State of Illinois - Department of Human Services
Substance Use Prevention and Recovery

DARTS

Record Layouts and Descriptions for FY 2020

Revised May 1, 2019

Record Layout for DARTS Patient Master File

Record Name: Patient Master File

System: D.A.R.T.S.

Total Bytes: 1422

Standard Name	Position		Bytes	Reference
	From	Thru		
Master Key:				
Provider Number	1	4	4	
Unique Client/Patient Identifier (RIN)	5	13	9	*(formerly known as Patient ID Number)* For clients opened after 6/30/2007, this field must be the RIN
Open Date				
Open Year	14	17	4	
Open Month	18	19	2	
Open Day	20	21	2	
Demographic Information:				
Name				
Last Name	22	38	17	
First Name	39	50	12	
Middle Initial	51	51	1	
Assessment Date				
Assessment Year	52	55	4	
Assessment Month	56	57	2	
Assessment Day	58	59	2	
Street Address	60	99	40	
City	100	139	40	
State	140	141	2	
Zip Code	142	150	9	
Geocode				
County	151	153	3	
Township	154	155	2	
Birth Date				

Standard Name	Position		Bytes	Reference
	From	Thru		
Birth Year	156	159	4	
Birth Month	160	161	2	
Birth Day	162	163	2	
Provider Patient ID	164	172	9	
No. of children 25 and under	173	174	2	*(Required for ALL clients who have an admission date or service date after 6/30/2014.)*
No. of children living with someone else due to child protection court order	175	176	2	*(Required for ALL clients who have an admission date or service date after 6/30/2014.)*
No. of children for whom patient/client lost parental rights	177	178	2	*(Required for ALL clients who have an admission date or service date after 6/30/2014.)*
Filler	179	179	1	
Primary Language	180	180	1	
Interpreter	181	181	1	
NILF (Not in Labor Force) Detail	182	182	1	
Criminal Justice Referral (CJR) Detail	183	183	1	
Ethnicity	184	184	1	
Race	185	185	1	
Sex	186	186	1	
Marital Status	187	187	1	
Veteran Status	188	188	1	
Patient Type	189	189	1	
Living Arrangement	190	190	1	
Pregnant at Opening	191	191	1	
Source of Income / Support	192	192	1	
Client Identifier Status	193	193	1	
Employment Status	194	194	1	
Filler	195	195	1	
Filler	196	196	1	
Educational Level	197	198	2	

Standard Name	Position		Bytes	Reference
	From	Thru		
Health Insurance	199	199	1	*(formerly known as Third Party Payor)*
Number of Arrests 30 days prior to admission	200	201	2	
Filler	202	202	1	
Filler	203	203	1	
Involved with DCFS	204	204	1	
English Proficiency	205	205	1	
School / Job Training Enrollment	206	206	1	
Substance Abuse Information:				
Problem Area	207	207	1	
Primary Alcohol/Drug Information:				
Problem Code, Primary	208	209	2	*(formerly called 'Primary Drug Abused')*
Frequency, Primary	210	210	1	
Age of First Use, Primary	211	212	2	
Route of Administration, Primary	213	213	1	
Additional Client Information:				
Filler	214	215	2	*(formerly 'Recommended Service Setting')*
Secondary Alcohol/Drug Info:				
Problem Code, Secondary	216	217	2	*(formerly called 'Secondary Drug Abused')*
Frequency, Secondary	218	218	1	
Age of First Use, Secondary	219	220	2	
Route of Administration, Secondary	221	221	1	
Methadone Information				
Methadone Status	222	222	1	
Tertiary Abuse Info: (Note: See Age First Used for Tertiary in position 232)				
Problem Code, Tertiary	223	224	2	*(formerly called 'Tertiary Drug Abused')*
Frequency, Tertiary	225	225	1	
Filler	226	226	1	

Standard Name	Position		Bytes	Reference
	From	Thru		
Route of Administration, Tertiary	227	227	1	
Medical Treatment/Income Info.				
ICD-9/DSM-IV Diagnosis #1	228	233	6	*(Format 999.99)*
ICD-9/DSM-IV Diagnosis #2	234	239	6	*(Format 999.99)*
Age of First Used, Tertiary	240	241	2	
Self-Help Group	242	242	1	
Self-Help Group Detail	243	244	2	
Supportive Interaction	245	245	1	
Family Income	246	251	6	
Income Eligibility Override	252	252	1	
Identification Number (RIN)				
Recipient Identification Number (RIN)	253	261	9	
Medicaid Fields:				
Physician ID	262	271	10	
Third Party Liability Information:				
Payer Name	272	288	17	
TPL Code	289	291	3	
TPL Name				
Last Name	292	311	20	
First Name	312	321	10	
Middle Initial	322	322	1	
Insured ID	323	339	17	
MCO Fields:				
MCO Provider	340	341	2	
MCO Eligibility Begin Date				
MCO Eligibility Begin Year	342	345	4	
MCO Eligibility Begin Month	346	347	2	
MCO Eligibility Begin Day	348	349	2	
Filler	350	355	6	
ICD-10 Diagnosis:				

Standard Name	Position		Bytes	Reference
	From	Thru		
ICD-10 Diagnosis #1	356	363	8	*Format X99.9999 (Required for patients who are opened or have services after 9/30/2015.)*
ICD-10 Diagnosis #2	364	371	8	*Format X99.9999*
ICD-10 Diagnosis #3	372	379	8	*Format X99.9999*
Additional Fields:				
Filler	380	386	7	
ICD-9/DSM-IV Diagnosis #3	387	392	6	*(Format 999.99)*
Filler	393	400	8	
Dependents	401	402	2	
Filler	403	404	2	
Total Number of children in which Primary Care Giver	405	406	2	
Filler	407	409	3	
Filler	410	410	1	*(formerly 'Medicaid Payee Indicator')*
Service Setting Code Table (including Outcome Measures data) OCCURS 12 TIMES				*(This table occupies positions 411 - 1226)*
Service Setting Code			2	
Start Date (for Service Setting Code)				
Start Year			4	
Start Month			2	
Start Day			2	
End Date (for Service Setting Code)				
End Year			4	
End Month			2	
End Day			2	
Discharge Reason			1	
Last Contact Date				
Last Contact Year			4	
Last Contact Month			2	
Last Contact Day			2	
Employment Status (at discharge)			1	

Standard Name	Position		Bytes	Reference
	From	Thru		
Living Arrangement (at discharge)			1	
Education Level (at discharge)			2	
No. of Arrests 30 days prior to discharge			2	
School / Job Training Enrollment (at discharge)			1	
NILF (Not in Labor Force) Detail (since admission)			1	
Baby Delivered during Treatment			1	
Drugfree Baby			1	
Self-Help Group (at discharge)			1	
Self-Help Group Detail (at discharge)			2	
Supportive Interaction (at discharge)			1	
Filler			15	
Problem Code, Primary Information (at discharge):				
Problem Code, Primary (at discharge)			2	
Frequency, Primary (at discharge)			1	
Filler			1	
Problem Code, Secondary Information (at discharge):				
Problem Code, Secondary (at discharge)			2	
Frequency, Secondary (at discharge)			1	
Filler			1	
Problem Code, Tertiary Information (at discharge):				
Problem Code, Tertiary (at discharge)			2	
Frequency, Tertiary (at discharge)			1	
Filler			1	
Other DARTS Fields:				
Close Date				
Close Year	1227	1230	4	

Standard Name	Position		Bytes	Reference
	From	Thru		
Close Month	1231	1232	2	
Close Day	1233	1234	2	
Filler	1235	1238	4	
Cargo field	1239	1247	9	*For third party providers use*
Treatment Episodes	1248	1248	1	
Filler	1249	1254	6	
Filler (LAN-Date)	1255	1260	6	
Filler	1261	1262	2	
Medicaid Eligible	1263	1263	1	
Patient Last Transaction Date	1264	1271	8	
Patient Last Service Date	1272	1279	8	
Filler	1280	1290	11	
Initial Contact Date				
Initial Contact Year	1291	1294	4	
Initial Contact Month	1295	1296	2	
Initial Contact Day	1297	1298	2	
Filler	1299	1308	10	
MISA	1309	1309	1	
Referral Source	1310	1310	1	
Filler	1311	1422	112	

Record Layout for **.FCT** file

Record Name: Patient Transaction File

System: D.A.R.T.S.

Total Bytes: 1354 File Extension: .FCT

Standard Name	Position		Bytes	Reference
	From	Thru		
Transaction Key:				
Provider Number	1	4	4	
Unique Client Identifier	5	13	9	*(formerly known as Patient ID Number)* For clients opened after 6/30/2007, this field must be the RIN
Open Date				
Open Year	14	17	4	
Open Month	18	19	2	
Open Day	20	21	2	
Julian Date	22	26	5	
Transaction Time	27	34	8	
Type of Action	35	35	1	
Key Change	36	36	1	
Filler	37	37	1	
Master Key:				
Provider Number	38	41	4	
Unique Client/Patient Identifier (RIN)	42	50	9	*(formerly known as Patient ID Number)* For clients opened after 6/30/2007, this field must be the RIN
Open Date				
Open Year	51	54	4	
Open Month	55	56	2	
Open Day	57	58	2	
Demographic Information:				
Name				

Standard Name	Position		Bytes	Reference
	From	Thru		
Last Name	59	75	17	
First Name	76	87	12	
Middle Initial	88	88	1	
Assessment Date				
Assessment Year	89	92	4	
Assessment Month	93	94	2	
Assessment Day	95	96	2	
Street Address	97	136	40	
City	137	176	40	
State	177	178	2	
Zip Code	179	187	9	
Geocode				
County	188	190	3	
Township	191	192	2	
Birth Date				
Birth Year	193	196	4	
Birth Month	197	198	2	
Birth Day	199	200	2	
Patient Secondary ID	201	209	9	(optional)
No. of children 25 and under	210	211	2	*(Required for ALL clients who have an admission date or service date after 6/30/2014.)*
No. of children living with someone else due to child protection court order	212	213	2	*(Required for ALL clients who have an admission date or service date after 6/30/2014.)*
No. of children for whom patient/client lost parental rights	214	215	2	*(Required for ALL clients who have an admission date or service date after 6/30/2014.)*
Filler	216	216	1	
Primary Language	217	217	1	
Interpreter	218	218	1	
NILF (Not in Labor Force) Detail	219	219	1	

Standard Name	Position		Bytes	Reference
	From	Thru		
Criminal Justice Referral (CJR) Detail	220	220	1	
Ethnicity	221	221	1	
Race	222	222	1	
Sex	223	223	1	
Marital Status	224	224	1	
Veteran Status	225	225	1	
Patient Type	226	226	1	
Living Arrangement	227	227	1	
Pregnant at Admission	228	228	1	
Source of Income / Support	229	229	1	
Client Identifier Status	230	230	1	
Employment Status	231	231	1	
Filler	232	233	2	
Educational Level	234	235	2	
Health Insurance	236	236	1	*(formerly known as Third Party Payor)*
Number of Arrests 30 days prior to admission	237	238	2	
Filler	239	240	2	
Involved with DCFS	241	241	1	
English Proficiency	242	242	1	
School / Job Training Enrollment	243	243	1	
Substance Abuse Information:				
Problem Area	244	244	1	
Primary Alcohol/Drug Information:				
Problem Code, Primary	245	246	2	*(formerly called 'Primary Drug Abused')*
Frequency, Primary	247	247	1	
Age of First Use, Primary	248	249	2	
Route of Administration, Primary	250	250	1	
Additional Client Information:				
Filler	251	252	2	*(formerly 'Recommended Service Setting)'*
Secondary Alcohol/Drug Info:				

Standard Name	Position		Bytes	Reference
	From	Thru		
Problem Code, Secondary	253	254	2	*(formerly called 'Secondary Drug Abused')*
Frequency, Secondary	255	255	1	
Age of First Use, Secondary	256	257	2	
Route of Administration, Secondary	258	258	1	
Methadone Information				
Methadone Status	259	259	1	
Tertiary Abuse Info: Note: See Age First Used for Tertiary in position 269)				
Problem Code, Tertiary	260	261	2	*(formerly called 'Tertiary Drug Abused')*
Frequency, Tertiary	262	262	1	
Filler	263	263	1	
Route of Administration, Tertiary	264	264	1	
Medical Diag. (ICD-9) / Income Info.				
DSM-4/ICD-9 Diagnosis #1	265	270	6	*(Format 999.99) Required for patients who will be receiving services prior to 10/1/2015*
DSM-4/ICD-9 Diagnosis #2	271	276	6	*(Format 999.99)*
Age of First Used, Tertiary	277	278	2	
Self-Help Group	279	279	1	
Self-Help Group Detail	280	281	2	
Supportive Interaction	282	282	1	
Family Income	283	288	6	
Income Eligibility Override	289	289	1	
Recipient ID Number (RIN)	290	298	9	
Filler	299	376	78	
MCO Fields:				
MCO Provider	377	378	2	
MCO Eligibility Begin Date				
MCO Eligibility Begin Year	379	382	4	
MCO Eligibility Begin Month	383	384	2	
MCO Eligibility Begin Day	385	386	2	

Standard Name	Position		Bytes	Reference
	From	Thru		
Filler	387	392	6	
ICD-10 Diagnosis:				
ICD-10 Diagnosis #1	393	400	8	*Format X99.9999 (Required for patients who are opened or have services after 9/30/2015.)*
ICD-10 Diagnosis #2	401	408	8	*Format X99.9999*
ICD-10 Diagnosis #3	409	416	8	*Format X99.9999*
Additional Fields:				
Filler	417	423	7	
DSM-4/ICD-9 Diagnosis #3	424	429	6	*(Format 999.99)*
Filler	430	437	8	
Number of Dependents	438	439	2	
Filler	440	441	2	
Number of Children in which Primary Care Giver	442	443	2	
Filler	444	447	4	
Service Setting Code Table (including Outcome Measures data) OCCURS 12 TIMES				*(This table occupies positions 448 - 1263)*
Service Setting Code			2	
Start Date (for Service Setting Code)				
Start Year			4	
Start Month			2	
Start Day			2	
End Date (for Service Setting Code)				
End Year			4	
End Month			2	
End Day			2	
Discharge Reason			1	
Last Contact Date				
Last Contact Year			4	
Last Contact Month			2	
Last Contact Day			2	
Employment Status (at discharge)			1	

Standard Name	Position		Bytes	Reference
	From	Thru		
Living Arrangement (at discharge)			1	
Education Level (at discharge)			2	
No. of Arrests 30 days prior to Discharge			2	
School / Job Training Enrollment (at discharge)			1	
NILF (Not in Labor Force) Detail (since admission)			1	
Baby Delivered during Treatment			1	
Drugfree Baby			1	
Self-Help Group (at discharge)			1	
Self-Help Group Detail (at discharge)			2	
Supportive Interaction (at discharge)			1	
Filler			15	
Problem Code, Primary Information (at discharge):				
Problem Code, Primary (at discharge)			2	
Frequency, Primary (at discharge)			1	
Filler			1	
Problem Code, Secondary Information (at discharge):				
Problem Code, Secondary (at discharge)			2	
Frequency, Secondary (at discharge)			1	
Filler			1	
Problem Code, Tertiary Information (at discharge):				
Problem Code, Tertiary (at discharge)			2	
Frequency, Tertiary (at discharge)			1	
Filler			1	
Other DARTS Fields:				
Close Date				
Close Year	1264	1267	4	

Standard Name	Position		Bytes	Reference
	From	Thru		
Close Month	1268	1269	2	
Close Day	1270	1271	2	
Filler	1272	1275	4	
Filler (Cargo field)	1276	1284	9	For use by 3rd Party Systems
Treatment Episodes	1285	1285	1	
Filler	1286	1291	6	*(Reserved)*
Filler (LAN-Date)	1292	1297	6	
Filler	1298	1313	16	*(Reserved)*
Initial Contact Date				
Initial Contact Year	1314	1317	4	
Initial Contact Month	1318	1319	2	
Initial Contact Day	1320	1321	2	
Filler	1322	1331	10	
MISA	1332	1332	1	
Referral Source	1333	1333	1	
Key Change Information:				
Patient ID Key Change	1334	1342	9	
Opening Date Key Change				
Opening Date Year	1343	1346	4	
Opening Date Month	1347	1348	2	
Opening Date Day	1349	1350	2	
Filler	1351	1354	4	

Record Layout for **.FCT** Header Record

Record Name: Patient Transactions Header Record

System: D.A.R.T.S.

Total Bytes: 1354 File Extension: .FCT

Standard Name	Position		Bytes	PIC	Reference
	From	Thru			
Provider Number	1	4	4	X	
Header/Footer Identifier	5	13	9	X	‘000000000' for header record
Filler	14	64	51		
Record Count	65	71	7		
Agency FEIN	72	80	9		
Provider FTP ID	81	88	8		
FTP Sequence Number	89	97	9		Reserved
Primary E-Mail Address	98	137	40		
Secondary E-Mail Address	138	177	40		
Filler	178	1345	1168	X	
File Extension	1346	1348	3	X	'FCT'
3rd Party Identifier Code	1349	1353	5	X	
SUPR Generated Tag	1354	1354	1	X	Reserved

Field Descriptions for Patient Transaction (.FCT) Record

General rules for the DARTS Demographic file:

- There can only be one episode ("Open Date" thru "Close Date") per client for a particular date range.
- A client cannot start a new episode on the same date as the previous episode was closed.
- A record's "Patient Type" cannot be changed from 'I' (Intervention) to 'T' (Treatment) after the initial record was accepted (or vice versa.)
- A "Transaction Type" of '4' (Delete) will not be accepted if there have been services accepted for that client for that date range.
- A "Transaction Type" of '2' (Add) will not be accepted for a client if an episode with an earlier date has not been discharged. A "Transaction Type" of '2' (Add) will be accepted for a client for a prior episode ONLY if it contains complete set of discharge data.

TRANSACTION KEY FIELDS

PROVIDER NUMBER

All numeric and valid provider number

UNIQUE CLIENT IDENTIFIER

For clients opened after 6/30/07, this field must match the RIN (Recipient ID Number) field. For clients opened prior to that date, this field can also be the SSN or a Generated ID number.

OPEN DATE

This is date in which clients can begin to bill for SUPR services and is part of the key of the record. (For clients already opened in DARTS, prior to FY 2010, the Open Date must be the same as the former "Admission Assessment Date" field.)

- Must be valid century, year, month, day
- Cannot be a future date

JULIAN DATE

Valid Julian date (YYDDD) of transaction entry. (For DARTS users, this is the date stamp taken from the computer.)

TRANSACTION TIME

Unique time (HHMMSSSS) of the transaction entry (all numeric). For DARTS users, this field is the time stamp from the computer at the time of entry. This field, along with the Julian Date field, should NOT be identical for every record transmitted to SUPR. The combination of "Transaction Date" and "Transaction Time" and the rest of the key of the record determines the order in which records are processed at the DARTS Mainframe level.

TYPE OF ACTION

2 = Add; 3 = Change (If Changing the Patient ID Number or Opening Date, see "Key Change Cross-Edits" at the end of this section); 4 = Delete

KEY CHANGE

Enter 'X' if changing Patient ID Number or Opening Date; otherwise, leave as space (See "Key Change Cross-Edits" at the end of this section)

CLIENT MASTER FIELDS

PROVIDER NUMBER

All numeric and valid provider number

UNIQUE CLIENT IDENTIFIER

- An assigned 9-digit (all numeric) ID which is unique to that individual.

The RIN (Recipient ID Number) which was assigned by the State of Illinois

- For clients opened after 6/30/07, this Unique Client Identifier field must match the RIN (Recipient ID Number) field.
- For clients billed for services with service dates after 6/30/07, this Unique Client Identifier field must match the RIN (Recipient ID Number) field.
- For clients who have a "Client Identifier Status" = 'D', this "Unique Client Identifier" field must match the RIN.

OPEN DATE

Must be valid century, year, month, day (all numeric). This date must match the Transaction Key Open Date (in columns 14 thru 19) unless a key change is necessary on the Open Date.

DEMOGRAPHICS:

If there is an "(*)" within the list of valid codes, that means that the field can be filled with spaces if "Patient Type" = 'O', which represents an Old record which the provider needs to close; OR if the record is an Intervention demographic (Patient Type = 'I') and the "Open Date" is prior to 7/01/04.

NAME

Last Name and First Name must be entered (*). Middle Initial is optional, but if entered, must be alphabetic.

ASSESSMENT DATE

This is date of the client's Assessment. (For clients opened prior to 7/01/2009, the Assessment Date must be the same as the "Open Date" field.)

- Must be valid century, year, month, day
- Cannot be a future date

STREET ADDRESS

Address must be entered (*)

CITY

City must be entered (*)

STATE

Valid 2-digit state code (*)

ZIP CODE

The first 5-digits must be all numeric (*). It must also be a valid zip code for that state. (For example, if the "State" = 'IL', the "Zip Code" must begin with 60, 61, or 62.) The last 4 places of the 9-digit zip code must be all spaces OR all numeric.

GEOCODE

Valid county/township code (*) if state is 'IL' (see Geocode Manual published by the State of Illinois), otherwise, if out-of-state, must be '10300'.

BIRTH DATE

Must be all numeric, and a valid century, year, month, day. This date cannot be after the current date. This date must be prior to the "Open Date".

INTERNAL CLIENT ID

This is an optional secondary ID field, which can be used to help identify a patient.

NUMBER OF CHILDREN 25 AND UNDER

This is required for ALL clients who have an admission date or service date after 6/30/2014. It must be numeric and cannot be more than 30.

NUMBER OF CHILDREN LIVING WITH SOMEONE ELSE
DUE TO A CHILD PROTECTION COURT ORDER

This is required for ALL clients who have an admission date or service date after 6/30/2014. It must be numeric and cannot be more than 30.

NUMBER OF CHILDREN FOR WHOM PATIENT/CLIENT LOST PARENTAL RIGHTS

This is required for ALL clients who have an admission date or service date after 6/30/2014. It must be numeric and cannot be more than 30.

PRIMARY LANGUAGE

Valid codes are A - P (*). This field is required for clients who are opened after 6/30/07, or have services after 6/30/07.

INTERPRETER

Valid codes are 1 - 3 (*). This field is required for clients who are opened after 6/30/07, or have services after 6/30/07.

NOT IN LABOR FORCE (NILF) DETAIL

- Valid codes are 1 - 9 (*). This field is required for clients who are opened after 6/30/07, or have services after 6/30/07.
- When the answer in the "Employment Status" field is '4' (Not in Labor Force), the NILF field must be '1'- '6', or '8' - '9'.
- When the answer in the "Employment Status" field is any other value than '4', the NILF field must be '7' (Not Applicable).
- If "Not in Labor Force" = '3' (Retired), computed age from Birth date must be > 17

CRIMINAL JUSTICE REFERRAL (CJR) DETAIL

Valid codes are 1 - 8 (*), and must be entered when the "Referral Source" = 'I' (Criminal Justice), for clients who have an admission date or a service date after 6/30/2007.
This field must be a space if the "Referral Source" is any value other than 'I'.

ETHNICITY

Valid codes are 1 - 6 (*). This field is required for ALL clients who have an admission date or service date after 6/30/2007.

RACE

Valid codes are A - F, or L (*)

SEX

Valid codes are 'M' or 'F' (*); (See cross-edit on "Pregnant at Admission")

MARITAL STATUS

Valid codes are 1 - 5 (*);
If computed age from Birth date is < 12, Marital Status must be '1' (Single)

VETERAN STATUS

Valid codes are 'Y' or 'N' (*)

PATIENT TYPE

Valid codes are 'T' (Treatment Patient) and 'I' (Intervention Patient). This field CANNOT be changed from 'T' to 'I' OR from 'I' to 'T'.

LIVING ARRANGEMENT

Valid codes are A - J (*) for clients who's opening date is AFTER 6/30/11.(*)
(For clients opened BEFORE 7/1/11, the valid codes are 1 - 3)

PREGNANT AT ADMISSION

Valid codes are 'Y' or 'N' (*); If "Sex" = 'M', "Pregnant at Admission" must be = 'N'

SOURCE OF INCOME / SUPPORT

Valid codes are 1, 2, 3, 4, 6 (*)

CLIENT IDENTIFIER STATUS

Valid codes are A - D (*). For clients opened after 6/30/07, this entry must be 'D' - RIN.

EMPLOYMENT STATUS

Valid codes are 1 - 4 (*);
If Employment Status = '1' (full-time), computed age from Birth date must be > 11

EDUCATIONAL LEVEL

Must be all numeric and between 00 - 20 (*);
If Educational Level > '09' (high school), computed age from Birth date must be > 9
If Educational Level > '12' (graduate), computed age from Birth date must be > 13
If Educational Level > '16' (post-graduate), computed age from Birth date must be > 18

HEALTH INSURANCE

- Must be 1 - 8 (*).
- If "Health Insurance" = '4' (Medicaid), the RIN must be entered in the RIN field.
- When "Health Insurance" = '4' (Medicaid), the Alcohol/Substance Abuse Diagnosis Code must be a valid HFS Diagnosis Code.
- If "Health Insurance" = '8' (MCO Provider), there must be valid entries in the "MCO Provider" and "MCO Eligibility Begin Date" fields.

NUMBER OF ARRESTS 30 DAYS PRIOR TO ADMISSION

Must be all numeric between 00 - 99 (*). If the "Open Date" is after 6/30/2008, this field cannot be more than 30.

INVOLVED WITH DCFS

Must be 'Y' or 'N' (*). This field is required if the "Open Date" is after 6/30/2004.

ENGLISH PROFICIENCY

Must be 'Y' or 'N' (*). Also, this field must be 'Y', if the "Primary Language" = 'A' (English).

SCHOOL / JOB TRAINING ENROLLMENT

If the Opening Date is > 6/30/2011, this field must be 1 - 3(*). This field is defaulted as '1' (Not Enrolled), if the "Not in Labor Force" = '5' (Inmate of Institution).

SUBSTANCE INFORMATION:
(For additional substance information editing, also see the "Problem Area Cross-edits" listed at the end of this section)

PROBLEM AREA
Must be 1 - 7 (*).

PROBLEM CODE, PRIMARY
There are three places for "Problem Codes" to be entered. If '01' (None) is entered in the "Problem Code, Primary" field, '01' (None) must also be entered in "Problem Code, Secondary" and "Problem Code, Tertiary". The only Problem Code, which can be repeated in the three Problem Code fields, is '01' (None). The valid Problem Codes (*) are:

01 (None)	14 (Tranquilizers)
02 (Alcohol)	15 (Barbiturates)
03 (Cocaine/Crack)	16 (Other Non-Barbiturate Sedatives or Hypnotics)
04 (Marijuana/Hashish)	17 (Inhalants)
05 (Heroin)	18 (Over-the-counter)
06 (Non-Prescribed Methadone)	19 (Nicotine)
07 (Other Opiates and Synthetics)	20 (Other)
08 (PCP-phencyclidine)	21 (Gambling)
09 (Other Hallucinogens)	22 (Ecstasy)
10 (Methamphetamine)	23 (Rohypnol)
11 (Other Amphetamines)	24 (Steroids)
12 (Other Stimulants)	25 (Ephedrine/Pseudoephedrine)
13 (Benzodiazepine)	

FREQUENCY, PRIMARY
Must be 1 - 5 (*). (For Intervention clients ("Patient Type" = 'I'), the field can be spaces if the "Open Date" is prior to 7/01/2002, but is required for any client for whom services were reported since FY03.)

AGE AT FIRST USE, PRIMARY
Must be all numeric (*). This age must not be greater than the present age of the patient as calculated from the "Birth Date".
"Age of First Use, Primary" must be spaces, if any of the following apply:

- "Problem Code, Primary" = '01' (None) or '21' (Gambling)
- The client is an Intervention Client ("Patient Type" = 'I')
- "Problem Area" = '4' (Co-Dependent) or '5' (None)

ADMINISTRATION ROUTE, PRIMARY

This field must be 1 - 5 (*). Cross-edits are as follows:

- If "Problem Code, Primary" = '01', this "Administration Route" must = '5'
- If "Problem Code, Primary" = '02', this "Administration Route" must = '1'
- If "Problem Code, Primary" = '08', this "Administration Route" must = '2' or '3' or '4'
- If "Problem Code, Primary" = '17', this "Administration Route" must = '3'
- If "Problem Code, Primary" = '21', this "Administration Route" must = '5'
- If "Problem Code, Primary" = '22' ,this "Administration Route" must = '1' or '4'
- If "Problem Code, Primary" = '23', this "Administration Route" must = '1'
- If "Problem Code, Primary" = '24', this "Administration Route" must = '1' or '4'
- If "Problem Code, Primary" = '25', this "Administration Route" must = '1' or '3'

PROBLEM CODE, SECONDARY

- Refer to edit checks above in "Problem Code, Primary".
- This field should be entered when there is a secondary problem code for the client, and edits will require the field in certain situations (i.e. "Problem Area" cross-edits).
- If any one of the 4 fields of secondary drug information is entered, then required Secondary Problem information must be entered.
- The Secondary Problem fields cannot be entered unless the Primary Problem fields are entered.

FREQUENCY, SECONDARY

Refer to edit checks above in "Frequency, Primary".

AGE AT FIRST USE, SECONDARY

Refer to edit checks above in "Age of First Use, Primary". ("Age at First Use, Secondary" is not required for any client who was opened prior to 7/01/07 AND who has not received services since 7/01/07).

ADMINISTRATION ROUTE, SECONDARY

Refer to edit checks above in "Administration Route, Primary"

METHADONE STATUS

Must be 'Y' or 'N' (*). The only time "Methadone Status" can = 'Y' is when "Problem Code, Primary", "Primary Code, Secondary", or "Primary Code, Tertiary" = '05' or '06' or '07'.

PROBLEM CODE, TERTIARY

- Refer to edit checks above in "Problem Code, Primary".
- This field should be entered when there is a tertiary problem code for the client, and edits will require the field in certain situations (i.e. "Problem Area" cross-edits).
- If any one of the 4 fields of tertiary drug information is entered, then required Secondary Problem information must be entered.
- The Tertiary Problem fields cannot be entered unless the Primary and Secondary Problem fields are entered.

FREQUENCY, TERTIARY

Refer to edit checks above in "Frequency, Primary".

ADMINISTRATION ROUTE, TERTIARY

Refer to edit checks above in "Administration Route, Primary".

MEDICAL DIAGNOSIS ICD-9/DSM-IV (#1)

- *This field is only required for patients who are opened prior to 10/01/2015*
- Refer to ICD-9 or DSM IV manuals for a list of valid codes.
- This field is required (*) for any client who has a "Patient Type" = 'T' (Treatment).
- Diagnosis Codes are not allowed for clients who have a "Patient Type" = 'I'.
- Diagnosis codes cannot be repeated in any of the three diagnosis fields.
- When MISA = 'Y', one of the three Medical Diagnosis codes (ICD-9/DSM-IV) must be a Mental Health Diagnosis code (which do not begin with 291, 292, 303, 304, or 305).
- When "Health Insurance" = '4' (Medicaid), the Alcohol/Substance Abuse Diagnosis Code must be a valid HFS Diagnosis Code.
- If "Problem Area" = '1', '2', '3', or '6', either the first or second diagnosis code must begin with 291, 292, 303, 304, or 305.

MEDICAL DIAGNOSIS ICD-9/DSM-IV (#2)

Refer to edit checks above in "Medicaid Diagnosis ICD-9/DSM-IV (#1)". This field may be used if the client has a second diagnosis code. *(This field is only used for treatment patients who are opened prior to 10/01/2015)*

AGE AT FIRST USE, TERTIARY

Refer to edit checks above in "Age of First Use, Primary". ("Age at First Use, Tertiary" is not required for any client who was opened prior to 7/01/07 AND who has not received services since 7/01/07).

SELF-HELP GROUP

Must be 'Y', 'N', 'R', or 'D' (*) and is required for all clients opened after 6/30/2007, OR who received a service after 6/30/2007.

SELF-HELP GROUP DETAIL

If "Self-Help Group" = 'Y', this field must be a 2-digit number, 'RF', or 'DK' (*) for all clients opened after 6/30/2007, OR received a service after 6/30/2007.
If the client has a "Self-Help Group" entry other than 'Y', this field must be spaces.

SUPPORT INTERACTION

Must be 'Y', 'N', 'R', or 'D' (*)

FAMILY INCOME

All numeric (*)

INCOME ELIGIBILITY OVERRIDE

For Patients who are billed toward the contract and are beyond the income eligibility limits, enter a '1'-'7' to override the limits due to hardship guidelines (addressed in the Contractual and Policy Manual). For any patient who was opened after 6/30/08 OR receive services after 6/30/08, a value of '1' - '7' is required. (For a patient who was opened prior to that date and received no services prior to FY09, a 'Y' is an acceptable value.) If the client is not beyond the income eligibility limits, this field should be filled with a space.

The Patient Income Eligibility criteria is 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

RECIPIENT IDENTIFICATION NUMBER (RIN)

The RIN is an assigned number from the state of Illinois. An algorithm is also used in the system to whereas the 9th digit is a check digit. The RIN is required for:

- All Medicaid clients (Health Insurance = '4')
- All clients opened after 6/30/2007
- Any client who receives a service after 6/30/2007

MCO (Managed Care Organization) Provider

When the "Health Insurance" field is an '8' (MCO Provider), enter the code for the MCO Provider.

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

MCO (Managed Care Organization) Start Date

When the "Insurance Type" field is an '8' (MCO Provider), there must be a valid date entered into the "MCO Eligibility Begin Date" field, and the date must be after Apr. 30, 2011.

MEDICAL DIAGNOSIS ICD-10 (#1)

- If the Opening Date is after 9/30/2015 OR there are any services for the client with a Service Date after 9/30/2015, the following ICD-10 code edits will be made:
  - There must be a valid ICD-10 code (checked against the valid ICD-10 table)
  - ICD-10 Codes cannot be repeated
  - If the Problem Area is 1, 2, 3, or 6 (alcohol/drugs), there must be at least one valid ICD-10 code starting with F10, F11, F12, F13, F14, F15, F16, (F17 is tobacco – this can only be entered as a "secondary" code), F18, F19.
  - If the Problem Area is 4 (codependent), the ICD-10 code must Z65.8
  - If the Problem Area is 5 (No diagnosis), the ICD-10 code must be Z03.89
  - If the Problem Area is 6 (alcohol/drugs and gambling codes), there must be one valid ICD-10 gambling code as F63.0 in one of the ICD-10 diagnosis codes
  - If the Problem Area is 7 (gambling only), the diagnosis code must be F63.0
  - If the MISA/Dually Diagnosed field is answered "Y", there must be at least one mental health ICD-10 code (valid codes starting with F01-F09, or F20-F99) in one of the ICD-10 diagnosis code fields

MEDICAL DIAGNOSIS ICD-10 (#2)

(See above edits in ICD-10 (#1))

MEDICAL DIAGNOSIS ICD-10 (#3)

(See above edits in ICD-10 (#1))

MEDICAL DIAGNOSIS ICD-9/DSM (#3)

Refer to edit checks above in "Medicaid Diagnosis ICD-9/DSM (#1)". This field may be used if the client has a third diagnosis code. (*This field is only used for treatment patients who are opened prior to 10/01/2015.)*

NUMBER OF DEPENDENTS

All numeric and greater than zeroes (*). This number cannot be more than 30 (for clients opened after 6/30/08).

NUMBER IN WHICH PRIMARY CARE GIVER

All numeric (*)

SERVICE SETTING CODE TABLE

The following fields in this table occur 12 times within the record layout. As a client moves between the various Service Settings (listed below), the code must be entered into the table in the record, along with the "Start Date". When the client leaves that Service Setting, an "End Date" must be entered into the record, along with the complete set of additional Outcome Measurement questions. This continues until the client has been discharged from all "Service Settings". To close the record, the "Closing Date" must be entered.

SERVICE SETTING CODE

The following 2-digit codes are valid:
'OP' (Outpatient)
'OR' (Intensive Outpatient)
'RR' (Residential Rehabilitation)
'DX' (Detoxification)
'HH' (Residential Extended Care (Halfway House))
'RH' (Recovery Home)
'IN' (Intervention) Only valid if the Client has a Patient Type of 'I'
(This will be the ONLY Service Setting Code Entry on the table for these clients.)
'FY' - for clients with an Open Date before 7/01/09
(This will be the ONLY Service Setting Code Entry on the table for these clients.)
'AS' - for Treatment clients who only have an assessment
(This will be the ONLY Service Setting Code Entry on the table for these clients.)

For clients with a "Patient Type" of 'I' (Intervention), the "Service Setting Code" must be 'IN'. There will be only one occurrence in the Service Setting Code Table, the "Service Setting Start Date" will be the same as the "Open Date", and the "Service Setting End Date" will be identical to the "Closing Date".

For clients opened prior to 07/01/2009, there can only be one occurrence in the Service Setting Table. The "Service Setting Code" will be 'FY', the "Service Setting Start Date" will be the same as the "Open Date", and the "Service Setting End Date" will be identical to the "Closing Date".

For clients with a "Problem Area" of '5' (No Problem), there will be only one occurrence in the Service Setting Code Table, the "Service Setting Start Date" "Service Setting End Date", and "Closing Date" will be the same as the "Open Date", while the Discharge Reason will be 'A'.

START DATE *(for Service Setting Code)*

Must be all spaces or a valid century, year, month, and day. This date:

- Cannot be a future date
- Must be greater than or equal to the "Open Date"
- Must be on the date of the first service entered for the client for that Setting Code

DISCHARGE DEMOGRAPHIC INFORMATION:
(The following Discharge Outcome Measures Data Set can only be entered (and is then mandatory) when the "End Date" and "Discharge Reason" for the Service Setting occurrence have been completed. The only exceptions are if the "Problem Area" code is '4' or '5, OR the "Discharge Reason" is 'C' or 'G', OR the "End Date" is prior to '7/01/2000', OR this is an Intervention client (Patient Type = 'I') who was closed prior to 7/01/04)

END DATE *(for Service Setting Code)*

Must be all spaces or a valid century, year, month, and day. This date CANNOT be:

- A future date
- Must be greater than the "Open Date"
- Must be on the date of the last service entered for the client for that Setting Code
- When billing a "Program Number" '48' with an "Activity Code" of '71' (Assessment Discharge) on the service record, the client/patient must have the same date entered on the corresponding demographic record's "Discharge Date" as was entered on the service date for the service.

DISCHARGE REASON *(for Service Setting Code)*

- Must be a space, A, B, C, D, F, G, H, I, J, T, U, V.
- The value of 'E' is valid if the End Date is before 7/1/2009.
- The value of 'H' is valid if the End Date is after 2/28/2011 OR before 7/1/2009.
- The value of 'V' is valid if the End Date is after 2/28/2011.
- The value of 'A' can only be used with the "Problem Area" of '5' (None)

LAST CONTACT WITH PATIENT *(at time of discharge from Service Setting Code)*
Must be all spaces, OR a valid century, year, month, and day. This date CANNOT be:

- A future date
- A date prior to the "Open Date"
- A date later than the "Discharge Assessment Date"

This date was not required for those clients discharged prior to 12/31/2004.

EMPLOYMENT STATUS *(at time of discharge from Service Setting Code)*

Valid codes are 1 - 4 (*)

LIVING ARRANGEMENT *(at time of discharge from Service Setting Code)*

Valid codes are A - J (*) for clients who's transfer/discharge date is AFTER 6/30/11. (*)
(For clients with a transfer/discharge date BEFORE 7/1/11, the valid codes are 1 - 3)

EDUCATIONAL LEVEL *(at time of discharge from Service Setting Code)*

Must be all numeric between 00 - 20 (*) This field cannot be less than the response given for the "Educational Level" when the client was first admitted.

NUMBER OF ARRESTS 30 DAYS PRIOR TO DISCHARGE
(at time of discharge from Service Setting Code)

This field must be an all numeric between 00 - 30 (*).

SCHOOL / JOB TRAINING ENROLLMENT *(at time of discharge from Service Setting Code)*

If the Discharge Date is > 6/30/2011, this field must be 1 - 3(*). (This field is defaulted as ‘1' (Not Enrolled), if the ANot in Labor Force” = ‘5' (Inmate of Institution)).

NOT IN LABOR FORCE (NILF) DETAIL *(at time of discharge from Service Setting Code)*

Valid codes are 1 - 9 (*). This field is required to be 1 - 6, or 8-9, if the Employment Status *(at time of discharge/closing)* is ‘4'; otherwise the response should be ‘7'. (This field is required for any client who was closed after 6/30/07.)

DELIVERED BABY DURING TREATMENT *(at time of discharge from Service Setting Code)*

Valid codes are ‘Y' or ‘N' (*). If Sex = ‘M’, this field cannot be ‘Y’.

DRUG FREE BABY *(at time of discharge from Service Setting Code)*

Valid codes are 'Y' or 'N'; This is a required field when “Delivered Baby During Treatment” = ‘Y’. If “Delivered Baby During Treatment” = ‘N’, this field CANNOT be answered as ‘Y’. Also if Sex = ‘M’, this field CANNOT be ‘Y’.

SELF-HELP GROUP *(at time of discharge from Service Setting Code)*

Must be ‘Y’, ‘N’, ‘R’, or ‘D’ (*) and is required for clients opened after 6/30/2007.

SELF-HELP GROUP DETAIL *(at time of discharge from Service Setting Code)*

- If “Self-Help Group” = ‘Y’, this field must be a 2-digit number, ‘RF’, or ‘DK’ (*) for clients opened after 6/30/2007.
- If the client has a “Self-Help Group (at time of discharge/closing)” entry other than ‘Y’, this field must be spaces.

SUPPORT INTERACTION *(at time of discharge from Service Setting Code)*

Must be ‘Y’, ‘N’, ‘R’, or ‘D’ (*) and is required for clients opened after 6/30/2007.

PROBLEM CODE, PRIMARY *(at time of discharge from Service Setting Code)*

- Refer to valid Problem Codes above in “Problem Code, Primary” (at time of admission) (*)
- Required for all Treatment clients, and for Intervention clients who were closed after 6/30/2002.
- This field will be ‘01' (None) for clients who have a “Problem Area” of ‘4' (Co-Dependent) or ‘5' (None).

FREQUENCY, PRIMARY *(at time of discharge from Service Setting Code)*

Must be 1 - 5 (*) for clients who were closed after 6/30/2002. For clients who have a “Problem Area, Primary (at time of discharge/closing)” of ‘4' (Co-Dependent) or ‘5' (None), this field will be ‘1' (None within one month prior to discharge.)

PROBLEM CODE, SECONDARY *(at time of discharge from Service Setting Code)*

- Refer to valid Problem Codes above in "Problem Code, Primary". (at time of admission).
- The "Problem Code, Secondary (at time of discharge/closing)" cannot be entered with a value greater than '01' (None), unless the Primary Problem fields (at time of discharge/closing) are entered.
- This field will be '01' (None) for clients who have a "Problem Area" of '4' (Co-Dependent) or '5' (None).

FREQUENCY, SECONDARY *(at time of discharge from Service Setting Code)*

Must be 1 - 5 (*) for clients who were closed after 6/30/2002. For clients who have a "Problem Area, Secondary (at time of discharge/assessment)" of '4' (Co-Dependent) or '5' (None), this field will be '1' (None within one month prior to discharge).

PROBLEM CODE, TERTIARY *(at time of discharge from Service Setting Code)*

- Refer to valid Problem Codes above in "Problem Code, Primary". (at time of admission).
- The "Problem Code, Tertiary (at time of discharge/closing)" cannot be entered with a value greater than '01' (None), unless the Primary and Tertiary Problem fields (at time of discharge/closing) have been entered.
- This field will be '01' (None) for clients who have a "Problem Area" of '4' (Co-Dependent) or '5' (None).

FREQUENCY, TERTIARY *(at time of discharge from Service Setting Code)*

Must be 1 - 5 (*) for clients who were closed after 6/30/2002. For clients who have a "Problem Area, Tertiary (at time of discharge/closing)" of '4' (Co-Dependent) or '5' (None), this field will be '1' (None within one month prior to discharge).

ADDITIONAL DARTS FIELDS

CLOSE DATE

Edits for this date include:

- Must be valid century, year, month, day
- Cannot be a future date
- Must be on or after each of the "End Dates" in the Service Setting Table, Open Date, Initial Contact Date, and Assessment Date

CARGO FIELD

This field is reserved for the use by third party providers.

PRIOR TREATMENT EPISODES

This field must be numeric (*).

INITIAL CONTACT DATE (Date of First Contact)

- Must be valid century, year, month, day (all numeric) (*).
- Cannot be after the "Open Date" or "Assessment Date"
- Cannot be more than 6 months prior to the "Open Date" (for clients opened after 6/30/08)
- The age computed from the Date of Birth must be > 6 at Date of First Contact

MISA

- Must be 'Y' or 'N' (*).
- If MISA = 'Y', there must include one mental health diagnosis in the diagnosis fields. *(For ICD-10 codes, these are codes which do NOT begin with F10, F11, F12, F13, F14, F15, F16, F17, F18, or F19. For ICD-9 codes, these are codes which do NOT Start with '291', '292', '303', '304', or '305'.)*
- If the "Patient Type" = 'I' (Intervention) and the "Open Date" is after 6/30/08, the "MISA" field must be 'N'.

REFERRAL SOURCE

- Must be A - I, J, K, or R (*).
- If Referral Source is 'J' (DCFS), the field "Involved with DCFS" must be 'Y'.

Key Change Data

UNIQUE CLIENT IDENTIFIER KEY CHANGE

Must be spaces, SSN, or Generated ID. (See below for Key Change Cross-Edits)

ADMISSION DATE KEY CHANGE

Must be spaces, or valid century, year, month, day (See below for Key Change Cross-Edits)

KEY CHANGE CROSS-EDITS

If there needs to be a change to a Unique Client Identifier or the Admission Date of a record, do the following:

- "Transaction Type" must be '3'
- "Key change" must be 'X'
- Enter the updated Client Identifier Status (position 222)
- The old key information must be in the transaction key information (positions 5 - 21)
- The new key information must be in the master record fields (positions 42 - 58)
- The new key information must be in the key change fields (positions 556 - 572)

PROBLEM AREA CROSS-EDITS

The following cross-edits apply for the "Problem Area" field:

If the "Problem Area" = '1',

- "Problem Code, Primary" must = '02'
- If the Opening Date is after 9/30/2015, OR there is a service for the client after 9/30/2015, there must be at least one valid ICD-10 code starting with F10, F11, F12, F13, F14, F15, F16, (F17 is tobacco – this can only be entered as a "secondary" code), F18, F19.
- If the Opening Date is before 10/01/2015, one of the ICD-9 diagnosis codes must begin with '291', '292, '303', '304', or '305'

If the "Problem Area" = '2',

- "Problem Code, Primary" must be a valid drug code, but must not be '01', '02', '19', or '21'.
- If the Opening Date is after 9/30/2015, OR there is a service for the client after 9/30/2015, there must be at least one valid ICD-10 code starting with F10, F11, F12, F13, F14, F15, F16, (F17 is tobacco – this can only be entered as a "secondary" code), F18, F19.
- If the Opening Date is before 10/01/2015, one of the ICD-9 diagnosis codes must begin with '291', '292, '303', '304', or '305'

If the "Problem Area" = '3',

- "Problem Code, Primary" must be a valid drug code, but must not be '01' ,'19', or '21'
- "Problem Code, Secondary" must be a valid drug code, but must not be '01', '19', or '21'
- One of the Problem Codes must be '02' (Alcohol), and the other must be a Problem Code OTHER than '01', '02', '19' or '21'
- If the Opening Date is after 9/30/2015, OR there is a service for the client after 9/30/2015, there must be at least one valid ICD-10 code starting with F10, F11, F12, F13, F14, F15, F16, (F17 is tobacco – this can only be entered as a "secondary" code), F18, F19.
- If the Opening Date is before 10/01/2015, one of the ICD-9 diagnosis codes must begin with '291', '292, '303', '304', or '305'

If the "Problem Area" = '4' :

- "Methadone Status" must be space
- "Age at First Use, Primary," "Age of First Use, Secondary," and "Age of First Use, Tertiary" must be spaces
- "Problem Code, Primary," "Problem Code, Secondary" and "Problem Code, Tertiary" must be '01' (none).
- "Frequency, Primary," "Frequency, Secondary" and "Frequency, Tertiary" must be '1' (None within one month prior to admission)
- "Route of Administration" for all 3 Drugs must be '5' (not applicable)
- If the Opening Date is after 9/30/2015, OR there is a service for the client after 9/30/2015, the ICD-10 code must be Z65.8, and the second and third ICD-10 diagnosis code must be spaces. (Z65.8 can only be used in the ICD-10 field when the "Problem Area" = '4'.)

- If the Opening Date is before 10/01/2015, the first "Diagnosis Code (ICD-9/DSM-IV) must be 'V61.9 ' and the second and third "Diagnosis Code" must be spaces. (V61.9 can only be used when the "Problem Area" = '4')
- This "Problem Area" can ONLY be used for clients who have a "Patient Type" of 'T'.
- When billing services, the only valid services are to the procedure codes of 'AAS' (Assessment), 'OPI' (Outpatient Individual), 'OPG' (Outpatient Group), 'CMH'(Case Mgt.), or 'PEV' (Psych. Eval).

If the "Problem Area" = '5':

- "Methadone Status" must be space
- "Age at First Use, Primary," "Age of First Use, Secondary," and "Age of First Use, Tertiary" must be spaces
- "Problem Code, Primary," "Problem Code, Secondary" and "Problem Code, Tertiary" must be '01'.
- "Frequency, Primary", "Frequency, Secondary", and "Frequency, Tertiary" must be '1' (None within one month prior to admission)
- "Route of Administration" for all 3 Drugs must be '5'
- If the Opening Date is after 9/30/2015, OR there is a service for the client after 9/30/2015, the ICD-10 code must be Z03.89, and the second and third ICD-10 diagnosis code must be spaces. Z03.89 can only be used in the ICD-10 field when the "Problem Area" = '5'.)
- If the Opening Date is before 10/01/2015, the first "Diagnosis Code (ICD-9/DSM-IV) must be 'V71.09 ' and the second and third "Diagnosis Code" must be spaces. ('V71.09' can only be used when the "Problem Area" = '5')
- This "Problem Area" can ONLY be used for clients who have a "Patient Type" of 'I' (Intervention).
- The "Open Date" must be the same as the "Discharge Assessment Date"
- The "Reason for Discharge/Closing" must be 'A'
- When billing services, the only valid service is to procedure codes of 'AAS' (Assessment).

If the "Problem Area" = '6',

- In one of the "Problem Codes", one must be '21', and the other must be a different valid Problem Code number other than '01' or '19'
- "Frequency of Use" for the gambling code must be '1'
- "Route of Administration for the gambling code must be '5'
- If the Opening Date is after 9/30/2015, OR there is a service for the client after 9/30/2015, there must be at least one valid ICD-10 code starting with F10, F11, F12, F13, F14, F15, F16, (F17 is tobacco – this can only be entered as a "secondary" code), F18, F19; <u>AND</u> there must be a valid ICD-10 gambling code as F63.0.
- If the Opening Date is before 10/01/2015, one "Diagnosis Code (ICD-9/DSM-IV) must be populated with '291', '292, '303', '304', or '305'; <u>AND</u> 312.30 or 312.31 in the other. (Diagnosis codes of 312.30 and 312.31 can only be used when the "Problem Area" is '6' or '7'.)
- This "Problem Area" can only be used by providers who have a Gambling Initiative contract with SUPR.

If the "Problem Area" = '7',

- "Methadone Status" must be spaces
- "Problem Code, Primary" must be '21'
- "Route of Administration, Primary" must be '5'

- “Problem Code, Secondary” and “Problem code, Tertiary” must be ‘01'
- If the Opening Date is after 9/30/2015, OR there is a service for the client after 9/30/2015, the first ICD-10 diagnosis code must be the gambling code of F63.0. The diagnosis codes cannot be alcohol/drug codes starting with F10, F11, F12, F13, F14, F15, F16, F18, F19.
- If the Opening Date is before 10/01/2015, the first “Diagnosis Code (ICD-9/DSM-IV) must be 312.30 or 312.31. (Diagnosis codes of 312.30 and 312.31 can only be used when the “Problem Area” is ‘6' or ‘7'). The diagnosis codes cannot include a code which begins with ‘291', ‘292, ‘303', ‘304', or ‘305'
- This “Problem Area” can only be used by providers who have a Gambling Initiative contract with SUPR.

Record Layout for **.FBT** file

Record Name: Services Transaction File

System: D.A.R.T.S.

Total Bytes: 400 File Extension: .FBT

Standard Name	Position		Bytes	PIC	Reference
	From	Thru			
Service Key:					
Provider Number	1	4	4	9	
Filler	5	6	2	X	
Patient Identification Number	7	15	9	X	
Begin Service Date					
Begin Service Year	16	19	4	9	
Begin Service Month	20	21	2	9	
Begin Service Day	22	23	2	9	
Start Service Time					(For all Case Mgt., Intervention, Level 1 and Level 2 services)
Start Hour	24	25	2	9	
Start Minute	26	27	2	9	
Start AM/PM	28	28	1	X	
Unit Number	29	32	4	9	
Program Number	33	34	2	9	
Hour/Day Indicator	35	35	1	X	
Julian Date	36	40	5	9	
Transaction Time	41	48	8	9	
Alternate Key Fields:					
Funding Indicator	49	50	2	X	
Service Data:					
Staff ID	51	59	9	X	(For all Case Mgt., Intervention, Level 1 and Level 2 services)
Collateral Client ID	60	68	9	X	
Filler (Recipient Code)	69	69	1	X	Coded at SUPR
Service Type	70	70	1	X	(For all Case Mgt., Intervention, Level 1 and Level 2 services)

Standard Name	Position		Bytes	PIC	Reference
	From	Thru			
Group ID	71	75	5	X	(For Intervention, Level 1 and Level 2 services)
Video Counseling	76	76	1	X	(For Individual, Counseling group, didactic group, psych evaluation, and med. monitoring)
Filler	77	80	4	X	*(Reserved)*
Service Hours	81	81	1	X	(For all Case Mgt., Intervention, Level 1 and Level 2 services)
Service Minutes	82	83	2	X	(For all Case Mgt., Intervention, Level 1 and Level 2 services) (Quarter hour increments)
Filler (Service Days)	84	85	2	X	Computed at SUPR
Toxicology Screens	86	86	1	X	(For Toxicology Program Only)
Activity Code	87	89	3	X	(For all Case Mgt., Intervention, Level 1 and Level 2 services)
Revision Code	90	90	1	X	
Filler	91	101	11	X	
Psych. Eval. Code	102	102	1	X	(For Level 3, Withdrawal Managment programs only)
Filler	103	103	1	X	
Dedicated Funding Code	104	104	1	X	
Filler	105	105	1	X	
Billing Information:					
Name					
Last Name	106	122	17	X	
First Name	123	134	12	X	
Middle Initial	135	135	1	X	
Birth Date					(Required for ALL Patients except for CIH and INT billings)
Birth Year	136	139	4	X	
Birth Month	140	141	2	X	
Birth Day	142	143	2	X	
Service End Date					
Service End Year	144	147	4	X	
Service End Month	148	149	2	X	
Service End Day	150	151	2	X	

Standard Name	Position		Bytes	PIC	Reference
	From	Thru			
Filler	152	155	4		
Site Number	156	157	2	X	(For all Intervention, Case Mgt. and Assessment Services)
Specialized Funding Additional Info:					
Sex	158	158	1	X	(Required for Childcare Residential Clients Only)
Mother's Unique Client Identifier	159	167	9	X	(Required for Childcare Residential Clients Only)
RIN Number					
Recipient ID Number (RIN)	168	176	9	X	
Medicaid Demographic Information:					
Diagnosis Code ICD-10 *(or ICD-9/DSM-IV Diagnosis for service date before 10/1/2015)*	177	184	8	X	This field is left justified. *(ICD-10's must be used if service date is after 9/30/2015)* X99.9999 (ICD-10 format) *(if the service date is after 9/30/2015)* 999.99 (ICD-9 format) *(if the service date is before 10/01/2015)*
Filler	185	185	1	X	
Filler	186	186	1	X	
Physician's ID	187	196	10	X	
Filler	197	197	1	X	*(formerly Payee Indicator)*
TPL Payer Name	198	214	17	X	
TPL Code	215	217	3	X	
TPL Insured's Name					
TPL Insured's Last Name	218	237	20	X	
TPL Insured's First Name	238	247	10	X	
TPL Insured's Middle Initial	248	248	1	X	
TPL Insured's ID	249	265	17	X	
More Service Information Section:					
Filler (Procedure Code)	266	268	3	X	Entered at SUPR by referencing the provider unit/program file
Medicaid Services Section:					

Standard Name	Position		Bytes	PIC	Reference
	From	Thru			
Filler (Formerly Occurrence End Year)	269	276	8	X	
Filler (Covered Days)	277	278	2	X	Computed at SUPR
Filler (Non-covered Days)	279	280	2	X	Computed at SUPR
Filler (formerly Medicaid Hours of Service)	281	283	3	X	
Due from Patient	284	290	7	X	99999V99
TPL Status	291	292	2	X	
TPL Payer Amount	293	299	7	X	99999V99
TPL Paid Date					
TPL Paid Year	300	303	4	X	
TPL Paid Month	304	305	2	X	
TPL Paid Day	306	307	2	X	
Misc. Data:					
Filler (ARC Number)	308	317	10		
Filler	318	338	21	X	*Reserved*
End Service Time					Computed at SUPR
End Hour	339	340	2	9	
End Minute	341	342	2	9	
End AM/PM	343	343	1	X	
Filler	344	366	23	X	
Cargo Field	367	375	9	X	
Filler (LAN-Date)	376	381	6	X	
Filler	382	392	11	X	
Open Date (on Demographic Record)					Must match the Patient Demographic Record that was submitted
Open Year	393	396	4	X	
Open Month	397	398	2	X	
Open Day	399	400	2	X	

Record Layout for **.FBT** Header Record

Record Name: Services Header Record

System: D.A.R.T.S.

Total Bytes: 400 File Extension: .FBT

Standard Name	Position		Bytes	PIC	Reference
	From	Thru			
Provider Number	1	4	4	X	
Record Count	5	11	7	X	
Record Type	12	12	1	X	AH" for Header Record
Agency FEIN	13	21	9		
Provider FTP ID	22	29	8		
FTP Sequence Number	30	38	9		Reserved
Primary E-Mail Address	39	78	40		
Secondary E-Mail Address	79	118	40		
Filler	119	391	273	X	
File Extension	392	394	3	X	'FBT'
3rd Party Identifier Code	395	399	5	X	
SUPR Generated Tag	400	400	1	X	Reserved

Field Descriptions for Services (.FBT) Record

General rules for the DARTS Services file:

- There must be a matching client record on the DHS-SUPR Demographic file with that service "Patient Identification Number" (in the Demographic AUnique Client Identifier" field), and that "Service Date" must also fall on or between the dates of the "Open Date" and the AClose Date". For clients who have an Open Date after 6/30/09, the service must fall within the Service Setting Begin and End Dates for the Service Setting Code being billed.
- The unit/program combination on the service record must be a valid unit/program resident on the UP10XXXX.FIL (where AXXXX" is the provider number of the agency.) If billing DM (DARTS Medicaid), the service must fall between the Medicaid Start and End Dates on this UP10XXXX.FIL. If billing DC (DARTS Contract), the service must fall between the Contract Start and End Dates on this same file. If billing DS (DARTS Split Medicaid/Contract), the service must fall between both be valid according to both sets of start and end dates.
- Exact duplicates are not accepted using the same key information. Other duplicate cross-edits are explained within this document.
- For any billings to contract ("Funding Indicator" of 'DC' or 'DS'), the "Service Date" cannot be past the lapse period for the fiscal year being billed.
- For any billings to Medicaid ("Funding Indicator" of 'DM' or 'DS'), the "Service Date" must be submitted to DHS and processed in a scheduled weekly run (Mondays at 5 p.m.) in time to be at HFS within 1 year from the date of service.
- For any billings to a Medicaid/Contract split (Funding Code 'DS'), the billing for the service must be submitted within the allowable time prior to the lapse period for payment (which is generally near Aug. 1st after the close of a fiscal year.) IF the billing for this split-payment service is sent AFTER the lapse period, you can only bill 'DM' for the treatment portion of the bill. The domiciliary portion of the bill (which is normally paid by contract) will no longer be eligible for payment.
- When billing a "Program Number" '48' with an "Activity Code" of '71' (Assessment Discharge), the client/patient must have the same date entered on the corresponding demographic record's "Close Date" as was entered on the "Service Date" for the service.

SERVICE KEY FIELDS

PROVIDER NUMBER

- All numeric
- The valid provider number from the unit/program (provider plan) file

PATIENT IDENTIFICATION NUMBER

- This number, used to identify the client/patient, must be the same one that was used for "Patient Identification Number" located in positions 40 - 48 of the Patient Transaction Record (.FCT).
- For clients who are receiving services in FY09, this id number should also be identical to the client/patient's RIN number assigned by DHS or by HFS
- For Intervention services ("Program number" = '42') in which the "Service Type" = '3' (Community Intervention), the "Patient Identification Number" must be left spaces.

- For all Interpreter Services and HIV Services (“Program number” = ‘64', ‘95' or ‘96’), the “Patient Identification Number" must be left spaces.

SERVICE BEGIN DATE

- Must be valid year, month, day, AND all numeric.
- For services that must be have a valid client demographic record (see “Patient Identification Number” description above), this date must fall between the client/patient’s “Open Date” and their “Discharge Assessment Date”.
- This date cannot be a future date.

SERVICE BEGIN TIME (For all Case Mgt., Assessment, Intervention, Level1, Level 2 and Interpreter services)

- Must be valid hour (01 - 12), minute (00 - 59), and ‘A’ or ‘P’ (Example: ‘1115A’ for 11:15 am, OR ‘0845P’ for 8:45 pm)
- This field is required when the “Hour/Day Indicator” is ‘H’ (“Program Number” is ‘05, ‘41', ‘42', ‘43', ‘44', ‘48', ‘49', ‘64', ‘95', or ‘96')

UNIT NUMBER

All numeric (located on provider unit/program file)

PROGRAM NUMBER

All numeric, and one of the codes listed below (located on provider unit/program file).

02 - Childcare Residential	47 - Level 3.5 - Rehabilitation - Adult
05 - Level 1 - Methadone	48 - Assessment
27 - Level 3.5 Rehabilitation Adult	52 - Toxicology
40 - Recovery Homes	64 - Interpreter Referral Services
41 - Case Management	78 - Level 3.5 Rehabilitation - Youth
42 - Intervention	
43 - Level 1	
44 - Level 2	
45 - Halfway House	
46 – Withdrawal Management	

HOUR / DAY INDICATOR

- 'H' (Hourly) for Program Numbers: Level 1 Methadone (05), Case Management (41), Early Intervention (42), Level 1 (43), Level 2 (44), Assessment (48), Interpreter Referral Services (64). (If you refer to the setting codes on the Agency's Unit/Pgm file, these corresponding codes are 'AS', 'CM', 'IN', 'OP', 'OR', 'SH'.)
- 'D' (Daily) for Program Numbers: Child Care Residential (02), Level 3.5 (27, 47 and 78), Recovery Home (40), Halfway House (45), Withdrawal Management (46), Toxicology (52) services. (If you refer to the "Setting Code" on the Agency's Unit/Pgm file, these corresponding codes are 'DX', 'RR', 'HH', 'RH', 'CR', 'TX'.)

JULIAN DATE

Valid Julian date (YYDDD) of transaction entry. (For DARTS users, this is the date stamp taken from the computer.)

TRANSACTION TIME

Unique time (HHMMSSSS) of the transaction entry (all numeric). For DARTS users, this field is the time stamp from the computer at the time of entry. This field, along with the Julian Date field, should NOT be identical for every record transmitted to SUPR. The combination of "Transaction Date" and "Transaction Time" and the rest of the key of the file, determines the order in which services are processed at the DARTS Mainframe level.

FUNDING INDICATOR

- Valid codes are: 'DC' = DARTS/Contract; 'DM' = DARTS/Medicaid; 'DS' = DARTS/Split Billing (Medicaid/Contract split)
- The "Procedure Code" must be a valid code for the provider's SUPR assigned unit/programs according to the Agency's Unit/Program Master file
- The "Funding Indicator" <u>must</u> be 'DM' or 'DC' for Program Numbers of '43', '44', and '48'; However, if the "Activity Code" is '08' (Telephonic) or '41' or '42' (Collaterals), the "Funding Indicator" must be 'DC'
- The "Funding Indicator" <u>must</u> be 'DC' for Program Numbers of '02' (Child Care Residential), '40' (Recovery Home), '41' (Case Mgt.), '42' (Intervention), '45' (Halfway House), '52' (Toxicology), '65' (Interpreter Services),
- The "Funding Indicator" <u>must</u> be 'DM' for Program Numbers of '05 (Methadone) and '27' (Level 3.5 Rehab. Medicaid only program)
- The "Funding Indicator" <u>must</u> be 'DC' or 'DS' for Program Numbers of '46' (Withdrawal Management), '47' (Level 3.5 Rehabilitation - Adult), or '78' (Level 3.5 Rehabilitation - Youth) if the billing for the service was submitted within the allowable time prior to the lapse period for payment (which is generally near Aug. 1st after the close of a fiscal year.) IF the billing for the service for one of these program numbers is sent AFTER the lapse period, you can only bill 'DM' for the treatment portion of the bill to be paid by Medicaid within one year of the service date, and the domiciliary portion of the bill (which is normally paid by contract) will no longer be eligible for payment.
- If the "Funding Indicator" is 'DM' or 'DS', the "Insurance Type" on the client's demographic record must be '4' (Medicaid).

SERVICE DATA FIELDS

STAFF ID (For all Assessment, Intervention, Case Mgt., Level 1, Level 2 and Interpreter services)

- All numeric, but not all zeroes
- This ID does not need to be the SSN of the Staff Member, but must be a unique 9-digit number assigned to the staff that is always used for that staff person.
- When the Activity Code is '038' or '138', the patient's RIN must be entered into this Staff ID field

COLLATERAL CLIENT ID

- Must be all numeric when the "Activity Code" is '041' or '141'; otherwise it must be spaces. This ID does not need to be the SSN of the Collateral client, but must be a unique 9-digit number assigned to that person.

RECIPIENT CODE *(This field is not required to be entered by users as it is coded at DHS)*

This field distinguishes Registered Clients/Patients from those who do not have a matching demographic record. (It is entered at DHS and not by the provider.)

- 'A' is entered in this field by DHS for Program Numbers of '05' (Methadone), '41' (Case Mgt.), '43' (Level 1), '44' (Level 2), and '48' (Assessment). An 'A' is also entered for "Program Number" '42' (Intervention) when the "Service Type" is '1' (Individual) or '2' (Group).
- 'B' is entered in this field by DHS for Program Numbers of '64' (Interpreter services). 'B' is also entered in this field when the "Program Number" '42' (Intervention) when the "Service Type" is '3' (Support).

SERVICE TYPE (For all Assessment, Intervention, Case Mgt., Level 1, Level 2 and Interpreter services)

1. Individual Service
2. Group Service
3. Support (Case Management, Community Intervention, and HIV)

- For Early Intervention ("Program Number" 42), must be 1 or 2
- For Community Intervention ("Program Number" 42), must be 3
- For Level 1 ("Program Number" 43), must be 1 or 2
- For Level 2 ("Program Number" 44), must be 1 or 2
- For Assessment ("Program Number" 48), must be 1
- For Case Management ("Program Number" 41), must be 3
- For Interpreter services ("Program Number" 65) must be 3

GROUP ID (Intervention, Level I, and Level II Only)

- If the "Service Type" is '1' (Individual) or '3' (Support), this field must be spaces
- If the "Service Type" is '2', this field must be entered, and must be comprised of 5 digits (which can consist of a combination of numbers and/or letters)
- The Group ID must be a unique identifier that will distinguish this group from other groups on the same date of service. The same Group ID cannot be used for multiple groups within the same day. It can be used again on a new date (i.e. A group that meets Mondays and Fridays could use that same Group ID on both days.)

VIDEO COUNSELING

- Valid entries are 'Y' or 'N'
- Required for the following services with FY13 service dates:

- Hourly reporting program numbers: 42 (Early Intervention), 43 (Level 1), 44 (Level 2), and 48 (Assessment) when the activity code is individual ('01'), counseling group ('02'), continued stay review and discharge planning ('04), treatment planning ('05), didactic group ('06'), psychiatric evaluation ('11'), medication monitoring ('12'), collateral – family/significant other ('41'), collateral – other ('42'), gambling ('63'), admission assessment ('70'), discharge assessment ('71'), gambling assessment ('72).
- Daily reporting program numbers: 27, 37, 47, and 78 (Level 3.5) for Psych Evaluations. Video services are billable to DARTS Contract (DC). Psychiatric evaluations can be billed to DARTS Medicaid (DM) when Medicaid guidelines are met.

SERVICE HOURS (For all Assessment, Intervention, Case Management, Level 1, Level 2 and Interpreter services)

- This field must numeric for the following "Program Numbers": Level 1 Methadone (05), Case Management (41), Early Intervention (42), Level 1 (43), Level 2 (44), Assessment (48), Interpreter Referral Services (64). If this field is zero, the "Service Minutes" field must be a number greater than zero.
- For any other "Program Number", this field must be a space

SERVICE MINUTES (For all Assessment, Intervention, Case Management, Level 1, Level 2 and Interpreter services)

- This field must all numeric and in quarter hour increments (i.e. 00, 15, 30, 45) for the following Program Numbers: Level 1 Methadone (05), Case Management (41), Early Intervention (42), Level 1 (43), Level 2 (44), Assessment (48), Interpreter Referral Services (64). If this field is zero for the service, the "Service Hours" field must be a number greater than zeroes.
- For any other "Program Number", this field must be spaces.

SERVICE DAYS - **Computed at SUPR**

This field is computed at SUPR by using the "Service Begin Date" and "Service End Date".

TOXICOLOGY SCREENS

Must be all numeric when billing for Toxicology (Program Number '52')

ACTIVITY CODE (For all Intervention, Case Mgt., Level 1and Level 2 services)

This field must be all numeric or all spaces. You may use this three-digit field in one of three different ways:

Location Codes (1st digit of Activity code)

0 - Service at provider location

1 - Off-site

Activity Type (2nd and 3rd digits of Activity code)

TREATMENT OR EARLY INTERVENTION SERVICE

(These are only allowed in "Program Number" '05', '42', '43' and '44')

01 - Individual Counseling ("Service Type" must be '1')
{"Procedure Code" will be automatically filled as EII, OPI, or IOI}

02 - Counseling Group ("Service Type" must be '2')
{"Procedure Code" will be automatically filled as EIG, OPG, or IOG}

04 - Continued Stay Review and Discharge planning ("Service Type" must be '1' or '2')
{"Procedure Code" will be automatically filled as EII, EIG, OPI, OPG, IOI, or IOG}

05 - Treatment Planning ("Service Type" must be '1' or '2')
{"Procedure Code" will be automatically filled as EII, EIG, OPI, OPG, IOI, or IOG}

06 - Didactic Group ("Service Type" must be '2')
{"Procedure Code" will be automatically filled as EIG, OPG, or IOG}

07 - Recreation ("Service Type" must be '2')
{"Procedure Code" will be automatically filled as EIG, OPG, or IOG}

08 - Telephonic Counseling
("Service Type" must be '1'; "Program Number" must be '42' or '43')
{"Procedure Code" will be automatically filled as EII or OPI}

09 – HIV Education

10 – TB Education

PSYCHIATRIC REVIEW

11 - Psychiatric evaluation ***(Only allowed in "Program Number" '42', '43' and '44', AND "Service Type" must be '1')***
{"Procedure Code" will be automatically filled as PEV}

12 - Medication Monitoring ***(Only allowed in "Program Number" '43' and '44', AND "Service Type" must be '1')***
{"Procedure Code" will be automatically filled as OPI}

CASE MANAGEMENT ***(These are only allowed in "Program Number" '41')***
{"Procedure Code" will be automatically filled as CMH}

22 - Intra-Agency staffings

23 - Coordination

COMMUNITY INTERVENTION / EARLY INTERVENTION

(These are only allowed in "Program Number" of '42', with a "Service Type" of '3')
{"Procedure Code" will be automatically filled as CIH}

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 training and to report such training to DARTS.)

37 - Client/Patient Transportation

38 – Language Interpreter (when billing this type of service, the client's RIN must be entered into the "Staff ID" field.)

COLLATERAL

***(These are only allowed in "Program Number" of '42', '43', and '44', AND* the "Service Type" must be '1' or '2')**
{"Procedure Code" will be automatically filled as EII, EIG, OPI, OPG, IOI, or IOG}

41 - Family

42 - Other

INTERPRETER REFERRAL ***(These are only allowed in "Program Number" '64')***
62 - Interpreter Referral Services

GAMBLING
63 – Gambling

ASSESSMENT ***(These are only allowed in "Program Number" '48')***
70 - Admission
71 - Discharge (there can only be one Discharge Assessment billed per client per episode.)
72 - Gambling (there can only be one per client per episode, and it can be no more than 30 minutes)

REVISION CODE

The Revision Code is used to indicate to the Mainframe portion of DARTS as to what should be done to the record.

'A' = **ADD** a New Record.

- For all funding codes ("DC," "DM," and "DS")
- This will be the code used most frequently. This indicates that a new billing is being submitted. First time claims must have an 'A' (Add).

'R' = **REVISE** a record which was previously submitted and accepted at the mainframe

- For Contract billings "DC" only
- To correct information on a previously submitted 'DC' claim, which was accepted thru the mainframe system, enter an 'R' (Revise). The fields which can be corrected using this code are: Dedicated Funding, Service Type, Activity Code, Group ID, Length of Service (hours, minutes), Site Number, Collateral ID, Pregnant, Number of Screenings (Toxicology), Child's Sex, Child's Birth Date, Mother's ID, (Childcare Residential), Number of Days, Psychiatric Evaluation (Resid, Halfway House, Recovery Home)
- This will not allow a provider to change a billing from one unit/program to a different unit/program, or change the Unique Client Identifier, Service Dates (Beginning or Ending), or Start Time, or Staff ID. 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 at the mainframe.

- For Contract billings "DC", only
- This code replaces the '-' in the credit indicator in prior fiscal years. Records, which were submitted **and** accepted at the mainframe, can be deleted using this code. The 'V' record needs to be entered exactly as it was in the original submission, so that a match can be made at the mainframe portion of DARTS, and the void can be made to the record.

PSYCHIATRIC EVALUATION. CODE *(For all Residential, Halfway House, and Recovery Home services only)*

- Enter 'P' when billing Psychiatric Evaluation billing for program numbers '27','40', '45','46','47', '78'
- Psych. Evals cannot be billed if the "Funding Indicator" is 'DS'.
- Enter space in this field for any other billings

DEDICATED FUNDING CODE

For services, which have a "Funding Indicator" of 'DC' or 'DS', enter one of the codes below to indicate the "Dedicated Funding" category in which to credit the service. Enter 'N' (for "None"), if the dedicated funding categories do not apply to the service. Each provider has a unique set of dedicated funding tags, which they are authorized to use. The codes valid for your agency are located on your agency's unit/program provider plan file. This file is used to edit this code against those valid codes.

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

COMMON BILLING INFO.

NAME

Enter the name of the Patient. For Medicaid billings, this must be the insured's name as it appears on the Medicaid card.

BIRTH DATE **(Required for ALL Patients EXCEPT CIH and INT services**)

Valid year, month, and day. (Note: Patients must be at least 12 years of age to bill Medicaid.)

SERVICE END DATE **(Required for ALL Patients)**

Enter the end date of the service. For any programs reported Hourly ('H' is in the "Hour/Day Indicator" field) or Psych. Evaluation billings, this field must be the SAME as the service begin date. For all services, Service End Month/Year must be the same as the Service Begin Month/Year.

SITE NUMBER

All Unit/Program combinations on the Agency's Unit/Pgm Plan file will have only one SUPR assigned Site Number to indicate from which address site the service was rendered; EXCEPT in the case of Case Management Services ("Program Number" Number of '41'), Intervention Services ("Program Number" Number of '42'), or Assessment services (for "Program Number" of '48' for billings after 6/30/08). For these program types, there may be multiple site numbers from which to choose the correct address site.

SPECIALIZED SERVICES ADDITIONAL INFO.

SEX **(Required for children in Childcare Residential programs only)**

Enter the sex of the child: 'M' or 'F'

MOTHER'S UNIQUE CLIENT IDENTIFIER

(Required for children in Childcare Residential programs only)

Enter the Unique Client Identifier of the mother whose child is receiving services in the Childcare Residential Program. The mother must also be opened and receiving services at this facility

RECIPIENT ID NUMBER

RECIPIENT IDENTIFICATION NUMBER (RIN)

The RIN is an assigned number from the state of Illinois. An algorithm is also used in the system to whereas the 9th digit is a check digit. The RIN is required for:

- All Medicaid clients
- All clients opened after 6/30/2007
- Any client who receives a service after 6/30/2007 (This is not required for Community Intervention (CIH), Interpreter Referral (INT), or HIV services (HIV) as they do not require a demographic record.)

MEDICAID DEMOGRAPHICS INFO.

DIAGNOSIS CODE

When the service date is after 9/30/2015, the Alcohol/Substance Abuse ICD-10 code must be entered. This code must be a valid ICD-10 code, and begin with F10, F11, F12, F13, F14, F15, F16, F18, or F19.

When the service date is before 10/01/2015, the Alcohol/Substance Abuse ICD-9 code must be entered. This code must be a valid ICD-9 code, and begin ‘291', ‘292, ‘303', ‘304', or ‘305'.

All codes must include a decimal point, and are left justified.

ATTENDING PHYSICIAN'S ID

Use a nine-digit all numeric ID (the Physician’s SSN, Public Aid Enrollment Number, or State License Number), OR 1 alpha digit plus 5 numbers (EX: D0010 - the Physician’s UPIN # if enrolled with Medicare), OR the 10-digit NPI number (which is 8 numbers followed by a 2-digit alphanumeric suffix).

TPL CLIENT INFORMATION

TPL Information is only valid for who are billing Medicaid. For these clients, the complete TPL information must be all spaces, or completely entered.

THIRD PARTY PAYER

Valid name

THIRD PARTY CODE

All numeric (from DPA Resource Code Directory Appendix 9)

THIRD PARTY INSURED’S NAME

Last name and first names must be entered

THIRD PARTY INSURED’S ID

All numeric

MORE COMMON BILLING INFORMATION

PROCEDURE CODE *(generated by DHS)*

- This field is automatically generated within DARTS and/or the Edit and Balance System by editing the data against the provider's unit/program master file. The following fields are used to validate the "Procedure Code" field: Unit, Program, Funding Code, Service Date, Service Type, and Activity Code.
- These codes are used to compute payments, and indicate for Level 3 the amount paid for the treatment and/or domiciliary portions.

MEDICAID SERVICE INFO.

DUE FROM PATIENT (SPENDDOWN)

- Must be all numeric.
- This is only for Medicaid billings ("Funding Indicator of 'DM' or 'DS')
- For Level 3.5 ("Setting Code" of 'RR'), the "Spenddown" cannot be > 30000.
- For Level 1 or 2 ("Program Number" Number of '43' or '44'), the "Spenddown" cannot be > 150.

TPL BILLING INFORMATION

TPL Information is only valid for who are billing Medicaid. For these clients, the complete TPL information must be all spaces, or completely entered.

THIRD PARTY STATUS

Must be '01', '02', '03', '05', '06', or '07'

THIRD PARTY AMOUNT

Must be all numeric

THIRD PARTY PAID DATE

- Must be valid year, month, and day and not prior to the "Open Date".
- TPL Date cannot be a future date.
- TPL Date must be after the "Service Date"

MISC. DATA

SERVICE END TIME (For services reported in hours only)

Must be valid hour, minute, and 'A' or 'P' in which the service ended. The time computed between the service begin time and the service end time must not exceed 9 hours and 45 minutes. (Example: '1115A' for 11:15 am, OR '0845P' for 8:45 pm)

CARGO FIELD

This field is for the use of third party providers.

Open Date (from the Demographic Record)

This field is required for all records with a service date after 6/30/07. It is the "Open Date" of the corresponding demographic record.

HOURLY SERVICES CROSS-EDIT TABLE
Assessment, Intervention, Case Management, Level I, Level II, HIV, and Interpreter Services

Pgm No.	Setting Code	Service Type	Activity Code	Procedure Code	Client/Patient ID	Collateral ID	Group ID
05	OP	1	01, 04, 05, 08	OPI	required	n/a	n/a
05	OP	1	11	PEV	required	n/a	n/a
05	OP	2	02, 06, 07	OPG	required	n/a	required
41	CM	3	22, 23	CMH	required	n/a	n/a
42	IN	1	01, 04, 05, 08, 12	EII	required	n/a	n/a
42	IN	1	41,42	EII	required	required	n/a
42	IN	1	11	PEV	required	n/a	n/a
42	IN	2	02, 06, 07	EIG	required	n/a	required
42	IN	2	41,42	EIG	required	required	required
42	IN	3	31,32, 33, 34, 35, 37	CIH	n/a	n/a	n/a
42	IN	3	38	CIH	*Patient RIN is entered into the Staff ID field*	n/a	n/a
43	OP	1	01, 04, 05, 08, 12	OPI	required	n/a	n/a
43	OP	1	41, 42	OPI	required	required	n/a
43	OP	1	11	PEV	required	n/a	n/a
43	OP	2	02, 06, 07	OPG	required	n/a	required
43	OP	2	41, 42	OPG	required	required	required
44	OR	1	01, 04, 05, 12	IOI	required	n/a	n/a
44	OR	1	41, 42	IOI	required	required	n/a
44	OR	1	11	PEV	required	n/a	n/a
44	OR	2	02, 06, 07	IOG	required	n/a	required
44	OR	2	41, 42	IOG	required	required	required
48	AS	1	70	AAS	required	n/a	n/a
48	AS	1 or 3	71	AAS	required	n/a	n/a
48	AS	1	72	AAS	required	n/a	n/a

Pgm No.	Setting Code	Service Type	Activity Code	Procedure Code	Client/Patient ID	Collateral ID	Group ID
48	AS	1	11	PEV	required	n/a	n/a
64	SH	3	62	INT	n/a	n/a	n/a

BILLING TYPE KEY:

AAS = Assessment
OPI = Outpatient Individual (Level 1)
OPG = Outpatient Group (Level 1)
CMH = Case Management Hours (Case Management)
EII = Early Intervention Individual (Intervention)
EIG = Early Intervention Group (Intervention)
IOI = Intensive Outpatient Individual (Level 2)
IOG = Intensive Outpatient Group (Level 2)
CIH = Community Intervention Hours (Intervention)
PEV = Psychiatric Evaluation (Intervention / Level 1 / Level 2)
INT = Interpreter Referral Service

GENERAL MEDICAID RULES

- You cannot bill a Patient to Medicaid who is over 20 years old at the time of service for Level III Youth

- You cannot bill a Patient to Medicaid who is under 16 years old at the time of service for a Level III Adult

ADDITIONAL CROSS-EDITS AND DUPLICATE EDITING

If the "Problem Area" is '4' (Co-Dependent), '5' (None), or '7' (Gambling Only), the client cannot have services billed for program numbers '46' (Withdrawal Management), '27', 47' or '78' (Level 3.5 Rehabilitation), '45' (Halfway House), or '40' (Recovery Home).

If the services are a daily service, (Daily/Hourly field is 'D' (Daily) and the Program Number is Level III (27, 47 and 78), Recovery Home (40), Halfway House (45), or Withdrawal Management (46), the Patient Type on the Demographic Record must be 'T' (Treatment.)

<u>Duplicate Checks (the 2-digit numbers referenced below in quotes is the Program Number)</u>:

- Exact billings with the same transaction date and time stamp are rejected as duplicates, no matter what the services are.

- No duplicate checks are made on Community Intervention ('42' with service type of '3') or Interpreter Referral Services ('64') as these have no Client/Patient ID entered, unless the key information is identical including the date/time stamp.

- Assessment billings ('48') can be done on the same day as any other billing.

- Psych Evaluation services (Activity Code '011' or '111') are allowed on the same date any other service, but more than one PEV service is not allowed per date.

- Toxicology services ('52') can be billed on the same date as any other service.

- There can be multiple collateral services ("Activity Code" of '041', '141', '042', '142') for a client/patient only if the "Collateral IDs" do not duplicate for that date/time. These are only valid if the "Service Type" is '2' (group). Duplicate collateral services billed with a "Service Type" of '1' (Individual), is an error. Collateral services can be done the same day as any other service for the client.

- Collateral billings (Activity Codes of '041', '141', '042' or '142') can be made to a client/patient id on the same date as any daily services

- There can be multiple Case Management ('41') services for a client/patient at the same date/time only if the "Staff ID" is different for those services

- Case Management Services ('41') can be billed at the same time as other hourly reported services Level 1 Outpatient ('43'), Level 2 Intensive Outpatient ('44') only IF the "Staff ID" is not the same.

- Case Management Services (‘41') can be billed the same date as services of Residential (‘27', ‘47', ‘78'), Withdrawal Management (‘46'), and Halfway House (‘45')

- Any hourly service (except for Intervention services ‘42') can be billed on the same date as Recovery Home (‘40') services

- Outpatient services (‘43' and ‘05') can be billed on the same day as Halfway House (‘45') services.

- Residential (‘27', 47', 78) and Detox (‘46') can have Medication Monitoring (activity code of ‘012' or ‘112') billed on the same day.

- Residential (‘27', 47', ‘78') can also have services in Level 1 (‘43'), and Level 2 (‘44') on the same date IF those hourly services are tagged as Gambling (Dedicated Funding code ‘L’)

- Child care residential (‘02') can be billed on the same date as another service.