Client Assignment and Registration System
Texas Health and Human Services

WebCARE Manual

Texas Health and Human Services System
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# Table of Contents

**Introduction**............................................................................................................................. 1  
Overview of the CARE System ........................................................................................................ 1  
WebCARE System Documentation ............................................................................................... 3  
WebCARE Forms ............................................................................................................................. 4  
Confidentiality and Security of Consumer Records ........................................................................ 5  
Accessing the WebCARE System .................................................................................................... 9  
Using and Exiting WebCARE ........................................................................................................ 12  
**WebCARE System**.................................................................................................................. 13  
WebCARE Main Menu................................................................................................................ 13  
Main Menu Modules.................................................................................................................... 14  
RDM: Resiliency & Disease Management Module........................................................................ 18  
  RDM Data Entry ......................................................................................................................... 19  
  RDM Workflow / Reports ........................................................................................................ 20  
325: Client Registration ............................................................................................................... 24  
330: Diagnostics ........................................................................................................................... 31  
346: MH Adult Uniform Assessment for RDM ............................................................................ 38  
164: MH Child/Adolescent Uniform Assessment for RDM......................................................... 58  
RDM Workflow / Reports .......................................................................................................... 77  
Reports .......................................................................................................................................... 77  
  246 Incomplete/Provider Complete Assessments - Adult ....................................................... 77  
  247: Assessments Expiring by Section – Adult ........................................................................ 82  
  248: Assessments to Expire - Adult ........................................................................................ 85  
  251: Completed Assessments - Adult .................................................................................... 89  
  252: Autoclosures – Adult ....................................................................................................... 93  
  264: Incomplete/Provider Complete Assessments – Child ...................................................... 96  
  265: Assessments Expiring - Child .......................................................................................... 100  
  267: Completed Assessments - Child ...................................................................................... 103  
  268: Autoclosures - Child ........................................................................................................ 107  
Automated Processes ..................................................................................................................... 110  
Error Codes and Related Business Rules ....................................................................................... 112  
Batch Processing and Electronic Data Transfer System (EDTS) ................................................ 115  

**Appendix: Business Rules by Sections**
Introduction

Overview of the CARE System

About CARE

The Client Assignment and Registration (CARE) System registers and tracks Texas Health and Human Services (HHS) individuals throughout the mental health and mental retardation service delivery system. This mainframe system has been in existence for over twenty years. A statewide data communications network links state schools, state hospitals, and community centers to CARE.

The central mainframe CARE system database is the operational repository for statewide individual information. A separate Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW), formerly Consumer Analysis Data Warehouse (accessed through Business Objects – InfoView) contains completed and static operational information for reporting and analysis purposes.

Mainframe CARE

The mainframe CARE system uses unique, statewide individual identification numbers to maintain descriptive information, such as demographics, county of residence, financial status, diagnostics, commitment status and mental health and mental retardation needs. Client reports, in addition to individual population statistical data, are available through on-line inquiry and standard production report generation.

Major Functions of Mainframe CARE

The mainframe CARE system supports the following major mental health Resiliency and Disease Management (RDM) functions:

- screening and registering individuals
- recording individual movement (assignment) throughout the service delivery system
- diagnostics, assessment, and level of care provided for individuals
- generating reports that profile individuals and components.
Overview of the CARE System, Continued

Resiliency and Disease Management (RDM)

RDM is a model for the provision of community-based mental health services for adults with bipolar disorder, schizophrenia, or clinically severe depression and for children or adolescents with serious emotional illness. RDM promotes the provision of high quality and effective community-based mental health services by individual-specific information that identifies a person’s mental healthcare needs, matches those needs to a particular mental health rehabilitative service(s), and evaluates and improves the effectiveness of the service provided.

About WebCARE

When Texas Department of Mental Health and Mental Retardation implemented RDM, the mainframe CARE system was selected as the operational system but required some programming changes. WebCARE was developed to modernize the CARE system and to incorporate RDM requirements. WebCARE’s purpose is to improve the integrity and consistency of individual data available for statewide resource management. Following the restructure of the human services system in 2004, WebCARE is operated by the Health and Human Services Commission in cooperation with the Department of State Health Services (behavioral health and Resiliency and Disease Management) and Department of Aging and Disability Services (mental retardation).

WebCARE Functions

WebCARE, the web-based front-end to the mainframe CARE system, provides registration, diagnostics, and assessment screens, as well as workflow and data management reporting capability. All data is stored in the same files/database on the mainframe for both CARE and WebCARE. Data may be entered into these files through WebCARE, CARE mainframe screens, or batch files.

About this Manual

This manual will focus on the WebCARE RDM functionality.
WebCARE System Documentation

Introduction  The following documents are available to help you use the WebCARE system. Whenever text is blue and underlined, a hyperlink is available. If this manual is being read electronically, point the cursor at the hyperlink and a hand \(\text{h} \) will appear. Click on the link and, if you are connected to the Internet and HHSC Intranet, your browser will display the referenced text.

Note: Some documents require Adobe Acrobat Reader®.(pdf files).

<table>
<thead>
<tr>
<th>User Guide</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WebCARE Manual</strong></td>
<td>This manual explains how you can use the WebCARE system’s Resiliency and Disease Management (RDM) functions. It contains descriptive information about how the WebCARE system functions, procedural information about using WebCARE, and WebCARE Screen Field Tables, Error Codes and Related Business Rules.</td>
</tr>
</tbody>
</table>
| **CARE Reference Manual** | The manual contains detailed information that you may occasionally need to use in working with mainframe CARE or WebCARE screens. It contains, for example:  
  - Decode Tables – codes and values used in WebCARE  
  - Component Codes – codes and values sorted differently  
  - County and Local Service Area Codes – codes, names and LSA’s  
  - AAMD Classifications – codes and values  
  - DSM Codes – codes and values  
  - Glossary – alphabetical list of mainframe CARE and WebCARE system terms and definitions. |
| **RDM Program Manual** | The manual addresses Resiliency and Disease Management as well as documentation and tools for implementation. |
WebCARE Forms

Introduction

When entering a new individual in WebCARE, the process is to enter:

1. a registration record,
2. a diagnostics record,
3. an assessment record,
4. an assignment record in mainframe CARE, and
5. monitor the individual record for needed updates via reports until the individual has been discharged and the record has been completed.

Note: Individuals are identified as “Clients” in the mainframe CARE and WebCARE system.

WebCARE Forms

To facilitate the entry of information into WebCARE, forms were created. WebCARE has the following data entry modules with associated forms:

- [Client Registration](#)
- [Client Diagnostics](#)
- [Adult Uniform Assessment](#) and [Instructions/Schedule](#)
- [Child/Adolescent Uniform Assessment](#) and [Instructions/Schedule](#)

Each form listed above has additional pages that list the:

- Field Name (as it is displayed on the screen),
- Type (Required, Displayed Only-Unchangeable, Optional, or a combination), and
- Contents of the field (explanation of what is entered in the field).
Confidentiality and Security of Consumer Records

All CARE and WebCARE Users

The information contained in the mainframe CARE / WebCARE (CARE) system is confidential. The same legal requirements and Commissioner’s rules, as with all other consumer records, govern this information. Everyone who uses the CARE system is responsible for ensuring the confidentiality and security of the consumer data stored in the system.

In accordance with Chapter 414, Subchapter A, Texas Administrative Code on Protected Health Information, CARE information should not be divulged to anyone not authorized to view, hear, or otherwise learn the contents of the information in question.

Security and Confidentiality Rules

The rules regarding security and confidentiality must be observed at all times. Failure to comply with these rules can result in a violation of both state and federal law, and may result in prosecution.

Component Administrators

Only staff members selected by a component’s administration (Superintendent, Director or Executive Director or other officially designated individual) may be authorized to use the CARE system. It is recommended that each component assign the CARE user access function to one or two knowledgeable center staff.

Those staff members given access to CARE should be selected because they need CARE access to perform their duties. They can be given one of five types of access to CARE.

<table>
<thead>
<tr>
<th>Type of Access</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE Access and Component Inquiry</td>
<td>Allows initial access to the CARE system and provides the ability to view all component data. All CARE system users must be authorized at this level.</td>
</tr>
<tr>
<td>Client Inquiry – Statewide</td>
<td>Allows user to view all consumer data statewide and to use the online consumer-related reporting function.</td>
</tr>
<tr>
<td>Component Data Entry</td>
<td>Allows user to add, change, and delete component data. Users given this level of authorization can only add, change, or delete data for that user’s component. Only two users at any one component will be given access to the component data entry. This gives access for changes in component name, address, contacts, QA Fees Rates, and Critical Incident Data.</td>
</tr>
</tbody>
</table>
Component Administrators, continued

<table>
<thead>
<tr>
<th>Type of Access</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Data Entry at Component</strong></td>
<td>Allows user to add, change, and delete consumer data (other than diagnostic data). A user given this level of authorization can only access data about consumers at that user’s component. State hospitals, state schools and state centers must indicate whether a CARE user should be authorized to enter: campus-based consumer data only, community-based consumer data only, or both campus- and community-based consumer data.</td>
</tr>
<tr>
<td><strong>Diagnostic Data Entry at Component</strong></td>
<td>Allows user to add, change, and delete consumer diagnostic data. Users given this level of authorization can only add, change or delete diagnostic data about consumers at that user’s component.</td>
</tr>
</tbody>
</table>

**Authorize CARE Access**

To authorize CARE access for your component, submit the appropriate completed Enterprise Security Management forms for each staff member authorized by your component’s administration to use the CARE/WebCARE system

**Centers: CARE and WebCARE Access Forms**

For centers to access mainframe CARE and WebCARE, the following forms are required. These forms can also provide access to mainframe JHS Exporter (reports) and HHS Intranet (for CARE documentation):

- **EASM SM 002 – Security and Privacy Agreement (SPA)** – This is a one-time submission for a new user requesting access. When the user information is entered in the security tracking system, an annual email will be sent to the user to re-affirm their SPA agreement online. If a user does not comply with this request, access will be denied or removed until such time as compliance is achieved.
- **IS 030 – Client Assignment & Registration System (CARE)**

**Centers: EDTS Access Forms**

For selected center staff, access to the Electronic Data Transfer System (EDTS) to download daily WebCARE or batched transactions:

- **Electronic Transmission Agreement (ETA)**
<table>
<thead>
<tr>
<th>Centers: FTP Access Form</th>
<th>For selected center staff, access to use File Transfer Protocol (FTP) to transfer batch files to mainframe CARE:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• IS 510 – Mainframe FTP</td>
</tr>
<tr>
<td>WebCARE Training</td>
<td>WebCARE Training is highly recommended before accessing WebCARE. To request training, see your center’s training coordinator. If training is not available at your center, send an email to:</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:RDM@dshs.state.tx.us">RDM@dshs.state.tx.us</a></td>
</tr>
<tr>
<td>User ID and Temporary Password</td>
<td>Information Services will assign a user ID and temporary password to each authorized CARE user. Upon receipt of the password, each CARE user must change the password. The password should be something that is easily remembered, but not obvious. For example, a user would not choose as the password his or her initials or those of any family members. All passwords must meet the minimum definition found in the Information Security Standards and Guidelines.</td>
</tr>
<tr>
<td>Change CARE Access Status</td>
<td>To change access status for CARE, call the Help Desk.</td>
</tr>
<tr>
<td>Protect PCs and Peripherals</td>
<td>Personal computers and peripherals should be shielded from viewing and protected from access by unauthorized individuals.</td>
</tr>
</tbody>
</table>
Rules for CARE/ WebCARE Users  You are required to observe the following CARE/WebCARE rules:

<table>
<thead>
<tr>
<th>Rule</th>
<th>Details</th>
</tr>
</thead>
</table>
| Maintain the secrecy of your account/user ID and your password | If you must write your Account/User ID and Password down, do not leave them where they can be seen by anyone other than you. If you suspect that someone has discovered your password or has breached security of the data in any way:  
  • Change your password immediately.  
  • Call the Help Desk at 512-438-4720 or 1-888-952-HELP (4357) and report the date and time you believe your User ID and Password was known to someone else and any other details known.  
  • Notify your local Center’s administration. |
| Maintain the security of your personal computer (pc)       | • Do Not leave your pc unattended when you are logged in to CARE/WebCARE.  
  • Do Not position your monitor so that others can see the screen.  
  • Do Not allow others to use your pc while you are logged on to the network. |
Accessing the WebCARE System

Access WebCARE

WebCARE requires an Internet browser (e.g. Internet Explorer or Netscape Navigator) for access. If your personal computer is connected to the Internet, start your browser.

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>In the Address (at the top of the screen, type the following Uniform Resource Locator (URL) exactly as it is written (or copy and paste the link into the Address): <a href="https://txmhmr.mhmr.state.tx.us:3610/PROD/WCARE/RDM">https://txmhmr.mhmr.state.tx.us:3610/PROD/WCARE/RDM</a></td>
<td></td>
</tr>
</tbody>
</table>

This will begin production WebCARE. For quicker access, this URL can be saved as a Favorite (for Internet Explorer) or a Bookmark (for Netscape Navigator).

For training or practice, use the WebCARE Demonstration system. In the Address (at the top of the screen, type the following URL exactly as it is written (or copy and paste the link into the Address): https://txmhmr.mhmr.state.tx.us:3610/dem/wcaredem/m

This will begin the WebCARE Demonstration system. This version of WebCARE has no “real” data; do not enter any real data. Use Demo User Name: F55TR01, Password: TRAIN01, and SSN: 111-11-1111.

Result: A Security Alert message is displayed.
Access WebCARE, continued

2. A sample Security Alert message is shown on the previous page. Select **Continue to this website (not recommended).**

Result: The Enter Network Password screen is displayed.

3. A sample screen is shown below. Enter the User Name (Identification Code) and password issued by ESM and click OK.

<table>
<thead>
<tr>
<th>If ...</th>
<th>Then ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are prompted to change your password</td>
<td>Change your mainframe CARE password using QWS3270 or your normal terminal emulator. This will change both your mainframe CARE and WebCARE passwords simultaneously. <strong>Important:</strong> If you change your password at this screen (for WebCARE only), your mainframe CARE password will be out of sync and you must call the Help Desk for assistance at 512-438-4720 or 1-888-952-4357.</td>
</tr>
<tr>
<td>You only have WebCARE access (and will <strong>NOT</strong> access mainframe CARE)</td>
<td>Use the following instructions.</td>
</tr>
</tbody>
</table>

Bugs Bunny needs a new password. His old one is ‘Carrots’ and Bugs wants to change his password to ‘Lettuce.’

To update his password, Bugs would:
1. enter his User ID in the User Name field,
2. tab to the next field,
3. type his old password (no spaces),
4. type a colon (no spaces), and
5. then type his new password in the Password field.
6. Click <OK>.

**Important:** **DO NOT** select “Save this password in your password list” for security reasons. If you forget your password or have any technical problems, call the Help Desk at 512-438-4720 or 1-888-952-HELP (4357).

Result: The CARE Access Verification Screen is displayed.
Accessing the WebCARE System, Continued

Access WebCARE, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 4    | A sample CARE Access Verification Screen is shown below. | • Enter your social security number without dashes, and  
• Press <Enter>, or  
• Click the <Submit_Signon> button. |

Before moving to the next screen, please read any notices that are displayed under the <Submit_Signon> and <Reset> buttons.

Note: This screen will display when you first enter WebCARE and after a period of inactivity.
Using and Exiting WebCARE

Using WebCARE  
After successfully completing the security screens, the WebCARE Main Menu is displayed. Since WebCARE is a web-based system, normal browser functionality can be expected. It is recommended, however, that the Back button not be used to return to a previous screen because data may have changed and using the Back button will not refresh the data. Navigation links are provided at the bottom of each screen to move between screens that are not listed as a menu item and to exit WebCARE.

Exiting WebCARE  
When you have finished using WebCARE, select the Q.Quit link at the bottom of any screen. This will exit you from the WebCARE session and you may close your browser window.
WebCARE System

WebCARE Main Menu

The WebCARE Main Menu (M:CARE Main Menu—Item M of the mainframe CARE system) is composed of the following modules:

```
<table>
<thead>
<tr>
<th>Module</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Client Name Search</td>
</tr>
<tr>
<td>200</td>
<td>General Client Inquiry</td>
</tr>
<tr>
<td>300</td>
<td>General Client Update</td>
</tr>
<tr>
<td>390</td>
<td>Case Maintenance</td>
</tr>
<tr>
<td>400</td>
<td>Registration/Demographics Update</td>
</tr>
<tr>
<td>500</td>
<td>Component Profile Inquiry</td>
</tr>
<tr>
<td>600</td>
<td>Component Data Entry</td>
</tr>
<tr>
<td>700</td>
<td>Performance/Workload Budget Data Entry</td>
</tr>
<tr>
<td>705</td>
<td>Performance/Workload Data Entry</td>
</tr>
<tr>
<td>770</td>
<td>Contract Reporting System</td>
</tr>
<tr>
<td>710</td>
<td>ICPME Menu</td>
</tr>
<tr>
<td>1000</td>
<td>NorthSTAR Menu</td>
</tr>
<tr>
<td>1100</td>
<td>Residency &amp; Disease Management Menu</td>
</tr>
</tbody>
</table>
```

Restricted Access

Access to most of the Main Menu modules is restricted. Only those with access to confidential individual data across the entire service delivery system will be able to access these modules.
## Main Menu Modules

Although this manual focuses on the Resiliency and Disease Management (RDM) module, a brief description or listing of all the modules as of December, 2007 and their related menus follow:

<table>
<thead>
<tr>
<th>Modules</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>100 – Client Name Search</strong></td>
<td>The Client Name Search function allows you to determine whether a prospective individual has been registered previously and, if so, to review the individual’s assignment history.</td>
</tr>
<tr>
<td><em>(Restricted Access)</em></td>
<td>Name Search uses data collected during the individual screening process to produce a listing of possible “matches,” of individuals with similar demographic characteristics who are registered in the system.</td>
</tr>
<tr>
<td></td>
<td>Search criteria are: Client Last Name, First Name, ID, Medicaid Recipient Number, Component Code/Local Case Number, SSN, Sex, Ethnicity, Age (+ or – 5 Years), Birth date, MH/MR, MH Authority, MR Authority, Assignment Status, Residential County, and Component Type. This name search will look for the Medicaid number entered into CARE files.</td>
</tr>
<tr>
<td><strong>200 – General Client Inquiry</strong></td>
<td>The General Client Inquiry is composed of six inquiries and searches:</td>
</tr>
</tbody>
</table>
| *(Restricted Access)*        | • 192 – DHS Medicaid Eligibility Search I  
• 193 – DHS Medicaid Eligibility Search II  
• 222 – Display of All Movements for a Client  
• 249 – Permanency Planning Review Approval Status  
• 286 – Critical Incident Data Inquiry  
• 771 – DSM/ICD Code and Text Search                                                                                                                |
| **300 – General Client Update** | The General Client Update provides seven methods for updating individual records:                                                                                                                       |
| *(Restricted Access)*        | • 330 – Diagnostics  
• 336 – State Operated ICF/MR Client Movements  
• 337 – Non-state Operated ICF/MR Client Movements  
• 346 – MH Adult Uniform Assessment for RDM  
• 360 – Death / Separation of Client                                                                                                                  |
| **390 – Case Maintenance**   | The Case Maintenance menu is for updating or deleting local case numbers and requesting individual identification information:                                                                               |
| *(Restricted Access)*        | • 395 – Local Case Number: Delete  
• 396 – Local Case Number: Change  
• 397 – Request Client ID Information                                                                                                                  |

continued on next page
### Menu Options continued

<table>
<thead>
<tr>
<th>Modules</th>
<th>Description</th>
</tr>
</thead>
</table>
| **400 – Registration / Demographics Update (Restricted Access)** | The Registration function in this module allows you to add, update, and display a limited number of individual’s identifying and demographic data and component identifying information.  
- 410 – Add Case to ID / Demographics  
- 413 – Medicaid / Medicare Number  
- 420 – Client Name  
- 430 – Client Address  
- 431 – Client Correspondent |
| **500 – Component Profile Inquiry (Restricted Access)** |  
- 530 – Component Names in Component Code Order  
- 565 – County Inquiry  
- 569 – ICF / MR Provider Information  
- 570 – ICF / MR Contract Information  
- 571 – ICF / MR Provider / Contract List  
- 572 – QAF Inquiry for Provider |
| **600 – Component Data Entry (Restricted Access)** |  
- 686 – Critical Incident Data |
| **B00 – Performance / Workload Budget Data Entry (Restricted Access)** |  
- B35 – FY 04 Thru 08 Performance/workload Expenditure/budget Data Entry  
- B36 – FY 04 Thru 08 Performance/workload Budget Amendments Data Entry  
- B33 – FY 04 Thru 08 Performance/workload in Kind Local Match Data Entry  
- B34 – FY 04 Thru 08 Performance/workload in Kind Local Match Amendment Entry  
- B40 – FY 04 Thru 08 Performance/workload Budget/expend Edits  
- 778 – *** Review Data Already Entered |
| **M00 – Performance / Workload Data Entry (Access Restricted to Central Office Only)** |  
- M62 – Performance/workload MH/MR Target Entry  
- M33 – CMGR Amendment Approval  
- F11 – Freeze/ Unfreeze Performance/ Workload I.A or II.A |
| **778 – FY 05/06 Contract System Reporting (Restricted Access)** |  
- Report by Component, Quarter, and Fiscal Year |

continued on next page


**Main Menu Modules, Continued**

Menu Options continued

<table>
<thead>
<tr>
<th>Modules</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1100 – ICF / MR Menu (Restricted Access)</td>
<td>ICF/MR Data Entry</td>
</tr>
<tr>
<td></td>
<td>• 336 – State Operated Client Movements</td>
</tr>
<tr>
<td></td>
<td>• 337 – Non-state Operated Client Movements</td>
</tr>
<tr>
<td></td>
<td>• 360 – Death / Separation of Client</td>
</tr>
<tr>
<td></td>
<td>• 1121 – Living Options Process Maintenance</td>
</tr>
<tr>
<td></td>
<td>• 1123 – Provider MR/RC Assessment</td>
</tr>
<tr>
<td></td>
<td>• L29 – Authority MR/RC Assessment</td>
</tr>
<tr>
<td></td>
<td>• 1125 – QA Fees Entry / Update By Provider</td>
</tr>
<tr>
<td></td>
<td>• 1126 – QA Fees Semi-annual Revenue Entry</td>
</tr>
<tr>
<td></td>
<td>• 1127 – QAF Entry / Update By SG 5 Provider</td>
</tr>
<tr>
<td></td>
<td>• 1128 – QAF Semi-annual Revenue By SG 5 Provider</td>
</tr>
<tr>
<td></td>
<td>Demographics Update</td>
</tr>
<tr>
<td></td>
<td>• 410 – Add Case to ID / Demographics</td>
</tr>
<tr>
<td></td>
<td>• 413 – Medicaid / Medicare Number</td>
</tr>
<tr>
<td></td>
<td>• 420 – Client Name</td>
</tr>
<tr>
<td></td>
<td>• 430 – Client Address</td>
</tr>
<tr>
<td></td>
<td>• 431 – Client Correspondent</td>
</tr>
<tr>
<td></td>
<td>Case Maintenance</td>
</tr>
<tr>
<td></td>
<td>• 395 – Local Case Number: Delete</td>
</tr>
<tr>
<td></td>
<td>• 396 – Local Case Number: Change</td>
</tr>
<tr>
<td></td>
<td>Additional Component Data</td>
</tr>
<tr>
<td></td>
<td>• 683 – ICF / MR Provider Characteristics</td>
</tr>
<tr>
<td></td>
<td>• 684 – ICF / MR Provider Email Address Maintenance</td>
</tr>
<tr>
<td></td>
<td>ICF/MR Inquiry</td>
</tr>
<tr>
<td></td>
<td>• 100 – Client Name Search</td>
</tr>
<tr>
<td></td>
<td>• 192 – DHS Medicaid Eligibility Search I</td>
</tr>
<tr>
<td></td>
<td>• 193 – DHS Medicaid Eligibility Search II</td>
</tr>
<tr>
<td></td>
<td>• 222 – Display of All Movements for a Client</td>
</tr>
<tr>
<td></td>
<td>• 286 – Critical Incident Data Inquiry</td>
</tr>
<tr>
<td></td>
<td>• 565 – County List</td>
</tr>
<tr>
<td></td>
<td>• 569 – Provider Information</td>
</tr>
<tr>
<td></td>
<td>• 570 – Contract Information</td>
</tr>
<tr>
<td></td>
<td>• 571 – Provider Contract List</td>
</tr>
<tr>
<td></td>
<td>• 572 – QAF Inquiry for Provider</td>
</tr>
<tr>
<td></td>
<td>• 771 – DSM / ICD Code and Text Search</td>
</tr>
<tr>
<td></td>
<td>• 1161 – Daily Census Report</td>
</tr>
<tr>
<td></td>
<td>• 1163 – Clients with Service Authorizations / Client Assessments Changed During Period</td>
</tr>
<tr>
<td></td>
<td>• 1164 – Computed Service Authorizations / Client Assessments / Medicaid Eligibility By Id</td>
</tr>
<tr>
<td></td>
<td>• 1165 – MR/RC Assessment Expiration</td>
</tr>
<tr>
<td></td>
<td>• 1168 – MR/RC Assessment Summary</td>
</tr>
<tr>
<td></td>
<td>• 1182 – MR/RC Assessment Pending</td>
</tr>
<tr>
<td></td>
<td>• 1183 – Individual MR/RC Assessment</td>
</tr>
<tr>
<td></td>
<td>• 1185 – Permanency Plan Status Report</td>
</tr>
<tr>
<td></td>
<td>• 1187 – MRA Contact Information</td>
</tr>
<tr>
<td></td>
<td>Download User Documentation</td>
</tr>
</tbody>
</table>
Menu Options continued

<table>
<thead>
<tr>
<th>Modules</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1600 – NorthSTAR Menu</strong>&lt;br&gt;<em>(Restricted Access)</em></td>
<td><strong>Inquiry</strong>&lt;br&gt;• 1650 – Name Search&lt;br&gt;• 1660 – Clients Registered Online Today&lt;br&gt;• 1665 – State Hospital Enrollees&lt;br&gt;• 1670 – Name Search - No Medicaid Information&lt;br&gt;• 1675 – Persons in State Hospital - not Enrolled&lt;br&gt;• 1680 – Persons Registered Online - not Enrolled</td>
</tr>
<tr>
<td><strong>RDM – Resiliency &amp; Disease Management</strong></td>
<td><strong>Data Entry</strong>&lt;br&gt;• 325 - Client Registration&lt;br&gt;• 330 - Diagnostics&lt;br&gt;• 164 - MH Child Uniform Assessment for RDM&lt;br&gt;• 169 - Provider Appeal for Child RDM Assessments (NorthSTAR Only)&lt;br&gt;• 346 - MH Adult Uniform Assessment for RDM&lt;br&gt;• 347 - Provider Appeal for Adult RDM Assessments (NorthSTAR Only)&lt;br&gt;<strong>Workflow / Reports</strong>&lt;br&gt;• 246 – Incomplete/Provider Complete Assessments – Adult&lt;br&gt;• 247 – Assessments Expiring By Section – Adult&lt;br&gt;• 248 – Assessments to Expire – Adult&lt;br&gt;• 251 – Completed Assessments – Adult&lt;br&gt;• 252 - Autoclosures - Adult&lt;br&gt;• 264 – Incomplete/Provider Complete Assessments – Child&lt;br&gt;• 265 – Assessments Expiring – Child&lt;br&gt;• 267 – Completed Assessments – Child&lt;br&gt;• 268 - Autoclosures - Child</td>
</tr>
</tbody>
</table>
RDM: Resiliency & Disease Management Module

Introduction

In this manual and in WebCARE,

- **RDM** refers to the Resiliency and Disease Management module of WebCARE.
- **RDM** is the acronym used for the Resiliency and Disease Management model. RDM is a systematic approach for needs assessment and service delivery that:

  1. Assures a more uniform approach to assessment and service assignment;
  2. Provides evidence-based services that are appropriate to address the needs of adults with severe mental illness and children and adolescents with serious emotional disturbance;
  3. Establishes statewide utilization guidelines to help ensure that individuals receive the proper amount of each service provided;
  4. Establishes fidelity standards that will help to ensure that the services that are provided conform to current clinical standards; and
  5. Provides a means of objectively measuring both provider performance and individual outcomes.
RDM Data Entry

Introduction

After selecting RDM from the M: CARE Main Menu, the following screen is displayed.

Functions

In the WebCARE RDM module, there are two groups of functions: Data Entry and Workflow / Reports.

Data is Entered

Individual data may be entered in three ways:
- WebCARE screens
- CARE mainframe screens, or
- Batch File (data is collected from a local system—batched—and electronically transferred via File Transfer Protocol [FTP] to a file on the mainframe. The data is then checked for errors and loaded into the CARE database.)

RDM CARE Daily Extract

A daily extract of all new, successfully entered RDM CARE records is placed in a directory accessible to local centers and can be transferred to the center via Electronic Data Transfer System (EDTS) for record verification and use by the provider’s local system.
RDM Workflow / Reports

Introduction

Workflow / Reports is a method of viewing previously entered data. It is organized so that you can quickly identify outstanding, expiring, or incomplete data. A sample screen is shown below.

<table>
<thead>
<tr>
<th>Data Entry</th>
<th>Workflow / Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>311 Client Reg.</td>
<td>246 Incomplete Provider Complete Assessments - Adult</td>
</tr>
<tr>
<td>331 Diagnostic</td>
<td>247 Assessments Expiring By Section - Adult</td>
</tr>
<tr>
<td>164 MH Child Uniform Assessment for RDM</td>
<td>248 Assessments to Expiry - Adult</td>
</tr>
<tr>
<td>346 MH Adult Uniform Assessment for RDM</td>
<td>351 Completed Assessments - Adult</td>
</tr>
</tbody>
</table>

Business Rule: Adult individuals who are members of the **Target Population**

- Diagnosis of Schizophrenia or Bipolar Disorder - or a diagnosis of Major Depression (with GAF <50) and members of the **Priority Population** (MH diagnosis and GAF < 50) who have been determined by a Licensed Practitioner of the Healing Arts (LPHA) to have a medical need for the services, require a Client Registration record, Diagnostics record, and the appropriate Assessment record.
- Individuals whose services are totally paid by a third party do not require an assessment record.

For more information on Priority Populations and Target Populations, see Performance Contract.

Business Rule: Child/Adolescent individuals (children ages 3 through 17) with a diagnosis of mental illness who exhibit serious emotional, behavioral or mental disorders and who:

1. have a serious functional impairment; or
2. are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
3. are enrolled in a school system’s special education program because of a serious emotional disturbance.
RDM Workflow / Reports, Continued

**Business Rule:**  Child/adolescent individuals are children ages 3 through 16. Individuals who are 17 or 18 years of age may be eligible for either child/adolescent services or adult services.

**RDM Examples**

To illustrate the use of the RDM module, two vignettes (one for an adult and one for a child/adolescent) are presented and the appropriate steps for entering the data for these fictional people will follow in the next chapters.

**Child/Adolescent**

Peter Piper is a 5-year-old Caucasian male diagnosed with ADHD. His father reports that he talks back, is bossy and demanding, is impulsive, accident-prone, and has poor attention. He reports that Peter can be very aggressive to both adults and other children, doesn’t follow rules, and has sneaked out of the house on several occasions. He reports that Peter has been kicked out of five daycares. Peter frequently destroys his toys, sometimes burning them. Peter’s father reported that Peter fell off a playscape and lost consciousness briefly at age 4. He has never received any mental health treatment.

Peter will start school in several months, but is currently being cared for at a new daycare. Peter’s mother left the home when Peter was 2 years old and is not currently a part of his life. Peter’s father reports he works a lot and is frustrated with all of the calls he gets from daycare because of Peter’s behavior. Peter’s father states that he may lose his job if Peter gets thrown out of this daycare. There is no other family or support system in the area.

The Qualified Mental Health Professional-Community Service (QMHP-CS) at the service center diagnosed Peter with “Attention Deficit Hyperactivity Disorder, Combined Hyperactive-Impulsive and Inattentive Type”.

_________________________________________________________
Of the three Principal Diagnosis Categories:

- Externalizing Disorders
- Internalizing Disorders, and
- Bipolar, Schizophrenia or related Disorders),

Peter has an **Externalizing Disorder** and qualifies to receive services.

For a more comprehensive explanation about Peter, see the [User’s Manual for the CA-TRAG](#).

---

**Adult**

Miguel de Cervantes is 19 years of age and has been diagnosed with Schizophrenia. The director of the homeless shelter where he lives brought him to his Licensed Professional of Healing Arts (LPHA). He denies suicidal ideation recently or in the past.

**Psychiatric History**

Miguel has had no recent hospitalizations. He is homeless and living in shelters. He is pleasant but quite psychotic and experiences persistent feelings of “double exposure” (i.e., believing he is being controlled and exposed by another “self”, namely Don Quixote).

**Substance Use History**

Miguel seems to have a history of substance dependence (most notably marijuana) although he was never able to get involved with a recovery program. Over the past few years, however, he has become increasingly involved instead with abuse of cold pills (mostly for the speedy effect) but also for reported relief of “double exposure.”

**Social History**

Miguel has a sister and father who live about 5 hours away. He sees them infrequently, and they are worried about him, yet they are unable to provide assistance or monitoring. He has been quite isolative and has no real friends. He is currently unemployed, and he has not held a job for more than a couple weeks at a time during the past year. He has been arrested twice within the past three months, with one misdemeanor conviction for drug possession and another misdemeanor conviction for theft.

**Mental Status**

Miguel appears oriented, but is disorganized, rambling, and loose. He reports auditory hallucinations and paranoid ideation. Miguel adamantly denies any intent to self-harm, only to get high. He denies that his behavior is risky and doesn’t really want to stop using, but agrees to get help if it will make his sister and father happy.
### RDM Examples, Continued

<table>
<thead>
<tr>
<th>Adult (continued)</th>
<th>Of the three Principal Diagnosis Categories:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Schizophrenia or related disorders,</td>
</tr>
<tr>
<td></td>
<td>• Bipolar Disorders, and</td>
</tr>
<tr>
<td></td>
<td>• Major Depression Disorders,</td>
</tr>
</tbody>
</table>

Miguel de Cervantes has **Schizophrenia** and qualifies to receive services.

For a more comprehensive explanation about Miguel, see the [User’s Manual for the Adult-TRAG](#).
325: Client Registration

Introduction

Client registration is the act of identifying a person as an individual of the Texas Health and Human Services (HHS) Service Delivery System. An individual/client is a person who is registered in the CARE/WebCARE system. Until a person is registered, they cannot be assigned to a service.

Registration Guidelines

<table>
<thead>
<tr>
<th>A person…</th>
<th>In the CARE/WebCARE System…</th>
</tr>
</thead>
</table>
| is registered | • *After* staff determines that  
| | 1. the person has a problem properly addressed by services provided by HHS, and that  
| | 2. the person is eligible for services, and  
| | • *At the time*, a staff member begins to provide services to the person. |
| is *not* to be registered | If the individual contacts an HHS Service Delivery System component seeking assistance and is:  
| | • told that HHS is not the appropriate service provider for that problem, and/or  
| | • referred to a service provider outside HHS, without the provision of services by HHS. |

Services

If a screening requires more staff time than usual, consider that the screener may have actually begun to provide billable services. Examples of services include, but are not limited to:

- administrating standard tests to determine whether an individual needs HHS services
- contacting other service providers to arrange services for an individual
- general service delivery activities.

Registration

The registration function in this module allows you to add, update, and display an individual’s identifying, demographic data, and component identifying information. In addition, reports can be produced for groups of individuals by selected demographic characteristics. The data entry features of WebCARE Client Registration are presented in this section.
### Client Registration Screen

The 325: Client Registration screen is used to generate a unique, statewide client identification number and to record such data as a client’s name, sex, ethnicity, birth date, social security number, presenting problem, address, county of residence and local case number at your component.

### Individuals are Registered Once

The CARE system maintains an unduplicated count of individuals. *The registration process is designed to ensure that individuals are registered only once.* After you submit the prospective individual’s data, the system searches all registered clients to determine whether the prospective new individual is already registered.

### Data Entry

*A client Registration record must be completed before a diagnosis or an assessment (including those for crisis individuals) may be entered. This function is the same for an adult or child/adolescent.*

*Note:* For a description of each screen field, see the screen field table on the pages following the Client Registration form. See also the list of Component Codes (your local center identifier) and the individual’s County of Residence.

### Client Registration Form

It is recommended that registration data be entered immediately into WebCARE by the person who registered the individual; however, the Client Registration form may be printed and completed with the individual’s most current data prior to WebCARE data entry if data entry will be delayed. WebCARE forms are subject to change.

continued on next page
When 325: Client Registration is selected, the following screen is displayed.

### Required fields
- **Component Code**: 030
- **Local Case Number**
- **Client Last Name/Suf**
- **Client First Name**
- **Client Middle Name**
- **Sex**
- **Ethnic/New Fed Race**
- **Fed Ethnicity**
- **Client Birthdate (mm/dd/yyyy)**
- **Social Security Number (n=none, u=unknown)**

### Optional fields
- **Medicaid Number**
- **Medicare Number**
- **Presenting Problem**
- **Registration Effective Date (mm/dd/yyyy)**
- **Registration Effective Time (hh:mm A/P)**
- **Street Address**
- **City**
- **State**
- **Zip Code/Suffix**
- **County of Residence**
- **Legal Guardianship**
- **Marital Status**
- **Estimated Annual Gross Family Income**
- **Family Size**

**Example only**: Component Code displayed will be for your local center.

**These two fields are automatically filled but may be changed**.

**The text for Required fields are blue and Optional fields are green.**
325: Client Registration, Continued

Registration Screen Example

If no existing Component Code and Local Case Number combination is found and all required fields are completed, the 325: Client Registration screen displays the client’s data prepared for entry into WebCARE. The following is an example for Peter Piper, our fictitious child.

<table>
<thead>
<tr>
<th>05.13.05 @12:59:53</th>
<th>325: Client Registration</th>
<th>VC111367</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Last Name/ Suf</td>
<td>PIPER</td>
<td>Client ID</td>
</tr>
<tr>
<td>Client First Name</td>
<td>PETER</td>
<td>Component Code</td>
</tr>
<tr>
<td>Client Middle Name</td>
<td>PEPPER</td>
<td>Local Case Number</td>
</tr>
</tbody>
</table>

Sex: M
Ethnicity: W
Fed Race: N
Client Birth Date: 01/01/2000
Social Security Number: 456540540
Medicaid Number: 
Medicare Number: 
Presenting Problem: 1
Registration Effective Date: 08/18/2005
Registration Time (Ishmun A/P): 12:45 P
Street Address: 1111 PICKLED PEPPER
City: AUSTIN
State: TX
Zip: 78701
Current County of Residence: 227
Legal Guardianship: 1 - MINOR
Marital Status: 5 - NEVER MARRIED
Estimated Annual Gross Family Income: 10000
Family Size: 3

Ready to Add (Y/N)

Submit_Update

Warning

You must enter a Y in the READY TO ADD (Y/N) box. If an N is entered in the READY TO ADD (Y/N) box or the box is left blank and the Submit_Update button is selected, all data is lost and you are returned to the blank 325: Client Registration data entry screen.
Statewide ID Displays

After successfully submitting the record, the following screen header displays with the client’s newly generated statewide identification number (for Peter Piper, his new number is 33987). The form is reset (except for the Component Code) so that additional client Registrations may be entered.

One Duplicate Combination

If only one exact duplicate Component Code and Local Case Number combination is entered, the following error message (in a red font) displays:

**MSG: 1907 THIS LOCAL CASE NUMBER ALREADY EXISTS FOR YOUR COMPONENT

Note: Other error messages may occur during data entry. See Error Codes and Related Business Rules in this manual.
Several Duplicate Combinations

If there are several duplicate Component Code and Local Case Number combinations the 325: Matching Client Characteristics screen will display. Characteristics, such as name, social security number, and sex of the individual are used to select potential duplicate individuals. The following screen is displayed after entering duplicate information for Peter Piper, our fictitious child.

Note: In this case, the options are: adding a local case number to an existing client by selecting the Add Case To button or creating a new ID by selecting the Create New Id button, if the person is not listed.
**325: Client Registration, Continued**

If a duplicate *Component Code* but a different *Local Case Number* combination is entered and all required fields are completed with the existing client’s data, the 325: Client Registration screen displays with the client’s data prepared for entry into WebCARE. The new *Local Case Number* is added to the client’s record. The following is an example header for Peter Piper, our fictitious child.

---

**Key Points**

- A Registration must be completed before a Diagnostics or Assessment record can be entered.
- Required fields for the Registration screen have a blue font.
- Optional fields for the Registration screen have a green font.
**330: Diagnostics**

**Introduction**

WebCARE allows you to record and update diagnostic data for individuals. You can add new diagnostic data, as well as change and delete previously submitted data. Diagnostic data must be entered before assessment data, except when the individual is in crisis.

For crisis individuals only: **“Treat then TRAG”**

**When Diagnostic Data is Collected**

In general, diagnostic data is collected about an individual (for both adult and child/adolescent) when one of the following three events occurs:

- a component determines that an individual will be served,
- an individual is reevaluated at the time of the annual staffing (every 365 days or at any other time that diagnostic update is needed), or
- an individual dies.

**TIMA Scales**

Diagnostics data will determine which Texas Implementation of Medical Algorithms (TIMA) scales will be applied.

*Note:* For a description of each screen field, see the screen field table on the pages following the Client Diagnostics form.

**Enter Diagnosis or Print Client Diagnostics Form**

It is recommended that diagnostic data be entered immediately into WebCARE by the person who diagnosed the individual; however, the Client Diagnostics form may be printed and completed prior to WebCARE data entry, if data entry will be delayed. CARE forms are subject to change. The following examples and additional information are provided for completion of the 330: Diagnostics screen.

**Business Rule**

The **Decision Date** is linked to the adult and child/adolescent assessments. The client Diagnostics decision date must be up to **365 days** prior to the **Assessment Date** for:

- Section 1: Adult-TRAG & Recommended Level of Care
- Section 1: Child/Adolescent TRAG
### 330: Diagnostics, Continued

#### Principal Diagnosis

The individual’s **Principal Diagnosis Axis** is required. Using [DSM](https://www.psychiatry.org/patients-and-families/dsm) codes, enter:

- 1=Axis I (Psychiatric Syndrome or Mental Health - MH)
- 2=Axis II (Personality and Specific Developmental Disorder or Mental Retardation - MR)

#### Axes

Diagnostic data for Mental Health (MH) is added into the Level/Axis matrix using the following Axes:

<table>
<thead>
<tr>
<th>Axis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Axis I</strong> - Psychiatric / MH</td>
<td>Level 1 is for most significant, Level 6 is least significant</td>
</tr>
<tr>
<td>Diagnosis from the Diagnostic</td>
<td>Axis 1, Level 1 is required if Principal Diag. Axis is 1= Axis I (MH).</td>
</tr>
<tr>
<td>and Statistical Manual of Mental</td>
<td>If MH, “Reason for Action” is 3 (Death) then Level 1 is required.</td>
</tr>
<tr>
<td>Disorders (<a href="https://www.psychiatry.org/patients-and-families/dsm">DSM Codes</a>)</td>
<td></td>
</tr>
<tr>
<td><strong>Axis II</strong> - Personality Developmental Disorders (<a href="https://www.psychiatry.org/patients-and-families/dsm">DSM Codes</a>).</td>
<td>Level 1 is for most significant, Level 4 is least significant</td>
</tr>
<tr>
<td></td>
<td>If MR, “Reason for Action” is 3 (Death) then Level 1 is required.</td>
</tr>
<tr>
<td><strong>Axis III</strong> - Physical Impairments from The International Classification of Diseases, 9th Revision, Clinical Modification (<a href="https://www.cdc.gov/icd-10-cm/index.html">ICD Codes</a>).</td>
<td>Level 1 is for most significant, Level 6 is least significant</td>
</tr>
<tr>
<td></td>
<td>Level 1 is required for a “Reason for Action” of 2=Reevaluation. Enter ‘None’ if no physical impairments and do NOT enter the Axis III Date. The Axis III Date is required if an ICD-9-CM Code is entered.</td>
</tr>
<tr>
<td><strong>Axis IV</strong> - Psychosocial and Environmental Stressors (<a href="https://www.cdc.gov/icd-10-cm/index.html">Axis IV Decode Table</a>).</td>
<td>See top of page 6 of the Decode Table.</td>
</tr>
<tr>
<td><strong>Axis V</strong> - Highest-Level Adaptive Functioning – Current and Past Year. (<a href="https://www.cdc.gov/icd-10-cm/index.html">Axis V Decode Table</a>).</td>
<td>See pages 6-7 of the Decode Table.</td>
</tr>
<tr>
<td></td>
<td>Current Global Assessment of Functioning (GAF) Score is required.</td>
</tr>
</tbody>
</table>
Additional Diagnostic Data

Additional diagnostic data recorded for Mental Retardation (MR) Individuals includes:

- Current and potential Adaptive Behavior Levels (ABL Decode Table). See page 4. *Required if Principal Diag Axis IS 2 (MR).*
- Primary, secondary and tertiary American Association on Mental Deficiency (AAMD Decode Table) classifications. *For MR Individuals Only.*
- Genetic defect. See page 15. *For MR Individuals Only.*
- Cranial Anomaly. See page 12. *For MR Individuals Only.*
- Sensory Impairment. See page 31. *For MR Individuals Only.*
- Perception. See page 28. *For MR Individuals Only.*
- Convulsive Disorder. See page 12. *For MR Individuals Only.*
- Psychiatric Impairment. See page 29. *For MR Individuals Only.*
- Intelligence Quotient (IQ) score, test date and test type. See page 18.
- Social Quotient (SQ) score, test date and test type. See page 34.

330: Diagnostics Screen

With the diagnostic information necessary for data entry, continue in WebCARE by selecting 330: Diagnostics. The first screen will require the Component Code and the Local Case Number to link to the Registration record. Submit the request, and then the Diagnostic history for your individual will be displayed, if there is previously entered diagnostic information.
First Record

If this is the first record for your individual, the following screen is displayed. The following screen is for our fictitious individual, Peter Piper.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>Piper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffix</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td>Peter</td>
</tr>
<tr>
<td>Middle Name</td>
<td>Pepper</td>
</tr>
</tbody>
</table>

Client ID: 39987
Component: 030
Local Case Number: 0000009996

continued on next page
Create a New Record

Create a new Diagnostic record by selecting **Create New**. When the screen is completed correctly; the following screen will be displayed.

**THE FOLLOWING INFORMATION HAS BEEN PROCESSED:**

08.18.05 @14:12:51

| Last Name | PEPPER | | Client ID | 33987 |
|-----------|--------|| Component | 630 |
| First Name | PEPPER | | Local Case Number | 0000009996 |
| Middle Name | PEPPER | | MH Pri Pop | 7 |

<table>
<thead>
<tr>
<th>Decision Date (mm/dd/yyyy)</th>
<th>07/01/05</th>
<th>Form Time (hh:mm:ss)</th>
<th>02:11P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Action</td>
<td>1 - AADM/PROV</td>
<td>Principal Axis</td>
<td>1 - AAX I</td>
</tr>
<tr>
<td>Location:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
</tr>
<tr>
<td></td>
<td>Axis I</td>
<td>31401</td>
<td>31281</td>
</tr>
<tr>
<td></td>
<td>Axis II</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Axis III</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Axis IV</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Axis V</td>
<td>Current</td>
<td>Past Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current ABL</th>
<th>Potential ABL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary AAMD</td>
<td>Secondary AAMD</td>
</tr>
<tr>
<td>Genetic</td>
<td>Cranial Anomaly</td>
</tr>
<tr>
<td>Perception</td>
<td>Convulsive Disorder</td>
</tr>
<tr>
<td>Motor Dysfunction</td>
<td>AAMD Date (mm/dd/yyyy)</td>
</tr>
<tr>
<td>DSM Version</td>
<td>ICD Version</td>
</tr>
<tr>
<td>IQ Score</td>
<td>IQ Test Date (mm/dd/yyyy)</td>
</tr>
<tr>
<td>SO Score</td>
<td>SO Test Date (mm/dd/yyyy)</td>
</tr>
</tbody>
</table>

**Previous Diagnostic Data**

If the client has previous diagnostic data for your component, WebCARE displays a summary of that diagnostic data. This data is provided so you will not need to reenter information that has stayed the same since the previous diagnosis.
**WebCARE Rule**

For a child/adolescent, only the diagnosis entered on Axis 1, Level 1 will be used for assessment calculations. For an adult, any diagnosis entered along Axis 1 (any level) may be used. If one of the diagnoses entered is part of the target population (schizophrenia or related, bipolar, or major depression) then this diagnosis is selected for assessment calculations.

---

**Update Incorrect Diagnosis or Enter Reevaluation**

To update an incorrect Diagnosis, select the Update button, make corrections and click **Update** at the bottom of the screen. To enter a reevaluation, select **Create_New** and enter the new diagnosis. The most recently entered diagnostic data is displayed first, followed by all others in reverse chronological order. Any data added using **Create_New** will be utilized by WebCARE for the Level of Care-Recommended (LOC-R) on the person’s assessment but will not change the previous diagnostic data.

---

**Review Assessment**

Since Assessment Level of Care Recommended (LOC-R) may change with a change in diagnosis, it is recommended that the person’s assessment be reviewed and updated following submittal of new Diagnostic data.

---

**Enter Assessment Record**

The next step is to enter an assessment record for the individual.
330: Diagnostics, Continued

Key Points

- A diagnosis must be determined and entered in the CARE system before a Uniform Assessment can be entered, except when an individual is in crisis at Intake. When the individual is no longer in crisis, a Diagnostics record is required before an Update assessment record can be entered.
- Diagnosis must be reevaluated and updated for each individual every 365 days.
- Diagnosis data will determine which TIMA scales will be applied.
Overview

The Adult Uniform Assessment is an instrument designed to assist in the selection of a benefit package and financing methodology for public mental health services in the state of Texas. The Mental Health Adult Uniform Assessment for Resiliency and Disease Management module of the WebCARE system is designed to record the individual’s assessment data, with the primary goal of using standard, quantifiable measures to guide the choice of service needs and to make appropriate “level of care” decisions.

Business Rule:

Age

An adult is any person 19 years of age or older. An individual age 17 or 18 may be served as either an adult or child/adolescent. Any individual who is age 16 or under is a child/adolescent. An individual who is being served as a child/adolescent will be discharged from child/adolescent services on their 19th birthday when an adult Intake record is entered to continue services.

Note: For specific instructions on completing the Adult Uniform Assessment form, refer to Adult Form Completion and Schedule.

Online Data Entry

Online data entry by those completing the assessment is preferred.

Centralized Data Entry

For centralized data entry, it is recommended that the MH Adult Uniform Assessment for Resiliency & Disease Management form be printed from the link above and completed prior to WebCARE data entry. WebCARE forms are subject to change. Examples and additional information is provided below for completion of the 346-MH Adult Uniform Assessment for RDM screen.

Local center authority or Utilization Management staff authorize service packages. If a data entry clerk is entering data, the form must be signed by the authorizer and must be in the individual’s clinical records.
Sequence of Assessment Types

The expected sequence of completed assessment types is:

1. One Crisis (if individual is in crisis before an Intake or following a Discharge). No Discharge assessment is required.
2. One Intake (If Intake Non-Admission – LOC-R=9 and LOC-A=9, then no Update or Discharge assessment is required) – used for initial admission into services, after a Discharge, or for Crisis Follow-up services after a hospital discharge.
3. One or more Update(s) – used for periodic reassessments, usually every 90 days.
4. One Discharge – used when services will no longer be provided.

WebCARE Error Code Help

If you receive an error code when entering data, click on Open Error Code help for this screen. A new window will appear that has the Error Code, Resolution, and Business Rules database. Select the error code from the list and Display Results. Close this new window when finished.

Request Screen

From the RDM Menu, select 346: MH Adult Uniform Assessment for RDM. The following screen will be displayed.
Enter Data  Enter the Component Code and Local Case Number for the adult to be assessed and select Submit_Request.

Note: Miguel de Cervantes, the fictitious adult, will be used as an example.

No Diagnostics Record  If no diagnostics record is found for the individual, the following screen will be displayed:

A diagnostics record must be entered for all individuals in WebCARE.

Business Rule: Crisis Individuals  For Crisis Individuals only, a Crisis assessment may be entered before a diagnostics record. However, when the individual is no longer in Crisis, a diagnostics record is required before an Intake assessment record may be entered. For a list of all Business Rules, see Error Codes and Related Business Rules.
Diagnostic Record

If a Diagnostics record has been entered and this is the first assessment record, the following screen is displayed.

---

**WebCARE Rule:**

Incomplete assessments, after 30 days with no updates or modifications, the Incomplete record will be deleted. Complete assessment records, for up to 7 days after completion, may be modified or deleted. If the Section 2: Authorized Level of Care (LOC-A) date is future-dated for notification of appeals, the future-dated record can be modified or deleted for up to 7 days after the LOC-A ASSESSMENT DATE. After 7 days, the Complete assessment will be viewable only with a Look_At button. Note: Only an authority or UM can delete a complete assessment within 7 days.
Create Assessment Record

To create a new assessment record, select **Create New**. The following screen is displayed. A sample screen is shown below and continued on the next page.
Create Assessment Record Continued

Note: For Miguel de Cervantes, our fictitious adult, an Intake assessment will be entered. For more information on each field, refer to the additional pages for the MH Adult Uniform Assessment for Resiliency & Disease Management (CARE-UA-RDM) form.

Sections 1, 3, and 4 Fields

The Section 1: Adult-TRAG & Recommended Level of Care, Section 3: Diagnosis-Specific Clinical Symptom Rating [TIMA] Scales, and Section 4: Community Data fields may be entered at once by the provider. Since WebCARE calculates the LOC-R, the LOC-R is not visible until the Submit_Update button is selected. Change the FORM STATUS to Incomplete or Provider Complete and select the Submit_Update button.

Section 2 Fields

A Local Mental Health Authority (LMHA) Utilization Management or authorized staff person must enter Section 2: Authorized Level of Care LOC-A data. If the Recommended Level of Care (LOC-R) does not match the LOC-A, at least one appropriate deviation reason must be selected. The general comment field is intended for communication between the staff who perform the assessment and the authorizer or UM. Note: When an assessment is complete, only an authority or UM can delete the assessment within 7 days.

Form Status Field

The following table describes the options for the FORM STATUS field.

<table>
<thead>
<tr>
<th>Form Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete</td>
<td>Intended for use by the provider to indicate that the data entered is partial and will be completed soon.</td>
</tr>
<tr>
<td>Provider Complete</td>
<td>Intended for use by the provider to indicate that the data entered is complete and ready for the authority or Utilization Management review and authorization.</td>
</tr>
<tr>
<td>Complete</td>
<td>Intended for use by the authority or Utilization Management staff to indicate that all data has been entered and the center is finished with the assessment.</td>
</tr>
</tbody>
</table>

If the Form Status is marked Incomplete or Provider Complete for more than 30 days without being changed, the WebCARE Auto-Delete process will automatically delete the assessment.

For Update Assessments, if the Form Status is marked Provider Complete and the prior authorization is still valid, the assessment form will be AutoCompleted. If the Provider wants the individual to be re-authorized or prefers that the Authority (UM staff) review the assessment, the Authority Review Requested? check box may be selected.
### Form Status Field (continued)

When assessment forms are marked complete, modifications can be made for up to 7 days. The authority may also delete the entire assessment form within those 7 days. On the 8th day, assessments may be viewed only; no changes can be made.

### Crisis Assessments While Receiving Services

The primary focus during a crisis must be TREATMENT: **“Treat, then TRAG”**

If the individual is already receiving services, treat the crisis and then re-TRAG after the crisis is resolved. Crisis services are included in all WebCARE service packages and the crisis does not need to be recorded in WebCARE.

If an individual does not respond to attempts to stabilize the crisis and needs Crisis Stabilization Unit (CSU) or hospital services, do not change the individual’s service package until after the individual has been stabilized and released. It is then appropriate to re-administer the RDM assessment, and if indicated by the TRAG scores or clinical judgment, to assign the individual to a different service package.

### Crisis Assessments Before Receiving Services

When an individual is not currently receiving services, is in crisis, and the crisis is entered into WebCARE, most of the assessment requirements are suspended.

A **Registration** record is **required** to be completed before entering any other information.

A **Diagnostics** record is **NOT** required.

A **Crisis Assessment** record is **required**. The timeline for crisis resolution is 7 days.
Following a Crisis

Following crisis resolution (which can be sooner than 7 days), enter an Intake Assessment.

- If the individual is a member of the Target population (individuals with schizophrenia and related disorders, bipolar disorder, or major depression with a GAF <= 50), the LPHA may enter a diagnostics record and assign the individual to a service package.

- If the individual is a member of the Priority population (individuals who are not Target population but who are at great risk), an LPHA may enter a diagnostics record and override the individual into a service package in accordance with the Adult UM Guidelines.

- If the individual is ineligible for services, the individual may be served for up to 30 days in Service Package 5 – Crisis Follow-up after the diagnostics record is completed. Service Package 5 – Crisis Follow-up is intended to complete the stabilization process and is also appropriate after an individual is discharged from a State Hospital.

Out of Area Crisis

If an ongoing individual at one center requires crisis services from a different center:

- The crisis for the individual can be entered at the “Out of Area” center using the E=Crisis Assessment Type.
- This crisis record will NOT impact any of the service package timelines from the individual’s “home” center. The “home” center is not required to discharge the individual during the crisis period.
- When the crisis has been resolved at the “Out of Area” center, the individual may return to the “home” center, continue services at the “Out of Area” center, or other.
   - If the individual returns to the “home” center for treatment, no further WebCARE entries are required for the “Out of Area” center.
   - If the individual continues treatment at the “Out of Area” center, the individual must be discharged from the “home” center. The “Out of Area” center then becomes the “home” center and an Intake assessment is required.
Crisis While on the Waiting List

Individuals in crisis that were previously assessed with a LOC-A of 8=Waiting for All Services require a Crisis Assessment. The Waiting List assessment does not prevent a Crisis Assessment from being entered and both assessments are treated as separate events. The individual will remain on the waiting list as if the crisis had not occurred.

If the center provides additional services after the crisis has been resolved, an Intake Assessment is required.

Crisis Assessment Section 1 Fields

For a Crisis assessment only, enter data in the following Section 1: TRAG & Recommended Level of Care Adult-TRAG Dimension Ratings fields.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RISK OF HARM *</td>
<td>Select 4 or 5.</td>
</tr>
<tr>
<td>FUNCTIONAL IMPAIRMENT *</td>
<td>Select 5.</td>
</tr>
<tr>
<td>CO-OCCURRING SUBSTANCE USE *</td>
<td>Select 5.</td>
</tr>
<tr>
<td>ASSESSMENT DATE</td>
<td>The date of the assessment.</td>
</tr>
<tr>
<td>ASSESSED BY</td>
<td>The name of the person who performed the assessment.</td>
</tr>
<tr>
<td>CREDENTIALS</td>
<td>The highest credentials of person who performed the assessment.</td>
</tr>
<tr>
<td>FORM STATUS</td>
<td>Select Incomplete or Provider Complete.</td>
</tr>
</tbody>
</table>

* For a crisis assessment with a level of care deviation (LOC-D) of 0, only one dimension rating is required (i.e., Risk of Harm, Functional Impairment, or Co-Occurring Substance Use).

Select the Submit_Update button.
The authority or Utilization Management staff will enter data in the Section 2: Authorized Level of Care (LOC-A) fields.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTHORIZED LEVEL OF CARE (LOC-A)</td>
<td>Select 0=Crisis Services.</td>
</tr>
<tr>
<td>AUTHORIZATION DATE</td>
<td>The date that the level of care was authorized and the Authorization Begin Date. (MMDDYYYY format)</td>
</tr>
<tr>
<td>AUTHORIZED BY</td>
<td>The name of the person who authorized the assessment.</td>
</tr>
<tr>
<td>CREDENTIALS</td>
<td>The highest credentials of person who authorized the assessment.</td>
</tr>
<tr>
<td>NOTES</td>
<td>Enter any notes for this section of the assessment.</td>
</tr>
<tr>
<td>FORM STATUS</td>
<td>Select Complete.</td>
</tr>
</tbody>
</table>

Select the Submit_Update button.

Note: Crisis Services are authorized for 7 days only. If an H0-36 (Adult Crisis Stabilization) Assignment has been entered for the individual, Crisis Services are authorized for up to 14 days.

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**WebCARE Rule**

The Section 1: TRAG ASSESSMENT DATE is compared to all other dates on the assessment to verify that these dates pass the business rules. The Section 2: LOC-A AUTHORIZATION DATE must be within 14 days of the Section 1: TRAG ASSESSMENT DATE. **Exception:** If the Section 2: LOC-A SUBJECT TO MEDICAID FAIR HEARING check box is checked, the Section 2: LOC-A AUTHORIZATION DATE must be within 30 days of the Section 1: TRAG ASSESSMENT DATE to allow for Medicaid Fair Hearing notification letter processing. All other section dates must be within 30 days of the Section 1: TRAG ASSESSMENT DATE.
Results Screen

After entering appropriate data, choosing the Form Status, entering any comments for the entire assessment, and selecting **Submit Update**, the following screen is displayed (continued).

### Results Screen

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>A - INTAKE</th>
<th>Reason for Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Section 1: Adult TRAG & Recommended LOC

- **A. Adult - TRAG Dimension Ratings**
  - Risk of Harm
  - Support Needs
  - Psych Related Hosp
  - Functional Impairment
  - Employment Problems
  - Housing Instability
  - Co-occurring Subst Use
  - Criminal Justice Involvement
  - Depressive Symptomatology (MDD Only)

- **B. Calculated LOC-R**

- **C. LOC-D Provider Recommended Deviations**

- **D. TCOOMMI Consumer ?**

- **E. Assessment Date (mmddyyyy) 08012005**

- **Assessed By:** MANO LAMANCHA
  - Credentials: 1. QMHP-CS

- **Notes**

#### Section 2: Authorized Level of Care (LOC-A)

- **A. Authorized Level of Care (LOC-A) 3 - SERV PACK 3**

- **B. Reasons for Deviation From LOC-R**
  - Resource Limitations: NO
  - Consumer Choice: NO
  - Consumer Need: NO
  - Cost Care Per Un Guide: NO
  - Other: NO

- **C. Authorization Date (mmddyyyy) 08012005**

- **Subject to Medicaid Fair Hearing**

- **Authorized By:** MANO LAMANCHA
  - Credentials: 1. QMHP-CS

- **Notes**

#### Section 3: Diag - Spec Clinical Rating Scales

- **A. Schizophrenia Algorithm (PSRS & BNSA)**
  - Total Positive Symptom Rating Scale (PSRS) (4-28) 20
  - Total Brief Negative Symptom Assessment (BNSA) (4-24) 20

- **B. Bipolar Algorithm (BDSS)**
  - Total Brief Bipolar Disorder Symptom Scale (BDSS) (10-70) 5

- **C. Major Depress Algorithm (QIDS-SR & QIDS-C)**
  - Total Quick Inventory of Depressive Sympt (QIDS) (0-27)

- **D. Assessment Date (mmddyyyy) 08012005**

- **E. Extended Review Period Requested**

- **Asessed By:** MANO LAMANCHA
  - Credentials: 1. QMHP-CS

- **Notes**

#### Section 4: Community Data

- **A. Residence Type (Current)**
  - 4 - HOMELESS

- **B. Paid Employment Type (Current)**
  - 4 - NOT IN LF

- **C. Main Reason for Being Out of Labor Force**
  - 4 - UNAB

- **D. Assessment Date (mmddyyyy) 08012005**

- **Notes**

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**COMP: 050 / CASE NO: 0000000994 / LAST NAME: DECRVANTES / FIRST NAME: MIGUEL**

As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the "Authorized Level of Care (LOC-A)" section above are medically necessary and I concur with the plan of care.

**Signature of LPHA:**

**LPHA Credentials:**

**Date:**

---

**Return Request**
Section 2 Data
A Local Mental Health Authority (LMHA) Utilization Management or authority staff person must enter **Section 2: AUTHORIZED LEVEL OF CARE (LOC-A)**. Note: Only an authority can delete a complete assessment within 7 days.

Reasons for Deviation
When the **REASONS FOR DEVIATION FROM LOC-R** are required (LOC-R does not match LOC-A), then appropriate reasons should be selected. When the LOC-A is lower intensity than the LOC-R, **Resource Limitations** and **Consumer Choice** are appropriate reasons. If the LOC-A is higher intensity than the LOC-R, **Consumer Need** and **Continuity of Care** are appropriate reasons.

The Reasons for Deviation are:

- **Resource Limitations** – Used when the Adult LOC-R was more intensive than the LOC-A because there are not enough resources to offer the more intensive service package.
- **Consumer Choice** – Used when the individual did not want the more intensive service package recommended.
- **Consumer Need** – Used when the Adult LOC-R was less intensive than the LOC-A because (based on the authority’s or UM’s clinical judgment and other information) the individual needs a more intensive service package.
- **Continuity of Care per UM Guidelines** – Used when the individual has been served in a more intensive service package, has improved, but still requires the higher intensity service package to become stabilized.
- **Other** – Used when none of the other deviations describe the reason for deviation. Enter details regarding the deviation in the Notes field.
Authorizations

After an individual has an Intake Assessment, an Update Assessment must be entered every 90 days, except for Extended Review Period that is every 180 days. The authorization period differs depending on the Level of Care Authorized and the authorization must be re-authorized or changed within the period listed below:

<table>
<thead>
<tr>
<th>Level of Care (LOC)</th>
<th>Authorization Period Valid for Up To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Package 0 – Crisis Services</td>
<td>7 days (one time)</td>
</tr>
<tr>
<td>Service Package 1</td>
<td>365 days</td>
</tr>
<tr>
<td>Service Package 2</td>
<td>180 days</td>
</tr>
<tr>
<td>Service Package 3</td>
<td>180 days</td>
</tr>
<tr>
<td>Service Package 4</td>
<td>180 days</td>
</tr>
<tr>
<td>LOC 5 – Crisis Follow-up</td>
<td>30 days</td>
</tr>
<tr>
<td>LOC 6 – Individual Refuses Services</td>
<td>0 days</td>
</tr>
<tr>
<td>LOC 8 – Waiting for All Authorized Services</td>
<td>365 days (Intake)</td>
</tr>
<tr>
<td>LOC 9 – Not Eligible for Services</td>
<td>0 days</td>
</tr>
</tbody>
</table>

WebCARE Rule

The Section 2: LOC-A AUTHORIZATION DATE is the date the LOC-A becomes effective, must be the same or after the Section 1: TRAG ASSESSMENT DATE, and must be within 14 days of the Section 1: TRAG ASSESSMENT DATE. Exception: When the Section 2: LOC-A SUBJECT TO MEDICAID FAIR HEARING check box is checked, the Section 1: TRAG ASSESSMENT DATE must be within 30 days of the Section 1: TRAG ASSESSMENT DATE to allow for Medicaid Fair Hearing notification letter processing.

Section 3 Data

The Section 3: Diagnosis-Specific Clinical Rating (TIMA) Scales are required for target population diagnoses for Intake, Update, and “Completed Services” Discharge assessments. The rating entered must match the diagnosis entered on the 330: Diagnostics screen.

If the diagnosis entered is not one of the target population diagnoses, no algorithm ratings are entered. The Section 3: Diagnosis-Specific Clinical Rating Scales ASSESSMENT DATE, ASSESSED BY, and CREDENTIALS are always required, even when a rating has not been entered.

If the diagnosis is for Schizo-affective Disorder, either the Schizophrenia Algorithm or the Bipolar Algorithm may be entered.
Data Collection

Diagnosis-Specific Symptom Measures are routinely obtained at every physician visit and are assessed by physicians or other qualified staff. The results are recorded on the Clinical Record Form (CRF) and are part of the clinical chart, according to the Texas Implementation of Medication Algorithm (TIMA) guidelines. Only one algorithm should be reported and all symptom measures associated with the other algorithms should be left blank.

Extended Review Period Requested

For an Update record, the EXTENDED REVIEW PERIOD REQUESTED box in Section 3: Diagnosis-Specific Clinical Rating Scales may be checked for the small number of highly stable ongoing individuals in Service Package 1 who are not scheduled to see a provider for another 180 days. Checking this box will extend the 90-day requirement for re-assessment to 180 days.

Section 4 Data

Section 4: Community Data can be entered at any time by Provider Qualified Mental Health Professional (QMHP) staff (including LVN’s). This data is required for Intake and “Completed Services” Discharge Assessments and is updated every 365 days. The Section 4: Community Data ASSESSMENT DATE must be completed within 30 days of the Section 1: TRAG ASSESSMENT DATE.

If PAID EMPLOYMENT TYPE is “Not in the Labor Force”, then MAIN REASON FOR BEING OUT OF LABOR FORCE must be entered, otherwise leave this field blank.

Return Request

After selecting Return_Request near the bottom of the screen, WebCARE returns you to the following screen so that other individual data may be entered.
Authorize Level Of Care  When Miguel’s record is ready for Utilization Management staff to authorize his level of care, data entry will continue with the following screen:

WebCARE Rule: 7 Days  A complete record can only be modified or deleted for up to 7 days. After 7 days, the complete record is viewable only with a Look_At button. If the Section 2: Authorized Level of Care (LOC-A) date is future-dated for notification of appeals, the future-dated record can be modified or deleted for up to 7 days after the LOC-A ASSESSMENT DATE.

Update Record  Select the Modify/Authorize button to update Miguel’s record. In the center of the screen, the TYPE OF ENTRY is Change. When the appropriate information is entered and the Submit_Update button is selected, the screen is populated with all the processed information. Select Return_Request near the bottom of the screen to continue.

Assignment Record  An assignment record should be entered in mainframe CARE to document where a person is receiving services and to track the individual’s movement throughout the service delivery system.
Intake Record Completed in Error

If the Intake record is completed in error and the Delete button is visible, select the Delete button and enter a new record by selecting Create New. Note: Only an authority can delete a complete assessment within 7 days.

Medical Necessity

At the bottom of completed Intake and Update records, a statement can be printed and signed by hand regarding medical necessity.

---

As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the "Authorized Level of Care (LOC-A)" section above are medically necessary and I concur with the plan of care.

Signature of LPHA: __________________________ LPHA Credentials: __________________________ Date: __________________________

---

continued on next page
Status is Complete but Evaluation Information Changes

The status for the Intake record is **Complete**, meaning the center is finished with the assessment. If any information in Sections 1, 2, 3, or 4 of the Uniform Assessment for Miguel changes because a:

- Review has occurred,
- TRAG dimension adjusts,
- Community Data item alters, or
- Different Level of Care is deemed necessary

then an Update record will be added. To enter an Update record, select **Create New**. A sample screen is shown below.

---

**Extended Review Period Requested**

For an Update record, the **EXTENDED REVIEW PERIOD REQUESTED** box in Section 3: TIMA Scales may be checked for the small number of highly stable ongoing consumers in Service Package 1 who are not scheduled to see a provider for another 180 days. Checking this box will extend the 90-day requirement for re-assessment to 180 days.

---

**AutoComplete**

If the authorization period has not expired and the Update record passes all the rules for completion, then when **Provider Complete** is selected, the FORM STATUS will automatically change to **Complete**.
346: MH Adult Uniform Assessment for RDM, Continued

If AutoComplete Should not be Applied

If this AutoComplete process should not be applied to this assessment, select the Authority Review Requested? box below the FORM STATUS field and add comments to alert the authority staff person or Utilization Management to review this record and change the LOC-A. The Authority Review Requested? field will not display unless the previous record is an Intake or Update.

Create Discharge Assessment

When Miguel is ready to be discharged from the center and will no longer receive services, create a discharge assessment by selecting the Create_New button. For data entry purposes, the DISCHARGE DATE may be dated up to 30 days prior to today’s date. If Miguel’s services were changing, a Discharge Assessment would not be entered. Miguel would be reevaluated (Update Assessment entered) and authorized into the appropriate service package.

WebCARE Rule: Discharge Dates for DISCHARGE REASON C=Level of Care Services Complete may be future-dated up to 14 days for planned discharges. All sections of the Adult Assessment are required for DISCHARGE REASON C=Level of Care Services Complete. All other reasons for discharge may not be future-dated and do not require any sections to be completed. Exception: If the SUBJECT TO MEDICAID FAIR HEARING box is checked, most reasons for discharge may be future-dated up to 30 days, except for J = Incarcerated in Jail or Prison.

Reasons for Discharge

There are eight discharge Reasons, but only seven reasons can be selected from the drop-down menu:

C – Level of Care Service Complete. Use this reason when the person’s needs have been met and there is no further need for services (also known as “Planned Discharge”). The Discharge Date can be future-dated up to 14 days from today’s date.
E – Elected a New Provider. Use this reason when a person chooses to leave the current center provider to receive services from a different provider.

J – Incarcerated in Jail or Prison. Use this reason when a person is incarcerated for long periods of time. Do not discharge a person if in jail overnight or for a short-term stay. Continuing services following a short-term stay provides a smoother return into the community. Persons in Service Packages 1, 2, or 3 can be incarcerated up to 30 days before being discharged. Persons in Service Package 4 can be incarcerated up to 90 days without being discharged. **Note:** The person must receive documented service activity during these time periods.

M – Moved out of Local Service Area. Use this when the person has moved out the LSA. **Note:** If the individual is hospitalized short-term and is returning to the LSA after release, a discharge is not required.

N – Never Returned for Services within Authorized Service Period, not to exceed 6 months. Use this reason when a person has been authorized for services and then:

- refuses services,
- doesn’t show up for services, or
- cannot be found.

This option is selected only after a documented “good faith” effort (at least two attempts to contact the person through phone calls, letters, home or job visits, or program alerts) has been made to locate and contact the person.

P – Change in NorthSTAR Eligibility. Use this reason when a person’s Medicaid eligibility changes the person’s NorthSTAR eligibility, and thus, NorthSTAR enrollment. This reason may be used when the person’s Medicaid eligibility initiates an enrollment into or out of NorthSTAR.

X – (System Generated) Auto-Closed. This option cannot be selected from the drop-down list and is automatically entered by WebCARE when an assessment has expired (authorization period has elapsed or assessment has expired).

Z – Other. This option is used for discharges related to Death or other reasons not listed above. Enter details in the **COMMENTS** field.
Discharge Record  The following screen displays the summary of a Discharge record:

![Discharge Record Screen](image)

Discharge Record is Complete  When the Discharge record has been completed, (all sections completed for REASON FOR DISCHARGE is C=Level of Care Services Complete), the authority or Utilization Management staff will change the FORM STATUS to Complete.

Key Points

- **Section 1** is completed every 90 days by LMHA QMHP staff at Intake or by Provider QMHP staff at Update, unless an Extended Review Period is requested in Section 3.

- **Section 1**: TRAG Assessment Date is compared to all other assessment dates to verify that these dates pass the business rules.

- The **Section 2**: LOC-A AUTHORIZATION DATE is the date the LOC-A becomes effective, must be the same or after the **Section 1**: TRAG ASSESSMENT DATE, and must be within 14 days of the **Section 1**: TRAG ASSESSMENT DATE. If **Section 2**: LOC-A SUBJECT TO MEDICAID FAIR HEARING has been checked, then the **Section 2**: LOC-A Authorization Date must be within 30 days of the **Section 1**: TRAG Assessment Date.

- All other section dates must be within 30 days of the **Section 1**: TRAG Assessment Date.
164: MH Child/Adolescent Uniform Assessment for RDM

Overview
The Child/Adolescent Uniform Assessment is an instrument designed to assist in the selection of a benefit package and financing methodology for public mental health services in the state of Texas. The Mental Health Child/Adolescent Uniform Assessment for Resiliency and Disease Management module of the WebCARE system is designed to record the individual’s assessment data, with the primary goal of using standard, quantifiable measures to guide the choice of service needs and to make appropriate “level of care” decisions.

Business Rule:

**Age**
Any individual age 16 or under is a child/adolescent. An individual age 17 or 18 may be served as either an adult or child/adolescent. An adult is any person 19 years of age or older. An individual who is being served as a child/adolescent will be discharged from child/adolescent services on their 19th birthday when an adult Intake record may be entered to continue services. When a person has been authorized for adult services, they may not return to child/adolescent services. A REASON FOR DISCHARGE of A=No Longer Meets Child Criteria for Services will be entered.

Note: For specific instructions on completing the Child/Adolescent Uniform Assessment Form, refer to Child Form Completion and Schedule.

Online Data Entry
Online data entry by those completing the assessments is preferred.

Centralized Data Entry
For centralized data entry, it is recommended that the Child & Adolescent Uniform Assessment for Resiliency & Disease Management form be printed and completed prior to WebCARE data entry. CARE forms are subject to change. Examples and additional information is provided in this section for completion of the 164: MH Child/Adolescent Uniform Assessment for RDM screen.

Utilization Management staff authorize service packages. If a data entry clerk is entering data, the form must be signed by the authorizer and must be in the individual’s clinical records.
### Sequence of Assessment Types

The expected sequence of completed assessment types is:

1. One Crisis (if individual is in crisis before an Intake or following a Discharge).
2. One Intake (If Intake Non-Admission – LOC-R=9 and LOC-A=9, then no Update or Discharge assessment is required) – used for initial admission into services, after a Discharge, or for Aftercare services following a hospital discharge.
3. One or more Update(s) – used for periodic reassessments, usually every 90 days. For Extended Review Period for Service Package 4-Aftercare, the reassessment is required every 180 days.
4. One Discharge – used when services will no longer be provided.

### Crisis Assessments While Receiving Services

The primary focus during a crisis must be TREATMENT: **“Treat, then TRAG”**

If the individual is already receiving services, treat the crisis and then re-TRAG after the crisis is resolved. Crisis services are included in all services packages and the crisis does not need to be recorded in WebCARE. Crisis Services for Children/Adolescents include 24-hour triage, crisis assessment, case coordination, physician services, and inpatient hospitalization, if indicated.

If an individual does not respond to attempts to stabilize the crisis, do not change the individual’s service package until after the individual has been stabilized. It is then appropriate to re-administer the RDM Assessment, and if indicated by the CA-TRAG scores or clinical judgment, to assign the individual to a different service package.

### Crisis Assessments Before Receiving Services

When an individual is not currently receiving services, is in crisis, and the crisis is entered into WebCARE, most of the assessment requirements are suspended.

Crisis Services are recommended for children or adolescents in any diagnostic category who have a rating of 5 for Risk of Self-Harm or for Co-Occurring Substance Use. A child or adolescent who presents a serious risk of harming another, regardless of the CA-TRAG dimension ratings, is recommended for Crisis Services. Intensive Crisis Residential is usually short-term (24-hour) residential services provided to a child or adolescent who is demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting.
A Registration record is required to be completed before entering any other information.

A Diagnostics record is NOT required.

A Crisis Assessment record is required. The timeline for crisis resolution is 7 days.

Following crisis resolution (which can be sooner than 7 days), enter an Intake Assessment.

- If the individual is ineligible for services, the individual may be served for up to 30 days in Service Package 5 – Crisis Follow-up after the diagnostics record is completed. Service Package 5 – Crisis Follow-up is intended to complete the stabilization process and is also appropriate after an individual is discharged from a State Hospital.

If an ongoing individual at one center requires crisis services from a different center:

- The crisis for the individual can be entered at the “Out of Area” center using the E=Crisis Assessment Type.
- This crisis record will NOT impact any of the service package timelines from the individual’s “home” center. The “home” center is not required to discharge the individual during the crisis period.
- When the crisis has been resolved at the “Out of Area” center, the individual may return to the “home” center, continue services at the “Out of Area” center, or other.
  - If the individual returns to the “home” center for treatment, no further WebCARE entries are required for the “Out of Area” center.
  - If the individual continues treatment at the “Out of Area” center, the individual must be discharged from the “home” center. The “Out of Area” center then becomes the “home” center and an Intake assessment is required.
Crisis While on the Waiting List

Individuals in crisis that were previously assessed with a LOC-A of 8=Waiting for All Services require a Crisis Assessment. The Waiting List assessment does not prevent a Crisis Assessment from being entered and both assessments are treated as separate events. The individual will remain on the waiting list as if the crisis had not occurred.

If the center provides additional services after the crisis has been resolved, an Intake Assessment is required.

Crisis Assessment

For a Crisis assessment only, the E=Crisis Assessment Type is selected; the authority or Utilization Management staff will enter data in the following Section 3: Authorized Level of Care fields.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOC-A</td>
<td>Select 0=Crisis Services.</td>
</tr>
<tr>
<td>AUTHORIZATION DATE</td>
<td>The date the Level of Care services were authorized. Also, the Authorization Begin Date. (MMDDYYYY format)</td>
</tr>
<tr>
<td>AUTHORIZED BY</td>
<td>The name of the person who authorized the assessment.</td>
</tr>
<tr>
<td>CREDENTIALS</td>
<td>The highest credentials of the person authorizing the assessment.</td>
</tr>
<tr>
<td>NOTES</td>
<td>Enter any notes for this section of the assessment.</td>
</tr>
</tbody>
</table>

Risk of Self-Harm/Co-Occurring Substance Abuse

If either the RISK OF SELF-HARM or CO-OCCURRING SUBSTANCE USE fields are set to 5 by the provider when completing Section 1: Child/Adolescent TRAG, then the AUTHORIZATION DATE, AUTHORIZED BY, and CREDENTIALS (highest credentials of person authorizing the assessment) fields for Section 1: Child/Adolescent TRAG are required. Exception: Exception: For a crisis assessment with a level of care deviation (LOC-D) of 0, only one dimension rating is required (i.e., Risk of Self-Harm, or Co-Occurring Substance Use). No other fields are required in Section 1. Complete Section 3: Level of Care Authorized with 0=Crisis Services, then the AUTHORIZATION DATE, AUTHORIZED BY, and fields for Section 3: Level of Care Authorized The Crisis Services are authorized for 7 days only.
164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Request Screen
From the RDM Menu, select 164: MH Child Evaluation Assessment for RDM. The following screen will be displayed.

Note: Peter Piper, the fictitious child, will continue to be used as an example.

Error Code Help
If you receive an error code when entering data, click on Open Error Code help for this screen. A new window will appear that has the Error Code, Resolution, and Business Rules database. Select the error code from the list and Display Results. Close this new window when finished.
No Diagnostics Record  If no diagnostics record is found for the individual, the following screen will be displayed.

A diagnostics record must be entered for all individuals in WebCARE.

**Business Rule: Crisis Individuals** For **Crisis Individuals only**, a Crisis assessment may be entered **before** a diagnostics record. However, when the individual is no longer in Crisis, a Diagnostics record is required before an Intake assessment record may be entered. For a list of all Business Rules, see [Error Codes and Related Business Rules](#).

Diagnostic Record Exists - First Assessment Record  If a Diagnostics record has been entered and this is the first assessment record, the following screen will display:
If previous assessments for this individual have been entered, the same screen will display but the prior assessments will be listed in reverse chronological order. The most recent entry will be modifiable with a **Correct/Modify** button. Other entries may also be modifiable, but will be limited such that the sequence business rules are preserved.

**WebCARE Rule: Prompt Completion**

For **Incomplete** assessments, after 30 days with no updates or modifications, the **Incomplete** record will be deleted. **Complete** assessment records, for up to 7 days after completion, may be modified or deleted. After 7 days the **Complete** assessment will be viewable only with a **Look At** button. If the **Section 3: Authorized Level of Care (LOC-A)** date is future-dated for notification of appeals, the future-dated record can be modified or deleted for up to 7 days after the **LOC-A ASSESSMENT DATE**.

continued on next page
Create Assessment  To create a new assessment record, select **Create New**. The following screen will display. A sample screen is shown below.

### Section 1: Child / Adolescent TRAG

#### Diagnostic Qualifier
A. Ohio Scales
1. Parent Ohio Problem Severity Scale Score (0-100)
2. Parent Ohio Functioning Scale Score (0-80)
3. Youth Ohio Problem Severity Scale Score (0-100)
4. Youth Ohio Functioning Scale Score (0-80)
5. Worker Ohio Problem Severity Scale Score (0-100)
6. Worker Ohio Functioning Scale Score (0-80)

#### B. CA-TRAG Dimension Ratings
1. Problem Severity - Ohio Scale Score
2. Functioning - Ohio Scale Score
3. Risk of Self Harm
4. Severe Disruptive or Aggressive Behavior
5. Family Resources
6. History of Psychiatric Treatment
7. Co-occurring Substance Use
8. Juvenile Justice Involvement
9. School Behavior
10. Psychoactive Medication Treatment?

#### C. Successfully Completed Service Package 1 or 2?

#### D. Level of Care Decisions
- Calculated Level of Care Recommendation (LOC-R)

#### E. LOC-D Provider Recommendation

#### F. FOSTER CARE

#### G. TCOMMI Consumer?

#### H. Assessment Date (mmddyyyy)

#### I. Extended Review Period Requested
- Assess By
- Credentials
- Notes (Limit to 220 Characters)

### Section 2: Community Data

#### Within Last 90 Days:
- A. Number of Arrests
- B. School Days Missed
- C. Primary Residence Type
- D. Assessment Date (mmddyyyy)
- Notes (Limit to 220 Characters)

### Section 3: Authorized Level of Care (LOC-A)

#### A. Actual Level of Care Authorized
- LOC-A

#### B. Reasons for Deviation From LOC-R
- Resource Limitations
- Consumer Choice
- Cost Care Per Unit Guide
- Consumer Need
- Other
- Authorization Date (mmddyyyy)

#### C. Authorization Date (mmddyyyy)
- Subject to Medicaid Fair Hearing
- Authorized By
- Credentials
- Notes (Limit to 220 Characters)
Create Assessment Record (continued)  

Note: For Peter Piper, our fictitious child, an Intake assessment will be entered. For more information on each field, refer to the additional pages for the Child and Adolescent Uniform Assessment for Resiliency & Disease Management Form (CARE-CUA-RDM).

Sections 1 and 2 Fields  
The Section 1: Child/Adolescent TRAG and Section 2: Community Data fields may be entered at once. Since WebCARE calculates the LOC-R, the LOC-R is not visible until the Submit_Update button is selected.

Do not enter zeroes for Ohio Scales Scores if no scores have been collected. A zero value is valid and will affect the results of the TRAG calculation. The Ohio Scales must be entered in pairs: (Parent/Primary Caregiver (1a and 1b), Youth-ages 12-17 (2a and 2b), or Worker/Agency Provider (3a and 3b). More than one set of scales may be entered; however, only one set of scales will be used to calculate the LOC-R.

Form Status Field  
The following table describes the options for the FORM STATUS field.

<table>
<thead>
<tr>
<th>Form Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete</td>
<td>Intended for use by the provider to indicate that the data entered is partial and will be completed soon.</td>
</tr>
<tr>
<td>Provider Complete</td>
<td>Intended for use by the provider to indicate that the data entered is complete and ready for the authority or Utilization Management review and authorization.</td>
</tr>
<tr>
<td>Complete</td>
<td>Intended for use by the authority or Utilization Management staff to indicate that all data has been entered and the center is finished with the assessment.</td>
</tr>
</tbody>
</table>

If the Form Status is marked Incomplete or Provider Complete for more than 30 days without being changed, the WebCARE Auto-Delete process will automatically delete the assessment.

For Update Assessments, if the Form Status is marked Provider Complete and the prior authorization is still valid, the assessment form will be AutoCompleted. If the Provider wants the individual to be re-authorized or prefers that the Authority (UM staff) review the assessment, the Authority Review Requested? check box may be selected.
Form Status Field (continued) When assessment forms are marked complete, modifications can be made for up to 7 days. The authority may also delete the entire assessment form within those 7 days. On the 8th day, assessments may be viewed only; no changes can be made.

Submit Update Select the Submit_Update button.

Diagnostics Qualifier If a child or adolescent is diagnosed with a disorder (DSM-IV code entered on the Diagnostics screen in Axis I, Level 1) that can be either internalizing or externalizing symptoms, a separate field is displayed at the top of Section 1: Child/Adolescent TRAG. The DIAGNOSTIC QUALIFIER drop-down box is displayed and “Internalizing”, “Externalizing”, or “Not Yet Stable” must be selected before the LOC-R is calculated.
Results Screen

After entering appropriate data and selecting **Submit_Update**, the following screen is displayed.

<table>
<thead>
<tr>
<th>Section 1: Child / Adolescent TRAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis: 2971 Delinquent Disorder</td>
</tr>
<tr>
<td>Diagnostic Qualifier E - EXTERNALIZING</td>
</tr>
<tr>
<td>A. Ohio Scales</td>
</tr>
<tr>
<td>1a. Parent Ohio Problem Severity Scale Score (0-100)</td>
</tr>
<tr>
<td>1b. Parent Ohio Functioning Scale Score (0-80)</td>
</tr>
<tr>
<td>2a. Youth Ohio Problem Severity Scale Score (0-100)</td>
</tr>
<tr>
<td>2b. Youth Ohio Functioning Scale Score (0-80)</td>
</tr>
<tr>
<td>3a. Worker Ohio Problem Severity Scale Score (0-100)</td>
</tr>
<tr>
<td>3b. Worker Ohio Functioning Scale Score (0-80)</td>
</tr>
<tr>
<td>B. CA-TRAG Dimension Ratings</td>
</tr>
<tr>
<td>1. Problem Severity - Ohio Scale Score</td>
</tr>
<tr>
<td>2. Functioning - Ohio Scale Score</td>
</tr>
<tr>
<td>3. Risk of Self-harm</td>
</tr>
<tr>
<td>4. Severe Disruptive or Aggressive Behavior</td>
</tr>
<tr>
<td>5. Family Resources</td>
</tr>
<tr>
<td>6. History of Psychiatric Treatment</td>
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<tr>
<td>7. Co-occurring Substance Use</td>
</tr>
<tr>
<td>8. Juvenile Justice Involvement</td>
</tr>
<tr>
<td>9. School Behavior</td>
</tr>
<tr>
<td>10. Psychotropic Medication Treatment?</td>
</tr>
<tr>
<td>C. Successfully Completed Service Package 1 or 2?</td>
</tr>
<tr>
<td>D. Level of Care Decisions</td>
</tr>
<tr>
<td>Calculated Level of Care Recommendation (LOC-R) 2.1 - INTENSIV OUTPT. - MULTI-SYST THER</td>
</tr>
<tr>
<td>E. LOC-D Provider Recom. Deviation</td>
</tr>
<tr>
<td>F. FOSTER CARE</td>
</tr>
<tr>
<td>G. TCoommi Consumer?</td>
</tr>
<tr>
<td>H. Assessment Date (mmddyyyy)</td>
</tr>
<tr>
<td>I. Extended Review Period Requested</td>
</tr>
<tr>
<td>Form Status</td>
</tr>
<tr>
<td>Notes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 2: Community Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Last 90 Days:</td>
</tr>
<tr>
<td>A. Number of Arrests</td>
</tr>
<tr>
<td>B. School Days Missed</td>
</tr>
<tr>
<td>C. Primary Residence Type</td>
</tr>
<tr>
<td>D. Assessment Date (mmddyyyy)</td>
</tr>
<tr>
<td>Notes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 3: Authorized Level of Care (LOC-A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Actual Level of Care Authorized</td>
</tr>
<tr>
<td>LOC-A 2.1 - INTENSIV OUTPT. - MULTI-SYST THER</td>
</tr>
<tr>
<td>B. Reasons for Deviation From LOC-R</td>
</tr>
<tr>
<td>Resource Limitation</td>
</tr>
<tr>
<td>Consumer Choice</td>
</tr>
<tr>
<td>Cost Care Per Unit Guide</td>
</tr>
<tr>
<td>Consumer Need</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>C. Authorization Date (mmddyyyy)</td>
</tr>
<tr>
<td>Subject to Medicaid Fair Hearing NO</td>
</tr>
<tr>
<td>Authorized By PQI</td>
</tr>
<tr>
<td>Credentials</td>
</tr>
<tr>
<td>Notes</td>
</tr>
</tbody>
</table>

As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the "Authorized Level of Care (LOC-A)" section above are medically necessary and I concur with the plan of care.

Signature of LPHA: ___________________________  LPHA Credentials: ___________________________  Date: ___________________________
Note: Warning messages for child/adolescent data can be found at the top of the screen. Warnings do not prevent submission of information but provide important information regarding the data entered. In this case, verify data accuracy since the Ohio Scales Scores are outside expected results when compared to the dimension ratings.

Section 2 Data

The Section 2: Community Data fields can be entered at any time by Provider Qualified Mental Health Professional (QMHP) staff (including LVNs), but the date must be within 30 days of the Section 1: Child/Adolescent TRAG Assessment Date.

For Intake and Update Assessments, this section is required every 90 days (or 180 days for Extended Review Period) and for “Completed Services” Discharges. Leave this section blank for Crisis Assessments and for Discharges other than “Completed Services”.

Section 3 Data

A Local Mental Health Authority (LMHA) Utilization Management or authorized staff/person must enter Section 3: Authorized Level of Care LOC-A data. If the Recommended Level of Care (LOC-R) does not match the LOC-A, at least one appropriate deviation reason must be selected. The general comment field is intended for communication between the staff who perform the assessment and the authorizer or UM. Note: When an assessment is complete, only an authority or UM can delete the assessment within 7 days.

Exception: For LOC-A Y = YES Waiver, the Authorization Date must be entered within 30 days after the Section 1: TRAG Assessment Date entered.

Notes: When an assessment is complete, only an authority can delete the assessment. For Update assessments, the LOC-A Assessment Date may be future-dated to allow for individual notification. The future-dated LOC-A Assessment Date must also be within 14 days of the Section 1: CA-TRAG Assessment Date.

Reasons for Deviation

When the REASONS FOR DEVIATION FROM LOC-R are required (LOC-R does not match LOC-A), then all appropriate reasons should be selected. When the LOC-A is lower intensity than the LOC-R, Resource Limitations and Individual Choice are appropriate reasons. If the LOC-A is higher intensity than the LOC-R, Individual Need and Continuity of Care are appropriate reasons. LOC-A of Y = YES Waiver is not included in the order of intensity. If the actual Level of Care Authorized (LOC-A) is Y = YES Waiver, and the Level of Care Recommended (LOC-R) is 9 = not eligible, then Consumer Need must
be the only Reason for Deviation. If LOC-A is Y for any LOC-R (other than 9), then Consumer Choice must be the only Reason for Deviation.

Reasons for Deviation (continued)

The Reasons for Deviation are:

- **Resource Limitations** – Used when the Adult LOC-R was more intensive than the LOC-A because there are not enough resources to offer the more intensive service package.
- **Individual Choice** – Used when the individual did not want the more intensive service package recommended or when the eligible individual chooses to participate in the YES Waiver and has any LOC-R other than 9 = not eligible.
- **Continuity of Care per UM Guidelines** – Used when the individual has been served in a more intensive service package, has improved, but still requires the higher intensity service package to become stabilized.
- **Individual Need** – Used when the Adult LOC-R was less intensive than the LOC-A because (based on the authority’s clinical judgment and other information) the individual needs a more intensive service package or when the eligible individual chooses to participate in the YES Waiver and has a LOC-R of 9 = not eligible.
- **Other** – Used when none of the other deviations describe the reason for deviation. Enter details regarding the deviation in the Notes field.

Authorizations

After an individual has an Intake Assessment, an Update Assessment must be entered every **90 days**, except for Extended Review Period that is every 180 days. The authorization period differs depending on the Level of Care authorized and the authorization must be re-authorized or changed within the period listed below:

<table>
<thead>
<tr>
<th>Level of Care (LOC)</th>
<th>Authorization Period Valid for Up To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Package 0 – Crisis Services</td>
<td>7 days (one time)</td>
</tr>
<tr>
<td>Service Package 1.1 or 1.2</td>
<td>90 days</td>
</tr>
<tr>
<td>Service Package 2.1, 2.2, 2.3, or 2.4</td>
<td>90 days</td>
</tr>
<tr>
<td>Service Package 4</td>
<td>180 days</td>
</tr>
<tr>
<td>LOC 5 – Crisis Follow-up</td>
<td>30 days</td>
</tr>
<tr>
<td>LOC 6 – Individual Refuses Services</td>
<td>0 days</td>
</tr>
<tr>
<td>LOC 8 – Waiting for All Authorized Services</td>
<td>365 days (Intake)</td>
</tr>
<tr>
<td>LOC 9 – Not Eligible for Services</td>
<td>0 days</td>
</tr>
<tr>
<td>LOC Y – YES Waiver</td>
<td>365 days</td>
</tr>
</tbody>
</table>
WebCARE Rule
The Section 3: LOC-A AUTHORIZATION DATE is the date the LOC-A becomes effective, must be the same or after the Section 1: CA-TRAG ASSESSMENT DATE, and must be within 14 days of the Section 1: CA-TRAG ASSESSMENT DATE. Exception: When the Section 3: LOC-A SUBJECT TO MEDICAID FAIR HEARING check box is selected, the Section 3: LOC-A AUTHORIZATION DATE must be within 30 days of the Section 1: CA-TRAG ASSESSMENT DATE. Exception: For LOC-A Y = YES Waiver, the AUTHORIZATION DATE must be entered within 30 days after the Section 1: TRAG ASSESSMENT DATE entered.

Return Request
After selecting Return_Request near the bottom of the screen, WebCARE returns you to the following screen so that other individual data may be entered. Notice that the Component Code remains:

continued on next page
Authorize Level of Care

When Peter’s record is ready for Utilization Management or authority staff to authorize his level of care, data entry will continue with the following screen:

WebCARE Rule: 7 Days

A complete record can only be modified or deleted for up to 7 days. After 7 days, the complete record is viewable only with a Look At button. If the Section 3: Authorized Level of Care (LOC-A) Authorization Date is future-dated for notification of appeals, the future-dated record can be modified or deleted for up to 7 days after the Section 3: Authorized Level of Care (LOC-A) Authorization Date.

Note: Only an authority or UM staff can delete a complete assessment within 7 days.

Update Record

Select the Modify/Authorize button to update Peter’s record. In the center of the screen, the Type of Entry is Change. When the appropriate information is entered and the Submit Update button is selected, the screen is populated with all the processed information. Select Return_Request near the bottom of the screen to continue.

Intake Record Completed in Error

If the Intake record is completed in error and the Delete button is visible, select the Delete button and enter a new record by selecting Create New.

Note: Only an authority or UM staff can delete a complete assessment within 7 days.
Assignment Record  An assignment record should be entered in mainframe CARE to
document where a person is receiving services and to track the
individual’s movement throughout the service delivery system.

Business Rule  Child/Adolescent individual’s assessments must be reviewed every 90
days. If a Crisis record has been completed, an Intake record must be
entered to continue services. After an Intake record has been
completed, either an Update record or a Discharge record must be
entered
For a list of all Business Rules, see Error Codes and Related Business
Rules.

WebCARE Rule: Date Edits  To allow for data entry of assessments and updated authorizations,
WebCARE permits the following:
• The Section 1: Child/Adolescent TRAG ASSESSMENT DATE can be
up to 30 days before today’s date but not future dated.
• The Section 2: Community Data ASSESSMENT DATE can be up to
30 days before or after the Section 1: Child/Adolescent TRAG
ASSESSMENT DATE and up to 30 days before or after the Section 3:
Authorized Level of Care (LOC-A) AUTHORIZATION DATE.
• The Section 3: Authorized Level of Care (LOC-A)
AUTHORIZATION DATE must be within 14 days of the Section 1:
Child/Adolescent TRAG ASSESSMENT DATE and within 30 days of
the Section 2: Community Data ASSESSMENT DATE. Exception:
For LOC-A Y = YES Waiver, the Authorization Date must be
entered within 30 days after the Section 1: TRAG Assessment Date
entered.

Sample Screen  A sample Complete Intake record is shown below.
Complete

The status for this *Intake* record is **Complete**, meaning the center is but Evaluation finished with this assessment. If any information in **Sections 1, 2 or 3** of the Uniform Assessment for Peter Piper changes because a:

- 90-day or other review has occurred,
- TRAG dimension adjusts,
- Community Data item alters, or
- different Level of Care is deemed necessary

then an Update record must be added. To enter an *Update* record, select **Create New**.

---

**Create Discharge Assessment**

When Peter Piper is ready to be discharged from the center and will no longer receive services, create a *Discharge* assessment by selecting the **Create New** button. In this case, Peter would be discharged on a future date.

---

**Reasons for Discharge**

There are eight Discharge Reasons, but only seven reasons can be selected from the drop-down menu:

**C** – **Level of Care Service Complete.** Use this reason when the person’s needs have been met and there is no further need for services (also known as “Planned Discharge”).

**E** – **Elected a New Provider.** Use this reason when a person chooses to leave the current center provider to receive services from a different provider.

**J** – **Texas Youth Commission (TYC).** Use this reason when a person is incarcerated for long periods of time. Do not discharge a person if incarcerated overnight or for a short-term stay. Continuing services following a short-term stay provides a smoother return into the community. Persons in Service Packages 1.1, 1.2, 2.1, 2.2, 2.3, or 2.4 can be incarcerated up to 30 days before being discharged. **Note:** The person must receive documented service activity during these time periods.

**M** – **Moved out of Local Service Area.** Use this when the person has moved out the LSA. **Note:** If the individual is hospitalized short-term and is returning to the LSA after release, a discharge is not required.

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Web Client Assignment and Registration System
WebCARE Technical Services
Version 6 January, 2010
74 164: MH Child/Adolescent Uniform Assessment for RDM, Continued
N – Never Returned for Services within Authorized Service Period, not to exceed 6 months. Use this reason when a person has been authorized for services and then:

- refuses services,
- doesn’t show up for services, or
- cannot be found.

This option is selected only after a documented “good faith” effort (at least two attempts to contact the person through phone calls, letters, home or job visits, or program alerts) has been made to locate and contact the person.

P – Change in NorthSTAR Eligibility. Use this reason when a person’s Medicaid eligibility changes the person’s NorthSTAR eligibility, and thus, NorthSTAR enrollment. This reason may be used when the person’s Medicaid eligibility initiates an enrollment into or out of NorthSTAR.

X – (System Generated) Auto-Closed. This option cannot be selected from the drop-down list and is automatically entered by WebCARE when an assessment has expired (authorization period has elapsed or assessment has expired).

Z – Other. This option is used for discharges related to Death or other reasons not listed above. Enter details in the COMMENTS field.

WebCARE Rule: Discharge

Discharge Dates for DISCHARGE REASON C = Level of Care Services Complete may be future-dated up to 14 days for planned discharges. All sections of the Child/Adolescent Assessment are required for DISCHARGE REASON C = Level of Care Services Complete. All other reasons for discharge may NOT be future-dated and do not require any sections to be completed. Discharge Dates may be dated up to 30 days prior to today’s date. Exception: If the SUBJECT TO MEDICAID FAIR HEARING box is checked, most reasons for discharge may be future-dated up to 30 days, except for J = Texas Youth Commission.

The following screen shows a Discharge record that was created on 8/19/2005 but displays a date of 8/29/05 (the future date of discharge):
Discharge Record is Complete

When the Discharge record has been completed, (all sections are completed for REASON FOR DISCHARGE is **C=Level of Care Services Complete**), the authority or Utilization Management staff will change the FORM STATUS to **Complete**. Note: Only an authority or UM staff can delete a complete assessment within 7 days. A complete Discharge Assessment closes any mainframe CARE Assignments (TC codes) for the person.

Key Points

- **All Sections** are completed every 90 days by LMHA QMHP staff at Intake or by Provider QMHP staff at Update, unless an Extended Review Period is requested in **Section 1: CA-TRAG**.

- **Section 1: TRAG** ASSESSMENT DATE is compared to all other assessment dates to verify that these dates pass the business rules.

- The **Section 3: LOC-A** AUTHORIZATION DATE must be within 14 days of the **Section 1: TRAG** ASSESSMENT DATE. If the **Section 3: LOC-A SUBJECT TO MEDICAID FAIR HEARING** has been checked, then the **Section 3: LOC-A** AUTHORIZATION DATE must be within 30 days of the **Section 1: TRAG** ASSESSMENT DATE. Exception: For LOC-A Y = YES Waiver, the Authorization Date must be entered within 30 days after the Section 1: TRAG Assessment Date entered.

- All other section dates must be within 30 days of the **Section 1: CA-TRAG** ASSESSMENT DATE.

This is the final step for a child/adolescent.
RDM Workflow / Reports

Introduction

The Workflow / Reporting modules in the WebCARE system allows one to display or print specific individual information and component information. These reports are provided to assist centers in reducing partially completed records and to help identify assessments requiring updates, resulting in timely and sequential completion of assessments. These reports may also be used for files batched to WebCARE and for Electronic Data Transfer System (EDTS) files created by WebCARE. For more information, see Batch Processing and EDTS of this manual.

Reports

246 Incomplete/Provider Complete Assessments - Adult

**Business Rule**

All Incomplete or Provider Complete records will be completed within 30 days. The goal is to prevent the entry of partial records that are not completed in a timely manner.

**WebCARE Rule**

All Incomplete or Provider Complete records older than 30 days will be deleted from the operational system.

Review Report

It is recommended that this report be reviewed continuously by the Utilization Management or authority staff to identify records requiring authorization.
RDM Workflow / Reports, Continued

Select Report

To identify outstanding adult assessments requiring update or completion, select 246 RDM Incomplete/Provider Complete Assessments – Adult on the RDM Main Menu.

Request Screen

A sample 246: RDM Incompl/Provider Compl Assessments-Adult screen is shown below.

![Request Screen](image-url)
### RDM Workflow / Reports, Continued

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter your Component code in the <strong>COMPONENT</strong> field, if Component code has not already been entered.</td>
</tr>
</tbody>
</table>
| 2    | Enter the dates through which you are checking for **Incomplete** or **Provider Complete** records.  
**Note:** The second date of the date range must be today’s date or a past date. Today’s date is automatically populated and a date one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed. |
| 3    | Click the box to select whether you want to include **Incomplete** records, **Provider Complete** records or both.  
**Note:** The default is set to both types of partially completed records. |
| 4    | Click to include **Incomplete** or **Provider Complete** records and select the appropriate **SORT BY** radio button. You can sort the report by local case number, date or the ID of the person who last updated the record or provider location. This step is optional. |
| 5    | Select **Submit_Request** when all the options have been set. |

---

**No Records Found**  
If no records are found, then no **Incomplete** or **Provider Complete** records meet the criteria set for the report. You may broaden the criteria for a more thorough search.

---

**Records are Found**  
If records are found, a screen similar to the one below will be displayed. All records are modifiable and should be completed as soon as practical.
Two Records Listed for One Case

If two Incomplete/Provider Complete records are listed for one Case, the oldest assessment must be completed first. This situation usually occurs when an individual is in crisis and a Crisis assessment has been entered. The Crisis assessment is awaiting authorization but in the meantime, the individual has recovered quickly and an Intake Assessment is entered before the Crisis assessment has been authorized and completed.

Change Record

When you select the Modify or Authorize button, the 346: Adult Uniform Assessment screen for changing a record displays. A sample screen is shown below.

Enter Data to Complete Record

Enter all required information to complete the record (usually entered by the authority or Utilization Management staff) and select Submit_Update at the bottom of the screen. The completed screen will display. Select Return_To_List to return to the 246: RDM Incomplete/Provider Complete Assessments list of outstanding records. The record you just completed is no longer in the list because it has been completed. A sample screen is shown below.
### RDM Workflow / Reports, Continued

#### WebCARE Technical Services

**Web Client Assignment and Registration System Version 6 January, 2010**

**246-RDM Incompl/Provider Compl Assessments Adult**

![Image of software interface]

- **Component**: 030
- **Date Range**: 01-01-2005 Through 08-29-2005

**Options**

- **Include : Incomplete**: YES
- **Include : Provider Complete**: YES

**Location**

- **Sort By**: Date

---

**2 RECORD(S) FOUND:**

<table>
<thead>
<tr>
<th>DATE</th>
<th>NAME</th>
<th>CASE</th>
<th>LOCNR</th>
<th>TYPE</th>
<th>STATUS</th>
<th>LOCA</th>
<th>LAST UPDATED BY</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modify</td>
<td>06/23/05</td>
<td>Mar, My</td>
<td>0000002030</td>
<td>Not Eligible</td>
<td>Incomplete</td>
<td>Serv Pack 1</td>
<td>6552062</td>
<td>030</td>
</tr>
<tr>
<td>Modify</td>
<td>08/01/05</td>
<td>Noting, Sometimes</td>
<td>00000321321</td>
<td>Sp4 - Act</td>
<td>Incomplete</td>
<td>6552062</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
247: Assessments Expiring by Section – Adult

Purpose

The purpose of 247: RDM Assessments Expiring by Section – Adult is to provide a tool to monitor when an individual should be scheduled for another evaluation so that a new assessment is entered in a timely manner.

Assessments Expire

WebCARE assessments expire when any of the following conditions exists:

1. The Section 1: TRAG has not been updated within 90 days (or 120 days in WebCARE to allow for data entry). Exception: Extended Review Period for adults has been selected, then 180 days (or 210 days in WebCARE to allow for data entry), or

2. The Level of Care Authorized (LOC-A) End Date has been reached (or 30 days after the End Date in WebCARE to allow for data entry). The Level of Care Authorized (LOC-A) End Date is calculated based on the service package selected.

Select Report

Select 247: RDM Assessments Expiring by Section – Adult on the RDM Main Menu.
247: Assessments Expiring by Section – Adult, Continued

Request Screen  Select 247: RDM Assessments Expiring by Section – Adult. When a completed assessment has been complete for over 7 days, the record is no longer modifiable. When a complete but expired record is displayed, the Look_At button is visible. A sample screen is shown below.

Note: Occasionally, an Incomplete or Provider Complete assessment will display on an expiring report. The record may still be modifiable.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter your Component code in the COMPONENT field, if Component code has not already been entered.</td>
</tr>
<tr>
<td>2</td>
<td>Enter the dates of potentially expiring records.</td>
</tr>
<tr>
<td>3</td>
<td>Use the drop down menu to select Section 1 (90-day TRAG rule), Section 2: LOC-A End Date, or other workflow issues in Sections 3 or 4.</td>
</tr>
<tr>
<td>4</td>
<td>Click to include Incomplete or Provider Complete records and select the appropriate SORT By radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, or provider location. This step is optional.</td>
</tr>
<tr>
<td>5</td>
<td>Click Submit_Request when all the options have been set.</td>
</tr>
</tbody>
</table>
247: Assessments Expiring by Section – Adult, Continued

No Records Found
If no expiring records are found for the component, date range, and section combination, the following screen is displayed.

At Least One Record is Found
If at least one expiring record is found for the component, date range, and section combination entered, a screen similar to the following screen is displayed.

Remove a Record
To remove a record from the expiring list, enter an Update or Discharge record. If an Incomplete or Provider Complete assessment exists for the individual, then their previous assessment will not be on this list.
248: Assessments to Expire - Adult

Purpose
The purpose of the 248: RDM Assessments to Expire – Adult is to provide a tool that considers all sections of the assessment to monitor when an individual should be scheduled for another evaluation so that a new assessment is entered in a timely manner. The 248: RDM Assessments to Expire – Adult is the same report as 247: RDM Assessments Expiring by Section – Adult except that Sections 1 and 2 are checked at the same time. This report is designed to show which assessments will expire according to existing business rules.

Note: Occasionally, an Incomplete or Provider Complete assessment will display on an expiring report. The record may still be modifiable.

WebCARE Assessments Expire
WebCARE assessments expire when any of the following conditions exists:

1. The Section 1: TRAG has not been updated within 90 days (or 120 days in WebCARE to allow for data entry). Exception: EXTENDED REVIEW PERIOD for adults has been selected, then 180 days (or 210 days in WebCARE to allow for data entry), or

2. The Level-of-Care Authorized (LOC-A) END DATE has been reached (or 30 days after the END DATE in WebCARE to allow for data entry).

Select Report
Select 248: RDM Assessments to Expire – Adult on the RDM Main Menu.
248: Assessments to Expire – Adult, Continued

Request Screen  A sample 248: RDM Assessments to Expire – Adult request screen is shown below.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter your Component code in the COMPONENT field, if Component code has not already been entered.</td>
</tr>
<tr>
<td>2</td>
<td>Enter the dates of potentially expiring records.</td>
</tr>
<tr>
<td>3</td>
<td>Enter the location in the LOCATION field, if appropriate.</td>
</tr>
<tr>
<td>4</td>
<td>Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, the Level of Care Authorized, or by the provider location.</td>
</tr>
<tr>
<td>5</td>
<td>Click Submit_Request when all the options have been set.</td>
</tr>
</tbody>
</table>

continued on next page
No Expiring Records Found
If no expiring records are found for the component, date range, and location combination, the following screen is displayed.

Record is Found
If at least one expiring record is found for the component, date range, and location combination entered, a similar screen to the following screen is displayed.
**Remove Records from List**

To remove these records from the expiring list, enter an **Update** or **Discharge** assessment. If an **Incomplete** or **Provider Complete** assessment exists for the individual, then their previous assessment will not be on this list.
251: Completed Assessments - Adult

Purpose
The purpose of the 251: RDM Completed Assessments – Adult report is for data verification and for printing the completed assessment that has the Medically Necessary statement for signature.

Business Rule
WebCARE assessments are complete when all sections of the assessment have been entered and have passed all business rules and it has been marked Complete by the center. If a Medicaid individual is receiving services (Intake or Update assessment), the Medically Necessary statement must be signed by the LPHA.

Select Report
Select 251: Completed Assessments – Adult on the RDM Main Menu.
251: Completed Assessments - Adult, Continued

Request Screen  A sample 251: RDM Completed Assessments – Adult request screen is shown below.

Note: If seven days has passed, the record is no longer modifiable and the **Look_At** button is visible.

---

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter your Component code in the <strong>COMPONENT</strong> field, if Component code has not already been entered.</td>
</tr>
</tbody>
</table>
| 2    | Enter the dates of completed records.  
*Note:* The second date of the date range must be today’s date or a past date. Today’s date is automatically populated and a date one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed. |
| 3    | Enter the location in the **LOCATION** field, if appropriate. |
| 4    | Click to select **AUTOCOMPLETED ONLY?** if you prefer to view AutoCompleted records Only. Refer to the beginning of this chapter for more information on AutoCompletion. |
| 5    | Click to select the appropriate **SORT BY** radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, the date that the Level of Care was authorized, or by the provider location. |
| 6    | Click **Submit_Request** when all the options have been set. |
No Records Found  If no completed records are found for the component, date range, and location, the following screen is displayed.

Records are Found  If at least one completed record is found for the component, date range, and location combination entered, the following screen is displayed.
Medicaid Individual  If an individual listed is a Medicaid individual, select Look At to print and sign the Medically Necessary statement at the bottom of the screen. A sample screen is shown below.

COMP: 030 / CASE NO: 0000000000 / LAST NAME: BLACK / FIRST NAME: JORDAN

As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the "Authorized Level of Care (LOC-A)" section above are medically necessary and I concur with the plan of care.

Signature of LPHA: ___________________  LPHA Credentials: ____________  Date: ____________

Return To List
252: Autoclosures – Adult

Purpose
The purpose of the 252: RDM Autoclosures – Adult report is for data verification and for authority or Utilization Management staff to review adult assessments that were automatically deleted.

Select Report
Select 252: Autoclosures – Adult on the RDM Main Menu.

<table>
<thead>
<tr>
<th>Data Entry</th>
<th>Workflow/Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>225 Client Registration</td>
<td>Incomplete/Provider Complete Assessments - Adult</td>
</tr>
<tr>
<td>330 Diagnostics</td>
<td>Assessments Expired By Section - Adult</td>
</tr>
<tr>
<td>164 MB Child Uniform Assessment for RDM</td>
<td>Assessments to Expire - Adult</td>
</tr>
<tr>
<td>246 MB Adult Uniform Assessment for RDM</td>
<td>Completed Assessments - Adult</td>
</tr>
<tr>
<td>252 Autoclosures - Adult</td>
<td></td>
</tr>
</tbody>
</table>
252: Autoclosures – Adult, Continued

Request Screen  A sample 252: RDM Autoclosures – Adult request screen is shown below.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter your Component code in the COMPONENT field, if Component code has not already been entered.</td>
</tr>
</tbody>
</table>
| 2    | Enter the dates of Autoclosed records.  
Note: The second date of the date range must be today’s date or a past date. Today’s date is automatically populated and a date one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed. |
| 3    | Enter the location in the LOCATION field, if appropriate. |
| 4    | Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, the date that the Level of Care was authorized, or by the provider location. |
| 5    | Click Submit_Request when all the options have been set. |
252: Autoclosures – Adult, Continued

No Records Found  If no completed records are found for the component, date range, and location, the following screen is displayed.

Records are Found  If at least one completed record is found for the component, date range, and location combination entered, the following screen is displayed.
264: Incomplete/Provider Complete Assessments – Child

Purpose
The purpose of the **264: RDM Incomplete/Provider Complete Assessments – Child** report is to identify outstanding child/adolescent assessments requiring update or completion.

**Business Rule**
All **Incomplete** or **Provider Complete** records will be completed within 30 days. The goal is to prevent the entry of partial records that are not completed in a timely manner.

**WebCARE Rule**
All **Incomplete** or **Provider Complete** records older than 30 days will be Autoclosed and deleted from the operational system.

Review Daily
It is recommended that this report be reviewed daily.

Select Report
Select **264: Incomplete/Provider Complete Assessments - Child** on the RDM Main Menu.
264: Incomplete/Provider Complete Assessments – Child, Continued

Request Screen  A sample 264: RDM Incomplete/Provider Complete Assessments – Child request screen is shown below.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter your Component code in the COMPONENT field, if Component code has not already been entered.</td>
</tr>
</tbody>
</table>
| 2    | Enter the dates of Incomplete or Provider Complete records.  
   Note: The second date of the date range may not be a future date and the first date may not be before the second date. |
| 3    | Enter the location in the LOCATION field, if appropriate. |
| 4    | Click to include Incomplete or Provider Complete records and select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, or the provider location. |
| 5    | Click Submit_Request when all the options have been set. |
264: Incomplete/Provider Complete Assessments – Child, Continued

No Records Found

If no records are found, then no Incomplete or Provider Complete records meet the criteria set for the report. You may broaden the criteria for a more thorough search. The following screen is displayed if no records are found.

Records are Found

If records are found, a screen similar to the one below will be displayed. All records are modifiable and should be corrected as soon as practical. To authorize a Level of Care, select the Authorize button. To change a record, select the Modify button to the left of the record to be updated.
264: Incomplete/Provider Complete Assessments – Child, Continued

Change Assessment

As an authority, when you select the **Authorize** button, the 164: MH Child & Adolescent Uniform Assessment for RDM screen for changing an assessment displays.

```plaintext
Enter Data

Enter all required information to complete the record, change the FORM STATUS to **Complete** and select **Submit Update** at the bottom of the screen. The completed screen will display. Select **Return To List** to return to the 264: RDM Incomplete/Provider Complete Assessments – Child list of outstanding records. The record you just completed is no longer in the list because it has been marked Complete.
```
### 265: Assessments Expiring - Child

#### Purpose
The purpose of the 265: Assessments Expiring – Child report is to identify all potentially expiring child/adolescent assessments. All Child/Adolescent Assessments expire after 90 days.

#### Select Report
Select 265: Assessments Expiring – Child on the RDM Main Menu.

<table>
<thead>
<tr>
<th>Data Entry</th>
<th>Workflow / Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>225 Client Registration</td>
<td>246 Incomplete Provider Complete Assessments - Adult</td>
</tr>
<tr>
<td>330 Diagnostics</td>
<td>247 Assessments Expiring By Section - Adult</td>
</tr>
<tr>
<td>164 MRI Child Uniform Assessment for EDM</td>
<td>248 Assessments to Expire - Adult</td>
</tr>
<tr>
<td>246 MRI Adult Uniform Assessment for EDM</td>
<td>251 Completed Assessments - Adult</td>
</tr>
<tr>
<td>252 Autoclosures - Adult</td>
<td>264 Incomplete Provider Complete Assessments - Child</td>
</tr>
<tr>
<td>255 Assessments Expiring - Child</td>
<td>267 Completed Assessments - Child</td>
</tr>
<tr>
<td>268 Autoclosures - Child</td>
<td></td>
</tr>
</tbody>
</table>

continued on next page
A sample 265: Assessments Expiring – Child screen is shown below.

### Request Screen

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter your Component code in the COMPONENT field, if Component code has not already been entered.</td>
</tr>
<tr>
<td>2</td>
<td>Enter the date range of potentially expiring child/adolescent assessments.</td>
</tr>
<tr>
<td>3</td>
<td>Enter the location in the LOCATION field, if appropriate.</td>
</tr>
<tr>
<td>4</td>
<td>Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, or the provider location.</td>
</tr>
<tr>
<td>5</td>
<td>Click Submit_Request when all the options have been set.</td>
</tr>
</tbody>
</table>
265: Assessments Expiring – Child, Continued

No Records Found    If no expiring records are found for the component and date range combination, the following screen is displayed.

Note: Occasionally, an Incomplete or Provider Complete assessment will display on an expiring report. The record may still be modifiable.

Record is Found    If at least one expiring record is found for the component, date range, and section combination entered, the following screen is displayed.

Remove Records From List    To remove these records from the expiring list, enter an Update or Discharge assessment. If an Incomplete or Provider Complete assessment exists for the individual, then their previous assessment will not be on this list.
267: Completed Assessments - Child

Purpose
The purpose of this report is for data verification and for printing the completed assessment that has the Medically Necessary statement for signature.

Business Rule
WebCARE assessments are complete when all sections of the assessment have been entered, have passed all business rules, and have been marked Complete by the center. If a Medicaid individual is receiving services (Intake or Update assessment), the Medically Necessary statement must be signed by the LPHA.

Select Report
Select 267: Completed Assessments – Child on the RDM Main Menu.
A sample 267: RDM Completed Assessments – Child screen is shown below. If seven days has passed and if a completed assessment expires, the record is no longer modifiable and the **Look At** button is visible.

### Step | Action
--- | ---
1 | Enter your Component code in the **COMPONENT** field, if Component code has not already been entered.
2 | Enter the dates of completed records.
   - **Note**: The second date of the date range must be today’s date or a past date. Today’s date is automatically populated and a date that is one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed.
3 | Enter the location code in the **LOCATION** field, if appropriate.
4 | Click to select the appropriate **SORT BY** radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, date the Level of Care was authorized, or provider location.
5 | Click **Submit_Request** when all the options have been set.
No Records Found  
If no completed records are found for the component, date range, and location, the following screen is displayed.

Completed Record is Found  
If at least one completed record is found for the component, date range, and location combination entered, a screen similar to the following is displayed.
Medicaid Individual

If an individual listed is a Medicaid individual, select **Look At** to print and sign the Medically Necessary statement at the bottom of the screen.

As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the "Authorized Level of Care (LOC-A)" section above are medically necessary and I concur with the plan of care.

Signature of LPHA: ____________________________

LPHA Credentials: ____________________________

Date: ____________________________

[Return To List]
### 268: Autoclosures - Child

**Purpose**

The purpose of the 268: RDM Autoclosures – Child report is for data verification and for authority or Utilization Management staff to review adult assessments that were automatically deleted.

**Select Report**

Select 268: Autoclosures – Child on the RDM Main Menu.

---

<table>
<thead>
<tr>
<th>Data Entry</th>
<th>Workflow / Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>325 Client Registration</td>
<td>246 Incomplete Provider Complete Assessments - Adult</td>
</tr>
<tr>
<td>330 Diagnostics</td>
<td>247 Assessments Expiring By Section - Adult</td>
</tr>
<tr>
<td>164 MHH Child Uniform Assessment for RDM</td>
<td>248 Assessments to Expire - Adult</td>
</tr>
<tr>
<td>246 MHH Adult Uniform Assessment for RDM</td>
<td>251 Completed Assessments - Adult</td>
</tr>
<tr>
<td>252 Autoclosures - Adult</td>
<td>264 Incomplete Provider Complete Assessments - Child</td>
</tr>
<tr>
<td>265 Assessments Expiring - Child</td>
<td>267 Completed Assessments - Child</td>
</tr>
<tr>
<td>268 Autoclosures - Child</td>
<td></td>
</tr>
</tbody>
</table>

---
Request Screen   A sample 268: RDM Autoclosures – Child screen is shown below.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter your Component code in the COMPONENT field, if Component code has not already been entered.</td>
</tr>
</tbody>
</table>
| 2    | Enter the dates of Autoclosed records.  
   **Note:** The second date of the date range must be today’s date or a past date.  
   Today’s date is automatically populated and a date that is one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed. |
| 3    | Enter the location code in the LOCATION field, if appropriate. |
| 4    | Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, date the Level of Care was authorized, or provider location. |
| 5    | Click Submit_Request when all the options have been set. |
268: Autoclosures - Child, Continued

No Records Found  If no completed records are found for the component, date range, and location, the following screen is displayed.

Completed Record is Found  If at least one completed record is found for the component, date range, and location combination entered, a screen similar to the following is displayed.
Automated Processes

WebCARE has three automated processes that are designed to keep mainframe CARE/WebCARE data accurate:

- Autoclose
- AutoComplete
- Auto-Delete

Autoclose

Adult and child/adolescent Crisis, Intake, or Update assessments are Autoclosed 30 days after their Section 1: TRAG or LOC-A authorization expires retroactive to the date of expiration of the authorized period. Section 1: TRAG ASSESSMENT DATE expires after 90 days unless EXTENDED REVIEW PERIOD REQUESTED? has been selected (Section 1: TRAG ASSESSMENT DATE expires after 180 days instead of 90 days). For LOC-A 8=Waiting List, the expiration is set to 365 days.

If a new assessment has not been started, the expired assessment is Autoclosed and a Discharge record is created with a DISCHARGE REASON code of X. A comment is added to the assessment that states that either the LOC-A or TRAG has expired. The newly created record will be included in the regular Electronic Data Transfer System (EDTS) file for the center that produced the expired/Autoclosed assessment.

If the assessment is Autoclosed and a Discharge record is created, this Discharge record, like any other Discharge record, will cause the termination of any open mainframe CARE community-based assignments for the individual. The assignments will be terminated based on the date of the discharge and the assignment code will be removed from the ASSIGN_CD field for discharge record sent to EDTS.

The center’s method of entry (batch or online) will not affect the Autoclose process.

*Note: A “No Overlapping Authorization” batch process is also run on a nightly basis. This process checks for authorizations that cover the same period for the same individual and changes the prior LOC-A AUTHORIZATION END DATE to the day before the new LOC-A AUTHORIZATION BEGIN DATE. If a Discharge record is found, the LOC-A AUTHORIZATION END DATE for the prior Intake or Update record will be changed to the day before the Discharge Date.
Automated Processes, Continued

AutoComplete

This is the process by which selected adult only Provider Complete Update assessments are automatically changed to Complete status.

After a provider has entered Sections 1: Adult TRAG, 3: Diagnosis Specific Clinical Symptom Rating [TIMA] Scales, and 4: Community Data (may be auto-filled if the data has not expired), the form is marked Provider Complete. The AutoComplete process validates the assessment against all of the business rules regarding completeness.

If the assessment passes the business rules for completeness, then the AutoComplete process will change the Form Status to Complete. This new status is processed immediately and will be displayed on the result screen.

If the assessment does not pass a business rule for completeness or the AUTHORITY REVIEW REQUESTED? check box is checked, then the assessment will remain at Provider Complete status and the authority or Utilization Management staff must modify/authorize the assessment. If the AUTHORITY REVIEW REQUESTED? check box is checked, the AutoCompletion process is interrupted. If the provider wants the authority (usually the Utilization Management staff) to review the assessment and manually change the FORM STATUS to Complete, the provider checks the AUTHORITY REVIEW REQUESTED? check box.

If the authorization period from the prior assessment will expire in less than 90 days, the Section 2: LOC-A will not be preloaded and the authority will need to fill in all of Section 2: LOC-A. The purpose for this requirement is to ensure that when the Section 1: TRAG is updated (valid for 90 days from Section 1: TRAG Assessment Date) that the Section 2: LOC-A is still appropriate and the new Section 2: LOC-A authorization period is valid for the same 90 days.

Auto-Delete

If an Incomplete or Provider Complete record is not updated for over 30 days, the Incomplete or Provider Complete record will be Auto-Deleted. All data entered on the deleted assessment must be re-entered. No record of the prior Incomplete or Provider Complete assessment is retained in WebCARE.
# Error Codes and Related Business Rules

CARE / WebCARE System

The CARE / WebCARE system was designed and developed based on Texas Department of State Health Services (DSHS) business rules. These rules were designed to meet the requirements set forth by legislation, clinical best practices, and procedural best practices of various community centers.

Since the CARE system was originally implemented in the early 1980’s, many business rules have changed and CARE has changed to reflect the new requirements. WebCARE was introduced to meet the new needs for Internet access to CARE. WebCARE is a front-end system to the CARE database and contains error codes and edits that enforce business rules in much the same way as the mainframe CARE screens do.

Error Resolutions

In an effort to ease the transition from CARE to WebCARE, a database was designed to display the error codes that may be encountered in WebCARE and the associated business rules for those errors. There are also error resolutions to assist in deciphering the error messages and to suggest ways to correct the error.

Error Codes Used Throughout CARE

Because error codes may be used throughout the CARE system, the screen number along with the error code will be required to determine which business rule and error resolution best fits your situation.
Using the Error Codes and Related Business Rules Database

Access to the WebCARE Error Code, Resolution, and Business Rule Database requires an Internet browser (like Internet Explorer). If your personal computer is connected to the Internet, start a new browser session. This way you can simultaneously use WebCARE in one browser window and have the WebCARE Error Code, Resolution, and Business Rule Database available in a different browser window. You must also have access to the legacy MHMR Intranet (see Confidentiality and Security of Consumer Records for more information).

The following table describes the steps taken to view Error Codes, Resolutions, and Business Rules.

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | _ _  | If, while you are using WebCARE, an error message displays and you want to look up information about the error message:  
• Write down the screen number where the error message appeared. The screen number can be found in the upper right corner of the browser window (it usually begins with VC).  
• Write down the error number (usually 4-5 numbers long in a red font with a description following it. It may also be preceded by ‘Msg:’). |
| 2    | _ _  | • Start a new browser session.  
• In the Address (at the top of the browser, type the following Uniform Resource Locator (URL) exactly as it is written (or click the link below):  
http://www2.hhsc.state.tx.us/655/cis/training/files/wbcare/frm_DisplayResolution1.asp  
Result: The WebCARE Error Codes, Resolutions, and Business Rules screen is displayed. |
| 3    | A sample screen is shown below.  
To view the Error Code:  
• Select the Screen Number from the list.  
• Click the Get Error Codes button.  
Result: A screen is displayed with only the associated error codes for the screen selected. |
### Using the Error Codes and Related Business Rules Database, Continued

#### Table, continued

<table>
<thead>
<tr>
<th>Step</th>
<th>View</th>
<th>Action</th>
</tr>
</thead>
</table>
| 4    | A sample screen is shown below | • Select the noted WebCARE error code. Verify that the screen name and error message is the same as the WebCARE screen and the error you received.  
• Select the **Display Results** button to view the associated Resolutions and Business Rules.  
• Select the **Previous Page** button to return to the list of screens.  
Result: The Resolutions and Business Rules for the screen and error code combination selected are displayed. |
| 5    | A sample screen is shown below. | • Select the **New Screen** button to select a different screen.  
• Select **Previous Page** to return to the list of error codes listed for the current screen. |

#### List All Business Rules

For a list of all Business Rules (grouped by section and then in no particular order) in Microsoft Excel format:

- In the Address (at the top of the browser, type the following Uniform Resource Locator (URL) exactly as it is written (or click the link below):
  

#### Contract Business Rules

Business Rules have also been derived from Performance Contract requirements. Some functionality in WebCARE may appear to cause Appropriateness report inconsistencies, but exceptions are listed in the contract. For more details on contract requirements, see:

**FY 2008 Performance Contract:**

Batch Processing and Electronic Data Transfer System (EDTS)

Enter Data Into CARE
There are two methods for entering data into the CARE system:

1. Direct data entry into the mainframe CARE system through a 3270 terminal emulator or through WebCARE using a web browser. R&DM Adult and Child/Adolescent Uniform Assessments for new and/or ongoing consumers may only be entered via WebCARE.

2. Batch submittal of data using File Transfer Protocol (FTP) to the mainframe. For Adult and Child/Adolescent Uniform Assessments information, batch files will be accepted into the CARE system after the center completes the Batch Certification process. Reports may be generated for centers and viewed through JHS Exporter. For more details, see the following documents:
   - Batch Information
   - CARE X/PTR Report Listing
     - CARE XPTR Numeric List
     - CARE XPTR by Directory

EDTS
An EDTS transactional file is created on a daily scheduled basis. When data is entered into WebCARE (either by batch or online data entry), it will be copied to the extract file. That file is placed in a directory specifically for the center submitting the data and may be transferred to the center for reporting or updating the local system. The files are part of the Electronic Data Transfer System (EDTS). For more information on EDTS, see the following documents:

- General Information About EDTS Files
- Adult EDTS Layout
- Child EDTS Layout
- Diagnosis EDTS Layout
- Registration EDTS Layout

WebCARE Data Movement Diagram
On the following page, the WebCARE Data Movement Diagram provides a visual representation of flows through the various systems. Start at the upper left corner and move in a clockwise direction.
WebCARE Data Movement Diagram

Local Service Center System
- Send batch “flat” file via FTP to MHMR mainframe
- Pulls WebCARE / CARE

PULL Assessment Data Files

EDTS Server
- Stores text files for Service

Mainframe CARE
1. Records are stored in CARE/WebCARE Assessment File -- both Complete and Incomplete records

WebCARE Data Entry
2. Extract Centers’ Assessment data (updated since the last extract was made.)
3. Splits the R&D adult and child records. Separates the above and Registration and Diagnosis records by record-type and by Center (ETIN identifier).

PUSH Batch file via FTP

Data Warehouse (MBOW)
5. Extract RDM Adult and Child/Adolescent data with related campus and community data, providing a combined record for each client for each month of service for the elapsed FY.
6. FTP the extracted data to the MBOW Warehouse.

PUSH Mainframe text files

HIPAA Server
- FTP’s the text files to the EDTS Server

PUSH Text Files

Version 6 January, 2010
WebCARE Technical Services
Web Client Assignment and Registration System