FILE SUBMISSIONS – QUICK TIPS

FILE FORMATTING:

1. There are 135 data fields on the file format.

2. The file must be in a .txt pipe delimited file format in order to upload and submit the file in DDaP. For instructions on formatting a file, see the Best Practices document in the DMHAS EQMI Website at: http://www.ct.gov/dmhas/lib/dmhas/eqmi/ddapbestpractices.pdf

3. There must be valid data in all required fields. *Do not enter zeros or nines if they are not valid values for the particular data field.* Refer to the Standard File Format document in the DMHAS EQMI website at: http://www.ct.gov/dmhas/lib/dmhas/eqmi/DDaPstandardfileformat.pdf

4. Missing leading zeros will generate errors. (Ex. SSN, Zip Codes and Medicaid Policy Numbers)

5. All dates must be in the correct date format (MM/DD/YYYY).

DIAGNOSIS fields:

1. There must be *at least one diagnosis code in AXIS I (field 87).* It can be 799.9 (Deferred) or a valid DSM or ICD code, but not both.

2. The Dx code must contain a decimal unless it is a valid 3-digit code, such as Dx code 311.

3. Deferred code 799.9 is not valid in Axis III. (field 99)

4. There must be a Type of Diagnosis (field 85). A = Admission, U = Update, D = Discharge

5. There must be an Effective Date of the Diagnosis. **NOTE**: *The Effective Date must be greater than or equal to the Admission Date and less than or equal to the Discharge Date.*

6. There must be a GAF Score in AXIS V (field 113). It can be 0 – 100.

PERIODIC ASSESSMENT fields:

1. The Periodic Assessment (fields 53 – 84) is required at Admission (Diagnosis Type = A), every six months (Diagnosis Type = U) and at Discharge (Diagnosis Type = D) for all Treatment Programs and for Non Treatment programs when required (See Treatment and Non Treatment Programs and Exclusions in the DDaP Training Guide.) Refer to the Standard File Format for the required fields.

2. The Periodic Assessment Date is a required field (field 53). There must be a new Periodic Assessment Date at Discharge time when the Periodic Assessment is required. (The old Periodic Assessment Date cannot be entered on a Discharge.)

3. At least one Drug (Drug 1 fields 65 – 68) must be entered for Treatment Programs. All fields are required for each drug type entered (Drug Type, Method Used, Days Used and Age First used.)

CO-OCCURRING SCREENING fields:

1. Co-Occurring Screening is required at Admission (Type of Diagnosis = A) for all Treatment Programs. It is optional for Non Treatment Programs.

2. If there is Co-Occurring Screening data, the Co-Occurring Assessment Date (field 43) is required, as well as the MH Screening Used (field 44) and SA Screening Used (field 45). Refer to the Standard File Format document for required fields. **NOTE**: *The Co-Occurring Assessment Date is required, even if the MH or SA Screening Used is 8 (Declined) or 9 (Medically or Clinically Inappropriate).*

SERVICES:

The system allows only ***one distinct service code for a client in a particular program per day***. *This applies to Treatment and Non-treatment programs.* An alert ⚠ will display in the History of Files Uploaded grid for duplicate services. If a client receives a case consultation service for 60 minutes in the morning and 60 minutes in the afternoon on the same day, the Service Units and Duration should be added together and reflect as one record on the file. (Same Start and End Date, '2' Units (2 case consultations) and '120' (60 + 60) for Duration)

Service Start Date   End Date   Unit Duration
|90888|01/06/2015|01/06/2015|**2**|**120**|

DISCHARGES:

1. If a Discharge is being processed after an Admission (on a subsequent day), there should be <u>2 records</u>:

    1. <u>One record for the Admission</u>: This should have the Admission Date (field 36), the Effective Date of Diagnosis (field 86) and the Diagnosis Type = A (Admission), but ***no discharge date or reason.***

    2. <u>One record for the Discharge</u>: This should have a Discharge Date (field 41) and Discharge Reason (field 42), the Effective Date of Diagnosis (field 86) should be the Discharge Date and Diagnosis Type (field 87) = D (Discharge).

    *   <u>And</u> *if a Periodic Assessment is required*, the Periodic Assessment Date for the Discharge must be <u>greater than</u> the Admission Date and all other previous Periodic Assessment Dates for that client or data will be overlaid.

2. If an Admission and Discharge are being processed on the <u>same day</u>, they should be on the <u>same 1 record</u>. The Admission Date, Discharge Date, Periodic Assessment Date (if required) and the Effective Date of Diagnosis *must be the same*. Diagnosis Type must = D and a Discharge Reason (field 42) is required.

FILE SUBMISSIONS AND ERROR CORRECTIONS:

1. A file can be deleted from DDaP <u>only</u> if: It has <u>not been submitted</u> OR, after submitting, there is <u>at least 1 error in every record</u>.

2. Once a file is submitted, if there are errors, an errors link will display next to the file listing. Select the <u>Errors</u> link in the 'History of Files Uploaded….' grid to view records with errors.

Two links will display:

*   The <u>View Errors</u> link takes the user to a window that lists screen links and the errors. Select the screen link to go to the screen to make corrections.

*   The <u>Fix</u> link takes user directly to the screen that has the error(s).

3. Once corrections are made, the user can select the arrow button at the bottom right hand corner of the screen, to take them to each screen / record that has an error.

4. After corrections are completed, select the RE-SUBMIT FILE button at the bottom of the screen. The system will note if the file submission is successful, or if errors remain. Repeat error corrections steps if errors remain.

5. Select the ERROR SUMMARY REPORT or ERROR DETAIL REPORT button to view error descriptions.

6. Refer to the DDaP Training Guide or the DDaP Electronic File Error Corrections Training guide for instructions regarding submitting files and making error corrections.

SERVICES-ONLY FILES:

1. The client must have an established admission in DDaP before a Service-Only file can be submitted.

2. There must be a match on the client's Name, DOB and SSN on the Services-Only file and the existing Name, DOB and SSN in DDaP.

3. The **Services Only File Admission Extract Report**, located in the Client Reports folder in the DDaP Data Warehouse, is an extract report that can be exported to excel and used for clients who require services. See the 'Best Practices' document (located on the DMHAS / EQMI website) for instructions on formatting the file.

4. Only **one distinct service record for a client in a particular program with specific method of contact per day** is allowed. A second service of the same type for the day can be sent as an update, but only the most recent service sent will be updated in DDaP. An alert ⚠ will display in the History of Files Uploaded grid if there are duplicate services in the file. (Full file or Services-Only file)
    Click on the alert⚠ to see a listing of the duplicate services and update as needed.