

## Mental Health Information System (MHIS) Manual

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### 5.1.4. Diagnostic Assessment and Substance Use Screening

#### DSM 4 or DSM 5 Tabs

The online MHIS data entry has been updated with a new tab that is called “Diag Assess (DSM-5).” This tab is to be used for the Diagnostic Assessment information or Crisis Diagnosis information, with a Diagnostic Assessment date of **10/1/14 or later**. Please note data cannot be entered into both tabs. If entering data in the DSM-5 tab, make sure that the DSM-4 tab data fields are empty. Diagnostic Assessments dates of October 1, 2015 or later, the DSM5 tab will allow the ICD-10 codes only.

#### **VARIABLE NAME: DIAGNOSIS ASSESSMENT DATE (DSM4 or DSM5)**

- **DESCRIPTION:** Identifies the most recent date the Diagnostic Assessment was completed.
- **VALID ENTRIES:** 2- digit month and day followed by the 4-digit year. The numeric format for months and days 1-9 must have a zero as the leading digit.
- **GUIDELINES:**
  - 9505.0371 Subpart2, items D and E:
  - D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:
    1. When the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;
    2. At least every three years following the initial diagnostic assessment for an adult who received mental health services;
    3. When the adult’s mental health condition has changed markedly since the adult’s most recent diagnostic assessment; or
    4. When the adult’s current mental health condition does not meet criteria of the current diagnosis.
  - E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.
  - Specific program requirements for new clients:
    1. **IRTS providers:** must complete a Diagnostic Assessment within five days of the recipient’s admission date. **OR** within five days of recipient’s admission, an adult diagnostic assessment update may be completed if a diagnostic assessment was completed within 180 days of the recipient’s admission. An Adult Update must be completed by, signed and dated by a MH professional who meets the requirements in section [245.462, subdivision 18](#), paragraphs (1) through (6).
    2. **ARMHS and ACT providers:** must complete a diagnostic assessment within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. An adult diagnostic assessment update must be completed when a referent diagnostic assessment is available that reflects the recipient's current status, and has been completed within three years preceding admission. If the recipient's mental health status has changed significantly

since the adult's most recent diagnostic assessment, a new diagnostic assessment is required [256B.0623 Subd 8](#).

- Use the following guidelines in the absence of a Diagnostic Assessment:
  1. **Crisis grantee's and provider's** - report the Crisis Assessment Date and diagnosis
  2. **Hospital's** - report the Psychiatric Assessment date and diagnosis
  3. **Housing with Supportive grantee's** - report mental health professional date and diagnosis
- If the client was not engaged with traditional mental health services prior to the status record, enter 01/01/1900 as the Diagnostic date, 999.9997 (Unknown) for the Primary level diagnosis.
- Update the fields once you are able to collect the information from Mental Health Provider, when the individual engages with traditional mental health services, or Diagnostic Assessment is completed.

**FIELD NUMBER: C32**

**FIELD LENGTH: 10**

**FIELD TYPE: DATE**

**FORMAT: MM/DD/YYYY**

## DSM 4 Tab Only

### VARIABLE NAME: AXIS 1 CLINICAL DISORDERS— ONE, TWO & THREE

- **DESCRIPTION:** Specifies the client's current clinical disorders, including major mental disorders, learning disorders and Substance Use disorders per specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - DSM-IV codes: 290 – 316 (XXX.XXXX) (XXX.XXX-) (XXX.XX--) (XXX.X---) (XXX.- ---) (XXX- --- -) WHERE – REPRESENTS A BLANK
  - 999.9996- NO SECONDARY AND/OR TERTIARY DIAGNOSIS
  - 999.9997- UNKNOWN
- **GUIDELINES:**
  - Valid entries generally will have 3 characters and a decimal point followed by 1 or 2 characters when ICD-9 or DSM IV codes are used. If a valid code has fewer than 5 characters and a decimal, the code should be left justified so that all remaining characters on the right are blank.
  - Agencies are allowed to report the three most recent AXIS I diagnoses current during the reporting period. Most recent is defined by the date when the diagnosis was reported.
  - Use code 999.9996 (No Secondary or Tertiary Diagnosis) if the client has only one diagnosis, which has been reported.
  - Use code 999.9997 (Unknown) if the Agency collects these data but for some reason a particular record does not reflect an acceptable value.

**FIELD NUMBER: C33-C34-C35**

**FIELD LENGTH: 8**

**FIELD TYPE: Text**

**FORMAT: XXX.XXXX**

### VARIABLE NAME: AXIS II PERSONALITY DISORDERS— ONE, TWO AND THREE

- **DESCRIPTION:** Specifies the client's current personality and intellectual disabilities per specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - DSM-IV codes: 301; 317 – 319 (XXX.XXXX) (XXX.XXX-) (XXX.XX--) (XXX.X---) (XXX.- ---) (XXX- --- -) WHERE – REPRESENTS A BLANK
  - 999.9996 NO DIAGNOSIS
  - 999.9997 UNKNOWN
- **GUIDELINES:**

- Use code 999.9996 (No Diagnosis) if the client has no diagnosis, which has been reported.
- Use code 999.9997 (Unknown) if the Agency collects these data but for some reason a particular record does not reflect an acceptable value.

**FIELD NUMBER: C36-C37-C38**

**FIELD LENGTH: 8**

**FIELD TYPE: Text**

**FORMAT: XXX.XXXX**

### **VARIABLE NAME: AXIS III GENERAL MEDICAL CONDITIONS– ONE, TWO AND THREE**

- **DESCRIPTION:** Specifies the client’s current acute medical conditions and physical disorders per specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - ICD-9: 001 – 289; 320 – 759; 780 – 999; V01 – V86 (XXX.XX) (XXX.X-) (XXX.- -) (XXX- - -) WHERE – REPRESENTS A BLANK
  - 999.9996 NO GENERAL MEDICAL CONDITIONS
  - 999.9997 UNKNOWN
  - 999.9998 REPORTED, BUT NOT BY CODE
- **GUIDELINES:**
  - Valid entries generally will have 3 characters and a decimal point followed by 1-4 characters when ICD-9 codes are used. If a valid code has fewer than 7 characters and a decimal, the code should be left justified so that all remaining characters on the right are blank.
  - Use code 999.9996 (No Primary medical conditions)
  - Use code 999.9996 (No Secondary or Tertiary Diagnosis) if the client has only one reported diagnosis.
  - Use code 999.9997 (Unknown) if the Agency collects these data but for some reason a particular record does not reflect an acceptable value.
  - Use code 999.9998 (Reported, but not by code)

**FIELD NUMBER: C39-C40-C41**

**FIELD LENGTH: 8**

**FIELD TYPE: Text**

**FORMAT: XXX.XXXX**

### **VARIABLE NAME: GLOBAL ASSESSMENT OF FUNCTIONING (ADULTS) /CHILDREN’S GLOBAL ASSESSMENT SCALE**

- **DESCRIPTION:** Specifies the client’s current GAF score per specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - 0-100 GAF/CGAS SCORE
  - 997 UNKNOWN
- **GUIDELINES:**
  - Report the client’s score at time of diagnostic assessment.
  - Use code 997 (Unknown) if the Agency collects these data but for some reason a particular record does not reflect an acceptable value.
  - CRISIS and HWS providers use code 997 (Unknown)

**FIELD NUMBER: C42**

**FIELD LENGTH: 3**

**FIELD TYPE: Numeric**

**FORMAT: XXX**

## DSM 5 Tab Only

### VARIABLE NAME: Primary level diagnosis

- **DESCRIPTION:** Specifies the client's current clinical disorders, including major mental disorders, learning disorders and Substance Use disorders per specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - DSM-5/ICD-9 codes
  - UNKNOWN: 999.9997
- **GUIDELINES:**
  - Agencies are allowed to report the three most recent diagnoses current during the reporting period. Most recent is defined by the date when the diagnosis was reported.
  - Use code 999.9997 (Unknown) if the Agency collects these data but for some reason a particular record does not reflect an acceptable value.
  - Starting October 1, 2015, the ICD-10 primary diagnosis will start with F, up to 8 characters

From April 1, 2014 (ICD-9)	From October 1, 2015 (ICD-10)
<b>FIELD NUMBER: C33</b>	<b>FIELD NUMBER: S1</b>
<b>FIELD LENGTH: 8</b>	<b>FIELD LENGTH: 8</b>
<b>FIELD TYPE: Text</b>	<b>FIELD TYPE: Text</b>
<b>FORMAT: XXX.XXXX</b>	<b>FORMAT: XXXXXXXX</b>

### VARIABLE NAME: Secondary level diagnosis

- **DESCRIPTION:** Specifies the client's current clinical disorders, including major mental disorders, learning disorders and Substance Use disorders per specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - DSM-5/ICD-9 codes
  - NO DIAGNOSIS: 999.9996
  - UNKNOWN: 999.9997
- **GUIDELINES:**
  - Use code 999.9996 (No Diagnosis) if the client has no diagnosis, which has been reported.
  - Use code 999.9997 (Unknown) if the Agency collects these data but for some reason a particular record does not reflect an acceptable value.
  - Starting October 1, 2015, the ICD-10 secondary diagnosis will start with F, up to 8 characters

From April 1, 2014 (ICD-9)	From October 1, 2015 (ICD-10)
<b>FIELD NUMBER: C34</b>	<b>FIELD NUMBER: S2</b>
<b>FIELD LENGTH: 8</b>	<b>FIELD LENGTH: 8</b>
<b>FIELD TYPE: Text</b>	<b>FIELD TYPE: Text</b>
<b>FORMAT: XXX.XXXX</b>	<b>FORMAT: XXXXXXXX</b>

### VARIABLE NAME: Tertiary level diagnosis

- **DESCRIPTION:** Specifies the client's current clinical disorders, including major mental disorders, learning disorders and Substance Use disorders per specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - DSM-5/ICD-9 codes
  - NO DIAGNOSIS: 999.9996
  - UNKNOWN: 999.9997
- **GUIDELINES:**

- Use code 999.9996 (No Diagnosis) if the client has no diagnosis, which has been reported.
- Use code 999.9997 (Unknown) if the Agency collects these data but for some reason a particular record does not reflect an acceptable value.
- Starting October 1, 2015, the ICD-10 tertiary diagnosis will start with F, up to 8 characters

From April 1, 2014 (ICD-9)	From October 1, 2015 (ICD-10)
<b>FIELD NUMBER: C35</b>	<b>FIELD NUMBER: S3</b>
<b>FIELD LENGTH: 8</b>	<b>FIELD LENGTH: 8</b>
<b>FIELD TYPE: Text</b>	<b>FIELD TYPE: Text</b>
<b>FORMAT: XXX.XXXX</b>	<b>FORMAT: XXXXXXXX</b>

### VARIABLE NAME: WHODAS 2.0 Score (12-item version)

- **DESCRIPTION:** Specifies the client's current WHODAS 12-item version score per specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - WHODAS 12-item version score: 12-60
  - 996 Not Required
  - 997 UNKNOWN
- **GUIDELINES:**
  - Report the client's score at time of diagnostic assessment.
  - Use code 996 (Not Required) if the WHODAS is not required.
  - Use code 997 (Unknown) if the Agency collects these data but for some reason a particular record does not reflect an acceptable value.
  - CRISIS and HWS providers use code 997 (Unknown)

**FIELD NUMBER: S4**  
**FIELD LENGTH: 3**  
**FIELD TYPE: Numeric**  
**FORMAT: XXX**

### VARIABLE NAME: WHODAS 2.0 Score (36-item version)

- **DESCRIPTION:** Specifies the client's current WHODAS 36-item version score per specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - WHODAS 36-item version score: 36-180
  - 996 Not Required
  - 997 UNKNOWN
- **GUIDELINES:**
  - Report the client's score at time of diagnostic assessment.
  - Use code 996 (Not Required) if the WHODAS is not required.
  - Use code 997 (Unknown) if the Agency collects these data but for some reason a particular record does not reflect an acceptable value.
  - CRISIS and HWS providers use code 997 (Unknown)

**FIELD NUMBER: S5**  
**FIELD LENGTH: 3**  
**FIELD TYPE: Numeric**  
**FORMAT: XXX**

## **VARIABLE NAME: SUBSTANCE ABUSE SCREENING (DSM4 or DSM5)**

- **DESCRIPTION:** Outcome of Substance Abuse screening that is completed at the time of the specified assessment in Diagnosis Assessment Date guideline.
- **VALID ENTRIES:**
  - 1 SCREENED – NEGATIVE
  - 2 SCREENED – POSITIVE
  - 3 NOT SCREENED
- **GUIDELINES:**
  - Screening for the likelihood of substance use disorders is required at the time that the assessment is completed. Screening must be done using a screening tool approved by the Commissioner. For more information on approved screening tools see the DHS IDDT webpage.

**FIELD NUMBER: C43**

**FIELD LENGTH: 1**

**FIELD TYPE: Text**

**FORMAT: X**