid OPB Anniversary
- On change

**Transaction ID:** 160.01**Action Codes:**

A	Add
C	Change
D	Delete

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

**Attribute:** *Dimension I Score***Transaction:**

LOCUS

**Definition:***Risk of Harm*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Minimal Risk of Harm
2	Low Risk of Harm
3	Moderate Risk of Harm
4	Serious Risk of Harm
5	Extreme Risk of Harm

**Attribute:** *Dimension II Score***Transaction:**

LOCUS

**Definition:***Functional Status*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Minimal Impairment
2	Mild Impairment
3	Moderate Impairment
4	Serious Impairment
5	Severe Impairment

**Attribute:** *Dimension III Score***Transaction:**

LOCUS

**Definition:***Medical, Addictive, and Psychiatric Co-Morbidity*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	No Co-morbidity
2	Minor Co-morbidity
3	Significant Co-morbidity
4	Major Co-morbidity
5	Severe Co-morbidity

**Attribute:** *Dimension IV A Score***Transaction:**  
LOCUS**Definition:**  
*Recovery Environment – Level of Stress*

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

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Low Stress Environment
2	Mildly Stressful Environment
3	Moderately Stressful Environment
4	Highly Stressful Environment
5	Extremely Stressful Environment

**Attribute:** *Dimension IV B Score***Transaction:**

LOCUS

**Definition:***Recovery Environment – Level of Support*

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

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Highly Supportive Environment
2	Supportive Environment
3	Limited Support in Environment
4	Minimal Support in Environment
5	No Support in Environment

**Attribute:** *Dimension V Score***Transaction:**

LOCUS

**Definition:***Treatment and Recovery History*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Fully Responsive to Treatment and Recovery Management
2	Significant Response to Treatment and Recovery Management
3	Moderate or Equivocal Response to Treatment and Recovery Management
4	Poor Response to Treatment and Recovery Management
5	Negligible Response to Treatment

**Attribute:** *Dimension VI Score***Transaction:**  
LOCUS**Definition:**  
*Engagement and Recovery Status*

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

**Procedure:**

- Record the clinician's assessment of the client in this dimension.
- To use '0', Rating not Reported Electronically, all dimensions ratings must be reported as '0'

**Required Documentation:**

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

**Type:** Number

Valid Codes	Definition
0	Rating not Reported Electronically
1	Optimal Engagement and Recovery
2	Positive Engagement and Recovery
3	Limited Engagement and Recovery
4	Minimal Engagement and Recovery
5	Unengaged and Stuck

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**Attribute:** *Composite Score*

**Transaction:**  
LOCUS

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

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

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

**Type:** Number

Valid Codes	Definition
0 - 35	Valid range

**Attribute:** *Level of Care Requested***Transaction:**

LOCUS

**Definition:**

Indicates the level of care requested by the clinician.

**Procedure:**

In general, the level of care requested should be consistent with the level derived from the LOCUS decision tree and/or the Determination Grid. Starting July 1, 2020, for mental health outpatient benefits (400/401), this attribute is no longer used. Record the level indicated by the corresponding composite score as shown below. This attribute shall be removed in a future Data Dictionary publication.

**Required Documentation:**

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

**Type:** Numeric

Valid Codes	Definition	Corresponding MH Benefit
0	Rating not Reported Electronically, Evidence is Maintained in Clinical Record	
1	<p>LEVEL ONE - Recovery Maintenance and Health Management</p> <p>This level of care provides treatment to clients who are living either independently or with minimal support in the community, and who have achieved significant recovery from past episodes of illness. Treatment and service needs do not require supervision or frequent contact.</p>	<p>400/401 (Comp Score 10-13)</p>
2	<p>LEVEL TWO - Low Intensity Community Based Services</p> <p>This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs.</p>	<p>400/401 (Comp Score 14-16)</p>

3	<p><b>LEVEL THREE - High Intensity Community Based Services</b></p> <p>This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic- based programs.</p>	<p>400/401 (Comp Score 17+)</p>
4	<p><b>LEVEL FOUR- Medically Monitored Non-Residential Services</b></p> <p>This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings but whose treatment needs require intensive management by a multidisciplinary treatment team. Services which would be included in this level of care have traditionally been described as partial hospital programs and as assertive community treatment programs.</p>	
5	<p><b>LEVEL FIVE - Medically Monitored Residential Services</b></p> <p>This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital; free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level.</p>	
6	<p><b>LEVEL SIX - Medically Managed Residential Services</b></p> <p>This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings.</p>	

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## Transaction: Medicaid Coverage

**Definition:**

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

**Procedure:**

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

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

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

**Required for:**

- Outpatient
- Residential

**Frequency:**

- Initial Assessment
- Continuation of Benefit
- On change

**Transaction ID:** 140.07**Action Codes:**

A	Add
C	Change
D	Delete

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

**Attribute:** *CSO Identifier***Transaction:**

Medicaid Coverage

**Definition:**

This attribute identifies whether the client is considered Medicaid Eligible for behavioral health services. Clients are considered Medicaid Eligible for behavioral health services if they are enrolled in one of the following qualifying plans on the date of assessment:

- AMG Fully Integrated Managed Care
- AMG Behavioral Health Services Only
- Coordinated Care Healthy Options Foster Care
- CCW Fully Integrated Managed Care
- CCW Behavioral Health Services Only
- CHPW Fully Integrated Managed Care
- CHPW Behavioral Health Services Only
- MHC Fully Integrated Managed Care
- MHC Behavioral Health Services Only
- UHC Fully Integrated Managed Care
- UHC Behavioral Health Services Only

**Procedure:**

- Providers shall determine Medicaid status as part of the assessment process and in each subsequent month during the authorized outpatient or residential benefit period.
- The *CSO Identifier* field cannot be left blank.

**Required Documentation:**

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

**Example:**

1. At the time of assessment, the client provided her ProviderOne services card to the clinician. The clinician used the ProviderOne Portal to look up the client. The clinician found a "MHC Fully Integrated Managed Care" entry in the "Managed Care" section with a date range that covers the assessment date. Enter 91.

**Type:** Text (1)

Valid Codes	Definition
91	Medicaid Eligible (Enrolled in MCO FIMC, BHSO or Foster Care plan)
99	Not Medicaid Eligible (Not enrolled in MCO FIMC, BHSO or Foster Care plan)

**Attribute:** *Medicare Indicator***Transaction:**

Medicaid Coverage

**Definition:**

Indicates whether a client is covered by Medicare.

**Procedure:**

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

**Required Documentation:**

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

**Example:**

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

**Type:** Text (1)

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

\*Medicare Part C is managed Medicare, sometimes called Medicare Advantage. It is NOT the Medicare prescription drug coverage, which is Medicare Part D.

**Attribute:** *Private Pay Indicator***Transaction:**

Medicaid Coverage

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Type:** Text (1)

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

**Attribute:** *Third-Party Coverage Indicator***Transaction:**

Medicaid Coverage

**Definition:**

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

**Required Documentation:**

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

**Type:** Text (1)

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

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**Attribute:** *ProviderOne Client ID Number***Transaction:**

Medicaid Coverage

**Definition:**

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

The value reported does not get stored in the database, although it is used as part of the MCO data matching process. If the KCID has no ProviderOne stored in g\_p1\_client, then the logic looks to see what the last ProviderOne ID submitted by an agency was for that person, so it is important that it is accurate. Providers are not able to change a ProviderOne ID number in our system. If a change is needed or a P1 ID needs to be added, please open a help ticket.

For Medicaid clients (code ‘91’), a valid ProviderOne ID is required. This field can be left blank for code ‘99’.

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## Transaction: Mobile Crisis Team Intervention

**Definition:**

Program specific information for the Mobile Crisis Response Team (MCRT).

**Required for:**

Mobile Crisis Team (76)

South County Mobile Crisis Team (176)

**Frequency:**

Every crisis episode

**Procedure:**

- Required for all crisis episodes to which the MCRT responds with an outreach.

**Required Documentation:**

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

**Transaction ID:** 850.02

**Start Date:** October 1, 2021

**Action Codes:**

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
<b>Reporting Unit ID</b>	Text	3	Y
<b>Case ID</b>	Text	10	
<b>Authorization Number</b>	Text (number)		
Diversion Type	Text	1	Y
Response Type	Text	2	Y
Episode Start Date/Time	Text (YYYYMMDDHHMM)	12	
Referral Source	Text	2	Y
Response Time	Text	1	Y
Interpreter Needed	Text	1	Y
Dispatch Date/Time	Text (YYYYMMDDHHMM)	12	
Arrival Date/Time	Text (YYYYMMDDHHMM)	12	
Primary Presenting Condition	Text	2	Y
Co-responder Involvement	Text	1	Y
Response Outcome	Text	2	Y
Referral(s) Given	Text	10	Y
Episode End Date/Time	Text (YYYYMMDDHHMM)	12	
Homeless Indicator	Text	1	
Zip Code	Text (number)	5	
Responder NPI	Text	10	Y
King County ID	Text (number)		

**Attribute:** *Diversion Type***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

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

**Type:** Text (1)

Valid Codes	Definition
H	Hospital
J	Jail
N	Neither

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**Attribute:** *Response Type***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

The Mobile Crisis Response Type identifies whether the response was in-person by a traditional Mobile Response Crisis Team, or if the Mobile Crisis Response Team responded via Telehealth. For more detailed information on the use of Telehealth, consult the SERI.

**Type:** Text (2)

Valid Codes	Definition
01	Mobile Crisis Response (In-Person)
02	Mobile Crisis Response provided via Telehealth

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**Attribute:** *Episode Start Date/Time***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

Indicates the beginning date and time (to the minute) when the Mobile Crisis Response Team received the referral from the referral source for this crisis event. This includes teams who respond via telehealth and is used to separate multiple crisis events for the same person on the same day.

**Procedure:**

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

**Type:** Date/Time (12)

YYYYMMDDHHMM

**Attribute:** *Referral Source***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

The Referral Source indicates the source of the referral for an MCR.

**Procedure:**

- Only one value is allowed.

**Type:** Text (2)

Valid Codes	Definition	Description	State Code (BHRD Use Only)
1	Family or Friend	Spouse, parent, child, sibling	1
2	Hospital		2
3	Professional	Physicians, Behavioral Health Treatment Providers	3
4	Care Facility	Assisted Living Facilities, Adult Family Homes, Nursing Homes, Behavioral Health Residential Setting, Rehabilitation Facilities	4
5	Legal Representative	The person with legal responsibility over/for the individual	5
6	School (Post Secondary)	Community College, College or University, Trade School	6
7	Social Service Provider	DSHS, Housing Providers, Adult Protective Services	7
8	Law Enforcement		8
9	Community	Landlord, business, neighbors	9
10	Self-Referral		10
11	Crisis Call Center Referral		11
12	DCR		12
13	Fire/EMS		97
97	Other	Another source not included in the list above	97

**Attribute:** *Response Time***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

The Response Time indicates the timeframe in which the Mobile Crisis Response Team must respond to an individual in crisis once a referral for MCR services is received.

**Type:** Text (1)

Valid Codes	Definition	Description
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
3	Routine/Follow-Up	Routine/Follow-up care occur after crisis response services are provided

**Attribute:** *Interpreter Needed***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

Indicates whether an interpreter was needed during the event.

**Type:** Text (1)

Valid Codes	Definition	State Code (BHRD Use Only)
1	No	2
2	Yes	1

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**Attribute:** *Dispatch Date/Time***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

Indicates the date and time (to the minute) that the Mobile Crisis Response Team is deployed (sent) to the scene of the event.

**Procedure:**

- Submit the time in a 24-hour clock format.
- The Dispatch Date/Time must be between the Episode Start Date/Time and Arrival Date/Time.
- For Telemedicine responses, this data element should be NULL and is only allowed as a NULL if Response Type is 02 (Mobile Crisis Response provided via Telehealth)

**Type:** Date/Time (12)

YYYYMMDDHHMM

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**Attribute:** *Arrival Date/Time***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

Indicates the date and time (to the minute) that the Mobile Crisis Response Team arrived on the scene of the event. For mobile crisis services provided via Telemedicine, this is the date/time that the encounter began.

**Procedure:**

- Submit the time in a 24-hour clock format.
- The Arrival Date/Time must be between Dispatch Date/Time and Episode End Date/Time.

**Type:** Date/Time (12)  
YYYYMMDDHHMM

**Attribute:** *Primary Presenting Condition***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

The Primary Presenting Condition describes the perceived nature of the behavioral health crisis at the beginning of a crisis episode that is a contributing factor to the circumstances leading to the intervention, as determined by the MCR provider.

**Type:** Text (2)

Valid Codes	Definition	State Code (BHRD Use Only)
MH	Mental Health	1
SA	Substance Use Disorder	2
BT	Both	3

**Attribute:** *Co-responder Involvement***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

Indicates whether a Law Enforcement co-responder was present at the scene of the event.

**Type:** Text (1)

Valid Codes	Definition	State Code (BHRD Use Only)
1	No	2
2	Yes	1

**Attribute:** *Response Outcome***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

The Response Outcome indicates the outcome of the MCR event.

**Procedure:**

- Report only one option.

**Type:** Text (2)

Valid Codes	Definition	Description
1	Routine Follow-up completed	May include referrals
2	Stabilized, no additional services needed	Stabilized no follow up needed
3	Stabilized with follow-up recommended	Either MCR follow up or referral given for independent follow-up
4	Transport to crisis triage/stabilization	Transport provided by MCR or other support team to crisis/triage, voluntarily by individual
5	Transport to community hospital (includes ER)	Transport provided by MCR or other support team to community hospital, voluntarily by individual
6	Police/911	Case handed off to police or 911
7	DCR for ITA evaluation/investigation	Case handed off to DCR
8	Unable to locate caller	
97	Other	Transport to shelters (homeless, domestic violence, etc.) or other safe location, voluntarily by individual or other selections not covered

**Attribute:** *Referral(s) Given***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

Specific referrals made, excluding services for which the individual was directly transported (e.g., crisis stabilization, E&T, ITA, SBC, etc), which should be entered in MCR Outcome.

**Procedure:**

- Report all that apply (up to five)
- Report multiple referrals together in one string. For example, if referred both to Mental Health Services and Alternative Housing Supports, report as '0119
- If no referrals are given, report Code 21

**Type:** Text (10)

Valid Codes	Definition	Examples
01	Referred to Substance Use Disorder and/or Mental Health services	Outpatient facility, Detox service, Crisis Stabilization/Triage, community behavioral health organization
02	Non-Behavioral Health Community Services	Medical Clinic
03	Forensic Projects for Assistance in Transition from Homelessness (F-PATH)	
04	Forensic Housing and Recovery through Peer Services (F-HARPS)	re
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 Insurances Services	
15	Dental Care	
16	SSI/SSDI	
17	Veteran's Administration (VA) Benefits	
18	Voluntary Inpatient Behavioral Health Services	
19	Alternative Housing Supports	Shelter, Drop-In Center
20	Food Bank	
21	No referrals given	

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**Attribute:** *Episode End Date/Time***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

Indicates the conclusion date and time (to the minute) at which the Mobile Crisis Response Team is finished with the person and any immediate associated consultation. For mobile crisis services provided via Telemedicine, this is the date/time that the encounter ended.

**Procedure:**

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

**Type:** Date/Time (12)

YYYYMMDDHHMM

**Attribute:** *Homeless Indicator***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

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

**Type:** Text (1)

Valid Codes	Definition
N	No
Y	Yes
U	Unknown

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**Attribute:** *Zip Code***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

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

**Procedure:**

- Submit the Zip Code for the location of the crisis episode if the person's Zip Code is unknown.  
**Do not use 99999 or 77777.**

**Type:** Text (number) (5)

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**Attribute:** *Responder NPI***Transaction:**

Mobile Crisis Team Intervention

**Definition:**

Identifies which individual servicing provider provided the response.

**Procedure:**

- Submit the responder's National Provider Identifier (NPI).
- Must be a valid NPI belonging to a DESC staff member, as listed in ep\_staff\_dur (From Staff Person NPI Data Transaction)
- This should match the NPI submitted in the corresponding CPT Service Encounter.

**Type:** Text (10)

## Transaction: Mobile Rapid Response Crisis Team

### Definition:

Program specific information for the Mobile Rapid Response Crisis Team (MRRCT). Mobile rapid response crisis is a community service provided to individuals experiencing or at imminent risk of experiencing a behavioral health crisis. The goals of these services are engagement, symptom reduction and stabilization.

### Required for:

- Program 276: Mobile Rapid Response Crisis Team (MRRCT)
- Program 13: CCORS (MRSS)

### Frequency:

- Every Crisis Episode

### Procedure:

- This transaction is required for all crisis episodes to which the MRRCT responds with an outreach and referrals that do not become outreaches, such as canceled outreaches.
- Referrals that do not become outreaches require a smaller subset of these attributes. Attributes that are not required are noted in their “Procedures”.
- There should be a MRRCT transaction for every encounter submitted with CPT code H2011 with a UB and HA or HB modifier.

### Required Documentation:

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

### Transaction ID: 840.02

### Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
Reporting Unit ID	Text	3	Y	Y
Case ID	Text	10		Y
Authorization Number	Text (number)			Y
MRRCT Response Type	Text	2	Y	Y
Referral Date/Time	Text (YYYYMMDDHHMM)	12		Y

Referring Call Center	Text	2	Y	Y
Referral Source	Text	2	Y	Y
Referral Source Agency Name	Text	80		C
Estimated Time until Arrival Provided to Referent	Text (number)	4		Y
Level of Acuity	Text	1	Y	Y
Interpreter Utilized	Text	1	Y	C
Dispatch Date/Time	Text (YYYYMMDDHHMM)	12		C
Dispatch Base	Text	2	Y	C
Responding Team	Text	2	Y	C
Arrival Date/Time	Text (YYYYMMDDHHMM)	12		C
Outreach Location Type	Text	2	Y	C
Outreach Location Nearest Address 1	Text	55		C
Outreach Location Nearest Address 2	Text	55		N
Outreach Location City	Text	30		C
Outreach Location Zip Code	Text	5		C
Presenting Problem(s)	Text	10	Y	C
Law Enforcement and Co-responder Involvement	Text	1	Y	C
Intervention(s) Delivered	Text	30	Y	C
MRRCT Services Outcome	Text	2	Y	Y
Referral(s) Given	Text	10	Y	C
Event End Date/Time	Text (YYYYMMDDHHMM)	12		Y
King County ID	Text (number)			Y

**Attribute:** *MRRCT Response Type***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Specifies whether MRRCT services were delivered in-person or via telemedicine. For more detailed information on the use of telemedicine consult the SERI.

**Procedure:**

- This is a required data element
- MRRCT services are most effective when provided in person. An in-person response should be offered initially and provided whenever requested.
- Submit Code 01 – “Mobile Crisis Response (In Person)” if services were provided in person.
- Submit Code 02 – “Mobile Crisis provided via Telemedicine” if only telehealth services were provided during the crisis event.

**Type:** Text (2)

Valid Codes	Definition	State Code (BHRD Use Only)
01	Mobile Crisis Response – In person	01
02	Mobile Crisis Response – Telemedicine (includes audio/video and audio only)	02

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**Attribute:** *Referral Date/Time***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates the exact date and time the MRRCT received the referral and is used to separate multiple crisis events for the same person on the same day.

**Procedure:**

- This is a required data element
- Submit the time in a 24-hour clock format.
- Can't be future date.
- The Referral Date/Time must be the same as the authorization 's assessment/start date.
- Must be before or equal to the Date/Time of Dispatch
- Must either match the Service Date or be within one day of the encounter where the CPT code is H2011 with modifier UB and modifier HA or HB.

**Type:** Date/Time (12)

YYYYMMDDHHMM

**Attribute:** *Referring Call Center***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates the Crisis Call Center from which the referral originated.

**Procedure:**

- This is a required data element

**Type:** Text (2)

Valid Codes	Definition
10	988
15	King County Regional Crisis Line
20	DCR Public Line
25	DCR Professional Line
30	One Call
35	Hot Phone
40	Business Line
45	Other

**Attribute:** *Referral Source***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

The Referral Source indicates the source of the referral for a MRRCT

**Procedure:**

- This is a required data element.
- Only one value is allowed.

**Type:** Text (2)

Valid Codes	Definition	Description	State Code (BHRD Use Only)
1	Family or Friend	Spouse, parent, child, sibling	1
2	Hospital	Medical or behavioral health hospitals, including emergency rooms	2
3	Professional	Medical or behavioral health providers: Physicians, Behavioral Health Treatment Providers	3
4	Care Facility	Assisted Living Facilities, Adult Family Homes, Nursing Homes, Behavioral Health Residential Setting, Rehabilitation Facilities, Daycare/Childcare Facility	4
5	Legal Representative	The person with legal responsibility over/for the individual	5
6	School	Pre-K through 12 <sup>th</sup> , Head Start, Colleges, Universities, and Trade Schools	6
7	Social Service Provider	DSHS, Adult Protective Services, Developmental Disability Administration, other social service agencies	7
8	Law Enforcement	Includes law enforcement co-responders	8
9	Community Member	Landlord, business, neighbors	9
10	Self-Referral		10
12	Designated Crisis Responder (DCR)		12
13	Fire/EMS, Other first responders		13
14	Juvenile Corrections		14
15	Adult Corrections		15

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16	MRRCT Follow-up	Use when providing MCR follow-up services	97
50	Youth-specific professional	Medical or behavioral health providers serving children or youth specifically: Physicians, Behavioral Health Treatment Providers	3
51	DCYF		7
52	Health Through Housing Provider		97
53	Permanent Supportive Housing Provider		97
54	Other Housing Provider		97
97	Other	Another source not included in the list above	97

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**Attribute:** *Referral Source Agency Name***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Specific name of the agency from which the referral came.

**Procedure:**

- If one of the following Referral Sources is selected, this data element is required, and you must enter the Referral Source Agency Name in this field:
  - 2 – Hospital
  - 3 – Professional
  - 4 – Care Facility
  - 6 – School
  - 7 – Social Service Provider
  - 8 – Law Enforcement
  - 13 – Fire/EMS, Other First Responders
  - 14 – Juvenile Corrections
  - 15 – Adult Corrections
  - 50 – Youth specific professional
  - 52 – Health Through Housing Provider
  - 53 – Permanent Supportive Housing Provider
  - 54 – Other Housing Provider

**Type:** Text (80)

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**Attribute:** *Estimated Time until Arrival Provided to Referent***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

The MRRCT's estimated time of arrival provided to the referent.

**Procedure:**

- This is a required data element.
- Report time in minutes.
- Needs to be a number between 1 and 1440.

**Examples:**

1. The estimated time that was provided to the referent was 10 minutes, report as 10.
2. The estimated time that was provided to the referent was 2 hours, report as 120.

**Type:** Text (MMMM)

**Attribute:** *Level of Acuity***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates the timeframe in which the MRRCT must respond to an individual in crisis once a referral for MRRCT is received.

**Procedure:**

- This is a required data element.
- Endorsed teams must follow statutory response times.

**Type:** Text (1)

Valid Codes	Definition	Description	State Code (BHRD Use Only)
1	Urgent	Urgent crises are moderate to serious risk and require a 24-hour response	1
2	Emergent	An emergent crisis is an extreme risk and requires a 2-hour response time	2
4	Behavioral Health Emergency	A significant BH crisis that requires an immediate in-person response within 1 hour due to the level of risk or lack of means for safety planning	4

**Attribute:** *Interpreter Utilized***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates whether an interpreter was utilized during the event.

**Procedure:**

- If outreach is canceled this data element is not required.

**Type:** Text (1)

Valid Codes	Definition	State Code (BHRD Use Only)
1	No	2
2	Yes	1

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**Attribute:** *Dispatch Date/Time***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates the exact date and time that the MRRCT is sent to the scene of the event.

**Procedure:**

- If outreach is canceled this data element is not required.
- Submit the time in a 24-hour clock format.
- Must be between the Referral Date/Time and Arrival Date/Time.
- Can't be future date.
- If MRRCT Response Type is 01 (in person) this field is required.
- If MRRCT Response Type is 02 (via telemedicine) this field can be NULL.

**Type:** Date/Time (12)

YYYYMMDDHHMM

**Attribute:** *Dispatch Base***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates the name of the provider facility from which the MRRCT departed to respond to the referral.

**Procedure:**

- If outreach is canceled this data element is not required.
- Additional team names can be added to the list of valid codes by King County, as requested by the provider.

**Type:** Text (2)

Valid Codes	Definition
20	DESC CSC
22	DESC Northgate
30	Sound North
32	Sound South
40	YMCA Bellevue
42	YMCA Social Impact Center – 2100 Building
44	YMCA University Family
46	YMCA Kent
48	YMCA Social Impact Center – Auburn Campus
50	YMCA North Shore
90	Not Dispatched from base

**Attribute:** *Responding Team***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates which crisis team is responding to referral.

**Procedure:**

- If outreach is canceled this data element is not required.
- Additional team names can be added by King County, as requested by the provider.

**Type:** Text (2)

Valid Codes	Definition
30	DESC CSC Night 1
31	DESC CSC Night 2
32	DESC CSC Day 1
33	DESC CSC Day 2
34	DESC CSC Day 3
35	DESC CSC Swing 1
36	DESC CSC Swing 2
37	DESC North Day 1
38	DESC North Day 2
39	DESC North Swing 1
40	DESC North Swing 2
41	Sound MTND1
42	Sound MTND2
43	Sound MTND3
44	Sound MTND4
45	Sound MTNS1
46	Sound MTNS2
47	Sound MTNS3
48	Sound MTNN1
49	Sound MTNN2
50	Sound MTSD1
51	Sound MTSD2
52	Sound MTSD3
53	Sound MTSD4
54	Sound MTSS1
55	Sound MTSS2
56	Sound MTSS3
57	Sound MTSN1

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58	Sound MTSN2
60	YMCA 2100 Team
61	Sound MTNS4
62	Sound MTSS4
63	YMCA North Day 1
64	YMCA North Day 2
65	YMCA Central Day 1
66	YMCA Central Day 2
67	YMCA South Day 1
68	YMCA South Day 2
69	YMCA After Hours

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**Attribute:** *Arrival Date/Time***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates the exact date and time that the MRRCT arrived on the scene of the event.

**Procedure:**

- If outreach is canceled this data element is not required.
- Submit the time in a 24-hour clock format.
- Must be between Dispatch Date/Time and Event End Date/Time.
- Can't be future date.
- If MRRCT response type is Code 01 (in person) this field is required.
- If MRRCT response type is Code 02 (telemedicine) this field can be NULL.
- If the client is not at the scene where they were previously reported to be located, still report the Arrival Date/Time the MRRCT arrived at the location originally planned to meet the client.

**Type:** Date/Time (12)  
YYYYMMDDHHMM

**Attribute:** *Outreach Location Type***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates the type of location at which the outreach took place.

**Procedure:**

- If MRRCT Response Type is 02 (telemedicine) this data element can be NULL.

**Type:** Text (2)

Valid Codes	Definition
10	Business
11	Outpatient Clinic
12	Emergency Department
13	Permanent Supportive Housing Site
14	Health Through Housing Site
15	Shelter
16	Other Housing Provider
17	Community Service Provider
18	Encampment
19	Street/Sidewalk/Park
20	Other Public Space
21	School
22	Jail
23	Foster Home
24	Home/Private Residence
25	Vehicle
90	Other

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**Attribute:** *Outreach Location Nearest Address 1***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Nearest address to the outreach location.

**Procedure:**

- If MRRCT Response Type is 02 (telemedicine) this data element can be NULL.

**Example:**

401 5<sup>th</sup> Ave

**Type:** Text (55)

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**Attribute:** *Outreach Location Nearest Address 2***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Nearest address to the outreach location, line two.

**Procedure:**

- This is not a required data element.

**Example:**

- Apt 21

**Type:** Text (55)

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**Attribute:** *Outreach Location City***Transaction:**

Mobile Rapid Response Crisis team

**Definition:**

City of the outreach location nearest address.

**Procedure:**

- If MRRCT Response Type is 02 (telemedicine) this data element can be NULL.

**Type:** Text (30)

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**Attribute:** *Outreach Location Zip Code***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Zip code of the outreach location nearest address.

**Procedure:**

- If MRRCT Response Type is 02 (telemedicine) this data element can be NULL.

**Type:** Text (5)

**Attribute:** *Presenting Problem(s)***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Describes the nature of the behavioral health crisis at the beginning of a crisis episode that is a contributing factor to the circumstances leading to the intervention, as determined by the MRRCT provider.

**Procedure:**

- If outreach is canceled this data element is not required.
- Report all that apply (up to five).
- Report multiple codes in one string, with no spaces or special characters.

**Example:**

- The responding MRRCT determines the circumstances leading to the intervention were depression, mood dysregulation, and intimate relationship problems. Report codes 10, 11, and 21 as '101121'.

**Type:** Text (10)

Valid Codes	Definition	State Codes (BHRD Use Only)
04	Suicidality	04
05	Harm/Risk of Harm to Self	05
06	Harm/Risk of Harm to Others	06
07	Harm/Risk of Harm from Others	07
08	Anxiety	08
09	Disruptive behavior	09
10	Depression	10
11	Mood Dysregulation	11
12	Family Conflict	12
13	Trauma	13
14	Peer Difficulties	14
15	School Problems	15
17	Eating Disturbance	17
18	Intellectual/Developmental Delays	18
19	Identity Discovery	19
20	Loneliness	20
21	Intimate Relationship Problems	21
22	Bereavement	22

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23	Critical Incident (Natural disaster, school violence, other significant incident)	23
24	Substance Use	24
25	Substance Intoxication	25
26	Substance Withdrawal	26
27	Neurocognitive symptoms	27
28	Chronic physical symptoms	28
29	Socioeconomic challenges	29
50	Medical/Physical health concerns	97
51	Psychosis – chronic	16
52	Psychosis – new onset	16
53	Mania	11
54	Unstable Living Arrangement	97
97	Other	97

**Attribute:** *Law Enforcement and Co-responder Involvement***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates whether law enforcement was present at the scene, with or without the presence of behavioral health or other co-responder.

**Procedure:**

- If outreach is canceled this data element is not required.

**Type:** Text (1)

Valid Codes	Definition	State Code (BHRD Use Only)
3	Law Enforcement Only	3
4	Law Enforcement with BH Co-responder	4
5	Law Enforcement with non BH Co-responder	5
8	Fire/EMS	6
7	No law enforcement and/or Co-responder present	7

**Attribute:** *Intervention(s) Delivered***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Indicates which interventions were delivered during the outreach.

**Procedure:**

- If outreach is canceled this data element is not required.
- Report all interventions that were delivered.
- Report multiple interventions in one string, with no spaces or special characters.

**Examples:**

- The responding MRRCT arrives and provides peer support and coordinates care with the client's provider. Report codes 11 and 21 as '1121'.
- The responding MRRCT arrives and works to deescalate the client, makes a crisis plan, removes access to means of self-harm, and works with the client's family/support system. Report Codes 14, 15, 16, 20 as '14151620'.

**Type:** Text (30)

Valid Codes	Definition
10	Provided psychoeducation/resources
11	Provided peer support
12	Motivational interviewing
13	Supported coping skills
14	Used de-escalation techniques
15	Made crisis/safety plan
16	Removed access to means of self-harm
17	Required physical restraints
18	Required emergency medication by EMS
19	Administered Narcan
20	Worked with family/support system
21	Coordinated care with providers
22	Arranged for inpatient admission
23	Supported medication refill
24	Provided SUD counseling
25	Behavioral intervention
26	Worked with community supports
27	Active listening
28	Identified triggers
29	Identified goals

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30	Debriefed crisis
31	Role Play
32	Skills training
98	No interventions delivered; unable to locate individual
99	Other

**Attribute: MRRCT Services Outcome****Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

The Response Outcome indicates the outcome of the MRRCT event.

**Procedure:**

- This is a required data element.
- Report only one option.

**Type:** Text (2)

Valid Codes	Definition	Description	State Code (BHRD Use Only)
2	MRRCT service completed, no follow-up recommended	MRRCT service completed, no follow-up recommended	2
3	MRRCT service completed, follow-up recommended	Referral given for independent follow-up	3
6	Law Enforcement	Case referred to law enforcement	6
7	DCR for ITA evaluation/investigation	Case referred to DCR	7
8	Unable to locate individual or individual not available, no follow-up recommended	MRRCT team unable to meet with the individual because they left the location, or they are unavailable for some other reason. No follow-up is recommended by the MRRCT team	8
9	Unable to locate the individual or individual not available, follow-up recommended	Unable to meet with individual because they left the location, or they are unavailable for some other reason. Follow-up is recommended by the MRRCT team	8
10	Voluntary placement at a shelter or other safe location	MRRCT team verified admission to a shelter or other safe location. May include voluntary transport provided by MRRCT or other support team to the facility	9

11	Assisted with transport to needed services (pharmacy, food, bank)	MRRCT team verified transportation was provided to the location of needed services	10
50	Assisted with scheduling a next day appointment		11
51	Assisted with scheduling follow up care		12
12	Individual declined or terminated MCR services, no follow-up recommended		13
13	Individual declined or terminated MCR services, follow-up recommended		13
14	In-home stabilization	Used when providing in-home stabilization services following the initial crisis phase.	14
15	Voluntary placement at a BH Crisis Center	MRRCT verified admission to a BH crisis facility (23 hr crisis relief center, crisis stabilization unit, peer respite, crisis solution center,)	15
52	Voluntary transfer to community hospital (includes ED)	MRRCT verified admission to a community hospital	16
16	Transfer to 911/EMS		97
53	Voluntary placement at a SUD treatment facility	MRRCT verified admission to Recovery Place Seattle, ORCA, excluding SWM (which is involuntary and will need to go through DCRs)	97
54	Returned to or remained in home/Current living situation	MRRCT/MRSS team verified admission to individual's home or current living situation	97
95	Outreach not initiated; referral withdrawn/canceled		97
96	Outreach not initiated, other scenario		97
97	Other	Other outcomes not covered	97

**Attribute:** *Referral(s) Given***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

Specific referrals made, excluding services for which the individual was directly transported (e.g., crisis stabilization, E&T, ITA, SBC, etc.), which should be entered in MRRCT Outcome. Information was given to the individual for the individual to independently follow up.

**Procedure:**

- If outreach is canceled this data element is not required.
- Report all that apply (up to five).
- Report multiple referrals together in one string, with no spaces or special characters.
- If no referrals are given, report Code 21. No other codes can be submitted along with code 21.

**Example:**

- If referred to both Mental Health Services and Alternative Housing Supports, report as '0119'.

**Type:** Text (10)

Valid Codes	Definition	Examples	State Code (BHRD Use Only)
51	Referred to Outpatient Substance Use Disorder	Outpatient facility, detox service, community behavioral health organization	01
50	Referred to Outpatient Mental Health Services		01
02	Non-Behavioral Health Community Services	Medical Clinic or Primary Care Provider	02
03	Forensic Projects for Assistance in Transition from Homelessness (F-PATH)		03
04	Forensic Housing and Recovery through Peer Services (F-HARPS)		04
05	Traditional HARPS		05
06	Traditional PATH		06
07	Other housing resources		07
08	Adult Protective Services		08
09	EBT/ABD (Food/Cash Benefits)		09
10	Educational Assistance		10
11	Employment Assistance		11

12	Home and Community Services		12
13	Job Training		13
14	Medical Insurances Services		14
15	Dental Care		15
16	SSI/SSDI		16
17	Veteran's Administration (VA) Benefits		17
18	Voluntary Inpatient Behavioral Health Services		18
19	Alternative Housing Supports	Shelter, Drop-In Center	19
20	Food Bank		20
21	No referrals given		21
22	Peer Respite		22
25	Recovery Navigator		23
26	WISe	Wraparound with intensive services include Multi-Systemic Therapy	24
27	TAY	Transitional Age Youth Program age 15-24 (includes TAY-Core and TAY-WISe) TAY independent housing	25
28	School Based Mental Health Services	Includes school-based SUD services, ESD or True North	26
29	Department of Children Youth and Families	CPS, any other DCYF programs, social worker, foster care system, child welfare	27
30	Developmental Disabilities Administration		28
31	Parenting Support	Parenting class, parent support group, COPE	29
32	Youth at Risk Information – Juvenile Justice		30

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**Attribute:** *Event End Date/Time***Transaction:**

Mobile Rapid Response Crisis Team

**Definition:**

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

**Procedure:**

- This is a required data element.
- Submit the time in a 24-hour clock format.
- Must be on or before the authorization's end date, and after the Arrival Date/Time.
- Can't be future date.

**Type:** Date/Time (12)

YYYYMMDDHHMM

## Transaction: Notice of Exit

### Definition:

A request by the provider to the KCICN to cancel or terminate a benefit or a program notice from the provider to the KCICN that a benefit/program will not be renewed.

### Procedure:

- A Notice of Exit is required for all KCICN-administered programs, except assessment only benefits.
- Notice of exit transactions are required when a client exits from an outpatient benefit unless another outpatient benefit is authorized within 90 days.
- Notice of exit transactions are required when a client exits from a Standard Supportive Housing benefit (373) unless another benefit with the same benefit/program code is authorized within 90 days.
- Notice of Exit transactions are required even if a benefit is terminated automatically by the system based on a provider change, changes reported by the provider (for example, to county of residence or income) or other automatic processes.
- BHRD will submit disposition data to the MCOs and state BHDS based on Notice of Exit data. Data will only be submitted when a client has not had an open outpatient or residential authorization for 90 days.
- BHRD will send a letter to inform the client that his or her services have ended when there is a termination of an authorization for any of these benefits or programs: 58, 66, 71, 72, 73, SRS. A letter will also be sent when there is a cancellation of an authorization for these same benefits/programs after the authorization letter has been sent to the client. The reason given in the letter will be based on the reported Reason for Termination/Cancellation.

### Required for:

All benefits/programs except 00 and assessment only benefits (SA0, SA1, 112)

See the “Benefits/Programs for which Notice of Exit must be reported” table below.

### Frequency:

Exit from a benefit or program.

**Transaction ID:** 613.01

### Action Codes:

A	Add
C	Change

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

### Programs/Benefits for which Notice of Exit must be reported

Program Code	Definition	Defined Length*	TM: use 09 CX: use 11	Manual Review Required
<b>Outpatient Level of Care (Mental Health)</b>				
400	Mental Health Outpatient Medicaid Funded			
401	Mental Health Outpatient MIDD Funded (Non-Medicaid)	X		
<b>Outpatient Level of Care (SUD)</b>				
500	SUD Outpatient - Medicaid			
501	SUD Outpatient - MIDD			
<b>Additional Outpatient Services</b>				
09	PES Care Manager (Harborview ED)			
25	Specialty Employment Program (SEP)		X	
57	PACT, Engagement			
58	PACT, Enrollment			
60	HOST Outreach		X	
61	HOST Intensive Case Management/Stabilization			
66	Expanding Community Services Intensive Community Support & Recovery Program			
90	Peer Bridger			
91	Familiar Faces Intensive Care Management Team			
93	SHARP Enrollment			
94	HARPS			
95	LINC			
100	Health Homes			
103	Re-entry Case Management	X		
107	MIDD Wraparound			
108	Family Treatment Court Wraparound			
111	Moral Reconciliation Therapy-Domestic Violence			
113	Transition Support Program			
114	HOME Outreach			
115	HOME Enrollment			

Program Code	Definition	Defined Length*	TM: use 09 CX: use 11	Manual Review Required
116	Outreach - Assisted Outpatient Treatment			
117	Court Ordered - Assisted Outpatient Treatment			
155	Competency Boundary Spanner			
156	Law Enforcement Assisted Diversion (LEAD)			
157	Community Outreach and Advocacy Team (COAT)			
159	Western State Hospital Peer Bridger Program			
BUP	Opioid Buprenorphine Contracts			
DOC	Department of Corrections			
LOE	(LEAD) Outreach and Engagement			
OST	SUD Opiate Substitution Treatment (MAT)			
PPW	SUD Pregnant or Parenting Women			
S03	Older Adult SUD Treatment			
AOS	Assisted Outpatient Services Program			
162	ACRS – Promoting Peace and Recovery			
163	ACRS - Community Center for Alternative Programs – SUD Services			
164	South King County Pretrial Services			
177	KCSARC Specialty Services			
178	Hero House NW Day Support			
179	Housing Outreach Partners			
180	New Journeys (First Episode Psychosis)			
300	WSH Discharge Transition			
403	Community Outreach and Advocacy Team (COAT) - Medicaid			
430	Path		X	
440	HOST - SUD		X	
445	Partial Hospitalization (PHP)			
446	Intensive Outpatient (IOP)			
451	Medication for Opioid Use Disorder (MOUD)			
460	Hospital Liaisons			
462	Peer Pathfinder			
520	Health of Housing (HtH) BH Mobile Team			
521	Permanent Supportive Housing (PSH) BH Mobile Team			
ADC	Adult Drug Court			

<b>Crisis Level of Care</b>				
13	Children's Crisis Outreach Response System (CCORS)		X	
15	CCORS Intensive Stabilization Services		X	
40	Adult Crisis Stabilization (including next day appointment)		X	
74	Adult Inpatient Diversion Bed		X	
75	Crisis Respite Program - DESC		X	
79	Crisis Diversion Interim Services			
80	Crisis Diversion Facility Team			
120	CORS-YA			
119	Overdose Recovery & Care Access (ORCA)			
160	Involuntary Treatment Triage			
166	Youth Connection Services YCS			
200	Connections - Urgent Care		X	
201	Connections - 23 Hour Observation		X	
202	Connections - Crisis Stabilization Unit		X	
203	Connections - Transitions		X	
276	Mobile Rapid Response Crisis Team (MRRCT)			
530	SUD Crisis Services NDA			
DTX	SUD Detoxification			
<b>Residential Level of Care (SUD)</b>				
SRS	SUD Residential {NOT SUBMITTED THROUGH THIS TRANSACTION; Entered by Authorizer through the Inpatient application.}			
<b>Residential Level of Care (Mental Health)</b>				
71	Adult Long-Term Rehabilitation Benefit			
72	Adult Supervised Living Benefit			
73	Adult Long-Term Rehabilitation Benefit (Benson Heights)			
121	Intensive Behavioral Health Treatment Facilities (IBHTF)			
122	Intensive Residential Treatment (IRT)			
123	Intensive Step-Down Phase 1			
124	Intensive Step-Down Phase 2			
366	Enhanced-Intensive Community Support and Recovery Program (E-ICSRP)			
372	Intensive Supportive Housing			
373	Standard Supportive Housing Benefit	X		

<b>Inpatient Level of Care</b>				
IP	Inpatient Benefit (NOT SUBMITTED THROUGH THIS TRANSACTION; Entered by Authorizer through the CCS or Inpatient application.)			

- \* An “X” in the “Defined Length” column means that when a benefit or program authorization is created, an expiration date is set. No “X” means that the expiration date remains NULL (blank) until the authorization is terminated.
- \*\* An “X” in the “TM: use 09, CX: use 11” column means that the only Exit Reason accepted to terminate the program authorization is code “09” and the only Exit Reason accepted to cancel the authorization is code “11.” “09” or “11” will only be accepted for programs that have an “X” in this column.
- \*\*\* An “X” in the “Manual Review Required” column means that a termination or cancellation request goes through a manual review process before being approved.

**Attribute:** *Event Date***Transaction:**

Notice of Exit

**Definition:**

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

**Required Documentation:**

Documentation supporting the reason and the effective date.

**Procedure:**

- For an event resulting in termination of a benefit or program, report the date of the event.
- When a benefit will expire without renewal, the date reported should be within 90 days following the benefit expiration date.
- For mental health residential programs (71, 72, 73) report the date the client last slept in the facility (i.e., was in the facility at midnight).

**Termination Rules:**All programs and benefits

- If the termination date is within 30 days from today (a future date), a warning is issued.
- If the termination date is more than 30 days in the future the transaction will fail.
- An agency can submit two termination change transactions. Subsequent requests should be submitted even though they will fail. Submit a help desk ticket requesting the change after the transaction fails.

Programs and benefits with a pre-determined expiration date

In ECLS the expiration date is populated at the time the authorization request processes.

- The termination date must be less than the pre-determined expiration date.

**Examples:**

1. Submit 20200303 when a client dies on March 3, 2020, regardless of when case manager learns of it.
2. A client tells her case manager on March 2, 2020, that she is moving to Boise on March 10. Submit March 10, 2020 in the format 20200310.
3. Towards the end of a “401” outpatient benefit authorization with an expiration date of January 2, 2023, the client is unsure if she wants to continue receiving services. She makes a plan with her therapist to contact him by the end of December with a decision. Three weeks later, on December 23, she calls the therapist and indicates that she does not think she needs further services. Submit December 23, 2022 in the format 20221223.
4. A client in an LTR bed moved out of the facility at 1pm on July 2, 2020. Submit July 1, 2020 (the last night they slept in the facility) in the format 20200701.

**Type:** (8)

YYYYMMDD

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**Attribute:** *Authorization Number*

**Transaction:**  
Notice of Exit

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

**Type:** Integer

**Attribute:** *Exit Code***Transaction:**

Notice of Exit

**Definition:**

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

**Required Documentation:**

Providers shall maintain documentation supporting the reason and the effective date.

**Procedure:**

- Change requests for cancelled authorizations will be rejected.
- See Reason for Termination/Cancellation/Non-Renewal Procedure for Reasons that cannot be changed.
- Some benefits have a pre-set expiration date. That is, when these authorizations are first processed, the expiration date has a value. Whether an authorization has a pre-set expiration date or not has an impact on which Exit Code to use in the Notice of Exit transaction. Refer to the “Defined Length” column in the “Benefits/Programs for which Notice of Exit must be reported” table.

**Type:** Text (2)

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

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## Valid Codes – Additional Information

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

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

### 02 Termination:

Code '02' is valid only for authorizations currently in 'AA' status. On termination, the authorization status code is changed from 'AA' to 'TM', the authorization status is set to the submitted exit reason, and the authorization termination date is changed from the pre-set expiration date (if any) to the submitted event date. If the authorization has a pre-set expiration date, then the authorization is considered "terminated" if it ends before the pre-set expiration date. The termination date submitted must be less than the preset date. See exit code '03' for an alternative approach.

For MH outpatient and residential benefits paid on a case rate basis, no payments are made for the months following the termination date. For SUD FFS, no payments are made for services with event dates following the termination date.

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

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

### 04 Two Uses:

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

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

**Attribute:** Reason for Termination/Cancellation/Non-Renewal**Transaction:**

Notice of Exit

**Definition:**

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

**Required Documentation:**

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

**Procedure:**

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

**Examples:**

See the “Benefits/Programs for which Notice of Exit must be reported” table at the beginning of this transaction for guidance on which programs may be terminated with an “09” code.

1. An adult is authorized to receive SEP (Specialty Employment Program – code 25) services starting May 1, 2019. Her services end July 15, 2019. At that time, the provider submits a notice of exit transaction with an Event Date of 20190715 and with code “09” as the Reason for Termination. This transaction will end the authorization: the status code will be changed to “TM” and the expiration date will be set to July 15, 2019.
2. An adult is authorized to a 400 (Medicaid MH Outpatient) benefit starting 9/1/2020, but the client loses Medicaid on 1/1/2022. The provider submits a Notice of Exit with code 07 (Client who had Medicaid at start of benefit lost Medicaid and is eligible for Non-Medicaid funding) and an event date of 12/31/2021.

An adult is authorized to a 401 (Non-Medicaid MH Outpatient) benefit starting 10/15/2021. The benefit expires on 10/14/2022. The client begins a new 401 benefit 12/1/2022. The provider does not need to submit a notice of exit for the 401 benefit that expired on 10/14/2022.

An adult is authorized to a 400 MH outpatient benefit starting 2/1/2022. Because of ongoing problems with his living situation, he is assessed and approved for a Standard Supportive Housing (373) benefit to begin on 8/20/2022. The outpatient benefit provider submits a Notice of Exit transaction with an event date of 8/19/2022 and code 20 for Reason for Termination.

**Type:** Text (2)

Valid Codes	Definition	Exit Type **	Additional Usage Information	State Code (BHRD Use Only)
02	Client died	C,T,E		7 6 - If EO indicates death by suicide.
04	Client moved to another county - no referral/transfer to another ASO	C,T,E		8
05	Client who did not have Medicaid at start of benefit does not now meet Non- Medicaid financial eligibility requirements (e.g., third-party payor, income too high)	C,T,E		8
06	Client who had Medicaid at start of benefit lost Medicaid and is not eligible for Non-Medicaid funding	C,T,E	For termination this only applies to outpatient or residential benefits paid on a case rate basis--for other program authorizations or benefits losing Medicaid is NOT a reason to terminate.	8
07	Client who had Medicaid at start of benefit lost Medicaid and is eligible for Non-Medicaid funding	C,T,E	<p>For termination this only applies to outpatient and residential benefits paid on a case rate basis--for other program authorizations or benefits losing Medicaid is NOT a reason to terminate.</p> <p>This should be sent whether or not the provider plans to request a new OPB authorization with Non-Medicaid funding <u>unless a more basic reason, like “31 Client completed treatment” also applies</u>, in which case the other reason should be reported.</p> <p>BHRD programming will determine whether a new program authorization is</p>	8

Valid Codes	Definition	Exit Type **	Additional Usage Information	State Code (BHRD Use Only)
			started within 90 days, and won't send data to MCOs and BHDS if it is.	
NO CODE SUB-MITTED	Client received an intake but did not meet medical necessity	NA	An "MN" status reason code is assigned by the IS if "00" is the only program requested and there is an intake service submitted. This only applies to Medicaid.	N/A
09	Discharge from crisis or other specified program.	T	See the "Benefits/Programs for which Notice of Exit must be reported" table for the programs that can use this reason.	N/A
11	Cancelled by provider	C	This code will only be accepted for programs with an "X" in the "09 and 11 only" column in the Program table above.	N/A
12	Client enrolled in PACE	C,T,E		8
13	Client has been in hospital for 30 days and discharge is not occurring within an additional 60 days. Includes Children's Long-term Inpatient facilities	C,T,E		4
14	Client has been in prison, jail, Juvenile Rehabilitation Administration facilities, or juvenile detention for 30 days and release is not occurring within an additional 30 days. [For MIO- CTP - use 42 if it applies]	C,T,E		5
NO CODE SUB-MITTED	Client transferred to different MH agency within KCICN	T	A "VC" (Vendor change) status reason code is assigned by the IS when an	8

Valid Codes	Definition	Exit Type **	Additional Usage Information	State Code (BHRD Use Only)
			outpatient benefit is terminated because another provider has submitted an outpatient benefit authorization request.	
15	Client desires/has been referred/transferred to another ASO for services	C,T,E	Report this when a referral or transfer to another ASO is made in conjunction with an out of county move.	4
16	Client referred to primary care to manage MH needs	C,T,E		8
17	Client-desires/has been referred/transferred to another (non-ASO, non-primary care) service system, agency or facility	C,T,E		8
20	Client changing program type or provider	C,T,E	This code is needed to explain a program or provider termination date for those programs where a more informative reason than “discharge” (code 09) is required.	4
21	Provider is unable to provide services to client for other reason	C*,T*,E	This code should only be used if no other specific code applies.	8
22	No qualifying service provided	C*	This code should only be used if no other specific code applies.	N/A
23	Data error in authorization request	C		N/A
31	Client completed treatment, no longer meets continued stay criteria, meets discharge criteria, opted in (MHC only), or graduated	C,T,E		1

Valid Codes	Definition	Exit Type **	Additional Usage Information	State Code (BHRD Use Only)
32	Client's whereabouts unknown (lost to contact)	C*,T*,E		02
33	Client exited from program due to violating program rules, or revoked for non-compliance with court conditions	T,E	This code will only be accepted for Housing Voucher program.	N/A
34	No longer eligible: Not competent or Charges dismissed – MHC only	T		N/A
35	Client refused services or declined to participate in program. Clinician must talk with client to use this code. If client is simply not attending treatment and cannot be reached, use code 32.	C*,T*,E		8
37	Not clinically eligible – MHC only	T		N/A
42	Returned to prison - FIRST only	T		5
43	Completed sentence and declined further service – MIO – CTP only	T		8
44	Released by oversight committee and/or program – FIRST only	T		8

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

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

## Transaction: Program Referral

### Definition:

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

### Procedure:

Submit one transaction for each referral.

### Required for:

Outpatient, Crisis

### Frequency:

Initial Assessment: referral type '01' (except Continuation of Benefits)

Initial Assessment: referral type '02' (except Continuation of Benefits)

Not required for Continuation of Benefits or where there is less than a 90-day gap between two outpatient benefits (of the same treatment focus).

Discharge if applicable: referral type '03'

### Transaction ID: 616.02

### Action Codes:

A	Add
C	Change
D	Delete

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

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**Attribute:** *Event Date*

**Transaction:**  
Program Referral

**Definition:**  
This is the date of the referral.

**Procedure:**

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

**Type:** Date (8)  
YYYYMMDD

**Attribute:** *Referral Type*

**Transaction:**  
Program Referral

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

**Procedure:**

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

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

**Type:** Text (2)

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

**Attribute:** *Program Type***Transaction:**

Program Referral

**Definition:**

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

Example: Head Start Program

**Procedure:**

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

**Required Documentation:**

All sources of referral must be maintained in provider records.

**Type:** Text (4)

Program Type	Description
08	Harborview Emergency Department – ROI on file
110	Mental Health Services – General
111	Mental Health Crisis Services – General
112	Voluntary Inpatient Programs – General
113	Involuntary Inpatient Programs – General
114	Active Outreach by Mental Health Services provider
115	Mental Health Services – Outpatient Screening (Network Providers)
116	Mental Health Services – Referral to Tiering Agency (Network Providers)
117	Mental Health Services – Outpatient Non-Network Provider
118	Mental Health Services – Provider Out of State
120	Medical Care – General
121	Emergency Medical Care – General
122	Nursing Home Programs – General
130	Legal Services – General
131	Law Enforcement / Police
132	Juvenile Justice Services
133	Legal Services – Mental Health Court

<b>Program Type</b>	<b>Description</b>
134	Alcohol & Substance Abuse Services – Involuntary Commitment
140	Alcohol & Substance Abuse Services – General
141	Alcohol & Substance Abuse Services – Detox
142	Alcohol & Substance Abuse Services – CDNDA
143	Alcohol & Substance Abuse Services – ADATSA
144	Alcohol & Substance Abuse Services – Sobering
145	Alcohol & Substance Abuse Services – REACH
146	Alcohol & Substance Abuse Services – Inpatient Public
147	Alcohol & Substance Abuse Services – Inpatient Private
148	Alcohol & Substance Abuse Services – Outpatient Public
149	Alcohol & Substance Abuse Services – Outpatient Private
150	Residential/Housing Programs – General (excluding nursing homes)
160	Vocational Services – General
165	Veterans’ court services
170	Developmental Disability Services - General
180	Other Social Services – General (may include DSHS Home and Community Services, Aging/Youth Services, and any social services other than mental health)
190	Educational Services - General
198	Other Services – General (any services not listed)
200	Housing list
201	Transportation
202	Religious organization
203	Senior center
204	Cultural center
205	Community center
60	HOST – Outreach
61	HOST – Intensive Case Management
9151	Respite Bed Program
9152	Diversion Bed Program
9153	Temporary Housing Services
9154	Shelter Services
9998	Not applicable

**Attribute:** Agency / System**Transaction:**

Program Referral

**Definition:**

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

Example: Valley Cities, Division of Child and Family Services

**Procedure:**

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

**Required Documentation:**

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

**Example:**

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

**Type:** Text (4)

Agency/System	Definition	State Code (Referral In Only) (BHRD Use Only)
<b>Mental Health System</b>		
1010	Outpatient Network Mental Health Providers – Non-specific	3
1011	Outpatient Non-network Mental Health Providers – Non-specific (including psychiatrists, counselors, treatment centers)	3
1012	Inpatient Mental Health Facilities – Non-specific	3
1013	Designated Crisis Responder (DCR)	3
1014	Children’s Crisis Response Team	3
1015	Geriatric Regional Assessment Team	3
1016	TRACE	9
1113	Re-entry Case Management	8
1114	Co-Occurring Disorder (COD) treatment program/IDDT	4

1125	Center for Community Alternatives Program (CCAP)	8
1126	King County Work and Education Release (WER)	8
<b>Medical System</b>		
1020	Inpatient Medical Facilities – Non-specific	4
1021	Primary Care Practitioners – Non-specific	4
1022	Emergency Rooms – Non-specific	4
1023	Nursing Home	9
1024	Ambulance Services	4
1025	Amerigroup MCO	4
1026	CHPW MCO	4
1027	Coordinated Care MCO	4
1028	Molina MCO	4
1029	United Healthcare MCO	4
<b>Legal System</b>		
1030	Police – Non-specific	8
1031	Jail – Non-specific	8
1032	Attorneys	8
1033	Law Enforcement	8
1034	Court Referral, including LROs	8
1035	Pre-booking Diversion (HARBORVIEW EMERGENCY DEPARTMENT)	8
1036	Police booked or cited (HARBORVIEW EMERGENCY DEPARTMENT)	8
1037	Regional Mental Health Court	8
1038	Municipal Mental Health Court	8
1039	King County Drug Court	8
1120	Electronic Home Detention	8
1130	KC Superior Court Felony Drop Down (Regional MHC only)	N/A
1131	KC Regional Court Misdemeanors (Regional MHC only)	N/A
1132	City Transfer Cases (Regional MHC only)	N/A
200	Burien law enforcement	8
201	Burien law enforcement (Trueblood service eligible)	8
202	White Center law enforcement	8
203	White Center law enforcement (Trueblood service eligible)	8
204	Kent law enforcement	8
205	Kent law enforcement (Trueblood service eligible)	8
206	Renton law enforcement	8
207	Renton law enforcement (Trueblood service eligible)	8
208	Auburn law enforcement	8
209	Auburn law enforcement (Trueblood service eligible)	8
210	Misc. jurisdiction law enforcement	8

211	Misc. jurisdiction law enforcement (Trueblood service eligible)	8
301	King County Correction Facility (see the ECLS Agency List)	8
302	Regional Justice Center (see the ECLS Agency List)	8
303	Division of Youth Services (see the ECLS Agency List)	8
305	Juvenile Rehabilitation Administration (see the ECLS Agency List)	8
306	Seattle Police Department (see the ECLS Agency List)	8
307	Department of Correction (see the ECLS Agency List)	8
311	South Correctional Entity (SCORE) (see the ECLS Agency List)	8
933	Metro Transit Police (see the ECLS Agency List)	8
934	Sound Transit Police (see the ECLS Agency List)	8
<b>Substance Abuse Facilities</b>		
1040	Substance Abuse System – non-specific	2
1041	Outpatient Substance Abuse Facilities – Public, non-specific	2
1042	Inpatient Substance Abuse Facilities – Public, non-specific	2
1043	Outpatient Substance Abuse Facilities – Private, non-specific	2
1044	Inpatient Substance Abuse Facilities – Private, non-specific	2
1045	Self-help Associations (AA, NA, etc.)	5
490	Seattle Recovery Center (SRC) (see the ECLS Agency List)	2
491	South King County Recovery Center (see the ECLS Agency List)	2
492	Sobering Center (see the ECLS Agency List)	2
<b>Housing System</b>		
1050	Housing System – Non-specific	9
<b>Developmental Disabilities System</b>		
1060	Developmental Disabilities System – Non-specific	9
<b>Vocational System</b>		
1070	Vocational System – Non-specific	9
<b>Social Services System</b>		
1110	Social Services System – Non-specific	9
1111	Children's Administration (formerly DCFS)	9
1112	DSHS	9
<b>Educational System</b>		
1080	Educational System – Non-specific	6
<b>Other Systems</b>		
1090	Other Systems – Non-specific	97
1091	Veteran Affairs System – Non-specific	9

1092	Family Support System – Non-specific (including family, friends)	9
1093	Community Support System – Non-specific (including ministry, community support organizations)	9
1094	Self-Referral	1
1095	Wraparound Services	9
1096	Parent Support System/Network	9
920	Hopelink	9
921	Recovery café	9
922	MAT suboxone in primary care	9
923	Integrated medical clinic at behavioral health agency	9
924	Dental	9
925	Optometrist	9
926	Mobile/outreach medical (e.g., medical van, HHOT nurses)	9
927	Food/meal programs	9
928	Gym/YMCA/YWCA	9
929	MCO care management	9
930	Personal care/chore worker	9
1133	Fire--Non-specific	9
9998	Not applicable	97
935	Kent Fire Department (see the ECLS Agency List)	9
931	United Way Benefits Hub	9
<b>BHRD Use Only</b>		
	Specific Agency ID not listed above	9

**Attribute:** *Linkage Indicator*

**Transaction:**  
Program Referral

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

**Procedure:**

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

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

**Type:** Text (2)

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

## Transaction: Residential Absence

### Definition:

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

### Procedure:

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

### Required for:

LTR, Supervised Living

### Frequency:

On Occurrence

**Transaction ID:** 115.01

### Action Codes:

A	Add
C	Change
D	Delete

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

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**Attribute:** *Absence Start Date***Transaction:**

Residential Absence

**Definition:**

The start date of client's absence from the facility.

**Procedure:**

- Report the date the client leaves the facility (the first date the client is not in the facility at midnight).
- BHRD will stop the reporting of residential per-diem service to the MCOs and State BHDS starting on the Absence Start Date until and including the Absence Last Date.

**Required Documentation:**

Providers shall document all dates in clinical or personnel records.

**Type:** Date (8)

YYYYMMDD

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**Attribute:** *Absence Last Date***Definition:**

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

**Procedure:**

- Absence Last Date is a required field and cannot be null.
- When a client returns from an absence, report the Absence Last Date as the date of the last day where the client was **not** in the residential facility at midnight. For example, if the client returns to the facility on December 1, 2019, before midnight, then report November 30, 2019 as the Absence Last Date.
- If a client is only gone overnight, the start and end date will be the same.
- BHRD will resume the reporting of residential per-diem service to the MCOs and State BHDS on the day following the Absence Last Date.

**Required Documentation:**

Provider shall document all dates in clinical or personnel record.

**Type:** Date (8)  
YYYYMMDD

**Attribute:** *Absence Reason***Transaction:**

Residential Absence

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

Providers shall maintain documentation supporting the reason.

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

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**Attribute:** *Facility Code*

**Transaction:**  
Residential Absence

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

**Procedure:**

- Report the Facility Code using the Facility Code list under the Residential Facility transaction.

## Transaction: Residential Arrangement

### Definition:

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

### Required for:

All programs

### Frequency:

Initial Assessment

Continuation of Benefit

Medicaid OPB Anniversary

On change

**Transaction ID:** 110.06

### Action Codes:

A	Add
C	Change
D	Delete

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

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**Attribute:** *Start Date***Transaction:**

Residential Arrangement

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

Provider shall document all dates in clinical or personnel records.

**Type:** Date (8)

YYYYMMDD

**Attribute:** *Residential Arrangement Code***Transaction:**

Residential Arrangement

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Examples:**

1. A 10-year-old client lives with her mother in a transitional housing site for women coming out of prison. Report 06 for "Transitional Housing."
2. A client receiving services under a Long-Term Residential benefit lives in an agency-operated residential facility, which is also licensed as an Institute for Mental Disease. Report 07 for "Residential Care."
3. A man who has recently been sleeping on the streets, with a few brief stays at his brother's house, is involuntarily hospitalized. Continue to report code 82 for "Homeless," unless he remains in inpatient psychiatric facilities for 90 days.
4. A 16-year-old client lives in a group home operated by another social service agency. Report 07 for "Residential Care"

**Type:** Text (2)

In the following definitions:

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

Valid Codes	Definitions	State Code (BHRD Use Only)
<b>Type of housing</b>		
01	Permanent housing – unassisted: Without intensive supporting services required to maintain housing. A house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO), rented or owned, with an expectation of long-term residency. Includes dependent children living with parents or legal guardians but not in foster care.	8: Adults 10: Children (< 18)
02	Permanent housing – assisted: With intensive supporting services required to maintain housing. A house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO), rented or owned, with an expectation of long-term residency.	9: Adults 10: Children
03	Temporary housing – unassisted: Without intensive supporting services required to maintain housing, and without an expectation of long-term residency.	8: Adults 10: Children
04	Temporary housing –assisted: With intensive supporting services required to maintain housing, and without an expectation of long-term residency.	9: Adults 10: Children
05	Temporary housing – dependent: Living with friends or family temporarily including “couch surfing” and includes emancipated youth.	12: Adults 10: Children
06	Transitional housing: Housing provided as part of participation in a housing readiness program with time-limited housing and supporting services provided with the goal of permanent housing.	11
07	Residential Care: May include a Group Home, Therapeutic Group Home, Board and Care, Residential Treatment, Rehabilitation Center, or Agency-operated residential care facilities.	3
08	Skilled Nursing/Nursing/Intermediate Care Facility	5
09	Other institutional setting: A licensed institutional treatment and care facility not covered by other codes, including Institute of Mental Disease (IMD), DD Facility, or Medical Hospital.	5

Valid Codes	Definitions	State Code (BHRD Use Only)
22	Adult Family Home: Regular neighborhood homes licensed by the state for two to six residents where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision, and varying levels of assistance with care are provided.	9?
25	Residential Drug/Alcohol treatment – treatment for 90 days or more. If the client is in treatment for less than 90 days, use the code for the living arrangement just prior to treatment.	3
26	Foster Care (for children) A Licensed Foster Home to provide foster care to children and adolescents including Therapeutic Foster Care Facilities.	2
61	Jail/Juvenile Correctional Facility - Incarceration for 60 days or more. If the client is incarcerated for less than 60 days, use the code for the living arrangement just prior to incarceration.	6
62	Psychiatric Inpatient Facility – Voluntary or involuntary hospitalization for 90 days or more; includes CLIP programs. Types of facility include Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), Veterans Affairs Hospital, or State Hospital. If the client is hospitalized for less than 90 days, use the code for the living arrangement just prior to hospitalization.	5
82	Homeless - Those persons of all ages who lack a fixed, regular, and adequate nighttime residence including persons whose primary nighttime residence is one of the following: <ul style="list-style-type: none"> <li>• Emergency shelter (e.g., missions, churches) where residence is on a ‘night by night basis’</li> <li>• Living on the streets, in a vehicle, or abandoned building.</li> <li>• Being discharged/discharged from an institution (e.g., jail, medical or psychiatric hospital) with no arranged residence</li> <li>• Temporary living accommodations by a voucher system (e.g., motel vouchers)</li> <li>• Living in a public or private place not designed for, or not ordinarily used as, a regular sleeping accommodation for human beings</li> </ul>	1

**Attribute:** *Zip code***Transaction:**

Residential Arrangement

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Example:**

- Client is homeless and received assessment on the corner of 3<sup>rd</sup> & James downtown Seattle. Use zip code 98104.

**Type:** Text (9)

Valid Codes	Definition
5-digit zip code	Zip Code
77777	Out of County - Unknown
99999	Unknown

**Attribute:** *County Code***Transaction:**

Residential Arrangement

**Definition:**

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

**Procedure:**

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

**Type:** Text (2)

Valid Codes	Definition
01	Adams
02	Asotin
03	Benton
04	Chelan
05	Clallam
06	Clark
07	Columbia
08	Cowlitz
09	Douglas
10	Ferry
11	Franklin
12	Garfield
13	Grant
14	Grays Harbor
15	Island
16	Jefferson
17	King
18	Kitsap
19	Kittitas
20	Klickitat
21	Lewis
22	Lincoln

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<b>Valid Codes</b>	<b>Definition</b>
23	Mason
24	Okanogan
25	Pacific
26	Pend Oreille
27	Pierce
28	San Juan
29	Skagit
30	Skamania
31	Snohomish
32	Spokane
33	Stevens
34	Thurston
35	Wahkiakum
36	Walla Walla
37	Whatcom
38	Whitman
39	Yakima
90	Out of state
98	Out of County - county unknown

## Transaction: Residential Facility

### Definition:

This is the transaction that describes the residential facility where the client lives.

### Procedure:

- This transaction is only required when the client is living in a KCICN-funded residential facility as reported in the Residential Arrangement transaction.
- This transaction must be reported by the provider holding the residential authorization when the client enters and exits the facility, or changes level of care within the same facility.

### Required for:

LTR, Supervised Living

### Frequency:

Assessment

On change

**Transaction ID:** 112.01

### Action Codes:

A	Add
C	Change
D	Delete

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

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**Attribute:** *Start Date*

**Transaction:**  
Residential Facility

**Definition:**  
The date a client moved into a residence.

**Procedure:**

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

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

**Type:** Date (8)  
YYYYMMDD

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**Attribute:** *Exit Date***Transaction:**

Residential Facility

**Definition:**

The date a client moved out of a residence.

**Procedure:**

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

**Required Documentation:**

Provider shall document all dates in clinical or personnel record.

**Type:** Date (8)

YYYYMMDD

**Attribute:** *Facility Code***Transaction:**

Residential Facility

**Definition:**

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

**Procedure:**

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

**Required Documentation:**

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

**Facility Names and Codes**

Valid Codes	Definition
222	Avondale House
219	Benson Heights
9170	Cascade Hall – LTR (Community House)
9171	Cascade Hall – SL (Community House)
166	Chartley House
123	Firwood
221	Highest Residence
158	Hilltop Center
9169	Keystone- SL (Sound)
9049	Keystone – LTR (Sound)
225	Midway Residential
8123	SeaMar Geriatric Facility (ISD Phase 1)
8124	SeaMar Geriatric Facility (ISD Phase 2)
164	Spring Manor
224	Stillwater
148	Transitional Resources

## Transaction: Staff Person NPI

### Definition:

Information about staff employed by behavioral health providers.

### Procedure:

It is not possible to change the "Start Date" for existing data. If a correction is required, contact the King County Help desk.

### Required for:

All staff

### Frequency:

On hire

On change

On discharge

**Transaction ID:** 810.07

**Effective Date:** February 1, 2022

### Action Codes:

A	Add
C	Change

Attribute	Type	Size	Coded
<b>Reporting Unit ID</b>	Text	3	Y
<b>Staff Person ID</b>	Text	10	
<b>Start Date</b>	Text (YYYYMMDD)	8	
End Date	Text (YYYYMMDD)	8	
Surname	Text	30	
Given Name	Text	30	
Gender	Text	2	Y
Language Code	Text	15	Y
NPI	Text	10	

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**Attribute:** *Staff Person ID***Transaction:**

Staff Person

**Definition:**

The identifier established by a Reporting Unit that uniquely identifies a staff person. A Staff ID submitted by a Reporting Unit should not be identical to a client Case ID submitted by that Reporting Unit. This uniquely identifies the staff person within an agency who is providing and reporting a service to a client. Where a staff person is also a case manager, the staff ID and the case manager ID should be identical.

**Required Documentation:**

All services provided to a client must be documented in the clinical record with the date, type, location (in/out), and duration of the service episode and the name of the clinician providing the service.

**Type:** Text (10)

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**Attribute:** *Start Date***Transaction:**

Staff Person

**Definition:**

The date an agency staff person began employment.

**Required Documentation:**

Providers shall document all start and change dates in personnel records.

**Type:** Date (8)

YYYYMMDD

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**Attribute:** *End Date***Transaction:**

Staff Person

**Definition:**

This is the date the staff person leaves the agency.

**Procedure:**

- For the Staff Person transaction, it is the end of the staff person's employment or volunteer work at the agency.
- Transmit a NULL if not applicable.

**Required Documentation:**

All end dates must be documented in provider records.

**Example:**

1. A case manager terminates his employment at an agency. Report the last date of employment.

**Type:** Date (8)

YYYYMMDD

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**Attribute:** *Surname***Transaction:**

Staff Person

**Definition:**

The surname/family/last name of a staff person as provided by a Reporting Unit. In general, follow the rules of the appropriate culture when determining which name is the surname.

**Procedure:**

- Consistency is important; the last name will be used as one element to uniquely identify the person across our system.
- Only the following characters are allowed: alphabetic characters, hyphens, space (but not as the first character), apostrophe (single quotation mark). No numeric characters are permitted.

**Type:** Text (30)

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**Attribute:**      *Given Names***Transaction:**

Staff Person

**Definition:**

The given/first/legal names of a staff person as provided by a reporting unit. In general, follow the rules of the appropriate culture when determining which name is the surname and which the given name.

**Procedure:**

- Consistency in reporting each name is important; the last name and given names will be used as elements to uniquely identify the person across our system.
- The middle name is a required entry. If only the middle initial is known, enter the middle initial. If there is no middle name, leave the field blank.
- The given name as recorded on significant documentation can be used to resolve contradictions. Use reasonable judgment to determine the best choice.
- Given names may include spaces, apostrophe (single quote) and hyphens. No numeric characters are allowed.

**Example:**

1. Garry D. Richards, Jr. should be entered as Garry D Jr (dropping the period after the middle initial and the abbreviation).

**Type:** Text (30)

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**Attribute:** *Gender***Transaction:**

Staff Person

See description of the Gender attribute in the Client Demographics transaction.

Gender code “9” (“Unknown”) is acceptable.

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**Attribute:**      *Language Code***Transaction:**

Staff Person

**Definition:**

This code identifies the languages in which a staff person can provide services.

**Procedure:**

- Enter up to five codes that describe languages in which a staff person can provide services.
- Language code “und” (“Undetermined”) is not acceptable.

**Required Documentation:**

- Provider records shall document the languages in which a staff person can provide services.

**Type:** Text (15)

*See valid iso639-2 language codes at the end of the Data Dictionary (page 300)*

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**Attribute:** *NPI***Transaction:**

Staff Person

**Definition:**

This is the staff person's National Provider Identifier.

**Procedure:**

The staff person's NPI (and taxonomy codes) must also be registered with ProviderOne.

**Type:** Text (10)

## Transaction: Staff Qualifications

### Definition:

Describes the professional qualifications for provider staff.

### Required for:

All staff

### Procedure:

- Submit on hire and on change.
- Submit at least one transaction for every staff person.
- Submit one transaction for every specialty.

**Transaction ID:** 660.01

### Action Codes:

A	Add
D	Delete

Field	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Staff Person ID	Text	8	
Specialty Area	Text	2	Y

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**Attribute:** *Staff Person ID*

**Transaction:**  
Staff Qualifications

**Definition:**

This uniquely identifies the staff person within an agency who is providing and reporting a service to a client, including sub-contracted staff, or contracted mental health specialists. Where a staff person is also a case manager, the staff ID and the case manager ID should be identical. All staff person IDs should already exist in the BHRD system prior to submitting a Staff Qualification transaction.

For mental health specialists agencies must submit the mental health specialty as well as the educational attainment level. For the special '998' staff ID, submit the educational attainment level that your contracted MH specialists would have (typically 25 or 27).

**Procedure:**

- The staff ID assigned must remain unique to the staff person and cannot be reassigned.

**Required Documentation:**

The name of the staff person providing services to a client must be documented in provider records.

**Type:** Text (10)

**Attribute:** *Qualifications***Transaction:**

Staff Qualifications

**Definition:**

This codes the professional staff members who meet the requirements for mental health and mental health specialists according to WAC 388-865-0150.

**Procedure:**

- Code **each** specialist type for which a clinical staff person qualifies in a separate record.
- If a staff person is a mental health specialist, you must submit at least two codes – one identifying the mental health specialty and one identifying the educational attainment level. The mental health specialist qualification will be checked by the BHRD IS system when a special population evaluation is performed.
- This also describes staff educational attainment levels.

**Required Documentation:**

Providers must document each specialty area for which a staff person is qualified. For mental health professionals, documentation must include evidence supporting WAC 388-865-0150 or waiver status 388-865-0265. For mental health specialists, documentation must include the type and amount of training the staff person received in each specialty area, supervision information including hours, name and qualifications of supervisor and span of time supervision was provided. Documentation should include graduation or program completion records for the highest level of educational attainment for each staff person.

**Examples:**

1. A staff person is qualified both as a geriatric mental health specialist and as an Asian/Pacific Islander Ethnic Minority Health Specialist. Submit two records, one coded 02 and the other 04.
2. A staff person has completed a master's degree in counseling and has over two years of experience in mental health care. Code 25.

**Type:** Text (2)

Valid Codes	Definition	CPT Service Taxonomy Code
01	Child Mental Health Specialist [WAC 388-865-0150]	Map from licensure or education level below
02	Geriatric Mental Health Specialist [WAC 388-865-0150]	Map from licensure or education level below
03	African American Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	Map from licensure or education level below
04	Asian/Pacific Islander Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	Map from licensure or education level below
05	Hispanic Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	Map from licensure or education level below
06	Native American Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	Map from licensure or education level below

07	Disability Mental Health Specialist [WAC 388-865-0150]	Map from licensure or education level below
08	Sexual Minority Mental Health Specialist is defined as a mental health professional who: <ol style="list-style-type: none"> <li>Has completed a minimum of one hundred actual hours of specialized training devoted to a) a broad range of sexual minority issues; and b) effects of culture on mental health.</li> <li>Has the equivalent of one year of full-time direct service with the sexual minority population under the supervision of a mental health professional meeting the criteria of a sexual minority specialist.</li> <li>Can demonstrate cultural competence attained through on-going training or study regarding sexual minority issues totaling 8 to 16 hours per year. (See also Section VII, Quality Management, Attachment B.)</li> </ol>	104100000X – Social Worker or 1041C0700X – Social Worker Clinical License or 106H00000X – Marriage & Family Therapist or 101YM0800X – Mental Health Counselor
09	Other Ethnic Minority Mental Health Specialist	Map from licensure or education level below
21	Mental Health Professional: A physician or osteopath licensed under chapter 18.71 or 18.57 RCW, who is board eligible in psychiatry. [WAC 388-865-0150]	2084P0800X – Psychiatrist/Osteopathic Physician
22	Mental Health Professional: A psychologist licensed under chapter 18.83 RCW. [WAC 388-865-0150]	103T00000X - Psychologist
23	Mental Health Professional: A registered psychiatric nurse licensed under chapter 18.79 RCW with at least two years' experience in the direct treatment of mentally ill persons and who is an ARNP with prescriptive authority. [WAC 388-865-0150]	363LP0808X – Psych, Mental Health ARNP
24	Mental Health Professional: A registered psychiatric nurse licensed under chapter 18.79 RCW with at least two years' experience in the direct treatment of mentally ill persons and who is not an ARNP with prescriptive authority. [WAC 388-865-0150]	163W00000X – Registered Nurse or 164W00000X – Licensed Practical Nurse
25	Mental Health Professional: A person with at least a master's degree in counseling or one of the social services from an accredited college or university and at least two years' experience in the direct treatment of mentally ill persons. [WAC 388-865-0150]	101Y00000X – Counselor*

26	Mental Health Professional: A mental health counselor or marriage and family therapist licensed under chapter 18.225 RCW with at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional, OR a social worker licensed under chapter 18.225.RCW. [WAC 388-865-0150]	104100000X – Social Worker or 1041C0700X – Social Worker Clinical License or 106H00000X – Marriage & Family Therapist or 101YM0800X – Mental Health Counselor
27	Mental Health Professional: A person otherwise qualified to perform the duties of a mental health professional but who does not meet the requirements listed in (a) through (c) of the WAC, where the State has granted an exception to such requirements upon review of a written request by the ASO involved. [WAC 388-865-0150] [WAC 388-865-0265]	101Y00000X – Counselor*
28	Certified Consumer Peer Counselor: a consumer of mental health services who has met the educational, experience and training requirements, has satisfactorily passed the examination, and has been issued a certificate by the State Mental Health Division as specified in WAC 388-865-0107.	175T00000X - Peer Specialist
29	Peer Support Specialist: A paraprofessional who is a consumer of mental health services (or a parent of a child receiving mental health services) who receives training, supervision (by a mental health professional), and provides support to peers all according to the King County Standards for Peer Support Services.	172V00000X – Community Health Worker**
32	Non-Mental Health Professional - RN/LPN	163W00000X – Registered Nurse or 164W00000X – Licensed Practical Nurse
41	Nursing Assistant – Registered/Certified	376K00000X- Nursing Assistant Registered/Certified
71	Non-Mental Health Professional - M.D.	2084P0800X – Psychiatry & Neurology
72	Non-Mental Health Professional - Ph.D.	101Y00000X – Counselor*
73	Non-Mental Health Professional – Master’s	101Y00000X – Counselor*
74	Non-Mental Health Professional - Bachelors	101Y00000X – Counselor*
75	Non-Mental Health Professional - Associate	101Y00000X – Counselor*
76	Non-Mental Health Professional - High School or GED	101Y00000X – Counselor*
78	Non-Mental Health Professional - Osteopathic Physician Assistant	363A00000X – Osteopathic Physician Assistant
79	Mental Health Professional – An Osteopathic Physician Assistant working with a supervising psychiatrist	363A00000X – Osteopathic Physician Assistant

80	Substance Use Professional (SUP)	101YA0400X – Substance Use Professional (SUP)
81	Substance Use Professional Trainee (SUPT)	390200000X – Student in an Organized Health Care Education/Training Program****
20	Mental Health Professional: A physician assistant working with a supervising psychiatrist as defined in 71.05 and 71.34 RCW.	363A00000X – Physician Assistant
70	Non-Mental Health Professional – Physician Assistant	363A00000X – Physician Assistant
40	Medical Assistant – Certified	374700000X – Technician***
50	Doctor of Pharmacy (PharmD)	183500000X – Pharmacist

\* When enrolling in ProviderOne, providers must register under both the federal taxonomy code above and local (HCA) taxonomy code 101Y99995L (Below Masters Level); or 101Y99996L (Masters/PhD Unlicensed)

\*\* When enrolling in ProviderOne, providers must register under both the federal taxonomy code above and local (HCA) taxonomy code 175T99994L

\*\*\* When enrolling in ProviderOne, providers must register under both the federal taxonomy code above and local (HCA) taxonomy code 101Y99993L

\*\*\*\* When enrolling in ProviderOne, providers must register under both the federal taxonomy code above and local (HCA) taxonomy code 101Y99995L

## Transaction: Substance Use

### Definition:

A client history of substance specific information.

### Required for:

- SUD outpatient benefits
- SUD residential benefits (data submission and entry described in the SUD Residential Authorization Process Manual)
- Detox
- SUD OST
- SUD Assessment Only
- SUD Secure Detox

### Frequency:

- SUD Outpatient benefits
  - Initial authorization request
  - Every 180 days during a continuous episode of care  
A continuous episode of care is the period during which a client remains in an outpatient benefit at the same provider without interruption.
  - On change
  - Medicaid OPB Anniversary
  - On exit
- SUD residential benefits
  - On admit
  - On discharge
  - Every 90 days if stay exceeds 90 days
- Detox
  - Once per episode

**Transaction ID:** 150.01

### Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
<b>Reporting Unit ID</b>	Text	3	Y	Y
<b>Case ID</b>	Text	10		Y
<b>Event Date</b>	Date (YYYYMMDD)	8		Y
Substance 1 Code	Number	2	Y	Y
Substance 1 Frequency of Use	Number	1	Y	C
Substance 1 Frequency of Use Uncontrolled Environment	Number	1	Y	C
Substance 1 Peak Frequency	Number	1	Y	C
Substance 1 Method	Number	1	Y	C
Substance 1 Date Last used	Date (YYYYMMDD)	8		C
Substance 1 First Use Age	Number	2	Y	C
Substance 2 Code	Number	2	Y	Y
Substance 2 Frequency of Use	Number	1	Y	C
Substance 2 Frequency of Use Uncontrolled Environment	Number	1	Y	C
Substance 2 Peak Frequency	Number	1	Y	C
Substance 2 Method	Number	1	Y	C
Substance 2 Date Last used	Date (YYYYMMDD)	8		C
Substance 2 First Use Age	Number	2	Y	C
Substance 3 Code	Number	2	Y	Y
Substance 3 Frequency of Use	Number	1	Y	C
Substance 3 Frequency of Use Uncontrolled Environment	Number	1	Y	C
Substance 3 Peak Frequency	Number	1	Y	C
Substance 3 Method	Number	1	Y	C
Substance 3 Date Last used	Date (YYYYMMDD)	8		C
Substance 3 First Use Age	Number	2	Y	C
Substance 4 Code	Number	2	Y	C
Substance 4 Frequency of Use	Number	1	Y	C
Substance 5 Code	Number	2	Y	C
Substance 5 Frequency of Use	Number	1	Y	C
King County ID		10		Y

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**Attribute:**      *Substance 1 Code*

**Transaction:**  
Substance Use

**Definition:**

Indicates the substance with the number 1 ranking at the beginning of a continuous episode of care. For SUD residential and detox a continuous episode of care is the period between admit and discharge (inclusive). For SUD outpatient benefits a continuous episode of care is the period during which a client remains in an outpatient benefit at the same provider without interruption (this period of time could involve several consecutive authorizations).

**Procedure:**

- The substance must be ranked by relative importance of seriousness of dependency as provided by the client and determined by the counselor.
- The same top 3 substances must be reported during a continuous episode of care.
- This is a required attribute.
- Report “None” (code 1) if an assessment was performed and it was determined that the client is not using any substances.
- An authorization for treatment will not be granted if “None” (code 1) is reported.

**Required Documentation:**

Documentation of the client’s substance use must be provided in agency records.

**Type:** Number

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

**Attribute:** *Substance 1 Frequency of Use***Transaction:**  
Substance Use**Definition:**  
Indicates the frequency that the client used a specific substance in the last 30 days.**Procedure:**

- If the Substance 1 Code is '1' (None) then this attribute must be null. Otherwise, it is required.
- Report for the 30 days prior to the Event Date.
- Report the use for the last 30 days, even if it is "No use" (Code 1) because the person has been in a controlled environment like a jail or treatment facility.

**Required Documentation:**

Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	No use in the past month
2	1-3 times in the past month
3	4- 12 times in the past month
4	13 times in the past month
5	Daily

**Attribute:** *Substance 1 Frequency of Use Uncontrolled Environment***Transaction:**  
Substance Use**Definition:**

Indicates the frequency that the client used a specific substance in the last 30 days in which they were in an uncontrolled environment.

**Procedure:**

- If the Substance 1 Code is '1' (None) then this attribute must be null. Otherwise, it is required.
- If the person has been in an uncontrolled environment (for example, living at home) for the last 30 days, report the same value as reported for "Substance 1 Frequency of Use"
- If the person has been in a controlled environment (for example, in jail) for the last 30 days, report the frequency of use for the 30 days in which they were free to use.

**Required Documentation:**

Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	No use in the past month
2	1–3 times in the past month
3	4- 12 times in the past month
4	13 times in the past month
5	Daily

**Attribute:** *Substance 1 Peak Frequency***Transaction:**  
Substance Use**Definition:**  
Indicates the highest monthly use pattern in the 12 months preceding the continuous episode of care start date.**Procedure:**

- If the Substance 1 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.**Type:** Number

Valid Codes	Definition
1	No use in the 12 months preceding the episode of care start date
2	1–3 Times Per Month
3	4–12 Times Per Month
4	13 or More Times Per Month
5	Daily

**Attribute:** *Substance 1 Method*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the most common method the client uses to administer the substance.

**Procedure:**

- If the Substance 1 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	Inhalation
2	Injection
3	Oral
4	Other
5	Smoking

---

---

**Attribute:** *Substance 1 Date Last Used*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the date that client last used a specific substance.

**Procedure:**

- If the Substance 1 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Date (YYYYMMDD)

**Attribute:** *Substance 1 First Use Age*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the age at which the client first used the specific substance.

**Procedure:**

- If the Substance 1 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
0	Client born with a substance use disorder resulting from in-utero exposure
1-98	Age at first use, in years

**Attribute:** *Substance 2 Code*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the substance with the number 2 ranking at the beginning of a continuous episode of care.

**Procedure:**

- The substance must be ranked by relative importance of seriousness of dependency as provided by the client and determined by the counselor.
- The same top 3 substances must be reported during a continuous episode of care.
- This is a required attribute.
- Report “None” (code 1) if a second substance is not reported at the beginning of a continuous episode of care.

**Required Documentation:**  
Documentation of the client’s substance use must be provided in agency records.

**Type:** Number

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

**Attribute:** *Substance 2 Frequency of Use*

**Transaction:**  
Substance Use

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

**Procedure:**

- If the Substance 2 Code is '1' (None) then this attribute must be null. Otherwise, it is required.
- Report for the 30 days prior to the Event Date.
- Report the use for the last 30 days, even if it is "No use" (Code 1) because the person has been in a controlled environment like a jail or treatment facility.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	No use in the past month
2	1–3 times in the past month
3	4– 12 times in the past month
4	13 times in the past month
5	Daily

**Attribute:** *Substance 2 Frequency of Use Uncontrolled Environment***Transaction:**  
Substance Use**Definition:**

Indicates the frequency that the client used a specific substance in the last 30 days in which they were in an uncontrolled environment.

**Procedure:**

- If the Substance 2 Code is '1' (None) then this attribute must be null. Otherwise, it is required.
- If the person has been in an uncontrolled environment (for example, living at home) for the last 30 days, report the same value as reported for "Substance 2 Frequency of Use"
- If the person has been in a controlled environment (for example, in jail) for the last 30 days, report the frequency of use for the 30 days in which they were free to use.

**Required Documentation:**

Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	No use in the past month
2	1–3 times in the past month
3	4- 12 times in the past month
4	13 times in the past month
5	Daily

**Attribute:** *Substance 2 Peak Frequency*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the highest monthly use pattern in the 12 months preceding the continuous episode of care start date.

**Procedure:**

- If the Substance 2 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	No use in the 12 months preceding the episode of care start date
2	1–3 Times Per Month
3	4–12 Times Per Month
4	13 or More Times Per Month
5	Daily

**Attribute:** *Substance 2 Method*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the most common method the client uses to administer the substance.

**Procedure:**  
If the Substance 2 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	Inhalation
2	Injection
3	Oral
4	Other
5	Smoking

---

---

**Attribute:** *Substance 2 Date Last Used*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the date that client last used a specific substance.

**Procedure:**

- If the Substance 2 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Date (YYYYMMDD)

**Attribute:** *Substance 2 First Use Age*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the age at which the client first used the specific substance.

**Procedure:**

- If the Substance 2 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
0	Client born with a substance use disorder resulting from in-utero exposure
1-98	Age at first use, in years

**Attribute:** *Substance 3 Code***Transaction:**

Substance Use

**Definition:**

Indicates the substance with the number 3 ranking at the beginning of a continuous episode of care.

**Procedure:**

- The substance must be ranked by relative importance of seriousness of dependency as provided by the client and determined by the counselor.
- The same top 3 substances must be reported during a continuous episode of care.
- This is a required attribute.
- Report “None” (code 1) if a third substance is not reported at the beginning of a continuous episode of care.

**Required Documentation:**

Documentation of the client’s substance use must be provided in agency records.

**Type:** Number

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

**Attribute:** *Substance 3 Frequency of Use***Transaction:**  
Substance Use**Definition:**  
Indicates the frequency that the client used a specific substance in the last 30 days.**Procedure:**

- If the Substance 3 Code is '1' (None) then this attribute must be null. Otherwise, it is required.
- Report for the 30 days prior to the Event Date.
- Report the use for the last 30 days, even if it is "No use" (Code 1) because the person has been in a controlled environment like a jail or treatment facility.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.**Type:** Number

Valid Codes	Definition
1	No use in the past month
2	1–3 times in the past month
3	4- 12 times in the past month
4	13 times in the past month
5	Daily

**Attribute:** *Substance 3 Frequency of Use Uncontrolled Environment***Transaction:**  
Substance Use**Definition:**

Indicates the frequency that the client used a specific substance in the last 30 days in which they were in an uncontrolled environment.

**Procedure:**

- If the Substance 3 Code is '1' (None) then this attribute must be null. Otherwise, it is required.
- If the person has been in an uncontrolled environment (for example, living at home) for the last 30 days, report the same value as reported for "Substance 3 Frequency of Use"
- If the person has been in a controlled environment (for example, in jail) for the last 30 days, report the frequency of use for the 30 days in which they were free to use.

**Required Documentation:**

Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	No use in the past month
2	1-3 times in the past month
3	4- 12 times in the past month
4	13 times in the past month
5	Daily

**Attribute:** *Substance 3 Peak Frequency***Transaction:**  
Substance Use**Definition:**  
Indicates the highest monthly use pattern in the 12 months preceding the continuous episode of care start date.**Procedure:**  
If the Substance 3 Code is '1' (None) then this attribute must be null. Otherwise, it is required.**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.**Type:** Number

Valid Codes	Definition
1	No use in the 12 months preceding the episode of care start date
2	1–3 Times Per Month
3	4–12 Times Per Month
4	13 or More Times Per Month
5	Daily

**Attribute:** *Substance 3 Method*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the most common method the client uses to administer the substance.

**Procedure:**  
If the Substance 3 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	Inhalation
2	Injection
3	Oral
4	Other
5	Smoking

---

---

**Attribute:** *Substance 3 Date Last Used*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the date that client last used a specific substance.

**Procedure:**  
If the Substance 3 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Date (YYYYMMDD)

**Attribute:** *Substance 3 First Use Age*

**Transaction:**  
Substance Use

**Definition:**  
Indicates the age at which the client first used the specific substance.

**Procedure:**  
If the Substance 3 Code is '1' (None) then this attribute must be null. Otherwise, it is required.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
0	Client born with a substance use disorder resulting from in-utero exposure
1-98	Age at first use, in years

---

---

**Attribute:** *Substance 4 Code*

**Transaction:**  
Substance Use

**Definition:**  
Indicates an additional substance that is being used by the client.

**Procedure:**

- For convenience this substance has a '4' in its name, but ranking only applies to the top 3 substances.
- At the start of a continuous episode of care, reporting is only required for the three most clinically important substances. If clinically important use of another substance begins after the start of a continuous episode of care, report that substance with the next required data submission using the appropriate event date and report the frequency of use (next attribute) for that substance for the 30 days before the event date.
- Once a fourth substance is reported continue to report on this substance through the duration of the continuous episode of care.
- This is not a required attribute, but it becomes required for subsequent event dates once it is reported.

**Required Documentation:**

Documentation of the client's substance use must be provided in agency records.

**Type:** Number

---

---

<b>Valid Codes</b>	<b>Definition</b>
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

**Attribute:** *Substance 4 Frequency of Use***Transaction:**  
Substance Use**Definition:**  
Indicates the frequency that the client used a specific substance in the last 30 days.**Procedure:**

- This is a required attribute if the Substance 4 Code is not null.
- If a fourth substance is reported after the start of a continuous episode of care, report the frequency of use in the last 30 days for that substance and continue to report on it until the end of the continuous episode of care.

**Required Documentation:**  
Documentation of the client's substance use must be provided in agency records.**Type:** Number

Valid Codes	Definition
1	No use in the past month
2	1–3 times in the past month
3	4 –12 times in the past month
4	13 times in the past month
5	Daily

---

---

**Attribute:** *Substance 5 Code*

**Transaction:**  
Substance Use

**Definition:**  
Indicates an additional substance that is being used by the client.

**Procedure:**

- For convenience this substance has a '5' in its name but ranking only applies to the top 3 substances.
- At the start of a continuous episode of care, reporting is only required for the three most clinically important substances. If clinically important use of another substance begins after the start of a continuous episode of care, report that substance with the next required data submission using the appropriate event date and report the frequency of use (next attribute) for that substance for the 30 days before the event date.
- Once a fifth substance is reported continue to report on this substance through the duration of the continuous episode of care.
- This is not a required attribute, but it becomes required for subsequent event dates once it is reported.

**Required Documentation:**

Documentation of the client's substance use must be provided in agency records.

**Type:** Number

---

---

<b>Valid Codes</b>	<b>Definition</b>
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

**Attribute:** *Substance 5 Frequency of Use***Transaction:**  
Substance Use**Definition:**  
Indicates the frequency that the client used a specific substance in the last 30 days.**Procedure:**

- This is a required attribute if the Substance 5 Code is not null.
- If a fifth substance is reported after the start of a continuous episode of care, report the frequency of use in the last 30 days for that substance and continue to report on it until the end of the continuous episode of care.

**Required Documentation:**

Documentation of the client's substance use must be provided in agency records.

**Type:** Number

Valid Codes	Definition
1	No use in the past month
2	1–3 times in the past month
3	4–12 times in the past month
4	13 times in the past month
5	Daily

---

---

## Transaction: SUD Release of Information

**Definition:**

Used to report an SUD client's consent status regarding releasing their information to the King County behavioral health network for purposes of care coordination.

**Required for:**

All substance use disorder, co-occurring disorder and medication-assisted treatment programs, including:

- SUD Assessment Only
- SUD Outpatient
- SUD Residential
- COD Outpatient
- Detox
- MAT (OST)
- Buprenorphine Programs

**ISAC Notes:**

- This transaction will be required to reach OC data status.
- Consent does not expire but will be required for a new benefit.

**Frequency:**

Initial assessment

On change

New benefit request (not required for continuation of benefits)

**Procedure:**

- Report this transaction when the client initially signs the release of information form and any time it changes.
- An updated lookup consent form has been created for King County's new role as an integrated care network (ICN) contracting with managed care organizations (MCOs). This transaction should only be used to indicate that the client has signed a lookup consent form version date 10/01/2018 or higher.
- The SUD\_ROI\_Granted indicator from the *Dynamic Client Data* transaction becomes invalid on January 1, 2019.

**Transaction ID:** 210.01**Action Codes:**

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded	Required
<b>Reporting Unit ID</b>	Text	3	Y	Y
<b>Case ID</b>	Text	10		Y
<b>Event Date</b>	Date (YYYYMMDD)	8		Y
Form Revision Date	Date (YYYYMMDD)	8		Y
SUD_ROI_Granted	Number	1	Y	Y
King County ID	Number	10		Y

---

---

**Attribute:** *Event Date***Transaction:**

SUD Release of Information

**Definition:**

Indicates the date the client signed the form.

**Procedure:**

- Retain the signed form in the client file.

**Type:** Date

**Attribute:** *SUD\_ROI\_Granted***Transaction:**

SUD Release of Information

**Definition:**

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

**Procedure:**

- Required for clients receiving substance use disorder treatment or assessed for a substance use disorder (whether the authorization is for an assessment only or for treatment to be provided).

**Type:** Number

Code	Definition
1	No
2	Yes

---

---

**Attribute:** *Form Revision Date***Transaction:**

SUD Release of Information

**Definition:**

Lookup consent forms are updated periodically. The form revision date indicates which version of the form the client has signed.

**Procedure:**

- Report the form revision date as indicated on the hard-copy form signed by the client.
- Always use the most current version of the lookup consent form.

**Type:** Date

---

---

## Transaction: Vulnerability Assessment Transaction

**Definition:**

Describes the results of an assessment of a homeless person's functioning in ten life or risk domains; used to prioritize access to housing and supportive services.

**Required for:** Homeless adults who have had a vulnerability assessment completed using the standardized DESC vulnerability assessment tool, and who have given consent for the assessment results to be submitted to BHRD for inclusion in the integrated database that is used to identify high need candidates for housing resources.

**Frequency:**

On referral for shelter or housing. At each 12-month anniversary, if continuing to seek shelter/housing.

**Procedure:**

- All data for this transaction will be submitted by DESC, including vulnerability assessments performed by other agencies.

**Transaction ID:** 680.03**Action Codes:**

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
<b>Reporting Unit ID</b>	Text	3	Y
<b>Case ID</b>	Text	10	
<b>Event Date</b>	Text (YYYYMMDD)	8	
Survival Rating	Text (number)	1	Y
Basic Needs	Text (number)	1	Y
Indicated Mortality Risks	Text (number)	1	Y
Medical Risks	Text (number)	1	Y
Organization Orientation	Text (number)	1	Y
Mental Health	Text (number)	1	Y
Substance Use	Text (number)	1	Y
Communication	Text (number)	1	Y
Social Behaviors	Text (number)	1	Y
Homelessness	Text (number)	1	Y
Veteran Status	Text	1	Y
Assessor ID	Text	8	Y
King County ID	Text (number)		
ROI Consent Granted	Text	1	Y
Provisional Assessment	Text	1	Y

---

**Attribute:** *Reporting Unit ID*

**Transaction:**  
Vulnerability Assessment Transaction

**Procedure:**

- Always submit DESC Agency ID: 152

---

---

**Attribute:** *Case ID***Transaction:**

Vulnerability Assessment Transaction

**Definition:**

The unique client identifier in the DESC information system.

**Procedure:**

- Even if the assessment was done by another agency, submit the DESC Case ID. All clients assessed using the DESC Vulnerability assessment tool and reported to the BHRD IS are identified as DESC clients.

---

**Attribute:** *Event Date*

**Transaction:**  
Vulnerability Assessment Transaction

**Definition:**  
The date the assessment was completed.

---

---

**Attribute:** *Domains Assessed*

- *Survival Rating*
- *Basic Needs*
- *Indicated Mortality Risks*
- *Medical Risks*
- *Organization Orientation*
- *Mental Health*
- *Substance Use*
- *Communication*
- *Social Behaviors*
- *Homelessness*

**Transaction:**

Vulnerability Assessment Transaction

**Definition:**

See the DESC Vulnerability Assessment Tool for definitions of, and procedures for scoring, the assessment domains.

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**Attribute:** *Assessment Values***Transaction:**

Vulnerability Assessment Transaction

**Definition:**

Assessment values for the first nine domains are 1 through 5.  
Homelessness values are 1 through 3.

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**Attribute:** *Veteran Status*

**Transaction:**  
Vulnerability Assessment Transaction

**Definition:**  
Indicates whether the client reported being a military veteran.

---

---

**Attribute:** *Assessor ID*

**Transaction:**  
Vulnerability Assessment Transaction

**Definition:** An identifier in the BHRD system of the person who assessed a client using the Vulnerability Assessment Tool.

**Procedure:**

- For DESC staff, use the KCID assigned to the person in the BHRD system.
- For assessors who are not DESC staff, DESC staff will assign the alphanumeric Assessor ID and report it to the DCHS IT staff. DCHS IT staff will manually update the sud\_vul\_assessor table.

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---

**Attribute:** *King County ID*

**Transaction:**  
Vulnerability Assessment Transaction

**Procedure:**

- Each reported client should have a KCID. If the person assessed does not have a KCID, DESC will need to submit a Client Demographics transaction with Agency ID '152' to get a KCID assigned.

---

---

**Attribute:** *ROI Consent Granted***Transaction:**

Vulnerability Assessment Transaction

**Definition:**

This attribute indicates if the client has granted consent to release information.

**Type:** Text (1)

Valid Codes	Definition
1	No – The client has not granted consent to share his/her Vulnerability Assessment data.
2	Yes – The client has granted consent to share his/her Vulnerability Assessment data.

---

**Attribute:** *Provisional Assessment***Transaction:**

Vulnerability Assessment Transaction

**Definition:**

This attribute indicates if this was a provisional assessment.

**Type:** Text (1)

Valid Codes	Definition
1	No – This was not a provisional assessment.
2	Yes – This was a provisional assessment.

---

---

**Transaction: Universal Attributes and Definitions**

*Attribute:*      *Case ID*

**Definition:**

The identifier established by a Reporting Unit which uniquely identifies a client. A case ID should never be recycled to another client.

**Type:** Char (10)

**Valid Codes:**

No restrictions. Up to 10 characters may be used.

---

---

**Attribute:** *King County ID***Transaction:**

Universal

**Definition:**

The unique King County identifier assigned to a person by the BHRD IS after the KCICN system has unduplicated person records across all data sources.

**Procedure:**

- This identification number uniquely identifies a client receiving services from the King County KCICN, or staff providing services at King County KCICN.
- If providers know the client's King County ID, it must be submitted in the authorization request for an outpatient or residential benefit. It is the responsibility of the reporting provider to check the ECLS for the correct King County ID. The KCID is required for all indicated transactions except an initial authorization request and the service detail record for a client not already assigned a KCID.
- This attribute may be null if the provider does not know it for the initial authorization request but must be used in subsequent transactions.

**Required Documentation:**

The client's KCID must be maintained in the clinical record.

**Type:** Integer

---

---

**Attribute:** *Reporting Unit ID***Required for:**

Listed entities

**Definition:**

A code established by the Mental Health Division to uniquely identify an organization delivering services to a client.

**Type:** Char (5)

---

## Definitions

**Initial Assessment:** The first assessment of an individual that a provider does for any KCICN-funded services.

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**Attribute:** *Event Date***Definition:**

The date an event actually occurred or the date an agency learned of the event or change.

**Type:** Date (8)

YYYYMMDD

## Required Transaction and Data Status / Event Date Rule

### Behavioral Health - Outpatient

Transaction	Data Status	Event Date Rule / Required			Master Tables
		Initial Authorization	Anniversary/COB		
			400	401	
Authorization Request	OC	2		2	au_master cl_auth_request
CALOCUS/LOCUS	PY	1	3	1	ep_calocus cl_calocus ep_locus cl_locus
Case Manager Link	OC	4			mp_mgr_link cl_case_mgr_link
Client Demographics					client_master g_person g_demogrphic mp_ethnicity cl_demographic
COD Assessment	OC	2			ea_cod_assessment cl_cod_assessment
COD Screening	OC	2			ea_cod_screening cl_cod_screening
Conditions at Assessment	N/A	2			ea_cond_ass cl_cond_ass
CPT Service	OC	1	3	1	ea_cpt_service ea_cpt_service_modifier cl_cpt_service
Diagnosis ICD-10-CM	PY	1	3	1	ea_diag cl_icd_10_cm
Disability	OC	1			ep_disability cl_disability
Dynamic Client Data	OC	1			ep_dynamic_client cl_dynamic_client
Income Category	PY	5		5	ep_income cl_income02
Key Dates	OC	*			au_key_dates cl_key_dates
Mobile Crisis Team Intervention	OC	?			cl_mct
Medicaid Coverage	PY	5		5	ep_medicaid_cov

					cl_medicaid_cov
Program Referral Referral In Screening Contact	OC	**			cl_program_ref ma_prgm_ref_in ma_screen_cont
Residential Arrangement	PY	5	3	5	ep_residence cl_resid_arrng
Staff Person NPI		Required before submitting CPT Service			g_person g_demographic client_master ep_staff_dur cl_staff_person_npi
Staff Qualifications		Required before submitting CPT Service			mp_staff_special cl_???
Notice of exit	N/A	On Discharge			ma_notice_of_exit cl_notice_of_exit

**\*Key Dates:** The dates must be in a logical sequential order; with the Request for Service and First Offered Intake date being on or before the benefit start date and the First Offered Routine Service must be on or after the benefit start date.

**\*\*Program Referral:** The date must be prior to (in sequential order) or same as Authorization Date.

**On Discharge:** The date of discharge. For system edits, this date must always be within the benefit period.

Code	Definition
PY	Payment data set. Payment will begin when all PY data elements are submitted within the first two months of the benefit.
OC	Outcome data set. This represents all remaining required data elements.
1	The event date needs to be between <i>Assessment Date</i> and <i>Authorization Cutoff Date</i>
2	The event date must be as the same as <i>Assessment / Authorization Start Date</i>
3	The event date must be between [ <i>First day of Anniversary Month – 2 months</i> ] and [ <i>Last day of Anniversary Month + 2 months</i> ]
4	No event date exists – check for the existence of a record
5	The event date must be between [ <i>First day of the month preceding the month of Authorization Start Date</i> ] and [ <i>Authorization Start Date</i> ]
6	The event date must be between [ <i>Assessment – 1 year</i> ] and [ <i>Assessment Date</i> ]

**NOTE:** The computer system or data entry date should not be entered as the event date unless it really is.

## SUD Outpatient

Transactions	Data Status	Event Date Rule / Required			Master Tables
		Initial Authorization	Anniversary		
			500	501	
ASAM Placement	PY	1	3	1	ep_asam_placement cl_asam_placement
Authorization Request	OC	2		2	au_master cl_auth_request
Case Manager Link	OC	4			mp_mgr_link cl_case_mgr_link
Client Demographics					client_master g_person g_demogrphic mp_ethnicity cl_demographic
COD Screening	OC	2			ea_cod_screening cl_cod_screening
COD Assessment	OC	2			ea_cod_assessment cl_cod_assessment
CPT Service	OC	1	3	1	ea_cpt_service ea_cpt_service_modifier cl_cpt_service
Diagnosis ICD-10-CM	PY	1	3	1	ea_diag cl_icd_10_cm
Disability	OC	1			ep_disability cl_disability
Dynamic Client Data	OC	1			ep_dynamic_client cl_dynamic_client
Income Category	PY	5		5	ep_income cl_income02
Key Dates	OC	*			au_key_dates cl_key_dates
Medicaid Coverage	PY	5		5	ep_medicaid_cov cl_medicaid_cov
Program Referral Referral In Screening Contact	OC	**			cl_program_ref ma_prgm_ref_in ma_screen_cont
Residential Arrangement	PY	5	3	5	ep_residence cl_resid_arrng
Substance Use	PY	1	3	1	ep_substance_use cl_substance_use

SUD ROI	OC	1		ep_sud_roi cl_sud_roi
Staff Person NPI	Y	Required before submitting CPT Service		g_person g_demogrphic client_master ep_staff_dur cl_staff_person_npi
Staff Qualifications	Y	Required before submitting CPT Service		mp_staff_special
Notice of exit	N/A	On Discharge		ma_notice_of_exit cl_notice_of_exit

**\*Key Dates:** The dates must be in a logical sequential order; with the Request for Service and First Offered Intake date being on or before the benefit start date and the First Offered Routine Service must be on or after the benefit start date.

**\*\*Program Referral:** The date must be prior to (in sequential order) or same as Authorization Date.

**On Discharge:** The date of discharge. For system edits, this date must always be within the benefit period.

Code	Definition
PY	Payment data set. Payment will begin when all PY data elements are submitted within the first two months of the benefit.
OC	Outcome data set. This represents all remaining required data elements.
1	The event date needs to be between <i>Assessment Date</i> and <i>Authorization Cutoff Date</i>
2	The event date must be as the same as <i>Assessment / Authorization Start Date</i>
3	The event date must be between [ <i>First day of Anniversary Month – 2 months</i> ] and [ <i>Last day of Anniversary Month + 2 months</i> ]
4	No event date exists – check for the existence of a record
5	The event date must be between [ <i>First day of the month preceding the month of Authorization Start Date</i> ] and [ <i>Authorization Start Date</i> ]
6	The event date must be between [ <i>Assessment – 1 year</i> ] and [ <i>Assessment Date</i> ]

**NOTE:** The computer system or data entry date should not be entered as the event date unless it really is.

## iso639-2 Language Codes

Valid Codes	Definition	State Code (BHRD Use Only)
abk	Abkhazian	abk
ace	Achinese	ace
ach	Acoli	ach
ada	Adangme	ada
ady	Adyghe; Adygei	ady
aar	Afar	aar
afh	Afrihili	afh
afr	Afrikaans	afr
afa	Afro-Asiatic languages	afa
ain	Ainu	ain
aka	Akan	aka
akk	Akkadian	akk
alb	Albanian	alb
ale	Aleut	ale
alg	Algonquian languages	alg
tut	Altaic languages	tut
amh	Amharic	amh
anp	Angika	anp
apa	Apache languages	apa
ara	Arabic	ara
arg	Aragonese	arg
arp	Arapaho	arp
arw	Arawak	arw
arm	Armenian	arm
rup	Aromanian; Arumanian; Macedo-Romanian	rup
art	Artificial languages	art
asm	Assamese	asm
ast	Asturian; Bable; Leonese; Asturleonese	ast
ath	Athapascan languages	ath
aus	Australian languages	aus
map	Austronesian languages	map
ava	Avaric	ava
ave	Avestan	ave
awa	Awadhi	awa
aym	Aymara	aym
aze	Azerbaijani	aze
ban	Balinese	ban
bat	Baltic languages	bat

bal	Baluchi	<b>bal</b>
bam	Bambara	<b>bam</b>
bai	Bamileke languages	<b>bai</b>
bad	Banda languages	<b>bad</b>
bnt	Bantu languages	<b>bnt</b>
bas	Basa	<b>bas</b>
bak	Bashkir	<b>bak</b>
baq	Basque	<b>baq</b>
btk	Batak languages	<b>btk</b>
bej	Beja; Bedawiyet	<b>bej</b>
bel	Belarusian	<b>bel</b>
bem	Bemba	<b>bem</b>
ben	Bengali	<b>ben</b>
ber	Berber languages	<b>ber</b>
bho	Bhojpuri	<b>bho</b>
bih	Bihari languages	<b>bih</b>
bik	Bikol	<b>bik</b>
bin	Bini; Edo	<b>bin</b>
bis	Bislama	<b>bis</b>
byn	Blin; Bilin	<b>byn</b>
zbl	Blissymbols; Blissymbolics; Bliss	<b>zbl</b>
nob	Bokmål, Norwegian; Norwegian Bokmål	<b>nob</b>
bos	Bosnian	<b>bos</b>
bra	Braj	<b>bra</b>
bre	Breton	<b>bre</b>
bug	Buginese	<b>bug</b>
bul	Bulgarian	<b>bul</b>
bua	Buriat	<b>bua</b>
bur	Burmese	<b>bur</b>
cad	Caddo	<b>cad</b>
cat	Catalan; Valencian	<b>cat</b>
cau	Caucasian languages	<b>cau</b>
ceb	Cebuano	<b>ceb</b>
cel	Celtic languages	<b>cel</b>
cai	Central American Indian languages	<b>cai</b>
khm	Central Khmer	<b>khm</b>
chg	Chagatai	<b>chg</b>
cmc	Chamic languages	<b>cmc</b>
cha	Chamorro	<b>cha</b>
che	Chechen	<b>che</b>
chr	Cherokee	<b>chr</b>
chy	Cheyenne	<b>chy</b>

chb	Chibcha	<b>chb</b>
nya	Chichewa; Chewa; Nyanja	<b>nya</b>
chi	Chinese	<b>chi</b>
chn	Chinook jargon	<b>chn</b>
chp	Chipewyan; Dene Suline	<b>chp</b>
cho	Choctaw	<b>cho</b>
chu	Church Slavic; Old Slavonic; Church Slavonic; Old Bulgarian; Old Church Slavonic	<b>chu</b>
chk	Chuukese	<b>chk</b>
chv	Chuvash	<b>chv</b>
nwc	Classical Newari; Old Newari; Classical Nepal Bhasa	<b>nwc</b>
syc	Classical Syriac	<b>syc</b>
cop	Coptic	<b>cop</b>
cor	Cornish	<b>cor</b>
cos	Corsican	<b>cos</b>
cre	Cree	<b>cre</b>
mus	Creek	<b>mus</b>
crp	Creoles and pidgins	<b>crp</b>
cpe	Creoles and pidgins, English based	<b>cpe</b>
cpf	Creoles and pidgins, French-based	<b>cpf</b>
cpp	Creoles and pidgins, Portuguese-based	<b>cpp</b>
crh	Crimean Tatar; Crimean Turkish	<b>crh</b>
hrv	Croatian	<b>hrv</b>
cus	Cushitic languages	<b>cus</b>
cze	Czech	<b>cze</b>
dak	Dakota	<b>dak</b>
dan	Danish	<b>dan</b>
dar	Dargwa	<b>dar</b>
del	Delaware	<b>del</b>
din	Dinka	<b>din</b>
div	Divehi; Dhivehi; Maldivian	<b>div</b>
doi	Dogri	<b>doi</b>
dgr	Dogrib	<b>dgr</b>
dra	Dravidian languages	<b>dra</b>
dua	Duala	<b>dua</b>
dum	Dutch, Middle (ca.1050-1350)	<b>dum</b>
dut	Dutch; Flemish	<b>dut</b>
dyu	Dyula	<b>dyu</b>
dzo	Dzongkha	<b>dzo</b>
frs	Eastern Frisian	<b>frs</b>
efi	Efik	<b>efi</b>
egy	Egyptian (Ancient)	<b>egy</b>

eka	Ekajuk	<b>eka</b>
elx	Elamite	<b>elx</b>
eng	English	<b>eng</b>
enm	English, Middle (1100-1500)	<b>enm</b>
ang	English, Old (ca.450-1100)	<b>ang</b>
myv	Erzya	<b>myv</b>
epo	Esperanto	<b>epo</b>
est	Estonian	<b>est</b>
ewe	Ewe	<b>ewe</b>
ewo	Ewondo	<b>ewo</b>
fan	Fang	<b>fan</b>
fat	Fanti	<b>fat</b>
fao	Faroese	<b>fao</b>
fij	Fijian	<b>fij</b>
fil	Filipino; Pilipino	<b>fil</b>
fin	Finnish	<b>fin</b>
fiu	Finno-Ugrian languages	<b>fiu</b>
fon	Fon	<b>fon</b>
fre	French	<b>fre</b>
frm	French, Middle (ca.1400-1600)	<b>frm</b>
fro	French, Old (842-ca.1400)	<b>fro</b>
fur	Friulian	<b>fur</b>
ful	Fulah	<b>ful</b>
gaa	Ga	<b>gaa</b>
gla	Gaelic; Scottish Gaelic	<b>gla</b>
car	Galibi Carib	<b>car</b>
glg	Galician	<b>glg</b>
lug	Ganda	<b>lug</b>
gay	Gayo	<b>gay</b>
gba	Gbaya	<b>gba</b>
gez	Geez	<b>gez</b>
geo	Georgian	<b>geo</b>
ger	German	<b>ger</b>
gmh	German, Middle High (ca.1050-1500)	<b>gmh</b>
goh	German, Old High (ca.750-1050)	<b>goh</b>
gem	Germanic languages	<b>gem</b>
gil	Gilbertese	<b>gil</b>
gon	Gondi	<b>gon</b>
gor	Gorontalo	<b>gor</b>
got	Gothic	<b>got</b>
grb	Grebo	<b>grb</b>
grc	Greek, Ancient (to 1453)	<b>grc</b>

gre	Greek, Modern (1453-)	<b>gre</b>
grn	Guarani	<b>grn</b>
guj	Gujarati	<b>guj</b>
gwi	Gwich'in	<b>gwi</b>
hai	Haida	<b>hai</b>
hat	Haitian; Haitian Creole	<b>hat</b>
hau	Hausa	<b>hau</b>
haw	Hawaiian	<b>haw</b>
heb	Hebrew	<b>heb</b>
her	Herero	<b>her</b>
hil	Hiligaynon	<b>hil</b>
him	Himachali languages; Western Pahari languages	<b>him</b>
hin	Hindi	<b>hin</b>
hmo	Hiri Motu	<b>hmo</b>
hit	Hittite	<b>hit</b>
hmn	Hmong; Mong	<b>hmn</b>
hun	Hungarian	<b>hun</b>
hup	Hupa	<b>hup</b>
iba	Iban	<b>iba</b>
ice	Icelandic	<b>ice</b>
ido	Ido	<b>ido</b>
ibo	Igbo	<b>ibo</b>
ijo	Ijo languages	<b>ijo</b>
ilo	Iloko	<b>ilo</b>
smn	Inari Sami	<b>smn</b>
inc	Indic languages	<b>inc</b>
ine	Indo-European languages	<b>ine</b>
ind	Indonesian	<b>ind</b>
inh	Ingush	<b>inh</b>
ina	Interlingua (International Auxiliary Language Association)	<b>ina</b>
ile	Interlingue; Occidental	<b>ile</b>
iku	Inuktitut	<b>iku</b>
ipk	Inupiaq	<b>ipk</b>
ira	Iranian languages	<b>ira</b>
gle	Irish	<b>gle</b>
mga	Irish, Middle (900-1200)	<b>mga</b>
sga	Irish, Old (to 900)	<b>sga</b>
iro	Iroquoian languages	<b>iro</b>
ita	Italian	<b>ita</b>
jpn	Japanese	<b>jpn</b>
jav	Javanese	<b>jav</b>

jrb	Judeo-Arabic	<b>jrb</b>
jpr	Judeo-Persian	<b>jpr</b>
kbd	Kabardian	<b>kbd</b>
kab	Kabyle	<b>kab</b>
kac	Kachin; Jingpho	<b>kac</b>
kal	Kalaallisut; Greenlandic	<b>kal</b>
xal	Kalmyk; Oirat	<b>xal</b>
kam	Kamba	<b>kam</b>
kan	Kannada	<b>kan</b>
kau	Kanuri	<b>kau</b>
krc	Karachay-Balkar	<b>krc</b>
kaa	Kara-Kalpak	<b>kaa</b>
krl	Karelian	<b>krl</b>
kar	Karen languages	<b>kar</b>
kas	Kashmiri	<b>kas</b>
csb	Kashubian	<b>csb</b>
kaw	Kawi	<b>kaw</b>
kaz	Kazakh	<b>kaz</b>
kha	Khasi	<b>kha</b>
khi	Khoisan languages	<b>khi</b>
kho	Khotanese; Sakan	<b>kho</b>
kik	Kikuyu; Gikuyu	<b>kik</b>
kmb	Kimbundu	<b>kmb</b>
kin	Kinyarwanda	<b>kin</b>
kir	Kirghiz; Kyrgyz	<b>kir</b>
tlh	Klingon; tlhIngan-Hol	<b>tlh</b>
kom	Komi	<b>kom</b>
kon	Kongo	<b>kon</b>
kok	Konkani	<b>kok</b>
kor	Korean	<b>kor</b>
kos	Kosraean	<b>kos</b>
kpe	Kpelle	<b>kpe</b>
kro	Kru languages	<b>kro</b>
kua	Kuanyama; Kwanyama	<b>kua</b>
kum	Kumyk	<b>kum</b>
kur	Kurdish	<b>kur</b>
kru	Kurukh	<b>kru</b>
kut	Kutenai	<b>kut</b>
lad	Ladino	<b>lad</b>
lah	Lahnda	<b>lah</b>
lam	Lamba	<b>lam</b>
day	Land Dayak languages	<b>day</b>

lao	Lao	<b>lao</b>
lat	Latin	<b>lat</b>
lav	Latvian	<b>lav</b>
lez	Lezghian	<b>lez</b>
lim	Limburgan; Limburger; Limburgish	<b>lim</b>
lin	Lingala	<b>lin</b>
lit	Lithuanian	<b>lit</b>
jbo	Lojban	<b>jbo</b>
nds	Low German; Low Saxon; German, Low; Saxon, Low	<b>nds</b>
dsb	Lower Sorbian	<b>dsb</b>
loz	Lozi	<b>loz</b>
lub	Luba-Katanga	<b>lub</b>
lua	Luba-Lulua	<b>lua</b>
lui	Luiseno	<b>lui</b>
smj	Lule Sami	<b>smj</b>
lun	Lunda	<b>lun</b>
luo	Luo (Kenya and Tanzania)	<b>luo</b>
lus	Lushai	<b>lus</b>
ltz	Luxembourgish; Letzeburgesch	<b>ltz</b>
mac	Macedonian	<b>mac</b>
mad	Madurese	<b>mad</b>
mag	Magahi	<b>mag</b>
mai	Maithili	<b>mai</b>
mak	Makasar	<b>mak</b>
mlg	Malagasy	<b>mlg</b>
may	Malay	<b>may</b>
mal	Malayalam	<b>mal</b>
mlt	Maltese	<b>mlt</b>
mnc	Manchu	<b>mnc</b>
mdr	Mandar	<b>mdr</b>
man	Mandingo	<b>man</b>
mni	Manipuri	<b>mni</b>
mno	Manobo languages	<b>mno</b>
glv	Manx	<b>glv</b>
mao	Maori	<b>mao</b>
arn	Mapudungun; Mapuche	<b>arn</b>
mar	Marathi	<b>mar</b>
chm	Mari	<b>chm</b>
mah	Marshallese	<b>mah</b>
mwr	Marwari	<b>mwr</b>
mas	Masai	<b>mas</b>
myn	Mayan languages	<b>myn</b>

men	Mende	<b>men</b>
mic	Mi'kmaq; Micmac	<b>mic</b>
min	Minangkabau	<b>min</b>
mwł	Mirandese	<b>mwł</b>
moh	Mohawk	<b>moh</b>
mdf	Moksha	<b>mdf</b>
lol	Mongo	<b>lol</b>
mon	Mongolian	<b>mon</b>
mkh	Mon-Khmer languages	<b>mkh</b>
cnr	Montenegrin	<b>cnr</b>
mos	Mossi	<b>mos</b>
mul	Multiple languages	<b>mul</b>
mun	Munda languages	<b>mun</b>
nah	Nahuatl languages	<b>nah</b>
nau	Nauru	<b>nau</b>
nav	Navajo; Navaho	<b>nav</b>
nde	Ndebele, North; North Ndebele	<b>nde</b>
nbl	Ndebele, South; South Ndebele	<b>nbl</b>
ndo	Ndonga	<b>ndo</b>
nap	Neapolitan	<b>nap</b>
new	Nepal Bhasa; Newari	<b>new</b>
nep	Nepali	<b>nep</b>
nia	Nias	<b>nia</b>
nic	Niger-Kordofanian languages	<b>nic</b>
ssa	Nilo-Saharan languages	<b>ssa</b>
niu	Niuean	<b>niu</b>
nqo	N'Ko	<b>nqo</b>
zxx	No linguistic content; Not applicable	<b>zxx</b>
nog	Nogai	<b>nog</b>
non	Norse, Old	<b>non</b>
nai	North American Indian languages	<b>nai</b>
frr	Northern Frisian	<b>frr</b>
sme	Northern Sami	<b>sme</b>
nor	Norwegian	<b>nor</b>
nno	Norwegian Nynorsk; Nynorsk, Norwegian	<b>nno</b>
nub	Nubian languages	<b>nub</b>
nym	Nyamwezi	<b>nym</b>
nyn	Nyankole	<b>nyn</b>
nyo	Nyoro	<b>nyo</b>
nzi	Nzima	<b>nzi</b>
oci	Occitan (post 1500)	<b>oci</b>

arc	Official Aramaic (700-300 BCE); Imperial Aramaic (700-300 BCE)	arc
oji	Ojibwa	oji
ori	Oriya	ori
orm	Oromo	orm
osa	Osage	osa
oss	Ossetian; Ossetic	oss
oto	Otomian languages	oto
pal	Pahlavi	pal
pau	Palauan	pau
pli	Pali	pli
pam	Pampanga; Kapampangan	pam
pag	Pangasinan	pag
pan	Panjabi; Punjabi	pan
pap	Papiamento	pap
paa	Papuan languages	paa
nso	Pedi; Sepedi; Northern Sotho	nso
per	Persian	per
peo	Persian, Old (ca.600-400 B.C.)	peo
phi	Philippine languages	phi
phn	Phoenician	phn
pon	Pohnpeian	pon
pol	Polish	pol
por	Portuguese	por
pra	Prakrit languages	pra
pro	Provençal, Old (to 1500); Occitan, Old (to 1500)	pro
pus	Pushto; Pashto	pus
que	Quechua	que
raj	Rajasthani	raj
rap	Rapanui	rap
rar	Rarotongan; Cook Islands Maori	rar
roa	Romance languages	roa
rum	Romanian; Moldavian; Moldovan	rum
roh	Romansh	roh
rom	Romany	rom
run	Rundi	run
rus	Russian	rus
sal	Salishan languages	sal
sam	Samaritan Aramaic	sam
smi	Sami languages	smi
smo	Samoan	smo
sad	Sandawe	sad

sag	Sango	<b>sag</b>
san	Sanskrit	<b>san</b>
sat	Santali	<b>sat</b>
srd	Sardinian	<b>srd</b>
sas	Sasak	<b>sas</b>
sco	Scots	<b>sco</b>
sel	Selkup	<b>sel</b>
sem	Semitic languages	<b>sem</b>
srp	Serbian	<b>srp</b>
srr	Serer	<b>srr</b>
shn	Shan	<b>shn</b>
sna	Shona	<b>sna</b>
iii	Sichuan Yi; Nuosu	<b>iii</b>
scn	Sicilian	<b>scn</b>
sid	Sidamo	<b>sid</b>
sgn	Sign Languages	<b>sgn</b>
bla	Siksika	<b>bla</b>
snd	Sindhi	<b>snd</b>
sin	Sinhala; Sinhalese	<b>sin</b>
sit	Sino-Tibetan languages	<b>sit</b>
sio	Siouan languages	<b>sio</b>
sms	Skolt Sami	<b>sms</b>
den	Slave (Athapascan)	<b>den</b>
sla	Slavic languages	<b>sla</b>
slo	Slovak	<b>slo</b>
slv	Slovenian	<b>slv</b>
sog	Sogdian	<b>sog</b>
som	Somali	<b>som</b>
son	Songhai languages	<b>son</b>
snk	Soninke	<b>snk</b>
wen	Sorbian languages	<b>wen</b>
sot	Sotho, Southern	<b>sot</b>
sai	South American Indian languages	<b>sai</b>
alt	Southern Altai	<b>alt</b>
sma	Southern Sami	<b>sma</b>
spa	Spanish; Castilian	<b>spa</b>
srn	Sranan Tongo	<b>srn</b>
zgh	Standard Moroccan Tamazight	<b>zgh</b>
suk	Sukuma	<b>suk</b>
sux	Sumerian	<b>sux</b>
sun	Sundanese	<b>sun</b>
sus	Susu	<b>sus</b>

swa	Swahili	<b>swa</b>
ssw	Swati	<b>ssw</b>
swe	Swedish	<b>swe</b>
gsw	Swiss German; Alemannic; Alsatian	<b>gsw</b>
syr	Syriac	<b>syr</b>
tgl	Tagalog	<b>tgl</b>
tah	Tahitian	<b>tah</b>
tai	Tai languages	<b>tai</b>
tgk	Tajik	<b>tgk</b>
tmh	Tamashek	<b>tmh</b>
tam	Tamil	<b>tam</b>
tat	Tatar	<b>tat</b>
tel	Telugu	<b>tel</b>
ter	Tereno	<b>ter</b>
tet	Tetum	<b>tet</b>
tha	Thai	<b>tha</b>
tib	Tibetan	<b>tib</b>
tig	Tigre	<b>tig</b>
tir	Tigrinya	<b>tir</b>
tem	Timne	<b>tem</b>
tiv	Tiv	<b>tiv</b>
tli	Tlingit	<b>tli</b>
tpi	Tok Pisin	<b>tpi</b>
tkl	Tokelau	<b>tkl</b>
tog	Tonga (Nyasa)	<b>tog</b>
ton	Tonga (Tonga Islands)	<b>ton</b>
tsi	Tsimshian	<b>tsi</b>
tso	Tsonga	<b>tso</b>
tsn	Tswana	<b>tsn</b>
tum	Tumbuka	<b>tum</b>
tup	Tupi languages	<b>tup</b>
tur	Turkish	<b>tur</b>
ota	Turkish, Ottoman (1500-1928)	<b>ota</b>
tuk	Turkmen	<b>tuk</b>
tvl	Tuvalu	<b>tvl</b>
tyv	Tuvinian	<b>tyv</b>
twi	Twi	<b>twi</b>
udm	Udmurt	<b>udm</b>
uga	Ugaritic	<b>uga</b>
uig	Uighur; Uyghur	<b>uig</b>
ukr	Ukrainian	<b>ukr</b>
umb	Umbundu	<b>umb</b>

mis	Uncoded languages	<b>mis</b>
und	Undetermined	<b>und</b>
hsb	Upper Sorbian	<b>hsb</b>
urd	Urdu	<b>urd</b>
uzb	Uzbek	<b>uzb</b>
vai	Vai	<b>vai</b>
ven	Venda	<b>ven</b>
vie	Vietnamese	<b>vie</b>
vol	Volapük	<b>vol</b>
vot	Votic	<b>vot</b>
wak	Wakashan languages	<b>wak</b>
wln	Walloon	<b>wln</b>
war	Waray	<b>war</b>
was	Washo	<b>was</b>
wel	Welsh	<b>wel</b>
fry	Western Frisian	<b>fry</b>
wal	Wolaitta; Wolaytta	<b>wal</b>
wol	Wolof	<b>wol</b>
xho	Xhosa	<b>xho</b>
sah	Yakut	<b>sah</b>
yao	Yao	<b>yao</b>
yap	Yapese	<b>yap</b>
yid	Yiddish	<b>yid</b>
yor	Yoruba	<b>yor</b>
ypk	Yupik languages	<b>ypk</b>
znd	Zande languages	<b>znd</b>
zap	Zapotec	<b>zap</b>
zza	Zaza; Dimili; Dimli; Kirdki; Kirmanjki; Zazaki	<b>zza</b>
zen	Zenaga	<b>zen</b>
zha	Zhuang; Chuang	<b>zha</b>
zul	Zulu	<b>zul</b>
zun	Zuni	<b>zun</b>