

ILLINOIS
DEPARTMENT OF
HUMAN SERVICES

*Division of
Substance Use
Prevention and Recovery*

DARTS

A User's
Manual for
Substance Use
Disorder
Treatment
Counselors and
Computer Entry
Personnel

Department's
Automated
Reporting and
Tracking System
(DARTS)

2020

FISCAL YEAR

TROUBLESHOOTING/HELP DESK

For questions or problems concerning the use of the DARTS software, please refer to this manual before contacting the department. This is the quickest way to find answers. Check also the Web Page at <http://www.dhs.state.il.us/page.aspx?item=29747> as this site contains many reference materials. If problems cannot be resolved, Section IX of this manual contains guidelines for documentation of the problem and for contacting the Help Desk at DoIT.SUPRHelp@illinois.gov or faxing to 217-558-4656.

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How to Get Started

What is DARTS and How is it Used?

The Department's Automated Reporting and Tracking System (DARTS) is a software program used to report funded and/or Medicaid certified substance use disorder intervention and treatment services as authorized by the Division of Substance Use Prevention and Recovery (SUPR). Information extracted from DARTS is used to authorize grant fixed rate and fee-for-service payments, reconcile advance and reconcile disbursements, and determine compliance with State and Federal reporting requirements. Additionally, data extracted from DARTS is used to determine treatment and intervention service delivery patterns for budgetary purposes, measure outcomes and assist with long term planning. It is critically important that data is submitted correctly and in accordance with submission time frames.

How and When is Data Submitted?

All DARTS data must be submitted electronically using the internet. At a minimum, data must be submitted monthly but can be submitted daily if desired. All data is processed weekly as of 5:00 p.m. on Monday of each week.

When Do I Get Paid?

Payments are authorized monthly. Grant fixed rate and fee-for-service payments are based upon actual data received and accepted as of 5:00 p.m. of every second Monday of each month. Submissions not received in this time frame are used to authorize payment in the following month. Pre-approved Advance and Reconcile payments are authorized monthly and are reconciled to service submissions periodically, and at the end of the fiscal year.

How Do I Get Started?

Directions for loading and updating software are provided with the software. The four-digit provider number and initial password (DARTS) are also provided and are needed to begin using DARTS. Once the provider number is entered, it will automatically appear on any other screen where the number is required. Upon entry into DARTS, the password can be changed to identify a unique password for the organization.

What Information Should Be Entered into DARTS?

DARTS information is used to analyze its funded service delivery system and to extract information for grant fixed rate and fee-for-service payments and Advance and Reconcile funding reconciliation. All payments and reconciliations are based upon funding contained in an IDHS contract. The only services that should be entered into DARTS are those that are to be reimbursed by Medicaid or those that are to be reimbursed from or reconciled against non-Medicaid currently awarded funding.

What is the Process for Obtaining Information to Input into DARTS?

Hard copy data input forms are provided to use with DARTS software. It is strongly suggested that these forms be completed by clinical or other organization staff to document reportable and/or billable services **prior** to any entry into DARTS. Additionally, all individuals who complete and/or enter data from these forms should thoroughly read and understand the definition for each field on every form prior to use of the forms or the software.

Where Do I Start?

All entry into DARTS begins with the main menu bar and the following six options:

1. **Client/Patient Demographics (Openings/Closings)** - Used to record opening demographics, fix demographic errors and to record closing information and discharge outcomes.
2. **Services** - Used to report services.
3. **Unit/Program File** - Used to view unit number and program codes, funding codes and procedure codes.
4. **Reports** - Used to print and view reports.
5. **Utilities** - Used to submit service data, change passwords and load updates.
6. **DARTS Information** - Verifies the software version.

What are the Keyboard Functions?

Enter

Selected to save data and move forward through the screens. DATA IS NOT SAVED UNLESS THE MESSAGE “TRANSACTION SUCCESSFUL” IS DISPLAYED!

Escape

Selected to escape from any data input screen and back to the Menu Screen. In the process of entering data on a screen, selection of ESCAPE will display a message “ARE YOU SURE? (Y/N).” Responding “Y” will lose data entered on the most recent entry only! Responding “N” will allow continuation with the transaction.

F1

If selected, data in the demographic or service screens is displayed regarding the individual fields.

F2

If selected, will allow duplication of all the data for the same client/patient entered from the previous transaction except for the day the service was provided.

F3

This option is available on all service reporting screens except Level 3. It will allow duplication of all the data entered from the previous transaction except for the client/patient identification. This is particularly helpful when entering group services.

F5

As applicable, is used to go backwards to the previous data input screen.

Tab → moves to the next field.

Shift-tab ← moves to the previous field.

What are National Outcome Measures (NOMs) and How Do They Relate to DARTS?

National Outcome Measures are domains established by the federal government to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery from substance use disorders. DARTS collects information about these domains at admission and discharge from most levels of care within an episode of care. This data is submitted in aggregate to the federal government and used for analysis and process improvement. Outcome measures that are used to analyze change from admission to discharge are identified in DARTS as NOMs.

Unit/Program

Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the “Provider Unit/Program File.” If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from to year-to-year. All addresses should match those specified on facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify the Department immediately if errors are discovered may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Dedicated Funding Category Window (Non-Medicaid)

Dedicated funding is contained in many contracts to ensure that a specific portion of the funding is earned by delivery of services to special populations. Dedicated funding is applicable only to non-Medicaid earnings. Therefore, only services with a funding code of “DC” or “DS” can be tagged as dedicated funding. These specific dedicated funding amounts are contained in contract Exhibit 1 and only those categories, which are funded, will display on the software as follows:

- D - DCFS
- G - OMT Toxicology
- L - Gambling
- N - None
- O - STR-OMT

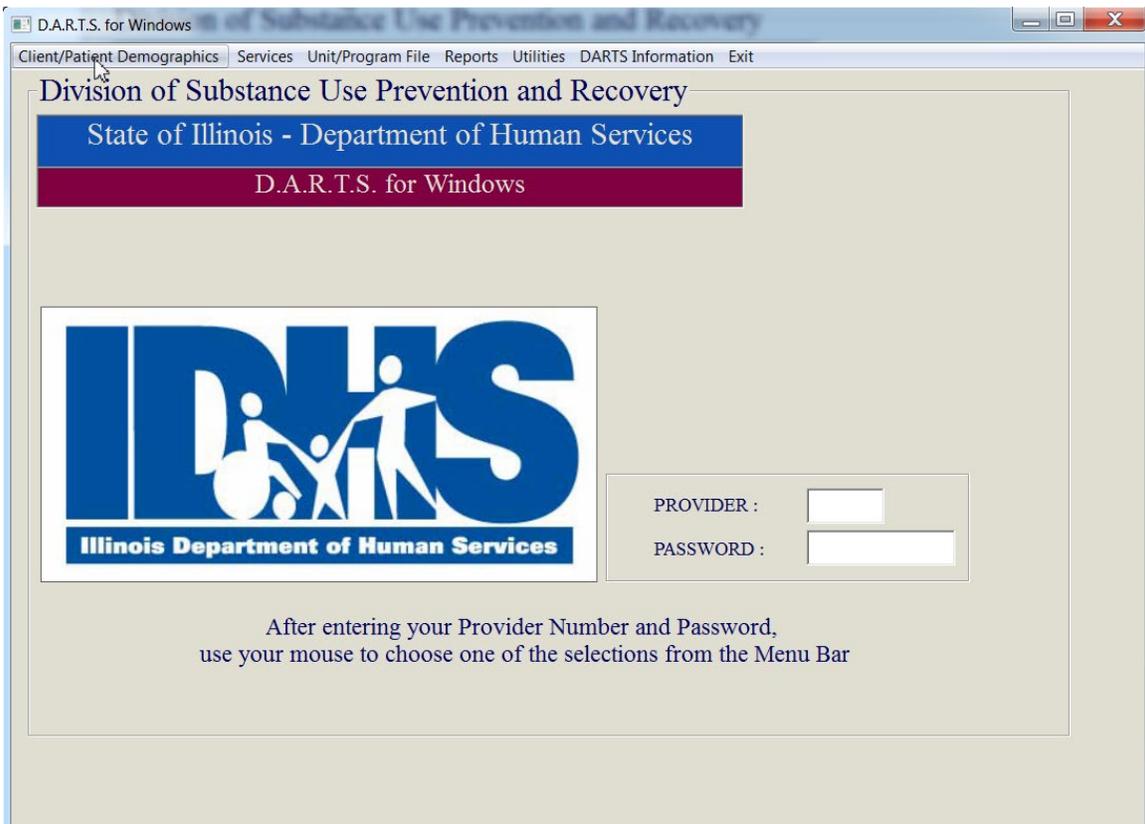
Not all contracts will have dedicated funding obligations. If the contract has no dedicated funding, no window will be displayed. If the contract has dedicated funding, but the service being reported does not apply to the patient, select “N” for none. It is very important that dedicated funding is reported correctly. This is how compliance with the contract is measured and these amounts are reflected on special dedicated funding reports.

Recipient Identification Number (RIN)

A recipient identification number (RIN) is required as the unique identifier for all client/patients. The RIN is based upon a mathematical computation and is displayed on the client/patient’s medical eligibility card if they are Medicaid eligible. If the client/patient is not Medicaid eligible and needs a RIN, it may be obtained from the following IDHS website: <http://www.dhs.state.il.us/page.aspx?item=32574>. When using this website, be sure to use the client/patient’s legal name, if possible, as this will help to prevent the assignment of multiple RIN’s for the same person.

Data Submission Errors

Specific error messages are displayed on the “Client Master File Update” and “Services Accepted/Rejected” reports that are posted on Mobius. When you receive an error message, the first step is READ the message and correct the problem. The Help Desk should be contacted only after you have read the report and tried to fix the problem. Some of the most common errors and directions on how to correct them and avoid them in the future are specified in Section XI of this manual.



Demographics

How Do I Enter Information into DARTS?

Information is entered into DARTS using the main menu and any of its data entry options. All early intervention and treatment services require a client/patient demographic record, and this must be completed before any services can be entered. This includes demographic information for all patients whose services are billed directly to an MCO. Community Intervention is the only reportable services that does not require demographics.

OPENING: How is a Client/Patient Opened into DARTS?

Demographics are required for each episode of care. Episode of care means the period of service between the beginning of a service for an alcohol or drug problem and the termination of services for the prescribed intervention or treatment plan. The first event in this episode is an admission and the last event is a discharge. Any change in service within the same Provider during a treatment episode is considered a discharge with a transfer code selected as the reason. Demographics required for opening are initially collected and recorded on the “Client/Patient Opening” data input form. The information contained on this form is then used to input the data into DARTS. The fields contained on each demographic screen are identified and defined as follows:

DEMOGRAPHIC SCREEN 1

D.A.R.T.S. for Windows

Services Unit/Program File Reports Exit

State of Illinois - DHS - Division of Substance Use Prevention and Recovery

Client/Patient Demographic Screen - #1 PROVIDER: 0079 D.A.R.T.S. for Windows

Unique Client/Patient ID: 220071336 Identifier Status: D Recipient ID Number: 220071336

Initial Contact: 04 / 01 / 2018 Open Date: 04 / 01 / 2018

Internal ID: 123456789 Patient Type: T Assessment Date: 04 / 01 / 2018

Last Name: DARTS First Name: DAVID Middle Initial: E

Address: 100 MAIN STREET

City: ANY TOWN State: IL Zip Code: 62704 -

Geocode: 100 - 00 Birth Date: 08 / 16 / 1959

Race: A Ethnicity: 1 Sex: M Veteran: N

Marital Status: 1 No. of Dependents: 01 Primary Care Number: 00 Continue

No. of Children - Age 25 and under: 00 No. of Children - Child Protection: 00 No. of Children - Lost Parental Rights: 00 Previous Screen

Pregnant at Assessment: N Living Arrangement: A Print It

Health Insurance: 4 MCO Patient: MCO Eligibility Begin Date: Exit

Press F1 Key on Data Field for Help

Unique Client/Patient Identifier (NOMs)

This is a key field for DARTS that identifies the client/patient as unique in our system and across other systems of care. This number is essential to state and federal government for the measurement of outcomes, the ability to track clients/patients who receive services from multiple agencies and to ensure that duplicate services are not billed for the same client/patient. For existing clients/patients who have been receiving services with no interruption over the past few fiscal years, this number might still be the social security number or a generated identification number. The Recipient Identification Number (RIN) is required for all new admissions and will default to the RIN field when entered.

Identifier Status

This field contains additional information concerning the status of the unique identifier.

D - The RIN is the unique identifier

For clients opened after 6/30/07, Identifier Status must be “D”

Recipient Identification Number (RIN)

Entering any of the nine digits incorrectly will display the error message “Invalid RIN Computed.” NOTE: If the RIN is used as the unique identifier, it will automatically default to this field.

Initial Date of Contact (NOMs)

The date of the initial contact means the first request for an early intervention or treatment service for the current episode of care, in which an appointment is made by the client/patient or someone on behalf of the client/patient. **NOTE: This date keys to a critical outcome measure related to the amount of time elapsed between the initial contact, the assessment, and the first intervention or treatment service.** Please ensure that this date is entered correctly. **This date SHOULD NOT be the date of the first assessment, early intervention, or treatment service unless that was the actual first contact with the client/patient.**

Open Date

This is a key field for DARTS. It means the first date of service for the episode of care. For billing purposes, this is the first date that a service can be billed. Any bill submitted with a date that precedes the opening date will be rejected.

Internal ID

An **optional** field to record a second identification number for the client/patient that may be used only by the provider.

Client/Patient Type

In this field, the type of client/patient is identified. “T” should be selected for an individual who will be receiving a Recovery Home service and/or who has completed the assessment, has a substance use disorder diagnosis of and who is recommended for admission to a SUPR funded **treatment** service. “I” should be selected for an individual, who has completed the assessment, has no diagnosis and who is recommended for admission to a funded **early intervention** service. “O” should be selected only for closure of patient demographic record opened prior to July 1, 2004 for which all demographic discharge information cannot be obtained.

Assessment Date (NOMs)

This field collected in the client/patient demographic record and means the first date of the process required by Administrative Rule, Part 2060 to collect and interpret information from a client/patient to make an initial determination of a substance use disorder and to make a recommendation for placement into intervention or treatment services. This date is used as a process improvement measurement to determine the time elapsed between the start of the assessment and the first clinical service. For data collection purposes, this date can precede the opening date. For billing purposes, it cannot. If the assessment is billed through DARTS, this date should match the first assessment billing date. Additionally, this date will default to the discharge date for any admission assessment that results in a problem area of “#5” - None.

Name (L, F, MI), Street Address, City, State, Zip Code

Geocode/County Code Quick Reference

Geocode is a five-digit number, which correctly identifies the county and township/community area. The first three positions identify the county and the next two identify the township/community area. Refer to the current Directory of Geographic Information published by the State of Illinois to find a geocode.

The corresponding three-digit code is specified for each county in Illinois and is a required field on the demographic screens in DSRS. A specific code (#103) is also given for out-of-state.

Geocode for **Chicago** begins with 105 and the Community Area is to be looked up in the Geocode Manual. Geocode for Suburban Cook begins with 016 and the Township is to be looked up in the Geocode Manual. Also, please spell Chicago “**CHICAGO**.” Do not use CHGO, CGO, etc.

Code	County	Code	County	Code	County
001	Adams	036	Henderson	071	Ogle
002	Alexander	037	Henry	072	Peoria
003	Bond	038	Iroquois	073	Perry
004	Boone	039	Jackson	074	Piatt
005	Brown	040	Jasper	075	Pike
006	Bureau	041	Jefferson	076	Pope
007	Calhoun	042	Jersey	077	Pulaski
008	Carroll	043	Jo Daviess	078	Putnam
009	Cass	044	Johnson	079	Randolph
010	Champaign	045	Kane	080	Richland
011	Christian	046	Kankakee	081	Rock Island
012	Clark	047	Kendall	082	Saline
013	Clay	048	Knox	083	Sangamon
014	Clinton	049	Lake	084	Schuyler
015	Coles	050	LaSalle	085	Scott
016	Cook (Suburb)	051	Lawrence	086	Shelby
017	Crawford	052	Lee	087	Stark
018	Cumberland	053	Livingston	088	St. Clair
019	DeKalb	054	Logan	089	Stephenson
020	DeWitt	055	Macon	090	Tazewell
021	Douglas	056	Macoupin	091	Union
022	DuPage	057	Madison	092	Vermilion
023	Edgar	058	Marion	093	Wabash
024	Edwards	059	Marshall	094	Warren
025	Effingham	060	Mason	095	Washington
026	Fayette	061	Massac	096	Wayne
027	Ford	062	McDonough	097	White
028	Franklin	063	McHenry	098	Whiteside
029	Fulton	064	McLean	099	Will
030	Gallatin	065	Menard	100	Williamson
031	Greene	066	Mercer	101	Winnebago
032	Grundy	067	Monroe	102	Woodford
033	Hamilton	068	Montgomery	103	Out-of-State
034	Hancock	069	Morgan	104	Unknown
035	Hardin	070	Moultrie	105	CHICAGO (City)

Birth Date

The numeric equivalent of month, day, and year (MM/DD/YYYY).

Race

- A - American Indian
- B - Alaska Native
- C - Asian
- D - Native Hawaiian or other Pacific Islander
- E - Black or African American
- F - White
- L - Other Single Race

Ethnicity

- 1 - Puerto Rican - of Puerto Rican origin regardless of race
- 2 - Mexican - of Mexican origin regardless of race
- 3 - Cuban - of Cuban origin regardless of race
- 4 - Other Specific Hispanic/Latino - of known Central or South American or any other Spanish cultural origin (including Spain), other than Puerto Rican, Mexican, or Cuban, regardless of race
- 5 - Not of Hispanic/Latino Origin
- 6 - Hispanic/Latino - Specific Origin Not Specified - of Hispanic/Latino origin but specific origin not known or not specified

Sex

Identifies the gender of the client/patient. Enter 'M' - Male or 'F' - Female.

Veteran

Indicates whether the client/patient has served in the Uniformed Services. Enter 'Y' - Yes or 'N' - No.

Marital Status

- 1 - Never Married
- 2 - Married
- 3 - Widowed
- 4 - Divorced
- 5 - Separated

Number of Dependents for Income Eligibility

The number of dependents living in the immediate household as well as any for whom financial responsibility exists.

Total Number of Children for Whom the Patient is the Primary Care Giver

The number of children, under the age of 21, living with the client/patient and/or for whom the client/patient is primary care giver. (Do not include children who have been placed by DCFS, temporarily or permanently with others for their care, whether relatives or other foster care.)

Number of Children Age 25 and Under

Count children for whom the client has ever had legal custody or has ever been legally responsible. Include adopted children, stepchildren and deceased children.

Number of Children Living with Someone Else Due to a Child Protection Court Order

Children living with someone else due to a formal order by a court or child protection agency describing where and under whose supervision the child will be living or staying.

Number of Children for Whom Patient/Client Lost Parental Rights

This number should include all children for whom parental rights have been revoked by a formal court order (not voluntary surrender). If a client voluntarily gives up his/her child for adoption, it is not counted here.

Pregnant at Assessment

Indicates if the client/patient is pregnant at the time of the assessment. Enter ‘Y’ - Yes or ‘N’ - No.

Living Arrangement (NOMs)

Describes the current living arrangement.

- A - Shelter (Safe Havens, Transitional Living Centers (TLC), Low Demand Facilities, Reception Centers, other Temporary Day, or Evening Facilities)
- B - Street/Outdoors - (Sidewalk, Doorway, Park, Public or Abandoned Building)
- C - Institutional - (Hospital, Nursing Home, Jail/Prison)
- D - Owned or Rented Apartment, Room, or House
- E - Someone Else’s Apartment, Room or House
- F - Dormitory/College Residence
- G - Residential Extended Care
- H - Residential Treatment
- I - Recovery Home
- J - Other Housed

Health Insurance

Identifies the primary insurance carrier or the primary coverage of the parent or guardian if the client/patient is carried as a dependent on that policy.

- 1 - Private (Other than Blue Cross/Blue Shield or an HMO)
- 2 - Blue Cross/Blue Shield
- 3 - Medicare
- 4 - Medicaid
- 5 - Health Maintenance Organization (HMO)
- 6 - Other
- 7 - None
- 8 - Medicaid Managed Care Organization (MCO)

Medicaid MCO Provider Identification

There is no need to change the Medicaid MCO Provider if the patient changes MCO Provider.

When the “Health Insurance” is an ‘8’ (Medicaid MCO), enter the code for the MCO Provider.

- ‘02’ – Blue Cross Blue Shield
- ‘05’ – County Care (*Cook*)
- ‘10’ – IlliniCare
- ‘11’ – Meridian
- ‘12’ – Molina
- ‘13’ – Next Level Health (*Cook*)

Medicaid MCO Eligibility Begin Date

When the “Health Insurance” is an ‘8’ (Medicaid MCO), there must be a valid date entered into the “Medicaid MCO Eligibility Begin Date” field. If the MCO changes, you do not need to change the begin date.

DEMOGRAPHIC SCREEN 2

The screenshot shows a software window titled "D.A.R.T.S. for Windows" with a menu bar (Services, Unit/Program File, Reports, Exit). The main title is "State of Illinois - DHS - Division of Substance Use Prevention and Recovery". Below this, it says "Client/Patient Demographic Screen - #2".

Fields displayed include:

- PROVIDER: 0079
- UNIQUE CLIENT/PATIENT ID: 220071336
- OPEN DATE: 04 / 01 / 20 18
- LAST NAME: DARTS, DAVID, E
- Employment Status: 1 (dropdown)
- Not in Labor Force (NILF) Detail: 7 (dropdown)
- School / Job Training Enrollment: 1 (dropdown)
- Educational Level: 11 (dropdown)
- Family Annual Income: 020000 (text field)
- Income Eligibility Override:
- Source of Income/Support: 1 (dropdown)
- Primary Language: A (dropdown)
- Can the patient speak English?: Y (dropdown)
- Interpreter Type: 1 (dropdown)
- Prior Treatment Episodes: 1 (dropdown)
- Referral Source: A (dropdown)
- Criminal Justice Referral:
- Patient involved with DCFS: N (dropdown)
- MISA: N (dropdown)
- Number of Arrests in the 30 days preceding Date of Admission: 00 (text field)
- Self-Help Group: N (dropdown)
- Self-Help Detail:
- Supportive Interaction: N (dropdown)

Buttons at the bottom right: Continue, Previous Screen, Exit. A note at the bottom says "Press F1 Key on Data Field for Help".

Employment Status (NOMs)

Describes the current employment status.

- 1 - Full-time (working 35 hours or more each week; includes members of the uniformed services)
- 2 - Part-time (working fewer than 35 hours each week)
- 3 - Unemployed (looking for work in the past 30 days or on layoff from a job)
- 4 - Not in Labor Force (NILF) (not looking for work in the last 30 days or homemaker, student, disabled, retired or an inmate of an institution)

Not in Labor Force (NILF) Detail (NOMs)

This field is required when the “Employment Status” = ‘4’ - Not in Labor Force.

- | | | |
|---------------|---------------------------|--------------------------|
| 1 - Homemaker | 4 - Disabled | 7 - Not Applicable |
| 2 - Student | 5 - Inmate of Institution | 8 - Volunteer Work |
| 3 - Retired | 6 - Other | 9 - Not Looking for Work |

Demographics

School/Job Training Enrollment

For incarcerated persons, this field must be “Not Enrolled”

- 1 - Not Enrolled
- 2 - Enrolled, Full Time
- 3 - Enrolled, Part Time

Educational Level (NOMs)

The highest school grade level completed. Enter “12” for a GED.

Family Annual Income

Enter all projected gross income per calendar year. A total family annual income eligibility criterion is utilized to determine the appropriateness of contract dollars to pay for substance use disorder early intervention or treatment as follows:

FAMILY INCOME ELIGIBILITY CRITERIA CONTRACT REIMBURSED (NON-MEDICAID)

FY 2020 FAMILY INCOME ELIGIBILITY

Number of Dependents	Annual Income
1	\$24,980
2	\$33,820
3	\$42,660
4	\$51,500
5	\$60,340
6	\$69,180
7	\$78,020
8	\$86,860

For each additional person, add \$8,840.

Income Eligibility Override

This field is required if the client/patient income exceeds the eligibility requirements. Select 1-7 from the following reasons to override the criteria:

1. a dependent adult whose spouse or other responsible party is unwilling to assume financial responsibility for the cost of treatment, and the dependent adult would, as a result, be denied access to treatment services; or
2. a dependent minor who is not covered by the Department of Healthcare and Family Services Medical Programs and/or whose parent(s) or legal guardian is unwilling to assume financial responsibility for the cost of treatment or intervention, and the dependent minor would, as a result, be denied access to treatment or intervention services; or
3. a pregnant woman who is not covered by the Department of Healthcare and Family Services Medical Programs and has no insurance benefit that covers the cost of treatment; or
4. a member of a family unit whose combined debt for prior medical expenses (not covered by insurance) exceeds 7.5% of the total gross family annual income, and the individual would be denied access to treatment due to the unwillingness or inability of the family to assume further debt; or
5. a patient with an extenuating circumstance that meets any additional hardship guidelines adopted by the provider's governing body; or
6. an individual for whom the fee is the sole inhibitor to accept treatment; or
7. other approved governing body criteria.

Source of Income/Support

The primary source of family income.

- | | |
|------------------------|----------------|
| 1 - Wages/Salary | 4 - Disability |
| 2 - Public Assistance | 6 - None |
| 3 - Retirement/Pension | |

Primary Language

Specify the primary language spoken by the client/patient.

- | | | |
|-------------|-------------|---------------------|
| A - English | G - Korean | L - Vietnamese |
| B - Arabic | H - Polish | M - Other - Asian |
| C - Chinese | I - Russian | N - Other - African |
| D - French | J - Spanish | O - Other - Indian |
| E - German | K - Urdu | P - Other |
| F - Hindi | | |

English Proficiency

Indicates if the client/patient can speak English. Enter 'Y' - Yes or 'N' - No.

Interpreter Type

Will interpreter services be needed? Select the type or enter none.

- 1 - Foreign Language
- 2 - Hearing Impaired
- 3 - None

Prior Treatment Episodes of Care

Treatment Episode of Care means the period of service between the beginning of a treatment service (admission) and the termination of services for the prescribed treatment (discharge). Indicate the number of previous treatment episodes the patient has received in any substance use disorder treatment program.

Referral Source

The referral sources.

- A - **Individual** - Includes the client/patient, a family member, friend, or any other individual who would not be included in any of the following categories.
- B - **Substance Use Disorder (SUD) Treatment Provider** - Any program, clinic or other health care provider whose principal objective is treating patients with SUD problems.
- C - **Early Intervention Provider** - Any program, clinic or other health care provider whose principal objective is the provision of early intervention services to clients with alcohol or drug related problems.
- D - **DHS/SAPP Prevention Provider** - Any program, clinic or other health care provider whose principal objective is the provision of prevention services targeted at preventing alcohol or drug related problems.
- E - **Other Health Care Provider** - A physician, psychiatrist or other licensed health care professional, or general hospital, psychiatric hospital, mental health program or nursing home.
- F - **School (Educational)** - A school principal, counselor or teacher or a Student Assistance Program, the school system or an educational agency.
- G - **Employer/EAP** - A supervisor or an employee counselor.
- H - **Other Community Referral** - Community or religious organization or any Federal, State or local agency that provides aid in the areas of poverty relief, shelter, unemployment, or other social services. Self-help groups are included in this category. Defense attorneys are also included in this category.
- I - **Criminal Justice Referral** - Any police official, judge, prosecutor, probation officer, or other person affiliated with a federal, state, or county judicial system. Includes referral for DUI and clients referred in lieu of or for deferred prosecution.
- J - **Child Welfare (DCFS/POS)** - If the value 'J' is entered as the Referral Source for a client, there must be a 'Y' (Yes) in the field "Patient Involved with DCFS."

Criminal Justice Referral Detail

Required when Referral Source = I - Criminal Justice Referral

- | | | |
|-------------------------|-----------------------------------|-----------|
| 1 - State/Federal Court | 4 - Other Recognized Legal Entity | 7 - DUI |
| 2 - Other Court | 5 - Diversionary Program | 8 - Other |
| 3 - Probation/Parole | 6 - Prison | |

DCFS Involved

Identifies if the client/patient is involved with DCFS. Enter 'Y' - Yes or 'N' - No.

Mentally Ill Substance Abuser (MISA)

Identifies if the patient is an individual with a co-occurring substance use disorder and any mental health Axis I or Axis II disorder as identified in the DSM-5. This information can be entered at any time during the treatment or intervention episode and must be diagnosed by a physician or a qualified mental health professional. Enter ‘Y’ - Yes or ‘N’ - No.

Answering “Yes” will require that a mental health diagnosis be entered into one of the diagnosis fields.

Number of Arrests in the 30 Days Preceding Date of Admission (NOMs)

Identifies the number of arrests in the 30 days preceding the date of admission.

Social Connectedness (NOMs)

Identifies the client/patient’s supportive interaction with family and friends and the level of involvement with self-help groups and other recovery support organizations.

Specify if the client/patient had, in the past 30 days, attended any self-help groups for recovery that were affiliated with a religious or faith-based organization or a peer-operated organization devoted to helping individuals with substance use related problems (i.e., Alcoholic Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety or Women for Sobriety, etc.).

Self-Help Group

Y - Yes N - No R - Refused D - Does Not Know

Self-Help Group Detail

If the answer to the Self-Help Group question is yes, specify how many times or:

RF - Refused
DK - Does Not Know

Specify if the client/patient had, in the past 30 days, interaction with family and/or friends that are supportive of his or her recovery:

Supportive Interaction

Y - Yes N - No R - Refused D - Does Not Know

MEDICAID DEMOGRAPHIC SCREEN

Completion of these fields is required if Medicaid is the payment source for the service. In order to receive services that are reimbursed by SUPR Medicaid, the patient must meet eligibility requirements under Title XIX (Medicaid Program) and Title XXI (Children’s Health Insurance Program) for covered services. The eligibility status of such patients can change frequently. In order to reduce the incidence of billing error and/or recoupments, the provider must make every effort to verify the patient’s eligibility PRIOR to service delivery. Learn the status of the patient’s eligibility using the MEDI (Medical Electronic Data Interchange) system, REV (Recipient Eligibility Vendor) or through the AVRS (Automated Voice Response System) by calling 1-800-842-1461. HFS currently produces semi-permanent durable medical cards. Therefore, it is imperative that all providers check the status of a client’s eligibility through one of the above systems. **Specific information relative to Managed Care Organization (MCO) coverage and Spenddown requirements should also be verified.**

D.A.R.T.S. for Windows

Services Unit/Program File Reports Exit

State of Illinois - DHS - Division of Substance Use Prevention and Recovery

Client/Patient Assessment
Medicaid Demographic Screen

PROVIDER ID: 0079

UNIQUE CLIENT/PATIENT ID: 220071336 OPEN DATE: 04 / 01 / 20 18

MEDICAID CLIENT FIELDS

Attending Physician NPI: 4234324333

THIRD PARTY LIABILITY

Payer Name: TPL Code:

Insured's Name (L,F,MI): ,

Insured's ID:

Duplicate Last Physician ID

Continue

Previous Screen

Exit

Press F1 Key on Data Field for Help

PRESS "F3" TO DUPLICATE LAST PHYSICIAN ID ENTERED

Attending Physician NPI

The ten-digit all numeric National Provider Identifier (NPI) of the Organization's Medical Director or physician authorized to oversee the patient's treatment episode and other medical procedures.

Third Party Liability (TPL) Information

If APPLICABLE, enter the following fields:

TPL Payer Name

The name of the paying organization from which the provider might expect some payment for treatment service (i.e., private insurance company, Medicare, Medicaid, etc.).

TPL Code

The corresponding Healthcare and Family Services code for the insurance company name.

TPL Insured's Name

The name of the person on the policy.

TPL Insured's ID

The ID of the person on the policy (i.e., insurance company's ID, Medicaid ID, etc.).

DEMOGRAPHIC PROBLEM AREA SCREEN

State of Illinois - DHS - Division of Substance Use Prevention and Recovery

Client/Patient Problem Area Screen

PROVIDER : _____

UNIQUE CLIENT/PATIENT ID: _____ OPEN DATE: / /

NAME (L,F,MI) : _____

Problem Area: OUD Patient:

PRIMARY

Problem Code: Frequency: Administration Route: Age of First Use:

SECONDARY

Problem Code: Frequency: Administration Route: Age of First Use:

TERTIARY

Problem Code: Frequency: Administration Route: Age of First Use:

Diagnosis (ICD-10) . . .

Diagnosis (ICD-9 / DSM-5) . . .

Continue

Previous Screen

Exit

Press F1 Key on Data Field for Help

Problem Area

The area that is the suspected or confirmed major reason that the client/patient requires Intervention or Treatment services.

- | | | |
|-----------------------|-------------------|--------------------------------|
| 1 - Alcohol | 4 - Co-Dependence | 6 - Alcohol/Drugs and Gambling |
| 2 - Drugs | 5 - None | 7 - Gambling |
| 3 - Alcohol and Drugs | | |

If the Problem Area is #5, indicating “none,” the only allowable billing is for assessment. Also, when “none” is selected, the assessment date will default into the discharge date field. The primary, secondary, and tertiary fields of problem code, frequency, and administration routes will be automatically completed.

If the Problem Area is #6 - Alcohol/Drugs and Gambling, the problem code must be alcohol or drugs. One of the diagnosis codes must indicate an alcohol or drug-related problem and the gambling diagnostic code must be an ICD-10 code of F63.0.

If the Problem Area is #7 - Gambling, the ICD-10 code must be F63.0. This code, as well as the primary, secondary, and tertiary fields of problem code, frequency and administration routes will be automatically completed.

Opioid Use Disorder (OUD) Treatment

Identifies whether the patient is receiving Medication Assisted Treatment (MAT) for an OUD. If the patient is not an OUD patient at admission, but becomes one during the course of treatment, the provider should update this field. Enter 'Y' - Yes or 'N' - No.

Primary Problem Code (NOMs)

This field provides additional information relative to the identified "Problem Area" field. For early intervention clients, this field identifies the area that precipitated the need for the early intervention service. NOTE: "01-None" may only be selected as the primary code if "None" is selected in the "Problem Area" field.

- 01 - None
- 02 - Alcohol
- 03 - Cocaine/Crack
- 04 - Marijuana/Hashish - includes THC and any other Cannabis Sativa preparations
- 05 - Heroin
- 06 - Non-Prescription Methadone
- 07 - Other Opiates and Synthetics - includes codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, Tramadol and any other drug with morphine-like effects
- 08 - PCP - Phencyclidine
- 09 - Other Hallucinogens - Includes LSD, DMT, STP, Hallucinogens, Mescaline, Peyote, Psilocybin, etc.
- 10 - Methamphetamine
- 11 - Other Amphetamines - Includes Amphetamines, Phenmetrazine, and other unspecified amines
- 12 - Other Stimulants - Includes Methylphenidate and any other stimulants
- 13 - Benzodiazepines - Includes Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate, Diazepam, Flunitrazepam, Flurazepam, Halazepam, Lorazepam, Oxazepam, Prazepam, Temazepam, Triazolam
- 14 - Other Non-Benzodiazepan Tranquilizers - Includes Meprobamate, Tranquilizers, etc.
- 15 - Barbiturates - Includes Amobarbital, Pentobarbital, Phenobarbital, Secobarbital, etc.
- 16 - Other Non-Barbiturate Sedatives or Hypnotics - Includes Chloral Hydrate, Ethchlorvynol, Glutethimide, Methaqualone, etc.
- 17 - Inhalants - Includes chloroform, ether, gasoline, glue, nitrous oxide, paint thinner, etc.
- 18 - Over-the-Counter - Includes aspirin, cough syrup, Diphenhydramine and other antihistamines, sleep aids and any other legally obtained non-prescription medication.
- 19 - Nicotine (Only available to use as a secondary or tertiary choice)
- 20 - Other - Includes Diphenylhydantoin/Phenytoin, GHB/GBL, Ketamine
- 21 - Gambling
- 22 - Ecstasy
- 23 - Rohypnol
- 24 - Steroids
- 25 - Ephedrine/Pseudoephedrine

Primary Frequency (NOMs)

- | | |
|---|------------------------|
| 1 - 0 within one month prior to admission | 4 - 3–6 times per week |
| 2 - 1–3 times in the past month | 5 - Daily |
| 3 - 1–2 times in the past week | |

Primary Administration Route

- | | |
|----------------|-----------------------------------|
| 1 - Oral | 4 - Injection IV or intramuscular |
| 2 - Smoking | 5 - Not Applicable |
| 3 - Inhalation | |

Primary Age of First Use

For drugs, this field identifies the age at which the client/patient first used the identified drug. For alcohol, this field records the age of first intoxication for treatment patients. For early intervention clients and patients with gambling as a primary diagnosis, this field is not required.

Secondary Problem Code (NOMs), Frequency (NOMs), Administration Route and Age of First Use

The same code choices as those designated under primary. If there is no secondary problem code, do not complete these fields.

Tertiary Problem Code (NOMs), Frequency (NOMs), Administration Route and Age of First Use

The same code choices as those designated under primary. If there is no tertiary problem code, do not complete these fields.

Diagnosis

No entry will be made in this field for early intervention clients. For treatment patients, an entry must be made in at least one field and a substance use disorder diagnosis is required as one of these fields unless Problem Area #4, #5 or #7 is selected.

If Problem Area #4 - (Co-Dependence) is selected, the diagnosis will be automatically entered by DARTS and only PEV, Level 1 and CM can be entered. (The ICD-10 Co-Dependence diagnosis code is “**Z65.9**”)

If Problem Area #5 - (None) is selected, the diagnosis will be automatically entered in DARTS. (The ICD-10 “None” diagnosis code is “**Z03.89**”)

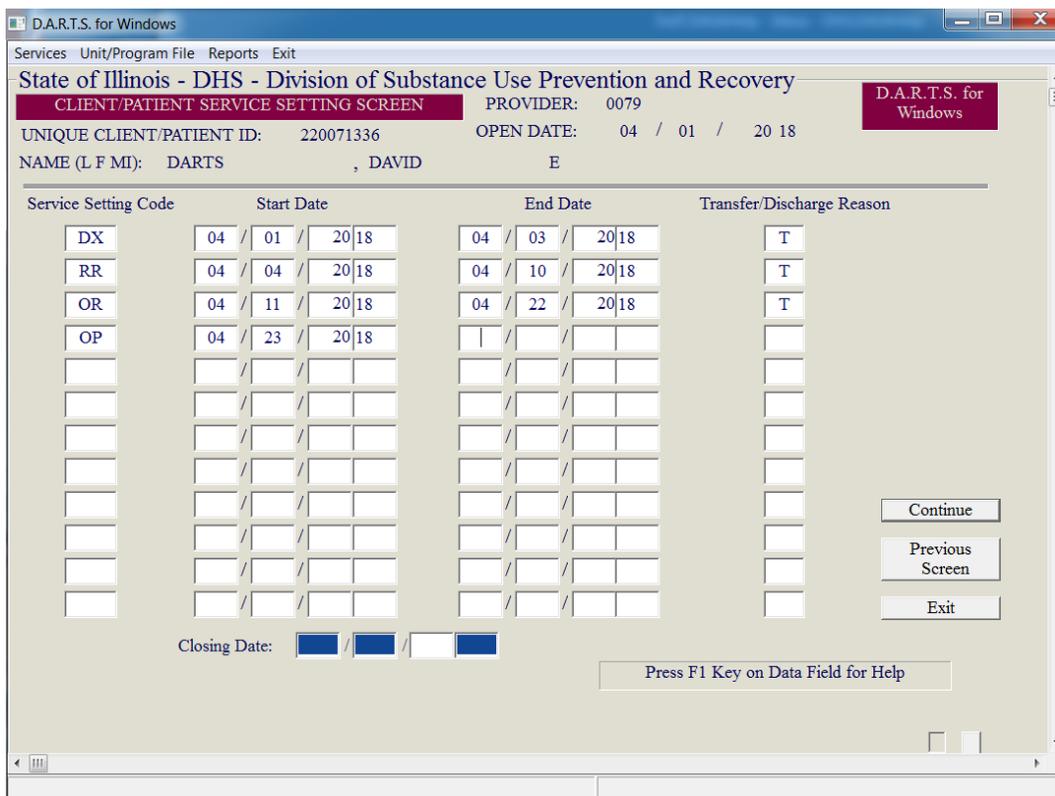
If Problem Area #7 - (Gambling) is selected, there must be a Gambling diagnosis code entered. (The ICD-10 code is **F63.0**)

Use of the second field and third fields are optional unless the patient is identified as MISA, in which case at least one of the diagnosis fields must contain a mental health diagnosis, or unless Problem Area #6 - Alcohol/Drugs and Gambling is selected in which case at least one of the diagnosis fields must contain gambling diagnosis.

DISCHARGE: How is a Client/Patient Closed from DARTS?

Demographics required for discharge are collected on the “Client/Patient Discharge” data input form. The information contained on this form is then used to input the data into DARTS. Discharge in DARTS is critical to reduce the incidence of submission errors and to ensure correct reporting of national outcome measures. Discharge means the termination of all services for the prescribed intervention or treatment by some action initiated by the organization and/or the client/patient. Any change in service within the same Provider during an episode of care is considered a discharge with a transfer code selected as the reason. The prescribed intervention/treatment should be assumed to have ended if the client/patient has not received a service in three days in the case of residential services and 30 days in the case of intervention or outpatient services. All discharge questions should be completed relative to the client/patient’s condition **at last known contact**. Billing for a discharge assessment is not allowed unless the client/patient is discharged in DARTS through completion and submission of information required on the following screens. When a discharge reason is entered on the Client/Patient Service Setting Screen, this then requires completion of the Client/Patient Discharge Outcome Measures Screen.

CLIENT/PATIENT SERVICE SETTING SCREEN



See examples of corresponding “Client/Patient Discharge Outcome Measures” screens in the next section on pages 22 and 23)

Service Setting Code

The two-digit code established by SUPR to identify the service the client/patient is receiving.

- OP - Level 1 (Outpatient)
- OR - Level 2 (Intensive Outpatient)
- HH - Level 3.1 (Residential Extended Care)
- RR - Level 3.5 (Residential Rehabilitation)
- DX - Level 3.2/3.7 (Withdrawal Management)
- RH - Recovery Home

Start Date

The date of admission into the specified service setting code.

End Date

The date of discharge from the specified setting code.

Transfer/Discharge Reason (NOMs)

This code was established to identify the reason for the transfer/discharge as follows:

- A - Assessment resulted in a finding of “none” in the problem area field contained within the demographic record. When “none” is entered into this field, the only allowable billing is for an assessment for admission.
- B - Completion of Intervention or Treatment services. This code is used to indicate completion of all planned treatment for the current episode of care. Completion of treatment at one level of care within the same provider is not “completion of treatment” if there is additional treatment planned as part of the treatment episode. When this occurs, a discharge reason indicating transfer code should be selected.
- C - Left against staff advice. This code should be selected when the client/patient chose not to complete services, with or without specific advice to continue. This includes clients/patients who “drop out” of intervention or treatment for unknown reasons and those who have not received services in three days following completion of residential services and 30 days for outpatient. This code is used every month to close old admission records at SUPR that have not had any service in over six months.
- D - Terminated by facility. This code is used when services are terminated by action of the provider, generally because of client/patient noncompliance or violation of rules, laws or procedures (not because client/patient dropped out of treatment, was incarcerated or some other client/patient motivated reason).
- F - Incarcerated. This code is to be used for all clients/patients whose intervention or treatment is terminated due to incarceration through jail, prison, or house confinement.
- G - Death.
- H - Discharged to another Provider. Utilization Management decision.
- I - External Transfer to another Provider. Non-completion of the current level of care treatment plan, transferred to another provider.
- J - External Transfer to another Provider. Completion of the current level of care treatment plan, transferred to another provider.
- T - Internal Transfer within the same Provider. Completion of the current level of care treatment plan, transferred to a different level of care.
- U - Internal Transfer within the same Provider. Non-completion of the current level of care treatment plan, transferred to a different level of care.
- V - Internal Transfer within the same Provider. Transferred to another level of care. Utilization Management decision.

Closing Date

The last date of service for the **episode of care**. For billing purposes, this is the last date that a service can be billed. Any bill submitted with a date after that of the closing date will be rejected as an error.

CLIENT/PATIENT DISCHARGE OUTCOME MEASURES SCREEN

The following three examples of Discharge Screens are for the Example Discharges on the “Client/Patient Service Setting Screen” on page 19 of this manual. The examples demonstrate how the collection of outcomes should be documented for each service setting code.

The screenshot shows the following data on the CLIENT/PATIENT DISCHARGE OUTCOME MEASURES SCREEN:

- State of Illinois - DHS - Division of Substance Use Prevention and Recovery
- CLIENT/PATIENT DISCHARGE OUTCOME MEASURES SCREEN
- PROVIDER: 0079
- UNIQUE CLIENT/PATIENT ID: 220071336
- OPEN DATE: 04 / 01 / 20 18
- NAME (L F MI): DARTS, DAVID E
- Setting Code: DX
- Start Date: 04 / 01 / 20 18
- End Date: 04 / 03 / 20 18
- Reason for Transfer/Discharge: T
- Date of Last Contact: 04 / 03 / 20 18
- Living Arrangement: A
- Employment Status: 1
- Not in Labor Force (NILF) Detail: 7
- School/Job Training Enrollment: 1
- Educational Level: 11
- No. of Arrests in 30 days preceding discharge: 00
- Baby delivered during treatment: N
- Drug Free Baby:
- Self-Help Group: N
- Self-Help Detail:
- Supportive Interaction: N
- PRIMARY Problem Code: 02
- Frequency of Use: 1
- SECONDARY Problem Code: 05
- Frequency of Use: 1
- TERTIARY Problem Code: 01
- Frequency of Use: 1

Buttons: Continue, Previous Screen, Exit

Press F1 Key on Data Field for Help

Example 1: Discharge Screen for Withdrawal Management Service Setting Code

Demographics

Example 2: Discharge Screen for Level 3 Service Setting Code

The screenshot shows the 'D.A.R.T.S. for Windows' application window. The title bar reads 'D.A.R.T.S. for Windows'. The menu bar includes 'Services', 'Unit/Program File', 'Reports', and 'Exit'. The main window title is 'State of Illinois - DHS - Division of Substance Use Prevention and Recovery'. Below this, a red banner contains 'CLIENT/PATIENT DISCHARGE OUTCOME MEASURES SCREEN'. The 'PROVIDER:' field is '0079'. The 'UNIQUE CLIENT/PATIENT ID:' is '220071336'. The 'OPEN DATE:' is '04 / 01 / 2018'. The 'NAME (L F MI):' is 'DARTS, DAVID E'. The 'Setting Code:' is 'RR'. The 'Start Date:' is '04 / 04 / 2018'. The 'End Date:' is '04 / 10 / 2018'. The 'Reason for Transfer/Discharge:' is 'T'. The 'Date of Last Contact:' is '04 / 10 / 2018'. The 'Living Arrangement:' is 'A'. The 'Employment Status:' is '1'. The 'Not in Labor Force (NILF) Detail:' is '7'. The 'School/Job Training Enrollment:' is '1'. The 'Educational Level:' is '11'. The 'No. of Arrests in 30 days preceding discharge:' is '01'. The 'Baby delivered during treatment:' is 'N'. The 'Drug Free Baby:' field is empty. The 'Self-Help Group:' is 'N'. The 'Supportive Interaction:' is 'N'. The 'PRIMARY Problem Code:' is '02' with a 'Frequency of Use:' of '1'. The 'SECONDARY Problem Code:' is '05' with a 'Frequency of Use:' of '1'. The 'TERTIARY Problem Code:' is '07' with a 'Frequency of Use:' of '1'. On the right side, there are three buttons: 'Continue', 'Previous Screen', and 'Exit'. At the bottom, there is a text box that says 'Press F1 Key on Data Field for Help'.

Example 3: Discharge Screen for Level 2 Service Setting Code

The screenshot shows the 'D.A.R.T.S. for Windows' application window. The title bar reads 'D.A.R.T.S. for Windows'. The menu bar includes 'Services', 'Unit/Program File', 'Reports', and 'Exit'. The main window title is 'State of Illinois - DHS - Division of Substance Use Prevention and Recovery'. Below this, a red banner contains 'CLIENT/PATIENT DISCHARGE OUTCOME MEASURES SCREEN'. The 'PROVIDER:' field is '0079'. The 'UNIQUE CLIENT/PATIENT ID:' is '220071336'. The 'OPEN DATE:' is '04 / 01 / 2018'. The 'NAME (L F MI):' is 'DARTS, DAVID E'. The 'Setting Code:' is 'OR'. The 'Start Date:' is '04 / 11 / 2018'. The 'End Date:' is '04 / 22 / 2018'. The 'Reason for Transfer/Discharge:' is 'T'. The 'Date of Last Contact:' is '04 / 22 / 2018'. The 'Living Arrangement:' is 'A'. The 'Employment Status:' is '1'. The 'Not in Labor Force (NILF) Detail:' is '7'. The 'School/Job Training Enrollment:' is '1'. The 'Educational Level:' is '11'. The 'No. of Arrests in 30 days preceding discharge:' is '00'. The 'Baby delivered during treatment:' is 'N'. The 'Drug Free Baby:' field is empty. The 'Self-Help Group:' is 'Y'. The 'Supportive Interaction:' is 'N'. The 'PRIMARY Problem Code:' is '01' with a 'Frequency of Use:' of '1'. The 'SECONDARY Problem Code:' is '01' with a 'Frequency of Use:' of '1'. The 'TERTIARY Problem Code:' is '01' with a 'Frequency of Use:' of '1'. On the right side, there are three buttons: 'Continue', 'Previous Screen', and 'Exit'. At the bottom, there is a text box that says 'Press F1 Key on Data Field for Help'.

Date of Last Contact (NOMs)

The date of the last contact with the client/patient even if this date is the same as the discharge date.

Living Arrangement (NOMs)

Identifies the current living arrangement at the time of discharge.

- A - Shelter (Safe Havens, Transitional Living Center (TLC), Low Demand Facilities, Reception Centers, other Temporary Day or Evening Facilities)
- B - Street/Outdoors (Sidewalk, Doorway, Park, Public or Abandoned Building)
- C - Institution (Hospital, Nursing Home, Jail/Prison)
- D - Owned or Rented Apartment, Room or House
- E - Someone Else’s Apartment, Room or House
- F - Dormitory/College Residence
- G - Residential Extended Care
- H - Residential Treatment
- I - Recovery Home
- J - Other Housed

Employment Status (NOMs)

Describes the current employment status at the time of discharge.

- 1 - Full-time (working 35 hours or more each week; includes members of the uniformed services)
- 2 - Part-time (working fewer than 35 hours each week)
- 3 - Unemployed (looking for work in the past 30 days or on layoff from a job)
- 4 - Not in Labor Force (NILF) (not looking for work in the last 30 days or homemaker, student, disabled, retired or an inmate of an institution)

Not in Labor Force (NILF) Detail (NOMs)

This field is required when “Employment Status at the time of discharge” = ‘4’ (Not in Labor Force).

- | | | |
|---------------|---------------------------|--------------------------|
| 1 - Homemaker | 4 - Disabled | 7 - Not Applicable |
| 2 - Student | 5 - Inmate of Institution | 8 - Volunteer Work |
| 3 - Retired | 6 - Other | 9 - Not Looking for Work |

School/Job Training Enrollment

For incarcerated persons, this field must be “Not Enrolled”

- 1 - Not Enrolled
- 2 - Enrolled, Full Time
- 3 - Enrolled, Part Time

Educational Level (NOMs)

The highest school grade level completed at the time of discharge. Enter “12” for a GED.

Number of Arrests in the 30 Days Preceding the Date of Discharge (NOMs)

The number of times, if any, that the client/patient has been arrested in the thirty days preceding the date of discharge.

Baby Delivered During Treatment (NOMs)

Indicates if the client/patient delivered a baby while receiving treatment. If yes, indicate if the baby was drug free.

Social Connectedness (NOMs)

Identifies the client/patient's supportive interaction with family and friends and the level of involvement with self-help groups and other recovery support organizations at the time of discharge.

Specify if the client/patient had, in the past 30 days, attended any self-help groups for recovery that were affiliated with a religious or faith-based organization or a peer-operated organization devoted to helping individuals with substance use related problems (i.e., Alcoholic Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety or Women for Sobriety, etc.).

Self-Help Group

- Y - Yes
- N - No
- R - Refused
- D - Does Not Know

Self-Help Group Detail

If the answer to the Self-Help Group question is yes, specify how many times or:

- RF - Refused
- DK - Does Not Know

Specify if the client/patient had, in the past 30 days, interaction with family and/or friends that are supportive of his or her recovery:

Supportive Interaction

- Y - Yes
- N - No
- R - Refused
- D - Does Not Know

Primary Problem Code (NOMs)

This field provides additional information relative to the identified "Problem Area" field at the time of discharge.

- 01 - None
- 02 - Alcohol
- 03 - Cocaine/Crack
- 04 - Marijuana/Hashish - includes THC and any other Cannabis Sativa preparations
- 05 - Heroin
- 06 - Non-Prescription Methadone
- 07 - Other Opiates and Synthetics - includes codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, Tramadol and any other drug with Morphine-like effects.
- 08 - PCP - Phencyclidine
- 09 - Other Hallucinogens - Includes LSD, DMT, STP, Hallucinogens, Mescaline, Peyote, Psilocybin, etc.
- 10 - Methamphetamine
- 11 - Other Amphetamines - Includes Amphetamines, Phenmetrazine, and other unspecified amines
- 12 - Other Stimulants - Includes Methylphenidate and any other stimulants
- 13 - Benzodiazepines - Includes Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate, Diazepam, Flunitrazepam, Flurazepam, Halazepam, Lorazepam, Oxazepam, Prazepam, Temazepam, Triazolam
- 14 - Other Non-Benzodiazepan Tranquilizers - Includes Meprobamate, Tranquilizers, etc.

Demographics

- 15 - Barbiturates - Includes Amobarbital, Pentobarbital, Phenobarbital, Secobarbital, etc.
- 16 - Other Non-Barbiturate Sedatives or Hypnotics - Includes Chloral Hydrate, Ethchlorvynol, Glutethimide, Methaqualone, etc.
- 17 - Inhalants - Includes chloroform, ether, gasoline, glue, nitrous oxide, paint thinner, etc.
- 18 - Over-the-Counter - Includes Aspirin, cough syrup, Diphenhydramine and other antihistamines, sleep aids and any other legally obtained non-prescription medication.
- 19 - Nicotine (Only available to use as a secondary or tertiary choice)
- 20 - Other - Includes Diphenylhydantoin/Phenytoin, GHB/GBL, Ketamine
- 21 - Gambling
- 22 - Ecstasy
- 23 - Rohypnol
- 24 - Steroids
- 25 - Ephedrine/Pseudoephedrine

Primary Frequency (NOMs)

- 1 - 0 within one month prior to discharge
- 2 - 1–3 times in the past month
- 3 - 1–2 times in the past week
- 4 - 3–6 times per week
- 5 - Daily

Secondary Problem Code (NOMs)

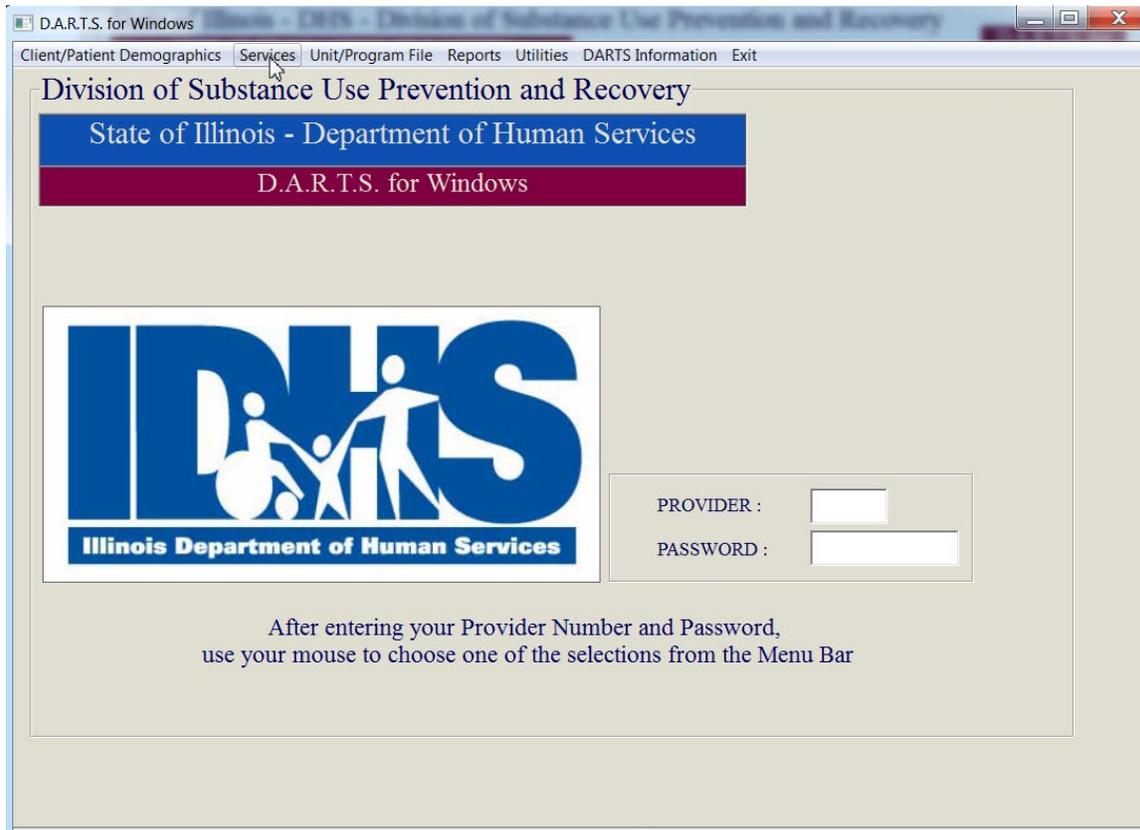
The same code choices as those designated under primary. If there is no secondary problem code, do not complete these fields.

Tertiary Problem Code (NOMs)

The same code choices as those designated under primary. If there is no tertiary problem code, do not complete these fields.

How Do I Enter Delivered Services into DARTS?

Service delivery information is collected and recorded on DARTS data input forms. The information contained on these forms is then used to input data into DARTS through the Service Reporting Menu, which contains three sections for data entry. To enter services, choose “Service” from the main menu bar. The following screen will be displayed.



What Types of Services Can Be Entered?

Services are entered onto specific data entry screens that relate to how the service paid, either hourly, per event or per diem. The hourly services that can be reported are Assessment, Early Intervention, Community Intervention, Level 1, 2 Individual and Group Counseling, Case Management, and Interpreter Referral services. These services are paid with an hourly rate that can be reported in quarter hour increments.

SERVICE REPORTING SCREEN - HOURLY

The following fields are required for completion of this screen.

Unit/Program

The valid unit and program number for the service that is reported. Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the “Provider Unit/Program File.” If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from to year-to-year. All addresses should match those specified on facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify the Department immediately if errors are discovered, may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Site Number

This field is required **ONLY** for billing of Assessment, Case Management, Early Intervention or Community Intervention at more than one site.

Staff ID

The unique nine-digit identification number for the staff member providing services.

Service Date

The date of service.

Funding Code

The funding code is what directs DARTS to the correct payment source for the service. The following codes are used:

DC - DARTS/Contract: A Service, which is supported in full or in part by CONTRACT (Non-Medicaid) funding

DM - DARTS/Medicaid: A Service, which is supported in full or in part by MEDICAID funding that is not reimbursed by an MCO. Services linked to a DM code are processed and forwarded on to the Department of Healthcare and Family Services (HFS) for reimbursement. HFS produces the Medicaid Remittance Report.

Unique Client/Patient Identifier

The 9-digit Unique Client/Patient Identifier must match the demographic record for the client/patient.

Service Type

There are three service types that can be used to report services that are paid hourly:

1. **Individual**
2. **Group Service**
3. **Support (Includes Case Management, Community Intervention, and Interpreter Referral.)**

Activity Code

Activity codes are **mandatory** and are used for identification of specific types of activity that relate to a general service. The activity code is three digits comprised of the specific type of service activity that was performed, and the location as follows:

Location Codes

- 0 - Service at Provider Location
- 1 - Off Site

Assessment (Only allowed for use with Program Number “48”)

- 70 - Admission
- 71 - Discharge
- 72 - Gambling Assessment (only for use by providers with specific funding for gambling services)

Assessment should be used only for diagnosis and assessment of the six (6) ASAM dimensions in order to place the patient into a level of care.

Treatment or Early Intervention Service (Only allowed for use with Program Number “42”, “43” and “44”)

- 01 - Individual Counseling
- 02 - Counseling Group
- 04 - Continued Stay Review and Discharge Planning
- 05 - Treatment Planning
- 06 - Didactic Group
- 07 - Recreation
- 08 - Telehealth
- 09 - HIV Education
- 10 - TB Education

Psychiatric Review

- 11 - Psychiatric Evaluation
- 12 - Medication Monitoring

Case Management (Only allowed for use with Program Number “41”)

- 22 - Intra-Agency Staffings
- 23 - Case Coordination

Case management services can be bundled and reported in larger increments of time. For example, a treatment patient’s case is staffed 10 minutes each day on 24 different days during one month. These minutes can be bundled into hour increments and reported once as four hours of case management. Services should be bundled by staff ID linked to each patient ID and the date of service entered into DARTS should be the last date of service in the bundle.

Community Intervention (CIH) (Only allowed for use with Program Number “42” and a Service Type of “3”)

- 31 - In-reach
- 32 - Out-reach
- 33 - Case Finding
- 34 - Crisis Intervention
- 35 - Training (Can only be used by providers who are specifically funded to deliver or obtain training and to report such training to DARTS)
- 37 - Client/Patient Transportation
- 38 - Language Interpreter Services (Can only be used by providers who have services authorized by a linkage agreement and approved in the Annual Certification Plan). When billing this type of service, the client’s RIN must be entered into the “Staff ID” field.

Community Intervention can be bundled and reported in larger increments of time. Services should be bundled by staff ID and the date of service entered into DARTS should be the last date of service in the bundle.

Collateral (Only allowed for use with Program Number “42”, “43” and “44” with a Service Type of “1” or “2”)

- 41 - Family or Significant Other
- 42 - Other (Employer, Friend, Minister, etc.)

Interpreter Referral - (Only allowed for use with program number “64”)

- 62 - Interpreter Referral Services

Gambling - (Only allowed for use by providers with funded gambling services. Patient type must be “T”, using program number “43”, Service Type 2, with an “L” dedicated funding tag and a problem area of 1, 2 or 3.)

- 63 - Gambling

Procedure Code

This field is not entered by the user. When the date, unit/program, funding code and service type are entered, DARTS will check to assure that the user has been funded for the type of service entered and will automatically enter the procedure code. Procedure codes with their associated funding codes are as follows:

Funding Code “DM” or “DC”:

- AAS - Assessment
- OPI - Outpatient Individual
- IOI - Intensive Outpatient Individual
- OPG - Outpatient Group
- IOG - Intensive Outpatient Group
- PEV - Psychiatric Evaluation

Funding Code “DC” Only:

- EII - Early Intervention Individual
- EIG - Early Intervention Group
- CMH - Case Management
- CIH - Community Intervention
- INT - Interpreter Referral

Group ID

The group ID should be a unique five-digit combination of numbers and/or letters that will distinguish the treatment counseling group from other such groups on the same date of service. This Group ID is used for auditing purposes to determine the number of patients per counseling group. Only 16 patients (Medicaid or Contract funds) per counseling group can be reimbursed.

Start Time

The time of day in which the service began, including ‘A’ for AM, or ‘P’ for PM.

Length of Service

Hours of Service:

The number of hours the service was provided. Hours must be entered as whole numbers.
(For DFI, use this field to enter the number of transportation tokens.)

Minutes of Service:

Minutes of service should be rounded to the nearest quarter-hour increment based upon the actual number of minutes of delivered service (i.e., 1 hour, 45 minutes; 30 minutes; etc.). This field may be left blank, if there were “00” minutes.

EXAMPLES OF ROUNDING

- | | |
|---------------------------------|---------------------------------|
| 11 minutes = Rounded 15 minutes | 34 minutes = Rounded 30 minutes |
| 20 minutes = Rounded 15 minutes | 40 minutes = Rounded 45 minutes |
| 29 minutes = Rounded 30 minutes | 52 minutes = Rounded 45 minutes |

Collateral ID

When an activity code of 041 or 141, the collateral is a family member or significant other, a unique identifier shall be entered. There must be a demographic record in DARTS for client/patient in order to serve a collateral.

Video Counseling

Was this service delivered via telehealth? Enter 'Y' - Yes or 'N' - No.

For program numbers '42' (Early Intervention), '43' (Level 1) and '44' (Level 2), the following Activity Codes allowed for telehealth services:

- 01 - Individual
- 02 - Counseling Group
- 04 - Continued Stay Review and Discharge Planning
- 05 - Treatment Planning
- 06 - Didactic Group
- 11 - Psychiatric Evaluation
- 12 - Medication Monitoring
- 41 - Collateral – Family/Significant other
- 42 - Collateral – Other (Employer, friend, minister, etc.)
- 63 - Gambling
- 70 - Admission Assessment
- 71 - Discharge Assessment
- 72 - Gambling Assessment

(The Funding Code must be "DC" (DARTS Contract) – except for Activity code "11" (Psych Eval., which can be "DM" or "DC").

Medicaid Spend Down (Due from Patient)

The amount that the patient is responsible for before Medicaid Eligibility can be established. If not applicable, leave this field blank.

Third Party Liability (TPL) Information

If applicable, enter the following fields:

TPL Status - Enter the adjudication status of the amount in question:

- 01 - TPL adjudicated - total payment shown
- 02 - TPL adjudicated - patient not covered
- 03 - TPL adjudicated - services not covered
- 05 - Patient not covered
- 06 - Services not covered
- 07 - Billed insurance/not paid

TPL Payer Amount - Enter the amount of payment received from the third-party health resource or the patient.

TPL Paid Date - If the status is **01**, **02**, or **03** - enter the Third-Party Adjudication Date. If the STATUS is **05**, **06**, or **07** - enter the service.

NOTE: If the TPL Information is entered on any Service Screen, the admission record for this patient must have completed all TPL demographic information.

Revision Code

This field is to add, revise or void a service. The default is 'A' (Add) and is used with all funding codes. The 'R' (Revise) or 'V' (Void) codes are used as follows:

'R' = **REVISE** a record which was previously submitted and accepted by SUPR.

Only for use with funding code "DC." This code corrects information on a previously submitted 'DC' claim, which was accepted by SUPR. Use of this code will not allow a billing to be changed from one unit/program to a different unit/program or to make any change to the Unique Client Identifier, Staff ID, Service Dates (Beginning or Ending) or Start Time as these fields make a billing unique and allow for matching. The only way to change any of these fields is to send in a 'V' (Void) claim for the original billing, and then an 'A' (Add) claim for the corrected billing.

'V' = **VOID** a record which was previously submitted and accepted by SUPR.

Only for use with funding code "DC." This code voids a record that was submitted and accepted by SUPR. The 'V' record needs to be entered exactly as it was in the original submission, so that a match can be made, and the void can be made to the record.

Dedicated Funding Category Window (Non-Medicaid)

Dedicated funding is contained in many contracts to ensure that a specific portion of the funding is earned by delivery of services to special populations regardless of whether such funding is contained in a global cost center. Dedicated funding is applicable only to non-Medicaid earnings. Therefore, only services with a funding code of "DC" or "DS" can be tagged as dedicated funding. These specific dedicated funding amounts are contained in contract Exhibit 1 and only those categories, which are funded, will display on the software as follows:

- D - DCFS
- G - OMT Toxicology
- L - Gambling
- N - None
- O - STR-OMT

Not all contracts will have dedicated funding obligations. If the contract has no dedicated funding, no window will be displayed. If the contract has dedicated funding but the service being reported does not apply to the patient, select "N" for none. It is very important that dedicated funding is reported correctly. This is how compliance is measured with the contract and these amounts are reflected on special dedicated funding reports.

What are Some Examples of Types of Hourly Services and How They Would Be Entered?

The following information provides some examples of specific combinations of client/patient types, program number, service type, procedure, and activity codes and may be helpful in determining how to enter services:

Assessment

The assessment is a distinctly reported and separately billed service and the assessment date is entered in the demographic record.

- The client/patient receives an assessment and is recommended for a treatment service. (Client/Patient Type is "T," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 070)
- The client/patient receives an assessment and is recommended for an early intervention service. (Client/Patient Type is "I," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 070)
- The client/patient receives an assessment and is not recommended for any service. (Client/Patient Type is "I," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 070) A closing for the demographic record is also completed and submitted.

Early Intervention - Individual or Group (Client/Patient Type - “I”)

- The client meets with a staff member for an individual session to discuss the content and structure of the early intervention services that the client will receive. (Program Number - 42, Service Type - 1, Procedure Code - EII, Activity Code - 001)
- A staff member meets with the parents of an adolescent who is receiving early intervention services. (Program Number - 42, Service Type - 1, Procedure Code - EIG, Activity Code - 041)
- The client participates in a group didactic session. (Program Number - 42, Service Type - 2, Procedure Code - EIG, Activity Code - 006)
- The client is participating in an individual session because of a Moderate Risk classification resulting from an arrest for Driving Under the Influence of Alcohol or Other Drugs (DUI). (Program Number - 42, Service Type - 1, Procedure Code - EII, Activity Code - 001)
- The client participates in a recreational activity. (Program Number - 42, Service Type - 2, Procedure Code - EIG, Activity Code - 007)
- The client meets with a physician for medication monitoring. (Program Number - 42, Service Type - 1, Procedure Code - EII, Activity Code - 012)

Community Intervention - (Client/Patient Type - “I”)

- A meeting is held with a group of local IDHS office workers to discuss screenings and referrals for substance use disorder services. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 031)
- A meeting is held with a group of high school teachers and administrators to discuss how to intervene with and refer students who are caught with alcohol or other drugs as school. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 032)
- A staff member speaks with a person on the phone who is unsure if they have a substance use related problem or uncertain if they want to come to the facility and will not schedule an appointment. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 034)
- A meeting is held with an Employee Assistance Coordinator of a local business. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 033)
- A patient is transported to and from the treatment center. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 037)

Outpatient or Intensive Outpatient - Individual or Group - (Client/Patient Type - “T”)

- The patient meets with a clinician for an individual counseling session. (Program Number - 43 or 44, Service Type - 1, Procedure Code - OPI or IOI, Activity Code - 001)
- The patient meets with a clinician for a continued stay review. (Program Number - 43 or 44, Service Type - 1, Procedure Code - OPI or IOI, Activity Code - 004)
- The patient meets with a physician for medication monitoring. (Program Number - 43 or 44, Service Type - 1, Procedure Code - OPI or IOI, Activity Code - 012)
- The clinician meets with a family member to discuss a patient’s care. (Program Number - 43 or 44, Service Type - 1, Procedure Code - OPI or IOI, Activity Code - 041)
- The patient participates in a counseling group session. (Program Number - 43 or 44, Service Type - 2, Procedure Code - OPG or IOG, Activity Code - 002)
- The patient participates in a didactic group session. (Program Number - 43 or 44, Service Type - 2, Procedure Code - OPG or IOG, Activity Code - 006)
- The patient participates in a recreational activity. (Program Number - 43 or 44, Service Type - 2, Procedure Code - OPG or IOG, Activity Code - 007)

Case Management

- A discussion with other providers regarding supportive services to the patient (e.g., child care, Medicaid needs, public assistance, etc.). (Program Number 41, Service Type - 3, Procedure Code - CMH, Activity Code - 023)
- The Provider contacts another staff member within the same organization to discuss the patient's treatment or discharge planning. (Program Number 41, Service Type - 3, Procedure Code - CMH, Activity Code - 022)
- The organization has a weekly meeting to staff treatment patients. (Program Number 41, Service Type - 3, Procedure Code - CMH, Activity Code - 022)

Psychiatric Evaluation

- An early intervention client receives a psychiatric evaluation. (Program Number 42, Service Type - 1, Procedure Code - PEV, Activity Code - 011)
- A treatment client receives a psychiatric evaluation. (Program Number 43 or 44, Service Type - 1, Procedure Code - PEV, Activity Code - 011)

Discharge Assessment

The discharge assessment is a distinctly reported and separately billed service. Billing for a discharge assessment will be rejected unless the client/patient discharge demographic record has been submitted.

- The treatment episode of care has ended for the patient. The demographic record in DARTS is closed and submitted and a discharge assessment is reported. (Client/Patient Type is "T," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 071).
- The early intervention episode of care has ended for the client. The demographic record in DARTS is closed and submitted and a discharge assessment is reported. (Client/Patient Type is "I," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 071).

SERVICE REPORTING SCREEN: RESIDENTIAL AND RECOVERY HOME SERVICES

The screenshot shows a software window titled "D.A.R.T.S. for Windows" with a menu bar: Client/Patient Demographics, Services, Unit/Program File, Reports, Exit. The main title is "State of Illinois - DHS - Division of Substance Use Prevention and Recovery" and the subtitle is "RESIDENTIAL AND RECOVERY HOME SERVICES SCREEN".

Fields include:

- PROVIDER : 0079
- UNIT : 0003 PROGRAM : 47 YEAR: 2018 MONTH: 04
- Funding Code: DC Unique Client/Patient ID: 220071336
- Billing Begin Date: 04 / 04 / 20 18 Billing End Date: 04 / 10 / 20 18
- Number of Days Billed for Month: 07 Procedure Code: RHB
- Psychiatric Eval. Bill: N Video Counseling: N
- MEDICAID BILLING DATA: Spenddown (Due from Patient): 00000 .00
- Third Party Liability Information: Status: Payer Amount: 00000 .00 Paid Date: / /
- Revision Code: A

Buttons on the right: Save, Previous Screen, Duplicate, Exit. A "Press F1 for Help" button is at the bottom center.

The Residential and Recovery Home Services screen is where all Level 3 and Recovery Home services reimbursed per diem are reported. Additionally, psychiatric evaluations for patients receiving these services can also be reported on this screen and are reimbursed per event. The following fields are required for completion of this screen.

Unit/Program

The unit and program number of the service that is reported. Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the “Provider Unit/Program File.” If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from year to year. All addresses should match those specified on facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify the Department immediately if errors are discovered may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Year, Month

The year and month of the service.

Funding Code

The funding code is what directs DARTS to the correct payment source for the service. The following codes are used:

DC - DARTS/Contract: A Service which is supported in full or in part by CONTRACT (Non-Medicaid) funding

DM - DARTS/Medicaid: A Service, which is supported in full or in part by MEDICAID funding not reimbursed by an MCO. Services linked to a DM code are processed and forwarded on to the Department of Healthcare and Family Services (HFS) for reimbursement. HFS produces the Medicaid Remittance Report.

DS - DARTS/Split Billing: A Service, which is supported, by both CONTRACT AND MEDICAID funding. This funding code is only used to report certain LEVEL 3 services in which the treatment cost is paid by Medicaid and domiciliary cost is paid by Contract.

Unique Client/Patient Identifier

The 9-digit Unique Identifier must match an opening in DARTS.

Billing Begin and End Date

The Billing Begin Date through the Billing End Date reports the time period for which the provider is seeking payment. If billing Medicaid ('DM' or 'DS'), the patient must be eligible for Medicaid during this date. If the patient is not Medicaid eligible for the continuous stay, each continuous segment must be billed separately. (Example: A patient enters a program on the 5th of the month, and he stays through the 25th of that month; however, the patient is NOT Medicaid eligible on the 10th and 11th. Two 'DM' or 'DS' billing records would be created. The first record would be for the 5th through the 9th. The second record would be the 12th through the 25th.)

Additionally, when a Level 3 or Recovery Home service spans two months, the service must be entered as two separate transactions. Example: There would be two entries for a patient who receives a Level 3 or Recovery Home service from 07/15/2017 through 08/04/2017. The first would be 07/15/2017 - 07/31/2017, and the second would be 08/01/2017 - 08/04/2017.

Number of Days

This number is automatically computed by the dates entered into the Billing Begin and End Date fields.

Procedure Code

This field is not entered by the user. When the date/unit/program/funding code and billing type are entered, DARTS will check the Unit/Program file to assure that the agency has been funded for the type of service entered and will complete the procedure code automatically.

The following procedure codes (linked to the funding code) are used for **LEVEL 3 service**:

If the program is **MEDICAID CERTIFIED and ENROLLED** for **DAY TREATMENT or MEDICALLY MONITORED WITHDRAWAL MANAGEMENT** and also **has other CONTRACT funding**:

Funding Code "DS"	DCY - Youth Residential Day Treatment (treatment portion of bill paid by Medicaid); <u>AND</u>
	RBD - Residential Domiciliary (room and board portion of bill paid by Contract)
	DCA - Adult Residential Day Treatment (treatment portion of bill paid by Medicaid); <u>AND</u>
	RBD - Residential Domiciliary (room and board portion of bill paid by Contract)
	DXT - Medically Monitored Withdrawal Management Treatment (treatment portion of bill paid by Medicaid) <u>AND</u>
	DXB - Medically Monitored Domiciliary (room and board portion of bill paid by Contract)

If the program is **MEDICAID CERTIFIED and ENROLLED** for **DAY TREATMENT or MEDICALLY MONITORED WITHDRAWAL MANAGEMENT**; **BUT** has no other **CONTRACT funding** or is billed after the final submission date when contract funds for the previous fiscal year can no longer be accessed, the following procedure codes will be used for billing:

Funding Code "DM"	DCY - Youth Residential Day Treatment (treatment portion only will be billed)
	DCA - Adult Residential Day Treatment (treatment portion only will be billed)
	DXT - Medically Monitored Withdrawal Management Treatment (treatment portion only will be billed)

If the program is JCAHO accredited and Medicaid CERTIFIED for Residential Rehabilitation Youth or enrolled for Medically Monitored Withdrawal Management in a hospital subacute setting, the following procedure codes may be used for billing:

Funding Code "DM"	RHY - Residential Rehabilitation Youth
	DXD - Medically Monitored Withdrawal Management

Funding Code "DC"	RHB - Adult Residential Rehabilitation (Contract funding is billed for the entire treatment episode - treatment and domiciliary.)
	RHY - Youth Residential Rehabilitation (Contract Funding is billed for the entire treatment episode - treatment and domiciliary.)
	DXD - Withdrawal Management
	HHD - Residential Extended Care
	RHD - Recovery Home

Psychiatric Evaluation

If the service is for a Psychiatric Evaluation, enter a 'Y.' If not, enter a 'N' in this field. **Entering a 'Y' in this field will link to the established rate for this service, which pays for one event per day regardless of the hours and minutes entered in the time field, and 'PEV' will be automatically displayed in the Procedure Code field.**

Video Counseling

Psychiatric evaluations can be delivered to patients in Level 3 care via video counseling. Was this psychiatric evaluation delivered via video counseling? Enter 'Y' - Yes or 'N' - No.

Medicaid Spend Down (Due from Patient)

The amount that the patient is responsible for before Medicaid Eligibility can be established. If not applicable, leave this field blank.

Third Party Liability (TPL) Information

If applicable, enter the following fields:

TPL Status - Enter the adjudication status of the amount in question:

- 01 - TPL adjudicated - total payment shown
- 02 - TPL adjudicated - patient not covered
- 03 - TPL adjudicated - services not covered
- 05 - Patient not covered
- 06 - Services not covered
- 07 - Billed insurance/not paid

TPL Payer Amount - Enter the amount of payment received from the third-party health resource or the patient.

TPL Paid Date - If the status is **01**, **02**, or **03** - enter the Third Party Adjudication Date. If the STATUS is **05**, **06**, or **07** - enter the service.

NOTE: If the TPL Information is entered on any Service Screen, the admission record for this patient must have completed all TPL demographic information.

Revision Code

This field is to add, revise or void a service. The default is 'A' (Add) and is used with all funding codes. The 'R' (Revise) or 'V' (Void) codes are used as follows:

'R' = **REVISE** a record which was previously submitted and accepted.

Only for use with funding code "DC." This code corrects information on a previously submitted and accepted 'DC' claim. Use of this code will not allow a billing to be changed from one unit/program to a different unit/program or to make any change to the Unique Client Identifier, Staff ID, Service Dates (Beginning or Ending) or Start Time as these fields make a billing unique and allow for matching. The only way to change any of these fields is to send in a 'V' (Void) claim for the original billing, and then an 'A' (Add) claim for the corrected billing.

'V' = **VOID** a record which was previously submitted and accepted.

Only for use with funding code "DC." This code voids a record that was submitted and accepted. The 'V' record needs to be entered exactly as it was in the original submission, so that a match and void can be made to the record.

Dedicated Funding Category Window (Non-Medicaid)

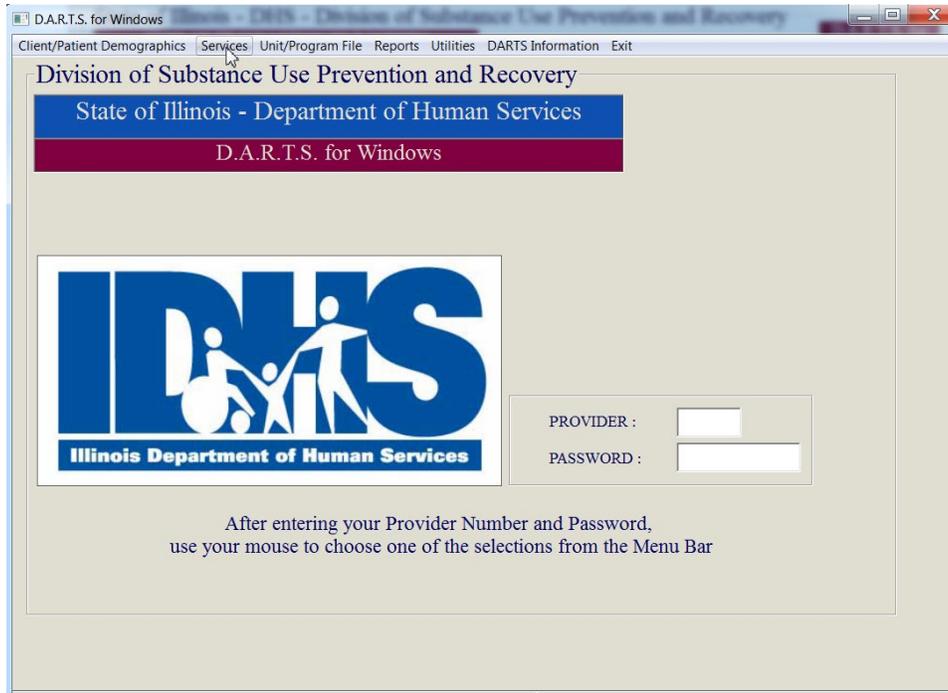
Dedicated funding is contained in many SUPR contracts to ensure that a specific portion of the funding is earned by delivery of services to special populations regardless of whether such funding is contained in a global cost center. Dedicated funding is applicable only to non-Medicaid earnings. Therefore, only services with a funding code of "DC" or "DS" can be tagged as dedicated funding. These specific dedicated funding amounts are contained in contract Exhibit 1 and only those categories, which are funded, will display on the software as follows:

- D - DCFS
- G - OMT Toxicology
- L - Gambling
- N - None
- O - STR-OMT

Not all contracts will have dedicated funding obligations. If the contract has no dedicated funding, no window will be displayed. If the contract has dedicated funding but the service being reported does not apply to the patient, select "N" for none. It is very important that dedicated funding is reported correctly. This is how SUPR measures compliance with the contract and these amounts are reflected on special dedicated funding reports.

SERVICE REPORTING SCREEN: SPECIALIZED SERVICES

This screen allows for the reporting of toxicology services or services to children in residential care with their parent and is only used by agencies that are specifically funded to provide these services. The correct report screen will be displayed when the appropriate unit and program number is entered.



SERVICE REPORTING SCREEN: CHILDCARE RESIDENTIAL

When children accompany their parent in residential care and the child occupies a funded bed, the following information is required:

The screenshot shows a web-based form titled "State of Illinois - DHS - Division of Substance Use Prevention and Recovery Childcare Residential Service Reporting Screen". The form is designed for data entry and includes the following fields and controls:

- Provider:** A text input field.
- Unit:** A text input field.
- Program:** A text input field.
- Year:** Two text input fields for year digits.
- Month:** A text input field.
- Funding Code:** A dropdown menu currently showing "DC".
- Child's Unique Identifier:** A text input field.
- Billing Begin Date:** A date selection field (MM/DD/YYYY).
- Billing End Date:** A date selection field (MM/DD/YYYY).
- Number of Days:** A text input field.
- Procedure Code:** A text input field.
- Birth Date:** A date selection field (MM/DD/YYYY).
- Sex:** A dropdown menu.
- Parent's Unique Client/Patient ID:** A text input field.
- Revision Code:** A text input field.
- Buttons:** "Save", "Exit", "Duplicate", and "Previous Screen".

Unit/Program

Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the "Provider Unit/Program File." If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from to year to year. All addresses should match those specified on facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify immediately if errors are discovered may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Child's Unique Number

The child's unique 9-digit identifier.

Billing Begin and End Date

The Billing Begin Date through the Billing End Date reports the time period for which the provider is seeking payment. When a Level 3 service spans two months, enter the service as two separate transactions. Example: There would be two entries for a patient who receives a Level 3 service from 07/15/2017 through 08/04/2017. The first would be 07/15/2017 - 07/31/2017, and the second would be 08/01/2017 - 08/04/2017.

Number of Days

This number is automatically computed by the dates entered into the Billing Begin and End Date fields.

Birth Date

The child's date of birth.

Sex

The gender of the child. Enter 'M' - Male or 'F' - Female.

Parent's Unique Client/Patient Identifier

The Unique Client/Patient Identifier of the child's parent. The parent must have a demographic record and be receiving services in a residential program.

Revision Code

This field is to add, revise or void a service. The default is 'A' (Add) and is used with all funding codes. The 'R' (Revise) or 'V' (Void) codes are used as follows:

'R' = **REVISE** a record which was previously submitted and accepted.

Only for use with funding code "DC." This code corrects information on a previously submitted 'DC' claim, which was accepted. Use of this code will not allow a billing to be changed from one unit/program to a different unit/program or to make any change to the Unique Client Identifier, Staff ID, Service Dates (Beginning or Ending) or Start Time as these fields make a billing unique and allow for matching. The only way to change any of these fields is to send in a 'V' (Void) claim for the original billing, and then an 'A' (Add) claim for the corrected billing.

'V' = **VOID** a record which was previously submitted and accepted.

Only for use with funding code "DC." This code voids a record that was submitted and accepted. The 'V' record needs to be entered exactly as it was in the original submission, so that a match and the void can be made to the record.

SERVICE REPORTING SCREEN: TOXICOLOGY

The screenshot shows a web-based form titled "State of Illinois - DHS - Division of Substance Use Prevention and Recovery Toxicology Service Reporting Screen". The form is designed for data entry and includes the following fields and controls:

- Provider:** A text input field.
- Unit:** A text input field.
- Program:** A text input field.
- Year:** Two adjacent text input fields for year digits.
- Month:** A text input field.
- Funding Code:** A dropdown menu currently set to "DC".
- Client/Patient Unique ID:** A text input field.
- Billing Begin Date:** A date selection field with slashes for month and day.
- Billing End Date:** A date selection field with slashes for month and day.
- Toxicology Tests:** A text input field.
- Revision Code:** A text input field.
- Procedure Code:** A text input field.
- Navigation Buttons:** Four buttons are stacked vertically on the right: "Save", "Exit", "Duplicate", and "Previous Screen".

Unit/Program

Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the "Provider Unit/Program File." If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from to year to year. All addresses should match those specified on facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify the Department immediately if errors are discovered may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Unique Client/Patient Identifier

The 9-digit Unique Client/Patient Identifier must match a patient with an open demographic record in DARTS, and the service date entered must fall between the admission assessment and closing dates.

Billing Begin and End Date

Record the time period in which the toxicology tests were administered.

Toxicology Tests

The number of toxicology tests on and between the Billing Begin and End Dates.

Revision Code

This field is to add, revise or void a service. The default is 'A' (Add) and is used with all funding codes. The 'R' (Revise) or 'V' (Void) codes are used as follows:

'R' = **REVISE** a record which was previously submitted and accepted.

Only for use with funding code "DC." This code corrects information on a previously submitted 'DC' claim, which was accepted. Use of this code will not allow a billing to be changed from one unit/program to a different unit/program or to make any change to the Unique Client Identifier, Staff ID, Service Dates (Beginning or Ending) or Start Time as these fields make a billing unique and allow for matching. The only way to change any of these fields is to send in a 'V' (Void) claim for the original billing, and then an 'A' (Add) claim for the corrected billing.

'V' = **VOID** a record which was previously submitted and accepted by SUPR.

Only for use with funding code "DC." This code voids a record that was submitted and accepted. The 'V' record needs to be entered exactly as it was in the original submission, so that a match and the void can be made to the record.

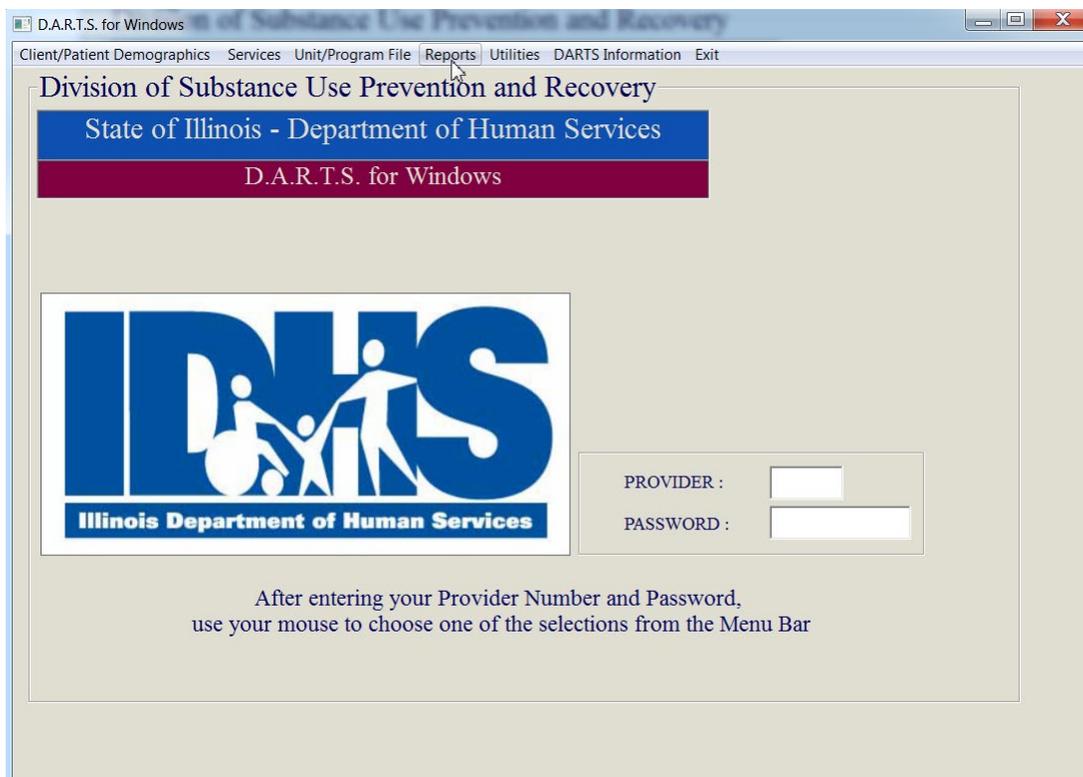
PC Reports - Main Menu

What are PC Reports and How Do I Use Them?

PC reports are produced from your computer and are very important for reconciling and verifying data that is against DARTS Mainframe Reports and Medicaid billings. All PC reports should be printed and reviewed prior to data submissions to ensure that accurate data is submitted.

These reports are simple to use and may either be printed or displayed on the screen. As many types of reports as needed may be viewed or printed.

To access the PC Report section, choose the Reports option from the Menu Bar. No data will be damaged or destroyed when utilizing these reports.

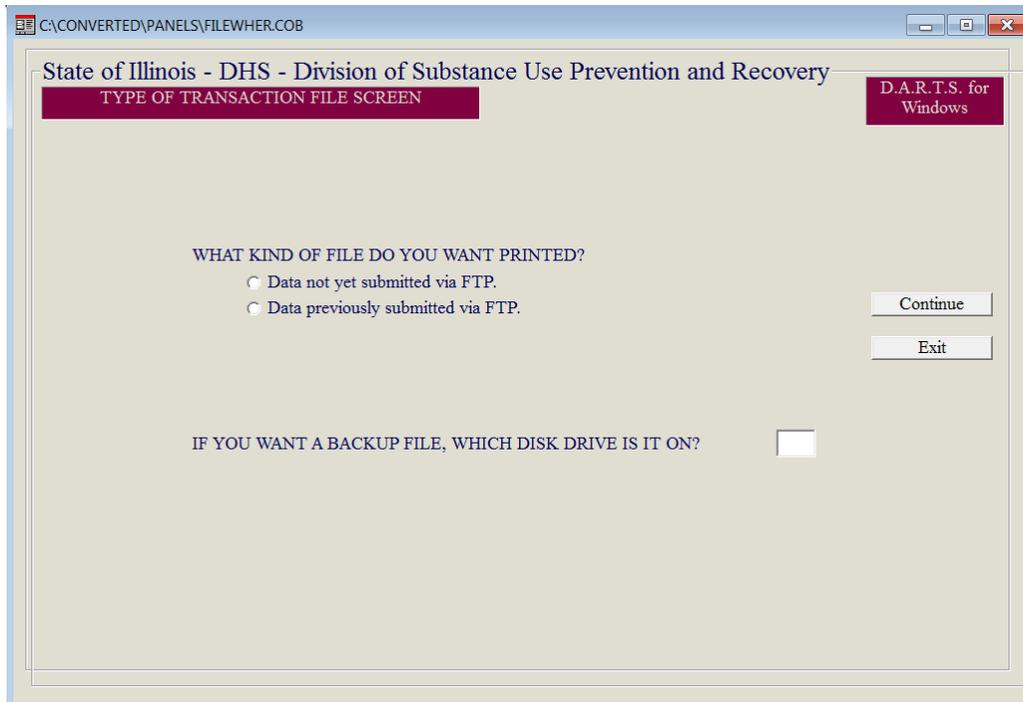


Reports can be printed from data contained in the following two file types:

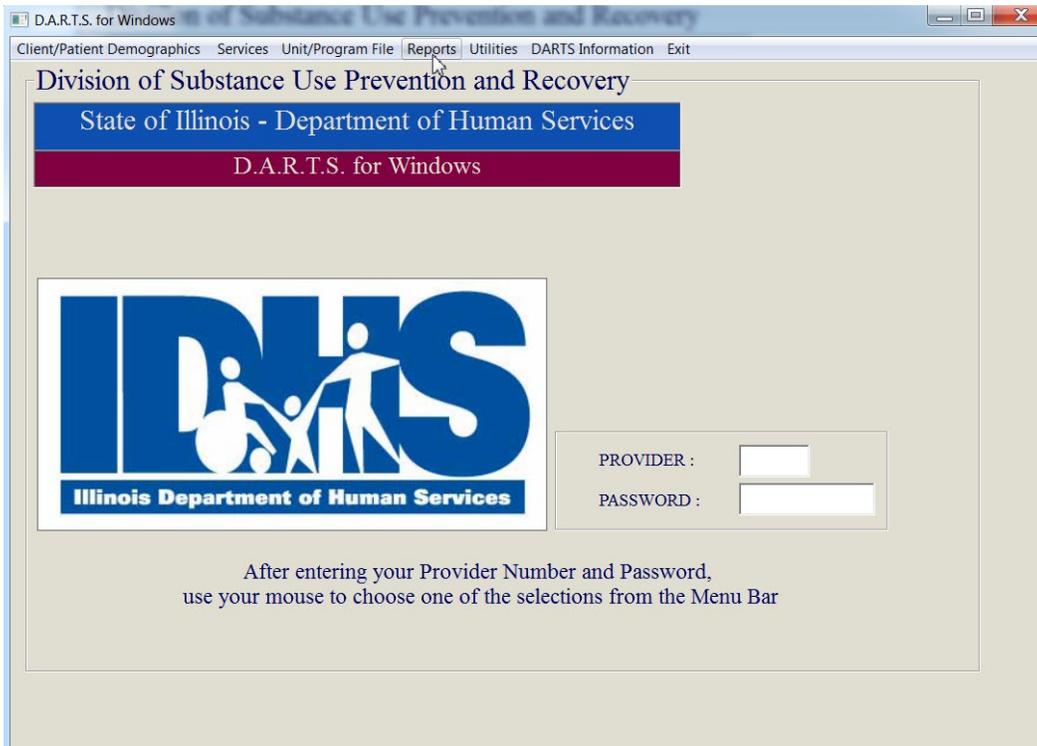
- 1) Services: includes service data entered into DARTS, which will be submitted, via FTP.
- 2) Demographics: this includes reports generated from the client/patient master file and transaction files, which are sent via File Transfer Protocol (FTP).

The first screen displayed provides a choice for the type of transaction file that will be printed:

- data not yet submitted via FTP OR
- a back-up file that contains data previously submitted via FTP. When choosing a back-up file, the resident drive must be entered. The resident drive is usually hard drive C or the network drive.



SERVICE REPORTS: What are the Types of Service Reports That Can Be Printed?



There are five choices for service reports as follows:

Billing Report: This report should be printed prior to the submission of any services to ensure accuracy. The printed report can also be used to compare service totals on DARTS Mainframe Reports. When printing this report, the following choices are available:

- **Field Specific Information:** Unit/Program, Procedure Code, Unique Client/Patient Identifier, etc.
By entering data into one or more of these fields, only the records, which match the criteria entered, will be printed. (i.e., entering “RHY” in procedure code will print only patients billed to Level 3 Youth; entering the patient’s Unique Client/Patient Identifier will print only that client/patient’s billings.) Any or all of the above fields can be left blank.
- **Funding Codes:** DM, DC or DS
- Enter an ‘X’ next to each of the funding codes to be included in the report. One or more funding codes may be chosen.
- **Clients/Patients to be included:**
This allows for tracking of all clients/patients or only DCFS clients/patients.
- **Unit/Program, Procedure Code, or Unique Client/Patient Identifier Order:**
This option will allow sorting of the report in one of three different ways: 1) in order of Unit/Program, 2) in order of Procedure Code, or 3) in the order of Unique Client/Patient Identifier.
- **Type of Report:**
This option allows printing of: 1) Both Records and Totals, OR 2) Totals Only. The first report (Records and Totals) is useful to verify that a client/patient has billings for the correct number of hours, etc. This type of report will also list the date of service and procedure code, which is useful when verifying monthly totals. Unit/Program Totals are also printed. The second report (Totals Only) provides one-page totals for every unit/program entered.

Hourly Services Report: This report should be printed prior to the submission of any services to ensure accuracy. The printed report can also be used to compare service totals on DARTS Mainframe Reports. When printing this report, the following choices are available:

- Unit/Program, Unique Client/Patient Identifier, Internal ID, Service Year/Month, etc.
Leave these fields blank to print all services. However, to print only a specific unit and program, a particular client/patient’s records, or data for a particular service month, enter the desired combination.

- **Type of Report:**
 - 1) Report in Order of Client/Patient ID (client/patient hours) - This will print a service report in order of client/patient ID's, and will total the hours entered for every client/patient. Hours accumulated are referred to as "Client/Patient Hours."
 - 2) Report in Order of Staff ID (staff hours) - This will print the report that may monitor the activity of each staff. Totals of hours and events will also be printed for each staff member. Hours accumulated are referred to as "Staff Hours."
 - 3) Report in Order of Staff ID with Activity Codes (staff hours) - This report will print in an order that allows monitoring of the hours of each staff, while also totaling hours for each of the activity codes entered for that staff member. This is especially useful when using the activity code field for monitoring special services. Hours accumulated are referred to as "Staff Hours."
 - 4) Group Report - This report will print all of the clients/patients in each group and will print in the order of Group ID.
- **Clients/Patients to be Included**
This allows for tracking of all clients/patients or only DCFS clients/patients.
- **Records to be Printed**
Choose to print 1) Both Records and Totals, OR 2) Totals only. The first report (Records and Totals) can be very useful to verify that a client/patient has been entered into DARTS for the correct number of hours, etc. This type of report will also list the date of service, which is useful when verifying monthly totals. Unit/program totals are also printed. The second report (Totals Only) gives one-page totals for every unit/program entered. When printing the Totals Only Report, the numbers may reflect service hours for multiple months (in case more than one month of data was entered since the last submission).

Unit/Program File Exit

State of Illinois - DHS - Division of Substance Use Prevention and Recovery

ASSESSMENT / INTERVENTION / CASE MANAGEMENT / LEVEL I / LEVEL II

Transaction File Report

D.A.R.T.S. for Windows

PROVIDER: 0180

ENTER THE NECESSARY FIELDS BELOW OR LEAVE FIELD(S) SPACES ...

UNIT: [] PROGRAM: [] YEAR: [] / MONTH: []

PATIENT UNIQUE CLIENT ID: [] INTERNAL PATIENT ID: []

STAFF ID: [] PROCEDURE CODE: []

SITE NO.: [] DEDICATED FUNDING: []

CHOOSE THE TYPE OF REPORT YOU WOULD LIKE:

Report in Order of Patient ID (Client Hours)

Report in Order of Staff ID (Staff Hours)

Report in Order of Staff ID with Activity Codes (Staff Hours)

Group Report

WHAT WOULD YOU LIKE PRINTED? Both Records and Totals Totals Only

WHERE WOULD YOU LIKE THIS REPORT SENT? Printer Screen

Generate Report

Exit

Daily Services Report: This report should be printed prior to the submission of any services to ensure accuracy. The printed report can also be used to compare service totals on DARTS Mainframe Reports received from SUPR. When printing this report, the following choices are available:

- Unit/Program, Unique Client/Patient Identifier, Internal ID, Service Year/Month, etc.
Leave these fields blank to print all services. However, to print only a specific unit and program, a particular client/patient’s records, or data for a particular service month, enter the desired combination.
- Clients/Patients to be Included
This allows for tracking of all clients/patients or only DCFS clients/patients.
- Records to be Printed
Choose to print 1) Both Records and Totals, OR 2) Totals only. The first report (Records and Totals) can be very useful to verify that a client/patient has been entered into DARTS for the correct number of hours, etc. This type of report will also list the date of service, which is useful when verifying monthly totals. Unit/program totals are also printed. The second report (Totals Only) gives one-page totals for every unit/program entered. When printing the Totals Only Report, the numbers may reflect service hours for multiple months (in case more than one month of data was entered since the last submission).

Unit/Program File Exit

State of Illinois - DHS - Division of Substance Use Prevention and Recovery

Residential and Recovery Home Transaction Report

D.A.R.T.S. for Windows

PROVIDER: 0180

ENTER THE NECESSARY FIELDS BELOW OR LEAVE FIELD(S) SPACES ...

UNIT: / PROGRAM:

PATIENT UNIQUE CLIENT ID: INTERNAL PATIENT ID:

YEAR: / MONTH:

WHAT TYPE OF REPORT DO YOU WANT:

Both Records and Totals Totals Only

WHERE WOULD YOU LIKE THIS REPORT SENT?

Printer Screen

Generate Report

Exit

Specialized Services Report: This report should be printed prior to the submission of any services to ensure accuracy. The printed report can also be used to compare service totals on DARTS Mainframe Reports. When printing this report, the following choices are available:

- Unit/Program, Unique Client/Patient Identifier, Internal ID, Service Year/Month, etc.
Leave these fields blank to print all services. However, to print only a specific unit and program, a particular client/patient’s records, or data for a particular service month, enter the desired combination.
- Client/Patients to be Included
This allows for tracking of all clients/patients or only DCFS clients/patients.
- Records to be Printed
Choose to print 1) Both Records and Totals, OR 2) Totals only. The first report (Records and Totals) can be very useful to verify that a client/patient has been entered into DARTS for the correct number of hours, etc. This type of report will also list the date of service, which is useful when verifying monthly totals. Unit/program totals are also printed. The second report (Totals Only) gives one-page totals for every unit/program entered. When printing the Totals Only Report, the numbers may reflect service hours for multiple months (in case more than one month of data was entered since the last submission).

The screenshot shows a software window titled "Unit/Program File Exit" for "State of Illinois - DHS - Division of Substance Use Prevention and Recovery". The main title is "SPECIALIZED SERVICES TRANSACTION REPORT (Toxicology / Childcare Residential)". A "D.A.R.T.S. for Windows" logo is in the top right. The form contains the following elements:

- PROVIDER:
- ENTER THE NECESSARY FIELDS BELOW OR LEAVE FIELD(S) SPACES ...
- UNIT: / PROGRAM:
- PATIENT UNIQUE CLIENT ID: INTERNAL PATIENT ID:
- YEAR: / MONTH:
- WHAT TYPE OF REPORT DO YOU WANT?
 Both Records and Totals Totals Only
- WHERE WOULD LIKE THIS REPORT SENT?
 Printer Screen
- Buttons: "Generate Report" and "Exit"

Medicaid Transaction Report: This report lists all of the information about each Medicaid billable service. Each billing will print one full page and it is strongly recommended that this report be used to reconcile Medicaid billings. The following fields are referenced on this screen:

- Unit/Program, Procedure Code, Client/Patient Unique Identifier, Internal Client/Patient ID and Recipient Identification Number.

State of Illinois - DHS - Substance Use Prevention and Recovery

D.A.R.T.S. for Windows

PROVIDER:

ENTER ONE OR MORE OF THE FIELDS BELOW (OR LEAVE SPACES ...)

Unit:

Program:

Procedure Code:

Patient's Unique Client ID:

Internal Client ID:

Recipient No:

Where would you like this report sent? Printer Screen

DEMOGRAPHIC REPORTS: What are the Types of Demographic Reports That Can Be Printed?

There are three choices for demographic reports as follows:

Demographic Master File Report: This report lists all clients/patients who have an admission record in DARTS. Since there may be thousands of patients who have been entered, view the report on the screen before printing. Choices are given to customize the report. These choices include 1) printing in order of the Unique Client/Patient Identifier or Name, AND 2) printing all records, only admission records, or only discharge records.

Unit/Program File Exit

State of Illinois - DHS - Division of Substance Use Prevention and Recovery

PATIENT DEMOGRAPHIC MASTER REPORT SCREEN

D.A.R.T.S. for Windows

IN WHAT ORDER WOULD YOU LIKE THE PATIENT MASTER PRINTED?

Print in order of Patient Unique Client ID Print in order of Name Print in order of Recipient ID (RIN)

WHAT TYPE OF RECORDS DO YOU WANT TO SEE?

All Records Opened Records Only Closed Records Only

WHICH TYPE OF PATIENTS WOULD YOU LIKE TO INCLUDE?

Both Treatment and Intervention Patients Treatment Patients Only Intervention Patients Only

WHERE WOULD YOU LIKE TO SEE THE REPORT?

Printer Screen

Generate Report

Exit

Client/Patient Demographic Transaction Report: Choosing this option will print all one or all client/patient demographic records that have been submitted. Every time a client/patient’s record is added to, changed or deleted, that data is written onto the hard drive. This report will show these changes and print demographic, problem area, and discharge information. This date reflects information entered on this date—not admitted on this date. (i.e., a review of all admission records entered into the PC today.) In most cases, it is not necessary to print or view this report every month. Each client/patient record takes up one printed page, therefore, only refer to the report when necessary for error reconciliation. The date range feature allows the date range to be chosen so that only demographic records added or changed within that data range are printed.

Unit/Program File Exit

State of Illinois - DHS - Division of Substance Use Prevention and Recovery

PATIENT DEMOGRAPHIC TRANSACTION REPORT SCREEN D.A.R.T.S. for Windows

WHAT DATE RANGE WOULD YOU LIKE TO USE FOR THIS REPORT?

(Either fill in the date fields, or you may leave one or both of the fields blank.)

START DATE : / /

END DATE: / /

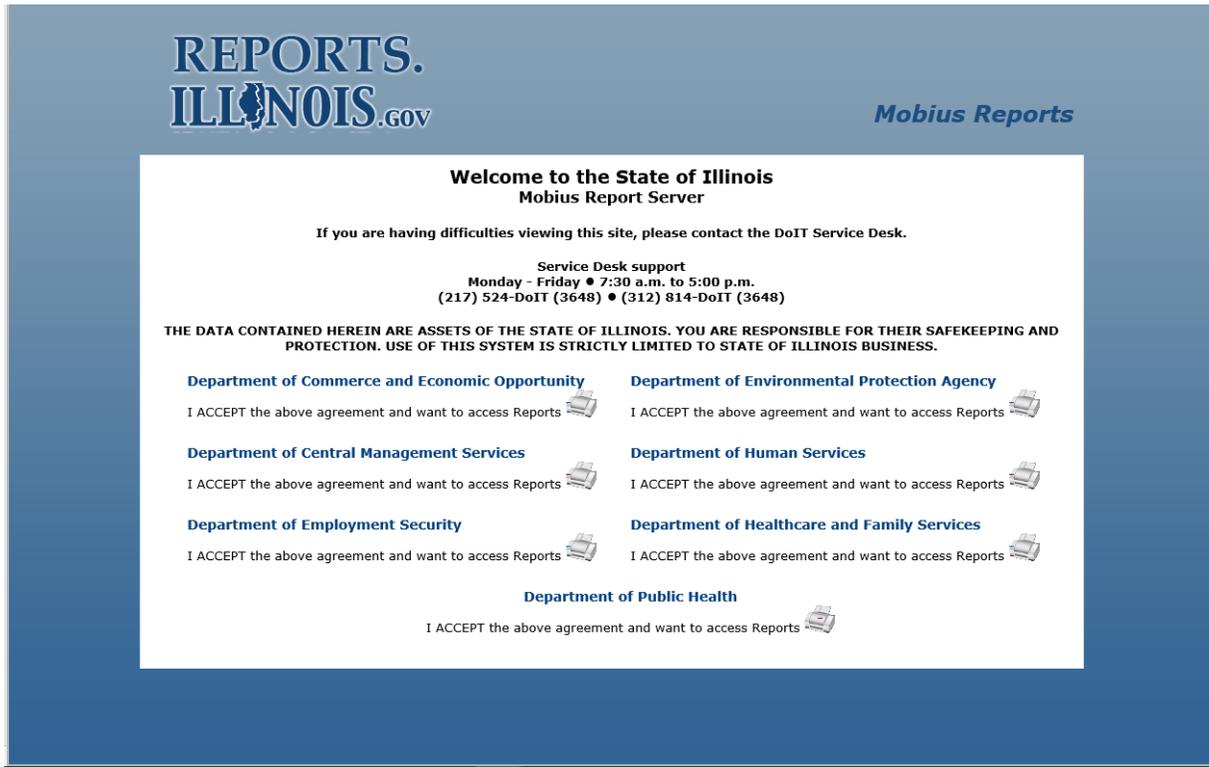
ENTER THE CLIENT/PATIENT UNIQUE ID (or leave blank for all records):

WHERE WOULD YOU LIKE TO SEE THE REPORT?

Printer Screen

DEPRESS F5 KEY FOR FILE TYPE SCREEN

Mobius Document Direct: Choosing this option will allow providers to view DARTS mainframe reports online. (See Mobius User Manual Addendum I for more detailed information.)



The following DARTS Mainframe Reports are available on Mobius:

WEEKLY DARTS REPORTS (ran every Monday after 5:00 p.m.)

PASDMWR1 - Client Update Report (Accepted/Rejected Client Demographic Records)

PASDMWR2 - Service Accepted/Rejected Update Report

PASDMWR3 - Service Accepted/Rejected Summary Report

MONTHLY DARTS REPORTS (ran every second Monday after 5:00 p.m.)

PASDMRR1 - YTD Site Report by Month

PASDMRR2 - Service Report Code Counter by Month

PASDMRR3 - YTD Activity Report

PASDMRR4 - Allocations and Earnings for CMH, EI, and CIH

PASDMRR5 - Active Client Listing

PASDMRR6 - All Client Listing

PASDMCR7 - All Service Setting Codes

PASDMCR8 - Services and the Opening Dates They are Tied to

PASDMXR1 - Warning Report of Openings with No Service Activity Within the Last Three Months

PASDMXR2 - Openings with No Service Activity Within the Last Four Months that have been Administratively Closed

QUARTERLY DARTS REPORTS (ran after the completion of each quarter within a fiscal year)

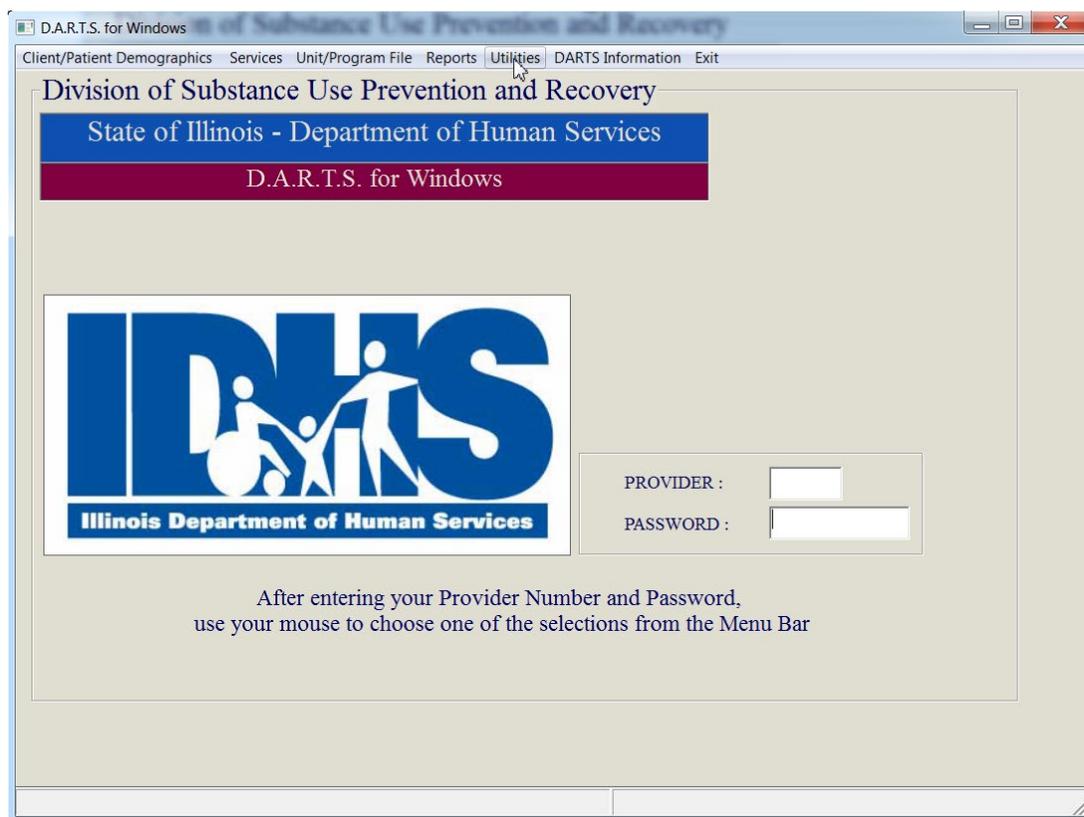
These reports will begin with letters "PASDMQ".

Pharmacy/OMT reports begin with the letters "PASPH".

Utility Functions - Main Menu

What are Utility Functions?

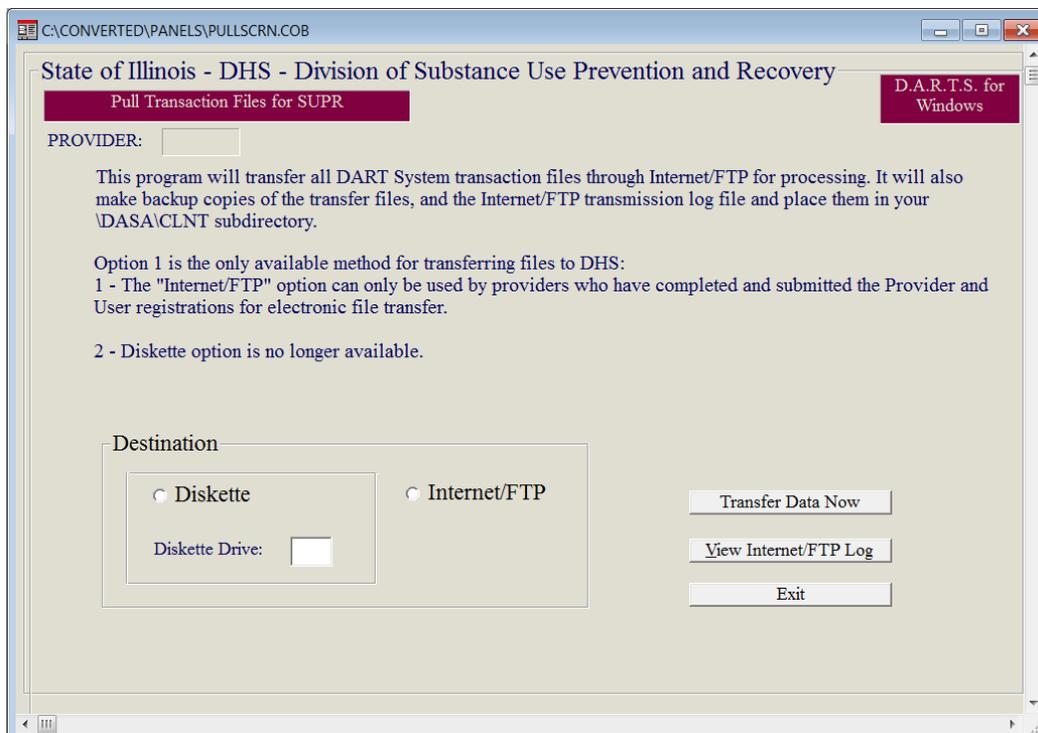
Utility functions are used to submit service data, change passwords, and load software updates and remove out of date discharge records from the client/patient admission master file.



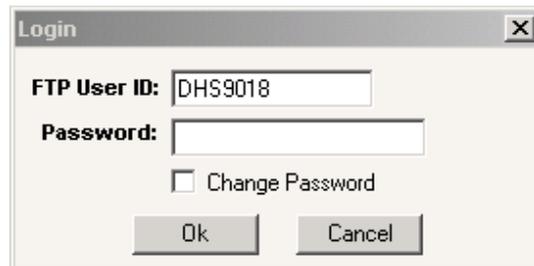
The following information will be helpful in using utility functions:

Create Submission Files: This option extracts entered service data. File Transfer Protocol (FTP) is the required method of submission. However, this section contains information on FTP and diskette submission in the event that diskette submission is necessary.

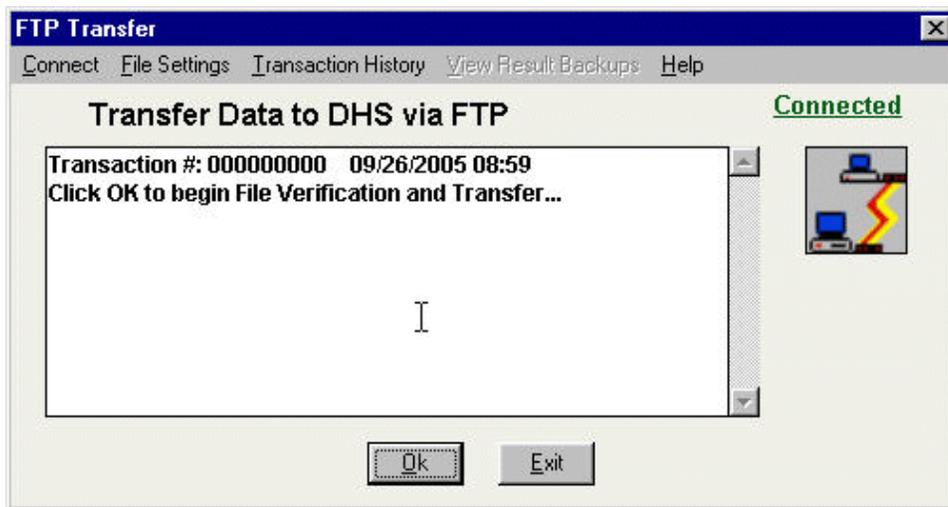
FTP Submission: Once the organization has successfully registered with IDHS, files may be transmitted via FTP. If a fire wall is utilized, then port 2021 must be open for connectivity. A connection to the Internet is required. Before the first FTP submission, click on “Agency Information” from the DARTS Menu Bar. This screen allows the setup of your FTP Provider ID and e-mail addresses. Information on this screen needs to be entered only one time.



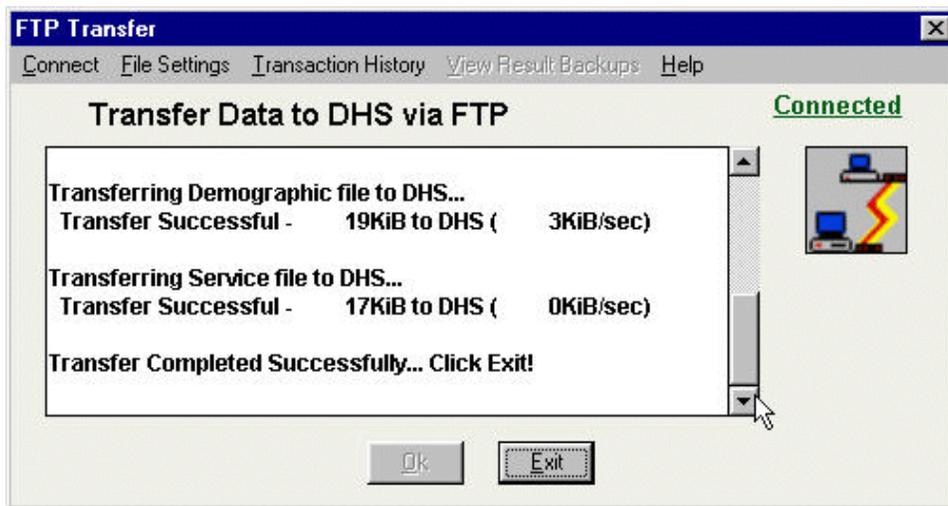
To submit your DARTS data to IDHS, select **Create Submission File** from the **Utilities** drop down menu. Click **Transfer File Now** to continue or **Exit** to abort the transfer. Next, the Login window will be displayed. Enter your **FTP User ID** and **Password** then click **Ok** to continue. If an error box is displayed, check that the FTP User ID and Password are correct. **Note:** The first time you log into the system, enter your FTP User ID as the password and then you will be prompted to change your password. The password is case sensitive and must be changed every 30 days.



The above screen appears after successfully connecting to the FTP server. (To have your password reset, please contact MIS Security at DoIT.MISSecurity@illinois.gov. The password reset request **MUST** be sent via e-mail with the user's name, user ID, agency name/license number and a contact phone number.)



Click **Ok** on the screen below to begin the transfer to IDHS. The FTP Transfer dialog box will display information about the transfer process. To verify a successful transfer, scroll to the bottom of the dialog box to view the transfer results.



A provider may delete a file from the FTP server if desired, providing they do so BEFORE the upcoming Monday evening.

Deleting FTP'd File: Go to the FTP and proceed with login to ensure connection. The first window displayed on menu bar will include an option "FTP Server View/Delete". Click on this option. Your list of files that you have FTP'd since the previous Monday will be displayed. Highlight the file to delete and choose "delete".

Change DARTS Password: A password is required on the DARTS Main Menu for entry into the system. The default password is DARTS; however, a new password can be entered into DARTS. From the Menu Bar, click on “Utilities,” then “Change Password.” Enter both the old password and new password and click on “Process” or press enter.

The screenshot shows a web-based password change interface. At the top, the window title is "State of Illinois - DHS - Division of Substance Use Prevention and Recovery". Below the title bar, there is a maroon header with the text "Password Change Screen" on the left and "D.A.R.T.S. for Windows" on the right. The main content area is light beige and contains the following elements: a "PROVIDER:" label followed by a text input field containing "0274"; an "OLD PASSWORD:" label followed by a text input field; a "NEW PASSWORD:" label followed by a text input field; a "Process" button located to the right of the "OLD PASSWORD:" field; and a "Go Back" button located to the right of the "NEW PASSWORD:" field.

Clear Record Locks: Since DARTS provides for use on local area network (LAN) systems, record locking is provided. In the event a record cannot be accessed and the message “Record is locked by LAN” is displayed, this option can be used to clear all record locks.

Update Unit/Program File: Periodically, files are e-mailed from the Department, which will update the unit/program file. The provider unit/program file contains all of the valid unit/program combinations. Updates of this file are sent at the beginning of every fiscal year, as well as throughout the year if there are any additions or changes. After receiving a file, please update the provider unit/program file in a prompt manner! Check the provider unit/program file by choosing “Unit/Program File” from the Menu Bar.

To update the Unit/Program File, copy the unit/program attachment file directly to your \SUPR\fdb folder OR copy the e-mailed file to a diskette and update using the following steps:

- From the Menu Bar, click on “Utilities,” then “Update Unit/Program File”
- Load the update diskette
- Identify the drive, which contains this update diskette
- After successfully updating, the screen will display a successful message

Client/Patient Master Rollover: This option allows for removal of out-of-date discharged records from the Client/Patient Admission Master file. Each year as more and more clients/patients are admitted, the Admission Master file may become quite large and can slow down the system or fill up the hard drive. It may become necessary and/or desirable to “clean off” some of these old records. First view or print the Client/Patient Admission Master file report from the PC to see what the client/patient database looks like.

When removing a large number of discharged clients/patients, the rollover procedure is ideal. Two dates are entered during this process. First, the current date, and second, the date for deletion of discharged clients/patients. (i.e., if 07/01/17 is selected as the date to use to delete records, only discharged records, which were opened before 07/01/17, will be deleted.) The system will not allow a date to be selected within the fiscal year.

Backing Up DARTS Files!

Computers have hard disk crashes or users can delete files by accident. Backing up the system is a quick and painless experience and **COULD SAVE DAYS OR WEEKS OF WORK!**

Computers come equipped with several different options for back-up. Depending on the type of computer, the command on how to back up computer data files varies.

The Client/Patient Admission Master File (DASA\CLNT\CLNTMAST.FIL) is located on the hard drive or network drive and contains all of the information about admissions and discharges. If the computer crashes, there are only two ways to reinstall all admissions and discharges: 1) restore the data from the most current back-up OR 2) re-enter all admission/discharge records. If there is no back-up, all records must be re-entered.

Decide on the best way to back up files but it is suggested this process occur at least weekly. This will not only prevent loss of DARTS data, but also Word Processing files, Spreadsheet data, etc. All data files are resident in the DASA\CLNT subdirectory on the computer.

Help Desk Guidelines

The Help Desk can be reached through e-mail at DOIT.SUPRHELP@ILLINOIS.GOV or through fax at 217-558-4656. All questions to the Help Desk should specify the problem and include examples, if appropriate. Be sure to include the Provider name and four-digit Provider number and the name, number and e-mail address of the contact person so the Help Desk staff can respond. Most Help Desk requests are answered by staff within three working days. However, questions that must be referred to other IDHS offices may take longer. For questions regarding reports on Mobius, please specify the name of the report.

It is very important to be familiar with the drive in which DARTS resides. Most systems use the C drive to keep DARTS, but others may use D:, E:, etc. For LAN users, it is important to know what “Login ID” was used when the problem occurred. Different login ID’s are given different rights on LAN systems, and this could be the basis of the problem. When a problem occurs entering data into DARTS, write down the *COMPLETE* error message, which is displayed, on the bottom of the screen. Without this information, staff cannot assist with correcting the problem. Depress the “Print Scan or Print Screen” key while both the message and data in error are still displayed on the screen and this will print a copy of what the screen looked like when the error was encountered. If the error message concerns a particular field (i.e., Living Arrangement, Annual Income, Recipient Identification Number, etc.), please refer to that field in this manual to check for the definition and valid field responses.

IDHS assigns User ID’s and passwords that are used for FTP processing, e-RIN requests and Mobius report viewing. If you experience problems with this User ID or password, e-mail the CMS Customer Solution Center - IT Support at DoIT.MISSecurity@illinois.gov and provide the following information:

- Full Name
- Organization
- User ID (this is the id that begins with “HSD”)
- Telephone number for call-back

Please note that agents process e-mailed password reset requests in the order in which they are received and use the provided telephone number to contact the requester with the new password.

If the user’s information cannot be verified, the user will receive an e-mail reply suggesting that they resubmit the request with the correct information. A requester will never receive a return e-mail or voice mail that includes a password.

In order to serve you better, a new e-mail portal has been designed specifically for E-RIN Providers’ requests. You may now contact us at DHS.ERIN@ILLINOIS.GOV. To help ensure a timely response, do not send multiple e-mails for the same request. Please include the following information:

- Organization/Company Name;
- Provider NPI or FEIN;
- Contact E-mail Address;
- Contact Phone Number;
- Issue (Duplicate RIN or Case Correction);
- Customer Day of Birth;
- Last 4 Digits of SSN; and
- Recipient Identification Numbers.

You may now contact the DHS ERIN Help Desk by submitting your DHS Social Services backdate issues; multiple RIN; and other inquiries directly to: DHS.ERIN@ILLINOIS.GOV for an immediate response. By submitting your inquiries electronically, you will receive a response almost instantly and secure, allowing us to serve you more efficiently.

Tables of Commonly Used Data Elements

Setting Codes

Identified in Provider Unit/Program File and Mainframe Reports

AS - Assessment	RH - Recovery Home
OP - Level 1 (Outpatient)	IN - Intervention
OR - Level 2 (Intensive Outpatient)	TX - Toxicology
RR - Level 3 (Residential Rehabilitation)	CM - Case Management
DX - Withdrawal Management	CR - Childcare Residential
HH - Residential Extended Care	SH - Staff Hour

Program Numbers

02 - Childcare Residential	44 - Level 2 - Adult or Adult/Youth
05 - Level 1 - Methadone	45 - Residential Extended Care
27 - Level 3 Rehabilitation - Adult (<i>Medicaid only programs</i>)	46 - Withdrawal Management
40 - Recovery Home	47 - Level 3 Rehabilitation - Adult
41 - Case Management	48 - Assessment
42 - Intervention	52 - Toxicology
43 - Level 1 - Adult or Adult/Youth	64 - Interpreter Referral Services
	78 - Level 3 Rehabilitation - Youth

Data Submission Errors

How to Correct Them and Prevent Future Errors

CLIENT MASTER FILE UPDATE REPORT

Error Code 984 - A Previous Opening Has Not Been Closed

The master file holds multiple openings for the same client/patient if they contain both an opening and a closing date. However, this file will only allow one open record with no associated closing. DARTS contains PC edits that will not allow a new opening for the same client/patient until the previous open record is closed. However, this error can still occur when the client/patient is closed in DARTS at the PC level (especially in organizations that submit data from multiple sites), but a closing is never submitted or when data is lost at the provider level and thus the provider was unable to send in a discharge or with a third-party system.

Solution: The “Client Master File Update” report will display ALL accepted and rejected openings and closings and any demographic updates. Always check to ensure that openings have been accepted before submitting any additional services. This will help to avoid many errors of this type.

When this error does occur, the message will specify the opening date of the record that must be closed. All transactions are processed in date and time order. Therefore, to correct this error you must first close the previous opening before submission of the new opening. Otherwise, the same error will reoccur. Additionally, if the opening record is not correct, all services reported against that opening will also reject.

To help reduce this type of error, providers should always check the “Client Master File Update” report to make sure that openings are not in error and submit closing records for any client/patient in early intervention or outpatient who has not received services, other than case management, in over 30 days or any residential patient who has not received services, other than case management, in over 3 days. The Division also routinely deletes any opening record off the master file that has not had any reported services for over 6 months.

Error Code 982 - Duplicate Opening

This error message means that an exact duplicate of the opening is already on the master file. This error occurs most often with third party users because there is no connection to the master file to alert the user that the opening is a duplicate. Also, if a change is made to the demographic record and it is marked as an “add” instead of “change”, the system will reject it as a new opening.

Solution: Examine the error report and source documentation to determine the cause of the error. If it relates to a demographic change that was erroneously submitted as an “add”, the record should be resubmitted as a “change”. If it was simply a duplicate opening submission, nothing needs to be done.

Error Code 980 - Cannot Change Due to a Service Date Outside of the Opening Date Range

This error occurs when a change is sent for the opening date and a service has already been accepted that would then fall outside of the new date range. The message will specify what type of service and on what date.

Solution: Examine the error report and source documentation to determine the cause of the error. If the opening date is incorrect, it cannot be changed until the accepted service is voided. The only accepted and paid services that can be voided in DARTS are those with a funding code of DC (contract funds). To void a service in DARTS, the submission must match identically to the original submission with the exception of the “Revision Code” field, which must be completed with a “V”.

Error Code 981 - Cannot Delete Opening Record Due to an Accepted Service Against That Opening

No opening record can be deleted from the Master File if there is an accepted service associated with that admission.

Solution: If the opening record needs to be deleted, any accepted DC service will have to be voided prior to the submission of the opening record deletion. Remember the processing order of date and time. Void the service first and then delete the opening.

Error Code 987 - Cannot Change Closing Date Due to an Accepted Discharge Assessment Service

This error occurs when there is an attempt to change the closing date after a discharge assessment has already been accepted. The error message will specify the date of the discharge assessment. The discharge assessment is the final service submission that can be accepted against an open record and this service will not be accepted unless a closing is also submitted.

Solution: No service can be accepted after payment for a discharge assessment. If the closing date needs to be changed, the discharge assessment must be voided first.

Error Code 986 - This Opening Has Treatment Services. Cannot Change to an Intervention Opening

The opening record in DARTS specifies the client/patient type. This is identified through selection of “T” for treatment and “I” for Intervention and only one can be selected. The service billed against the opening record must match the client/patient type. If a treatment service is accepted against an opening record identified as a “T”, a subsequent attempt to change the client/patient type to “I” will be rejected.

Solution: If the client/patient type needs to be changed, void the accepted services prior to submitting the change against the opening record.

MAIN FRAME CROSS EDITS

At main frame processing, many cross edits are checked to ensure that all demographics fields are correctly completed with the proper values. The error messages that result from this checking are generally self-explanatory and are mainly the result of keystroke errors or errors in data collection. However, they must be corrected in the opening record or all services will continue to reject. The first step in correcting these types of errors is to obtain the source documentation for the data entry to determine what needs to be fixed. Some examples of these types of error messages are:

Error Code 317 - Age of first use cannot be greater than age at admission. For example, case the age of first use was submitted as 20 and the age at admission was 19.

Error Code 044 - Invalid Problem Area. This error occurs when a problem area is selected that does not match the primary problem code. For example, if “Drugs” are selected as the problem area, the primary problem code cannot be “alcohol”.

Error Code 174 - Dually Diagnosed Require Both Diagnosis. This error occurs when the patient is identified as “MISA” in the opening record and there is no mental health diagnosis entered in one of the diagnosis fields.

SERVICES ACCEPTED/REJECTED REPORT

Error Code 930 - No Matching/Unit/Program. The unit/program number used for the service billing must match one that is contained within the facility file. When this error occurs, it is held in suspense for the next five submissions in anticipation of a correction to the submission. If this does not occur, the service will have to be resubmitted.

Solution: Verify that you are using the most current update to your software. This is particularly important if you have relocated a facility or ended or started a new funded service. Often when this occurs, reporting numbers change or are given new begin and end dates. If you determine that you are using the most current unit and program file, it will be necessary to contact the Help Desk as the error may be in our files.

Error Code 931 - Service not within the contract date range (begin and end date) for the associated unit/program number. A submitted service cannot have been delivered on a date that is not within the begin and end date for the associated reporting unit/program number. When this error occurs, it is held in suspense for the next five submissions in anticipation of a correction to the submission. If this does not occur, the service will have to be resubmitted.

Solution: Verify that you are using the most current update to your software. This is particularly important if you have relocated a facility or ended or started a new funded service. Often when this occurs, reporting numbers change or are given new begin and end dates. If you determine that you are using the most current unit and program file, it will be necessary to contact the Help Desk as the error may be in our files.

Error Code 934 - No Valid Opening Record. Resubmit Record. There must be a **valid opening** for any reported service except community intervention, which is not linked to a specific client/patient. A valid opening is one with complete and correct demographic fields that has not been rejected as an error. This error frequently occurs when the opening record identifies the patient as a client/patient type “I” for intervention and a treatment service is submitted against that opening or vice versa. It also occurs when a submitted service is not within the date range of the opening record. When this error occurs, the service is held in suspense for the next five submissions in anticipation of a correction to the opening. If this does not occur, the service will have to be resubmitted.

Solution: Check all copies of the “Client Master File Update” report to ensure that the associated opening record for the submitted service has been accepted. Generally, if this error occurs, the opening record rejected and has not been corrected. All associated services will continue to reject until the opening record is corrected.

Error Code 935 - No Opening Record. Services cannot be accepted without an opening record and it should be submitted prior to submission of any service. When this error occurs, the services are held in suspense for the next five submissions in anticipation of a correction to the opening. If this does not occur, the service will have to be resubmitted.

Solution: Always ensure that the opening has been accepted on the next “Client Master File Update” report that is sent after your opening record submission. If there is a problem with the opening, correct it before submitting any additional services.

Error Code 944 - Incomplete Demographics in the Opening Record. This error generally occurs when a new demographic field or value to a field is added and the opening record has not been amended. When this error occurs, the services are held in suspense for the next five submissions in anticipation of a correction to the opening.

Solution: Generally, these types of enhancements are only made at the beginning of the fiscal year. However, whenever they are made, notifications are sent indicating that the change will have to be made for any new openings or to existing open records for clients/patients who continue to receive services. Be sure to make all demographic changes as soon as they are required.

Error Code 921 - Duplicate Service. This error occurs when an exact duplicate of the service has already been accepted or where service dates/times conflict.

Solution: Determine what caused the duplicate submission. If the most recent submission was sent in error, no correction to the submission is necessary, as it will not be resubmitted. However, examination is needed to determine why duplicates were submitted and corrective action should be implemented to prevent such submissions in the future.

If there is a service/date time conflict, determine which submission is correct. If the second submission is correct, the first submission will have to be voided before the second submission can be accepted.

Error Code 962 - Assessment is After Another Service Date. Once a treatment or an intervention service is delivered, submitted and accepted, no assessment service submission can be accepted if it occurred after the treatment or intervention service. This error may occur because the wrong activity code is used for a discharge assessment vs. an admission assessment.

Solution: Adopt internal practice to ensure that all clinicians know that submission of an admission assessment service cannot occur after submissions for intervention or treatment services have been accepted. The billing for assessment is for admission (pre-treatment) and discharge (post-treatment) purposes only. Ensure that the correct activity code is used for admission assessment (70) and discharge assessment (71).

Error Code 954 - No Valid Opening Record - Pharmacy Patient. This error occurs when a funded Opioid Maintenance Therapy (OMT) patient has a submitted service on the Pharmacy Log but no valid opening in the master file. A valid opening is one with complete and correct demographic fields that has not been rejected as an error. Generally, when this error occurs with an OMT patient it is because there may be an old opening record on the master file that does not match the date range for the OMT service. No payment for the pharmacy service can be authorized until there is a match to a valid opening record in DARTS.

Solution: Check all copies of the “Client Master File Update” report to determine the error. This may involve checking source documentation related to demographic fields. Correct the error or submit a new opening record if the invalid opening relates to a previous treatment episode. Once submitted, check the “Client Master File Update” to ensure that the opening was accepted.

Error Code 955 - No Opening Record - Pharmacy Patient. Every funded patient on the Pharmacy Log must have an open record in the master file. This error occurs when the only funded service is OMT and no opening record for the patient has ever been submitted. For payment to be processed, the patient must be on the pharmacy log and have a valid opening.

Solution: Complete and submit an opening record for the patient.

Mobius User Manual

Accessing and Using Mobius Document Direct

Use the following Web address to access Mobius Document Direct: <https://reports.illinois.gov>.

NOTE: It is strongly advised that you turn your popup blocker off while using this website.

**REPORTS.
ILLINOIS.GOV**

Mobius Reports

**Welcome to the State of Illinois
Mobius Report Server**

If you are having difficulties viewing this site, please contact the DoIT Service Desk.

Service Desk support
Monday - Friday • 7:30 a.m. to 5:00 p.m.
(217) 524-DoIT (3648) • (312) 814-DoIT (3648)

THE DATA CONTAINED HEREIN ARE ASSETS OF THE STATE OF ILLINOIS. YOU ARE RESPONSIBLE FOR THEIR SAFEKEEPING AND PROTECTION. USE OF THIS SYSTEM IS STRICTLY LIMITED TO STATE OF ILLINOIS BUSINESS.

Department of Commerce and Economic Opportunity
I ACCEPT the above agreement and want to access Reports

Department of Environmental Protection Agency
I ACCEPT the above agreement and want to access Reports

Department of Central Management Services
I ACCEPT the above agreement and want to access Reports

Department of Human Services
I ACCEPT the above agreement and want to access Reports

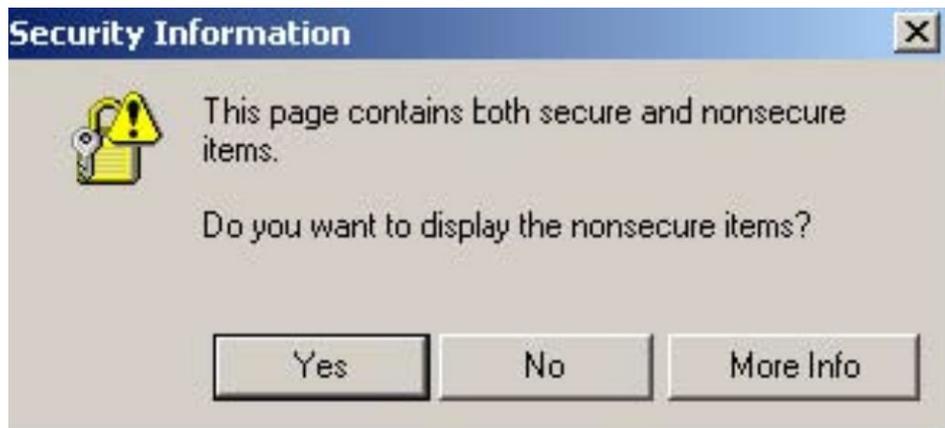
Department of Employment Security
I ACCEPT the above agreement and want to access Reports

Department of Healthcare and Family Services
I ACCEPT the above agreement and want to access Reports

Department of Public Health
I ACCEPT the above agreement and want to access Reports

Click the printer icon “Department of Human Services” on the Mobius Report Server screen to enter the site.

Select “Yes” on the Security Information Window to continue.

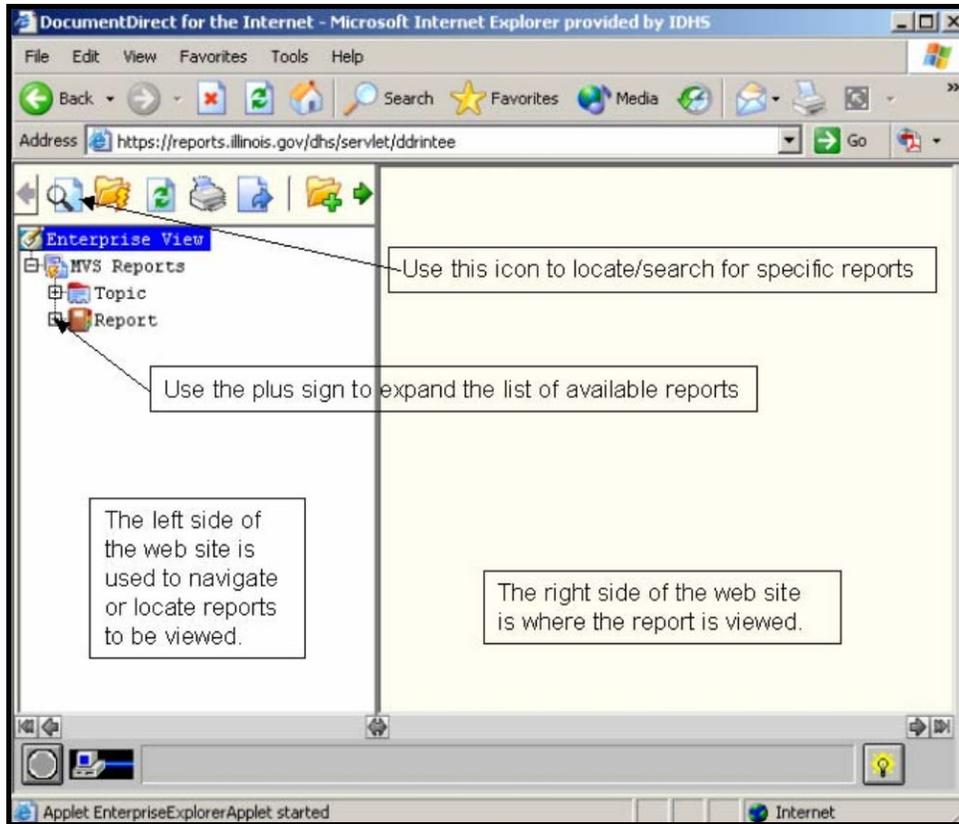


The following window will appear. Enter your IDHS User ID and password, then click on the green circle with the check mark.



The following screen appears after successful log on.

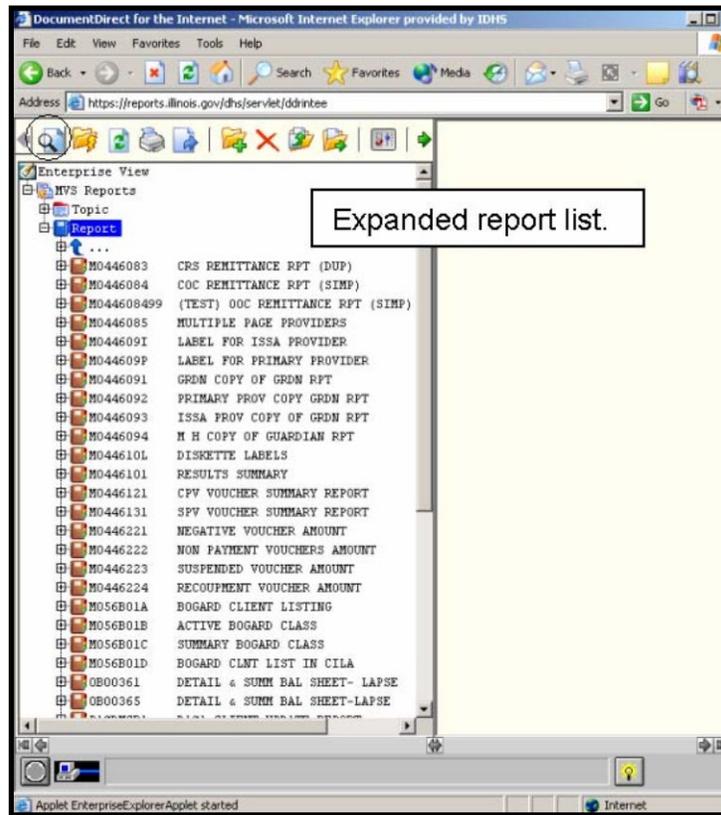
NOTE: This website does not allow you to update or change your password. If your password is revoked, you will need to contact the CMS Service Desk for assistance (1-800-366-8768, first menu option will be 2, second menu option will be 11).



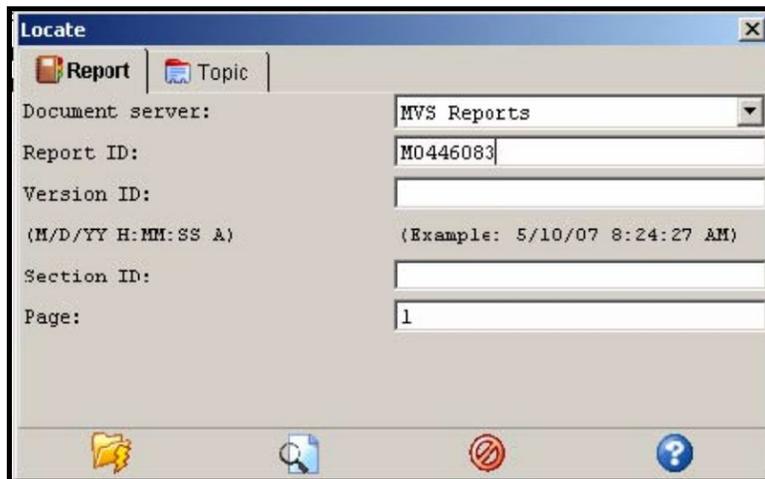
Click on the plus sign to the left of “Reports” to display the list of reports on the left side of the screen.

The reports are listed in alphabetic order by report ID. If your community agency does not submit data for all IDHS Systems, some reports may not contain information. There are also reports generated for Mobius (e.g., EXITRAF) that can be ignored. Below are the report prefixes and corresponding system.

- | | |
|---------------|--------------------|
| PASDM - DARTS | CR/ECR - CRS (ffs) |
| PDLAS - DLA | M020 - DD Waiver |
| PROCS - ROCS | M044 - CRS (ffs) |
| PPUNS - PUNS | |

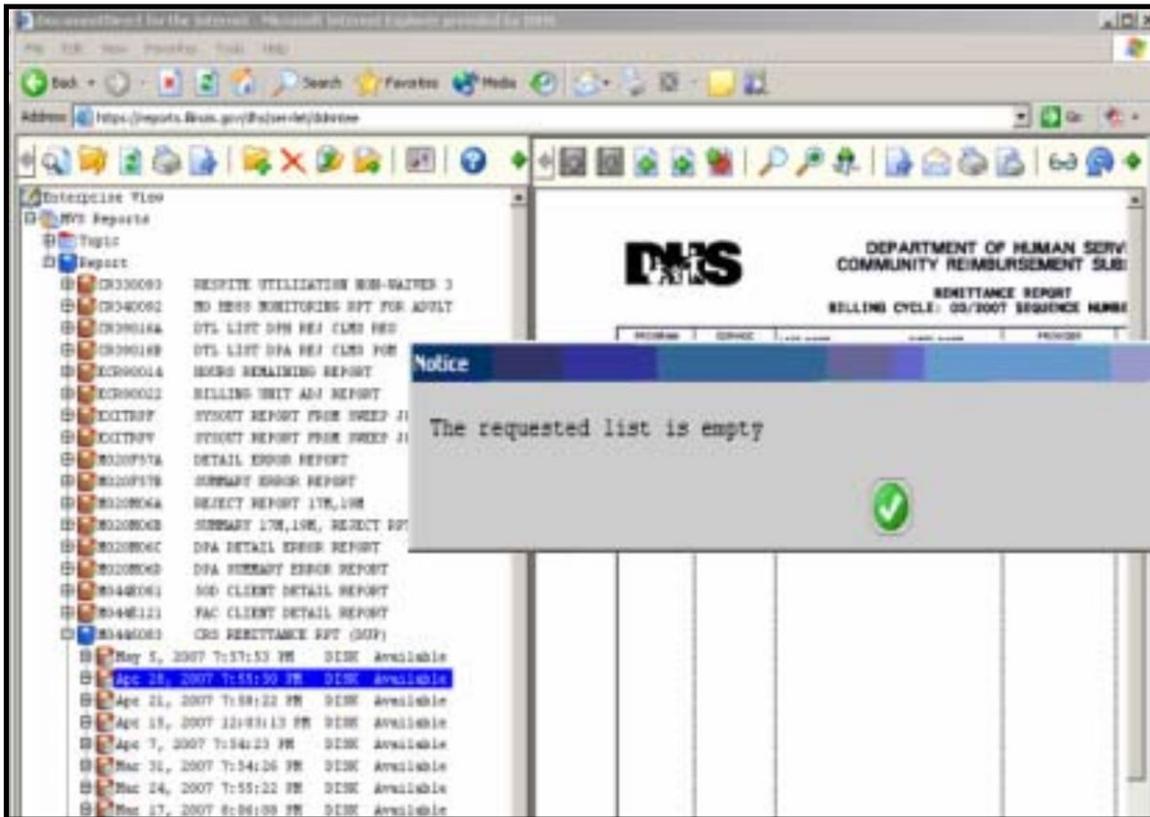


The icon  can be used to search/locate a specific report. When this icon is selected, the following window will appear. Enter the Report ID in the correct space, then click on the icon  at the bottom of the window to locate the report.

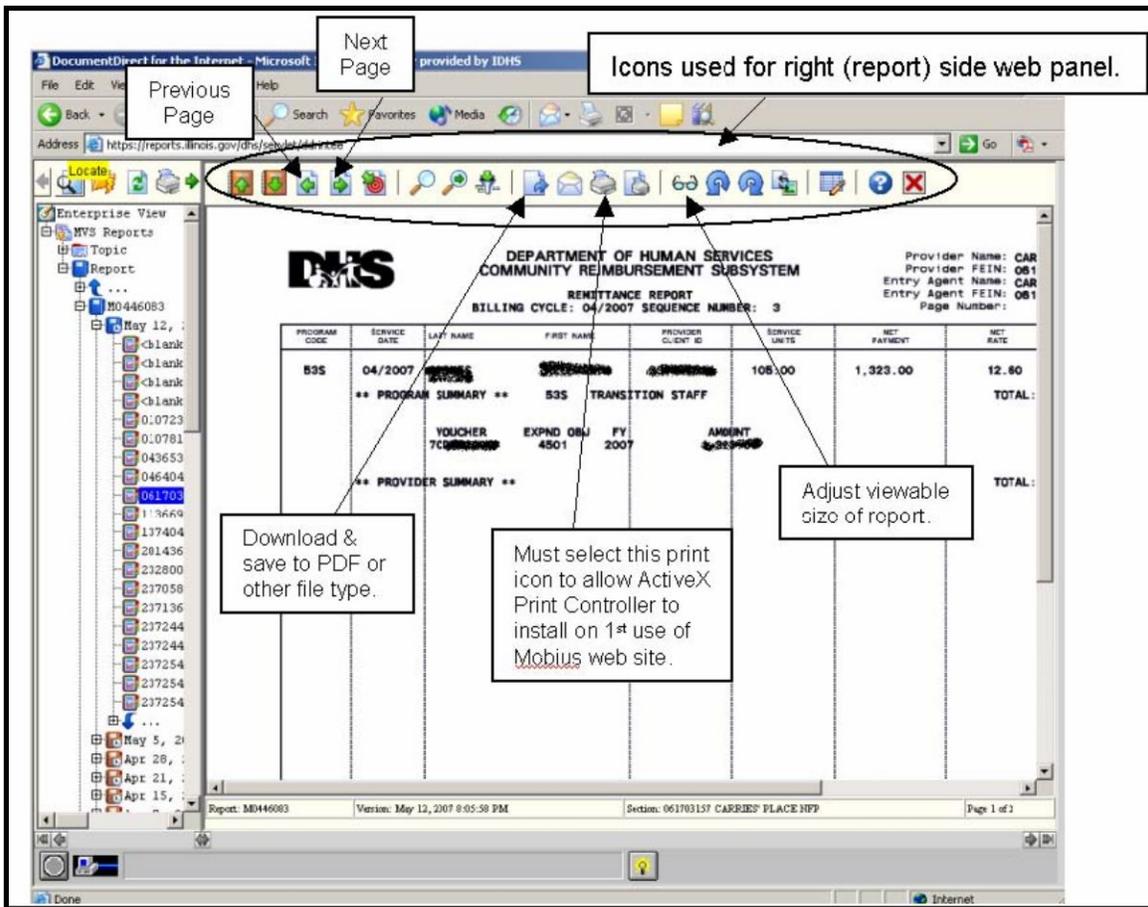


After the report is found, the left side (Enterprise View) will be populated with the date/time the report was moved to Mobius for multiple production schedules. Click on the disk icon and the report will be displayed in the window on the right side of the screen.

If an error message is received indicating, “**The requested list is empty**,” this means no data was submitted by the community agency for that particular production schedule. If another date is selected and data was submitted for that production schedule, the report will appear.



The icon  shown at the top of the screen may be used to search/locate specific information.



Printing:

To activate the Mobius print function, click on the larger printer icon at the top of the screen in the right panel to allow the print application (ActiveX Print Controller) to load to the computer. This only needs to be done once and takes just a few seconds. The popup blocker must be turned off for this application to download.

Verifying that the ActiveX Print Controller has been successfully installed:

On the Document Direct screen, select **Tools** from the menu bar then select **Internet Options** from the drop-down list.



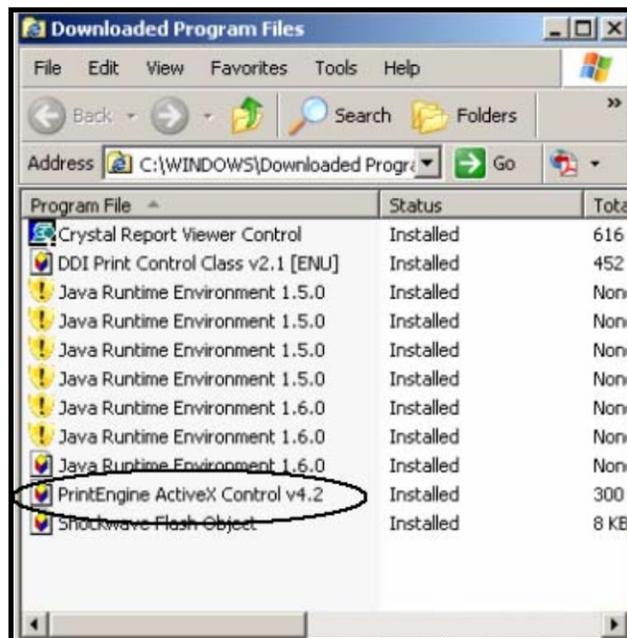
The **Internet Options** window will appear with the **General** tab displayed. Click on **Settings** under **Temporary Internet files** section of the screen.



The **Settings** window will appear. Click on **View Objects**.



After the **Downloaded Program Files** window is displayed PrintEngine ActiveX Control v4.2 will be visible. This indicates the print control installed properly and reports from Mobius will be allowed to print.



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