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.

<table>
<tr><td>Clients</td><td colspan="2">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.</td></tr>
<tr><td>Services

* SD/MC reimbursable service.</td><td>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 *

Day Services (Mode 10)
Crisis Stabilization - Emergency Room *
Crisis Stabilization - Urgent Care *
Vocational Services
Socialization
SNF Augmentation

Outpatient Services (Mode 15)
Case Management, Brokerage *
Collateral *
Professional Inpatient Visit - Collateral *
Mental Health Services (MHS) *
Professional Inpatient Visit - MHS *</td><td>
Jail Inpatient
Residential - Other
Adult Residential *
Semi-Supervised Living
Independent Living
Mental Health Rehab Center

Day Treatment Intensive - Half Day *
Day Treatment Intensive - Full Day *
Day Rehabilitation - Half Day *
Day Rehabilitation - Full Day *

Medication Support (MS) *
Professional Inpatient Visit - MS *
Crisis Intervention - (CI) *
Professional Inpatient Visit - CI *</td></tr>
</table>

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 Mental Health 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 Mental Health. Information about CONREP clients and services are reported through the CONREP system to the Department of Mental Health.

TIP TWO: <u>REPORTING SERVICE RECORDS - 24 HOUR MODE OF SERVICE</u>

Tip Two is about reporting the 24-Hour Mode of Service 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 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 records are 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 blank for 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				

TIP THREE: REPORTING MENTAL HEALTH AND PHYSICAL HEALTH DIAGNOSIS CODES

Tip Three is about reporting the five diagnoses allowed by the Client and Service Information (CSI) system in the following three data fields: S-09.0 Principal Mental Health Diagnosis, S-10.0 Secondary Mental Health Diagnosis, and S-11.0 Additional Mental or Physical Health Diagnosis.

The Principal and Secondary Mental Health Diagnoses must be diagnoses for which mental health services are provided. The Principal Mental Health Diagnosis should reflect the DSM-IV diagnosis that is the primary focus of attention or treatment for mental health services. This diagnosis may be on either Axis I or Axis II. The Secondary Mental Health Diagnosis should reflect the DSM-IV diagnosis that is the secondary focus of attention or treatment for mental health services. This diagnosis may be on either Axis I or Axis II and may be a mental, substance use, or developmental disorder. Also, for the Principal and Secondary Mental Health Diagnoses, ICD-9-CM codes that are within the mental disorder range of 290-319 but are not in the DSM-IV will be accepted.

Up to three diagnoses are allowed in the data field Additional Mental or Physical Health Diagnosis. They may include mental, substance use, or developmental disorders in DSM-IV, or physical health disorders in ICD-9-CM. If there are more than three diagnoses available to be reported, list the three most important.

Examples of Valid Diagnosis Codes

	Principal Mental Health Diagnosis	**Secondary Mental Health Diagnosis**	**Additional Mental or Physical Health Diagnosis**		
			Third Diagnosis	**Fourth Diagnosis**	**Fifth Diagnosis**
Example 1	DSM-IV, Axis I or Axis II	DSM-IV, Axis I or Axis II	DSM-IV *or* ICD-9-CM	DSM-IV *or* ICD-9-CM	DSM-IV *or* ICD-9-CM
Example 2	DSM-IV, Axis I or Axis II	7999 (Deferred)	ICD-9-CM	0000000	0000000
Example 3	DSM-IV, Axis I or Axis II	0000000	0000000	0000000	0000000
Example 4	7999 (Deferred)	0000000	0000000	0000000	0000000
Example 5	V7109 (No mental health DX)	0000000	ICD-9-CM	0000000	0000000

Examples of Invalid Diagnosis Codes

	Principal Mental Health Diagnosis	Secondary Mental Health Diagnosis	Additional Mental or Physical Health Diagnosis		
			Third Diagnosis	Fourth Diagnosis	Fifth Diagnosis
Example 1	DSM-IV, Axis I or Axis II	ICD-9-CM	DSM-IV, Axis I or Axis II	0000000	0000000

Note: Principal and Secondary Diagnoses must be mental health.

Example 2	DSM-IV, Axis I or Axis II	7999 (Deferred)	DSM-IV, Axis I or Axis II	0000000	0000000

Note: If there are two mental health diagnoses, they must be placed in the Principal and Secondary Mental Health Diagnosis fields.

Example 3	7999 (Deferred)	DSM-IV, Axis I or Axis II	ICD-9-CM	0000000	0000000

Note: If there is only one diagnosis, it must be placed in the Principal Mental Health Diagnosis field.

Example 4	0000000	0000000	DSM-IV, Axis I or Axis II	0000000	0000000

Note: If there is a mental health diagnosis, it must be placed in the Principal Mental Health Diagnosis field.

Example 5	DSM-IV, Axis I or Axis II	V7109 (No mental health diagnosis)	0000000	0000000	0000000

Note: V7109, which indicates there is no mental health diagnosis, must not be placed in the data fields Secondary Mental Health Diagnosis and/or Additional Mental or Physical Health Diagnosis. When a mental health diagnosis is reported in the Principal Mental Health Diagnosis field, it is not logical to place V7109 in any of the remaining diagnosis fields.

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 Submitting Record (Submitting County Code), S-04.0 Medi-Cal Number, 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 Mental Health. This code will be the same on all records submitted by a County/City/Mental Health Plan. Must be reported in every record; that is, the client, service, periodic, 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.
Medi-Cal Number	First two digits of this 14-digit data field is the county code. Must be reported in a service record if the client is a Medi-Cal recipient or a Healthy Families Plan recipient.	This is usually the county of residence. It may not be the county of residence if the client moves and does not re-establish eligibility. If the client is a “hard to place for adoption child”, then the county of adoption is listed.
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 any of these three data fields.