Department of Health Care Services Client and Service Information System (CSI) Data Dictionary

Version 2.10

January 2023

Contents

Introduction

Welfare Institutions Code (WIC) §5610 requires County/City/Mental Health Managed Care Plans (MHMCP, formerly Mental Health Plans) to report data to California Department of Health Care Service (DHCS) for nonduplicative client-based information including all information necessary to meet federal Medicaid reporting requirements, as well as any other state requirements established by law. The current Client and Service Information (CSI) system began July 1, 1998 and replaced the CDS (Client Discharge System). The CSI system collects data pertaining to clients of mental health services for MHMCPs. All persons served in treatment programs must be reported to the CSI system. This includes both Medi-Cal and non-Medi-Cal clients, and persons served by the private practitioners that were formerly in the Fee-For-Service (FFS) system. The CSI system contains the information to meet state and federal reporting requirements for client based information regarding persons served by MHMCPs. MHMCPs send a CSI submission file to DHCS monthly and are required to submit data no later than 60 days after the end of the month in which the services were provided.

History of Revisions

Date	Description
July 1998	Client and Service Information replaced the Client Discharge System.
July 2006	Race and Ethnicity fields revised; evidence-based practice fields added.
October 2015	Diagnosis changed from International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9) fields to 10th revision, (ICD-10) fields; This changed lead to diagnosis fields being re-purposed and others removed. Diagnosis codes were changed from non-fatal to fatal errors.
November 2021	Assessment records added to CSI & parts of dictionary merged into a single document.
August 2022	Revised list of valid codes for Principal & Secondary Mental Health Diagnoses; updated definition of assessment; added Peer Support Services to Mode 15 Service Function table.
January 2023	Revised Peer Support Services to Service Function “20” and Linkage (TCM)/Brokerage to “01-05, 08” under Mode 15.

Document Organization

This data dictionary contains information designed to inform the submission of records to the CSI system managed by the DHCS. Submission entities are the MHMCP. The MHMCPs are also referred to as ‘Local Mental Health’ and sometimes as ‘county’ throughout this document.

The main body of this document is dedicated to describing all of the variables included in the CSI submission file. **Appendices 1-17** provide further detail for specific variable codes, and are referenced appropriately on the pages for each respective variable. **Appendices A-F** provide further supplemental information and tips for reporting, as summarized here in this section.

A basic principle of the CSI system is that it reflects both Medi-Cal and non-Medi-Cal clients, and services provided in the MHMCP. Appendix F1: CSI Technical Supplement F - Reporting Tip 1 further describes the information about the clients, services and providers that must be reported to CSI. The MHMCP is responsible for submitting all records of service provided, even for those persons for which the MHMCP may not have fiscal responsibility. Thus, Appendix F4: CSI Technical Supplement F - Reporting Tip 4 provides further information about how to report as a submitting county on behalf of fiscally responsible counties.

Each month, the MHMCPs submit a CSI Submittal File to DHCS, which must be zipped and encrypted and follow specific naming conventions, further detailed in Appendix G: CSI Technical Supplement G - Naming Convention.

There are six types of record formats which are submitted in a CSI submission file. One is a Control record, and five are transaction records: Client, Service, Periodic, Assessment, and Key Change records. Each of these types of records have a specific format definition in the submission file, which is described in Appendix A: CSI Technical Supplement A – Record Layouts. Also described in this appendix is a seventh type of record from a return file, the Error File. The Error Record is a record which is provided back to the MHMCPs in an Error File, in cases in which one or more submission records resulted in fatal or non-fatal errors during processing of the record. The full list of possible types of errors are listed in Appendix 15: Error Codes and Error Messages with further information available in Appendix E: CSI Technical Supplement E - Edit Criteria.

There are eight type of variables described in this document, indicated by the leading letter of the variable. These are briefly summarized in the Types of Variables table in this section, and more detailed information can be found in Appendix B: CSI Technical Supplement B - Record Descriptions.

The five types of transactions (Client, Service, Periodic, Assessment, and Key Change) are further described in Appendix C: CSI Technical Supplement C - Transaction Processing with examples in Appendix D: CSI Technical supplement D - Transaction Examples.

For service records, specific tips for reporting 24 hour mode (Mode 05) of service records are located in Appendix F2: CSI Technical Supplement F - Reporting Tip 2. Specific information about reporting diagnosis codes (ICD-10) for services received after 09/30/2015 is identified by variables S-09.0, S-10.0, and S-11.0 and further detailed in Appendix 12: Diagnosis Reference Tables. Alternatively, specific information about reporting diagnosis codes (ICD-9)

for services between 07/01/2006 and 09/30/2015 is identified by variables S-28.0 – S-33.0, and S-35.0 – S-36.0 and further detailed in Appendix F3: CSI Technical Supplement F - Reporting Tip 3. For assessment records, specific tips for reporting are detailed in Appendix F5: CSI Technical Supplement F - Reporting Tip 5.

See Appendix H: Frequently Asked Questions (FAQs) for frequent questions and answers.

Types of Variables

Letter	Name	Description	Found In
H	Header	Four fields describing the record and identifying it as one of the six types of submission records: Control, Client, Service, Periodic, Assessment, and Key Change.	Required in every submission record
X	Control	The Control Record describes the CSI transaction file and contains counters that the CSI update process will compare against the number of records read to verify that all records have been processed.	There must be at least one Control record on the file for each submitting MHMCP
C	Client	The information in the Client Record uniquely describes the client receiving service. It is reported once, at the first contact with each county, and may be corrected as needed.	Required for each client record
S	Service	The information in the Service Record describes the service delivered to the client; that is, the type of service, as well as, where and when the service is provided. It is reported for each service. There are small differences in the type of information reported for the various types of services; for example, 24-hour mode of service, outpatient, etc.	Required for each service record
P	Periodic	A Periodic record describes the current education, employment, conservatorship/court status, living arrangement and caregiver status for a person. The information in the Periodic Record is used to measure the effectiveness of services. It is reported at admission to county mental health, annually thereafter, and at formal discharge from county mental health.	Required for each periodic record
A	Assessment	This record tracks a person's initial encounters to establish eligibility, first contact request for services, subsequent appointment offer dates, assessment start and end dates, and treatment appointment first offer date.	Required for each assessment record
K	Key Change	The Key Change Record is used to: 1) change a County Client Number (CCN); 2) change Service and Periodic Records on the CSI Master database from one or more CCN(s) to a different CCN; or 3) merge two or more CCNs on the CSI Master database into one CCN.	Required to change or merge county client numbers (CCNs)

Letter	Name	Description	Found In
E	Error Record	There are two types of error records: • Fatal errors will prevent the updating of the Master database. The transaction record will be used to build an error record that will be written to the error file and returned to the county for correction. • Non-fatal errors will allow the updating of the Master database with the exception of fields in error, which will be left blank on the Master database. The transaction record will be used to build an error record that will be written to the error file and returned to the county for correction.	The error record is contained in an Error File returned from CSI after submission of records

H-01.0 County/City/Mental Health Plan (MHP) Submitting Record (Submitting County Code)

Purpose:

Identifies the County/City/Mental Health Plan submitting the record to the Department of Health Care Services. This code will be the same on all records submitted by a County/City/Mental Health Plan.

Field Description:

Type:	Character
Byte(s):	2
Format:	XX
Required On:	All Records
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 6: Valid County/City/Health Plan Codes.

Comments:

Alpha codes will be used for entities other than counties acting as the Mental Health Plan (MHP). If the entity serves as the Mental Health Plan (MHP) for more than a single county, a unique code will be assigned for each county.

For information about this and other data elements containing a County Code, see Appendix F4: CSI Technical Supplement F - Reporting Tip 4.

User / Usage Information:

As a Header Field, this data element must be reported in every record.

This is one of several data elements needed for record identification, error corrections, and linkage to the County Cost Reports. It is a part of the CLIENT KEY.

For more information about the CLIENT KEY, see Appendix 16: Unique Keys for Records.

H-02.0 County Client Number (CCN)

Purpose:

Identifies the identification number by which the client is known by a particular agency or institution.

Field Description:

Type:	Character
Byte(s):	9
Format:	XXXXXXXXX Right justify, zero fill
Required On:	All Records (Please see Comments Section below)
Source:	Local Mental Health

Valid Codes:

- If a Control Record, then this nine-digit field must be nine spaces.
- For a Header Record, this nine-digit field must be the actual county client number.

Comments:

A CCN is required for all records with the exception below for Assessment Records:

- A CCN is not required until a client has an Assessment Start Date.
- For Assessment Records without an Assessment Start Date, this field can be filled with zeros.
- Once an Assessment Record has an Assessment Start Date, a 9 character CCN must be entered for the client although a CCN can be entered at any time in the Assessment Record.

User / Usage Information:

As a Header Field, this data element must be reported in every record, even when all zeros. For the Assessment Record, once an Assessment Start Date is established the client is assigned the CCN. The CCN is one of several data elements needed for record identification and error corrections. It is a part of the CLIENT KEY.

For more information about the CLIENT KEY, see Appendix 16: Unique Keys for Records.

H-03.0 Record Type

Purpose:

Identifies the type of record reported, i.e., Client, Key Change, Service, Periodic, Control, or Assessment Record.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Records
Source:	Local Mental Health

Valid Codes:

C = Client Record
K = Key Change Record
P = Periodic Record
S = Service Record
X = Control Record
A = Assessment Record

Comments:

None.

User / Usage Information:

As a Header Field, this data element must be reported in every record.

H-04.0 Transaction Code

Purpose:

Identifies the record as an Add/Replace, Delete or Key Change transaction.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Records
Source:	Local Mental Health

Valid Codes:

If a Transaction Record, then:

D = Delete
K = Change Client Number
' ' (enter one space) = Add/Replace

If a Control Record, then this field must be one space.

Comments:

None.

User / Usage Information:

As a Header Field, this data element must be reported in every record.

CSI does not currently allow Key Change transactions to Assessment Records.

X-01.0 Production or Test Indicator

Purpose:

Identifies the type of data, i.e. Production or Test.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	Control Record
Source:	Local Mental Health

Valid Codes:

P = Production

T = Test

Comments:

None.

User / Usage Information:

This data element indicates how each County Submission File is to be processed.

X-02.0 From Report Period

Purpose:

Identifies the “first” year and month of the Report Period for the County Submission File.

Field Description:

Type:	Numeric
Byte(s):	6
Format:	YYYYMM
Required On:	Control Record
Source:	Local Mental Health

Valid Codes:

>=199801

CONDITIONS:

1. YYYY must be greater than 1997.
2. The From Report Period must not duplicate any previously submitted and accepted Report Period.
3. The From Report Period must be equal to or later than the Through Report Period.
4. The numeric form for the months from 1 to 9 must have a zero as the first digit.
5. Do not use special characters such as slashes, commas, or hyphens.

Refer to Appendix 1: Report Period Formatting (Year and Month).

Comments:

For monthly file submissions use the same year and month:

- For this field: X-02.0 From Report Period.
- For the next field: X-03.0 Through Report Period.

User / Usage Information:

This is one of the three data elements in the Control Record used to uniquely identify each County Submission File.

X-03.0 Through Report Period

Purpose:

Identifies the “last” year and month of the Report Period for the County Submission File.

Field Description:

Type:	Numeric
Byte(s):	6
Format:	YYYYMM
Required On:	Control Record
Source:	Local Mental Health

Valid Codes:

>=199801

CONDITIONS:

1. YYYY must be greater than 1997.
2. The Through Report Period must not duplicate any previously submitted and accepted Report Period.
3. The Through Report Period must be equal to or later than the From Report Period.
4. The numeric form for the months from 1 to 9 must have a zero as the first digit.
5. Do not use special characters such as slashes, commas, or hyphens.

Refer to Appendix 1: Report Period Formatting (Year and Month).

Comments:

For monthly file submissions use the same year and month:

- For this field: X-03.0 Through Report Period.
- For the prior field: X-02.0 From Report Period.

User / Usage Information:

This is one of the three data elements in the Control Record used to uniquely identify each County Submission File.

X-04.0 Creation Date

Purpose:

Identifies the date the Submission File was created by the County/City/Mental Health Plan.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Control Record
Source:	Local Mental Health

Valid Codes:

>=19980101

CONDITIONS:

1. YYYY must be greater than 1997.
2. The numeric form for the months and days from 1 to 9 must have a zero as the first digit.
3. Do not use special characters such as slashes, commas, or hyphens.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

The Creation Date must be prior to or equal to the Current Date.

User / Usage Information:

This is one of the three data elements in the Control Record used to uniquely identify each County Submission File.

X-05.0 Key Change Record Count

Purpose:

Identifies the number of Key Change Records within this Submission File*.

Field Description:

Type:	Numeric
Byte(s):	7
Format:	XXXXXXX Right justify, zero fill
Required On:	Control Record
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 4: Numeric Formatting.

Comments:

None.

User / Usage Information:

This data element is used to confirm that all Key Change Records were received for processing.

*CSI does not currently allow Key Change transactions to Assessment Records.

X-06.0 Client Record Count

Purpose:

Identifies the number of Client Records within this Submission File.

Field Description:

Type:	Numeric
Byte(s):	7
Format:	XXXXXXX Right justify, zero fill
Required On:	Control Record
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 4: Numeric Formatting.

Comments:

None.

User / Usage Information:

This data element is used to confirm that all Client Records were received for processing.

X-07.0 Service Record Count

Purpose:

Identifies the number of Service Records within this Submission File.

Field Description:

Type:	Numeric
Byte(s):	7
Format:	XXXXXXX Right justify, zero fill
Required On:	Control Record
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 4: Numeric Formatting.

Comments:

None.

User / Usage Information:

This data element is used to confirm that all Service Records were received for processing.

X-08.0 Periodic Record Count

Purpose:

Identifies the number of Periodic Records within this Submission File.

Field Description:

Type:	Numeric
Byte(s):	7
Format:	XXXXXXX Right justify, zero fill
Required On:	Control Record
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 4: Numeric Formatting.

Comments:

None.

User / Usage Information:

This data element is used to confirm that all Periodic Records were received for processing.

X-09.0 Assessment Record Count

Purpose:

Identifies the number of Assessment Records within this Submission File.

Field Description:

Type:	Numeric
Byte(s):	7
Format:	XXXXXXX Right justify, zero fill
Required On:	Control Record
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 4: Numeric Formatting.

Comments:

None.

User / Usage Information:

This data element is used to confirm that all Assessment Records were received for processing.

C-01.0 Birth Name

Purpose:

Identifies the name of the client as it appears on the birth certificate as reported by the client.

Field Description:

Type:	Character
Byte(s):	53 total characters: • First: 15 characters • Middle: 15 characters • Last: 20 characters • Suffix: 3 characters = 53 total
Format:	FFFFFFFFFFFFFFF MMMMMMMMMMMMMMM LLLLLLLLLLLLLLLLLLL SSS Left justify each subfield with trailing spaces
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 5: Multi-Part Field Formatting.

Comments:

- Use UPPER CASE only. If mixed or lower case is used, DHCS will make it all UPPER CASE.
- Embedded hyphens and apostrophes are acceptable if comprised as part of a name.
- Do not use commas or periods. If commas or periods are used, they will be removed by DHCS.
- Appellations such as Sr., Jr., III, etc. are acceptable in the suffix field.
- Do NOT include titles such as MD, PhD, etc. in the suffix field.

See Appendix 17: Core/Confirmatory Data Elements.

User / Usage Information:

This data element is a DHCS core data element.

C-02.0 Mother's First Name

Purpose:

Identifies the first name of the client's mother.

Field Description:

Type:	Character
Byte(s):	15
Format:	FFFFFFFFFFFFFFF Left justify with trailing spaces
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 3: Character Formatting.

Comments:

- Use UPPER CASE only. If mixed or lower case is used, DHCS will make it all UPPER CASE.
- Embedded hyphens and apostrophes are acceptable if comprised as part of a name.
- Do not use commas or periods. If commas or periods are used, they will be removed by DHCS.
- Appellations such as Sr., Jr., III, etc. are acceptable in the suffix field.
- Do NOT include titles such as MD, PhD, etc. in the suffix field.
- Report UNKNOWN in this field if Mother's First Name is unavailable or unknown.

See Appendix 17: Core/Confirmatory Data Elements.

User / Usage Information:

This data element is a DHCS core data element.

C-03.0 Date of Birth

Purpose:

Identifies the date on which the client was born.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

When the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth must be reported. If only the age is known, report the estimated year of birth and zeros for the month and day. If the year and month of birth are known, and the exact day is not, report the year and month only, and zeros for the day.

The birth date must be prior to or equal to the current date. If subfield MM or DD is unknown, zeros must be entered in that particular subfield.

See Appendix 17: Core/Confirmatory Data Elements.

User / Usage Information:

This data element is a DHCS core data element. This data element is used to compute age, and to analyze utilization patterns.

C-04.0 Place of Birth

Purpose:

Identifies the place in which the client was born:

1. County if in California
2. State if in USA
3. Country

Field Description:

Type:	Character
Byte(s):	6 total characters: • County: 2 • State: 2 • Country: 2 = 6 total
Format:	CCSSXX
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

County (CC):

00	=	Not a California County
99	=	Unknown County
01 – 58	=	County Code (Refer to Appendix 7)

State (SS):

00	=	Not a U.S. State
UN	=	Unknown State
CA	=	California
XX	=	Other U.S. State 2-Character State Abbreviation Code (Refer to Appendix 8)

Country (XX):

00	=	Country Not Listed
99	=	Unknown Country
US	=	United States
XX	=	Other 2-Character Country Abbreviation Code (Refer to Appendix 9)

Examples: (Described further in comments based on example number.)

1) 01CAUS = Alameda County in California, United States.
2) 99CAUS = Unknown County in California, United States.
3) 00TXUS = Texas, United States.
4) 00UNUS = United States with Unknown State.
5) 0000MX = Mexico.
6) 000000 = Not in United States and Country is Not Listed in Appendix 9.
7) 000099 = Birth Place Unknown.

Comments:

The field consists of three separate subfields: Birth County, Birth State, Birth Country. All subfields must be completed.

CLIENT BORN IN CALIFORNIA:

(1) If county of birth is known, enter the two digit County Code listed in the Valid California County Codes section for the Birth County, CA for the Birth State, and US for the Birth Country.

(1) If the county of birth is not known but the city or town of birth in California is known, identify the city or town of birth and enter the corresponding two-digit County Code.

(2) If county of birth is not known, enter 99 for the Birth County, CA for the Birth State, and US for the Birth Country

CLIENT BORN OUTSIDE OF CALIFORNIA BUT INSIDE THE UNITED STATES:

(3) If state of birth is known, enter 00 for the Birth County, the two character alphabetic code listed in the Valid State Codes section (which is the U.S. Postal Service code for states) for the Birth State, and US for the Birth Country.

(4) If state of birth is not known, enter 00 for the Birth County, UN for the Birth State, and US for the Birth Country.

CLIENT BORN OUTSIDE OF THE UNITED STATES:

(5) If the country of birth is known, enter 00 for the Birth County, 00 for the Birth State, and the two character code listed in the Valid Country Codes section (which is the FIPS 10-4 code set) for the Birth Country.

(6) If the country of birth is known but not listed, enter 00 for the Birth County, 00 for the Birth State, and 00 for the Birth Country.

(7) If the country of birth is not known, enter 00 for the Birth County, 00 for the Birth State, and 99 for the Birth Country.

NOTES:

Puerto Rico, the Virgin Islands, Guam, etc. are coded as countries, not as states of the US.

See Appendix 17: Core/Confirmatory Data Elements.

User / Usage Information:

This data element is a DHCS core data element.

C-05.0 Gender

Purpose:

Identifies the gender of the client.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

F	=	Female
M	=	Male
O	=	Other
U	=	Unknown / Not Reported

Comments:

Other includes gender changes, undetermined gender, and persons with congenital abnormalities which obscure gender identification.

Unknown / Not Reported indicates that the gender of the client was not available.

User / Usage Information:

This data element is a DHCS core data element.

C-07.0 Primary Language

Purpose:

Identifies the primary language utilized by the client.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 10: Valid Language Codes.

Comments:

None.

User / Usage Information:

This data element is needed to summarize ethnicity data for cultural competency issues.

C-08.0 Preferred Language

Purpose:

Identifies the language in which the client would prefer to receive Mental Health Service (MHS).

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 10: Valid Language Codes.

Comments:

None.

User / Usage Information:

This data element is needed to summarize ethnicity data for cultural competency issues.

C-09.0 Ethnicity

Purpose:

Identifies whether or not the client is of Hispanic or Latino ethnicity.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

Y = Yes

N = No

U = Unknown/Not Reported

Comments:

Is the client of Hispanic or Latino ethnicity?

User / Usage Information:

This data element is needed to summarize ethnicity data for cultural competency issues.

C-10.0 Race

Purpose:

Identifies the race(s) of the client.

Field Description:

Type:	Character
Byte(s):	5
Format:	XXXXX Left justify, no embedded spaces
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 11: Valid Race Codes.

Comments:

- This is one field.
- You may enter up to 5 race codes for a total of 5 bytes.

Please note that you will need to right fill the spaces to ensure that 5 bytes are utilized. For example, if a client has two race codes, you will need to enter the 2 codes and right fill the remaining 3 bytes with spaces.

User / Usage Information:

This data element is needed to summarize racial data for cultural competency issues and will be used to compare the race groups in the county population to the race groups in the client population. It will also be used to analyze utilization patterns by the different race groups across the state and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

C-11.0 Data Infrastructure Grant Indicator

Purpose:

Identifies whether or not the Client Record contains Data Infrastructure Grant (DIG) data.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Client Records
Source:	Local Mental Health

Valid Codes:

0 = Client Record does not contain DIG data

1 = Client Record does contain DIG data

Comments:

Beginning with CSI data for the July 2006 reporting period, all Client Records reported to CSI must contain either a:

- 1 in the DIG Indicator field to indicate a new Client Record containing DIG data.

or

- 0 in the DIG Indicator field to indicate an existing Client Record that does not yet contain DIG data.

For example: all new Client Records (i.e., Client Records reported to CSI in the July 2006 reporting period) must contain a 1 in the DIG Indicator and contain valid data in the DIG data fields.

NOTES:

- When correcting or resubmitting an existing CSI Client Record that does not contain DIG data, then the DIG Indicator field must contain a 0 and spaces in the DIG data fields.
- However, to report an existing Client Record that contains DIG data, the DIG Indicator field must contain a 1 and valid data in the DIG data fields.
- Counties are encouraged to collect and report DIG data for each Client Record until all of the county's CSI Client Records, for both new and existing clients, contain valid data in the DIG data fields.

User / Usage Information:

This data element is needed to identify whether or not the Client Record contains Data Infrastructure Grant data.

S-01.0 Record Reference Number (RRN)

Purpose:

Identifies the unique number assigned to any record in order to locate and retrieve the record.

Field Description:

Type:	Character
Byte(s):	23
Format:	XXXXXXXXXXXXXXXXXXXXXXX Right justify, zero fill, no embedded spaces
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

There must be no embedded spaces. Otherwise, all values accepted.

Comments:

None.

User / Usage Information:

This is one of several data elements needed for record identification and error corrections.

S-02.0 Current Legal Name / Beneficiary Name

Purpose:

Identifies the current legal name of the client.

Field Description:

Type:	Character
Byte(s):	53 total characters: • First: 15 characters • Middle: 15 characters • Last: 20 characters • Suffix: 3 characters = 53 total
Format:	FFFFFFFFFFFFFFF MMMMMMMMMMMMMMM LLLLLLLLLLLLLLLLLLL SSS Left justify each subfield with trailing spaces
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 5: Multi-Part Field Formatting.

Comments:

- Use UPPER CASE only. If mixed or lower case is used, DHCS will make it all UPPER CASE.
- Embedded hyphens and apostrophes are acceptable if comprised as part of a name.
- Do not use commas or periods. If commas or periods are used, they will be removed by DHCS.
- Appellations such as Sr., Jr., III, etc. are acceptable in the suffix field.

See Appendix 17: Core/Confirmatory Data Elements.

User / Usage Information:

This data element is a DHCS confirmatory data element.

S-03.0 Social Security Number

Purpose:

Identifies the Social Security Number of the client.

Field Description:

Type:	Character
Byte(s):	9
Format:	XXXXXXXXX
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

A Valid 9-Digit Social Security Number

000000000 = Unknown Social Security Number

12345678P = Pseudo-Social Security Number

Comments:

- Do NOT use any spaces or special characters such as hyphens.
- Do not allow all 1s, all 2s, etc., 123456789, and similar artificial numbers.
- If the Social Security Code is unknown, enter 000000000.
- Pseudo-Social Security Numbers are accepted. (A pseudo-Social Security Number is defined as eight number digits followed by a P. For example: 98545843P).
- This data element must be reported if reporting an IMD service, which is a 24-Hour Service (Mode 05) and Service Function in the range of 35-39.

See Appendix 17: Core/Confirmatory Data Elements.

User / Usage Information:

This data element is a DHCS confirmatory data element. This data element is to be used by DHCS to match to the DHCS Medi-Cal Eligibility Data System (MEDS) Monthly Extract File (MMEF) to obtain Medi-Cal eligibility information.

S-05.0 Mode of Service

Purpose:

Identifies, in broad terms, the category of service [i.e., 24-Hour Service (Mode 05), Day Service (Mode 10), and/or Outpatient Service (Mode 15)].

Field Description:

Type:	Character
Byte(s):	2
Format:	XX
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

05 = 24-Hour Service (Mode 05)

10 = Day Service (Mode 10)

15 = Outpatient Service (Mode 15)

The coding scheme follows the County Cost Report definitions.

DEFINITIONS:

24-Hour Service (Mode 05) =

Services designed to provide a therapeutic environment of care and treatment within a residential setting. Depending on the severity of mental disorder, and the need for related medical care, treatment would be provided in one of a variety of settings.

Day Service (Mode 10) =

Services which provide a range of therapeutic and rehabilitative programs as an alternative to inpatient care.

Outpatient Service (Mode 15) =

Services designed to provide short-term or sustained therapeutic intervention for persons experiencing acute and/or ongoing psychiatric distress.

Comments:

For information about reporting clients, services, and providers, see Appendix F1: CSI Technical Supplement F: Reporting Tip 1.

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

For more details on these definitions, see the California Code of Regulations, Title 9, Chapter 11 and the County Cost Report documentation.

User / Usage Information:

This data element is needed to identify the categories of services being provided as well as for linking to County Cost Reports.

S-06.0 Service Function

Purpose:

Identifies the specific type of service received by the client within 24-Hour Service (Mode 05), Day Service (Mode 10), and/or Outpatient Service (Mode 15).

Field Description:

Type:	Character
Byte(s):	2
Format:	XX
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

The coding scheme follows the County Cost Report definitions.

DEFINITIONS:

24-Hour Service (Mode 05):

10-18	=	Hospital Inpatient
19	=	Hospital Administrative Day
20-29	=	Psychiatric Health Facility (PHF)
30-34	=	SNF Intensive
35	=	IMD Basic (no Patch)
36-39	=	IMD With Patch
40-49	=	Adult Crisis Residential
50-59	=	Jail Inpatient
60-64	=	Residential, Other
65-79	=	Adult Residential
80-84	=	Semi-Supervised Living
85-89	=	Independent Living
90-94	=	Mental Health Rehab Center
95-98	=	Therapeutic Foster Care

Outpatient Service (Mode 15):

01-05, 08	=	Linkage (TCM)/Brokerage
06	=	Child and Family Team (CFT)
07	=	Intensive Care Coordination (ICC)
10-18	=	Collateral
19	=	Professional Inpatient Visit - Collateral
20	=	Peer Support Services
30-38	=	Mental Health Services (MHS)
39	=	Professional Inpatient Visit - MHS
40-48	=	Mental Health Services (MHS)
49	=	Professional Inpatient Visit - MHS
50-55	=	Mental Health Services (MHS)
56	=	Child and Family Team (CFT) Assessment
57	=	Intensive Home Based Services
58	=	Therapeutic Behavioral Services (TBS)
59	=	Professional Inpatient Visit - MHS
60-68	=	Medication Support (MS)
69	=	Professional Inpatient Visit - MS
70-78	=	Crisis Intervention (CI)
79	=	Professional Inpatient Visit - CI

Day Service (Mode 10):

20-24	=	Crisis Stabilization - Emergency Room
25-29	=	Crisis Stabilization - Urgent Care
30-39	=	Vocational Services
40-49	=	Socialization
60-69	=	SNF Augmentation
81-84	=	Day Treatment Intensive - Half Day
85-89	=	Day Treatment Intensive - Full Day
91-94	=	Day Rehabilitation - Half Day
95-99	=	Day Rehabilitation - Full Day

See Appendix 13: Service Function Definitions

Comments:

For information about reporting clients, services, and providers, see Appendix F1: CSI Technical Supplement F: Reporting Tip 1.

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element is needed for detailed identification of the types of services being given as well as for linking to County Cost Reports.

S-07.0 Units of Service

Purpose:

Identifies the quantity of services provided.

Field Description:

Type:	Numeric
Byte(s):	2
Format:	XX Right justify, zero fill
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

00 - 31

Types of Unit of Service Measurements:

1. Enter number of days for:
    - 24-Hour Service (Mode 05) of service.
    - Day Service (Mode 10) of service except for Crisis Stabilization Day.
2. Enter each occurrence of the event for:
    - Crisis Stabilization of Day Service (Mode 10).
3. Each client or support person contact for:
    - Outpatient Service (Mode 15).

Enter 00 for:

- Outpatient Service (Mode 15) whenever there is no contact with a client or support person.
- 24-Hour Service (Mode 05) when the From/Entry Date and Through/Exit Date are equal and the From Entry/ and Through/Exit Dates are less than or equal to the Discharge Date and the Admission Date is prior to the From/Entry Date, Through/Exit Date, and Discharge Date.
- All other services must be numeric and greater than zero.

Enter 01-31 for:

- 24-Hour Service (Mode 05); must be appropriate for the length during the month including a leap year.

Enter units of time for:

- Day Treatment Intensive (Mode 10).
- Day Rehabilitation (Mode 10).

Note: For Day Treatment Intensive and Day Rehabilitation, units of service must equal units of time.

Comments:

Must be numeric.

Definitions and the counting of units of service will be consistent with the California Code of Regulations, Title 9, Chapter 11 and the County Cost Report documentation.

Units of service must be greater than zero if the Mode of Service is 24-Hour Service (Mode 05) or Day Service (Mode 10) except for 24-Hour Service (Mode 05) when the From/Entry Date and the Through/Exit Date are equal and the From/Entry and Through/Exit Dates are prior to or equal to the Discharge Date and the Admission Date is prior to the From/Entry Date, Through/Exit Date, and Discharge Date. Units of service must be zero filled if the Mode of Service is Outpatient and there is no contact with a client or support person.

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element is needed to capture statistics on the amount of services provided to each client. This will also be used to calculate units of service by diagnosis, age, etc.

S-08.0 Units of Time

Purpose:

Identifies the amount of time for selected services in Day Service (Mode 10) and all Outpatient Service (Mode 15).

Field Description:

Type:	Numeric
Byte(s):	4
Format:	XXXX Right justify, zero fill
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

0000 - 1440

Enter 0000 for:

- 24-Hour Service (Mode 05, all Service Functions).
- SNF Augmentation (Mode 10, Service Functions 60-69).
- All other services must be numeric and greater than zero.

CONDITIONS:

- For Day Treatment Intensive and Day Rehabilitation, units of time must equal units of service.
- The maximum value must not exceed 1440 minutes.

Definitions and the counting of units of time will be consistent with the California Code of Regulations, Title 9, Chapter 11 and the County Cost Report documentation.

Refer to Appendix 4: Numeric Formatting.

Comments:

Must be numeric. A unit of time is a measure of professional input into services (or client time for Mode 10 Day Services).

Type of Service	Unit of Time Measurement
24-Hour Service (Mode 05) & SNF Augmentation:	Zero fill
Crisis Stabilization:	Hourly increments
Vocational Services Socialization:	4-Hour increments
Day Treatment Intensive Day Rehabilitation:	Half day or Full day
Outpatient Service (Mode 15):	Minutes

Units of Time must be greater than zero if the Mode of Service is Outpatient Service (Mode 15) and there is contact with a client or support person.

User / Usage Information:

This data element is needed as a base measure of professional time expended with or on behalf of a client or amount of time a client spends in an activity.

S-09.0 Principal Mental Health Diagnosis

Purpose:

Identifies the principal Mental Health diagnosis, which is the primary focus of attention or treatment for the Mental Health Service (MHS).

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces or decimals, no spaces filling
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

All ICD-10 codes are accepted.

9999999 = Unknown/Deferred Diagnosis

0000000 = No Diagnosis

CONDITIONS:

- Enter all letters and/or numbers of the ICD-10 code. Do not enter a decimal point when entering the code.
- For a detailed description of valid codes refer to Appendix 12.
- Enter 0000000 if the client does not have a Mental Health diagnosis.
- Enter 9999999 in the principal Mental Health diagnosis field if the Mental Health diagnosis unknown or deferred.

Comments:

International Classification of Diseases 10th Edition (ICD-10) code is required. Enter all letters and/or numbers of the ICD-10 code. Do not enter a decimal point when entering the code.

For examples of reporting the diagnosis codes, see Appendix 12: Diagnosis Reference Tables.

User / Usage Information:

This data element is needed to determine the frequency of clients with multiple Mental Health diagnoses and to analyze the length of treatment for clients with multiple diagnoses.

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Service (CMHS).

S-10.0 Secondary Mental Health Diagnosis

Purpose:

Identifies the secondary Mental Health diagnosis, which is the secondary focus of attention or treatment for the Mental Health Service (MHS).

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces or decimals, no spaces filling
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

All ICD-10 codes are accepted.

9999999 = Unknown/Deferred Diagnosis

0000000 = No Diagnosis

CONDITIONS:

- Enter all letters and/or numbers of the ICD-10 code. Do not enter a decimal point when entering the code.
- For a detailed description of valid codes refer to Appendix 12.
- Enter 0000000 if there is no secondary Mental Health diagnosis.
- Enter 9999999 in the secondary Mental Health diagnosis field if Mental Health diagnosis unknown or deferred.

Comments:

International Classification of Diseases 10th Edition (ICD-10) code is required.

When a client has more than one Mental Health diagnosis, this is the second most important diagnosis. Enter all letters and/or numbers of the ICD-10 code for the secondary Mental Health diagnosis. Do not enter a decimal point when entering the code.

For examples of reporting the diagnosis codes, see Appendix 12: Diagnosis Reference Tables.

User / Usage Information:

This data element is needed to determine the frequency of clients with multiple Mental Health diagnoses and to analyze the length of treatment for clients with multiple diagnoses.

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Service (CMHS).

S-11.0 Additional Mental or Physical Health Diagnosis

Purpose:

Identifies up to three additional diagnoses which may be mental or physical health, if any.

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces or decimals, no spaces filling; This field occurs three times
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

All ICD-10 codes are accepted.

9999999 = Unknown/Deferred Diagnosis

0000000 = No Diagnosis

CONDITIONS:

- Enter all letters and/or numbers of the ICD-10 code. Do not enter a decimal point when entering the code.
- For a detailed description of valid codes refer to Appendix 12.
- Enter 0000000 if there is no additional mental or physical health diagnosis(es).
- Enter 9999999 if mental or physical health diagnosis(es) are unknown or deferred.

Comments:

International Classification of Diseases 10th Edition (ICD-10) code is required.

When a client has more than two Mental Health diagnoses, the three Additional Mental or Physical Health Diagnosis fields may be used for additional diagnoses. These three fields may also be used to report physical health diagnoses. For each additional diagnosis, enter all letters and/or numbers of the code for the mental (including a substance use or developmental disorder) or physical health diagnosis. Do not enter a decimal point when entering each code.

For examples of reporting the diagnosis codes, see Appendix 12: Diagnosis Reference Tables.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-12.0 Special Population

Purpose:

Identifies any special population services for statistical purposes.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

A = Assisted Outpatient Treatment service(s) (AB 1421)

C = Individualized Education Plan (IEP) required service(s) (AB 3632)

G = Governors Homeless Initiative (GHI) service(s)

N = No special population service(s)

W = Welfare-to-Work plan specified service(s)

Comments:

None.

User / Usage Information:

This data element will be used to determine the number and types of services being provided to specified client groups.

S-13.0 Provider Number

Purpose:

Identifies the organization providing a service. This is the four-digit number assigned by the Department of Health Care Service (DHCS).

Field Description:

Type:	Character
Byte(s):	4
Format:	XXXX
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

The provider number, along with the Mode of Service and Service Function range, must match the codes in the DHCS Provider File.

Comments:

The four-digit provider number assigned to a provider usually consists of the two-digit numeric County Code and a two-digit alphanumeric code.

The codes are assigned in sequence as new providers are added to the CSI System.

- Provider codes of inactive providers will not be re-assigned.
- Active and inactive provider numbers are stored in the DHCS Provider File.

The provider number will allow DHCS IT staff to retrieve the following required data from the DHCS Provider File to report to the Department of Health Care Services:

- Provider Name
- Provider Type Code
- Zip Code of Provider
- County Code of Provider

For information about reporting clients, services, and providers, see Appendix F1: CSI Technical Supplement F - Reporting Tip 1.

User / Usage Information:

This data element is needed to link to the DHCS Provider File and the County Cost Reports.

S-14.0 County/City/Mental Health Plan (MHP) with Fiscal Responsibility for Client

Purpose:

Identifies the County/City/Mental Health Plan (MHP) responsible for directly or indirectly paying for the client's services.

Field Description:

Type:	Character
Byte(s):	2
Format:	XX
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

Refer to Appendix 6: Valid County/City/Health Plan Codes.

Comments:

In most cases, this will be the same as the County/City/Mental Health Plan (MHP) submitting the record (see Field Number H-01.0, COUNTY/CITY/MENTAL HEALTH PLAN (MHP) SUBMITTING RECORD).

In a contract relationship or regional program that involves more than one County/City/Mental Health Plan (MHP) the code for the County/City/Mental Health Plan (MHP) with fiscal responsibility will be reported in this field.

- Alpha codes will be used for entities other than counties acting as the Mental Health Plan (MHP).
- If the entity serves as the Mental Health Plan (MHP) for more than one county, a unique code will be assigned for each county

For information about this and other data elements containing a County Code, see Appendix F4: CSI Technical Supplement F - Reporting Tip 4.

User / Usage Information:

This data element is needed to develop more accurate counts of unduplicated clients receiving services, the range of services offered as well as utilization patterns of services in County/City/Mental Health Plan (MHP)s.

S-15.0 Admission Date

Purpose:

Identifies the date the client was admitted to a 24-Hour Service (Mode 05).

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	All 24-Hour Service (Mode 05) Records
Source:	Local Mental Health

Valid Codes:

Enter the date the client was admitted to a 24-Hour Service (Mode 05), i.e., hospital, long term care facility, independent living, semi-supervised living, residential, etc.

- The Admission Date must always be prior or equal to the date of discharge.
- The Admission Date is required for each service record.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

The Admission Date must be prior or equal to the Discharge Date, the From/Entry Date, or the Through/Exit Date.

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element will be used to determine the number of clients that started treatment in a month, year, or fiscal year-to-date time period. It may also be used to determine the length of stay for 24-Hour Service (Mode 05).

S-16.0 From/Entry Date

Purpose:

Identifies the first date of service, which may be the same as the Admission Date, or it may be the first date of the month if the admission occurred in a prior month. It may also be the date the client returns to the facility after an absence.

When the length of stay crosses over several months, then a record is submitted for each month. If the client is not discharged but leaves and returns to the same facility during the month, then a record is needed for each occurrence.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	All 24-Hour Service (Mode 05) Records
Source:	Local Mental Health

Valid Codes:

>19980630

CONDITIONS:

- The From/Entry Date must be greater than June 30, 1998.
- The From/Entry Date must be equal to or later than the Admission Date.
- The From/Entry Date must be prior or equal to the Through/Exit Date or the Discharge Date.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

The From/Entry Date must always be prior or equal to the Through/Exit Date. When the service record begins and ends on the same day, the From/Entry and Through/Exit dates of service shall be the same. The From/Entry Date must never be later than the Through/Exit Date.

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element will be needed to link services to specific dates for summarizing information on a monthly and/or yearly basis. It is also needed to analyze trends in service delivery on a monthly basis.

This data element will be used to track clients in a Skilled Nursing Facility declared by the federal government to be an Institute for Mental Diseases (IMD) when the clients are out of the IMD facility for Fee-For-Service Medi-Cal reimbursement of medical, professional, and ancillary services.

S-17.0 Through/Exit Date

Purpose:

Identifies the last date a client is in a 24-Hour facility, which may be the same as the Discharge Date, or it may be the last date of the month if the client is staying until the next month. It may also be the date a client leaves the facility for an absence and is not discharged. When the length of stay crosses over several months, then a record is submitted for each month. If the client is not discharged but leaves and returns to the same facility during the month, then a record is needed for each occurrence.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	All 24-Hour Service (Mode 05) Records
Source:	Local Mental Health

Valid Codes:

>19980630

CONDITIONS:

- The Through/Exit Date must be greater than June 30, 1998.
- The Through/Exit Date must be equal to or later than the From/Entry Date or the Admission Date.
- The Through/Exit Date must be equal to or prior to the Discharge Date when there is a Discharge Date.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

The Through/Exit Date must always be the last date a client is in a facility pertaining to the reported record. When the service record begins and ends on the same day, the From/Entry Date and Through/Exit Dates of service shall be the same. The Through/Exit Date must never be prior to the From/Entry Date.

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element will be needed in sequencing a service that occurs over several report months and may also be used to analyze trends in service delivery on a monthly basis.

This data element will be used to track clients in a Skilled Nursing Facility declared by the federal government to be an Institute for Mental Diseases (IMD) when the clients are out of the IMD facility for Fee-For-Service Medi-Cal reimbursement of medical, professional, and ancillary services.

S-18.0 Discharge Date

Purpose:

Identifies the date the client was discharged from a 24-Hour Service (Mode 05).

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	All 24-Hour Service (Mode 05) Records
Source:	Local Mental Health

Valid Codes:

>19980630

Enter the date the client was discharged from a 24-Hour Service (Mode 05, e.g., hospital, long term care facility, independent living, semi-supervised living, residential).

- If the client dies, use the date of death for the Discharge Date.
- If the client has not been discharged at the time the record is reported to DHCS, zero fill this field.
- 00000000 = Client has not been discharged at the time the record is reported to DHCS.

CONDITIONS:

- The Discharge Date must be greater than June 30, 1998.
- The Discharge Date must be equal to or later than the Admission Date, the From/Entry Date, or the Through/Exit Date.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

Do not enter any future or expected dates of discharge.

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element will be used to determine the number of discharges and the length of stay for 24-Hour Service (Mode 05).

S-19.0 Patient Status Code

Purpose:

Indicates the status of the client as of the Through/Exit Date.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All 24-Hour Service (Mode 05) Records Except for Service Functions 80-94
Source:	Local Mental Health

Valid Codes:

A = Still a patient or expected to return
B = Discharged to home, self care, foster care, shelter care
C = Discharged/transferred to Residential/Board and Care (not locked, supervised living, no treatment)
D = Discharged/transferred to Community Residential Treatment (not locked, custodial)
E = Discharged/transferred to Community Treatment Facility (locked, no nursing care)
F = Discharged/transferred to Skilled Nursing Facility/Intermediate Care Facility (unlocked or locked)
G = Discharged/transferred to Acute Care Hospital or Psychiatric Health Facility (PHF)
H = Discharged/transferred to State Hospital
I = Discharged/transferred to Jail
J = Unplanned discharge
K = Expired
L = Other
U = Unknown / Not Reported

Comments:

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element is required by the Department of Health Care Services.

S-20.0 Legal Class – Admission

Purpose:

Identifies the legal class under which the client is admitted to acute 24-Hour Mental Health Service (MHS).

Field Description:

Type:	Character
Byte(s):	2
Format:	XX
Required On:	All Hospital, PHF, and SNF Service Records
Source:	Local Mental Health

Valid Codes:

DEFINITIONS:

(1) Voluntary - A person who voluntarily seeks admission.
(2) Involuntary civil - A person committed for a non-criminal proceeding, whether for purposes of examination and observation or for treatment, either by a physician's certificate, a court proceeding, or by police or associated agencies.
(3) Involuntary criminal - A person committed pursuant to one of the codes in section (3) below.
(9) Other.

CODES:

(1) Voluntary:

1A = Voluntary

(2) Involuntary civil:

2A = 72 Hour Evaluation and Treatment for Adults (W&I Code, Section 5150)
2B = 72 Hour Evaluation and Treatment for Children (W&I Code, Section 5585)
2C = 14 Day Intensive Treatment (W&I Code, Section 5250)
2D = Additional 14 Day Hold (W&I Code, Section 5260)
2E = Additional 30 Day Hold (W&I Code, Section 5270.15)
2F = Additional 180 Day Hold (W&I Code, Section 5300)
2G = Other involuntary civil status

(3) Involuntary criminal - A person committed pursuant to one of the following:

3A = Charges and/or convictions pending (Penal Code, Sections 47.6, 47.8)
3B = Determination of competency to stand trial (Penal Code, Section 1370)

3C = Found “not guilty by reason of insanity” or “guilty but insane” (Penal Code, Section 1026)
3D = Determination of sexual psychopathy and related legal categories
3E = Transferred from correctional facilities (Penal Code, Section 2684)
3F = Other involuntary criminal status

(9) Other

9A = Unknown / Not Reported

Comments:

Report this data element at admission.

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element is needed to produce summary or detailed statistics on the types of clients being treated in local Mental Health (e.g., voluntary, involuntary civil, involuntary criminal). This is particularly important in analyzing the utilization and units of service in 24-Hour care.

S-21.0 Legal Class – Discharge

Purpose:

Identifies the legal class of the client at the time of discharge from acute 24-Hour Mental Health Service (MHS)

Field Description:

Type:	Character
Byte(s):	2
Format:	XX
Required On:	All Hospital, PHF, and SNF Service Records
Source:	Local Mental Health

Valid Codes:

DEFINITIONS:

(1) Voluntary - A person who voluntarily stays in an acute 24-Hour Mental Health Service.

(2) Involuntary civil - A person committed for a non-criminal proceeding, whether for purposes of examination and observation or for treatment, either by a physician's certificate, a court proceeding, or by police or associated agencies.

(3) Involuntary criminal - A person committed pursuant to one of the codes in section (3) below.

(9) Other.

CODES:

(1) Voluntary:

1A = Voluntary

(2) Involuntary civil:

2A = 72 Hour Evaluation and Treatment for Adults (W&I Code, Section 5150)

2B = 72 Hour Evaluation and Treatment for Children (W&I Code, Section 5585)

2C = 14 Day Intensive Treatment (W&I Code, Section 5250)

2D = Additional 14 Day Hold (W&I Code, Section 5260)

2E = Additional 30 Day Hold (W&I Code, Section 5270.15)

2F = Additional 180 Day Hold (W&I Code, Section 5300)

2G = Other involuntary civil status

(3) Involuntary criminal - A person committed pursuant to one of the following:

3A = Charges and/or convictions pending (Penal Code, Sections 47.6, 47.8)
3B = Determination of competency to stand trial (Penal Code, Section 1370)
3C = Found “not guilty by reason of insanity” or “guilty but insane” (Penal Code, Section 1026)
3D = Determination of sexual psychopathy and related legal categories
3E = Transferred from correctional facilities (Penal Code, Section 2684)
3F = Other involuntary criminal status

(9) Other

9A = Unknown / Not Reported

Comments:

Report this data element at discharge.

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element is needed to produce summary or detailed statistics on the change in legal status from admission to discharge for clients in local Mental Health (e.g., 72-hour hold to 14-day or 72-hour hold to voluntary).

S-22.0 Admission Necessity Code

Purpose:

Identifies the type or reason for the client's admission into an acute care hospital.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Hospital, PHF, and SNF Service Records
Source:	Local Mental Health

Valid Codes:

1 = Emergency

2 = Planned (Prior Authorization)

9 = Unknown / Not Reported

The coding scheme is consistent with the one in the DHCS Managed Care Encounter Data Dictionary.

Comments:

For examples of reporting this data element, see Appendix F2: CSI Technical Supplement F - Reporting Tip 2.

User / Usage Information:

This data element is required by the Department of Health Care Services.

S-23.0 Date of Service

Purpose:

Identifies the date of service for Mode of Service 10 and Mode of Service 15 services.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	All Mode of Service 10 and Mode of Service 15 Service Records
Source:	Local Mental Health

Valid Codes:

> 19980630

CONDITIONS:

- The Date of Service must be greater than June 30, 1998.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

None.

User / Usage Information:

This data element will be used to link services to specific dates for summarizing information on a monthly and/or yearly basis. It is also needed to analyze trends in service delivery on a monthly basis.

S-24.0 Place of Service

Purpose:

Identifies the location where the service was rendered.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Non-24-Hour Service (Mode 05) Records
Source:	Local Mental Health

Valid Codes:

A = Office [formerly Office (including phone)]
B = Field (unspecified) [(formerly Field (when the location is away from the clinicians usual place of business, except for Correctional Institution and Inpatient)]
C = Correctional Facility (e.g., Jail, Prison, camp/ranch, etc.) [(formerly Correctional Institution)]
D = Inpatient (e.g., Hospital, PHF, SNF, IMD, MHRC)
E = Homeless / Emergency Shelter
F = Faith-based (e.g., church, temple, etc.)
G = Health Care / Primary Care
H = Home
I = Age-Specific Community Center
J = Client's Job Site
L = Residential Care - Adults
M = Mobile Service
N = Non-Traditional service location (e.g., park bench, on street, under bridge, abandoned building)
O = Other Community location
P = Phone
R = Residential Care - Children
S = School
T = Telehealth
U = Unknown / Not Reported

Comments:

None.

User / Usage Information:

This data element is required by the Department of Health Care Services. In addition, the values for this data element have been expanded in order to capture information

consistent with the vision of the Mental Health Services Act with respect to appropriate service integration, increased access and outreach.

S-25.0 Evidence-Based Practices/Service Strategies

Purpose:

Identifies up to three Evidence-Based Practices / Service Strategies that further describe the service the client received.

Field Description:

Type:	Character
Byte(s):	6
Format:	XXXXXX Three 2 byte fields Six bytes total Left justify, no embedded spaces
Required On:	All Services Records
Source:	Local Mental Health

Valid Codes:

EVIDENCE-BASED PRACTICES:

01 = Assertive Community Treatment
02 = Supportive Employment
03 = Supportive Housing
04 = Family Psychoeducation
05 = Integrated Dual Diagnosis Treatment
06 = Illness Management and Recovery
07 = Medication Management
08 = New Generation Medications
09 = Therapeutic Foster Care
10 = Multisystemic Therapy
11 = Functional Family Therapy
99 = Unknown Evidence-Based Practice / Service Strategy

SERVICE STRATEGIES:

50 = Peer and/or Family Delivered Services
51 = Psychoeducation
52 = Family Support
53 = Supportive Education
54 = Delivered in Partnership with Law Enforcement (includes courts, probation, etc.)
55 = Delivered in Partnership with Health Care
56 = Delivered in Partnership with Social Services
57 = Delivered in Partnership with Substance Abuse Services

58 = Integrated Services for Mental Health and Aging
59 = Integrated Services for Mental Health and Developmental Disability
60 = Ethnic-Specific Service Strategy
61 = Age-Specific Service Strategy
99 = Unknown Evidence-Based Practice / Service Strategy

DEFINITIONS:

See Appendix 14: Evidence Based Practices / Service Strategies Definitions.

Comments:

Evidence based practices are programs/services delivered in a culturally-competent manner that incorporate practices with generally accepted scientific fidelity, and that measure the impact of the practice on clients, participants and/or communities.

User / Usage Information:

This data element captures information consistent with the vision of the Mental Health Services Act with respect to appropriate service integration, increased access and outreach.

S-26.0 Trauma

Purpose:

Identifies clients that have experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident, or having been the victim of physical, emotional, or sexual abuse.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Services Records
Source:	Local Mental Health

Valid Codes:

Y = Yes

N = No

U = Unknown

Comments:

None.

User / Usage Information:

This data element will be used to determine the number of clients that have experienced trauma.

S-27.0 Client Index Number

Purpose:

Identifies Medi-Cal or Healthy Families Plan recipients. The Client Index Number (CIN) must be reported if the client is a Medi-Cal recipient or Healthy Families Plan recipient. If the client is neither a Medi-Cal recipient or a Healthy Families Plan recipient this field must be zero filled.

Field Description:

Type:	Character
Byte(s):	9
Format:	9XXXXXXXA Left justify, no embedded spaces, no spaces filling
Required On:	All Services Records
Source:	Local Mental Health

Valid Codes:

This field must be filled with a valid Client Index Number if client is a Medi-Cal recipient or a Healthy Families Plan recipient. If client is neither a Medi-Cal recipient or a Healthy Families Plan recipient, then this 9-digit field must be zero filled.

000000000 = No Client Index Number (CIN)

Comments:

In addition, the CIN must be reported if reporting an IMD service, which is a 24-Hour Service (Mode 05) and Service Function in the range of 35-39.

See Appendix F2: CSI Technical Supplement F - Reporting Tip 2. Example 2.

CIN FORMAT:

- The CIN is a system-generated 9-digit identification number used by Medi-Cal and issued by the State of California.
- The CIN is a unique client identifier and is printed on each recipient's Beneficiary Identification Card (BIC).
- The CIN always starts with a 9, has 7 numeric digits and ends with an alpha character of: A, C through H, M, N, and S through Y.
- These characters are invalid endings for the CIN: B, I, J, K, L, O, P, Q, R, and Z.
- Note that Client Index Numbers never end with a P.
- Do not allow all 1s, all 2s, etc., 123456789, 987654321, and similar artificial numbers.

For information about this and other data elements containing a County Code, see Appendix F4: CSI Technical Supplement F - Reporting Tip 4.

See Appendix 17: Core/Confirmatory Data Elements.

User / Usage Information:

This variable is a DHCS confirmatory data element and is used by the Department of Health Care Services to match clients in IMD facilities to other Medi-Cal or Health Families Plan services.

S-28.0 (Filler – formerly Axis I Diagnosis)

Purpose:

Identifies the Axis I diagnosis, which may be the primary focus of attention or treatment for Mental Health Service (MHS).

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces or decimals, no spaces filling, no zero filling
Required On:	All Service Records of services between 07/01/2006 and 09/30/2015
Source:	Local Mental Health

Valid Codes:

This is only applicable for records of services between 07/01/2006 and 09/30/2015.

All DSM-IV-TR Axis I codes and ICD-9-CM codes within the DSM-IV-TR Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification are accepted.

The V7109 and 7999 codes are valid in the Axis I Diagnosis field. V7109 means No Diagnosis or Condition on Axis I, and 7999 means the Diagnosis or Condition is Deferred on Axis I. However, if there is a valid DSM-IV-TR Axis I or ICD-9-CM code within the DSM-IV-TR Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification, then V7109 and 7999 are not allowed in the Axis I Diagnosis field.

EDITS:

To be edited against a file of DSM-IV-TR Axis I codes and ICD-9-CM codes within the DSM-IV-TR. Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification.

Comments:

Diagnostic and Statistical Manual - Fourth Edition - Text Revision (DSM-IV-TR) Axis I code is preferred, but International Classification of Diseases - Clinical Modifications, Revision 9 (ICD-9-CM) code within the DSM-IV-TR Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification is also accepted. The diagnosis will usually reflect a mental disorder but may also be a substance use or developmental disorder.

Enter all letters and/or numbers of the DSM-IV-TR or ICD-9-CM code. Do not enter a decimal point when entering the code.

For examples of reporting the diagnosis codes, see Appendix F3: CSI Technical Supplement F - Reporting Tip 3.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-29.0 (Filler – formerly Axis I Primary)

Purpose:

Identifies whether or not the Axis I diagnosis is the primary Mental Health diagnosis, which should reflect the primary focus of attention or treatment for Mental Health Service (MHS).

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Service Records of services between 07/01/2006 and 09/30/2015
Source:	Local Mental Health

Valid Codes:

This is only applicable for records of services between 07/01/2006 and 09/30/2015.

Y = Yes, the Axis I diagnosis is the primary Mental Health diagnosis
N = No, the Axis I diagnosis is not the primary Mental Health diagnosis
U = Unknown / Not Reported

This field must not contain N if N is reported in the Axis II Primary field, unless Axis I Diagnosis and Axis II Diagnosis are both coded V7109. V7109 means No Diagnosis or Condition on Axis I. Only one diagnosis, either the Axis I Diagnosis or the Axis II Diagnosis, can be designated as the primary Mental Health diagnosis.

Comments:

Identifies whether the DSM-IV-TR Axis I or ICD-9-CM code within the DSM-IV-TR Axis I Clinical Disorders /Other Conditions That May Be a Focus of Clinical Attention classification is the primary diagnosis and reason for the Mental Health service or visit.

For examples of reporting the Axis I primary code, see Appendix F3: CSI Technical Supplement F - Reporting Tip 3.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-30.0 (Filler – formerly Additional Axis I Diagnosis)

Purpose:

Identifies an additional Axis I diagnosis.

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces or decimals, no spaces filling
Required On:	All Service Records of services between 07/01/2006 and 09/30/2015
Source:	Local Mental Health

Valid Codes:

This is only applicable for records of services between 07/01/2006 and 09/30/2015.

All DSM-IV-TR Axis I codes and ICD-9-CM codes within the DSM-IV-TR Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification are accepted.

V7109, which means No Diagnosis or Condition on Axis I, is not allowed in the Additional Axis I Diagnosis field. If there is no Additional Diagnosis or Condition on Axis I, then zero fill this field.

7999, which means Diagnosis or Condition Deferred on Axis I, is allowed. However, if there is a valid additional DSM-IV-TR Axis I or ICD-9-CM code within the DSM-IV-TR Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification, then 7999 is not allowed.

0000000 = No Additional Diagnosis or Condition on Axis I

EDITS:

To be edited against a file of DSM-IV-TR Axis I codes and ICD-9-CM codes within the DSM-IV-TR Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification.

Comments:

Diagnostic and Statistical Manual - Fourth Edition - Text Revision (DSM-IV-TR) Axis I code is preferred, but International Classification of Diseases - Clinical Modifications, Revision 9 (ICD-9-CM) code within the DSM-IV-TR Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification is also accepted.

The diagnosis will usually reflect a mental disorder but may also be a substance use or developmental disorder.

Enter all letters and/or numbers of the DSM-IV-TR or ICD-9-CM code. Do not enter a decimal point when entering the code.

For examples of reporting the diagnosis codes, see Appendix F3: CSI Technical Supplement F - Reporting Tip 3.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-31.0 (Filler – formerly Axis II Diagnosis)

Purpose:

Identifies the Axis II diagnosis, which may be the primary focus of attention or treatment for Mental Health Service (MHS).

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces or decimals, no spaces filling
Required On:	All Service Records of services between 07/01/2006 and 09/30/2015
Source:	Local Mental Health

Valid Codes:

This is only applicable for records of services between 07/01/2006 and 09/30/2015.

All DSM-IV-TR Axis II codes and ICD-9-CM codes within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification are accepted.

The V7109 and 7999 codes are valid in the Axis II Diagnosis field. V7109 means No Diagnosis on Axis II, and 7999 means Diagnosis is Deferred on Axis II. However, if there is a valid DSM-IV-TR Axis II or ICD-9-CM code within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification, then V7109 and 7999 are not allowed in the Axis II Diagnosis field.

V7109 = No Diagnosis on Axis II

7999 = Diagnosis Deferred on Axis II

EDITS:

To be edited against a file of DSM-IV-TR Axis II codes and ICD-9-CM codes within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification.

Comments:

Diagnostic and Statistical Manual - Fourth Edition - Text Revision (DSM-IV-TR) Axis II code is preferred, but International Classification of Diseases - Clinical Modifications, Revision 9 (ICD-9-CM) code within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification is also accepted. The diagnosis will reflect a personality disorder or mental retardation.

Enter all letters and/or numbers of the DSM-IV-TR or ICD-9-CM code. Do not enter a decimal point when entering the code.

For examples of reporting the diagnosis codes, see Appendix F3: CSI Technical Supplement F - Reporting Tip 3.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-32.0 (Filler – formerly Axis II Primary)

Purpose:

Identifies whether the Axis II diagnosis is the primary Mental Health diagnosis, which may be the primary focus of attention or treatment for Mental Health Service (MHS).

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Service Records of services between 07/01/2006 and 09/30/2015
Source:	Local Mental Health

Valid Codes:

This is only applicable for records of services between 07/01/2006 and 09/30/2015.

Y = Yes, the Axis II diagnosis is the primary Mental Health diagnosis

N = No, the Axis II diagnosis is not the primary Mental Health diagnosis

U = Unknown / Not Reported

This field must not contain an N if N is reported in the Axis I Primary field, unless Axis I Diagnosis and Axis II Diagnosis are both coded V7109. V7109 means No Diagnosis on Axis II. Only one diagnosis, either the Axis I Diagnosis or the Axis II diagnosis, can be designated the primary Mental Health diagnosis.

Comments:

Indicates whether the DSM-IV-TR Axis II or ICD-9-CM code within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification is the primary diagnosis and reason for the Mental Health service or visit.

For examples of reporting the diagnosis codes, see Appendix F3: CSI Technical Supplement F - Reporting Tip 3.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-33.0 (Filler – formerly Additional Axis II Diagnosis)

Purpose:

Identifies an additional Axis II diagnosis.

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces or decimals, no spaces filling
Required On:	All Service Records of services between 07/01/2006 and 09/30/2015
Source:	Local Mental Health

Valid Codes:

This is only applicable for records of services between 07/01/2006 and 09/30/2015.

All DSM-IV-TR Axis II codes and ICD-9-CM codes within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification are accepted.

V7109, which means No Diagnosis on Axis II, is not allowed in the Additional Axis II Diagnosis field. If there is no Additional Axis II diagnosis, then zero fill this field.

7999, which means Diagnosis Deferred on Axis II, is allowed. However, if there is a valid additional DSM-IV-TR Axis II or ICD-9-CM code within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification, then 7999 is not allowed.

0000000 = No Additional Diagnosis on Axis II

EDITS:

To be edited against a file of DSM-IV-TR Axis II codes and ICD-9-CM codes within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification.

Comments:

Diagnostic and Statistical Manual - Fourth Edition - Text Revision (DSM-IV-TR) Axis II code is preferred, but International Classification of Diseases - Clinical Modifications, Revision 9 (ICD-9-CM) code within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification is also accepted. The diagnosis will reflect a personality disorder or mental retardation.

Enter all letters and/or numbers of the DSM-IV-TR or ICD-9-CM code. Do not enter a decimal point when entering the code.

For examples of reporting the diagnosis codes, see Appendix F3: CSI Technical Supplement F - Reporting Tip 3.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-34.0 General Medical Condition Summary Code

Purpose:

Identifies up to three General Medical Condition Summary Codes from the list below that most closely identify the client's general medical condition(s), if any.

Field Description:

Type:	Character
Byte(s):	2
Format:	XX Left justify, no embedded spaces This field occurs three times
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

Select up to three codes from the list of general medical conditions below:

01 = Arterial Sclerotic Disease
02 = Heart Disease
03 = Hypercholesterolemia
04 = Hyperlipidemia
05 = Hypertension
06 = Birth Defects
07 = Cystic Fibrosis
08 = Psoriasis
09 = Digestive Disorders (Reflux, Irritable Bowel Syndrome)
10 = Ulcers
11 = Cirrhosis
12 = Diabetes
13 = Infertility
14 = Hyperthyroid
15 = Obesity
16 = Anemia
17 = Allergies
18 = Hepatitis
19 = Arthritis
20 = Carpal Tunnel Syndrome
21 = Osteoporosis

22 = Cancer
23 = Blind / Visually Impaired
24 = Chronic Pain
25 = Deaf / Hearing Impaired
26 = Epilepsy / Seizures
27 = Migraines
28 = Multiple Sclerosis
29 = Muscular Dystrophy
30 = Parkinson's Disease
31 = Physical Disability
32 = Stroke
33 = Tinnitus
34 = Ear Infections
35 = Asthma
36 = Sexually Transmitted Disease (STD)
37 = Other
99 = Unknown / Not Reported General Medical Condition
00 = No General Medical Condition

For your convenience, below are the General Medical Condition Summary Codes displayed alphabetically:

17 = Allergies
16 = Anemia
01 = Arterial Sclerotic Disease
19 = Arthritis
35 = Asthma
06 = Birth Defects
23 = Blind / Visually Impaired
22 = Cancer
20 = Carpal Tunnel Syndrome
24 = Chronic Pain
11 = Cirrhosis
07 = Cystic Fibrosis
25 = Deaf / Hearing Impaired
12 = Diabetes
09 = Digestive Disorders (Reflux, Irritable Bowel Syndrome)
34 = Ear Infections

26 = Epilepsy / Seizures
02 = Heart Disease
18 = Hepatitis
03 = Hypercholesterolemia
04 = Hyperlipidemia
05 = Hypertension
14 = Hyperthyroid
13 = Infertility
27 = Migraines
28 = Multiple Sclerosis
29 = Muscular Dystrophy
00 = No General Medical Condition
15 = Obesity
21 = Osteoporosis
37 = Other
30 = Parkinson's Disease
31 = Physical Disability
08 = Psoriasis
36 = Sexually Transmitted Disease (STD)
32 = Stroke
33 = Tinnitus
10 = Ulcers
99 = Unknown / Not Reported General Medical Condition

EDITS:

To be edited against the above list of General Medical Condition Summary Codes.

Comments:

- All three fields of the S-34.0 General Medical Condition Summary Code cannot be left blank.
- The first of the three fields must be populated with a valid General Medical Condition Summary Code.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS)

Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-35.0 (Filler – formerly General Medical Condition Diagnosis)

Purpose:

Identifies up to three general medical condition diagnoses that most closely identifies the client's general medical condition(s), if any.

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces or decimals This field occurs three times
Required On:	All Service Records of services between 07/01/2006 and 09/30/2015
Source:	Local Mental Health

Valid Codes:

This is only applicable for records of services between 07/01/2006 and 09/30/2015.

All DSM-IV-TR Axis III codes, ICD-9-CM codes within the DSM-IV-TR Axis III General Medical Conditions classification, or ICD-9-CM general medical condition codes, are accepted, including 7999. The ICD-9-CM defines 7999 as Other Unknown and Unspecified Cause.

V7109 is not allowed in the General Medical Condition Diagnosis field. If there is no general medical condition diagnosis, zero fill this field.

0000000 = No General Medical Condition Diagnosis

EDITS:

To be edited against a file of DSM-IV-TR Axis III codes, ICD-9-CM codes within the DSM-IV-TR Axis III General Medical Conditions classification, and ICD-9-CM general medical condition codes.

Comments:

Report up to three separate DSM-IV-TR Axis III diagnosis codes, ICD-9-CM codes within the DSM-IV-TR Axis III General Medical Conditions classification, or ICD-9-CM general medical condition codes. The code(s) should reflect a general medical condition such as those that may be potentially relevant to the understanding or management of the client's mental disorder.

Note that this field must be space filled if the S-34.0 General Medical Condition Summary Code field is utilized to report information to CSI. For each Service Record, do not report general medical condition Summary Code(s) in the S-34.0 General Medical Condition Summary Code field if reporting to the S-35.0 General Medical Condition Diagnosis field. Utilize either the S-35.0 General Medical Condition Diagnosis field or the S-34.0 General Medical Condition Summary Code field to report information to CSI, but not both on the same Service Record.

Enter all letters and/or numbers of the DSM-IV-TR or ICD-9-CM code. Do not enter a decimal point when entering the code.

For examples of reporting the diagnosis codes, see Appendix F3: CSI Technical Supplement F - Reporting Tip 3.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-36.0 (Filler – formerly Axis-V/GAF Rating)

Purpose:

Identifies the Global Assessment of Functioning (Axis-V / GAF) rating of the client.

Field Description:

Type:	Character
Byte(s):	3
Format:	XXX
Required On:	All Service Records of services between 07/01/2006 and 09/30/2015
Source:	Local Mental Health

Valid Codes:

This is only applicable for records of services between 07/01/2006 and 09/30/2015.

001 through 100	=	Valid Axis-V / GAF Rating
000	=	Unknown / Inadequate Information for Axis-V / GAF Rating

EDITS:

To be edited against the DSM-IV-TR Axis-V / GAF rating scale.

Comments:

Enter 000 if Axis-V / GAF rating cannot be determined.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-37.0 Substance Abuse/Dependence

Purpose:

Identifies whether or not the client has a substance abuse / dependence issue.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

Y = Yes, the client has a substance abuse / dependence issue

N = No, the client does not have a substance abuse / dependence issue

U = Unknown

Z = Not Reported

Comments:

If the client has a substance abuse / dependence issue, report Y in S-37.0 Substance Abuse / Dependence and, in addition, also report the substance abuse / dependence diagnosis in the following data element, S-38.0 Substance Abuse / Dependence Diagnosis.

If a substance abuse/dependence issue exists, but no diagnosis is currently available, then report Y in this field and enter 9999999 (Diagnosis Unknown/Deferred) in the S-38.0 Substance Abuse/Dependence Diagnosis.

For examples of reporting the diagnosis codes, see Appendix F3: CSI Technical Supplement F - Reporting Tip 3.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-38.0 Substance Abuse/Dependence Diagnosis

Purpose:

Identifies the client's substance abuse / dependence diagnosis, if any.

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces or decimals, no spaces filling
Required On:	All Service Records
Source:	Local Mental Health

Valid Codes:

- All ICD-10 codes within the mental, behavioral and neurodevelopmental disorders range (F10-19) are accepted.
- 0000000 = No Diagnosis
- 9999999 = Unknown/Deferred Diagnosis

CONDITIONS:

- Enter 0000000 (No Diagnosis) if N or Z were reported in the previous data element, S-37.0 Substance Abuse / Dependence.
- Enter 9999999 (Unknown/Deferred Diagnosis) in the substance abuse /dependence diagnosis field if U was reported in the previous data element, S-37.0 Substance Abuse /Dependence, or if Y was entered and the diagnosis is unknown or deferred.

Comments:

- International Classification of Diseases 10th Edition (ICD-10) code from the mental, behavioral and neurodevelopmental disorders range (F10-19) is required. The diagnosis should reflect a substance abuse / dependence disorder.
- Enter all letters and/or numbers of the ICD-10 code. Do not enter a decimal point when entering the code.
- To be edited against an ICD-10 codes file within the Substance-Related Disorders classification.
- If Y (Yes, the client has a substance abuse / dependence issue) or U (Unknown) was reported in the S-37.0 Substance Abuse / Dependence field, then 0000000 (No Diagnosis) is not allowed in the S-38.0 field.
- If N (No, the client does not have a substance abuse / dependence issue) or Z (Not Reported) was reported in the S-37.0 Substance Abuse / Dependence field, then 9999999 (Unknown/Deferred Diagnosis) is not allowed in the S-38.0 field.

- Diagnosis for Mental and behavioral disorders due to psychoactive substance use are found in the ICD-10 (F10-19) range. These codes can be used in S-09.0 Principal, S-10.0 Secondary, and S-11.0 Additional Mental Health Diagnosis fields. If an ICD-10 (F10-19) range code is entered in the S-09.0, S-10.0, or S-11.0 field, then the same code should be entered in the S-38.0 field. If the patient has multiple ICD-10 (F10-19) range codes in the Principal, Secondary, and Additional Mental Health Diagnosis fields, then it is at the discretion of the clinician to select which code goes in the S-38.0 field.

For examples of reporting the diagnosis codes, see Appendix F3: CSI Technical Supplement F - Reporting Tip 3.

User / Usage Information:

This data element is needed to describe clients by types of diagnoses, to analyze length of treatment by diagnosis, and to meet annual federal reporting requirements as stipulated by the United States Department of Health and Human Service (DHHS) Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Service (CMHS).

S-39.0 District of Residence

Purpose:

Identifies the district where the person resides in relation to the district that provides the services.

Field Description:

Type:	Character
Byte(s):	7
Format:	XXXXXXX Left justify, no embedded spaces
Required On:	All AB3632 Service Records (where S-12.0 Special population = C)
Source:	Local Education Agencies (LEAs) via Local Mental Health Agency

Valid Codes:

CCDDDDD [7-byte CDE issued seven-byte COUNTY-DISTRICT-SCHOOL (CDS) code provided to Local Education Agencies (LEAs) from the California Public School Directory]:

CC = two byte County Code in which the district is located
DDDDD = five-byte district/site code

CONDITIONS:

- There must be no embedded spaces.
- Only for Service Records where S-12.0 Special Population is marked with a C (AB 3632 service).
- LEAs refer to the California Public School Directory to obtain correct codes.

DEFINITIONS:

This is the California Department of Education issued seven-byte COUNTY-DISTRICT-SCHOOL (CDS) code provided to Local Education Agencies (LEAs). The first two digits are the County Code in which the district is located, followed by a five-digit district/site code.

A district/site code may include:

- The district where the student lives or resides [includes students in Licensed Children's Institutions (LCI)]
- The district where the parent resides if the student is placed in an out-of-home district through the Individualized Education Program (IEP) process
- The district receiving the student under an inter-district transfer

- The district or county office authorizing a charter school, unless the charter school has a seven-digit district code
- The district or County Office of Education, only for wards of the court if none of the above conditions apply.

Local Mental Health departments must obtain the District of Residence code from LEAs for each client receiving services as part of their Individualized Education Program (IEP) plan.

Comments:

Local Mental Health departments must report the District of Residence code for all clients/students receiving Mental Health Service (MHS) as part of their Individualized Education Program (IEP) plan. CMHDs must obtain the District of Residence code from Local Education Agencies (LEAs) at the time of an IEP referral, IEP assessment, IEP team meeting or update, IEP annual staffing, or at any time the code is changed or updated.

Local Education Agencies (LEAs) report, maintain and update this code as required by CDE. Codes are verified only via the Special Education Local Plan Areas (SELPAs) Management Information Systems and via LEAs report submission to the California Special Education Management Information System (CASEMIS) as data field A-5 DIST_RESI (District of Residence).

Local Mental Health departments must work with LEAs to ensure valid and up-to-date codes are reported to the CSI System.

User / Usage Information:

This data element is added to the CSI System for data reporting beginning with State Fiscal Year 2007-08 (July 1, 2007) as a result of collaborative workgroup meetings by DHCS with the California Department of Education (CDE), California Mental Health Directors Association (CMHDA), CMHDs, county offices of education (COEs), Local Education Agencies (LEAs), and Special Education Local Plan Areas (SELPAs). This data element is added to CSI in an effort to assist CMHDs in meeting their reporting requirements, and to provide COEs and Special Education Local Plan Areas (SELPAs) with a way to link and compare data on clients/students that were provided services by CMHDs pursuant to each client’s IEP plan.

P-01.0 Date Completed

Purpose:

Identifies the date the information for this record is completed.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	All Periodic Records
Source:	Local Mental Health

Valid Codes:

> 19980630

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

- Report at admission to Local Mental Health, annually thereafter, and at formal discharge from Local Mental Health.
- If the data is collected over several days, use the last date as the Date Completed.
- The Date Completed must be greater than June 30, 1998.

User / Usage Information:

This is one of several data elements needed for record identification and error corrections.

P-02.0 Education

Purpose:

Identifies the highest grade level completed by the client.

Field Description:

Type:	Numeric
Byte(s):	2
Format:	XX
Required On:	All Periodic Records
Source:	Local Mental Health

Valid Codes:

00 = None, Kindergarten

01 – 20 = Grade levels - Indicate highest grade completed.

98 = Other - Includes vocational education and training.

99 = Unknown / Not Reported

CONDITIONS:

- If the highest grade completed is greater than 20, code 20 as the highest grade completed.
- Use Code 12 for GED.

Comments:

Report at admission to Local Mental Health, annually thereafter, and at formal discharge from Local Mental Health.

User / Usage Information:

This data element is one of the determinants of socio-economic status. It may also be compared to the educational levels of the total population.

P-03.0 Employment Status

Purpose:

Identifies the current employment status of the client.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Periodic Records
Source:	Local Mental Health

Valid Codes:

Employed in competitive job market:

A = Full time, 35 hours or more per week

B = Part time, less than 35 hours per week

Employed in noncompetitive job market (sheltered workshop, protected environment):

C = Full time, 35 hours or more per week

D = Part time, less than 35 hours per week

Not in the paid work force:

E = Actively looking for work

F = Homemaker

G = Student

H = Volunteer Worker

I = Retired

J = Resident / inmate of institution

K = Other

U = Unknown / Not Reported

Comments:

Report at admission to Local Mental Health, annually thereafter, and at formal discharge from Local Mental Health.

User / Usage Information:

This data element is useful in relating changes in the economy to the utilization of public Mental Health Service (MHS).

P-08.0 Conservatorship/Court Status

Purpose:

Identifies whether or not the client has a conservatorship or juvenile court status.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Periodic Records
Source:	Local Mental Health

Valid Codes:

A = Temporary Conservatorship (W&I Code, Section 5353)

Permanent Conservatorship:

B = Lanterman-Petris-Short (W&I Code, Section 5358)
C = Murphy (W&I Code, Section 5008)
D = Probate (Probate Code, Division 4, Section 1400)
E = PC 2974 (Penal Code, Section 2974)
F = Representative Payee Without Conservatorship (W&I Code, Section 5686)
G = Juvenile Court, Dependent of the Court (W&I Code, Section 300)
H = Juvenile Court, Ward - Status Offender (W&I Code, Section 601)
I = Juvenile Court, Ward - Juvenile Offender (W&I Code, Section 602)
J = Not Applicable
U = Unknown / Not Reported

Comments:

Report at admission to Local Mental Health, annually thereafter, and at formal discharge from Local Mental Health.

User / Usage Information:

This data element is needed to produce summary or detailed statistics on persons and agencies responsible for clients being treated in Local Mental Health, i.e., conservatorships, Lanterman-Petris-Short (LPS), agencies responsible for minors, etc. This is particularly important in analyzing the utilization and units of service in 24-Hour care.

P-09.0 Living Arrangement

Purpose:

Identifies the living arrangement of the client.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Periodic Records
Source:	Local Mental Health

Valid Codes:

A = House or apartment (includes trailers, hotels, dorms, barracks, etc.)
B = House or apartment and requiring some support with daily living activities (applies to adults only)
C = House or apartment and requiring daily support and supervision (applies to adults only)
D = Supported housing (applies to adults only)
E = Foster family home
F = Group Home (includes Levels 1-12 for children)
G = Residential Treatment Center (includes Levels 13-14 for children)
H = Community Treatment Facility
I = Board and Care
J = Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility
K = Mental Health Rehabilitation Center (24-Hour)
L = Skilled Nursing Facility/Intermediate Care Facility/Institute of Mental Disease (IMD)
M = Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital
N = State Hospital
O = Justice-related (Juvenile Hall, Department of Corrections and Rehabilitation Youth Facility, correctional facility, jail, etc.)
P = Homeless, no identifiable residence
Q = Other
U = Unknown / Not Reported

Comments:

Report at admission to Local Mental Health, annually thereafter, and at formal discharge from Local Mental Health.

User / Usage Information:

This data element provides information on the degree to which a client is independent or requires supervision for daily living.

P-10.0 Caregiver

Purpose:

Identifies the number of persons the client cares for / is responsible for at least 50% of the time.

Field Description:

Type:	Character
Byte(s):	4
Format:	XXXX
Required On:	All Periodic Records
Source:	Local Mental Health

Valid Codes:

Subfield A:

00	=	None
01 – 98	=	Number of children less than 18 years of age that the client cares for / is responsible for at least 50% of the time
99	=	Unknown / Not Reported

Subfield B:

00	=	None
01 – 98	=	Number of dependent adults 18 years of age and above that the client cares for / is responsible for at least 50% of the time
99	=	Unknown / Not Reported

Comments:

Report at admission to Local Mental Health, annually thereafter, and at formal discharge from Local Mental Health.

The field consists of two separate subfields:

- Subfield A: Number of children less than 18 years of age the client cares for / is responsible for at least 50% of the time.
- Subfield B: Number of dependent adults 18 years of age and above the client cares for / is responsible for at least 50% of the time.

User / Usage Information:

This data element is needed to produce summary data on the number of clients who have dependent children under 18 years of age and/or dependent adults 18 years and older, how many dependents, and if the client is primary caregiver in order to identify patterns of need. This information will help reflect critical areas of the lives of California's Mental Health clients.

A-01.0 Assessment Reference Number (ARN)

Purpose:

A persistent identifier unique to one Assessment Record. Assigned by the county.

Field Description:

Type:	Character
Byte(s):	23
Format:	XXXXXXXXXXXXXXXXXXXXXXX • Right justify • Zero fill • No embedded Blanks
Required On:	All Assessment Records
Source:	Local Mental Health

Valid Codes:

There must be no embedded Blanks. Otherwise, all values accepted. Assessment Reference Number must not be Blank.

Comments:

When adding or replacing an Assessment Record, the Submitting County Code + County Client Number (CCN) + Assessment Reference Number (ARN).

User / Usage Information:

This is one of several data elements needed for record identification and error corrections.

A-02.0 Date of First Contact to Request Services

Purpose:

Identifies the Date of first contact to request Specialty Mental Health Services.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

CONDITIONS:

- The Date of First Contact to Request Services is required for each Assessment Record.
- Date of First Contact to Request Services must not be blank.
- Date of First Contact to Request Services must not be a space.
- Date of First Contact to Request Services must greater than or equal to January 1, 2018.
- Do not use special characters such as slashes, commas, or hyphens.
- Date of First Contact to Request Services must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. If a person other than a prospective client contacts the MHP seeking services for the prospective client, the **Date of First Contact to Request Services** depends on the legal statusof that person making the initial contact.
2. If the person contacting the MHP is legally authorized to consent to services for the prospective client, the **Date of First Contact to Request Services** will be the date that personcontacted the MHP.
3. If the person requesting services does not have legal authorization to consent to services, thisinitial contact should not be considered as the **Date of First Contact to Request Services**. Rather, when the prospective client is contacted, expresses an interest in service, and is offered an assessment appointment that date should be the **Date of First Contact to RequestServices.**

Important note regarding Crisis Services:

1. If a client enters the system via a crisis intervention, an Assessment Record is initiated on that date (this would be considered the **Date of First Contact to Request Services**).
2. When a client enters the system via a crisis stabilization or in-patient service, this is not the **Date of First Contact to Request Services.** Rather, the **Date of First Contact to Request Services** is initiated on the date that the first stepdown service is requested.

Example: The client is discharged and a follow-up appointment/stepdown service is requested by the provider, client, or other referral source - that date is considered the Date of First Contact to Request Services.

User / Usage Information:

This data element will be used to establish the date that a county Mental Health Plan (MHP) was first contacted by a client or client's legal representative to request services.

A-03.0 Referral Source

Purpose:

Identifies who referred the client.

Field Description:

Type:	Numeric
Byte(s):	2
Format:	XX
Required On:	Optional on All Assessment Records until further notice
Source:	Local Mental Health

Valid Codes:

01 = Self
02 = Family Member
03 = Significant Other
04 = Friend / Neighbor
05 = School
06 = Fee-For-Service Provider
07 = Medi-Cal Managed Care Plan
08 = Federally Qualified Health Center
09 = Emergency Room
10 = Mental Health Facility / Community Agency
11 = Social Services Agency
12 = Substance Abuse Treatment Facility / Agency
13 = Faith-based Organization
14 = Other County / Community Agency
15 = Homeless Services
16 = Street Outreach
17 = Juvenile Hall/Camp/Ranch/Division of Juvenile Justice
18 = Probation/Parole
19 = Jail / Prison
20 = State Hospital
21 = Crisis Services
22 = Mobile Evaluation
23 = Other referred
Spaces (if unused)

Comments:

If populated, the Referral Source must be a valid entry.

User / Usage Information:

This data element will be used to determine which referral source referred the client to the Mental Health Plan (MHP).

A-04.0 Assessment Appointment First Offer Date

Purpose:

Identifies the First Assessment Date offered to client. Note, all fields related to assessment appointments refer exclusively to initial encounters used to establish eligibility.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

CONDITIONS:

- Assessment Appointment First Offer Date is required for each Assessment Record.
- Assessment Appointment First Offer Date must be greater than or equal to January 1, 2018.
- Assessment Appointment First Offer Date must be greater than or equal to Date of First Contact to Request Services.
- The Assessment Appointment First Offer Date must not be blank.
- Assessment Appointment First Offer Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. The first assessment appointment offered to a client is captured in the Assessment Appointment First Offer Date field.
2. The Assessment Appointment First Offer Date is recorded whether a client accepts any assessment appointment offer or not.

If the client accepts the Assessment Appointment First Offer Date, that date should be recorded in both:

1. The Assessment Appointment First Offer Date field.
2. The Assessment Appointment Accepted Date field.

User / Usage Information:

This data element will be used to identify the first assessment appointment date offered to a client from the Mental Health Plan (MHP).

A-05.0 Assessment Appointment Second Offer Date

Purpose:

Identifies the Second Assessment Date offered to the client. Note, all fields related to assessment appointments refer exclusively to initial encounters used to establish eligibility.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Assessment Appointment Second Offer Date is conditional for each Assessment Record.
2. If Assessment Appointment Second Offer Date is populated, then:
   - Must be greater than or equal to January 1, 2018.
   - Must be greater than Assessment Appointment First Offer Date.
   - Assessment Appointment First Offer Date must not be space filled.
   - Assessment Appointment Second Offer Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. If a client does not accept the Assessment Appointment First Offer Date, but accepts the Assessment Appointment Second Offer Date, then:
   - The Assessment Appointment First Offer Date should be recorded in the Assessment Appointment First Offer Date field.
   - The Assessment Appointment Second Offer Date should be recorded in the Assessment Appointment Second Offer field and also entered in the Assessment Appointment Accepted Date field.

User / Usage Information:

This data element will be used to identify the second assessment appointment date offered to a client from the Mental Health Plan (MHP).

A-06.0 Assessment Appointment Third Offer Date

Purpose:

Identifies the Third Assessment Date offered to the client. Note, all fields related to assessment appointments refer exclusively to initial encounters used to establish eligibility.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Assessment Appointment Third Offer Date is conditional for each Assessment Record.
2. If Assessment Appointment Third Offer Date is populated, then:
   - Must be greater than or equal to January 1, 2018.
   - Must be greater than Assessment Appointment Second Offer Date.
   - Assessment Appointment Second Offer Date must not be space filled.
   - Assessment Appointment Third Offer Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. If a client does not accept the Assessment Appointment First Offer Date nor the Assessment Appointment Second Offer Date, but accepts the Assessment Appointment Third Offer Date, then:
   - The Assessment Appointment First Offer Date should be recorded in the Assessment Appointment First Offer Date field.
   - The Assessment Appointment Second Offer Date should be recorded in the Assessment Appointment Second Offer Date field.
   - The Assessment Appointment Third Offer Date should be recorded in the Assessment Appointment Third Offer Date field and also entered in the Assessment Appointment Accepted Date field.

2. If a client does not accept the Assessment Appointment First Offer Date, the Assessment Appointment Second Offer Date, nor the Assessment Appointment Third Offer Date, but accepts a later date, then:
    - The Assessment Appointment First Offer Date should be recorded in the Assessment Appointment First Offer Date field.
    - The Assessment Appointment Second Offer Date should be recorded in the Assessment Appointment Second Offer Date field.
    - The Assessment Appointment Third Offer Date should be recorded in the Assessment Appointment Third Offer Date field
    - The accepted date should be entered in the Assessment Appointment Accepted Date field.
3. If the process terminates anywhere among the process steps of the Assessment Appointment First Offer Date, the Assessment Appointment Second Offer Date, or the Assessment Appointment Third Offer Date and the client accepts none of the offered dates, then:
    - The Assessment Record should be closed out with a CLOSED OUT DATE and closure reason of 01 = Client did not accept any offered assessment dates.
    - It is not necessary to populate the Assessment Appointment Second Offer Date, or the Assessment Appointment Second Offer Date in order to populate the CLOSED OUT DATE.

Note: An Assessment Record may have one, two, or three offered appointment dates with a 01 = Client did not accept any offered assessment dates closure reason.

User / Usage Information:

This data element will be used to identify the third assessment appointment date offered to a client from the Mental Health Plan (MHP).

A-07.0 Assessment Appointment Accepted Date

Purpose:

Identifies the Assessment Date accepted by the client. Note, all fields related to assessment appointments refer exclusively to initial encounters used to establish eligibility.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Assessment Appointment Accepted Date is conditional for each Assessment Record.
2. If the Assessment Appointment Accepted Date is populated, then:
   - Must be greater than or equal to January 1, 2018.
   - Assessment Appointment Accepted Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. If the Assessment Appointment Second and Third Offer Dates are spaces then:
   - The Assessment Appointment Accepted Date must be equal to Assessment Appointment First Offer Date.
2. If the Assessment Appointment Accepted Date, and the Assessment Appointment Second Offer Date is populated and the Assessment Appointment Third Offer Date is spaces then:
   - The Assessment Appointment Accepted Date must be equal to Assessment Appointment Second Offer Date.
3. If the Assessment Appointment Accepted Date, and the Assessment Appointment Third Offer Date is populated then:
   - The Assessment Appointment Accepted Date must be greater than or equal to the Assessment Appointment Third Offer Date.

User / Usage Information:

This data element will be used to identify the date a client accepts a first assessment appointment with the Mental Health Plan (MHP).

A-08.0 Assessment Start Date

Purpose:

Identifies the Date of First Assessment Appointment. Note, all fields related to assessment appointments refer exclusively to initial encounters used to establish eligibility.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Assessment Start Date is conditional for each Assessment Record.
2. If Assessment Start Date is populated, then:
   - Must greater than or equal to January 1, 2018.
   - Must be greater than or equal to the Assessment Appointment Accepted Date.
   - The CCN must be populated.
   - The Assessment Appointment Accepted Date must not be space filled.
   - Assessment Start Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

None

User / Usage Information:

This data element will be used to identify the date of a client's first assessment appointment with the Mental Health Plan (MHP).

A-09.0 Assessment End Date

Purpose:

Identifies the Date of Final Assessment Appointment. Note, all fields related to assessment appointments refer exclusively to initial encounters used to establish eligibility.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Assessment End Date is conditional for each Assessment Record.
2. If the Assessment Start Date is space filled then the Assessment End Date should be space filled.
3. If Assessment End Date is populated, then:
   - Must greater than or equal to January 1, 2018.
   - Must be greater than or equal to the Assessment Start Date.
   - Assessment End Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. If the Assessment Start Date is space filled, then the Assessment End Date should be space filled.
2. When the Assessment Start Date is populated, then Assessment Appointment Accepted Date must not be space filled.

User / Usage Information:

This data element will be used to identify the date of a client's final assessment appointment with the Mental Health Plan (MHP).

A-10.0 Treatment Appointment First Offer Date

Purpose:

Identifies the First Specialty Mental Health Services Date offered to the client.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Treatment Appointment First Offer Date is conditional for each Assessment Record.
2. If Treatment Appointment First Offer Date is populated, then:
   - Must greater than or equal to January 1, 2018.
   - Must be greater than or equal to Assessment Start Date.
   - Treatment Appointment First Offer Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. The first treatment appointment offered to a client after an assessment has started is captured in the Treatment Appointment First Offer Date field.
2. If the client accepts the Treatment Appointment First Offer Date, then that date should be recorded in both:
   - The Treatment Appointment First Offer Date field.
   - The Treatment Appointment Accepted Date field.

User / Usage Information:

This data element will be used to identify the first treatment appointment date for Specialty Mental Health Service (SMHS) offered to a client from the Mental Health Plan (MHP).

A-11.0 Treatment Appointment Second Offer Date

Purpose:

Identifies the Second Specialty Mental Health Services Date offered to the client.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Treatment Appointment Second Offer Date is conditional for each Assessment Record.
2. If Treatment Appointment Second Offer Date is populated, then:
   - Must be greater than or equal to January 1, 2018.
   - Must be greater than Treatment Appointment First Offer Date.
   - Treatment Appointment First Offer Date must not be space filled.
   - Treatment Appointment Second Offer Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. If a client does not accept the Treatment Appointment First Offer Date, but accepts the Treatment Appointment Second Offer Date then:
   - The Treatment Appointment First Offer Date should be recorded in the Treatment Appointment First Offer Date field.
   - The Treatment Appointment Second Offer Date should be recorded in the Treatment Appointment Second Offer field and also entered in the Treatment Appointment Accepted Date field.

User / Usage Information:

This data element will be used to identify the second treatment appointment date for Specialty Mental Health Service (SMHS) offered to a client from the Mental Health Plan (MHP).

A-12.0 Treatment Appointment Third Offer Date

Purpose:

Identifies the Third Specialty Mental Health Services Date offered to the client.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Treatment Appointment Third Offer Date is conditional for each Assessment Record.
2. If Treatment Appointment Third Offer Date is populated, then:
   - Must be greater than or equal to January 1, 2018.
   - Must be greater than Treatment Appointment Second Offer Date.
   - Treatment Appointment Second Offer Date must not be space filled.
   - Treatment Appointment Third Offer Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

A. If a client does not accept the Treatment Appointment First Offer Date nor the Treatment Appointment Second Offer Date, but accepts the Treatment Appointment Third Offer Date, then:
   1. The Treatment Appointment First Offer Date should be recorded in the Treatment Appointment First Offer Date field.
   2. The Treatment Appointment Second Offer Date should be recorded in the Treatment Appointment Second Offer Date field.
   3. The Treatment Appointment Third Offer Date should be recorded in the Treatment Appointment Third Offer Date field and also entered in the Treatment Appointment Accepted Date field.

B. If a client does not accept the Treatment Appointment First Offer Date, the Treatment Appointment Second Offer Date, nor the Treatment Appointment Third Offer Date, but accepts a later date, then:
    1. The Treatment Appointment First Offer Date should be recorded in the Treatment Appointment First Offer Date field.
    2. The Treatment Appointment Second Offer Date should be recorded in the Treatment Appointment Second Offer Date field.
    3. The Treatment Appointment Third Offer Date should be recorded in the Treatment Appointment Third Offer Date field.
    4. The accepted date should be entered in the Treatment Appointment Accepted Date field.
C. If the process terminates anywhere among the process steps of the Treatment Appointment First Offer Date, the Treatment Appointment Second Offer Date, or the Treatment Appointment Third Offer Date and the client accepts none of the offered dates, then:
    1. The Assessment Record should be closed out with a CLOSED OUT DATE and closure reason of 04 = Client completed assessment process but declined offered treatment dates.
    2. It is not necessary to populate the Treatment Appointment Second Offer Date, or the Treatment Appointment Second Offer Date in order to populate the CLOSED OUT DATE.

Note: A complete Assessment Record will minimally consist of DATE OF FIRST CONTACT TO REQUEST SERVICES, ASSESSMENT APPOINTMENT FIRST OFFER DATE, and CLOSED OUT DATE as well as Header Record fields.

User / Usage Information:

This data element will be used to identify the third treatment appointment date for Specialty Mental Health Service (SMHS) offered to a client from the Mental Health Plan (MHP).

A-13.0 Treatment Appointment Accepted Date

Purpose:

Identifies the Third Specialty Mental Health Services Date offered to the client.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Treatment Appointment Accepted Date is conditional for each Assessment Record.
2. If Treatment Appointment Accepted Date is populated, then:
   - Must be greater than or equal to January 1, 2018.
   - Treatment Appointment Accepted Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. If Treatment Appointment Second and Treatment Appointment Third Offer Dates are spaces, then:
   - The Treatment Appointment Accepted Date must be equal to Treatment Appointment First Offer Date.
2. If the Treatment Appointment Accepted Date, and the Treatment Appointment Second Offer Date is populated and the Treatment Appointment Third Offer Date is spaces, then:
   - The Treatment Appointment Accepted Date must be equal to Treatment Appointment Second Offer Date.
3. If the Treatment Appointment Accepted Date, and the Treatment Appointment Third Offer Date is populated, then:
   - The Treatment Appointment Accepted Date must be greater than or equal to the Treatment Appointment Third Offer Date.

4. If the Treatment Appointment Accepted Date is spaces then the Treatment Appointment First Offer Date should be spaces.

User / Usage Information:

This data element will be used to identify the date a client accepts a treatment appointment date for Specialty Mental Health Service (SMHS) from the Mental Health Plan (MHP).

A-14.0 Treatment Start Date

Purpose:

Identifies the Date of First Treatment Appointment attended by the client following the Assessment Start Date.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Treatment Start Date is conditional for each Assessment Record.
2. If Treatment Start Date is populated, then:
   - Must greater than or equal to January 1, 2018
   - Must be greater than or equal to the Treatment Appointment Accepted Date.
   - Treatment Appointment Accepted Date must not be space filled.
   - Treatment Start Date must not be after the Report Period.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

None.

User / Usage Information:

This data element will be used to identify the date following the Assessment Start Date a client first attended a treatment appointment for Specialty Mental Health Service (SMHS) from the Mental Health Plan (MHP).

A-15.0 Closure Reason

Purpose:

Identifies the list of reasons the assessment treatment process was discontinued, other than successful completion of the process.

Field Description:

Type:	Numeric
Byte(s):	2
Format:	XX
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

01	=	Client did not accept any offered assessment dates.
02	=	Client accepted offered assessment date but did not attend initial assessment appointment.
03	=	Client attended initial assessment appointment but did not complete assessment process.
04	=	Client completed assessment process but declined offered treatment dates.
05	=	Client accepted offered treatment date but did not attend initial treatment appointment.
06	=	Client did not meet medical necessity criteria.
07	=	Out of county/presumptive transfer.
08	=	Unable to contact (e.g., deceased or client unresponsive).
09	=	Other
Spaces		(if unused)

Comments:

The Closure Reason, if populated, must be a valid entry.

User / Usage Information:

This data element contains the list of reasons the assessment treatment process may be discontinued.

A-16.0 Closed Out Date

Purpose:

Identifies the Date the assessment and initial treatment process was closed out due to the client not showing up or being unreachable for scheduled appointment(s). It is not necessarily the final date that the client was seen.

Field Description:

Type:	Numeric
Byte(s):	8
Format:	YYYYMMDD
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

>=20180101

Spaces (if unused)

CONDITIONS:

1. The Closed Out Date is conditional for each Assessment Record.
2. If Closed Out Date is populated, then:
   - Must greater than or equal to January 1, 2018.
   - Must be greater than or equal to the Treatment Appointment Accepted Date (if populated).
   - Must be greater than or equal to the Treatment Appointment Third Offer Date (if populated).
   - Must be greater than or equal to the Treatment Appointment Second Offer Date (if populated).
   - Must be greater than or equal to the Treatment Appointment First Offer Date (if populated).
   - Must be greater than or equal to the Assessment End Date (if populated).
   - Must be greater than or equal to the Assessment Start Date (if populated).
   - Must be greater than or equal to the Assessment Appointment Accepted Date (if populated).
   - Must be greater than or equal to the Assessment Appointment Third Offer Date (if populated).
   - Must be greater than or equal to the Assessment Appointment Second Offer Date (if populated).
   - Must be greater than or equal to the Assessment Appointment First Offer Date (if populated).

- Must be greater than or equal to the Date of First Contact To Request Service (if populated).
- Closed Out Date must not be after the Report Period.

3. The Closed Out Date must be populated if Treatment Start Date is not populated and:
   - The Treatment Appointment Accepted Date is populated.
   - The Treatment Appointment Third Offer Date is populated.
   - The Treatment Appointment Second Offer Date is populated.
   - The Treatment Appointment First Offer Date is populated.
   - The Assessment End Date is populated.
   - The Assessment Start Date is populated.
   - The Assessment Appointment Accepted Date is populated.
   - The Assessment Appointment Third Offer Date is populated.
   - The Assessment Appointment Second Offer Date is populated.
   - The Assessment Appointment First Offer Date is populated.
4. Both Treatment Start Date and Closed Out Date should not be populated.
5. When Treatment Appointment Accepted Date is populated, then either the Treatment Start Date or Closed Out Date should be populated.

Refer to Appendix 2: Date Formatting (Year, Month and Day).

Comments:

1. The Closed Out Date is the date that the Mental Health Plan (MHP) closes out an assessment record and/or unsuccessful assessment process. The Closed Out Date may be the same date as the client was last seen, but more likely will be later when the assessment process is administratively terminated.
2. The Closed Out Date on the Assessment Record defines the reporting period.

User / Usage Information:

This data element will be used to identify the date the assessment and initial treatment process was closed out due to the client not showing up or being unreachable for scheduled appointment(s).

A-17.0 Referred To

Purpose:

Identifies where the client was Referred To (if applicable).

Field Description:

Type:	Numeric
Byte(s):	2
Format:	XX
Required On:	Optional on All Assessment Records
Source:	Local Mental Health

Valid Codes:

01 = Managed Care Plan

02 = Fee-For-Service Provider

03 = Other (Specify)

04 = No Referral

Spaces (if unused)

Comments:

If populated, Referred To must be a valid entry.

User / Usage Information:

This data element identifies where the client was Referred To (if applicable).

K-01.0 First Source County Client Number

Purpose:

Identifies the First Source County Client Number (CCN) in the Key Change Transaction Record.

Field Description:

Type:	Character
Byte(s):	9
Format:	XXXXXXXXX Right justify, zero fill, no embedded spaces
Required On:	All Key Change Records
Source:	Local Mental Health

Valid Codes:

Must match a County Client Number (CCN) in the Master Database.

Comments:

1. If the Target CCN (see comments under Field Number H-02.0, COUNTY CLIENT NUMBER) is in the Master Database, then:
   - The Client, Service, and Periodic Records with the Target CCN are retained.
   - The CCNs of all Service and Periodic Records that match the First Source CCN will be changed to the Target CCN.
   - The Client Record of the First Source CCN will be deleted.
2. If the Target CCN is not in the Master Database:
   - The Client, Service, and Periodic Records with CCNs equal to First Source CCN will have their CCNs changed to the Target CCN.

For further information, Key Change transactions are detailed in Appendix C: CSI Technical Supplement C: Transaction Processing.

User / Usage Information:

This data element is used to specify an existing County Client Number (CCN) to be changed to a new County Client Number (CCN) or merged into an existing County Client Number (CCN).

K-02.0 Additional Source County Client Number

Purpose:

Identifies up to 28 Additional Source County Client Numbers (CCN) in the Key Change Transaction Record.

Field Description:

Type:	Character
Byte(s):	9
Format:	XXXXXXXXX Right justify, zero fill, no embedded spaces This field occurs 28 times
Required On:	All Key Change Records
Source:	Local Mental Health

Valid Codes:

Must match a County Client Number (CCN) in the Master Database.

Spaces (if unused)

Comments:

1. Client Record(s) for the Additional Source CCNs will be deleted.
2. The CCNs of all Service and Periodic Records that match the Additional Source CCNs will be changed to the Target CCN (see comments under Field Number H-02.0, COUNTY CLIENT NUMBER).
3. Unused fields must contain spaces.

User / Usage Information:

This data element is used to merge multiple County Client Numbers (CCN) into an existing or new County Client Number (CCN).

E-01.0 Error Level

Purpose:

Describes the error level (Fatal or Non-fatal) of records on the Error File.

Field Description:

Type:	Character
Byte(s):	1
Format:	X
Required On:	All Error Records
Source:	State Department of Health Care Services

Valid Codes:

F = Transaction Record contains at least one Fatal error

N = Transaction Record contains only Non-fatal error(s)

Comments:

Levels of errors are detailed in Appendix E: CSI Technical Supplement E - Edit Criteria.

User / Usage Information:

This data element is used to indicate whether or not the Master Database is updated.

E-02.0 Field/Relational and System Codes

Purpose:

Identifies the Field in error or indicates a Relational and System Error.

Field Description:

Type:	Character
Byte(s):	3
Format:	XXX
Required On:	All Error Records This field occurs 33 times
Source:	State Department of Health Care Services

Valid Codes:

If it is a Field in error, this is the first three characters (excluding the hyphen) of the Data Dictionary Field Number. For example, Field Number S-08.0 would become Field Code S08.

Spaces (if unused)

CONDITIONS:

- If a Relational and System Error, this field is coded 999.

EDITS:

Edit criteria are detailed in Appendix E: CSI Technical Supplement E - Edit Criteria.

Comments:

Unused fields will contain spaces.

User / Usage Information:

This code, when used in conjunction with the error message identified by Field Number E-03.0, ERROR CODE, identifies the type of error and briefly describes the error.

E-03.0 Error Codes

Purpose:

Identifies the error message.

Field Description:

Type:	Character
Byte(s):	3
Format:	XXX
Required On:	All Error Records This field occurs 33 times
Source:	State Department of Health Care Services

Valid Codes:

Refer to Appendix 15: Error Codes and Error Messages.

Comments:

Unused fields will contain spaces.

User / Usage Information:

This code, when used in conjunction with the code identified by Field Number E-02.0, FIELD / RELATIONAL AND SYSTEM CODE, identifies the type of error and briefly describes the error.

Appendix 1: Report Period Formatting (Year and Month)

4-digit year followed by 2-digit month (YYYYMM).

- Must be numeric.
- MM must be a value between 01 and 12. The numeric form for the months from 1 to 9 must have a zero as the first digit.
- Do not use special characters such as slashes, commas, or hyphens.

Examples:

- April 2018 would be **201804**
- November 2018 would be **201811**

Appendix 2: Date Formatting (Year, Month and Day)

4-digit year followed by 2-digit month and 2-digit day (YYYMMDD)

- Must be numeric.
- MM must be a value between 01 and 12. The numeric form for the months from 1 to 9 must have a zero as the first digit.
- DD must be between 01 and 31
- DD must be appropriate for length of month including a leap year.
- Do not use special characters such as slashes, commas, or hyphens.

Examples:

- April 1, 2018 would be: **20180401**
- November 15, 2018 would be: **20181115**

Appendix 3: Character Formatting

- Use UPPER CASE only.
- Left justify with trailing blanks.

Example:

- For a 10 character field, ‘HELLO’ would be entered as ‘HELLO ’ (without quotes), with five spaces after HELLO.

Appendix 4: Numeric Formatting

- Right justify, zero fill left.
- Must be numeric.
- Do not use special characters such as commas, periods, etc.

Example:

- For a 10 byte numeric field, the number 123456 would be entered as 0000123456.

Appendix 5: Multi-Part Field Formatting

Multi-Part fields (e.g., C-01.0 Birth Name) are single data elements divided into segments. Each segment is fixed length, which means that spaces must be inserted to fill out the length of the segment.

Example:

- For a 12 character element field that is expected in segments of 6 bytes each, ‘HELLOWORLD’ would be entered as ‘HELLO ’ (without quotes), with one space after HELLO; followed by ‘WORLD ’ with one space after WORLD.

Appendix 6: Valid County/City/Health Plan Codes

01	= Alameda	22	= Mariposa	43	= Santa Clara
02	= Alpine	23	= Mendocino	44	= Santa Cruz
03	= Amador	24	= Merced	45	= Shasta
04	= Butte	25	= Modoc	46	= Sierra
05	= Calaveras	26	= Mono	47	= Siskiyou
06	= Colusa	27	= Monterey	48	= Solano
07	= Contra Costa	28	= Napa	49	= Sonoma
08	= Del Norte	29	= Nevada	50	= Stanislaus
09	= El Dorado	30	= Orange	52	= Tehama
10	= Fresno	31	= Placer	53	= Trinity
11	= Glenn	32	= Plumas	54	= Tulare
12	= Humboldt	33	= Riverside	55	= Tuolumne
13	= Imperial	34	= Sacramento	56	= Ventura
14	= Inyo	35	= San Benito	57	= Yolo
15	= Kern	36	= San Bernardino	63	= Sutter/Yuba[1]
16	= Kings	37	= San Diego	65	= Berkeley City
17	= Lake	38	= San Francisco	66	= Tri-City[2]
18	= Lassen	39	= San Joaquin		
19	= Los Angeles	40	= San Luis Obispo		
20	= Madera	41	= San Mateo		
21	= Marin	42	= Santa Barbara		

[1] The counties of Sutter (51) and Yuba (58) act jointly under a Joint Powers Authority (JPA) Agreement as Sutter/Yuba (63) Behavioral Health to provide public mental health services.
[2] The communities of Pomona, Claremont, and La Verne act jointly under a Joint Powers Authority (JPA) Agreement as Tri-City Mental Health (66) to provide public mental health services.

Appendix 7: Valid County Codes

01	=	Alameda	22	=	Mariposa	43	=	Santa Clara
02	=	Alpine	23	=	Mendocino	44	=	Santa Cruz
03	=	Amador	24	=	Merced	45	=	Shasta
04	=	Butte	25	=	Modoc	46	=	Sierra
05	=	Calaveras	26	=	Mono	47	=	Siskiyou
06	=	Colusa	27	=	Monterey	48	=	Solano
07	=	Contra Costa	28	=	Napa	49	=	Sonoma
08	=	Del Norte	29	=	Nevada	50	=	Stanislaus
09	=	El Dorado	30	=	Orange	51	=	Sutter
10	=	Fresno	31	=	Placer	52	=	Tehama
11	=	Glenn	32	=	Plumas	53	=	Trinity
12	=	Humboldt	33	=	Riverside	54	=	Tulare
13	=	Imperial	34	=	Sacramento	55	=	Tuolumne
14	=	Inyo	35	=	San Benito	56	=	Ventura
15	=	Kern	36	=	San Bernardino	57	=	Yolo
16	=	Kings	37	=	San Diego	58	=	Yuba
17	=	Lake	38	=	San Francisco			
18	=	Lassen	39	=	San Joaquin	00	=	Not California County
19	=	Los Angeles	40	=	San Luis Obispo	99	=	Unknown County
20	=	Madera	41	=	San Mateo			
21	=	Marin	42	=	Santa Barbara			

Appendix 8: Valid State Codes

AL	=	Alabama	LA	=	Louisiana	OK	=	Oklahoma
AK	=	Alaska	ME	=	Maine	OR	=	Oregon
AZ	=	Arizona	MD	=	Maryland	PA	=	Pennsylvania
AR	=	Arkansas	MA	=	Massachusetts	RI	=	Rhode Island
CA	=	California	MI	=	Michigan	SC	=	South Carolina
CO	=	Colorado	MN	=	Minnesota	SD	=	South Dakota
CT	=	Connecticut	MS	=	Mississippi	TN	=	Tennessee
DE	=	Delaware	MO	=	Missouri	TX	=	Texas
DC	=	District of Columbia	MT	=	Montana	UT	=	Utah
FL	=	Florida	NE	=	Nebraska	VT	=	Vermont
GA	=	Georgia	NV	=	Nevada	VA	=	Virginia
HI	=	Hawaii	NH	=	New Hampshire	WA	=	Washington
ID	=	Idaho	NJ	=	New Jersey	WV	=	West Virginia
IL	=	Illinois	NM	=	New Mexico	WI	=	Wisconsin
IN	=	Indiana	NY	=	New York	WY	=	Wyoming
IA	=	Iowa	NC	=	North Carolina			
KS	=	Kansas	ND	=	North Dakota	UN	=	Unknown State
KY	=	Kentucky	OH	=	Ohio	00	=	Not US State

Appendix 9: Valid Country Codes

Sorted by Country Name

AF	=	AFGHANISTAN	LA	=	LAOS
AL	=	ALBANIA	LG	=	LATVIA
AG	=	ALGERIA	LE	=	LEBANON
AQ	=	AMERICAN SAMOA	LT	=	LESOTHO
AN	=	ANDORRA	LI	=	LIBERIA
AO	=	ANGOLA	LY	=	LIBYA
AV	=	ANGUILLA	LS	=	LIECHTENSTEIN
AY	=	ANTARCTICA	LH	=	LITHUANIA
AC	=	ANTIGUA AND BARBUDA	LU	=	LUXEMBOURG
AR	=	ARGENTINA	MC	=	MACAU
AM	=	ARMENIA	MK	=	MACEDONIA
AA	=	ARUBA	MA	=	MADAGASCAR
AT	=	ASHMORE AND CARTIER ISLANDS	MI	=	MALAWI
AS	=	AUSTRALIA	MY	=	MALAYSIA
AU	=	AUSTRIA	MV	=	MALDIVES
AJ	=	AZERBAIJAN	ML	=	MALI
BF	=	BAHAMAS, THE	MT	=	MALTA
BA	=	BAHRAIN	IM	=	MAN, ISLE OF
FQ	=	BAKER ISLAND	RM	=	MARSHALL ISLANDS
BG	=	BANGLADESH	MB	=	MARTINIQUE
BB	=	BARBADOS	MR	=	MAURITANIA
BS	=	BASSAS DA INDIA	MP	=	MAURITIUS
BO	=	BELARUS	MF	=	MAYOTTE
BE	=	BELGIUM	MX	=	MEXICO
BH	=	BELIZE	MQ	=	MIDWAY ISLANDS
BN	=	BENIN	MD	=	MOLDOVA
BD	=	BERMUDA	MN	=	MONACO
BT	=	BHUTAN	MG	=	MONGOLIA
BL	=	BOLIVIA	MW	=	MONTENEGRO
BK	=	BOSNIA AND HERZEGOVINA	MH	=	MONTSERRAT
BC	=	BOTSWANA	MO	=	MOROCCO
BV	=	BOUVET ISLAND	MZ	=	MOZAMBIQUE
BR	=	BRAZIL	WA	=	NAMIBIA
IO	=	BRITISH INDIAN OCEAN TERRITORY	NR	=	NAURU
VI	=	BRITISH VIRGIN ISLANDS	BQ	=	NAVASSA ISLAND
BX	=	BRUNEI	NP	=	NEPAL
BU	=	BULGARIA	NL	=	NETHERLANDS
UV	=	BURKINA	NT	=	NETHERLANDS ANTILLES

BM = BURMA
BY = BURUNDI
CB = CAMBODIA
CM = CAMEROON
CA = CANADA
CV = CAPE VERDE
CJ = CAYMAN ISLANDS
CT = CENTRAL AFRICAN REPUBLIC
CD = CHAD
CI = CHILE
CH = CHINA
KT = CHRISTMAS ISLAND
IP = CLIPPERTON ISLAND
CK = COCOS (KEELING) ISLANDS
CO = COLOMBIA
CN = COMOROS
CF = CONGO
CW = COOK ISLANDS
CR = CORAL SEA ISLANDS
CS = COSTA RICA
IV = COTE D'IVOIRE
HR = CROATIA
CU = CUBA
CY = CYPRUS
EZ = CZECH REPUBLIC
DA = DENMARK
DJ = DJIBOUTI
DO = DOMINICA
DR = DOMINICAN REPUBLIC
EC = ECUADOR
EG = EGYPT
ES = EL SALVADOR
EK = EQUATORIAL GUINEA
ER = ERITREA
EN = ESTONIA
ET = ETHIOPIA
EU = EUROPA ISLAND
FK = FALKLAND ISLANDS (ISLAS MALVINAS)
FO = FAROE ISLANDS
FM = FEDERATED STATES OF MICRONESIA
FJ = FIJI
NC = NEW CALEDONIA
NZ = NEW ZEALAND
NU = NICARAGUA
NG = NIGER
NI = NIGERIA
NE = NIUE
NF = NORFOLK ISLAND
CQ = NORTHERN MARIANA ISLANDS
NO = NORWAY
MU = OMAN
PK = PAKISTAN
PS = PALAU
LQ = PALMYRA ATOLL
PM = PANAMA
PP = PAPUA NEW GUINEA
PF = PARACEL ISLANDS
PA = PARAGUAY
PE = PERU
RP = PHILIPPINES
PC = PITCAIRN ISLANDS
PL = POLAND
PO = PORTUGAL
RQ = PUERTO RICO
QA = QATAR
RE = REUNION
RO = ROMANIA
RS = RUSSIA
RW = RWANDA
SM = SAN MARINO
TP = SAO TOME AND PRINCIPE
SA = SAUDI ARABIA
SG = SENEGAL
SR = SERBIA
SE = SEYCHELLES
SL = SIERRA LEONE
SN = SINGAPORE
LO = SLOVAKIASI SLOVENIA
BP = SOLOMAN ISLANDS
SO = SOMALIA
SF = SOUTH AFRICA
SX = SOUTH GEORGIA AND THE SOUTH SANDWICH ISLANDS

FI	=	FINLAND
FR	=	FRANCE
FG	=	FRENCH GUIANA
FP	=	FRENCH POLYNESIA
FS	=	FRENCH SOUTHERN AND ANTARCTIC LANDS
GB	=	GABON
GA	=	GAMBIA, THE
GZ	=	GAZA STRIP
GG	=	GEORGIA
GM	=	GERMANY
GH	=	GHANA
GI	=	GIBRALTAR
GO	=	GLORIOSO ISLANDS
GR	=	GREECE
GL	=	GREENLAND
GJ	=	GRENADA
GP	=	GUADELOUPE
GQ	=	GUAM
GT	=	GUATEMALA
GK	=	GUERNSEY
GV	=	GUINEA
PU	=	GUINEA-BISSAU
GY	=	GUYANA
HA	=	HAITI
HM	=	HEARD ISLAND AND MCDONALD ISLANDS
HO	=	HONDURAS
HK	=	HONG KONG
HQ	=	HOWLAND ISLAND
HU	=	HUNGARY
IC	=	ICELAND
IN	=	INDIA
ID	=	INDONESIA
IR	=	IRAN
IZ	=	IRAQ
EI	=	IRELAND
IS	=	ISRAEL
IT	=	ITALY
JM	=	JAMAICA
JN	=	JAN MAYEN
JA	=	JAPAN
SP	=	SPAIN
PG	=	SPRATLY ISLANDS
CE	=	SRI LANKA
SH	=	ST. HELENA
SC	=	ST. KITTS AND NEVIS
ST	=	ST. LUCIA
SB	=	ST. PIERRE AND MIQUELON
VC	=	ST. VINCENT AND THE GRENADINES
SU	=	SUDAN
NS	=	SURINAME
SV	=	SVALBARD
WZ	=	SWAZILAND
SW	=	SWEDEN
SZ	=	SWITZERLAND
SY	=	SYRIA
TW	=	TAIWAN
TI	=	TAJIKISTAN
TZ	=	TANZANIA
TH	=	THAILAND
TO	=	TOGO
TL	=	TOKELAU
TN	=	TONGA
TD	=	TRINIDAD AND TOBAGO
TE	=	TROMELIN ISLAND
TS	=	TUNISIA
TU	=	TURKEY
TX	=	TURKMENISTAN
TK	=	TURKS AND CAICOS ISLANDS
TV	=	TUVALU
UG	=	UGANDA
UP	=	UKRAINE
TC	=	UNITED ARAB EMIRATES
UK	=	UNITED KINGDOM
US	=	UNITED STATES
UY	=	URUGUAY
UZ	=	UZBEKISTAN
NH	=	VANUATU
VT	=	VATICAN CITY
VE	=	VENEZUELA
VM	=	VIETNAM

DQ	=	JARVIS ISLAND	VQ	=	VIRGIN ISLANDS
JE	=	JERSEY	WQ	=	WAKE ISLAND
JQ	=	JOHNSTON ATOLL	WF	=	WALLIS AND FUTUNA
JO	=	JORDAN	WE	=	WEST BANK
JU	=	JUAN DE NOVA ISLAND	WI	=	WESTERN SAHARA
KZ	=	KAZAKHSTAN	WS	=	WESTERN SAMOA
KE	=	KENYA	YM	=	YEMEN
KQ	=	KINGMAN REEF	CG	=	ZAIRE
KR	=	KIRIBATI	ZA	=	ZAMBIA
KN	=	KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF	ZI	=	ZIMBABWE
KS	=	KOREA, REPUBLIC OF			
KU	=	KUWAIT	00	=	Country Not Listed
KG	=	KYRGYZSTAN	99	=	Unknown Country

Sorted by Country Code

AA	=	ARUBA	KT	=	CHRISTMAS ISLAND
AC	=	ANTIGUA AND BARBUDA	KU	=	KUWAIT
AF	=	AFGHANISTAN	KZ	=	KAZAKHSTAN
AG	=	ALGERIA	LA	=	LAOS
AJ	=	AZERBAIJAN	LE	=	LEBANON
AL	=	ALBANIA	LG	=	LATVIA
AM	=	ARMENIA	LH	=	LITHUANIA
AN	=	ANDORRA	LI	=	LIBERIA
AO	=	ANGOLA	LO	=	SLOVAKIASI SLOVENIA
AQ	=	AMERICAN SAMOA	LQ	=	PALMYRA ATOLL
AR	=	ARGENTINA	LS	=	LIECHTENSTEIN
AS	=	AUSTRALIA	LT	=	LESOTHO
AT	=	ASHMORE AND CARTIER ISLANDS	LU	=	LUXEMBOURG
AU	=	AUSTRIA	LY	=	LIBYA
AV	=	ANGUILLA	MA	=	MADAGASCAR
AY	=	ANTARCTICA	MB	=	MARTINIQUE
BA	=	BAHRAIN	MC	=	MACAU
BB	=	BARBADOS	MD	=	MOLDOVA
BC	=	BOTSWANA	MF	=	MAYOTTE
BD	=	BERMUDA	MG	=	MONGOLIA
BE	=	BELGIUM	MH	=	MONTSERRAT
BF	=	BAHAMAS, THE	MI	=	MALAWI
BG	=	BANGLADESH	MK	=	MACEDONIA
BH	=	BELIZE	ML	=	MALI
BK	=	BOSNIA AND HERZEGOVINA	MN	=	MONACO

BL	=	BOLIVIA
BM	=	BURMA
BN	=	BENIN
BO	=	BELARUS
BP	=	SOLOMAN ISLANDS
BQ	=	NAVASSA ISLAND
BR	=	BRAZIL
BS	=	BASSAS DA INDIA
BT	=	BHUTAN
BU	=	BULGARIA
BV	=	BOUVET ISLAND
BX	=	BRUNEI
BY	=	BURUNDI
CA	=	CANADA
CB	=	CAMBODIA
CD	=	CHAD
CE	=	SRI LANKA
CF	=	CONGO
CG	=	ZAIRE
CH	=	CHINA
CI	=	CHILE
CJ	=	CAYMAN ISLANDS
CK	=	COCOS (KEELING) ISLANDS
CM	=	CAMEROON
CN	=	COMOROS
CO	=	COLOMBIA
CQ	=	NORTHERN MARIANA ISLANDS
CR	=	CORAL SEA ISLANDS
CS	=	COSTA RICA
CT	=	CENTRAL AFRICAN REPUBLIC
CU	=	CUBA
CV	=	CAPE VERDE
CW	=	COOK ISLANDS
CY	=	CYPRUS
DA	=	DENMARK
DJ	=	DJIBOUTI
DO	=	DOMINICA
DQ	=	JARVIS ISLAND
DR	=	DOMINICAN REPUBLIC
EC	=	ECUADOR
EG	=	EGYPT
MO	=	MOROCCO
MP	=	MAURITIUS
MQ	=	MIDWAY ISLANDS
MR	=	MAURITANIA
MT	=	MALTA
MU	=	OMAN
MV	=	MALDIVES
MW	=	MONTENEGRO
MX	=	MEXICO
MY	=	MALAYSIA
MZ	=	MOZAMBIQUE
NC	=	NEW CALEDONIA
NE	=	NIUE
NF	=	NORFOLK ISLAND
NG	=	NIGER
NH	=	VANUATU
NI	=	NIGERIA
NL	=	NETHERLANDS
NO	=	NORWAY
NP	=	NEPAL
NR	=	NAURU
NS	=	SURINAME
NT	=	NETHERLANDS ANTILLES
NU	=	NICARAGUA
NZ	=	NEW ZEALAND
PA	=	PARAGUAY
PC	=	PITCAIRN ISLANDS
PE	=	PERU
PF	=	PARACEL ISLANDS
PG	=	SPRATLY ISLANDS
PK	=	PAKISTAN
PL	=	POLAND
PM	=	PANAMA
PO	=	PORTUGAL
PP	=	PAPUA NEW GUINEA
PS	=	PALAU
PU	=	GUINEA-BISSAU
QA	=	QATAR
RE	=	REUNION
RM	=	MARSHALL ISLANDS
RO	=	ROMANIA

EI	=	IRELAND	RP	=	PHILIPPINES
EK	=	EQUATORIAL GUINEA	RQ	=	PUERTO RICO
EN	=	ESTONIA	RS	=	RUSSIA
ER	=	ERITREA	RW	=	RWANDA
ES	=	EL SALVADOR	SA	=	SAUDI ARABIA
ET	=	ETHIOPIA	SB	=	ST. PIERRE AND MIQUELON
EU	=	EUROPA ISLAND	SC	=	ST. KITTS AND NEVIS
EZ	=	CZECH REPUBLIC	SE	=	SEYCHELLES
FG	=	FRENCH GUIANA	SF	=	SOUTH AFRICA
FI	=	FINLAND	SG	=	SENEGAL
FJ	=	FIJI	SH	=	ST. HELENA
FK	=	FALKLAND ISLANDS (ISLAS MALVINAS)	SL	=	SIERRA LEONE
FM	=	FEDERATED STATES OF MICRONESIA	SM	=	SAN MARINO
FO	=	FAROE ISLANDS	SN	=	SINGAPORE
FP	=	FRENCH POLYNESIA	SO	=	SOMALIA
FQ	=	BAKER ISLAND	SP	=	SPAIN
FR	=	FRANCE	SR	=	SERBIA
FS	=	FRENCH SOUTHERN AND ANTARCTIC LANDS	ST	=	ST. LUCIA
GA	=	GAMBIA, THE	SU	=	SUDAN
GB	=	GABON	SV	=	SVALBARD
GG	=	GEORGIA	SW	=	SWEDEN
GH	=	GHANA	SX	=	SOUTH GEORGIA AND THE SOUTH SANDWICH ISLANDS
GI	=	GIBRALTAR	SY	=	SYRIA
GJ	=	GRENADA	SZ	=	SWITZERLAND
GK	=	GUERNSEY	TC	=	UNITED ARAB EMIRATES
GL	=	GREENLAND	TD	=	TRINIDAD AND TOBAGO
GM	=	GERMANY	TE	=	TROMELIN ISLAND
GO	=	GLORIOSO ISLANDS	TH	=	THAILAND
GP	=	GUADELOUPE	TI	=	TAJIKISTAN
GQ	=	GUAM	TK	=	TURKS AND CAICOS ISLANDS
GR	=	GREECE	TL	=	TOKELAU
GT	=	GUATEMALA	TN	=	TONGA
GV	=	GUINEA	TO	=	TOGO
GY	=	GUYANA	TP	=	SAO TOME AND PRINCIPE
GZ	=	GAZA STRIP	TS	=	TUNISIA
HA	=	HAITI	TU	=	TURKEY
HK	=	HONG KONG	TV	=	TUVALU
HM	=	HEARD ISLAND AND MCDONALD ISLANDS	TW	=	TAIWAN
HO	=	HONDURAS	TX	=	TURKMENISTAN
HQ	=	HOWLAND ISLAND	TZ	=	TANZANIA

HR	=	CROATIA	UG	=	UGANDA
HU	=	HUNGARY	UK	=	UNITED KINGDOM
IC	=	ICELAND	UP	=	UKRAINE
ID	=	INDONESIA	US	=	UNITED STATES
IM	=	MAN, ISLE OF	UV	=	BURKINA
IN	=	INDIA	UY	=	URUGUAY
IO	=	BRITISH INDIAN OCEAN TERRITORY	UZ	=	UZBEKISTAN
IP	=	CLIPPERTON ISLAND	VC	=	ST. VINCENT AND THE GRENADINES
IR	=	IRAN	VE	=	VENEZUELA
IS	=	ISRAEL	VI	=	BRITISH VIRGIN ISLANDS
IT	=	ITALY	VM	=	VIETNAM
IV	=	COTE D'IVOIRE	VQ	=	VIRGIN ISLANDS
IZ	=	IRAQ	VT	=	VATICAN CITY
JA	=	JAPAN	WA	=	NAMIBIA
JE	=	JERSEY	WE	=	WEST BANK
JM	=	JAMAICA	WF	=	WALLIS AND FUTUNA
JN	=	JAN MAYEN	WI	=	WESTERN SAHARA
JO	=	JORDAN	WQ	=	WAKE ISLAND
JQ	=	JOHNSTON ATOLL	WS	=	WESTERN SAMOA
JU	=	JUAN DE NOVA ISLAND	WZ	=	SWAZILAND
KE	=	KENYA	YM	=	YEMEN
KG	=	KYRGYZSTAN	ZA	=	ZAMBIA
KN	=	KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF	ZI	=	ZIMBABWE
KQ	=	KINGMAN REEF			
KR	=	KIRIBATI	00	=	Country Not Listed
KS	=	KOREA, REPUBLIC OF	99	=	Unknown Country

Appendix 10: Valid Language Codes

The coding scheme is similar to the one in the DHCS MEDS Data Dictionary.

Sorted by Language Code

0	=	American Sign Language (ASL)	H	=	Hmong
1	=	Spanish	I	=	Lao
2	=	Cantonese	J	=	Turkish
3	=	Japanese	K	=	Hebrew
4	=	Korean	L	=	French
5	=	Tagalog	M	=	Polish
6	=	Other Non-English	N	=	Russian
7	=	English	P	=	Portuguese
A	=	Other Sign Language	Q	=	Italian
B	=	Mandarin	R	=	Arabic
C	=	Other Chinese Dialects	S	=	Samoan
D	=	Cambodian	T	=	Thai
E	=	Armenian	U	=	Farsi
F	=	Ilocano	V	=	Vietnamese
G	=	Mien	9	=	Unknown / Not Reported

Sorted by Language Name

For your convenience, below are the Valid Language Codes displayed in alphabetical order.

0	=	American Sign Language (ASL)	B	=	Mandarin
R	=	Arabic	G	=	Mien
E	=	Armenian	C	=	Other Chinese Dialects
D	=	Cambodian	6	=	Other Non-English
2	=	Cantonese	A	=	Other Sign Language
7	=	English	M	=	Polish
U	=	Farsi	P	=	Portuguese
L	=	French	N	=	Russian
K	=	Hebrew	S	=	Samoan
H	=	Hmong	1	=	Spanish
F	=	Ilocano	5	=	Tagalog
Q	=	Italian	T	=	Thai
3	=	Japanese	J	=	Turkish
4	=	Korean	9	=	Unknown / Not Reported
I	=	Lao	V	=	Vietnamese

Appendix 11: Valid Race Codes

The coding scheme is similar to the one in the DHCS MEDS Data Dictionary.

Sorted by Race Code

1	=	White or Caucasian	M	=	Samoan
3	=	Black or African American	N	=	Asian Indian
5	=	American Indian or Alaska Native	O	=	Other Asian
7	=	Filipino	P	=	Native Hawaiian
C	=	Chinese	R	=	Guamanian
H	=	Cambodian	S	=	Mien
I	=	Hmong	T	=	Laotian
J	=	Japanese	V	=	Vietnamese
K	=	Korean	8	=	Other
L	=	Other Pacific Islander	9	=	Unknown / Not Reported

Sorted by Race Name

For your convenience, below are the Valid Race Codes displayed in alphabetical order.

5	=	American Indian or Alaska Native	T	=	Laotian
N	=	Asian Indian	S	=	Mien
3	=	Black or African American	P	=	Native Hawaiian
H	=	Cambodian	8	=	Other
C	=	Chinese	O	=	Other Asian
7	=	Filipino	L	=	Other Pacific Islander
R	=	Guamanian	M	=	Samoan
I	=	Hmong	V	=	Vietnamese
J	=	Japanese	9	=	Unknown / Not Reported
K	=	Korean	1	=	White or Caucasian

Appendix 12: Diagnosis Reference Tables

The following table is a visual illustration of the rules referenced above of what codes are allowed in the Secondary (S- 10.0) Mental Health Diagnosis, and the Third, Fourth, and Fifth Additional Mental or Physical Health Diagnoses Fields (S-11.0) fields based on what is entered in the Principal (S-9.0) Mental Health Diagnosis field.

Please refer to Appendix F3: CSI Technical Supplement F - Reporting Tip 3 for examples of valid and invalid code entries for diagnoses on service records between 07/01/2006 and 09/30/2015.

Reference Table of Valid Code Entries for Fields S-09.0, S-10.0, and S-11.0

Examples / Conditions	S-09.0 Principal Mental Health Diagnosis	S-10.0 Secondary Mental Health Diagnosis	S-11.0 Third Additional Mental or Physical Health Diagnosis	S-11.0 Fourth Additional Mental or Physical Health Diagnosis	S-11.0 Fifth Additional Mental or Physical Health Diagnosis
If Principal is ICD-10 code	ICD-10 or 9999999 or 0000000	ICD-10 or 9999999 or 0000000	ICD-10 or 9999999 or 0000000 or ICD-10 Physical Health Diagnosis Codes	ICD-10 or 9999999 or 0000000 or ICD-10 Physical Health Diagnosis Codes	ICD-10 or 9999999 or 0000000 or ICD-10 Physical Health Diagnosis Codes
Rule: *If an ICD-10, 9999999 (Unknown/Deferred Diagnosis), or 0000000 (No Diagnosis) code is entered in the Principal Mental Health Diagnosis field (S-09.0), then an ICD-10 code of 9999999 (Unknown/Deferred Diagnosis), or 0000000 (No Diagnosis) can be entered in the Secondary Mental Health (S-10.0) and the Third, Fourth, and Fifth Additional Mental or Physical Health Diagnoses (S-11.0) fields. Additionally, an ICD-10 code for physical health diagnoses can be entered in any of the S-11.0 fields.*					
If Principal is 9999999	9999999	9999999 or 0000000	0000000 or ICD-10 Physical Health Diagnosis Codes *9999999	0000000 or ICD-10 Physical Health Diagnosis Codes *9999999	0000000 or ICD-10 Physical Health Diagnosis Codes *9999999
Rule: *If 9999999 (Unknown/Deferred Diagnosis) is entered in the S-09.0 field, then only 9999999 (Unknown/Deferred Diagnosis) or 0000000 (No Diagnosis) can be entered in the S-10.0 field. Code 0000000 (No Diagnosis), ICD-10 codes for Physical Health Diagnosis, or code 9999999 (Unknown/Deferred Diagnosis) can be entered in the S-11.0 fields.* ****Note: Code 9999999 will be allowed to be entered in S-11.0 field without generating an error message; however, as a best practice, it is recommended that code 9999999 not be entered in the S-11.0 fields when the scenario described above is present.***					
If Principal is 0000000	0000000	0000000	0000000 or ICD-10 Physical Health Diagnosis Codes *9999999	0000000 or ICD-10 Physical Health Diagnosis Codes *9999999	0000000 or ICD-10 Physical Health Diagnosis Codes *9999999
Rule: *If 0000000 (No Diagnosis) is entered in the S-09.0 field, then the S-10.0 must also be 0000000 (No Diagnosis). Code 0000000 (No Diagnosis) or, ICD-10 for Physical Health Diagnosis can be entered in the S-11.0 fields.* ***Note: Code 9999999 will be allowed to be entered in S-11.0 field without generating an error message; however, as a best practice, it is recommended that code 9999999 not be entered in the S-11.0 fields when the scenario described above is present.**					

Reference Table of Invalid Code Entries

Examples / Conditions	S-09.0 Principal Mental Health Diagnosis	S-10.0 Secondary Mental Health Diagnosis	S-11.0 Third Additional Mental or Physical Health Diagnosis	S-11.0 Fourth Additional Mental or Physical Health Diagnosis	S-11.0 Fifth Additional Mental or Physical Health Diagnosis
Unknown / Deferred Diagnosis in Principal and ICD-10 (F01-99) in Secondary	9999999	F01-99 is not allowed	F01-99 is not allowed	F01-99 is not allowed	F01-99 is not allowed
Rule: *If code 9999999 (Unknown/Deferred Diagnosis) is enter in the Principal Mental Health Diagnosis (S- 09.0) field, then ICD-10 (F01-99) range codes for Mental Health diagnosis cannot be entered in the S-10.0 and S-11.0 fields.*					
No diagnosis in Principal with ICD-10 (F01-99) diagnosis in Secondary	0000000	F01-99 and 9999999 are not allowed	F01-99 is not allowed	F01-99 is not allowed	F01-99 is not allowed
Rule: *If code 0000000 (No Diagnosis) was entered in the S-09.0 field, then Mental Health Diagnosis codes, ICD-10 (F01-99) and 9999999 (Unknown/Deferred Diagnosis) are not allowed in the S.10.0 field. The S-10.0 field must be coded 0000000 if 0000000 was entered into the S-09.0 field. The S-11.0 fields may contain 0000000, or any ICD-10 Physical Health Diagnosis Code.* **Note: Code 9999999 will be allowed to be entered in S-11.0 field without generating an error message; however, as a best practice, it is recommended that code 9999999 not be entered in the S-11.0 fields when the scenario described above is present.**					
Repeated F01-99 Codes	F32	F32 is not allowed	F32 is not allowed	F99	F99 is not allowed
Rule: *If a valid ICD-10 (F01-99) code is entered in the S-09.0 field, then the same code cannot be repeatedly entered in the S-10.0 or S-11.0 fields. A client's Principal, Secondary, and Additional Mental Health Diagnoses must all be different. In the example above code F32 cannot be entered in S-10.0 and S-11.0 (Third Additional Diagnosis) because F32 is entered in S-09.0; and code F99 cannot be entered in S-11.0 (Fifth Additional Diagnosis) because F99 is entered in S-11.0 (Fourth Additional Diagnosis) field.*					

Appendix 13: Service Function Definitions

This appendix provides definitions for service functions.

For more details on these definitions, see the California Code of Regulations, Title 9, Chapter 11 and the County Cost Report documentation.

24 Hour Services / Mode 05 Definitions

24 Hour Services/Mode 05	
Hospital Inpatient (10-18)	Services provided in an acute psychiatric hospital or a distinct acute psychiatric part of a general hospital that is approved by the Department of Health Care Services to provide psychiatric services.
Hospital Administrative Day (19)	Local Hospital Administrative Days are those days that a patient's stay in the hospital is beyond the need for acute care and there is a lack of nursing facility beds.
Psychiatric Health Facility (PHF) (20-29)	Psychiatric Health Facility Services are therapeutic and/or rehabilitation services provided in a non-hospital 24-hour inpatient setting, on either a voluntary or involuntary basis. Must be licensed as a Psychiatric Health Facility by the Department of Health Care Services.
SNF Intensive (30-34)	A licensed skilled nursing facility which is funded and staffed to provide intensive psychiatric care.
IMD (Institute for Mental Disease) Basic (35) With Patch (36-39)	For this service function an IMD is a SNF where more than 50% of the patients are diagnosed with a mental disorder. The federal government has designated these facilities as IMDs. No Patch. Organized therapeutic activities which augment and are integrated into an existing skilled nursing facility.
Adult Crisis Residential (40-49)	Therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for persons experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care.
Jail Inpatient (50-59)	A distinct unit within an adult or juvenile detention facility which is staffed to provide intensive psychiatric treatment of inmates.

24 Hour Services/Mode 05	
Residential, Other (60-64)	This service function includes children residential programs, former SB 155 programs, former Community Care Facility (CCF) augmentation, and other residential programs that are not Medi-Cal certified or defined elsewhere.
Adult Residential (65-79)	Rehabilitative services, provided in a non-institutional, residential setting, which provide a therapeutic community including a range of activities and services for persons who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program.
Semi-Supervised Living (80-84)	A program of structured living arrangements for persons who do not need intensive support but who, without some support and structure, may return to a condition requiring hospitalization. This program may be a transition to independent living.
Independent Living (85-89)	This program is for persons who need minimum support in order to live in the community.
Mental Health Rehab Center (90-94)	This is a 24 hour program which provides intensive support and rehabilitation services designed to assist persons 18 years or older, with mental disorders who would have been placed in a state hospital or another Mental Health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning.
Therapeutic Foster Care (95-98)	Services for children within private homes of trained families. The approach combines the normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturing family home.

Day Services / Mode 10 Definitions

Day Services/Mode 10	
Crisis Stabilization - Emergency Room (20-24)	This is an immediate face-to-face response lasting less than 24 hours, to or on behalf of a client exhibiting acute psychiatric symptoms, provided in a 24-hour health facility or hospital based outpatient program. Service activities are provided as a package and include but are not limited to Crisis Intervention, Assessment, Evaluation, Collateral, Medication Support Services, and Therapy.
Crisis Stabilization - Urgent Care (25-29)	This is an immediate face-to-face response lasting less than 24 hours, to or on behalf of a client exhibiting acute psychiatric symptoms, provided at a certified Mental Health Rehabilitation provider site. Service activities are provided as a package and include but are not limited to Crisis Intervention, Assessment, Evaluation, Collateral, Medication Support Services, and Therapy.
Vocational Service (30-39)	Services designed to encourage and facilitate individual motivation and focus upon realistic and attainable vocational goals. To the extent possible, the intent is to maximize individual client involvement in skill seeking and skill enhancement, with an ultimate goal of self-support.
Socialization (40-49)	Services designed to provide activities for persons who require structured support and the opportunity to develop the skills necessary to move toward more independent functioning.
SNF Augmentation (60-69)	Organized therapeutic activities which augment and are integrated into an existing skilled nursing facility.
Day Treatment Intensive Half Day (81-84) Full Day (85-89)	Day Treatment Intensive service provides an organized and structured multi-disciplinary treatment program as an alternative to hospitalization, to avoid placement in a more restrictive setting, or to maintain the client in a community setting.
Day Rehabilitation Half Day (91-94) Full Day (95-99)	Day Rehabilitation service provides evaluation and therapy to maintain or restore personal independence and functioning consistent with requirements for learning and development.

Outpatient Services/Mode 15 Definitions

Outpatient Services/Mode 15	
Linkage/Brokerage (01-05, 08)	Linkage/Brokerage services are activities that assist a client to access medical, educational, social, prevocational, vocational, rehabilitative, or other needed community services.
Child and Family Team (06)	Services for children and families delivered in the context of a single, integrated team that includes the child or youth, his or her family, natural and community supports, and professionals. In California, the Child and Family Team (CFT) process is key to the success of the Continuum of Care Reform efforts and the well-being of children, youth, and families served by public agencies and their partners. It is based on the belief that children, youth, and families have the capacity to resolve their problems if given sufficient support and resources to help them do so.
Intensive Care Coordination (ICC) (07)	A targeted case management service that facilitates assessment of, care planning for and coordination of services, including urgent services for members of the Katie A. subclass.
Collateral (10-18) Mental Health Services (MHS) (30-38, 40-48, 50-55)	Collateral and Mental Health Services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhanced self-sufficiency.
Peer Support Services (20)	Culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals.
Child and Family Team (CFT) Assessment (56)	Services for children and families delivered in the context of a single, integrated team that includes the child or youth, his or her family, natural and community supports, and professionals.
Intensive Home Based Services (IHBS) (57)	Individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family

Outpatient Services/Mode 15	
	ability to help the child/youth successfully function in the home and community.
Therapeutic Behavioral Services (TBS) (58)	These services are the same as collateral and Mental Health Services, except they consist of one-to-one therapeutic contacts with a Mental Health provider and a beneficiary for a specified short-term period of time (shadowing), which are designed to maintain the child/youths residential placement at the lowest appropriate level by resolving target behaviors and achieving short-term treatment goals. The Mental Health provider is on-site and is immediately available to intervene for a specified period of time, up to 24 hours a day, depending on the need of the child/youth.
Professional Inpatient Visit - Collateral or MHS (19, 39, 49, 59)	These services are the same as Mental Health Services except the services are provided in a non-SD/MC inpatient setting by professional staff.
Medication Support (60-68)	Medication support services include prescribing, administering, dispensing, and monitoring of psychiatric medication or biologicals necessary to alleviate the symptoms of mental illness.
Professional Inpatient Visit - Medication Support (69)	These services are the same as Medication Support except the services are provided in a non-SD/MC inpatient setting by professional staff.
Crisis Intervention (70-78)	Crisis Intervention is a service, lasting less than 24 hours, to on behalf of a client for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy.
Professional Inpatient Visit - Crisis Intervention (79)	These services are the same as Crisis Intervention except the services are provided in a non-SD/MC inpatient setting by professional staff.

Appendix 14: Evidence Based Practices / Service Strategies Definitions

This appendix provides definitions for evidence-based practices and service strategies.

Evidence Based Practice are programs/services delivered in a culturally-competent manner that incorporate practices with generally accepted scientific fidelity, and that measure the impact of the practice on clients, participants and/or communities.

These evidence-based practices are more fully described by the Substance Abuse and Mental Health Services Administration (SAMHSA) and are available using the search function at WWW.NRI-INC.ORG.

Toolkits for some of the evidence-based practices are available using the search function at WWW.SAMHSA.GOV.

The following report, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs, provides information about Evidence-Based Practices (EBPs):* Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs. (For more information, search www.congress.gov.)

Page 34 of the report presents the following information:

- **Performance and quality information systems activities:** for example, the Evidence-Based Practices Resource Center (EBP Resource Center), a searchable online database of mental health and substance abuse information supported by scientific research. The EBP Resource Center aims to "provide communities, clinicians, policy-makers, and others" with "the information and tools they need to incorporate evidence-based practices into their communities or clinical settings." Launched in April 2018, the EBP Resource Center replaced the National Registry of Evidence-based Programs and Practices—in existence since 1997—after the Cures Act codified and amended the responsibilities of SAMHSA to publicly provide information on evidence-based program and practices.

- Evidence-Based Practices Resource Center | SAMHSA
  Evidence-Based Practices Resource Center aims to provide communities, clinicians, policy-makers and others in the field with the information and tools they need to incorporate evidence-based practices into their communities or clinical settings. The Resource Center contains a collection of scientifically-based resources for a broad range of audiences, including Treatment Improvement Protocols, toolkits, resource guides, clinical practice guidelines, and other science-based resources.

Service Strategies:

The service strategies selected for reporting to the CSI System were chosen based on the MHSA process and the Community Services and Support (CSS) plans submitted by the counties.

Service strategies are intended as modifiers of the service mode and service function data fields. However, we recognize that the definitions given for service strategies are general. We anticipate that there may be variability in how reporting on this data field will be implemented, both within and between counties.

Assertive Community Treatment (01)	A team-based approach to the provision of treatment, rehabilitation, and support services. Core components include: Small caseloads Team approach Full responsibility for treatment services Community-based services Assertive engagement mechanisms Role of consumers and/or family members on treatment team
Supportive Employment (02)	Services that promote rehabilitation and a return to productive employment for persons with serious mental illness. Core components include: Vocational services staff Integration of rehabilitation with Mental Health treatment No exclusion criteria Rapid search for competitive jobs Jobs as transition Follow-along supports
Supportive Housing (03)	Services to assist individuals in finding and maintaining appropriate housing arrangements and independent living situations. Criteria include: Housing choice Functional separation of housing from service provision Affordability Integration (with persons who do not have mental illness) The right to tenure Service choice Service individualization Service availability

Family Psychoeducation (04)	Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through active involvement of family members in treatment and management. Core components include: Family Intervention Coordinator Quality of clinician-family alliance Education curriculum Structured problem-solving technique
Integrated Dual Diagnosis Treatment (05)	Treatments that combine or integrate Mental Health and substance abuse interventions at the level of the clinical encounter. Core components include: Multidisciplinary team Stage-wise interventions Substance abuse counseling Outreach and secondary interventions
Illness Management and Recovery (06)	A practice that includes a broad range of health, lifestyle, self-assessment and management behaviors by the client, with the assistance and support of others. Core components include: Comprehensiveness of the curriculum Illness Management Recovery goal setting Cognitive-behavioral techniques Relapse prevention training
Medication Management (07)	A systematic approach to medication management for severe mental illnesses that includes the involvement of consumers, families, supporters, and practitioners in the decision-making process. Includes monitoring and recording of information about medication results. Critical elements include: Utilization of a systemic plan for medication management Objective measures of outcome are produced Documentation is thorough and clear Consumers/family and practitioners share in the decision-making
New Generation Medications (08)	A practice that tracks adults with a primary diagnosis of schizophrenia who received atypical second generation medications (including Clozapine) during the reporting year.
Therapeutic Foster Care (09)	Services for children within private homes of trained families. The approach combines the normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturing family home.

Multisystemic Therapy (10)	A practice that views the individual as nestled within a complex network of interconnected systems (family, school, peers). The goal is to facilitate and promote individual change in this natural environment. The caregiver(s) is viewed as the key to long-term outcomes.
Functional Family Therapy (11)	A program designed to enhance protective factors and reduce risk by working with both the youth and their family. Phases of the program are engagement, motivation, assessment, behavior change, and generalization.
Peer and/or Family Delivered Services (50)	Services and supports provided by clients and family members who have been hired as treatment program staff, or who provide adjunct supportive or administrative services, such as training, information dissemination and referral, support groups and self-help support and empowerment. Please note that if the service/support is to be reimbursed by Medi-Cal, client and family member staff duties and credentials must meet Medi-Cal provider certification requirements.
Psychoeducation (51)	Services that provide education about: Mental health diagnosis and assessment Medications Services and support planning Treatment modalities Other information related to Mental Health services and needs
Family Support (52)	Services provided to a client's family member(s) in order to help support the client.
Supportive Education (53)	Services that support the client toward achieving educational goals with the ultimate aim of productive work and self-support.
Delivered in Partnership with Law Enforcement (includes courts, probation, etc.) (54)	Services that are integrated, interdisciplinary and/or coordinated with law enforcement, probation or courts (e.g., Mental Health courts, jail diversion programs, etc.) for the purpose of providing alternatives to incarceration/detention for those with mental illness/emotional disturbance and criminal justice system involvement.
Delivered in Partnership with Health Care (55)	Integrated, interdisciplinary and/or coordinated physical and Mental Health services, including co-location and/or collaboration between Mental Health and primary care providers, and/or other health care sites.
Delivered in Partnership with Social Services (56)	Integrated, interdisciplinary and/or coordinated social services and Mental Health services, including co-location and/or collaboration between Mental Health and social services providers.

Delivered in Partnership with Substance Abuse Services (57)	Integrated, interdisciplinary and/or coordinated substance use services and Mental Health services, including co-location and/or collaboration between Mental Health providers and agencies/providers of substance use services. This strategy is distinguished from the Federal evidence- based practice, "Integrated Dual Diagnosis Treatment", in that for this strategy the integration does not need to occur at the level of the clinical encounter.
Integrated Services for Mental Health and Aging (58)	Integrated, interdisciplinary and/or coordinated services for Mental Health and issues related to aging, including co-location and/or collaboration between Mental Health providers and agencies/providers of services specific to aging (e.g., health, social, community service providers, etc.).
Integrated Services for Mental Health and Developmental Disability (59)	Integrated, interdisciplinary and/or coordinated Mental Health services and services for developmental disabilities, including co-location and/or collaboration between Mental Health providers and agencies/providers of services specific to developmental disabilities.
Ethnic-Specific Service Strategy (60)	Culturally appropriate services that reach and are tailored to persons of diverse cultures in order to eliminate disparities. Includes ethnic-specific strategies and community cultural practices such as traditional practitioners, natural healing practices, and ceremonies recognized by communities in place of, or in addition to, mainstream services.
Age-Specific Service Strategy (61)	Age-appropriate services that reach and are tailored to specific age groups in order to eliminate disparities. Age-specific strategies should promote a wellness philosophy including the concepts of both recovery and resiliency.

Appendix 15: Error Codes and Error Messages

This appendix provides the error message for all error codes.

100-199: ALL records (Key Change, Client, Service, Periodic, or Assessment)

100-199: ALL records (Key Change, Client, Service, Periodic, or Assessment)		
100	=	Blank.
101	=	Invalid code.
102	=	Invalid value.
103	=	Not numeric.
104	=	Not valid date.
105	=	County Client Number is not right justified and/or zero filled and/or has embedded Blanks.
106	=	Assessment Start Date is populated and CCN is all zeros.

200-299: KEY CHANGE Records

200-299: KEY CHANGE Records		
200	=	Multiple Key Change Records for the same Target County Client Number.
201	=	Transaction Code is blank and Record Type is K but does not appear to be a Key Change Record.
202	=	Key Change Record has no Source County Client Number.
203	=	First Source County Client Number (CCN) does not match a CCN on the Master database.
204	=	Second Source County Client Number (CCN) does not match a CCN on the Master database.
205	=	Third Source County Client Number (CCN) does not match a CCN on the Master database.
206	=	Fourth Source County Client Number (CCN) does not match a CCN on the Master database.
207	=	Fifth Source County Client Number (CCN) does not match a CCN on the Master database.
208	=	Sixth Source County Client Number (CCN) does not match a CCN on the Master database.
209	=	Seventh Source County Client Number (CCN) does not match a CCN on the Master database.
210	=	Eighth Source County Client Number (CCN) does not match a CCN on the Master database.
211	=	Ninth Source County Client Number (CCN) does not match a CCN on the Master database.
212	=	Tenth Source County Client Number (CCN) does not match a CCN on the Master database.
213	=	Eleventh Source County Client Number (CCN) does not match a CCN on the Master database.
214	=	Twelfth Source County Client Number (CCN) does not match a CCN on the Master database.

200-299: KEY CHANGE Records		
215	=	Thirteenth Source County Client Number (CCN) does not match a CCN on the Master database.
216	=	Fourteenth Source County Client Number (CCN) does not match a CCN on the Master database.
217	=	Fifteenth Source County Client Number (CCN) does not match a CCN on the Master database.
218	=	Sixteenth Source County Client Number (CCN) does not match a CCN on the Master database.
219	=	Seventeenth Source County Client Number (CCN) does not match a CCN on the Master database.
220	=	Eighteenth Source County Client Number (CCN) does not match a CCN on the Master database.
221	=	Nineteenth Source County Client Number (CCN) does not match a CCN on the Master database.
222	=	Twentieth Source County Client Number (CCN) does not match a CCN on the Master database.
223	=	Twenty-first Source County Client Number (CCN) does not match a CCN on the Master database.
224	=	Twenty-second Source County Client Number (CCN) does not match a CCN on the Master database.
225	=	Twenty-third Source County Client Number (CCN) does not match a CCN on the Master database.
226	=	Twenty-fourth Source County Client Number (CCN) does not match a CCN on the Master database.
227	=	Twenty-fifth Source County Client Number (CCN) does not match a CCN on the Master database.
228	=	Twenty-sixth Source County Client Number (CCN) does not match a CCN on the Master database.
229	=	Twenty-seventh Source County Client Number (CCN) does not match a CCN on the Master database.
230	=	Twenty-eighth Source County Client Number (CCN) does not match a CCN on the Master database.
231	=	Twenty-ninth Source County Client Number (CCN) does not match a CCN on the Master database.
232	=	First Source County Client Number (CCN) and Target CCN are identical.
233	=	Second Source County Client Number (CCN) and Target CCN are identical.
234	=	Third Source County Client Number (CCN) and Target CCN are identical.
235	=	Fourth Source County Client Number (CCN) and Target CCN are identical.
236	=	Fifth Source County Client Number (CCN) and Target CCN are identical.
237	=	Sixth Source County Client Number (CCN) and Target CCN are identical.
238	=	Seventh Source County Client Number (CCN) and Target CCN are identical.
239	=	Eighth Source County Client Number (CCN) and Target CCN are identical.
240	=	Ninth Source County Client Number (CCN) and Target CCN are identical.
241	=	Tenth Source County Client Number (CCN) and Target CCN are identical.
242	=	Eleventh Source County Client Number (CCN) and Target CCN are identical.
243	=	Twelfth Source County Client Number (CCN) and Target CCN are identical.
244	=	Thirteenth Source County Client Number (CCN) and Target CCN are identical.
245	=	Fourteenth Source County Client Number (CCN) and Target CCN are identical.
246	=	Fifteenth Source County Client Number (CCN) and Target CCN are identical.

200-299: KEY CHANGE Records		
247	=	Sixteenth Source County Client Number (CCN) and Target CCN are identical.
248	=	Seventeenth Source County Client Number (CCN) and Target CCN are identical.
249	=	Eighteenth Source County Client Number (CCN) and Target CCN are identical.
250	=	Nineteenth Source County Client Number (CCN) and Target CCN are identical.
251	=	Twentieth Source County Client Number (CCN) and Target CCN are identical.
252	=	Twenty-first Source County Client Number (CCN) and Target CCN are identical.
253	=	Twenty-second Source County Client Number (CCN) and Target CCN are identical.
254	=	Twenty-third Source County Client Number (CCN) and Target CCN are identical.
255	=	Twenty-fourth Source County Client Number (CCN) and Target CCN are identical.
256	=	Twenty-fifth Source County Client Number (CCN) and Target CCN are identical.
257	=	Twenty-sixth Source County Client Number (CCN) and Target CCN are identical.
258	=	Twenty-seventh Source County Client Number (CCN) and Target CCN are identical.
259	=	Twenty-eighth Source County Client Number (CCN) and Target CCN are identical.
260	=	Twenty-ninth Source County Client Number (CCN) and Target CCN are identical.

300-399: CLIENT Records

300-399: CLIENT Records		
300	=	Multiple Client Records with the same CLIENT KEY are in the same county file.
301	=	Transaction Code is blank and Record Type is C but does not appear to be a Client Record.
302	=	Data fields in a Delete Client Record are not blank.
303	=	Delete Client Record has Service Records.
304	=	Delete Client Record does not match a Client Record on the Master database by the CLIENT KEY.
305	=	Year of Birth is prior to 1801.
306	=	Ethnicity / Race subfield A is invalid.
307	=	Ethnicity / Race subfield B is invalid.
308	=	Ethnicity / Race subfields A and B are identical.
309	=	Ethnicity / Race subfield A coded X.
310	=	Ethnicity / Race subfield B coded 9.
311	=	Place of Birth combination is invalid.
312	=	Data Infrastructure Grant Indicator is coded 1 and discontinued field contains data.
313	=	Two or more Race categories are identical.
314	=	Race is not left justified and/or contains embedded blanks.
315	=	Data Infrastructure Grant Indicator is coded 0 and Data Infrastructure Grant field(s) contains data.

400-499: All SERVICE Records

400-499: All SERVICE Records		
400	=	Multiple Service Records with the same CLIENT KEY and Record Reference Number are in the same county file.
401	=	Transaction Code is blank and Record Type is S but does not appear to be a Service Record.
402	=	Service Record has no matching Client Record on the Master database by CLIENT KEY.
403	=	Data fields in a Delete Service Record are not blank.
404	=	Delete Service Record does not match a Service Record on the Master database by the CLIENT KEY and Record Reference Number.
405	=	Record Reference Number is not right justified and/or zero filled and/or has embedded blanks.
406	=	Social Security Number is not zero filled or all real numbers.
407	=	Mode of Service is invalid for CSI reporting.
408	=	Service Function is invalid where Mode of Service is 05.
409	=	Service Function is invalid where Mode of Service is 10.
410	=	Service Function is invalid where Mode of Service is 15.
411	=	Provider is not in the Provider File.
412	=	Mode of Service is not in the Provider File.
413	=	Service Function range is not in the Provider File.
414	=	Not a DSM-IV-TR or ICD-9-CM diagnosis.
415	=	Principal Mental Health Diagnosis field is not coded with a mental health diagnosis.
416	=	Secondary Mental Health Diagnosis field is not coded with a mental health diagnosis.
417	=	Principal, Secondary, Third, Fourth and/or Fifth Diagnoses are coded the same.

400-499: All SERVICE Records		
418	=	Secondary, Third, Fourth, and/or Fifth Diagnoses are coded V7109. For records submitted before 7/1/2006.
419	=	Secondary, Third, Fourth and/or Fifth Diagnoses indicate a mental health diagnosis but the Principal Mental Health Diagnosis is coded V7109. For records submitted before 7/1/2006.
420	=	Secondary, Third, Fourth and/or Fifth Diagnoses indicate a mental health diagnosis but the Principal Mental Health Diagnosis is coded 7999. For records submitted before 7/1/2006.
421	=	Third, Fourth and/or Fifth Diagnoses indicate a mental health diagnosis but the Secondary Mental Health Diagnosis is coded 7999. For records submitted before 7/1/2006.
422	=	Special Population is C [Individualized Education Program (IEP) plan] and age is less than 3 or greater than 21.
423	=	Special Population is W (Welfare-To-Work Plan) and age is less than 16 or greater than 65. (REMOVED- December 2001).
424	=	Third Diagnosis is invalid.
425	=	Fourth Diagnosis is invalid.
426	=	Fifth Diagnosis is invalid.
427	=	Special Population is C [Individualized Education Program (IEP) plan] and the Client Record has an invalid Date of Birth.
428	=	Evidence-Based Practices / Service Strategies are not left justified and/or contain embedded blanks.
429	=	Two or more Evidence-Based Practices / Service Strategies are identical.
430	=	Evidence-Based Practices / Service Strategies field contains data and From/Entry Date of Service or Date of Service is prior to July 1, 2006.
431	=	Trauma field contains data and From/Entry Date of Service or Date of Service is prior to July 1, 2006.
432	=	Date of Service or From/Entry Date of Service is greater than or equal to July 1, 2006 and discontinued field(s) contains data.
433	=	Date of Service or From/Entry Date of Service is prior to July 1, 2006 and Data Infrastructure Grant field(s) contains data.
434	=	Axis I Primary is coded Y and Axis I Diagnosis is coded V7109. For records of services between 7/1/2006 and 9/30/2015.
435	=	Axis I Diagnosis and Additional Axis I Diagnosis are identical and are not coded 7999. For records of services between 7/1/2006 and 9/30/2015.
436	=	Axis II Primary is coded Y and Axis II Diagnosis is coded V7109. For records of services between 7/1/2006 and 9/30/2015.
437	=	Axis I Primary and Axis II Primary are both coded Y. For records of services between 7/1/2006 and 9/30/2015.
438	=	Axis I Primary and Axis II Primary are both coded N and both Axis I Diagnosis and Axis II Diagnosis are not coded V7109. For records of services between 7/1/2006 and 9/30/2015.
439	=	Axis II Diagnosis and Additional Axis II Diagnosis are identical and are not coded 7999. For records of services between 7/1/2006 and 9/30/2015.
440	=	Two or more General Medical Condition Summary Codes are identical.
441	=	General Medical Condition Summary Code is not left justified and/or contains embedded blanks.
442	=	Two or more General Medical Condition Diagnoses are identical. For records of services between 7/1/2006 and 9/30/2015.

400-499: All SERVICE Records		
443	=	General Medical Condition Diagnosis is not left justified and/or contains embedded blanks.
444	=	Both General Medical Condition Summary Code and General Medical Condition Diagnosis fields are blank. For records of services between 7/1/2006 and 9/30/2015.
445	=	Both General Medical Condition Summary Code and General Medical Condition Diagnosis fields contain data. For records of services between 7/1/2006 and 9/30/2015.
446	=	Substance Abuse/Dependence is coded N and Substance Abuse/Dependence Diagnosis is coded with a substance-related disorders diagnosis.
447	=	Date of Service or From/Entry Date is out of range with the Provider Start Date and End Date in the DHCS Provider System.
448	=	Special Population is C [Individualized Education Program (IEP) plan] and District of Residence does not contain data.
449	=	Service Record cannot be processed because it is within the CSI archive period.
450	=	Date of Service or From/Entry Date of Service is on or after October 1, 2015 and S-37.0 Substance Abuse/Dependence is Y or U, 0000000 (No Diagnosis) is not allowed in S-38.0 Substance Abuse/Dependence Diagnosis.
451	=	Date of Service or From/Entry Date of Service is on or after October 1, 2015 and S-37.0 Substance Abuse/Dependence is N or Z, 9999999 (Unknown/Deferred Diagnosis) is not allowed in S-38.0 Substance Abuse/Dependence Diagnosis.
452	=	When Date of Service or From/Entry Date of Service is before October 1, 2015, S-38.0 Substance Abuse/Dependence Diagnosis is coded 9999999, which doesn't exist.
453	=	Date of Service or From/Entry Date of Service is on or after October 1, 2015 and discontinued field(s) contains data.
454	=	Date of Service or From/Entry Date of Service is on or after October 1, 2015 and Principal Mental Health Diagnosis field (S-09.0) is coded 0000000 (No Diagnosis) or 9999999 (Unknown/Deferred Diagnosis), diagnosis within mental, behavioral and neurodevelopmental disorders range (F01-99) are not allowed in secondary (S-10.0), and additional 3 mental or physical health diagnosis (S-11.0).
455	=	Date of Service or From/Entry Date of Service is on or after October 1, 2015 and Secondary Mental Health Diagnosis field is coded 0000000 (No Diagnosis) or 9999999 (Unknown/Deferred Diagnosis), diagnosis within mental, behavioral and neurodevelopmental disorders range (F01-99) are not allowed in additional 3 mental or physical health diagnosis.

500-599: SERVICE Records with Mode of Service 05

500-599: SERVICE Records with Mode of Service 05		
500	=	Mode of Service is 05 and Admission Date is blank.
501	=	Mode of Service is 05 and Admission Year is prior to 1981.
502	=	Mode of Service is 05 and Admission Date is after Report Period.
503	=	Mode of Service is 05 and From/Entry Date is blank.
504	=	Mode of Service is 05 and From/Entry Date is prior to July 1, 1998.
505	=	Mode of Service is 05 and From/Entry Date is after Report Period.
506	=	Mode of Service is 05 and From/Entry Date is prior to Admission Date.
507	=	Mode of Service is 05 and From/Entry Date is after Through/Exit Date.
508	=	Mode of Service is 05 and From/Entry Date is after Discharge Date.

500-599: SERVICE Records with Mode of Service 05		
509	=	Mode of Service is 05 and Through/Exit Date is blank.
510	=	Mode of Service is 05 and Through/Exit Date is prior to July 1, 1998.
511	=	Mode of Service is 05 and Through/Exit Date is after Report Period.
512	=	Mode of Service is 05 and Through/Exit Date is prior to Admission Date.
513	=	Mode of Service is 05 and Through/Exit Date is after Discharge Date.
514	=	Mode of Service is 05 and Discharge Date is blank.
515	=	Mode of Service is 05 and Discharge Date is prior to July 1, 1998.
516	=	Mode of Service is 05 and Discharge Date is after Report Period.
517	=	Mode of Service is 05 and Discharge Date is prior to Admission Date.
518	=	Units of Service is greater than number of days between From/Entry Date and Through/Exit Date.
519	=	Mode of Service is 05 and the year and month for the Through/Exit Date does not equal the year and month for the From/Entry Date.
520	=	Mode of Service is 05 and the From/Entry Date and/or the Through/Exit Date overlaps with another record for the same client and the same provider but with different Record Reference Numbers.
521	=	Mode of Service is 05, Units of Service is zero (00), From/Entry Date and the Through/Exit Date are not equal, and/or the From/Entry Date and Through/Exit Dates are not less than or equal to the Discharge Date, and/or the Admission Date is not prior to From/Entry Date, Through/Exit Date, and Discharge Date.
522	=	Mode of Service is 05, Provider Number begins with 00, and Service Function is in the range of 35 through 39, and there is neither a Social Security Number, Medi-Cal Number, or Client Index Number.
523	=	Age could not be calculated for Special Population C due to an invalid From/Entry Date.
524	=	Legal Class Discharge must be blank if Discharge Date is 00000000.
525	=	Mode of Service is 05 and Discharge Date is not equal to 00000000, Through/Exit Date is not prior to or equal to the Discharge Date. (REMOVED 12/21/01).
526	=	Mode of Service is 05 and the Non 24-Hour Service fields contain data.

600-699: SERVICE Records with Mode of Service 10 or 15

600-699: SERVICE Records with Mode of Service 10 or 15		
600	=	Mode of Service is 10 or 15 and Date of Service is blank.
601	=	Mode of Service is 10 or 15 and Date of Service is prior to July 1, 1998.
602	=	Mode of Service is 10 or 15 and Date of Service is after Report Period.
603	=	Units of Service is greater than Units of Time.
604	=	Age could not be calculated for Special Population C due to an invalid Date of Service.
605	=	Mode of Service is 10 and Service Function is in the range of 81 through 99, Units of Service is not 01 per record.
606	=	Mode of Service is 10 and Service Function is in the range of 81 through 99, Units of Time is not 0001 per record.
607	=	Mode of Service is 10 and Service Function is in the range of 60 through 69, Units of Time is not 0000 per record.
608	=	Mode of Service is 10 or 15 and the 24-Hour Service fields contain data.

700-799: PERIODIC Records

700-799: PERIODIC Records		
700	=	Multiple Periodic Records with the same CLIENT KEY and Date Completed are in the same county file.
701	=	Transaction Code is blank and Record Type is P but does not appear to be a Periodic Record.
702	=	Periodic Record has no matching Client Record by CLIENT KEY.
703	=	Data fields in a Delete Periodic Record are not blank.
704	=	Delete Periodic Record does not match a Periodic Record on the Master database by the CLIENT KEY and Date Completed.
705	=	Date Completed date is prior to July 1, 1998.
706	=	Date Completed is after Report Period or Processing Date.
707	=	Conservatorship/Court Status is A, B, C, D, E, or F and age is less than 14.
708	=	Conservatorship/Court Status is G, H, or I and age is greater than 25.
709	=	Date Completed is greater than or equal to July 1, 2006 and discontinued field(s) contains data.
710	=	Date Completed is prior to July 1, 2006 and Data Infrastructure Grant field contains data.

800-899: ASSESSMENT Records

800-899: ASSESSMENT Records		
800	=	Multiple Assessment Records with the same CLIENT KEY and Assessment Reference Number are in the same county file.
801	=	Transaction Code is blank and Record Type is A, but does not appear to be an Assessment Record.
802	=	Data fields in a Delete Assessment Record are not blank.
803	=	Delete Assessment Record does not match an Assessment Record on the Master database by the CLIENT KEY and Assessment Reference Number.
804	=	Assessment Reference Number is not right justified and/or zero filled and/or has embedded blanks.
805	=	Date of First Contact to Request Services is after Report Period.
806	=	Assessment Appointment First Offer Date is after the Report Period.
807	=	Assessment Appointment First Offer Date is less than Date of First Contact To Request Services.
808	=	Assessment Appointment Second Offer Date is after the Report Period.
809	=	Assessment Appointment Second Offer Date is equal to or less than the Assessment Appointment First Offer date.
810	=	Assessment Appointment Second Offer Date is entered and Assessment Appointment First Offer Date is blank.
811	=	Assessment Appointment Third Offer Date is after the Report Period.
812	=	Assessment Appointment Third Offer Date is equal to or less than the Assessment Appointment Second Offer date.
813	=	Assessment Appointment Third Offer Date is entered and Assessment Appointment Second Offer Date is blank.
814	=	Assessment Appointment Accepted Date is after the Report Period.
815	=	Assessment Appointment Accepted Date is less than or greater than Assessment Appointment First Offer Date.

800-899: ASSESSMENT Records		
816	=	Assessment Appointment Accepted Date is less than or greater than Assessment Appointment Second Offer Date.
817	=	Assessment Appointment Accepted Date is less than Assessment Appointment Third Offer Date.
818	=	Assessment Start Date is after the Report Period.
819	=	Assessment Start Date is less than Assessment Appointment Accepted Date.
820	=	Assessment Start Date is entered and the Assessment Appointment Accepted Date is blank.
821	=	Assessment End Date is after the Report Period.
822	=	Assessment End Date is less than Assessment Start Date.
823	=	Assessment End Date is entered and Assessment Start Date is blank.
824	=	Treatment Appointment First Offer Date is after the Report Period.
825	=	Treatment Appointment First Offer Date is less than Assessment Start Date.
826	=	Treatment Appointment First Offer Date is entered and Assessment Start Date is blank.
827	=	Treatment Appointment Second Offer Date is after the Report Period.
828	=	Treatment Appointment Second Offer Date is less than or equal to the Treatment Appointment First Offer Date.
829	=	Treatment Appointment Second Offer Date is entered and Treatment Appointment First Offer Date is blank.
830	=	Treatment Appointment Third Offer Date is after the Report Period.
831	=	Treatment Appointment Third Offer Date is less than or equal to the Treatment Appointment Second Offer Date.
832	=	Treatment Appointment Third Offer Date is entered and Treatment Appointment Second Offer Date is blank.
833	=	Treatment Appointment Accepted Date is after the Report Period.
834	=	Treatment Appointment Accepted Date is less than or greater than Treatment Appointment First Offer Date.
835	=	Treatment Appointment Accepted Date is less than or greater than Treatment Appointment Second Offer Date.
836	=	Treatment Appointment Accepted Date is less than Treatment Appointment Third Offer Date.
837	=	Treatment Appointment Accepted Date is entered and Treatment Appointment First Offer Date is blank.
838	=	Treatment Start Date is after the Report Period.
839	=	Treatment Start Date is less than Treatment Appointment Accepted Date.
840	=	Treatment Start Date is entered and Treatment Appointment Accepted Date is blank.
841	=	Closed Out Date is after the Report Period.
842	=	Closed Out Date is less than Treatment Appointment Accepted Date, Treatment Appointment Third Offer Date, Treatment Appointment Second Offer Date, Treatment Appointment First Offer Date, Assessment End Date, Treatment Start Date, Assessment Appointment Accepted Date, Assessment Appointment Third Offer Date, Assessment Appointment Second Offer Date, Assessment Appointment First Offer Date and Date of First Contact To Request Services.
843	=	Treatment Start Date and Closed Out Date are both populated.
844	=	Treatment Start Date and Closed Out Date are both blank.
845	=	Closed out date should not be blank.
846	=	Date of First Contact to Request Services is less than January 1, 2018.
847	=	Assessment Appointment First Offer Date is less than January 1, 2018.
848	=	Assessment Appointment Second Offer Date is less than January 1, 2018.

800-899: ASSESSMENT Records		
849	=	Assessment Appointment Third Offer Date is less than January 1, 2018.
850	=	Assessment Appointment Accepted Date is less than January 1, 2018.
851	=	Assessment Start Date is less than January 1, 2018.
852	=	Assessment End Date is less than January 1, 2018.
853	=	Treatment Appointment First Offer Date is less than January 1, 2018.
854	=	Treatment Appointment Second Offer Date is less than January 1, 2018.
855	=	Treatment Appointment Third Offer Date is less than January 1, 2018.
856	=	Treatment Appointment Accepted Date is less than January 1, 2018.
857	=	Treatment Start Date is less than January 1, 2018.
858	=	Closed Out Date is less than January 1, 2018.
859	=	Assessment Appointment Accepted Date is entered and Assessment Appointment First Offer Date is blank.
860	=	Closure Reason is entered and Closed Out Date is blank.
861	=	Treatment Start Date is entered and Closure Reason is populated.
862	=	Closure Reason 06 (Beneficiary did not meet medical necessity criteria) is populated and Referred To is Blank.
863	=	Closure Reason 01, 02, 03, 04, 05, 07, 08, 09 is populated and Referred to is not blank.
864	=	Closed Out Date is populated and Closure Reason is blank.
USER/USAGE INFORMATION:		
This code, when used in conjunction with the code identified by Field Number E-02.0, FIELD / RELATIONAL AND SYSTEM CODE, identifies the type of error and briefly describes the error.		

Appendix 16: Unique Keys for Records

CLIENT KEY

Two data elements which identify a record. The data elements are the County/City/Mental Health Plan Submitting Record (Submitting County Code) and the County Client Number (CCN).

A Client Record and a Key Change Record are uniquely identified by the Client Key. A Service Record is uniquely identified by the Client Key and a unique Record Reference Number. A Periodic Record is uniquely identified by the Client Key and the Date Completed. An Assessment Record is uniquely identified by the Client Key and a unique Assessment Reference Number.

Appendix 17: Core/Confirmatory Data Elements

A list of five core and seven confirmatory data elements are recommended by the Department of Health Care Service (DHCS) and the Office of Statewide Health Planning and Development to be used for linking records across state agencies. This list grew out of work conducted by the California Health Information for Policy Project funded by the Robert Wood Johnson Foundation.

The five core data elements are Birth Name, Birth Date, Birth Place, Mother's First Name, and Gender. All core data elements are incorporated into the CSI system.

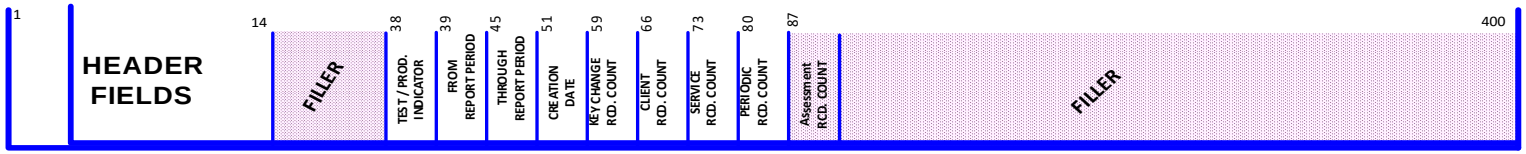
The three confirmatory data elements incorporated into the CSI system are Social Security Number, Other Client Number, and Current Name. Other Client Number became data elements County Client Number (CCN) and Medi-Cal Number on the CSI system. The four confirmatory data elements that were considered but rejected for incorporation into the CSI system are Father's Name, Mother's Maiden Last Name, Client's County of Residence, and Zip Code of Client's Residence.

Appendix A: CSI Technical Supplement A – Record Layouts

CLIENT AND SERVICE INFORMATION SYSTEM

CONTROL RECORD LAYOUT

CSI CONTROL RECORD



HEADER FIELDS:

Bytes 1 - 2 contain SUBMITTING -COUNTY-CODE.

Bytes 3 - 11, COUNTY-CLIENT-NUMBER, contains SPACES, indicating that this is the Control Record. There is only one Control Record per county file.

Byte 12, RECORD-TYPE, contains X, indicating that this is the Control Record.

Byte 13, TRANSACTION -CODE, contains a space.

Byte 14 contains a space for future use.

Bytes 15 - 37 contain spaces.

CONTROL RECORD DATA FIELDS :

Byte 38 contains TEST-PROD-INDICATOR
P = File contains Production data
T = File contains Test data

Bytes 39 - 44 contain FROM-REPORT-PERIOD. YYYYMM - Year and Month of the beginning Report Period for the file being submitted. Bytes 45 - 50 contain THROUGH-REPORT-PERIOD. YYYYMM - Year and Month of the ending Report Period for the file being submitted Bytes 51 - 58 contain CREATION-DATE. YYYYMMDD - Year, Month, Day that the file was created by the County/City/Mental Health Plan.

Bytes 59 - 65 contain KEY-CHANGE-RECORD-COUNT - The number of Key-Change Records in the file. Bytes 66 - 72 contain CLIENT-RECORD-COUNT - The number of Client Records in the file.

Bytes 73 - 79 contain SERVICE-RECORD-COUNT - The number of Service Records in the file.

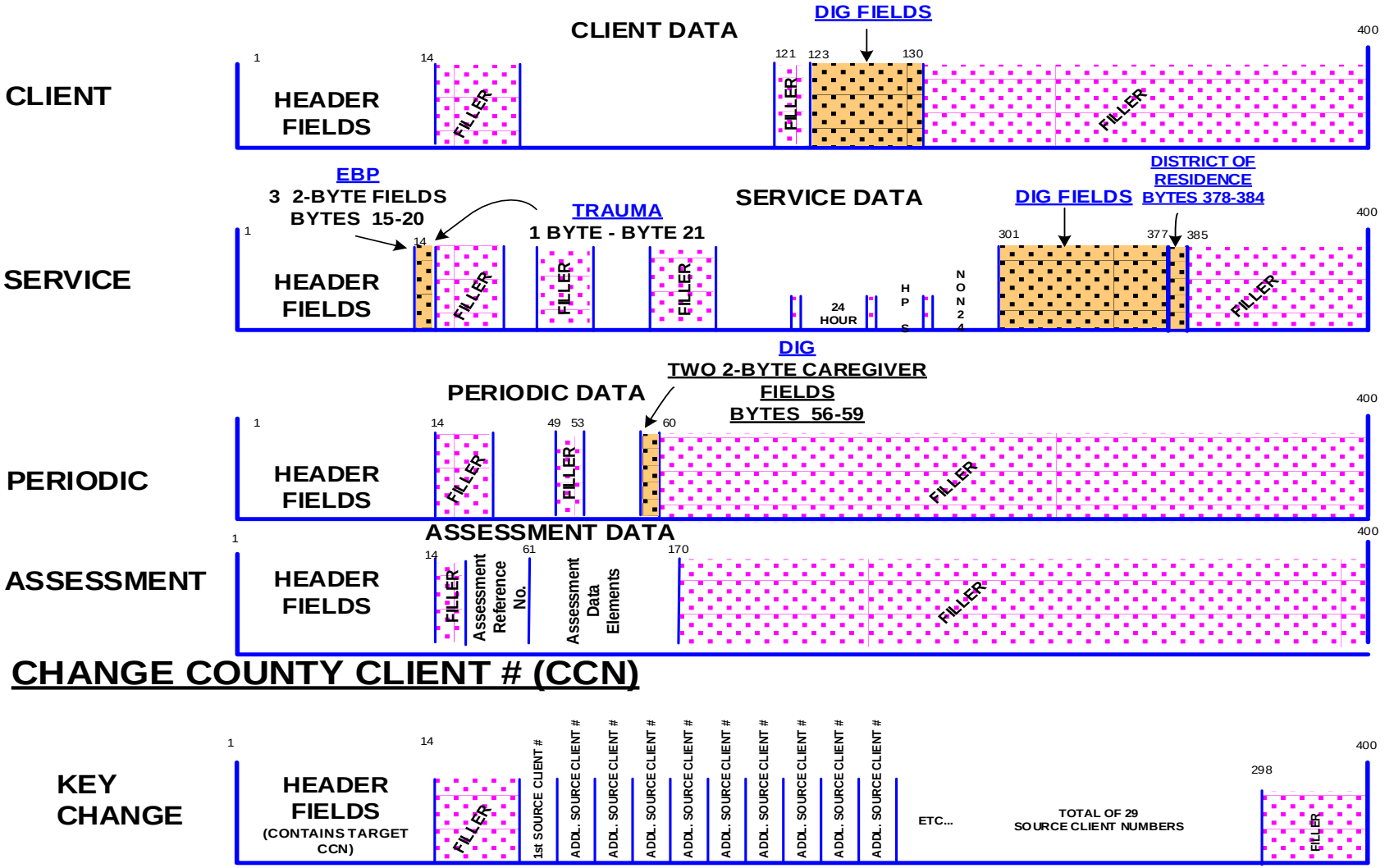
Bytes 80 - 86 contain PERIODIC -RECORD-COUNT - The number of Periodic Records in the file.

Bytes 87 – 93 contain ASSESSMENT RECORD COUNT – The number of Assessment Records in the file.

Bytes 94 - 400 contain spaces.

CLIENT AND SERVICE INFORMATION SYSTEM

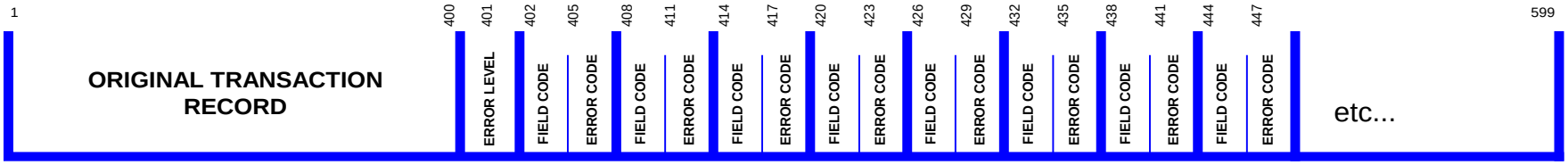
TRANSACTION RECORD LAYOUTS



CHANGE COUNTY CLIENT # (CCN)

CLIENT AND SERVICE INFORMATION SYSTEM

ERROR RECORD LAYOUT



CSI Error Records are fixed-length, 599 bytes in length.

Bytes 1 - 400 of the record contain the original CSI Transaction Record as it was sent from the

county. Byte 401 contains the ERROR-LEVEL (E-01).

This field will contain an F if the original transaction record contains any Fatal Errors that prevent it from being written to the CSI Master database.

This field will contain an N if the original transaction record contains only Non-Fatal Errors which allow it to be written to the CSI Master database.

Bytes 402 - 599 contain 33 pairs of FIELD-CODE and ERROR-CODE fields.

The FIELD-CODE (E-02) fields are 3 bytes, alphanumeric, and designate a field in the original transaction record that contains an error. The contents of this field will correspond to that field's Data Element number in the CSI Data Dictionary.

The ERROR-CODE (E-03) fields contain a 3-byte alphanumeric code that represents a specific error condition. Refer to the Data Dictionary for Error-Code descriptions.

If a FIELD-CODE contains 999, its associated ERROR-CODE field contains a code representing a non-field-specific error or relational error, such as if the original transaction record is a Service or Periodic record for a client that does not exist on the CSI Master database.

Unused FIELD-CODE and ERROR-CODE fields will contain spaces.

Appendix B: CSI Technical Supplement B - Record Descriptions

HEADER FIELDS - REQUIRED IN EVERY CSI RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
κ County/City/Mental Health Plan Submitting Record SUBMITTING-COUNTY-PLAN-CODE	H-01.0	1	2	X(2)	Identifies the county/city/mental health plan submitting the record to DHCS. This code will be the same on all records submitted by a County/City/ Mental Health Plan.
κ County Client Number (CCN) COUNTY-CLIENT-NBR OR: TARGET-CLIENT-NBR for Key-Change Transactions	H-02.0	3	11	X(9)	Identifies the identification number by which the client is known by a particular agency or institution. This will be the Target Client Number for transactions that change the County Client Number (CCN). (Record Type and Transaction Code = K). For Assessment Records, this field is zero-filled when there is no CCN. Once an Assessment Start Date is established, the field must be populated with a 9-character identification number (CCN) for the client. For the Control Record, enter SPACES in this field.
Record Type RECORD-TYPE	H-03.0	12	12	X(1)	Identifies the type of Transaction Record (e.g., Client, Service, Periodic, Assessment, Key Change, or Control): C = Client S = Service P = Periodic A = Assessment K = Key Change X = Control
Transaction Code TRANSACTION-CODE	H-04.0	13	13	X(1)	Identifies Delete and Change County-Client-Nbr (CCN) transactions. D = Delete K = Change County-Client-Nbr (CCN) (This field will be blank for Add and Replace Record Transactions. This field will also be blank on the Control Record.)
HEADER FILLER	N/A	14	14	X(1)	Header Filler - Space for future use.

κ = Key Field
X = Character (Alphanumeric or Symbol)
N = Numeric
D.D. NBR = Data Dictionary Data Element Number

CONTROL RECORD FIELDS - ONE CONTROL RECORD REQUIRED FOR EACH COUNTY FILE

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
HEADER FIELDS	H-01-04	1	14		SEE PAGE 1.
FILLER	N/A	15	37	X(23)	Filler - Space for future use.
Test or Production Indicator TEST-PROD-INDICATOR	X-01.0	38	38	X(1)	Identifies the type of data (e.g., production or test): P = Production T = Test
Beginning Report Period FROM-REPORT-PERIOD	X-02.0	39	44	N(6) YYYYMM	Identifies the year and month of the beginning Report Period for the submission file.
Ending Report Period THROUGH-REPORT-PERIOD	X-03.0	45	50	N(6) YYYYMM	Identifies the year and month of the ending Report Period for the submission file.
Creation Date CREATION-DATE	X-04.0	51	58	N(8) YYYYMMDD	Identifies the date the submission file was created by the County/City/Mental Health Plan.
Key Change Record Count KEY-CHANGE-RECORD-COUNT	X-05.0	59	65	N(7)	Identifies the number of Key Change Records within this submission file.
Client Record Count CLIENT-RECORD-COUNT	X-06.0	66	72	N(7)	Identifies the number of Client Records within this submission file.
Service Record Count SERVICE-RECORD-COUNT	X-07.0	73	79	N(7)	Identifies the number of Service Records within this submission file.
Periodic Record Count PERIODIC-RECORD-COUNT	X-08.0	80	86	N(7)	Identifies the number of Periodic Records within this submission file.
Assessment Record Count ASSESSMENT-RECORD-COUNT	X-09.0	87	93	N(7)	Identifies the number of Assessment Records within this submission file.
FILLER	N/A	94	400	X(307)	Filler - Space for future use.

CLIENT RECORD FIELDS - REQUIRED FOR EACH CLIENT RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
HEADER FIELDS	H-01-04	1	14		SEE PAGE 1.
Data Infrastructure Grant Indicator DIG-INDICATOR	C-11.0	15	15	X(1)	Identifies whether or not the Client Record contains DIG data: 0 = Client Record does not contain DIG data 1 = Client Record contains DIG data
FILLER	N/A	16	37	X(22)	Filler - Space for future use.
Birth Name	C-01.0	38	90	X(53)	Identifies the name of the client as it appears on the birth certificate as reported by the client. Each subfield is to be left justified, with trailing blanks.
BIRTH-FIRST-NAME		38	52	First: X(15)	
BIRTH-MIDDLE-NAME		53	67	Middle: X(15)	
BIRTH-LAST-NAME		68	87	Last: X(20)	
BIRTH-SUFFIX		88	90	Suffix: X(3)	
Mother's First Name MOTHERS-FIRST-NAME	C-02.0	91	105	X(15)	Identifies the first name of the client's mother.
Date of Birth DATE-OF-BIRTH	C-03.0	106	113	N(8) YYYYMMDD	Identifies the date on which the client was born.
Place of Birth	C-04.0	114	119	X(6) - CCSSXX	Identifies the place in which the client was born: CC = County, if in California SS = State, if out of California XX = Country, if out of USA
PLACE-OF-BIRTH					
POB-COUNTY		114	115	Cnty: X(2)	
POB-STATE		116	117	State: X(2)	
POB-COUNTRY		118	119	Country: X(2)	
Gender GENDER	C-05.0	120	120	X(1)	Identifies the gender of the client: M = Male F = Female O = Other U = Unknown / Not Reported
FILLER	N/A	121	122	X(2)	Filler - formerly C-06.0 Ethnicity/Race.
Primary Language PRIMARY-LANGUAGE	C-07.0	123	123	X(1)	Identifies the primary language utilized by the client.
Preferred Language PREFERRED-LANGUAGE	C-08.0	124	124	X(1)	Identifies the language in which the client prefers to receive mental health services.
Ethnicity ETHNICITY	C-09.0	125	125	X(1)	Identifies whether or not the client is of Hispanic or Latino ethnicity.
Race RACE	C-10.0	126	130	X(5)	Identifies the race of the client. Report up to 5 race codes from the list.
FILLER	N/A	131	400	X(270)	Filler - Space for future use.

SERVICE RECORD FIELDS - REQUIRED FOR EACH SERVICE RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
HEADER FIELDS	H-01-04	1	14		SEE PAGE 1
Evidence-Based Practices / Service Strategies EBP-SS	S-25.0	15	20	X(6)	Report up to three (3) Evidence-Based Practices / Service Strategies from list: Evidence-Based Practices: 01 = Assertive Community Treatment (ACT) 02 = Supportive Employment 03 = Supportive Housing 04 = Family Psychoeducation 05 = Integrated Dual Diagnosis Treatment 06 = Illness Management and Recovery 07 = Medication Management 08 = New Generation Medications 09 = Therapeutic Foster Care 10 = Multisystemic Therapy 11 = Functional Family Therapy 99 = Unknown Evidence-Based Practice / Service Strategy Service Strategies: 50 = Peer and/or Family Delivered Services 51 = Psychoeducation 52 = Family Support 53 = Supportive Education 54 = Delivered in Partnership with Law Enforcement 55 = Delivered in Partnership with Health Care 56 = Delivered in Partnership with Social Services 57 = Delivered in Partnership with Substance Abuse Services and Aging 58 = Integrated Services for Mental Health 59 = Integrated Services for Mental Health and Developmental Disability 60 = Ethnic-Specific Service Strategy 61 = Age-Specific Service Strategy 99 = Unknown Evidence-Based Practice / Service Strategy
Trauma TRAUMA	S-26.0	21	21	X(1)	Identifies whether or not the client has experienced trauma: Y = Yes N = No U = Unknown
FILLER	N/A	22	37	X(16)	Filler – Space for future use.

SERVICE RECORD FIELDS - (Continued) - REQUIRED FOR EACH SERVICE RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
κ Record Reference Number (RRN) RRN	S-01.0	38	60	X(23)	The unique number assigned to a Service record in order to locate and retrieve it. (Possibly a date/time stamp plus a sequence number.)
Current Legal Name / Beneficiary Name BENE-FIRST-NAME BENE-MIDDLE-NAME BENE-LAST-NAME BENE-SUFFIX	S-02.0	61 61 76 91 111	113 75 90 110 113	X(53) First: X(15) Middle: X(15) Last: X(20) Suffix: X(3)	Identifies the Current Legal Name / Beneficiary Name of the client.
Social Security Number SOCIAL-SECURITY-NBR	S-03.0	114	122	X(9)	Identifies the Social Security Number of the client.
FILLER	N/A	123	136	X(14)	Filler - formerly S-04.0 Medi-Cal Number.
Mode of Service MODE-OF-SERVICE	S-05.0	137	138	X(2)	Identifies, in broad terms, the category of service: 05 = 24-Hour services 10 = Day services 15 = Outpatient services
Service Function SERVICE-FUNCTION	S-06.0	139	140	X(2)	Identifies the specific type of service received by the client.
Units of Service UNITS-OF-SERVICE	S-07.0	141	142	N(2)	Identifies the quantity of services provided.
Units of Time UNITS-OF-TIME	S-08.0	143	146	N(4)	Identifies amount of time for selected services in Day Services and all Outpatient Services.

κ = Key Field
X = Character (Alphanumeric or Symbol)
N = Numeric
D.D. NBR = Data Dictionary Data Element Number

SERVICE RECORD FIELDS - (Continued) - REQUIRED FOR EACH SERVICE RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
Principal Mental Health Diagnosis PRINCIPAL-MH-DIAG	S-09.0	147	153	X(7)	Identifies the principal mental health diagnosis. This diagnosis may be any ICD-10 code.
Secondary Mental Health Diagnosis SECOND-MH-DIAG	S-10.0	154	160	X(7)	Identifies the secondary mental health diagnosis. This diagnosis may be any ICD-10 code.
Additional Mental or Physical Health Diagnosis THIRD-DIAG	S-11.0	161	167	X(7)	Identifies additional mental or physical health diagnosis, if any. This diagnosis may be any ICD-10 mental (including a substance use or developmental disorder) or physical health diagnosis.
Additional Mental or Physical Health Diagnosis FOURTH-DIAG	S-11.0	168	174	X(7)	Identifies additional mental or physical health diagnosis, if any. This diagnosis may be any ICD-10 mental (including a substance use or developmental disorder) or physical health diagnosis.
Additional Mental or Physical Health Diagnosis FIFTH-DIAG	S-11.0	175	181	X(7)	Identifies additional mental or physical health diagnosis, if any. This diagnosis may be any ICD-10 mental (including a substance use or developmental disorder) or physical health diagnosis.
Special Population SPECIAL-POPULATION	S-12.0	182	182	X(1)	Identifies any special population for statistical purposes: A = Assisted Outpatient Treatment service(s) (AB 1421) C = Individualized Education Program (IEP) plan required service(s) (AB 3632) G = Governor's Homeless Initiative (GHI) service(s) N = No special population service(s) W = Welfare-to-Work plan specified service(s)
Provider Number (Reporting) PROVIDER-NBR	S-13.0	183	186	X(4)	Identifies the organization providing a service. This is the four-character code assigned by DHCS.
County/City/Mental Health Plan With Fiscal Responsibility for Client FISCALLY-RESP-COUNTY	S-14.0	187	188	X(2)	Identifies the County/City/Mental Health Plan responsible for directly orindirectly paying for the client's services.
FILLER	N/A	189	198	X(10)	Filler - Space for future use.

SERVICE RECORD FIELDS REQUIRED FOR EACH STAY IN THE 24-HOUR MODE OF SERVICE (Continued)
(MODE OF SERVICE = 05)

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
Admission Date ADMISSION-DATE	S-15.0	199	206	N(8) YYYYMMDD	Identifies the date the client was admitted. Required on every record.
From/Entry Date FROM/ENTRY DATE	S-16.0	207	214	N(8) YYYYMMDD	Identifies the first date of service.
Through/Exit Date THROUGH/EXIT DATE	S-17.0	215	222	N(8) YYYYMMDD	Identifies the last date a client is in a 24-Hour facility.

SERVICE RECORD FIELDS REQUIRED FOR EACH STAY IN THE 24-HOUR MODE OF SERVICE
(MODE OF SERVICE = 05)

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
Discharge Date DISCHARGE-DATE	S-18.0	223	230	N(8) YYYYMMDD	Identifies the date the client was discharged.
Patient Status Code PATIENT-STATUS	S-19.0	231	231	X(1)	Indicates the status of the client as of the last date of service.
FILLER	N/A	232	241	X(10)	Filler - Space for future use.

SERVICE RECORD FIELDS REQUIRED FOR EACH STAY IN A HOSPITAL, PHF, OR SNF
(MODE OF SERVICE = 05 AND SERVICE FUNCTION = 10-39)

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
Legal Class at Admission LEGAL-CLASS-ADMIT	S-20.0	242	243	X(2)	Identifies the legal class under which the client is admitted to acute 24-hour mental health services.
Legal Class upon Discharge LEGAL-CLASS-DISCHG	S-21.0	244	245	X(2)	Identifies the legal class of the client at the time of discharge from acute 24-hour mental health services.
Admission Necessity Code ADMIT-NECESSITY-CODE	S-22.0	246	246	X(1)	Identifies the type or reason for the client's admission into an acute care hospital: 1 = Emergency 2 = Planned (Prior Authorization) 9 = Unknown / Not Reported
FILLER	N/A	247	256	X(10)	Filler - Space for future use.

SERVICE RECORD FIELDS REQUIRED FOR EACH STAY IN A NON-24-HOUR MODE OF SERVICE (Continued)
(MODE OF SERVICE = 10 OR 15)

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
Date of Service DATE-OF-SERVICE	S-23.0	257	264	N(8) YYYYMMDD	Identifies the date of service for a non-24-hour mode of service.
Place of Service PLACE-OF-SERVICE	S-24.0	265	265	X(1)	Identifies the location where the service was rendered: A = Office [formerly Office (including phone)] B = Field (unspecified) [formerly Field (when the location is away from the clinicians usualplace of business, except for Correctional Facility and Inpatient)] C = Correctional Facility (e.g., jail, prison, camp / ranch) [(formerly Correctional Institution)] D = Inpatient (e.g., Hospital, PHF, SNF, IMD, MHRC) E = Homeless / Emergency Shelter F = Faith-based (e.g., church, temple, etc.) G = Health Care / Primary Care H = Home I = Age-Specific Community Center J = Clients Job Site L = Residential Care - Adults M = Mobile Service N = Non-Traditional service location (e.g., park bench, on street, under bridge, abandoned building) O = Other Community location P = Phone R = Residential Care - Children S = School T = Telehealth U = Unknown / Not Reported
FILLER	N/A	266	300	X(35)	Filler - Space for future use.

SERVICE RECORD FIELDS - (Continued) - REQUIRED FOR EACH SERVICE RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
Client Index Number CIN	S-27.0	301	309	9XXXXXXXA (9)	Identifies Medi-Cal or Healthy Families Plan recipients.
FILLER	N/A	310	316	X(7)	Filler – formerly S-28.0 Axis I Diagnosis.
FILLER	N/A	317	317	X(1)	Filler – formerly S-29.0 Axis I Primary.
FILLER	N/A	318	324	X(7)	Filler – formerly S-30.0 Additional Axis I Diagnosis.
FILLER	N/A	325	331	X(7)	Filler – formerly S-31.0 Axis II Diagnosis.
FILLER	N/A	332	332	X(1)	Filler – formerly S-32.0 Axis II Primary.
FILLER	N/A	333	339	X(7)	Filler – formerly S-33.0 Additional Axis II Diagnosis.
General Medical Condition Summary Code GMC-SUMMARY-PRIMARY	S-34.0	340	341	X(2)	Identifies a General Medical Condition Summary Code that most closely identifies the client's primary general medical condition, if any.
General Medical Condition Summary Code GMC-SUMMARY-SECONDARY	S-34.0	342	343	X(2)	Identifies a General Medical Condition Summary Code that most closely identifies the client's secondary general medical condition, if any.
General Medical Condition Summary Code GMC-SUMMARY-TERTIARY	S-34.0	344	345	X(2)	Identifies a General Medical Condition Summary Code that most closely identifies the client's tertiary general medical condition, if any.

SERVICE RECORD FIELDS (Continued) - REQUIRED FOR EACH SERVICE RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
FILLER	N/A	346	352	X(7)	Filler – Formerly S-35.0 General Medical Condition Diagnosis.
FILLER	N/A	353	359	X(7)	Filler – Formerly S-35.0 General Medical Condition Diagnosis.
FILLER	N/A	360	366	X(7)	Filler – Formerly S-35.0 General Medical Condition Diagnosis.
FILLER	N/A	367	369	X(3)	Filler – Formerly S-36.0 Axis-V / GAF Rating.
Substance Abuse / Dependence SUBSTANCE-ABUSE	S-37.0	370	370	X(1)	Identifies whether or not the individual has a substance abuse / dependence issue.
Substance Abuse / Dependence Diagnosis SUBSTANCE-ABUSE-DIAG	S-38.0	371	377	X(7)	Identifies a substance abuse / dependence diagnosis, if any, within the Substance-Related Disorders classification of the ICD-10 codes.
District of Residence DISTRICT-OF-RESIDENCE	S-39.0	378	384	X(7)	County mental health departments (CMHDs) must obtain the District of Residence code from local education agencies (LEAs) for each client/student receiving services as part of their Individualized Education Program (IEP) plan. This is the California Department of Education issued seven-byte COUNTY-DISTRICT-SCHOOL (CDS) code provided to LEAs. The first two digits are the county code in which the district is located, followed by a five-digit district/site code. A district/site code may include: 1) the district where the student resides [includes students in Licensed Children's Institutions (LCI)]; 2) the district where the student lives; 3) the district where the parent resides if the student is placed in an out-of-home district through the Individualized Education Program (IEP) process; 4) the district receiving the student under an inter-district transfer; 5) the district or county office authorizing a charter school, unless the charter school has a seven-digit district code; 6) the district or county office, only for wards of the court if none of the above conditions apply. LEAs refer to the *California Public School Directory* to obtain correct codes.
FILLER	N/A	385	400	X(16)	Filler - Space for future use.

PERIODIC RECORD FIELDS - REQUIRED FOR EACH PERIODIC RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
HEADER FIELDS	H-01 - 04	1	14		SEE PAGE 1.
FILLER	N/A	15	37	X(23)	Filler – Space for future use.
κ Date Completed DATE-COMPLETED	P-01.0	38	45	N(8) YYYYMMDD	Date the Periodic information for this record was collected.
Education EDUCATION	P-02.0	46	47	N(2)	Identifies the highest grade level completed by the client: 00 = None, Kindergarten 01 - 20 = Grade levels, indicate highest grade completed. If the highest grade completed is greater than 20, code 20 as the highest grade completed. 12 = GED 98 = Other, includes vocational education and training. 99 = Unknown / Not Reported
Employment Status EMPLOYMENT-STATUS	P-03.0	48	48	X(1)	Identifies the current employment status of the client: • Employed in competitive job market A = Full time, 35 hours or more per week B = Part time, less than 35 hours per week • Employed in noncompetitive job market C = Full time, 35 hours or more per week D = Part time, less than 35 hours per week • Not in the paid work force E = Actively looking for work F = Homemaker G = Student H = Volunteer Worker I = Retired J = Resident / inmate of institution K = Other U = Unknown / Not Reported

κ = Key Field
X = Character (Alphanumeric or Symbol)
N = Numeric
D.D. NBR = Data Dictionary Data Element Number

PERIODIC RECORD FIELDS (Continued) - REQUIRED FOR EACH PERIODIC RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
FILLER	N/A	49	50	X(2)	Filler - formerly P-04.0 Axis-V / GAF.
FILLER	N/A	51	51	X(1)	Filler - formerly P-05.0 Other Factors Affecting Mental Health - Substance Abuse.
FILLER	N/A	52	52	X(1)	Filler - formerly P-06.0 Other Factors Affecting Mental Health - Developmental Disabilities.
FILLER	N/A	53	53	X(1)	Filler - formerly P-07.0 Other Factors Affecting Mental Health - Physical Health Disorders.
Conservatorship / Court Status CONSERV-COURT-STATUS	P-08.0	54	54	X(1)	Identifies whether or not the client has a conservatorship or juvenile court status: A = Temporary Conservatorship Permanent Conservatorship B = Lanterman-Petris-Short C = Murphy D = Probate E = PC 2974 F = Representative Payee Without Conservatorship G = Juvenile Court, Dependent of the Court H = Juvenile Court, Ward - Status Offender I = Juvenile Court, Ward - Juvenile Offender J = Not Applicable U = Unknown / Not Reported
Living Arrangement LIVING-ARRANGMENT	P-09.0	55	55	X(1)	Indicates the living arrangement of the client.
Caregiver CAREGIVER	P-10.0	56	59	X(4)	Indicates the number of persons the client cares for / is responsible for at least 50% of the time: Bytes 56-57: Subfield A - Number of children less than 18 years of age. Bytes 58-59: Subfield B - Number of dependent adults 18 years of age and above.
FILLER	N/A	60	400	X(341)	Filler - Space for future use.

ASSESSMENT RECORD FIELDS - REQUIRED FOR EACH ASSESSMENT RECORD

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
HEADER FIELDS	H-01-04	1	14		SEE PAGE 1.
FILLER	N/A	15	37	X(23)	Filler - Space for future use.
ASSESSMENT REFERENCE NUMBER (ARN)	A-01.0	38	60	X(23)	A persistent identifier unique to one assessment record. Assigned by the county.
DATE OF FIRST CONTACT TO REQUEST SERVICES	A-02.0	61	68	N(8) YYYYMMDD	Date of first contact to request Specialty Mental Health Services (SMHS).
REFERRAL SOURCE	A-03.0	69	70	N(2)	Who referred the client? 01 = Self 02 = Family Member 03 = Significant Other 04 = Friend/Neighbor 05 = School 06 = Fee-For-Service Provider 07 = Medi-Cal Managed Care Plan 08 = Federally Qualified Health Center 09 = Emergency Room 10 = Mental Health Facility/Community Agency 11 = Social Services Agency 12 = Substance Abuse Treatment Facility/ Agency 13 = Faith-based Organization 14 = Other County/Community Agency 15 = Homeless Services 16 = Street Outreach 17 = Juvenile Hall/Camp/Ranch/ Division of Juvenile Justice 18 = Probation/Parole 19 = Jail/Prison 20 = State Hospital 21 = Crisis Services 22 = Mobile Evaluation 23 = Other referred
ASSESSMENT APPOINTMENT FIRST OFFER DATE	A-04.0	71	78	N(8) YYYYMMDD	First Assessment Date offered to client.
ASSESSMENT APPOINTMENT SECOND OFFER DATE	A-05.0	79	86	N(8) YYYYMMDD	Second Assessment Date offered to client.
ASSESSMENT APPOINTMENT THIRD OFFER DATE	A-06.0	87	94	N(8) YYYYMMDD	Third Assessment Date offered to client.
ASSESSMENT APPOINTMENT ACCEPTED DATE	A-07.0	95	102	N(8) YYYYMMDD	Assessment Date accepted by client.
ASSESSMENT START DATE	A-08.0	103	110	N(8) YYYYMMDD	Date of first assessment appointment.
ASSESSMENT END DATE	A-09.0	111	118	N(8) YYYYMMDD	Date of final assessment appointment.

ASSESSMENT RECORD FIELDS - REQUIRED FOR EACH ASSESSMENT RECORD

TREATMENT APPOINTMENT FIRST OFFER DATE	A-10.0	119	126	N(8) YYYYMMDD	First Specialty Mental Health Service (SMHS) date offered to client.
TREATMENT APPOINTMENT SECOND OFFER DATE	A-11.0	127	134	N(8) YYYYMMDD	Second Specialty Mental Health Service (SMHS) date offered to client.
TREATMENT APPOINTMENT THIRD OFFER DATE	A-12.0	135	142	N(8) YYYYMMDD	Third Specialty Mental Health Service (SMHS) date offered to client.
TREATMENT APPOINTMENT ACCEPTED DATE	A-13.0	143	150	N(8) YYYYMMDD	Specialty Mental Health Service (SMHS) date accepted by the client.
TREATMENT START DATE	A-14.0	151	158	N(8) YYYYMMDD	Date of first treatment appointment attended by client following the assessment start date.
CLOSURE REASON	A-15.0	159	160	X(2)	List of reasons the assessment treatment process was discontinued other than successful completion of the process: 01 = Client did not accept any offered assessment dates. 02 = Client accepted offered assessment date but did not attend initial assessment appointment. 03 = Client attended initial assessment appointment but did not complete assessment process. 04 = Client completed assessment process but declined offered treatment dates. 05 = Client accepted offered treatment date but did not attend initial treatment appointment. 06 = Client did not meet medical necessity criteria. 07 = Out of county/presumptive transfer. 08 = Unable to contact (e.g. deceased or client unresponsive) 09 = Other
CLOSED OUT DATE	A-16.0	161	168	N(8) YYYYMMDD	Date the assessment and initial treatment process was closed out due to the client not showing up or being unreachable for scheduled appointment(s). Not necessarily the final date the client was seen.
REFERRED TO	A-17.0	169	170	X(2)	Referred To: 01 = Managed Care Plan 02 = Fee-For-Service Provider 03 = Other (Specify) 04 = No Referral
FILLER	N/A	171	400	X(229)	Filler - Space for future use.

KEY CHANGE RECORD FIELDS - REQUIRED TO CHANGE OR MERGE COUNTY CLIENT NUMBERS (CCNs)

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
HEADER FIELDS	H-01 - 04	1	14		SEE PAGE 1 **NOTE: For "Change County Client Number" transactions, the County-Client-Nbr (H-02.0) in the Header fields will contain the Target Client Number.** BUILDING A NEW COUNTY CLIENT NUMBER (CCN) If the Target-Client-Nbr field in the Header fields does not exist on the CSI Master file we have a situation where a new County Client Number (CCN) is being created from one or more existing CCNs. The County-Client-Nbr fields of the Client, Service and Periodic Records for the First Source County Client Number (K-01.0) specified in this Transaction Record will be changed to the Target-Client-Nbr, and the Service and Periodic Records for the Additional Source County Client Number(s) (K-02.0) specified in this Transaction Record (if any) will be changed to the Target-Client-Nbr. The Client Records of the Additional Source County Client Number(s) will then be deleted from the CSI Master data base. MERGING COUNTY CLIENT NUMBERS (CCNs) If the Target-Client-Nbr field in the Header fields already exists on the CSI Master file we have a situation where Service and Periodic data for other existing County Client Numbers (CCNs) will be merged with that already-existing CCN. The Client, Service, and Periodic ecords for the Target-Client-Nbr will remain unchanged. The County-Client-Nbr fields of the Service and Periodic Records for all the Source-Client-Nbr(s) specified in this Transaction Record (K-01.0 and all K-02.0s) will be changed to the Target-Client-Nbr (H-02.0 in the header fields), in effect merging those Service and Periodic Records into the Target-Client-Nbr. The Client Records of the merged Source-Client-Nbrs(s) will then be deleted from the CSI Master database.
FILLER	N/A	15	37	X(23)	Filler - Space for future use.

KEY CHANGE RECORD FIELDS (Continued) - REQUIRED TO CHANGE OR MERGE COUNTY CLIENT NUMBERS (CCNs)

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
First Source County Client Number FIRST-SOURCE-CLIENT-NBR	K-01.0	38	46	X(9)	Identifies a Source County Client Number (CCN) for Change County-Client-Nbr transactions. This CCN will be the source of Client, Service, and Periodic data when creating a new CCN, or of Service and Periodic data when merging into an existing CCN.
Additional Source County Client Number ADDITIONAL-SOURCE-CLIENT-NBR	K-02.0	47	55	X(9)	Identifies an Additional Source CCN for Change County-Client-Nbr transactions. Service and Periodic data will be taken from this CCN.
Additional Source County Client Number ADDITIONAL-SOURCE-CLIENT-NBR	K-02.0	56	64	X(9)	Identifies an Additional Source CCN for Change County-Client-Nbr transactions. Service and Periodic data will be taken from this CCN.
Additional Source County Client Number ADDITIONAL-SOURCE-CLIENT-NBR	K-02.0	65	73	X(9)	Identifies an Additional Source CCN for Change County-Client-Nbr transactions. Service and Periodic data will be taken from this CCN.
Additional Source County Client Number ADDITIONAL-SOURCE-CLIENT-NBR	K-02.0	74	82	X(9)	Identifies an Additional Source CCN for Change County-Client-Nbr transactions. Service and Periodic data will be taken from this CCN.
Additional Source County Client Number ADDITIONAL-SOURCE-CLIENT-NBR	K-02.0	83	91	X(9)	Identifies an Additional Source CCN for Change County-Client-Nbr transactions. Service and Periodic data will be taken from this CCN.
Additional Source County Client Number ADDITIONAL-SOURCE-CLIENT-NBR	K-02.0	92	100	X(9)	Identifies an Additional Source CCN for Change County-Client-Nbr transactions. Service and Periodic data will be taken from this CCN.
Additional Source County Client Number ADDITIONAL-SOURCE-CLIENT-NBR	K-02.0	101	109	X(9)	Identifies an Additional Source CCN for Change County-Client-Nbr transactions. Service and Periodic data will be taken from this CCN.
Additional Source County Client Number ADDITIONAL-SOURCE-CLIENT-NBR	K-02.0	110	118	X(9)	Identifies an Additional Source CCN for Change County-Client-Nbr transactions. Service and Periodic data will be taken from this CCN.
This field repeats. There are a total of 29 Additional Source Client Numbers	K-02.0	119	298	Multiple X(9)	Identifies Additional Source CCNs for Change County-Client-Nbr transactions. Service and Periodic data will be taken from these CCNs.
FILLER	N/A	299	400	X(102)	Filler - Space for future use.

ERROR FILE RECORDS

FIELD CONTENTS / FIELD CODING NAME	D.D. NBR	START	END	FORMAT	DESCRIPTION (See Data Dictionary for valid values.)
CSI TRANSACTION RECORD	N/A	1	400	X(400)	A CSI Transaction Record in its entirety.
Error Level Indicator ERROR-LEVEL	E-01.0	401	401	X(1)	F - If the CSI Transaction Record in bytes 1-400 contains any Fatal Errors. Records containing Fatal Errors will not be written to the Master database. N- If the CSI Transaction Record in bytes 1-400 contains Non-Fatal Errors, but no Fatal Errors. If there are no Fatal Errors, the CSI Transaction Record will be written to the CSI Master database. If a CSI Transaction Record contains either Fatal or Non-Fatal Errors, an Error File Record will be written to the CSI Error File, and will remain there until it passes all edits.
The following two fields go hand-in-hand as a pair in the error record, and are repeated 33 times. The fields in each pair are adjacent to one another. Refer to the illustration of the CSI Error Record Layout. Each pair consists of a Field Code that identifies a field in error or type of error, followed by an Error Code that specifies a specific error. A particular Field Code value may occur in the error record more than once if multiple errors are detected for it.					
Field Code FIELD-CODE	E-02.0	402 408 414 etc. to 594	404 410 416 etc. to 596	X(3)	Specifies the CSI Data Dictionary Data Element number of a field for which an error was detected, or indicates that the ERROR-CODE field represents a Relational or System Error.
Error Code ERROR-CODE	E.03.0	405 411 etc. to 597	407 413 etc. to 599	X(3)	A code representing a specific error condition. Refer to Technical Supplement E - Error Codes and Messages.

Appendix C: CSI Technical Supplement C - Transaction Processing

CLIENT AND SERVICE INFORMATION SYSTEM

TRANSACTION PROCESSING

The following documents may be helpful when reading this discussion of transaction processing:

- Technical Supplement A, Record Layouts - contains graphic representations of the CSI records.
- Technical Supplement B, Record Descriptions - contains detailed record and field-level information.
- Technical Supplement D, Transaction Examples - has specific transaction examples.

RECORD KEYS

Each record on the CSI Master database is uniquely identified. The fields used to identify a record depend upon its Record Type:

- **Client** Records are uniquely identified by the CLIENT KEY, which is composed of the Submitting County Code and the County Client Number (CCN). (Service, Periodic, and Assessment Records also contain these fields.)
- **Service** Records are uniquely identified by the combination of the CLIENT KEY and a RecordReference Number (RRN), which must be unique and must remain the same over time.
- **Periodic** Records are uniquely identified by the combination of the CLIENT KEY and the Date Completed.
- **Assessment** Records are uniquely identified by the combination of the CLIENT KEY and an AssessmentReference Number (ARN), which must be unique and remain the same over time.

CSI TRANSACTION RECORDS

There are five types of CSI Transaction Records: Client, Service, Periodic and Assessment Transaction Records, which are used to add, delete, and replace records on the CSI Master database; and Key Change Transactions, which are used to change County Client Numbers (CCNs) on the CSI Master database.

CLIENT RECORDS
There may be only one Client Transaction Record per County Client Number (CCN).

SERVICE RECORDS
There may be only one Service Transaction Record per County Client Number (CCN) andRecord Reference Number (RRN), and the RRN must be unique and remain the same over time.

PERIODIC RECORDS
There may be only one Periodic Transaction Record per County Client Number (CCN) andDate Completed.

ASSESSMENT RECORDS
There may be only one Assessment Transaction Record per County Client Number (CCN) and Assessment Reference Number (ARN), and the ARN must be unique andremain the same over time.

KEY-CHANGE RECORDS
There may be any number of Key Change Transaction Records on the county's CSI file, however,there may be only one per Target CCN.

CSI TRANSACTION RECORDS (Continued)

CONTROL RECORD
This is not a transaction record, as such. It identifies the CSI transaction file and contains counters that the CSI update process will compare against the number of records read to verify that all records have been processed. There must be one, and only one, Control Record on the file; except when a file contains CSI records for more than one county, in which case there must be a Control Record for each county.

PROCESSING ORDER

DHCS, the CSI data for each county will be processed in the following order:

1. The Control Record
   (Record Type = X and Transaction Code = SPACE)

2. Key Change Transactions
   (Record Type and Transaction Code both = K)

3. Delete Service/Periodic Record Transactions
   (Record Type = S or P and Transaction Code = D)

4. Delete Client Record Transactions
   (Record Type = C and Transaction Code = D)

5. Delete Assessment Record Transactions
   (Record Type = A and Transaction Code = D)

6. Add/Replace Client Record Transactions
   (Record Type = C and Transaction Code= Space)

7. Add/Replace Service Record Transactions
   (Record Type = S and Transaction Code =Space)

8. Add/Replace Periodic Record Transactions
   (Record Type = P and Transaction Code = Space)

9. Add/Replace Assessment Record Transactions
   (Record Type = A and Transaction Code = Space)

10. Records with Invalid Record Types and/or Transaction Codes, or combinations thereof.
    These records will be written to the Error File.

ADD, REPLACE, AND DELETE TRANSACTIONS

ADD AND REPLACE TRANSACTIONS
These transactions will add and replace individual Client, Service, Periodic, and Assessment Records on the CSI Master database. The data fields for any type of record to be added or replaced must be filled in and the Transaction Code field must be blank. If there is *no* matching record already on the database, the Transaction Record will be *added* to the database. If there *is* a matching record on the database, the Transaction Record will *replace* it.

DELETE TRANSACTIONS
Delete transactions will be used to delete individual Client, Service, Periodic, and Assessment Records from the CSI Master database. The data fields in these Transaction Records must be blank and the Transaction Code field must be coded D (for delete).

NOTE:
ONE Add/Replace or Delete Transaction Record is to be submitted for any record for which there has been some activity during the month - an addition/replacement or deletion. Even if there have been multiple transactions for a particular record during the month at the county level, only one transaction may be submitted for a given Client, Service, Periodic or Assessment Record. It is not necessary to submit records to DHCS if there has been no change to them since they were originally added to the file or since they were last updated and sent to DHCS. The monthly CSI submission file must bring the DHCS CSI database up to the status of the county information system as of the date that the county builds the submission file.

The following table illustrates Add, Replace and Delete Transactions. Note that if the Transaction Code is blank, and there is *no* matching record already on the database, the Transaction Record will be *added* to the database, but if the Transaction Code is blank and there *is* a matching record on the database it will be *replaced*.

RECORD TYPE	MATCH ON CSI MASTER DATABASE (DB) WILL BE BASED UPON:	MATCH ON DB?	TRANSACTION CODE	PROCESSING ACTION
Client	CLIENT KEY* only	N	Blank	Add record
Service	CLIENT KEY + Record Reference Number	N		
Periodic	CLIENT KEY + Date Completed	N		
Assessment	CLIENT KEY + ARN**			
Client	CLIENT KEY only	Y	Blank	Replace record
Service	CLIENT KEY + Record Reference Number	Y		
Periodic	CLIENT KEY + Date Completed	Y		
Assessment	CLIENT KEY + ARN**	Y		
Client	CLIENT KEY only	Y	D	Delete record
Service	CLIENT KEY + Record Reference Number	Y		
Periodic	CLIENT KEY + Date Completed	Y		
Assessment	CLIENT KEY + ARN**	Y		

* CLIENT KEY = Submitting County Code + County Client Number (CCN)
** ARN = Assessment Reference Number

*KEY CHANGE TRANSACTIONS**

Key Change Transactions may be used to:

- Change a County Client Number (CCN).
- Change Service and Periodic Records on the CSI Master database from one or more CCN(s) to adifferent CCN.
- Merge two or more CCN(s) on the CSI Master database into one CCN.

For Key Change Transactions, the Record Type and Transaction Code fields must both be coded K.

Key Change Transactions use Source and Target County Client Number (CCN) fields.

- A Source CCN is a County Client Number providing data to a Target CCN. A Source CCN must not be identical to a Target CCN. A Key Change Transaction may specify multiple Source CCN(s).
- The Target CCN is the County Client Number receiving the data. A Key Change Transaction specifiesonly one Target CCN.
- Any given Target CCN may be specified in only one Key Change Transaction per file.

Only one Key Change Transaction may be used to build a Target CCN. Do not use multiple compounding Key Change Transactions. The Key Change Transaction Record is capable of handling up to twenty-nineSource CCN(s), which should be adequate for any Key Change situation.

The source of the Client Record information for a Key Change Transaction depends on whether ornot the Target CCN is on the CSI Master database.

If the Target CCN *is* on the CSI Master database:

- The Client, Service, and Periodic Records with the Target CCN are retained.
- The CCN(s) of all Service and Periodic Records that match the Source CCN(s) will be changed to theTarget CCN.
- The Client Record(s) of the Source CCN(s) will be deleted.

If the Target CCN *is not* on the CSI Master database:

- The Client, Service, and Periodic Records with CCN(s) equal to the First Source CCN will have theirCCN(s) changed to the Target CCN.
- The CCN(s) of all Service and Periodic Records that match any Additional Source CCN(s) will bechanged to the Target CCN.
- Client Record(s) whose CCN(s) equal the Additional Source CCN(s) will be deleted.

KEY CHANGE TRANSACTIONS (Continued on next page)

The table below summarizes the above information on Key Change Transactions:

TRANSACTION CODE	IS TARGET CCN ON CSI MASTER?	PROCESSING ACTION
K	Yes	Retain Client data of the Target CCN. Change/Merge Source Service and Periodic Records into an existing Target CCN. Delete Client Records that have CCN(s) thatmatch any of the Source CCN(s).
K	No	Retain Client data of the First Source CCN. Change/Merge Additional Source Service and Periodic Records into the new Target CCN. Delete Client Records that have CCN(s) that match any of the Additional Source CCN(s).

*Currently, Key Change Transaction do not apply to Assessment Record submissions.

Appendix D: CSI Technical supplement D - Transaction Examples

CLIENT AND SERVICE INFORMATION SYSTEM

TRANSACTION EXAMPLES

The following are examples of CSI Transaction Records submitted by a county with a County Code of 33.

1 Adding/Replacing a Client, Service, Periodic or Assessment Record

When adding or replacing records, the Transaction Code field must be blank. The presence of or lack of a matching record on the CSI Master database determines whether a transaction record will Replace another record on the CSI Master database, or be Added to it, respectively.

1.1 Add/Replace a Client Record for County Client Number (CCN) 123456777

SUBMITTING COUNTY	COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	CLIENT FIELDS
33	123456777	C		FILLED IN

If there is no Client Record with the same Submitting County Code and CCN on the CSI Master database, the above record will be added. If there is a matching Client Record it will be replaced with the above transaction record.

1.2 Add/Replace a Service Record having an RRN of 20180701123000020000000 for County Client Number (CCN) 123456777

SUBMITTING COUNTY	COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	RRN	SERVICE FIELDS
33	123456777	S		20180701123000020000000	FILLED IN

If there is no Service Record with the same Submitting County Code, CCN, and RRN on the CSI Master database, the above record will be added. If there is a matching Service Record it will be replaced with the above transaction record.

1.3 Add/Replace a Periodic Record with a Date Completed of 20180701 for County Client Number (CCN) 123456777

SUBMITTING COUNTY	COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	DATE COMPLETED	PERIODIC FIELDS
33	123456777	P		20170701	FILLED IN

If there is no record with the same Submitting County Code, CCN, and Date Completed on the CSI Master database, the above record will be added. If there is a matching Periodic Record it will be replaced with the above transaction record.

1.4 Add/Replace an Assessment Record for Assessment Reference Number (ARN) 20180711230000200000000

SUBMITTING COUNTY	COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	ARN	ASSESSMENT FIELDS
33	123456777	A		20180701123000020000000	FILLED IN

If there is no Assessment Record with the same Submitting County Code, CCN, and ARN on the CSI Master database, the above record will be added. If there is a matching Assessment Record it will be replaced with the above transaction record.

2 Deleting a Service, Periodic or Assessment Record

2.1 Delete the Service Record having an RRN of 20180701123000020000000 for County Client Number (CCN) 123456777

SUBMITTING COUNTY	COUNTY CLIENT NUMBER	RRN	RECORD TYPE	TRANSACTION CODE	SERVICE FIELDS
33	123456777	20180701123000020000000	S	D	BLANKS

The Service Record having an RRN of 20180701123000020000000 for CCN 123456777 will be deleted from the CSI Master database. If no such record is found, the transaction will be rejected.

2.2 Delete the Periodic Record with a Date Completed of 20180701 for County Client Number (CCN) 123456777

SUBMITTING COUNTY	COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	DATE COMPLETED	PERIODIC FIELDS
33	123456777	P	D	20180701	BLANKS

The periodic Record that has a Date Completed of 20180701 for CCN 123456777 will be deleted from the CSI Master database. If no such record is found, the transaction will be rejected.

2.3 Delete the Assessment Record having an ARN of 20180701123000020000000 for County Client Number (CCN) 123456777

SUBMITTING COUNTY	COUNTY CLIENT NUMBER	ARN	RECORD TYPE	TRANSACTION CODE	ASSESSMENT FIELDS
33	123456777	20180701123000020000000	A	D	BLANKS

The Assessment Record having an ARN of 20180701123000020000000 for CCN 123456777 will be deleted from the CSI Master database. If no such record is found, the transaction will be rejected.

3 Deleting a Client and Periodic Record

This function will delete a Client Record and any of its associated Periodic Records from the CSI Master database - only if there are NO Service Records for the client. A client's Service Records must be deleted prior to deleting the Client Record.

3.1 Delete Client and Periodic Record for County Client Number (CCN) 123456777

SUBMITTING COUNTY	COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	CLIENT FIELDS
33	123456777	C	D	BLANKS

If there is no Client Record with a CCN of 123456777, or if there are Service Records for CCN123456777, the transaction will be rejected.

4 Key Change Transactions

Transactions that change the County Client Number (CCN) field of records on the CSI Master database utilize a different transaction record format than Add, Replace, and Delete transactions. Refer to the attached illustration of Transaction Record Layouts.

The following are examples of how Key Change transactions may be used to perform various CSI file maintenance operations.

4.1 Change A County Client Number (CCN) to a New CCN

The following is an example of a transaction used to change a County Client Number (CCN) from 123456789 to 987654321, when 987654321 is not yet a CCN on the CSI Master database. This transaction will cause the CCNs of all records with CCN = 123456789 for Client, Service, and Periodic to be changed to 987654321.

SUBMITTING COUNTY	TARGET COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	FIRST SOURCE CCN	ADD'L SOURCE CCN	ADD'L SOURCE CCN	ADD'L SOURCE CCN
33	987654321	K	K	12345678			

4.2 Merge Service & Periodic Data from One CCN into Another Already-Existing CCN

The following is an example of a transaction used to handle the situation where it is discovered that a client is on the CSI Master database with two County Client Numbers (CCNs). The Client, Service, and Periodic records from one CCN will be retained (that will be the Target CCN), and the Service and Periodic records that have been posted to the CSI Master database with the wrong CCN (the First Source CCN) will be changed to the Target CCN. The Client record for the First Source CCN will then be deleted.

In this example, the correct County Client Number (CCN) is 123456789, but Client, Service, and Periodic records for that client were also written with a CCN of 987654321. CCNs of 123456789 and 987654321 are both on the CSI Master database. This transaction will retain the Client, Service, and Periodic records for CCN 123456789 (the Target CCN), and will change the Service and Periodic records with CCN 987654321 (the First Source CCN) to 123456789. The Client record for CCN 987654321 will then be deleted.

SUBMITTING COUNTY	TARGET COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	FIRST SOURCE CCN	ADD'L SOURCE CCN	ADD'L SOURCE CCN	ADD'L SOURCE CCN
33	123456789	K	K	987654321			

4.3 Merge Two (or More) Existing CCNs into Another Already-Existing CCN

This works the same as the example above, which merges two CCN's, except that two (or more) Source CCNs are specified in the transaction. As in the example above, the Client, Service, and Periodic records for the Target CCN are retained. The First and Additional Source CCNs' Client records are deleted after changing the CCNs of their Service and Periodic records.

SUBMITTING COUNTY	TARGET COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	FIRST SOURCE CCN	ADD'L SOURCE CCN	ADD'L SOURCE CCN	ADD'L SOURCE CCN
33	123456789	K	K	987654321	454545454		

4.4 Merge Two (or More) Existing CCNs into a New CCN

This is an example of how two (or more) existing Source CCNs may be merged into a NEW Target CCN. The Client, Service, and Periodic records of the First Source CCN will have their CCNs changed to the Target CCN, and the Service and Periodic records for the Additional Source CCNs will have their CCNs changed to the Target CCN. The Client records for the Additional Source CCNs will then be deleted.

SUBMITTING COUNTY	TARGET COUNTY CLIENT NUMBER	RECORD TYPE	TRANSACTION CODE	FIRST SOURCE CCN	ADD'L SOURCE CCN	ADD'L SOURCE CCN	ADD'L SOURCE CCN
33	123456789	K	K	987654321	454545454	686868686	

Appendix E: CSI Technical Supplement E - Edit Criteria

CLIENT AND SERVICE INFORMATION SYSTEM
EDIT CRITERIA

Following are the Edit Criteria for Field, Relational and System Errors. There are two levels of error: Fatal **(F)** and Non-Fatal **(N)**.

- Fatal Errors will prevent the updating of the Master database. The transaction record will be used tobuild an Error Record that will be written to the Error File and returned to the county for correction.
- Non-Fatal Errors will allow the updating of the Master database with the exception of fields in error, which will be left blank on the Master database. The transaction record will be used to build an ErrorRecord that will be written to the Error File and returned to the county for correction.

Field Edits:

Field Number	F or N	Field Name	Required On	Edit Criteria
H-01.0	F	County/City/Mental Health Plan Submitting Record (Submitting County Code)	All Records	Must be a valid code (see this field for valid codes).
H-02.0	F	County Client Number	Control Record	Must be blank.
			All other Records	If less than nine characters in length, then must be right justified, zero filled, and no embedded blanks.
H-03.0	F	Record Type	All Records	Must be a valid code (C, K, P, S, X or A).
H-04.0	F	Transaction Code	All Records	Must be a valid code (D, K, or Blank).
X-01.0	F	Production or Test Indicator	Control Record	Must be a valid code (P or T).
X-02.0	F	From Report Period	Control Record	Must be valid month and year must be greater than June 1998.
X-03.0	F	Through Report Period	Control Record	Must be valid month and year must be greater than June 1998.
X-04.0	F	Creation Date	Control Record	Must be valid date and year must be greater than June 1998.
X-05.0	F	Key Change Record Count	Control Record	If less than seven numbers in length, then must be right justified and zero filled.
X-06.0	F	Client Record Count	Control Record	If less than seven numbers in length, then must be right justified and zero filled.
X-07.0	F	Service Record Count	Control Record	If less than seven numbers in length, then must be right justified and zero filled.
X-08.0	F	Periodic Record Count	Control Record	If less than seven numbers in length, then must be right justified and zero filled.

CLIENT AND SERVICE INFORMATION SYSTEM
EDIT CRITERIA

Field Number	F or N	Field Name	Required On	Edit Criteria
X-09.0	F	Assessment Record Count	Control Record	If less than seven numbers in length, then must be right justified and zero filled.
C-01.0	N	Birth Name	All Client Records	If any part of the name is less than the allowed characters, then must be left justified with trailing blanks.
C-02.0	N	Mothers First Name	All Client Records	If less than 15 characters, then must be left justified with trailing blanks.
C-03.0	N	Date of Birth	All Client Records	Must be a valid date and year must be greater than 1800.
C-04.0	N	Place of Birth	All Client Records	Must be a valid code (see this field for valid codes).
C-05.0	N	Gender	All Client Records	Must be a valid code (F, M, O, or U).
C-06.0	N/A	Filler	All Client Records	Formerly C-06.0 Ethnicity / Race. Space-fill this field after July 2006 reporting period and if DIG Indicator is 1.
C-07.0	N	Primary Language	All Client Records	Must be a valid code (see this field for valid codes).
C-08.0	N	Preferred Language	All Client Records	Must be a valid code (see this field for valid codes). Do not utilize prior to the July 2006 reporting period or if DIG Indicator is 0.
C-09.0	N	Ethnicity	All Client Records	Must be a valid code (Y, N, or U). Do not utilize prior to the July 2006 reporting period or if DIG Indicator is 0.
C-10.0	N	Race	All Client Records	Must be a valid code (see this field for valid codes). Do not utilize prior to July 1, 2006 or if DIG Indicator is 0.
C-11.0	F	Data Infrastructure Grant Indicator	All Client Records	Must contain a 0 if Client record does not contain DIG data or 1 if Client record does contain DIG data.
S-01.0	F	Record Reference Number	All Service Records	If less than 23 characters in length, then must be right justified, zero filled, and no embedded blanks.

Field Number	F or N	Field Name	Required On	Edit Criteria
S-02.0	N	Current Legal Name / Beneficiary Name	All Service records	If any part of the name is less than the allowed characters, then must be left justified with trailing blanks.
S-03.0	F	Social Security Number	All Service Records	Must be a real number or pseudo number.
S-04.0	N/A	Filler	All Service Records	Formerly S-04.0 Medi-Cal Number. Must be space filled. Space-fill this field for services delivered on or after July 1, 2006.
S-05.0	F	Mode of Service	All Service Records	Must be a valid code (05, 10, or 15) and match the Provider File.
S-06.0	F	Service Function	All Service Records	Must be a valid code for that Mode of Service (see this field for valid codes) and match within the service range in the Provider File.
S-07.0	F	Units of Service	All Service Records	Must be a valid code (see this field for valid values).
S-08.0	F	Units of Time	All Service Records	Must be a valid code (see this field for valid values).
S-09.0	F	Principal Mental Health Diagnosis	All Service Records	Must be a valid code (see this field for valid values).
S-10.0	F	Secondary Mental Health Diagnosis	All Service Records	Must be a valid code (see this field for valid values).
S-11.0	F	Additional Mental or Physical Health Diagnosis	All Service Records	Must be a valid code (see this field for valid values).
S-12.0	N	Special Population	All Service Records	Must be a valid code (A, C, G, N, or W).
S-13.0	F	Provider Number	All Service Records	Must match the Provider File.
S-14.0	N	County/City/Mental Health Plan with Fiscal Responsibility for Client	All Service Records	Must be a valid code (see this field for valid codes).
S-15.0	F	Admission Date	All Service Records where Mode of Service = 05	Must be valid date and must be greater than 1980.
S-16.0	F	From/Entry Date	All Service Records where Mode of Service = 05	Must be valid date and must be greater than June 30, 1998.
S-17.0	F	Through/Exit Date	All Service Records where Mode of Service = 05	Must be valid date and must be greater than June 30, 1998.
S-18.0	N	Discharge Date	All Service Records where Mode of Service = 05	Must be valid date and must be greater than June 30, 1998 or zero filled.
S-19.0	N	Patient Status Code	All Service Records where Mode of Service = 05 and Service Function = 10-79	Must be a valid code (see this field for valid codes).

CLIENT AND SERVICE INFORMATION SYSTEM
EDIT CRITERIA

Field Number	F or N	Field Name	Required On	Edit Criteria
S-20.0	N	Legal Class - Admission	All Service Records where Mode of Service = 05 and Service Function = 10-39	Must be a valid code (see this field for valid codes).
S-21.0	N	Legal Class - Discharge	All Service Records where Mode of Service = 05 and Service Function = 10-39	Must be a valid code (see this field for valid codes).
S-22.0	N	Admission Necessity Code	All Service Records where Mode of Service = 05 and Service Function = 10-39	Must be a valid code (1, 2, or 9).
S-23.0	F	Date of Service	All Service Records where Mode of Service = 10 or 15	Must be valid date and year must be greater than June 30, 1998.
S-24.0	N	Place of Service	All Service Records where Mode of Service = 10 or 15	Must be a valid code (see this field for valid codes).
S-25.0	N	Evidence-Based Practices / Service Strategies	All Service Records	Must be a valid code, left justified, with no embedded blanks and no duplicates if reporting multiple codes.Space-fill this field for services delivered prior to July 1, 2006.
S-26.0	N	Trauma	All Service Records	Must be a valid code (Y, N, or U). Space-fill this field for services delivered prior to July 1, 2006.
S-27.0	F	Client Index Number	All Service Records	Must be a valid Client Index Number (CIN) or zero filled. Do not utilize this field for services delivered prior to July 1, 2006.
S-28.0	N/A	Filler	All Service Records	Formerly S-28.0 Axis I Diagnosis. Space-fill this field for services delivered on or after October 1, 2015.
S-29.0	N/A	Filler	All Service Records	Formerly S-29.0 Axis I Primary. Donot utilize this field for services delivered on or after October 1, 2015.
S-30.0	N/A	Filler	All Service Records	Formerly S-30.0 Additional Axis I Diagnosis. Space-fill this field for services delivered on or after October 1, 2015.
S-31.0	N/A	Filler	All Service Records	Formerly S-31.0 Axis II Diagnosis. Space-fill this field for services delivered on or after October 1, 2015.
S-32.0	N/A	Filler	All Service Records	Formerly S-32.0 Axis II Primary. Do not utilize this field for services delivered on or after October 1, 2015.

Field Number	F or N	Field Name	Required On	Edit Criteria
S-33.0	N/A	Filler	All Service Records	Formerly S-33.0 Additional Axis II Diagnosis. Space-fill this field for services delivered on or after October 1, 2015.
S-34.0	F	General Medical Condition Summary Code	All Service Records	Report up to three separate General Medical Condition (GMC) Summary Codes. Must be a valid code (see this field for valid values).
S-35.0	N/A	Filler	All Service Records	Formerly S-35.0 General Medical Condition Diagnosis. Space-fill this field for services delivered on or after October 1, 2015.
S-36.0	N/A	Filler	All Service Records	Formerly S-36.0 Axis-V/GAF Rating.Space-fill this field for services delivered on or after October 1, 2015.
S-37.0	N	Substance Abuse/Dependence	All Service Records	Must be a valid code (Y, N, U, Z) (see this field for valid codes).
S-38.0	N	Substance Abuse/Dependence Diagnosis	All Service Records	Must be a valid code (see this field for valid values). Do not utilize this field for services delivered prior to July 1, 2006.
S-39.0	N	District of Residence	All Service Records where S-12.0 Special Population = C [Individualized Education Program (IEP) plan required service]	Must be seven bytes. No embedded blanks. Must report for IEP plan required services (where Service record S-12.0 Special Population field = C).

Field Number	F or N	Field Name	Required On	Edit Criteria
P-01.0	F	Date Completed	All Periodic Records	Must be a valid date and must be greater than June 30, 1998.
P-02.0	N	Education	All Periodic Records	Must be a valid code (see this field).
P-03.0	N	Employment Status	All Periodic Records	Must be a valid code (see this field for valid codes).
P-04.0	N/A	Filler	All Periodic Records	Formerly P-04.0 Axis-V / GAF. Space-fill this field for periodic data collected on or after July 1, 2006.

P-05.0	N/A	Filler	All Periodic Records	Formerly P-05.0 Other Factors Affecting Mental Health - Substance Abuse. Space-fill this field for periodic data collected on or after July 1, 2006.
P-06.0	N/A	Filler	All Periodic Records	Formerly P-06.0 Other Factors Affecting Mental Health - Developmental Disabilities. Space-fill this field for periodic data collected on or after July 1, 2006.
P-07.0	N/A	Filler	All Periodic Records	Formerly P-07.0 Other Factors Affecting Mental Health - Physical Health Disorders. Space-fill this field for periodic data collected on or after July 1, 2006.
P-08.0	N	Conservatorship / Court Status	All Periodic Records	Must be a valid code (see this field for valid codes).
P-09.0	N	Living Arrangement	All Periodic Records	Must be a valid code (see this field for valid codes).
P-10.0	N	Caregiver	All Periodic Records	Must be a valid code: Subfield A: 00 through 99 Subfield B: 00 through 99 Do not utilize this field for periodic data collected prior to July 1, 2006.
A-01.0	F	Assessment Reference Number (ARN)	All Assessment Records	There must be no embedded blanks. Otherwise, all values accepted. Assessment Reference Number must not be blank.
A-02.0	F	Date of First Contact to Request Services	All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018 (see this field for additional edits).

Field Number	F or N	Field Name	Required On	Edit Criteria
A-03.0	F	Referral Source	Optional on All Assessment Records untilfurther notice	Must be a valid code.
A-04.0	F	Assessment Appointment First Offer Date	All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-05.0	F	Assessment Appointment Second Offer Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-06.0	F	Assessment Appointment Third Offer Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-07.0	F	Assessment Appointment Accepted Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-08.0	F	Assessment Start Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-09.0	F	Assessment End Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-10.0	F	Treatment Appointment First Offer Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).

Field Number	F or N	Field Name	Required On	Edit Criteria
A-11.0	F	Treatment Appointment Second Offer Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-12.0	F	Treatment Appointment Third Offer Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-13.0	F	Treatment Appointment Accepted Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see the this field for additional edits).
A-14.0	F	Treatment Start Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-15.0	F	Closure Reason	Situational on All Assessment Records	Must be a valid code.
A-16.0	F	Closed Out Date	Situational on All Assessment Records	Must be a valid date and must be greater than or equal to January 1, 2018. (see this field for additional edits).
A-17.0	F	Referred To	Situational on All Assessment Records	Must be a valid code.
K-01.0	F	First Source County Client Number	All Key Change Records	If less than nine characters in length, then must be right justified, zero filled, and no embedded blanks. Otherwise, must be blank.

Field Number	F or N	Field Name	Required On	Edit Criteria
K-02.0	F	Additional Source County Client Number	All Key Change Records	If less than nine characters in length, then must be right justified, zero filled, and no embedded blanks. Otherwise, must be blank.

Relational and System Edits:

If any of the following Edit Criteria is not met, either a Fatal **(F)** or a Non-Fatal **(N)** Error will occur. Pleasenote that the CLIENT KEY refers to the data elements "Submitting County Code" and "County Client Number".

No.	F or N	Edit Criteria
1.	F	Only one Control Record shall be submitted per county file.
2.	F	If there is a field error in the Control Record, all records for the county will be rejected.
3.	F	Only one Key Change Record per unique Submitting County Code and Target CCN can be submitted per county file.
4.	F	If a Key Change Record Transaction (Record Type = K and Transaction Code = K), a. There must be a Submitting County Code and Target CCN. b. There must be at least one Source CCN. c. All Source CCN(s) must match the County Client Number(s) on the Master database. d. Source CCN must not be equal to Target CCN.
5.	F	Only one Client Record per unique CLIENT KEY can be submitted per county file.
6.	F	If a Client Record and Data Infrastructure Grant Indicator is 1, discontinued fields must not contain data.
7.	F	If a Client Record and Data Infrastructure Grant (DIG) Indicator is 0, DIG fields must not contain data.
8.	F	If an Add/Replace Client Record Transaction (Record Type = C and Transaction Code = blank), Client data fields must be filled in.
9.	F	If a Delete Client Record Transaction (Record Type = C and Transaction Code = D), a. CLIENT KEY must match a CLIENT KEY on the Master database. b. There must be no Service Records attached to the Client Record on the Master database. c. Client data fields must be blank.
10.	F	Only one Service Record per unique CLIENT KEY and Record Reference Number can be submitted per county file.
11.	F	If an Add/Replace Service Record Transaction (Record Type = S and Transaction Code = blank), a. CLIENT KEY must match the CLIENT KEY on a Master database Client Record. b. Service data fields must be filled in.
12.	F	If a Delete Service Record Transaction (Record Type = S and Transaction Code = D), a. CLIENT KEY and the Record Reference Number must match a CLIENT KEY and Record Reference Number on the Master database. b. Service data fields must be blank.

CLIENT AND SERVICE INFORMATION SYSTEM
EDIT CRITERIA

No.	F or N	Edit Criteria
13.	F	If a Service Record, and the Date of Service / Beginning Date of Service is greater than or equal to July 1, 2006, discontinued fields must not contain data.
14.	F	If a Service Record, and the Date of Service / Beginning Date of Service is prior to July 1, 2006, Data Infrastructure Grant fields must not contain data.
15.	N	If a Service Record, the Principal, Secondary, Third, Fourth and/or Fifth Diagnoses must be different except when coded with zeros or 7999.
16.	N	If a Service Record, the Principal Mental Health Diagnosis must not be V7109 if there is any other mental health diagnosis.
17.	N	If a Service Record and there is no mental health diagnosis, the Principal Mental Health Diagnosis may be V7109, but the Secondary Mental Health Diagnosis must be coded with zeros and the Third, Fourth, and Fifth Diagnoses must not be mental health diagnoses. If there is a mental health diagnosis, see item 16 above.
18.	N	If a Service Record, the Principal Mental Health Diagnosis must not be 7999, deferred, if there is any other mental health diagnosis.
19.	N	If a Service Record, the Secondary Mental Health Diagnosis must not be 7999, deferred,if there is a mental health diagnosis in the Third, Fourth, and/or Fifth Diagnosis fields.
20.	N	If a Service Record and the Axis I Primary is coded Y, the Axis I Diagnosis must not be coded V7109.
21.	N	If a Service Record, the Axis I Diagnosis and Additional Axis I Diagnosis must not be coded the same, unless both are coded 7999.
22.	N	If a Service Record and the Axis II Primary is coded Y, the Axis II Diagnosis must not be coded V7109.
23.	N	If a Service Record, both the Axis I Primary and Axis II Primary must not be coded Y.
24.	N	If a Service Record and both the Axis I Primary and Axis II Primary are coded N, then both the Axis I and Axis II Diagnoses must be coded V7109.
25.	N	If a Service Record, the Axis II Diagnosis and Additional Axis II Diagnosis must not be coded the same, unless both are coded 7999.
26.	N	If a Service Record, both the General Medical Condition Summary Code and the General Medical Condition Diagnosis fields must not be blank.
27.	N	If a Service Record, both the General Medical Condition Summary Code and the General Medical Condition Diagnosis fields must not contain data.
28.	N	If a Service Record and Substance Abuse / Dependence is coded N, the Substance Abuse / Dependence Diagnosis must not contain a Substance-Related Disorder diagnosis.
29.	N	If a Service Record and Special Population is C, age must be greater than 2 or less than 22.

No.	F or N	Edit Criteria
30.	F	If Mode of Service is 05, a. Admission Date must be prior or equal to the Report Period or the Discharge Date if there is a Discharge Date. b. From/Entry Date must be prior or equal to the Report Period, the Through/Exit Date, or the Discharge Date if there is a Discharge Date and equal to or later than the Admission Date. c. Through/Exit Date must be prior or equal to the Report Period or the Discharge Date if there is a Discharge Date and equal to or later than the From/Entry Date or the Admission Date. d. Discharge Date must be prior or equal to the Report Period and equal to or later than the Admission Date, the From/Entry Date, or the Through/Exit Date. e. Units of Service must be less than or equal to the number of days possible between the From/Entry Date and the Through/Exit Date. f. The year and month for the Through/Exit Date must equal the year and month for the From/Entry Date. g. The From/Entry and/or Through/Exit Dates must not overlap on those Service Records for the same client and same provider but with different Record Reference Numbers. h. Units of Service equal zero (00) is only acceptable when the From/Entry and Through/Exit Dates are equal and the From/Entry and Through/Exit Dates are less than or equal to the Discharge Date and the Admission Date is prior to the From/Entry Date, Through/Exit Date, and Discharge Date. i. Provider Number begins with 00 and Service Function is in the range of 35 through 39 (IMD service), there must be either a Social Security Number or Medi-Cal Number for services delivered prior to July 1, 2006, or a Social Security Number or Client Index Number (CIN) for services delivered on or after July 1, 2006. j. Age for Special Population is calculated when there is a valid From/Entry Date. k. Through/Exit Date must be prior to or equal to the Discharge Date when there is a Discharge Date. (REMOVED December 2001)
31.	F	If Mode of Service is 10 or 15, a. Date of Service must be equal or prior to the Report Period. b. Age for Special Population is calculated when there is a valid Date of Service.
32.	F	Only one Periodic Record per unique CLIENT KEY and Date Completed can be submitted per county file.
33.	F	If an Add/Replace Periodic Record Transaction (Record Type = P and Transaction Code = blank), a. CLIENT KEY must match the CLIENT KEY on a Master database Client Record. b. Periodic data fields must be filled in.
34.	F	If a Delete Periodic Record Transaction (Record Type = P and Transaction Code = D), a. CLIENT KEY and the Date Completed must match a CLIENT KEY and Date Completed on the Master database. b. Periodic data fields must be blank.
35.	F	If a Periodic Record and Date Completed is greater than or equal to July 1, 2006, discontinued fields must not contain data.
36.	F	If a Periodic Record and Date Completed is prior to July 1, 2006, Data Infrastructure Grant fields must not contain data.
37.	N	If a Periodic Record and Conservatorship / Court Status is A, B, C, D, E, or F, age must be greater than 13.

No.	F or N	Edit Criteria
38.	N	If a Periodic Record and Conservatorship / Court Status is G, H, or I, age must be less than26.
39.	N	If a Service Record and Special Population is W, age must be greater than 15 or less than 66. (REMOVED - December 2001)
40.	F	If a Periodic Record, the Date Completed must be prior or equal to the Report Period.
41.	N	If a Client Record, Ethnicity/Race subfield A must not equal subfield B.
42.	N	If a Client Record, Place of Birth must be a valid combination.
43.	F	If Mode of Service is 10, a. Units of Service must be equal to one day per record if Service Function is in the range of 81 through 99. b. Units of Time must be equal to one day per record if Service Function is in the range of 81 through 99. c. Units of Time must be zero filled if Service Function is in the range of 60 through 69.
44.	N	If a Service Record, Evidence-Based Practices / Service Strategies must not be reported for a service delivered prior to July 1, 2006.
45.	N	If a Service Record, Trauma must not be reported for a service delivered prior to July 1, 2006.
46.	F	If a Service Record, Date of Service or From/Entry Date must be within the range of theProvider Start Date and End Date in the DHCS Provider System.
47.	N	If a Service Record and Special Population is C, District of Residence must not be blank or must contain data.
48.	F	Only one Assessment Record per unique CLIENT KEY and Assessment Reference Number can be submitted per county file.
49.	F	If an Add/Replace Assessment record transaction (Record Type = A and Transaction Code = blank), Assessment data mandatory fields must be filled in.
50.	F	If a Delete Assessment Record Transaction (Record Type = A and Transaction Code = D). a. CLIENT KEY and the Assessment Reference Number must match a CLIENT KEY and Assessment Reference Number on the Master database. b. Assessment data fields must be blank.

Appendix F1: CSI Technical Supplement F - Reporting Tip 1 (Clients, Services, And Providers That Must Be Reported)

CLIENT AND SERVICE INFORMATION SYSTEM

REPORTING TIPS

TIP ONE: CLIENTS, SERVICES, AND PROVIDERS THAT MUST BE REPORTED

Tip One is about the clients, services, and providers that must be reported to the Client and Service Information (CSI) System using the following data fields: H-02.0 County Client Number (CCN), S-05.0 Mode of Service, S-06.0 Service Function, and S-13.0 Provider Number.

A basic principle of the CSI System is that it reflects both Medi-Cal and non-Medi-Cal clients, and services provided in the County/City/Mental Health Plan program. This includes all providers whose legal entities are reported to the County Cost Report under the category Treatment Program and the individual and group practitioners, most of which were formerly in the Fee-For-Service system. These practitioners are individual or group practice psychiatrists, psychologists, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC), and Registered Nurses (RN) as well as the Mixed Specialty group practices.

In county-staffed providers, all clients and services must be reported. In contract providers, those clients and services provided under the contract with the county mental health program must be reported.

Following is a description of the clients, services, and providers to be reported to the CSI System.

Clients	Persons with Medi-Cal eligibility. Persons who are medically indigent. Persons with private insurance, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Medicare, and Healthy Families Program; persons having Uniform Method for Determining Ability to Pay (UMDAP) liability; and, persons receiving any public funds to pay for all or part of their services.
Services * SD/MC reimbursable service.	*24 Hour Services (Mode 05)* Hospital Inpatient * Hospital Administrative Day * Psychiatric Health Facility (PHF) * SNF Intensive IMD Basic (no Patch) IMD With a Patch Adult Crisis Residential * Jail Inpatient Residential - Other Adult Residential * Semi-Supervised Living Independent Living Mental Health Rehab Center Therapeutic Foster Care * *Day Services (Mode 10)* Crisis Stabilization - Emergency Room * Crisis Stabilization - Urgent Care * Vocational Services Socialization SNF Augmentation Day Treatment Intensive - Half Day * Treatment Intensive - Full Day * Rehabilitation - Half Day * Rehabilitation - Full Day * *Outpatient Services (Mode 15)* Linkage (TCM)/Brokerage * Child and Family Team (CFT) * Intensive Care Coordination (ICC) * Linkage (TCM)/Brokerage Professional IP Visit * Collateral * Peer Support Services * Collateral: Professional Inpatient Visit * Professional Inpatient Visit - MHS * Mental Health Services (MHS) * Child and Family Team (CFT) Assessment * Intensive Home Based Services (IHBS) * Therapeutic Behavioral Services (TBS) * Medication Support (MS) * Professional Inpatient Visit - MS * Crisis Intervention - (CI) * Professional Inpatient Visit - CI *

CLIENT AND SERVICE INFORMATION SYSTEM

REPORTING TIPS

Providers	County organizations, county contracted organizations, and individual and group practitioners (most of which were formerly in the Fee-For-Service system).
Current Exception	Phase I (Inpatient) Consolidation providers and services are **not** currently reported to the CSI System. Reporting will be required when Medi-Cal funding changes from a claiming system to a capitation, allocation, or block grant funding system. Phase I Consolidation providers are hospitals which are not SD/MC certified. Presently, these hospitals bill directly through the Electronic Data System (EDS) for services provided to Medi-Cal beneficiaries in a psychiatric unit. The counties approve the service through the Treatment Authorization Request (TAR) process. Information about these clients and services is provided directly to the Department of Health Care Services after the claims are paid.
Exceptions	State Hospital and Conditional Release (CONREP) clients and services are not to be reported to the CSI System. Information about State Hospital clients and services are reported through the Admissions, Discharges, and Transfers (ADT) system directly to its headquarters, the Department of State Hospitals. Information about CONREP clients andservices are reported through the CONREP system to the Department of State Hospitals.

Appendix F2: CSI Technical Supplement F - Reporting Tip 2 (Reporting Service Records - 24 Hour Mode of Service)

TIP TWO: REPORTING SERVICE RECORDS - 24 HOUR MODE OF SERVICE

Tip Two is about reporting the 24-Hour Mode of Service records to the Client and Service Information (CSI) System. This tip is only about the following service record data fields: S-05.0 Mode of Service, S-06.0 Service Function, S-07.0 Units of Service, S-15.0 Admission Date, S-16.0 From/Entry Date, S-17.0 Through/Exit Date, S-18.0 Discharge Date, S-19.0 Patient Status Code, S-20.0 Legal Class - Admission, S-21.0 Legal Class - Discharge, and S-22.0 Admission Necessity Code.

Examples of how to report various situations on the 24-Hour Mode of Service records are illustrated. These examples use the above listed data fields along with these data fields: H-01.0 County/City/Mental Health Plan Submitting Record (Submitting County Code), H-02.0 County Client Number (CCN), H-03.0 Record Type, S-01.0 Record Reference Number (RRN), and S-02.0 Current Legal Name/Beneficiary Name.

In the following examples, please note how the reporting principle for the data field Units of Service corresponds with the situation.

- If a client is admitted and discharged from the same facility, the reporting principle is to count the date of admission and the days in the facility but **not** the date of discharge, except when the admission date is the same as the discharge date.
- If a client is transferred from a less acute facility to a more acute facility but is not discharged from the less acute facility, the reporting principle for the less acute facility is to count the date of admission and the days in the facility but **not** the date of transfer.
- If the client leaves and returns to the same facility but is not discharged and re-admitted, the reporting principle is to **not** count the days the client is away from the facility.

Example 1: Hospital Inpatient and Psychiatric Health Facility (PHF)

How to report:
- Service Function (SF) code changes during a report month.
- A stay that spans more than one report month.

Client XYZ is admitted August 3, 1998 to psychiatric inpatient and discharged August 7, 1998 (see line 1). The client is then re-admitted August 19, 1998 and discharged August 25, 1998 (see line 2). The client is re-admitted August 30, 1998. On September 4, 1998, the client is ready for transfer to a Skilled Nursing Facility (SNF) but a bed is not available. The client is then transferred to a SNF on September 8, 1998 (see lines 3 through 5). *Five Service Records are required. A separate record for the service function Administrative Days is required (see line 5).*

Please note that the data field Legal Class - Discharge is blank until the client has been discharged (see lines 3 and 4).

	CO	CCN	RT	RRN	Current Name	Mode of Service	SF	Units of Service	Admission Date	From/Entry Date	Through/ Exit Date	Discharge Date	Patient Status Code	Legal Class - Admission	Legal Class - Discharge	Admission Necessity Code
1	67	001	S	001	XYZ	05	10	04	19980803	19980803	19980807	19980807	B	2A	1A	1
2	67	001	S	002	XYZ	05	10	06	19980819	19980819	19980825	19980825	B	2A	1A	1
3	67	001	S	003	XYZ	05	10	02	19980830	19980830	19980831	00000000	A	2A		1
4	67	001	S	004	XYZ	05	10	03	19980830	19980901	19980903	00000000	A	2A		1
5	67	001	S	005	XYZ	05	19	04	19980830	19980904	19980908	19980908	F	2A	2C	1

Example 2: Skilled Nursing Facility (SNF) or Institute for Mental Disease (IMD)

How to report:
- Service Function (SF) code changes during a report month.
- A stay that spans more than one report month.
- When a client leaves a facility but is **not** discharged.

Client ABC was admitted on December 13, 1996 to an IMD. On July 1, 1998, the client is still in the IMD in a No Patch Program. On July 8, 1998, the client is changed from a No Patch Program to a Patch Program in the IMD (see lines 1 and 2). On August 15, 1998, the client breaks a leg and is admitted to an acute general hospital inpatient to have the leg set (see line 3). On August 17, 1998, the client returns to the IMD. On August 19, 1998, the client has a fever and other complications and is re-admitted to the general hospital for treatment (see line 4). On August 27, 1998, the client returns to the IMD and remains in the IMD through the September reporting period (see lines 5 and 6). *Six Service Records are required to report the services from July through September 1998.*

Please be advised that when reporting an IMD service, one of the following data fields must be provided: S-03.0 Social Security Number or S-04.0 Medi-Cal Number.

Please note that the Service Records from December 1996 through June 1998 are reported to the Client Data System (CDS).

	CO	CCN	RT	RRN	Current Name	Mode of Service	SF	Units of Service	Admission Date	From/Entry Date	Through/ Exit Date	Discharge Date	Patient Status Code	Legal Class - Admission	Legal Class - Discharge	Admission Necessity Code
1	67	002	S	001	ABC	05	35	07	19961213	19980701	19980707	00000000	A	2G		2
2	67	002	S	002	ABC	05	36	24	19961213	19980708	19980731	00000000	A	2G		2
3	67	002	S	003	ABC	05	36	14	19961213	19980801	19980815	00000000	G	2G		2
4	67	002	S	004	ABC	05	36	02	19961213	19980817	19980819	00000000	G	2G		2
5	67	002	S	005	ABC	05	36	05	19961213	19980827	19980831	00000000	A	2G		2
6	67	002	S	006	ABC	05	36	30	19961213	19980901	19980930	00000000	A	2G		2

Example 3: Residential

How to report:
- A stay that spans more than one report month.
- When a client leaves a facility but is **not** discharged.
- When the Discharge Date is the first day of the month.

Client LMN is admitted on August 3, 1998 to a residential facility. On August 15, 1998, the client is out of the facility on therapeutic leave (see line 1). The client returns to the facility on August 17, 1998. On August 29, 1998, the client is again on therapeutic leave (see line 2). The client returns on August 31, 1998 and remains in the residential facility until discharged on October 1, 1998 (see lines 3 through 5). *Five Service Recordsare required.*

Please note that when the From/Entry Date and Through/Exit Date are equal and the From/Entry and Through/Exit Dates are less than or equal to the Discharge Date and the Admission Date is prior to the From/Entry Date, Through/Exit Date and the Discharge Date, report zero (00) Units of Service (see line 5). When all four dates are the same, report one (01) Unit of Service. The data fields Legal Status - Admission, Legal Status - Discharge, and Admission Necessity Code are blank for 24-hour services other than Hospital, PHF, and SNF (including IMD).

	CO	CCN	RT	RRN	Current Name	Mode of Service	SF	Units of Service	Admission Date	From/Entry Date	Through/ Exit Date	Discharge Date	Patient Status Code	Legal Class - Admission	Legal Class - Discharge	Admission Necessity Code
1	67	003	S	001	LMN	05	65	12	19980803	19980803	19980815	00000000	A			
2	67	003	S	002	LMN	05	65	12	19980803	19980817	19980829	00000000	A			
3	67	003	S	003	LMN	05	65	01	19980803	19980831	19980831	00000000	A			
4	67	003	S	004	LMN	05	65	30	19980803	19980901	19980930	00000000	A			
5	67	003	S	005	LMN	05	65	00	19980803	19981001	19981001	19981001	B			

Example 4: Other 24-Hour Services

How to report: • Different types of 24 Hour services.

Client QRS is admitted on July 1, 1998 to Independent Living and discharged October 31, 1998. *Four Service Records are required.*

Please note that the data fields Patient Status Code, Legal Status - Admission, Legal Status - Discharge, and Admission Necessity Code are blankfor the following types of 24 Hour services: Semi-Supervised Living, Independent Living, and Mental Health Rehab Center.

	CO	CCN	RT	RRN	Current Name	Mode of Service	SF	Units of Service	Admission Date	From/Entry Date	Through/ Exit Date	Discharge Date	Patient Status Code	Legal Class - Admission	Legal Class - Discharge	Admission Necessity Code
1	67	004	S	001	QRS	05	88	31	19980701	19980701	19980731	00000000				
2	67	004	S	002	QRS	05	88	31	19980701	19980801	19980831	00000000				
3	67	004	S	003	QRS	05	88	30	19980701	19980901	19980930	00000000				
4	67	004	S	004	QRS	05	88	30	19980701	19981001	19981031	19981031				

Appendix F3: CSI Technical Supplement F - Reporting Tip 3 (Reporting Diagnosis Codes for records of services between 07/01/2006 and 09/30/2015)

TIP THREE: REPORTING DIAGNOSIS CODES

Tip Three provides examples for reporting the diagnoses required by the Client and Service Information (CSI) System in the following data fieldswithin the Service Record:

S-28.0 Axis I Diagnosis, S-29.0 Axis I Primary, S-30.0 Additional Axis I Diagnosis, S-31.0 Axis II Diagnosis, S-32.0 Axis II Primary, S-33.0 Additional Axis II Diagnosis, S-34.0 General Medical Condition Summary Code, S-35.0 General Medical Condition Diagnosis, S-36.0 Axis-V / GAF Rating, S-37.0 Substance Abuse / Dependence, and S-38.0 Substance Abuse / Dependence Diagnosis.

Diagnostic and Statistical Manual - Fourth Edition - Text Revision (DSM-IV-TR) codes are preferred, but International Classification of Diseases - Clinical Modifications, Revision 9 (ICD-9-CM) codes within the DSM-IV-TR classifications will be accepted. In addition, CSI will also accept ICD-9-CM codes that are within the mental disorder range.

The Axis I Diagnosis and/or Axis II Diagnosis must be a diagnosis for which mental health services are provided, while the Axis I Primary or Axis II Primary field should identify the Axis diagnosis that is the primary focus of attention or treatment for mental health services. The Additional Axis I and Additional Axis II Diagnosis fields should be used to identify additional mental health diagnoses that are also the focus of attention or treatment of mental health services.

For each Service Record, choose either the General Medical Condition (GMC) Summary Code field to report up to three General Medical Condition Summary Codes from the list provided, or the General Medical Condition Diagnosis field to report up to three GMC diagnoses. GMC diagnoses include codes within the DSM-IV-TR Axis III General Medical Conditions (with ICD-9-CM codes) classification and ICD-9-CM codes. Do not report data to both the General Medical Condition Summary Code and General Medical Condition Diagnosis fields within the same Service Record. If there are more than three GMC Summary Codes or GMC Diagnoses available to report, then report the three most important GMC Summary Codes or GMCDiagnoses.

Report the Global Assessment of Functioning (Axis-V / GAF) rating of the client on each Service Record. Ratings on the GAF Scale should be for the current period (i.e., the level of functioning at the time of the last evaluation) because ratings of current functioning will generally reflect the need for treatment or care.

Identify whether or not the client has a substance abuse / dependence issue in the Substance Abuse / Dependence field. If the client does have a substance abuse / dependence issue, then report the substance abuse / dependence diagnosis in the Substance Abuse / Dependence Diagnosis field.

The following pages present examples of both valid and invalid diagnosis code reporting.

EXAMPLES OF VALID DIAGNOSIS CODES

	Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
1	3004	Y	0000000	V7109	N	0000000	00						057	N	0000000

The Axis I Diagnosis is reported and identified as the Primary Diagnosis. No other diagnosis information, except the Axis-V / GAF Rating, is reported.

2	V7109	N	0000000	30181	Y	0000000				2190			085	N	0000000

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis II Diagnosis identified as the Primary Diagnosis. The record also contains a General Medical Condition (GMC) Diagnosis and an Axis-V / GAF Rating.

3	7999	Y	0000000	V7109	N	0000000	15						088	Y	30480

The Axis I Diagnosis is coded 7999 (Diagnosis or Condition Deferred on Axis I) and identified as the Primary Diagnosis. The record also contains V7109 (No Diagnosis on Axis II) in the Axis II Diagnosis, a GMC Summary Code, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

4	30081	U	0000000	V7109	N	0000000				71481	20010		000	N	0000000

The Axis I Diagnosis is reported and Axis I Primary is coded U (Unknown / Not Reported). The record also contains two GMC Diagnoses and an Axis-V / GAF Rating.

5	2973	Y	29012	7999	N	0000000	27						059	N	0000000

The Axis I Diagnosis is reported and identified as the Primary Diagnosis. The record also contains an Additional Axis I Diagnosis, a 7999 (Diagnosis Deferred on Axis II) code in the Axis II Diagnosis, a GMC Summary Code, and an Axis-V / GAF Rating.

6	29604	Y	7999	3019	N	30182	12	15					000	Y	30501

The Axis I Diagnosis is reported and identified as the Primary Diagnosis. The Additional Axis I Diagnosis is coded 7999 (Diagnosis or Condition Deferred on Axis I). The record also contains an Axis II Diagnosis, an Additional Axis II Diagnosis, two GMC Summary Codes, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

7	V7109	N	0000000	V7109	N	0000000				73681			064	N	0000000

The Axis I Diagnosis is coded V7109 (No Diagnosis or Condition on Axis I) and the Axis II Diagnosis is coded V7109 (No Diagnosis on Axis II). There is no Primary diagnosis. The record also contains a GMC Diagnosis and an Axis-V / GAF Rating.

EXAMPLES OF VALID DIAGNOSIS CODES, CONTINUED

	Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
8	V7109	N	0000000	319	Y	30189	99						050	Y	30451

The Axis II Diagnosis is reported and identified as the Primary Diagnosis. The record also contains an Additional Axis II Diagnosis, a General Medical Condition (GMC) Summary Code, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

9	3004	Y	0000000	V7109	N	0000000	08	16	17				078	N	0000000

The Axis I Diagnosis is reported and identified as the Primary Diagnosis and the Axis II Diagnosis field is coded V7109 (No Diagnosis on Axis II). The record also contains three GMC Summary Codes and an Axis-V / GAF Rating.

10	V7109	N	0000000	7999	Y	0000000	99						000	Y	30441

The Axis II Diagnosis is coded 7999 (Diagnosis Deferred on Axis II) and is also identified as the Primary Diagnosis. The record contains a GMC Summary Code, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

11	3006	N	0000000	3013	U	30159				53141	4611		061	N	0000000

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis II Diagnosis Primary reported as Unknown / Not Reported. The record also contains an Additional Axis II Diagnosis, Two GMC Diagnoses, and an Axis-V / GAF Rating.

12	30113	Y	0000000	30184	N	30111	00						076	Y	30402

The Axis I Diagnosis and Axis II Diagnosis are reported, with Axis I Diagnosis identified as the Primary Diagnosis. The record also contains an Additional Axis II Diagnosis, a GMC Summary Code, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

13	29011	N	2909	30110	Y	7999	01	37	32				059	N	0000000

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis II Diagnosis identified as the Primary Diagnosis. The record also contains an Additional Axis I Diagnosis, a 7999 (Diagnosis Deferred on Axis II) code in the Additional Axis II Diagnosis, multiple GMC Summary Codes, and an Axis-V / GAF Rating.

14	2970	Y	0000000	V7109	N	0000000	00						070	N	0000000

The Axis I Diagnosis is reported and identified as the Primary Diagnosis and the Axis II Diagnosis is coded V7109 (No Diagnosis on Axis II). The record also contains a GMC Summary Code and an Axis-V / GAF Rating.

EXAMPLES OF VALID DIAGNOSIS CODES, CONTINUED

	Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
15	30001	N	0000000	3014	Y	30182	11	19	24				075	Y	30433

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis II Diagnosis identified as the Primary Diagnosis. The record also contains an Additional Axis II Diagnosis, multiple General Medical Condition (GMC) Summary Codes, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

16	30282	Y	0000000	V7109	N	0000000	99						085	N	0000000

The Axis I Diagnosis is reported and identified as the Primary Diagnosis and the Axis II Diagnosis is coded V7109 (No Diagnosis on Axis II). The record also contains a GMC Summary Code and an Axis-V / GAF Rating.

17	3089	U	0000000	319	U	0000000	00						048	Y	30593

The Axis I Diagnosis and Axis II Diagnosis are reported and both the Axis I Primary and Axis II Primary are coded U (Unknown / Not Reported). The record also contains a GMC Summary Code, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

18	7999	N	7999	3019	Y	0000000				1701	7063	7865	068	Y	30480

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis II Diagnosis identified as the Primary Diagnosis. The record also contains a 7999 (Diagnosis or Condition Deferred on Axis I) code in the Additional Axis I Diagnosis, multiple GMC Diagnoses, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

19	30753	Y	0000000	V7109	N	0000000				0000000			060	N	0000000

The Axis I Diagnosis is reported and the Axis II Diagnosis is coded V7109 (No Diagnosis on Axis II), with the Axis I Diagnosis identified as the Primary Diagnosis. The record also contains a GMC Diagnosis and an Axis-V / GAF Rating.

20	30750	N	30759	30183	Y	30121				0000000			065	N	0000000

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis II Diagnosis identified as the Primary Diagnosis. The record also contains an Additional Axis I Diagnosis, an Additional Axis II Diagnosis, a GMC Diagnosis, and an Axis-V / GAF Rating.

21	V7109	N	0000000	3013	Y	0000000	21	12					000	Y	30420

The Axis I Diagnosis is coded V7109 (No Diagnosis or Condition on Axis I) and the Axis II Diagnosis is reported, with the Axis II Diagnosis identified as the Primary Diagnosis. The record also contains two GMC Summary Codes, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

EXAMPLES OF VALID DIAGNOSIS CODES, CONTINUED

	Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
22	30271	Y	0000000	V7109	N	0000000				0000000			073	Y	30532

The Axis I Diagnosis is reported and the Axis II Diagnosis is coded V7109 (No Diagnosis on Axis II), with the Axis I Diagnosis identified as the Primary Diagnosis. The record also contains a General Medical Condition (GMC) Diagnosis, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

23	30510	N	0000000	30159	Y	0000000	99						075	U	30510

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis II Diagnosis identified as the Primary Diagnosis. The record also contains a GMC Summary Code, an Axis-V / GAF Rating, and although the Substance Abuse / Dependence is coded U (Unknown / Not Reported), the record contains a reportable Substance Abuse / Dependence Diagnosis. Note that it is acceptable to have the Axis I Diagnosis and the Substance Abuse / Dependence Diagnosis coded the same since both diagnoses reside on Axis I.

24	7999	N	29604	30121	Y	0000000	35	09					085	Y	30411

The Axis I Diagnosis is coded 7999 (Diagnosis or Condition Deferred on Axis I) and the Axis II Diagnosis is reported and identified as the Primary Diagnosis. The record also contains an Additional Axis I Diagnosis, two GMC Summary Codes, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

25	29622	Y	0000000	30181	N	30184				20891			064	U	7999

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis I Diagnosis identified as the Primary Diagnosis. The record also contains an Additional Axis II Diagnosis, a GMC Diagnosis, an Axis-V / GAF Rating, and although the Substance Abuse / Dependence is coded U, the Substance Abuse Diagnosis fieldis coded 7999 (Diagnosis or Condition Deferred on Axis I).

26	V7109	N	0000000	3015	Y	0000000				2725	2749		079	Y	7999

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis II Diagnosis identified as the Primary Diagnosis. The record also contains multiple GMC Diagnoses, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a 7999 code (Diagnosis or Condition Deferred on Axis I) in the Substance Abuse / Dependence Diagnosis.

27	3004	Y	0000000	V7109	N	0000000	22	15					060	Y	0000000

The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis I Diagnosis identified as the Primary Diagnosis. The record also contains multiple GMC Summary Codes, an Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and although the Substance Abuse / Dependence is coded Y, the Substance Abuse / Dependence Diagnosis is coded 0000000 (No Substance Abuse / Dependence Diagnosis).

EXAMPLES OF INVALID DIAGNOSIS CODES

	Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
1	3010	N	3007	7999	U	0000000	36	02					000	U	7999

The diagnosis in the Axis I Diagnosis is not valid. The Axis I Diagnosis must be a valid DSM-IV-TR Axis I or ICD-9-CM code within the DSM-IV-TR Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification. 3010 is a DSM-IV-TR Axis II Diagnosis code.

2	V7109	Y	0000000	7999	N	0000000				0000000			078	Y	30572

The Axis I Diagnosis is coded V7109 (No Diagnosis or Condition on Axis I) and the Axis I Primary is coded Y. If the Axis I Primary is coded Y, then the Axis I Diagnosis must not be coded V7109.

3	V7109	N	3004	7999	U	0000000				0000000			078	Y	30572

The Axis I Diagnosis is coded V7109 (No Diagnosis or Condition on Axis I) and the Additional Axis I Diagnosis contains an Axis I diagnosis code. If the Axis I Diagnosis is coded V7109, then the Axis I Diagnosis must be coded 0000000.

4	30270	Y	30270	V7109	N	0000000	00						070	N	0000000

The Axis I Diagnosis and Additional Axis I Diagnosis are coded the same. The Axis I Diagnosis and Additional Axis I Diagnosis must not contain the same DSM-IV-TR Axis I codes or ICD-9-CM codes within the DSM-IV-TR Axis I Clinical Disorders / Other Conditions That May Be a Focus of Clinical Attention classification. Report 0000000 (No Additional Diagnosis or Condition on Axis I) if there is no additional diagnosis or condition on Axis I.

5	2979	Y	0000000		N	0000000	12						061	N	0000000

The Axis II Diagnosis is blank. The Axis II Diagnosis must be a valid DSM-IV-TR Axis II or ICD-9-CM code within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification. Report V7109 (No Diagnosis on Axis II) if there is no Axis II diagnosis.

6	29622	N	7999	V7109	Y	0000000				0000000			059	Y	0000000

The Axis II Primary is coded Y and the Axis II Diagnosis is coded V7109 (No Diagnosis on Axis II). If the Axis II Primary is coded Y, then the Axis II Diagnosis must not be coded V7109.

7	29590	Y	0000000	30110	Y	0000000	17						067	N	0000000

The Axis I Primary is coded Y and the Axis II Primary is coded Y. Only one Axis diagnosis, either Axis I or Axis II, can be the Primary Diagnosis.

8	30000	N	0000000	V7109	N	0000000				0300			000	Y	30580

The Axis I Primary is coded N and the Axis II Primary is coded N, and both the Axis I Diagnosis and the Axis II Diagnosis are not coded V7109. If both the Axis I Primary and the Axis II Primary are coded N, then both the Axis I Diagnosis and the Axis II Diagnosis must be coded V7109.

EXAMPLES OF INVALID DIAGNOSIS CODES, CONTINUED

	Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
9	30981	Y	7999	3181	N	3181	32	19					062	N	0000000

The Axis II Diagnosis and Additional Axis II Diagnosis are coded the same. The Axis II Diagnosis and Additional Axis II Diagnosis fields must not contain the same DSM-IV-TR Axis II codes or ICD-9-CM codes within the DSM-IV-TR Axis II Personality Disorders / Mental Retardation classification. Report 0000000 (No Additional Diagnosis on Axis II) if there is no additional diagnosis on Axis II.

10	31381	Y	0000000	V7109	N	0000000							062	N	0000000

The General Medical Condition (GMC) Summary Code is blank. For each Service record, choose either the GMC Summary Code field to report up to three separate GMC Summary Codes from the list provided, or the GMC Diagnosis field to report up to three separate GMC diagnoses. Report 99 (Unknown / Not Reported General Medical Condition) if the general medical condition is not known.

11	29530	Y	0000000	V7109	N	0000000	99	99	99				061	Y	30540

Two or more GMC Summary Codes are identical. For each Service record, report up to three separate GMC Summary Codes, but do not duplicate the GMC Summary Codes. When reporting 99 (Unknown / Not Reported GMC), 00 (No GMC), or a single GMC Summary Code, left justify the code and report it once.

12	V7109	N	0000000	30184	U	7999		10					090	Y	30580

The GMC Summary Code is not left justified and/or contains embedded blanks. When reporting up to three separate GMC Summary Codes, left justify the GMC Summary Codes and do not include embedded blanks.

13	2970	Y	30020	V7109	N	0000000							056	N	0000000

The GMC Diagnosis is blank. For each Service record, choose either the GMC Summary Code field to report up to three separate GMC Summary Codes from the list provided, or the GMC Diagnosis field to report up to three separate GMC diagnoses. Report 0000000 (No General Medical Condition Diagnosis) if there is no general medical condition diagnosis.

14	29530	Y	0000000	V7109	N	0000000				7999	7999	7999	061	Y	30502

Two or more GMC Diagnoses are identical. For each Service record, report up to three separate GMC Diagnoses, but do not duplicate the GMC Diagnoses. When reporting 7999 (Diagnosis Deferred), 0000000 (No GMC Diagnosis), or a single GMC Diagnosis, left justify the code and report it once.

15	3093	Y	0000000	V7109	N	0000000					0000000		075	N	0000000

The GMC Diagnosis is not left justified and/or contains embedded blanks. When reporting up to three separate GMC Diagnoses, left justify the GMC diagnoses and do not include embedded blanks.

EXAMPLES OF INVALID DIAGNOSIS CODES, CONTINUED

	Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
16	29532	Y	0000000	V7109	N	0000000	00			0000000			062	N	0000000

The GMC Summary Code field must be blank if the GMC Diagnosis field contains data. For each Service record, utilize either the GMC Summary Code field or GMC Diagnosis field to report general medical condition information to CSI, but not both fields within the same Service record.

17	30283	Y	0000000	V7109	N	0000000	00							Y	30390

The Axis-V / GAF Rating is blank. The Axis-V / GAF Rating must be a valid rating within the DSM-IV-TR Axis-V / GAF Scale. If Axis-V / GAF Rating is not known or not available, then report 000 (Unknown / Inadequate Information for Axis-V / GAF Rating).

18	7999	U	0000000	7999	U	0000000	15	02					000		0000000

The Substance Abuse / Dependence is blank. The Substance Abuse / Dependence must contain a valid code, either Y, N, or U. If Substance Abuse / Dependence is not known or not available, then report U (Unknown / Not Reported).

19	3006	U	0000000	V7109	U	0000000				78841			062	N	

The Substance Abuse / Dependence Diagnosis is blank. If the Substance Abuse / Dependence Diagnosis is not known or not available, then report 0000000 (No Substance / Dependence Diagnosis).

20	7999	N	0000000	7999	U	0000000	99						064	N	30502

The Substance Abuse / Dependence is coded N and the Substance Abuse / Dependence Diagnosis contains a DSM-IV-TR Axis I Substance-Related Disorder or an ICD-9-CM diagnosis within the DSM-IV-TR Axis I Substance-Related Disorders classification. If the Substance Abuse / Dependence Diagnosis contains a Substance Abuse / Dependence diagnosis, then Substance Abuse / Dependence must not be coded N (No Substance Abuse / Dependence Diagnosis).

21	V7109	N	0000000	317	Y	30110	10	11	27				040	Y	0019

The Substance Abuse / Dependence Diagnosis is not valid. If there is a Substance Abuse / Dependence issue, then report a DSM-IV-TR Axis I Substance-Related Disorder or an ICD-9-CM diagnosis within the DSM-IV-TR Axis I Substance-Related Disorders classification.

22	29630	U	0000000	V7109	N	0000000	30	35	02				081	N	7999

The Substance Abuse / Dependence Diagnosis is not valid. If Substance Abuse / Dependence is coded 7999 (Diagnosis or Condition Deferred on Axis I), then the Substance Abuse / Dependence must not be coded N.

Appendix F4: CSI Technical Supplement F - Reporting Tip 4 (Reporting Data Fields Containing a County Code)

TIP FOUR: REPORTING DATA FIELDS CONTAINING A COUNTY CODE

Tip Four is about reporting a county code to the Client and Service Information (CSI) System in the following data fields: H-01.0 County/City/Mental Health Plan (MHP) Submitting Record (Submitting County Code), and S-14.0 County/City/Mental Health Plan with Fiscal Responsibility for Client.

The following describes how these data fields with a county code are to be reported to the CSI System.

Data Field	Purpose	Comments
Submitting County Code	Identifies the two-digit county code of the County/City/Mental Health Plan submitting the record to the Department of Health Care Services. This code will be the same on all records submitted by a County/City/MentalHealth Plan. Must be reported in every record; that is,the Client, Service, Periodic, Assessment, Control, and Key Change Records.	This is usually the county that provides the service or contracts for the service. In a regional program, such as a regional Psychiatric Health Facility (PHF), the host county must submit the record. If a county contracts with another county to provide services to their out-of-county clients, the county providing the services must submit the record. When counties contract with private providers, the contracting county must submit the record.
County/City/ Mental Health Plan with Fiscal Responsibility for Client	Identifies the two-digit county code of the County/City/Mental Health Plan responsible for directly or indirectly paying for the client's services. Must be reported in every Service Record.	In a regional program, such as a regional Psychiatric Health Facility (PHF), the county using the facility is reported in this data field. If a county contracts with another county to provide services to their out-of-county clients, the county paying for the services is reported in this data field.

Each county will be provided with its own county-specific data whenever its county code is in either of these two data fields.

Appendix F5: CSI Technical Supplement F - Reporting Tip 5 (CSI Assessment Record - Alternative Designation of The First Request for Service, The Order In Which To Submit Data, Assessment Start Date And Treatment Appointment First Offer Date)

CLIENT AND SERVICE INFORMATION SYSTEM

REPORTING TIPS

TIP FIVE: CSI ASSESMENT RECORD - ALTERNATIVE DESIGNATION OF THE FIRST REQUEST FOR SERVICE, THE ORDER IN WHICH TO SUBMIT DATA, ASSESSMENT START DATE AND TREATMENT APPOINTMENT FIRST OFFER DATE

Note, all fields related to assessment appointments refer exclusively to initial encounters used to establish eligibility.

Alternative DATE OF FIRST CONTACT TO REQUEST SERVICES:

- If a person other than a prospective client contacts the Mental Health Plan (MHP) seeking services for the prospectiveclient the DATE OF FIRST CONTACT TO REQUEST SERVICES depends on the legal status of that person making the initial contact. If the person contacting the MHP is legally authorized to consent to services for the prospective client, the DATE OF FIRST CONTACT TO REQUEST SERVICES will be the date that person contacted the MHP. Conversely, if the person requesting services does not have legal authorization to consent to services, this initial contact should not be considered as the DATE OF FIRST CONTACT TO REQUEST SERVICES. Rather, when the prospective client is contacted, expresses an interest in service, and is offered an assessment appointment that date should be the DATE OF FIRST CONTACT TO REQUEST SERVICES.

- If a beneficiary enters the system via a crisis intervention, an Assessment Record is initiated on that date (this would be considered the DATE OF FIRST CONTACT TO REQUEST SERVICES).

- When a beneficiary enters the system via a crisis stabilization or in-patient service, this is not the DATE OF FIRST CONTACT TO REQUEST SERVICES. The DATE OF FIRST CONTACT TO REQUEST SERVICES is initiated on the date that the first stepdown service is requested
    - i.e., the beneficiary is discharged and a follow-up appointment/stepdown service is requested by the provider, client, or other referral source - that date is considered the DATE OF FIRST CONTACT TO REQUEST SERVICES

The order within which to submit data is as follows:

1. DATE OF FIRST CONTACT TO REQUEST SERVICES
2. REFERRAL SOURCE
3. ASSESSMENT APPOINTMENT FIRST OFFER DATE
    a. ASSESSMENT APPOINTMENT SECOND OFFER DATE (conditional)
    b. ASSESSMENT APPOINTMENT THIRD OFFER DATE (conditional)
4. ASSESSMENT APPOINTMENT ACCEPTED DATE
5. ASSESSMENT START DATE
    a. COUNTY CLIENT NUMBER (conditional)
6. ASSESSMENT END DATE
7. TREATMENT APPOINTMENT FIRST OFFER DATE
    a. TREATMENT APPOINTMENT SECOND OFFER DATE (conditional)
    b. TREATMENT APPOINTMENT THIRD OFFER DATE (conditional)

8. TREATMENT APPOINTMENT ACCEPTED DATE
9. TREATMENT START DATE
10. CLOSURE REASON (06-Referred To must NOT be blank)
11. CLOSED OUT DATE
12. REFERRED TO

- A complete Assessment Record will minimally consist of Header Record fields and an ASSESSMENT REFERENCE NUMBER, DATE OF FIRST CONTACT TO REQUEST SERVICES, ASSESSMENT APPOINTMENT FIRST OFFER DATE, CLOSED OUT DATE, and CLOSURE REASON.

Assessment and Treatment –

For Assessment Records, only the ASSESSMENT START DATE must be the same date or prior to the date that a treatment appointment is offered. The ASSESSMENT END DATE can be a date that is later than the treatment appointment date offered. An example scenario is as follows:

11/12/2018 - A client enters the system via a crisis intervention, upon referral from Crisis Services.

- DATE OF FIRST CONTACT TO REQUEST SERVICES
- REFERRAL SOURCE = 21 (see business rules)

11/12/2018 – The client is provided an assessment appointment instantly, and consents to the appointment.

- ASSESSMENT APPOINTMENT FIRST OFFER DATE
- ASSESSMENT APPOINTMENT ACCEPTED DATE

11/12/2018 – A psychiatrist begins assessing the client and, at the same time, the psychiatrist recommends, prescribes, and administers a medication to treat and calm the client at the client's consent. After the client receives the medication, the client consents to hospitalization for observation.

- ASSESSMENT START DATE
- COUNTY CLIENT NUMBER
- TREATMENT APPOINTMENT FIRST OFFER DATE
- TREATMENT APPOINTMENT ACCEPTED DATE
- TREATMENT START DATE

11/13/2018 – The next day, the psychiatrist continues assessing the client, the client is diagnosed and the psychiatrist concludes the assessment.

- ASSESSMENT END DATE

In this scenario, the TREATMENT APPOINTMENT FIRST OFFER DATE, TREATMENT APPOINTMENT ACCEPTED DATE, AND TREATMENT APPOINTMENT START DATE will be prior to the ASSESSMENT END DATE. The record will not be rejected. The rule only applies to the ASSESSMENT START DATE, which must be equal to or prior to the TREATMENT APPOINTMENT FIRST OFFER DATE, TREATMENT APPOINTMENT ACCEPTED DATE, AND TREATMENT APPOINTMENT START DATE.

Note, all fields related to assessment appointments refer exclusively to initial encounters used to establish eligibility.

Appendix G: CSI Technical Supplement G - Naming Convention

CLIENT AND SERVICE INFORMATION SYSTEM

CSI FILE NAMING CONVENTIONS

COUNTY CSI SUBMITTAL FILE

CSI Submittal Files are the data files the county submits to DHCS on a monthly basis. These files contain 400-byte CSI transaction records. Because these files contain confidential information, they must be zipped and encrypted before being transmitted to DHCS.

DHCS CSI processing is automated and is dependent upon receiving files with properly formatted file names.

The zipped/encrypted CSI Submittal file name in production must be:

CSI*cc*P*YYYYMM*#SUBMITTAL.ZIP

The name of the file within the zipped file in production must be:

CSI*cc*P*YYYYMM*#SUBMITTAL.TXT

Files not conforming to the above naming convention will not be processed by DHCS.

DHCS CSI OUTPUT - ERROR AND REPORT FILES

The CSI Error and Report files are created by DHCS's CSI system and placed on the DHCS BHIS/CSI/MOVEit server so the counties may download them, examine them, and correct any errors they may have submitted. These files will normally be available on the BHIS/CSI/MOVEit server the day after DHCS receives a CSI Submittal file.

CSI ERROR FILE

The CSI Error file and CSI Assessment Record Error file are cumulative files. The CSI Error file contains errors for Key Change, Client, Service and Periodic records. The CSI Assessment Error file contains errors for Assessments records. These Error files contain error records identifying errors in the most recent county CSI Submittal file (see above), plus records for any unresolved errors from previous CSI submittals. Because these files contain confidential information, both the CSI Error and CSI Assessment Error files are zipped and encrypted.

The zipped Error file name for Key Change, Client, Service, and Periodic records will be:

CSI*cc*PERRORS.ZIP

The zipped Assessment Error file name for Assessment records will be:

CSI*cc*PASSESSMENTRECORDERRORS.ZIP

The name of the Error file within the zipped file for Key Change, Client, Service and Periodic records will be:

CSI*cc*PERRORS.TXT

The name of the Error file within the zipped file for Assessment records will be:

CSI*cc*PASSESSMENTRECORDERRORS.TXT

CSI SUBMITTAL REPORTS FILE

The CSI Submittal Report's files contain the Detailed Pre-Edit Report and the County Update Summary report that the DHCS CSI system creates when running a county CSI Submittal file. Although this file contains no confidential information, it is password protected.

The report's file name will be:

CSI*cc*P*YYYYMM*#SUBMITTAL-REPORTS.zip

FOR ALL THE ABOVE FILE NAMES:

cc = County Code
P = P for Production files, or T for Test files (Staging environment)
YYYY = 4-digit Year for which the file is being submitted
MM = 2-digit Month for which the file is being submitted
= File Sequence Number (1 for the 1st submittal for a YYYYMM, 2 for the next, etc.)

ENCRYPTION PASSWORD

The encryption password for the CSI Submittal and Error files will be specific for each county. Please coordinate receiving your encryption password with DHCS CSI Support at MHCSISupport@dhcs.ca.gov.

Appendix H: Frequently Asked Questions (FAQs)

Client and Service Information (CSI) System

Frequently Asked Questions (FAQs)

Version: 2.10

January 2023

TABLE OF CONTENTS

1.0 What is an *Assessment*?

1.1 An assessment is any initial encounter used to establish eligibility.

2.0 How do we enter unscheduled walk-in appointments?

2.1 Would an unscheduled walk-in service that occurs following an assessment but prior to the scheduled treatment be considered a treatment appointment, or should MHPs only be reporting scheduled treatment appointments?

- The "Treatment Appointment First Offer Date" field should be completed. The walk-in can be considered a "same day" appointment and counted as a treatment session.

  The walk-in replaces the first scheduled treatment appointment, and the first scheduled treatment date gets cancelled because the first treatment session is considered to have already taken place, perhaps we can consider the first scheduled treatment appointment to have been "rescheduled" to the walk-in date.

- The following is the justification for allowing a walk-in treatment replace ascheduled appointment:

  The amount of time between professional assessment and the delivery of needed treatments and supports addresses an aspect of access to care. Delay in the delivery of needed services and supports may lead to exacerbation of symptoms and distress and poorer role functioning. Therefore, if a walk in session occurs after an assessment and demonstrates an urgent need for service prior to the appointment date, it would follow that some form of medical necessity dictates that this will be the first session in order to ensure timeliness of services.

2.2 If unscheduled walk-ins are considered treatment appointments, is it appropriate to leave the first, second, third offered appointment fields empty?

- The walk-in would be considered the first appointment. And if it is normal for all offered appointments to continue to be listed, then the rest of the appointments offered should remain, If not, then this appointment should be listed as the first appointment offered and the balance of the fields should remain empty.

3.0 How do we determine "*Date of First Contact"* and legal status of requester for services?

3.1 When referring new clients to our providers, is the contact date the date the client contacts us, or the date the org provider contacted the client to make an appointment?

- The Date of First Contact to Request Services is the date that the prospective client contacts the MHP seeking services

3.2 If a person other than a prospective client contacts the MHP seeking services for the prospective client the "Date of First Contact to Request Services" depends on the legal status of that person making the initial contact.

- If the person contacting the MHP is legally authorized to consent to services for the prospective client, the "Date of First Contact to Request Services' will be the date that person contacted the MHP.

- If the person requesting services does not have legal authorization to consent to services, this initial contact should not be considered as the "Date of First Contact to Request Services".

- Rather, when the prospective client is contacted, expresses an interest in service, and is offered an assessment appointment that date should be the "Date of First Contact to Request Services".

4.0 Is the CSI Assessment Record the same as Timely Access DataTool (TADT)?

4.1 Is the TADT the Assessment Record CSI Web Application we havebeen using to individually enter records manually into CSI via the online interface?

- The TADT is separate from the CSI Assessment Record and counties must continue to submit data via the CSI Assessment Record, in addition to TADT. Once all MHPs have successfully and accurately implemented Phase Two data elements of the CSI Assessment Record, it is DHCS's intention to use that data solely for analyzing timeliness and the TADT will be phased out. Until that time the TADT will act as a bridge until full CSI Assessment Record adoption is complete.

- The TADT spreadsheet was initially released in July 2020 as a means to resolve Corrective Action Plans for timely access. It will be required for the April 2021 submission of Network Adequacy Timely Access data and will be an enclosure to the BHIN for 2021 Network Adequacy Certification (NACT) requirements. That BHIN is currently being finalized with a target release date of March 2021.

4.2 Once we start officially submitting phase 2 data in CSI -- will we still have to submit TADT data with NACT?

- TADT and NACT are separate. NACT will continue even as TADT is phased out.

5.0 Duplicate Service Submissions: Replaces or Duplicates theservice?

5.1 If the county submitted a CSI service record for a client in a previous submission, if the same service is submitted again in the next submission, will the latest service override the older service record, or will therebe a service record duplication in the CSI system? Yes, it will overlay the existing record. Variables within the CSI Service Record like the SUBMITTING COUNTY CODE, COUNTY CLIENT NUMMBER (CCN), and the RECORD REFERENCE NUMBER (RRN) uniquely identify a CSI Service Record.

6.0 Is there a CSI System pre-edit (or any edit) that limits the CSI submittal file size?

6.1 No, however, there is a recommended file size to avoid tying up the CSI System's nightly processing window. For example, a .txt CSI submittal file with a compressed and zipped size of 24,120 KB requires 10+ HOURS TO PROCESS. Thus, DHCS IT is encouraging counties to keep compressed and zipped .txt CSI submittal files to LESS THAN 24,120 KB. A .txt file of that size would contain less than 650,000 CSI transaction records (Client, Service, Periodic, Assessment, and Key Change Records).

7.0 Is there a CSI system edit that ensures a certain % of records pertain to the reporting period?

7.1 No.

8.0 Is there a BHIS limitation of 1 CSI Submittal file per county per month?

8.1 No. However, file size does affect processing time – the larger the file, the greater amount of processing time required. With this caveat in mind, we recommend proceeding in a reasonable and judicious manner. For instance, the County would limit their reporting to one (1) CSI submittal file per week. This will allow DHCS to monitor the processing of each file to ensure that each one processes successfully and doesn't create an inordinate amount of errors before proceeding to report the next file. One (1) file per week also allows DHCS to process other county CSI submittal files in a timely manner. It would be ideal to establish a process where the County notifies DHCS of a submittal file being uploaded, and once processed, a review of the results can be shared with the County. Authorization to submit the next submittal file would depend upon each file's processing results. This would be an iterative process until the County is current.

9.0 Can you specify what data elements are required with a "Referred To" record submission?

9.1 If the "Closure Reason" is 06 (Beneficiary did not meet medical necessity criteria), then the "Referred To" and "Closed Out Date" must be completed. If any other selection is made for "Closure Reason", then "Referred To" should be blank, but "Closed Out Date" should be completed.

10.0 What is the fatal error criteria regarding the "Referred To" field?

10.1 A fatal error in the record will occur if Closure Reason 06 is selected and theReferred To field is blank or has an entry other than 01, 02, 03, or 04. Referred To error Codes are 862 and 863. The Close Out Date error codes are 860 and 864.

11.0 What is meant by Fatal Assessment error related to "ASSESSMENT END DATE - ASSESSMENT END DATE AFTER THE REPORT PERIOD"?

11.1 The error codes that relate to Assessment Record dates taking place after the Report Period of the County Submission File include: 805, 806, 808, 811, 814, 818, 821, 824, 827, 830, 833, 838, and 841. None of the Assessment Record date fields should be after the Report Period of the County Submission File.

12.0 What do the error codes *NA05809*, *NA11828*, *NA12831*, and *FA15863* refer to?

12.1 NA05809- Assessment Appointment Second Offer Date is after the Report period.

12.2 NA11828- Treatment Appointment Second Offer Date is less than or equal to the Treatment Appointment First Offer Date.

12.3 NA12831- Treatment Appointment Third Offer Date is less than or equal to the Treatment Appointment Second Offer Date.

12.4 FA15863- Closure Reason 01, 02, 03, 04, 05, 07, 08, and 09 is populated and "Referred To" is not blank.

12.5 The codes, when used in conjunction with the code identified by Field Number E-02.0, FIELD /RELATIONAL AND SYSTEM CODE, identifies the type of error and briefly describes the error.

13.0 What should we do in a situation where client does not have a CIN?

13.1 As a header field, this data element must be reported. If unknown make all zeros (000000000).

14.0 Can you collapse categories like Filipino, Chinese, and Korean under a broader category of Asian? Is this be acceptable?

14.1 DHCS requires specific race demographic data. Certain categories cannot be collapsed but must be reported separately.

14.2 The Race categories under CSI:

Race

1	=	White or Caucasian	M	=	Samoan
3	=	Black or African American	N	=	Asian Indian
5	=	American Indian or Alaska Native	O	=	Other Asian
7	=	Filipino	P	=	Native Hawaiian
C	=	Chinese	R	=	Guamanian
H	=	Cambodian	S	=	Mien
I	=	Hmong	T	=	Laotian
J	=	Japanese	V	=	Vietnamese
K	=	Korean	8	=	Other
L	=	Other Pacific Islander	9	=	Unknown / Not Reported

15.0 For the CSI record data fields which SMHS are considered treatment? Is Plan Development considered a treatment service, or do only Rehab, Collateral, and Therapy count as treatment?

15.1 Plan Development can be provided before a client plan is approved and is reimbursable. See MHSUDS Information Notice NO.: 17-040 for complete details.

16.0 Who is responsible for reviewing accuracy of data if a vendor is uploading data to the system? The vendor or the mental health plan (MHP)?

16.1 This should be discussed with the vender and an agreement should be made between the county and the vendor.

17.0 With CalAIM there will be new Access Criteria for SMHS but Medical Necessity criteria has not changed. Therefore a consumer may be assessed by us and meet medical necessity but should be moved to Managed Care for non-specialty mental health services. Do the current rules assume we'd offer an assessment appointment?

17.1 The business rules for the Assessment Record allow for entry that a beneficiary was referred to another delivery system.

18.0 Why do we have to submit the Network Adequacy TDAT if we submit CSI Monthly (double work), and can EQRO pull our timeliness from CSI instead of us having to pull it manually each year (triple work)?

18.1 DHCS is looking to reduce the duplicity of submissions once we receive accurate and reliable Assessment Record data. The Network Adequacy Tool shows us the complete network of service providers for the county. CSI is a system set up to receive those services and accept the providers counties have reported in the NACT--In CSI not every provider is reported and not every service provided is reportable to CSI. We rely on the Provider File and CSI to appropriately process service records, so we need a valid list of providers, the services they provide and the timeframe in which they provide them so we can validate that information in the CSI database.

19.0 Should access screening be recorded in the CSI Assessment Record?

19.1 Access screenings do not need to be recorded on Assessment Records.

20.0 How do we add services before assessment when there is no location to include them in CSI Assessment Record?

20.1 If there is a service before an assessment, it should be submitted through a CSI Service Record, not an Assessment Record. Treatment can begin before an assessment has ended, but not before an assessment has started.

21.0 We submitted some records erroneously early on. These cannot be deleted, yet they appear as errors each time we submit, even though we have not tried to submit them again. How can we remove these error records?

21.1 To delete accepted records see page 197 of the Data Dictionary. Deleting records with errors is not as easy. The best way to get rid of the errors is to correct them and resubmit them as replace records in a submittal file.

22.0 What if we do have some of the information for an Assessment Record but not all of it? For example, we are missing the *Treatment Appointment First Offer* date?

22.1 Minimum required fields need to be filled in for the assessment record to be accepted. First offered treatment appointment date is not a required field. If this field is required for your system, please work out with your vendor on how to fix this. You can also make the treatment first offer date the same date as the treatment date if needed. The reasoning for having the ability to input treatment offer dates is to show that counties have tried to provide timely access to care in cases that treatment doesn't occur in a timely fashion.

23.0 Do assessment records include only Medi-Cal beneficiaries or all clients?

23.1 This record was specifically created for Medi-cal and should not change.

24.0 Is a provider or other referral source legally allowed to request services for a client? If not, how would a county treat first date of contact for services from a referral source? Is it when the provider refers the client, or when the MHP contacts and verifies the client wants services?

24.1 There are internal processes and county policy on what is deemed a legally allowed person to request services. The list we have is based on all possible referral sources. Refer to your own county's internal processes on who is authorized per each client. Then use one of the referral sources listed.