BEHAVIORAL HEALTH INDIVIDUAL SERVICE LEVEL (ISL) ENCOUNTER REPORTING GUIDANCE

VERSION 1.0

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

This document is intended to serve as a primary source of guidance for counties to implement ISL encounter reporting. Counties and cities must use this guidance in conjunction with the ISL Code Library and the ISL Encounter Fields which together comprise the core technical resources for ISL reporting.

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INTRODUCTION AND OVERVIEW OF ISL

Behavioral Health Individual Service Level (ISL) encounter reporting captures individual level behavioral health services provided directly to clients by city agencies (Berkeley and Tri City Mental Health) and county behavioral health systems (collectively referred to as "counties"), and county provider networks (collectively referred to as "providers"). These reporting requirements apply only to services that are not reimbursable through the Medi-Cal program. Medi-Cal covered services delivered to a Medi-Cal enrolled individual must continue to be billed through Short Doyle and CA-MMIS and are not reported as ISL encounters.

ISL encounters are a critical component of Behavioral Health Services Act (BHSA) reporting and are necessary to support DHCS' statutory responsibilities. DHCS will use ISL data to gain an understanding of service provision under the BHSA, generate performance measures, and support population health management, among other functions. ISL encounters support a consistent view of the behavioral health services counties deliver and the individuals they serve.

Pursuant to WIC sections 5963.04(a)(2)(H) and (I), 5963.04(b), and 5897(d), effective January 1, 2027, counties are required to submit ISL encounters for all in scope services delivered on and after January 1, 2027, to DHCS. At a minimum, counties must submit ISL encounters to DHCS annually, no later than 90 days after the close of the fiscal year (FY) in which services were rendered.

For the first year of ISL reporting, counties are required to report services delivered between January 1, 2027, and June 30, 2027, by at least 90 days after the close of the 2027 FY (2027 FY Close: June 30, 2027, ISL 1st Year Reporting Deadline: September 30, 2027). For all subsequent years, counties must report the full fiscal year of ISL encounters in accordance with the same 90-day post FY close timeline.

Beginning July 1, 2026, counties may begin submitting ISL encounters to DHCS for services delivered between July 1, 2026, and December 31, 2026. This period will be for testing and technical assistance (TA) purposes only. DHCS will not utilize data submitted during this six-month period for county performance measures or monitoring, and data submitted will solely be used for purposes of refining and strengthening ISL reporting. Counties that do not submit ISL encounters during this time period will not be required to submit those encounters retroactively.

Counties are strongly encouraged to begin reporting ISL encounters starting in July 2026 to support system testing and receive early TA; however, all counties will receive TA leading up to and following January 1, 2027.

All ISL encounters must be submitted accurately and aligned with ISL guidance and technical resources.

DHCS will oversee and monitor counties' participation and fidelity to ISL requirements through the County Performance Contract and the Behavioral Health Delivery System (BHDS) contract.

In Scope for ISL Reporting

Behavioral health services delivered to an individual that are not claimable to Medi-Cal are in scope for ISL encounter reporting. This includes:

- Behavioral health services represented in the Medi-Cal benefit package that are delivered to individuals who are not enrolled in Medi-Cal on the date of service delivery.[1]
- Behavioral health services represented in the Medi-Cal benefit package that are delivered in settings that are locked out of Medi-Cal claiming.
- Behavioral health services represented in the Medi-Cal benefit package and for which a Medi-Cal member has exhausted the benefit.
- Behavioral health services or expenses that are not represented in the Medi-Cal benefit package and are represented in the non-Medi-Cal ("DHCS-defined") ISL code set.

In some cases, a county may submit an ISL encounter, then later seek to resubmit that same encounter as a billable Medi-Cal claim (if for example a client was approved for retroactive Medi-Cal coverage that covers the date of service). In these scenarios, the county must submit a void ISL encounter to avoid duplicative utilization records. See instructions for voiding ISL encounters in "Appendix B: Voiding and Replacing Encounters."

Please see the full list of in scope BH ISL service codes in the ISL Code Library.

Out of Scope for ISL Reporting

Behavioral health services not in scope for ISL encounter reporting include:

[1] Chapter 6, Section C.2.2 of the BHSA Policy Manual requires counties to ensure providers check for and support Medi-Cal enrollment for eligible individuals.

- Services delivered to Medi-Cal-enrolled individuals that are claimed and funded through Medi-Cal.
- Outreach and engagement services in which there is no identifiable client or that do not result in an identifiable client.
- Outreach, engagement, education or prevention services or activities directed towards community- or organization-level audiences (e.g., schools, senior centers, faith-based organizations).
- Investments in workforce recruitment, education, or training.
- Professional licensing or certification testing fees for county or county-contracted staff.
- Investments or ongoing support for county behavioral health call centers or hotlines.
- Investments to purchase, construct, or renovate housing.
- Contributions to a county or municipal housing flex pool (however, services paid for using these contributions is in scope for ISL reporting).
- Investments in the county's behavioral health facilities (e.g., purchase of buildings/land, repairs, renovations) or match funds for the Behavioral Health Infrastructure Bond Act of 2023 Behavioral Health Continuum Infrastructure Program (BHCIP) awards.
- Investments in county technology systems or infrastructure (e.g., electronic health records, telemedicine platforms, data warehouses).
- Any other county-funded services or expenditures for which service level codes are not defined in the ISL Code Library.

ISL ENCOUNTER FIELDS AND VALIDATION RULES

ISL Encounter Fields

The ISL Encounter Fields are the data elements that counties are required to populate for each ISL encounter they submit. ISL encounters leverage a subset of American National Standards Institute (ANSI) X12 837 data elements that counties currently submit through Medi-Cal Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMCODS) claims. DHCS intends to promote parity in the collection and reporting of individual-level behavioral health service and expenditure data, regardless of funding source.

ISL Validation Rules

The ISL validation rules describe the rules and logic used by DHCS to process encounters. It defines field dependencies, data element specifications, and data reference tables, and establishes the criteria used to conduct encounter processing.

Please see the ISL Validation Rules Catalog within the ISL application in the County Portal.

ISL Encounter Fields – Special Instructions

This section outlines special instructions for select ISL encounter fields that require additional guidance. Please see the complete list of ISL Encounter Fields for every field.

In this section, the *italicized text* indicates the definition of the encounter field being specified, and the » bulleted text are the special instructions for that associated encounter field.

Encounter ID

A county generated numeric-only identifier for each encounter.

- An encounter ID must contain numeric characters only.
- For an original encounter (i.e., not a void or replacement), the encounter ID must be unique. For void or replacement encounters, the encounter ID must match the original encounter being voided or replaced.

Encounter Submission Type

Encounter Submission Type specifies if the claim is original, replacement, or void.

- See "Appendix B: Void and Replacement Encounter Instructions" for detailed instructions on completing the Encounter Submission Type field.

Encounter Service Type

This field is not intended for county completion; however, residual elements of the field remain within the ISL system, and DHCS is flagging this for county awareness. Encounter Service Type indicates whether the service provided is Outpatient (O) (submitted on an 837P for Medi-Cal claims), Inpatient (I) (submitted on an 837I for Medi-Cal claims), or Expense (E). This field is used for back-end system validation and to support field dependencies. DHCS is developing system updates to automatically assign Encounter Service Type for each encounter, anticipated to be implemented in advance of the January 1, 2027 ISL go-live. Until this change is implemented, counties may choose not to include the Encounter Service Type field, assign a value (E, O, or I), or submit the field as NULL. At this time, this will not have any impact on how submitted data is processed. Counties may receive "accept with warning" errors related to this field; however, no action is required in response to these warnings. These warnings will be retired once the system update is implemented.

Client Social Security Number (SSN)

The client's social security number.

- If a county submits a "pseudo-SSN" (e.g., 999999999) in the Client SSN field, the submission must include a complete and valid value in either the Client Medi-Cal CIN field or the Client County Medical Record Number (MRN) field.

Client Date of Birth (DOB)

Date of birth of the client who received the service.

» If the client's date of birth is unknown at the time of the encounter, the county may submit NULL in the Client DOB field.

Client Insurance Status

The insurance(es) of the client who received the service, at the time of service (e.g. Medi-Cal, Medicare, Private/Commercial Insurance, Uninsured)

» If the client's insurance status is unknown at the time of the encounter, counties may submit UNKNOWN in the Client Insurance Status field.

» Counties may submit multiple Client Insurance Status values for a single client. When a client has more than one insurance value, counties must submit all applicable values in the Client Insurance Status field, separated by a comma (,) delimiter.

- Example: Insurance 1, Insurance 2, Insurance 3

Client Race/Ethnicity

Client's race(s) or ethnic group(s).

» Counties are encouraged to align race and ethnicity reporting with applicable standards published in the United States Core Data for Interoperability (USCDI). Please see the USCDI website for more details.

» Counties may submit multiple Race and/or Ethnicity values for a single client. When a client has more than one Race and/or Ethnicity value, counties must submit all applicable values in the Client Race/Ethnicity field, separated by a comma (,) delimiter.

- Example: Race 1, Ethnicity 1, Race 2, Race 3

Program Name

*The county-assigned Program Name across Short Doyle and CA-MMIS claims and ISL encounter data. For the purposes of Short Doyle and CA-MMIS claims, the Program Name may be found in NM1*77 Loop 2310C in the 837P and Loop 2310E in the 837I.*

» Counties must use the same Program Name consistently for all claims and encounters.

» Program Name must be payer agnostic and used consistently across Medi-Cal claiming in Short Doyle and CA-MMIS and ISL encounter reporting; Program

Names must not be exclusively used within Short Doyle, CA-MMIS, or ISL encounter reporting.

- County changes to Program Name must occur in ISL, Short Doyle, and in CA-MMIS and all DHCS Program Name related materials must be updated to reflect this change.

Service Date

The date the client was delivered the service.

- For inpatient stays, the county may submit NULL in the Service Date field.

Admission Date and Discharge Date

Admission Date is the date the client was admitted to the facility. Discharge Date is the date the client was discharged from the facility.

- For each inpatient stay, regardless of length of stay, counties must submit a single encounter with the Submission Type designated as Original and include both the Admission Date and Discharge Date.
- For stays that span fiscal years, the county must submit encounters by fiscal year, covering the dates of stay during each respective fiscal year. Counties must adhere to the reporting deadline and submit the stay for the fiscal year within 90 days after close of the fiscal year.

Diagnosis Code

Principle diagnosis of the client.

- For ISL encounters with an Expense Service Type, if the client's diagnosis is unknown at the time of the encounter, counties may submit UNKNOWN in the Diagnosis Code field.
- Counties are strongly encouraged to prioritize timely diagnosis capture, including the use of appropriate ICD-10-CM Z-codes when clinically applicable.

Secondary Diagnosis Codes

Secondary diagnoses of the client.

- Counties may submit multiple secondary diagnosis code values for a single client. When a client has multiple secondary diagnosis codes, counties must submit all secondary diagnosis codes in the Secondary Diagnosis Code field, separated by a comma (,) delimiter.
    - Example: Dx2, Dx3, Dx4

Place of Service Code

Location where service was delivered.

- The Place of Service Code must align with Medi-Cal billing manual standards and must reflect the physical location where the service occurred (i.e., where the client was located at the time of service).
- If the encounter is not an Inpatient or Outpatient Service Type, counties must use "99-Other" for the Place of Service Code.

Encounter Value

Encounter Value must reflect either (1) the actual cost incurred where the ISL encounter represents an invoice-based payment or direct expense, or (2) a standardized proxy valuation established by the county to reasonably represent the value of the reported ISL service when an encounter level payment amount is not available.

- See "Appendix A: Encounter Value Calculation Methodology" for additional detail and required calculation frameworks for completing the Encounter Value field.

ISL DATA QUALITY

Guidance on data quality for ISL encounters is forthcoming.

ISL CODE LIBRARY

Please see the full list of in scope ISL service codes in the ISL Code Library. Counties are required to follow all service coding instructions outlined in the ISL Code Library and the special instructions below.

Services with Existing Medi-Cal Service Codes

For ISL reported services that are identical to a covered Medi-Cal benefit but not claimed for Medi-Cal reimbursement, counties must submit the ISL encounter using the same procedure code and modifier combination that would be used for Medi-Cal billing, regardless of whether Medi-Cal paid for the service.

Services without Existing Medi-Cal Service Codes

For services that do not have existing Medi-Cal service codes, counties must report these services via ISL encounters using DHCS-defined ISL service codes and modifiers. These codes are specifically designed to capture non-Medi-Cal funded behavioral health services that are not otherwise represented in standard medical coding schemas.

ISL Code Library – Special Instructions

This guidance is for ISL purposes and counties should refer to relevant DHCS policy manuals, governing notices, regulations, guides, etc. for the most up-to-date requirements and definitions for the specific BHSA components listed below.

Housing Services

The ISL Encounter Code Library includes codes that differentiate whether a service was provided in an interim or permanent setting. For example, there are two codes for Rental Subsidies, Recovery Residences, Housing Services Cost Supplement and Operating Subsidies, with one code designated for interim settings and one for permanent settings. Counties must ensure the submitted ISL code aligns with the type of setting in which the service was provided.

Additionally, the housing services code set includes codes for some, but not all, specific setting types. Where setting-specific codes exist (e.g., Hotel/Motel Vouchers, Recovery Residences), counties must use those codes. Where a specific setting code does not exist, counties must use the appropriate general code based on: (1) whether the funding supports housing services provided to county clients residing in housing, a rental subsidy or an operating subsidy; and (2) whether the setting is an interim or permanent setting. These codes include:

- ISL 206 Rental Subsidy: Interim Setting
- ISL 207 Rental Subsidy: Permanent Setting

- ISL 208 Housing Services Cost Supplement: Interim
- ISL 209 Housing Services Cost Supplement: Permanent
- ISL 221 Operating Subsidy: Interim Setting
- ISL 222 Operating Subsidy: Permanent Setting

DHCS recognizes that counties may provide operating subsidies that are not directly tied to a single individual. Operating subsidy codes may be used when a county provides funding to a setting in which county clients reside, if a reasonable portion of the subsidy can be attributed to a specific individual. In these cases, the encounter should reflect the amount attributable to that individual (i.e., subsidy amount divided by number of county clients served).

Operating subsidy codes should not be used for counties covering the non-Medi-Cal coverable *"rent"* costs in an interim setting. For a Medi-Cal member receiving Transitional Rent in an interim setting, counties should use the code ISL 206 Rental Subsidy: Interim Setting code to capture the non-Medi-Cal share of costs.

Rental Subsidy Codes

- To assist DHCS with understanding how long an individual is receiving housing services, counties must:
- For interim settings (ISL205: Respite Residential, ISL 206 Rental Subsidy: Interim Setting, ISL 210 Hotel/Motel Vouchers, ISL 212 Recovery Residence: Interim Setting, ISL 215: Shelter, ISL 216: Shelter Plus Programming) and permanent settings (ISL 207 Rental Subsidy: Permanent Setting, ISL 213 Recovery Residence: Permanent Setting), submit distinct daily original encounters, each assigned a unique Encounter ID, for every day of service.
- For interim and permanent settings, if a client moves to, or is placed in a new setting, the county must submit new encounters. Similarly, if a client leaves a setting and returns at a later date, the county must submit separate encounters for each part of the client's stay.
- For stays that span fiscal years, the county must submit encounters by fiscal year, covering the dates of stay during each respective fiscal year. Counties must adhere to the reporting deadline and submit the stay for the fiscal year within 90 day after close of the fiscal year.

Full Service Partnership (FSP) Services

Counties are required to use specific service codes and modifiers for required FSP EBPs and other FSP services.

The table below outlines the service codes and modifiers counties must use when submitting ISL encounters for FSP services. Counties should refer to the BHSA Policy Manual, the SMHS and DMC/DMC-ODS billing manuals, and forthcoming Medi-Cal guidance for the most up-to-date information.

The ISL service codes and modifiers for ACT, FACT and IPS vary based on whether a county has opted to cover the EBPs as bundled Medi-Cal services. Counties that opt to cover ACT, FACT and/or IPS as bundled Medi-Cal services will use the same bundled service codes for Medi-Cal claims and for ISL encounters. Counties that have not opted to cover ACT, FACT and/or IPS as bundled Medi-Cal services must use individual "unbundled" service codes and an associated modifier for ISL encounters.

The ISL service codes and modifiers for HFW, FSP ICM, Assertive Field-Based SUD, and other FSP services[2] are the same for all counties. Counties must submit ISL encounters for each individual FSP service.

Counties that have approved exemptions for ACT, FACT and/or IPS must not submit any ISL encounters for those EBPs using the specified codes or modifiers in the FSP services table below.

[2] Includes all FSP services that are not captured as part of ACT, FACT, IPS, HFW, FSP ICM, and Assertive Field-Based SUD (e.g., FSP outreach, service planning, provider-staff coordination).

ACT Service	Service Code(s)	Modifier
County *opted in* to cover bundled Medi-Cal service	H0040	n/a
County *did not opt in* to cover bundled Medi-Cal service	Individual Service Codes (*Any SMHS codes)*	WJ
Other ACT services not Medi-Cal billable	Individual Service Codes (*Any SMHS codes)*	WJ

FACT Service	Service Code(s)	Modifier
County *opted in* to cover bundled Medi-Cal service	H0039	n/a
County *did not opt in* to cover bundled Medi-Cal service	Individual Service Codes (*Any SMHS codes)*	WK
Other FACT services not Medi-Cal billable	Individual Service Codes (*Any SMHS codes)*	WK

IPS Service	Service Code(s)	Modifier
County *opted in* to cover bundled Medi-Cal service	H2040	n/a
County *did not opt in* to cover bundled Medi-Cal service	Individual service codes *(Any SMHS, DMC, DMC-ODS codes)*	WD
Other IPS services not Medi-Cal billable	Individual Service Codes *(Any SMHS, DMC, DMC-ODS codes*	WD

HFW Service	Service Code(s)	Modifier
Individual service codes within the HFW monthly rate	H2022	n/a
HFW flex funds[3]	ISL406	n/a

[3] HFW flex funds are not part of the Medi-Cal benefit package. HFW flex funds must always be coded as a ISL Encounter, regardless of whether an individual is enrolled in Medi-Cal.

FSP Service	Service Code(s)	Modifier
FSP ICM	Individual service codes (*Any SMHS codes)*	WI
Assertive Field-Based SUD	Individual service codes (*Any DMC, DMC-ODS codes)*	WA
Other FSP Services	Individual services codes (*Any SMHS, DMC, DMC-ODS codes)*	WF

Behavioral Health Services and Supports

Counties are required to use specific service codes and modifiers for early intervention services that are EBPs and Community Defined Evidence Practices (CDEPs), early intervention services that are not EBPs or CDEPs, and Coordinated Specialty Care for First Episode Psychosis (CSC for FEP).

Codes for these services in the ISL Code Library align with the codes used for SMHS and DMC/DMC-ODS services. The table below outlines the service codes and modifiers counties must use when submitting ISL encounters for these services.

Counties that have opted into the BH-CONNECT demonstration waiver will use the designated Medi-Cal bundled billing code to capture CSC for FEP. Counties that have not opted into the BH-CONNECT demonstration waiver, must code and submit ISL encounters for each individual service delivered within the CSC for FEP program affixed with the CSC for FEP modifier.

For counties delivering early intervention services, the appropriate code and modifier combination is dependent on (1) whether the service code does or does not exist in the DHCS-defined ISL code set and (2) whether it is an EBP or CDEP or it is not an EBP or CDEP.

Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)	Service Code(s)	Modifier
If county is enrolled in BH-CONNECT:	Medi-Cal monthly bundled code: H2040	n/a
If county is not enrolled in BH-CONNECT:	Individual services codes for each service delivered within CSC for FEP model *(Any SMHS codes)*	WC

Early Intervention Services (EBPs or CDEPs)	Service Code(s)	Modifier
If the code exists in the ISL code set	Individual DHCS-defined ISL services codes (*Any SMHS, DMC, DMC-ODS codes)*	HX
If the code does not in the ISL code set	ISL313	n/a

Early Intervention Services (not EBPs or CDEPs)	Service Code(s)	Modifier
If the code exists in the ISL code set	Individual DHCS-defined ISL service codes (*Any SMHS, DMC, DMC-ODS codes)*	WB
If the code does not exist in the ISL code set	ISL312	n/a

APPENDIX

Appendix A: Encounter Value Calculation Methodology

This appendix provides the prescribed framework for completing the Encounter Value field. Encounter Value must represent the county's dollar value for the specific ISL encounter, using either: (1) the actual cost incurred (e.g., invoice-based payments and direct expenses); or (2) a standardized proxy value when an encounter-level payment amount is not otherwise available.

Calculation Approaches by ISL Unit Type/Expense Type

This guidance applies to ISL encounters representing services or expenditures funded by the county that are not reimbursed through Medi-Cal. In some cases, services reported to ISL may align with existing Medi-Cal service definitions and valuation methodologies but are not payable through Medi-Cal because the individual is not eligible for Medi-Cal or the individual has exhausted the Medi-Cal benefit. In such cases, existing Medi-Cal valuation methodologies must be used, as described below.

- **Time-Based ISL Services** (units = minutes). Use when the ISL code is reported in minutes.
- Units: Report the number of minutes to deliver the encounter.
- Encounter Value: Using outpatient Medi-Cal Practitioner Types, assign a per minute proxy value based on the role of the person who provided the service, then multiply that value by the reported minutes as follows:
    - Map the ISL renderer to a Medi-Cal practitioner type. To do this, identify the staff role of the person who rendered the ISL service and map it to the closest applicable Practitioner Type used in Medi-Cal billing standards for SMHS and DMC/DMCODS.
    - If the renderers classification is not typically mapped to a DHCS-claimable Practitioner Type (e.g., a Medical Office Assistant), select the closest comparable Practitioner Type for valuation purposes and apply it consistently. If no close match exists, an “Other Qualified Provider” Practitioner Type may be used as a standardized proxy.
    - Calculate Encounter Value using a per minute value. After selecting the Practitioner Type, use the county’s assigned Medi-Cal rate for that

Practitioner Type as the proxy, convert it to a per minute value using a consistent methodology, and multiply by the reported minutes (units).

- **Expense-Based ISL Services** (units = dollars). Use this option when the ISL code represents a direct cost, such as a purchased item or service.
- Units: Report units where 1 unit = $1 (i.e., the number of units equals the dollar amount of the expense incurred for the encounter).
- Encounter Value: Report the same dollar value represented by the expense, consistent with the county's financial record of the cost incurred.

- **Day-Based ISL Services** (units = days). Use when the ISL code is day-based (per diem).
- Units: Report the number of days represented by the encounter (units = 1 per day).
- Encounter Value: Apply an appropriate daily value to the reported days, based on one of the following methods arranged in order of priority:
    - Contract-operated services (per diem / per client day): Identify the contracted daily rate applicable to the service and use that rate to value the encounter based on the reported day units.
    - County-operated services: Use a County-defined proxy per diem that reasonably represents the county's cost of delivering the day-based service (e.g., County cost methodology used for internal rate development or cost allocation), applied to the number of reported days; ensure this rate is applied consistently where applicable.
    - Contract-operated services with non–per diem payment arrangements (e.g., operating subsidies): If the county subsidizes provider operating costs and the provider is not paid on a per day, per client basis, the County must use a standardized allocation method to translate the payment arrangement into a daily value for ISL reporting purposes. This approach is applicable only when the ISL service code requires a per day value (i.e., day-based codes).

- **CPT/HCPCS-Coded Services** Reported in ISL (not reimbursed by Medi-Cal). A service or cost incurred must be reported in ISL when it is tied to an individual and is

not reimbursed through Medi-Cal. For services that have an existing CPT or HCPCS code and would ordinarily be billed using Medi-Cal claiming standards, these standards must still be followed when the encounter is reportable in ISL. Therefore, the Encounter Value must be equal to the amount the county would have claimed to Medi-Cal.

- Units: Report units consistent with the applicable Medi-Cal service definition for the CPT or HCPCS coded service (e.g., units equal minutes, hours, days, etc.).
- Encounter Value: Use the applicable DHCS-established maximum rate associated with the HCPCS or CPT code, applied to the reported units.

Appendix B: Void and Replacement Encounters Instructions

This guidance describes the approach for counties' submission and DHCS' processing of void and replacement ISL encounters. First-time ISL encounter submissions that were rejected by DHCS must be corrected and resubmitted as encounters with Encounter Submission Type as Original, since they were not accepted into the system.

Previously accepted ISL encounters may be updated with:

- Replacement: When correcting or updating an existing accepted ISL encounter while keeping it valid
- Void: When the ISL encounter should be cancelled and no longer considered valid

Replacement and Void actions are only applicable to previously accepted ISL encounters.

Once an encounter is voided, no further updates (including replacements) are allowed.

Void of an Accepted Encounter

Counties may need to void an accepted encounter for the following reasons:

- The encounter was submitted in error.
- The encounter should not have been reported.
- The encounter needs to be removed from reporting and downstream processing (for example, a client was approved for retroactive Medi-Cal coverage that covers the date of service).

To void an accepted ISL encounter, counties must:

» Submit an encounter identical to the original accepted encounter, with the same Encounter ID, except for the new encounter's Encounter Submission Type is Void.

Example:

Date	Encounter ID	Encounter Submission Type	Is Active
3/1	0091234	Original	Y

Date	Encounter ID	Encounter Submission Type	Is Active
3/26	0091234	Void	N

Counties cannot replace an ISL encounter once it has been voided. Counties also cannot void an ISL encounter that has been rejected.

For inpatient encounters, counties submitting an encounter with an Encounter Submission Type as Void and using an Encounter ID that was used in a previous inpatient encounter voids all previously accepted encounters associated with that Encounter ID value.

Counties cannot void only one day or one encounter within an inpatient encounter chain. For any corrections to encounters in an inpatient chain, counties should replace one day or one encounter, not void.

Replacement of an Accepted Encounter

Counties must replace an accepted encounter if an encounter field was submitted incorrectly or inaccurately, but the entire encounter does not need to be voided. An encounter with Encounter Submission Type as Replacement updates and corrects the existing accepted encounter and retains the encounter for reporting and downstream processing.

To replace an accepted ISL encounter, counties must:

» Submit an encounter identical to the original accepted encounter, using the same Encounter ID, except for the new encounter's Encounter Submission Type is Replacement and the encounter fields that required correction have been revised.

Example:

Date	Encounter ID	Encounter Submission Type	Is Active
3/26	0091234	Original	Y

Date	Encounter ID	Encounter Submission Type	Is Active
3/28	0091234	Replacement	Y