STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
MEDI-CAL MANAGED CARE DIVISION

NCPDP POST-ADJUDICATION PAYER SHEET

FOR IMPLEMENTATION GUIDE VERSION 4.2

RELEASE 2.0

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Document History (Version Control)

Version	Date	Author	Brief Description of Modifications
1.0	02/19/2014	Jeff Jennings	Created – based upon 2.2 Payer Sheet version 1.53
1.1	06/02/2014	Greg Dawson	Apply changes consistent with 2.2 version 1.54
1.1a	06/11/2014	Greg Dawson	Correct offset for Submission Clarification Code
1.2	07/02/2014	Greg Dawson	Updated file naming convention description
1.21	07/17/2014	Greg Dawson	Correct usage of Adjustment Type for void and replacement. Add values for Sending Entity Identifier (897) and Group ID (301-C1)
1.22	08/05/2014	Greg Dawson	Correct value description for Transaction ID Cross Reference (897) must use the Encounter ID of the encounter being replaced or voided
1.3	09/10/2014	Greg Dawson	Include note for 442-E7 – Quantity Dispensed. Include Pharmacy Address fields. Add note to Compound Drug section 1.9
1.4	11/14/2014	Greg Dawson	Update descriptions for Record Indicator, Address Line 2, Fill Number, Dispensing Fee Paid and usage of the second compound drug record
1.5	11/25/2014	Greg Dawson	Update Compound Drug Section 1.9, update field definitions for: Product/Service ID Qualifier (436-E1) and Product/Service ID (407-D7)
1.6	01/14/2015	Greg Dawson	Include file size limitation

Version	Date	Author	Brief Description of Modifications
1.61	03/13/2015	Greg Dawson	Clarify format of Pharmacy zip code, Include valid values for Generic Indicator. Clarify values for Average Cost per Quantity Unit Price and Average Wholesale Unit Price
1.7	07/01/2015	Greg Dawson	Include void/replacement scenarios in Appendix C
1.71	10/17/2017	Jeff Jennings	Updated Section 1.5 Response File Naming Convention
1.72	04/13/2018	Bilochan Sainju	Added clarification that Denied Void and Denied Replacement Encounters cannot be acted on
1.73	05/22/2018	Wendy Ng	Updated as per EDQU suggestions • Clarified verbiage in the Note column for Appendix C.4 • Clarified verbiage on the reason scenario in Appendix C.4 for Encounter ID 0091234 cannot be corrected
1.8	01/08/2019	Serge Zelenov	Clarified use of 340B identifier
1.9	05/23/2019	Jeff Jennings	Added guidance on field 274 (Medicare Plan Code) in Section 2.2 History Detail Record.
2.0	7/22/2019	Jeff Jennings	Updated Section 1.4 Submitted File Name Convention.

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1. OPERATIONS

1.1 Transaction Submission

Encounter data files should be uploaded to a plan's designated Secure File Transfer Protocol (SFTP) "submission" folder administered by DHCS Information Technology Services Division (ITSD). File submission will proceed automatically. A DHCS process will tag the file with a date and time stamp and then forward the submitted file to a secure internal server for file validation. When processed by DHCS the submitted file will be deleted from the submission folder.

The lag-time between a file being uploaded to the submission folder and initiation of file processing will be a maximum of 30 minutes. The date and time stamp will constitute the "Submission Date and Time" of the file.

1.2 Available Transaction Responses

There are no standard response transactions defined for the Post-Adjudication 4.2. DHCS will make available an Encounter Validation Response (EVR) file that will detail each encountered error. The EVR file will be posted to a plan's designated SFTP "response" folder.

EVR file – a custom XML error report detailing each error including file position of each record found to be in error, error value and error message.

1.3 File Size Limitation

File size is limited to 50,000 encounters. A file with more than 50,000 encounters will be rejected.

Please be aware that the number of encounters on a file is calculated from the file size. The NCPDP record is a fixed length of 3,700 bytes (plus potentially two bytes for carriage returns), this gives a file size maximum allowed of 185,100,000 bytes.

1.4 Submitted Encounter File Naming Conventions

Submitted encounter files must use the following naming convention:

XXXXX—X_HHH_P42_MCE_YYYYMMDD_NNNNN.dat

Where:

XXXXX-X is the first node of the file name and is the name of the health plan as specified by the plan and approved by DHCS.

HHH is the HCP code for the encounters being submitted.

P42_MCE is a constant designating the file as an NCPDP Post-Adjudication v4.2 managed care encounter file for pharmacy.

YYYYMMDD is the date of the submission.

NNNNN is a unique numeric transaction identifier used to differentiate between encounter data files submitted on the same day by the same health plan.

Each node in the file name must be separated from the next node by an underscore, as shown in the example.

The First Node value must contain no underscores or other special characters. Using a dash in the First Node is allowed. Plans may elect to use multiple different values for the First Node depending upon their business needs. Each value must be approved by DHCS and used consistently within the terms of that approval.

Valid examples:

MYHEALTHPLAN_678_P42_MCE_20120930_00001.dat

MY HEALTH PLAN_678_P42_MCE_20120930_00001.dat

MYHP-VENDOR1_678_P42_MCE_20120930_00001.dat

MYHP-VOIDS_678_P42_MCE_20120930_00001.dat

A file submitted with a duplicate file name will be rejected.

1.5 Response File Naming Conventions

Response files will mirror the submitted file name with an added designation, as follows:

XXXXX—X_HHH_P42_MCE_YYYYMMDD_NNNNN_RESP_FFFNNN.EEE

Where:

RESP is a constant designating the file as a response file

FFF is “RPT” designating what format of response file has been created.

NNN is numeric value used when the response is an EVR file. The default number is 000. The first instance of an EVR file is numbered as “000”. This number is incremented when EVR generation is interrupted and restarted. If the EVR process is restarted for that file, the number increments by a single digit, to “001”, etc.

EEE is the file extension, “xml” for the EVR file.

Example:

MYHEALTHPLAN_678_P42_MCE_20120930_00001_RESP_RPT000.xml

The DHCS system will track the date and time that a response file was made available, this will be noted as the “Processed Date and Time” and will be used to track the time taken by a submitter to correct specific errors.

1.6 Provider Identifiers

Medi-Cal Managed Care requires the submission of the National Provider Identifier (NPI) on all submitted encounters.

1.7 Payment Information

Submitters are requested to provide actual payment information whenever possible using the established structure in the transaction. Specific fields as noted in the NCPDP 4.2 Implementation Guide are permitted to have a maximum value such as 9999999I, when such a value occurs, these fields will be considered equal to zero.

Any payments made to other health insurance carriers should be included in the relevant coordination of benefits segments.

1.8 Duplicate Encounters

Encounters found to be a duplicate of a previously submitted encounter or a previously paid fee-for-service claim will be denied.

For the purposes of an NCPDP 4.2 Pharmacy encounter, a duplicate would have the same following values as a previously submitted pharmacy encounter:

- Patient/member – Patient 332-CY
- Service Provider ID – Pharmacy 201-B1
- Date of Service – Claim 401-D1
- Product/Service ID – Claim 407-D7
- Prescription/Service Reference Number – Claim 402-D2
- Fill Number – Claim 403-D3

There are no exceptions to this duplicate logic.

1.9 Correcting a Submitted Encounter

Submitted pharmacy encounters will be either accepted or denied. All denied encounters will be reported on the available Error Report. In the EVR file a unique Encounter-ID is reported for each encounter, this Encounter-ID is the key identifier for our system.

Submitted encounters may be either voided or replaced.

To void a previously submitted encounter (accepted or denied):

- Submit a new encounter with the same Reference Category Transaction ID (896) as the record to be voided.
- The Encounter-ID (from the EVR file) of the encounter to be voided must be placed in the Adjustment Category Transaction ID Cross Reference (897) along with a value of “1” in Adjustment Category Adjustment Type (205).
- Record Indicator (398) must equal “2”.
- The void encounter record must reference the same HCP as the encounter record being voided.

- The void encounter record must have the same CIN as the encounter record being voided.

To replace a previously submitted encounter (accepted or denied):

- Submit a new encounter with the same Reference Category Transaction ID (896) as the record to be replaced.
- The Encounter-ID (from the EVR file) of the encounter to be replaced must be placed in the Adjustment Category Transaction ID Cross Reference (897) along with a value of “2” in Adjustment Category Adjustment Type (205).
- Record Indicator (398) must equal “1”.
- The replacement encounter record must reference the same HCP as the encounter record being replaced.

Denied Void and Denied Replacement encounters cannot be acted on.

1.10 Compound Drug Data Submission

When submitting compound drug data, submitters should follow the standard implementation guide. The Post Adjudication History Compound Detail Records are only sent if the encounter is for multi-ingredient compounds, Product/Service ID Qualifier (436-E1) equals “00”, Product/Service ID (407-D7) equals “0”, and Compound Code (406-D6) equals “2”.

The Post-Adjudicated NCPDP transaction only supports a maximum of fifteen ingredients. Plans are requested to rank compound ingredients in the order of most expensive to least expensive, with the most expensive ingredient being provided as the First Ingredient.

2. NCPDP POST-ADJUDICATION STANDARD V4.2

The batch file consists of three sections: the header, detail, and trailer, all sections are mandatory.

2.1 REQUIRED POST-ADJUDICATION FILE HEADER RECORD

The Batch Header Record is a fixed length record and occurs once during the transmission. All fields are mandatory. All fields are included for ease of use.

FIELD	FIELD NAME	FORMAT	SIZE	START	END	VALUE
601-04	Record Type	A/N	2	1	2	"PA"
102-A2	Version /Release Number	A/N	2	3	4	"42"
879	Sending Entity Identifier	A/N	24	5	28	Plan Federal Tax ID (no dashes)
806-5C	Batch Number	N	7	29	35	Matches Trailer
880-K2	Creation Date	N	8	36	43	Format = CCYYMMDD
880-K3	Creation Time	N	4	44	47	Format = HHMM
880-K7	Receiver ID	A/N	24	48	71	"DHCS Managed Care"
601-06	Reporting Period Start Date	N	8	72	79	Format = CCYYMMDD
601-05	Reporting Period End Date	N	8	80	87	Format = CCYYMMDD
702-MC	File Type	A/N	1	88	88	"P" = production "T" = test
981-JV	Transmission Action	A/N	1	89	89	"O" = Original; "C" = Correction
888	Submission Number	A/N	2	90	91	Numeric – incremented by one from the last submission of this file.
	Filler	A/N	3609	92	3700	Spaces

Note: The Health Plan ID (HPID) will be used in the Sender ID (879) and Receiver ID (880-K7) when implemented by CMS.

2.2 HISTORY DETAIL RECORD

The data record to be transmitted in this batch standard will follow the NCPDP Post Adjudication Standard Implementation Guide Version 4.2.

The following fields require specific DHCS processing and, as such, are required in our implementation, please follow the published standard for all other fields.

Field	FIELD NAME	FORMAT	SIZE	START	END	VALUE
601-04	Record Type	A/N	2	1	2	"DE"
398	Record Indicator	A/N	1	3	3	Required - Use: "0" – New record. "1" – Overwrite existing record - Replacement. (*) "2" – Delete existing record - Void. (*) * Use in conjunction with Adjustment Category fields 205 (Adjustment Type) and 897 (Transaction Id Cross Reference).
Eligibility Category						
No specific DHCS direction						
Cardholder Information						
302-C2	Cardholder ID	A/N	20	288	307	The value in field 302-C2 will reflect the following format: • Beneficiary County (2 bytes – see Appendix A for valid values) • Beneficiary Medi-Cal Aid Code (2 bytes); • "C" (1 byte) • Beneficiary CIN (9 bytes). • Bytes 15-20 will be spaces.
716	Last Name	A/N	35	308	342	Required
717	First Name	A/N	35	343	377	Required

Field	FIELD NAME	FORMAT	SIZE	START	END	VALUE
274	MediCare Plan Code	A/N	1	527	527	Use the following values for this field: • A Medicare Part A • B Medicare Part B • C Medicare Part C • D Medicare Part D • X Medicare Part Unknown • Z Not Medicare Eligible • (blank) Not Specified

Patient Information						
331-CX	Patient Id Qualifier	A/N	2	529	530	Required, use “06” = Medicaid ID
332-CY	Patient ID	A/N	20	531	550	Required, use patient CIN
304-C4	Date of Birth	N	8	761	768	Required, date format is CCYYMMDD
305-C5	Patient Gender Code	N	1	769	769	Requested: “1” = male “2” = female “0” = not specified
Benefit Category						
301-C1	Group ID	A/N	15	790	804	Required – use plan HCP number
308-C8	Other Coverage Code	N	2	863	864	Required, use standard coding: “0” = not specified by patient “1” = no other coverage “2” = other coverage exists – payment collected “3” = other coverage billed “4” = other coverage exists – payment not collected “8” = claim is billing for patient financial responsibility only.
601-01	Plan Type	A/N	4	867	870	Required - Use the three digit HCP number, left justified ‘NNNb‘
Pharmacy Category						
202-B2	Service Provider Id Qualifier	A/N	2	871	872	Mandatory - Use “01” = NPI
201-B1	Service Provider ID	A/N	15	873	887	Mandatory - Use NPI
833-5P	Pharmacy Name	A/N	70	912	981	Required
726	Address Line 1	A/N	40	982	1021	Required
727	Address Line 2	A/N	40	1022	1061	Required if available, otherwise use spaces.
728	City	A/N	30	1062	1091	Required
729	State	A/N	2	1092	1093	Required
730	Zip/Postal Code	A/N	15	1094	1108	Required – five or nine numeric digits only, left justified
887	Service Provider County Code	A/N	3	1109	1111	Required - See Appendix A for a list of valid county id numbers.

Prescriber Category						
466-EZ	Prescriber Id Qualifier	A/N	2	1148	1149	Required - Use “01” = NPI
411-DB	Prescriber ID	A/N	15	1150	1164	Required - Use NPI
296	Prescriber Taxonomy	A/N	10	1182	1191	Requested
Claim Category						
402-D2	Prescription/Service Reference Number	N	12	1374	1385	Mandatory
436-E1	Product/Service ID Qualifier	A/N	2	1386	1387	Mandatory “01” = UPC “02” = HRIC “03” = NDC “04” = HIBCC “07” = CPT4 “08” = CPT5 “09” = HCPCS “12” = GTIN If billing for a multi-ingredient prescription (compound), Product/Service ID Qualifier (436-E1) must be zero (Zero means “00”).
407-D7	Product/Service ID	A/N	19	1388	1406	Mandatory If billing for a multi-ingredient prescription (compound), Product/Service ID (407-D7) is zero. (Zero means “0”.) The compound product fields will contain the actual ingredients.
401-D1	Date of Service	N	8	1407	1414	Mandatory - Date format is CCYYMMDD
578	Adjudication Date	N	8	1415	1422	Mandatory - Date format is CCYYMMDD
213	Billing Cycle End Date	N	8	1442	1449	Required - Date format is CCYYMMDD
307-C7	Place of Service	N	2	1452	1453	Requested
384-4X	Patient Residence	N	2	1454	1455	Requested

442-E7	Quantity Dispensed	N	10	1548	1557	Required. Value includes an implied three decimal places – see Implementation Guide for an example.
403-D3	Fill Number	N	2	1558	1559	Required – can be zero
405-D5	Days Supply	N	3	1560	1562	Required
414-DE	Date Prescription Written	N	8	1563	1570	Requested
600-28	Unit of Measure	A/N	2	1575	1576	Required
406-D6	Compound Code	N	1	1605	1605	Requested – use “1” if this is NOT a compound, use “2” if this IS a compound.
492- WE	Diagnosis Code Qualifier (1)	A/N	2	1621	1622	First occurrence is requested, populate as many occurrences as needed.
424-DO	Diagnosis Code (1)	A/N	15	1623	1637	First occurrence is requested, populate as many occurrences as needed.
439-E4	Reason for Service Code (1)	A/N	2	1706	1707	First occurrence is requested, populate as many occurrences as needed.
440-E5	Professional Service Code (1)	A/N	2	1708	1709	First occurrence is requested, populate as many occurrences as needed.
441-E6	Result of Service Code (1)	A/N	2	1710	1711	First occurrence is requested, populate as many occurrences as needed.
Compensation Category						
No specific DHCS direction						
Product Category						
420-DK	Submission Clarification Code (1)	N	2	1946	1947	Required for 340B drug claims only – use “20” in any one of the three 420-DK fields.
420-DK	Submission Clarification Code (2)	N	2	1948	1949	
420-DK	Submission Clarification Code (3)	N	2	1950	1951	
Formulary Category						
No specific DHCS direction						
Pricing Category						

507-F7	Dispensing Fee Paid	D	8	2117	2124	Required – if available – may be zero. This should be the dispensing fee paid to the pharmacy by the PBM.
505-F5	Patient Pay Amount	D	8	2141	2148	Mandatory - This field must be numeric
572-4U	Amount of co-insurance	D	8	2157	2164	Required if a portion of the Patient Pay Amount is co-insurance
272	MAC Reduced Indicator	A/N	1	2229	2229	Use “Y”, “N” or blank
260	Generic Indicator	A/N	1	2232	2232	Use “G”, “B” or blank
209	Average Cost per Quantity Unit Price	D	9	2241	2249	Requested - This field must be numeric and can be zero
211	Average Wholesale Unit Price	D	9	2259	2267	Requested - This field must be numeric and can be zero
430-DU	Gross Amount Due	D	8	2277	2284	Required - This field must be numeric and can be zero
565-J4	Other Amount Paid (1)	D	8	2353	2360	First occurrence is required if Other Coverage Code = “3”. This field must be numeric
352-NQ	Other Payer-Patient Responsibility Amount (1)	D	10	2391	2400	First occurrence is required if Other Coverage Code = “3”. This field must be numeric
281	Net Amount Due	D	8	2413	2420	First occurrence is required, populate as many occurrences as needed. This field must be numeric and may be zero
Prior Authorization Category						
462-EV	Prior Authorization Number Submitted	N	11	2576	2586	Required if available.
Adjustment Category						
205	Adjustment Type	A/N	1	2603	2603	Required when Record Indicator (398) equals “1” or “2”. For reversals (voids), this field should equal “1”. For a replacement, this field should equal “2”

897	Transaction ID Cross Reference	A/N	30	2604	2633	Required if Adjustment type is populated. This field must be identical to the Encounter ID of the encounter that is being replaced or voided.
Coordination of Benefits Category						**Required when Benefit Category Other Coverage Code (308-C8) = "2"**
231	COB Primary Payor Deductible	D	8	2670	2677	Required – if available - This field must be numeric
Reference Category						
896	Transaction ID	A/N	30	2744	2773	Required – This field must be populated by a unique 13-digit numeric identifier. The first three bytes of this number must equal the HCP number.

Fields Added In Versions Category						
A33-ZX	CMS Part D Contract ID	A/N	5	3286	3290	Requested if member has Medicare
A34-ZY	Medicare Part D Plan Benefit Package (PBP)	N	3	3291	3293	Requested if member has Medicare
A73	Medicare Drug Coverage Code	A/N	2	3294	3295	Requested if member has Medicare

2.3 HISTORY COMPOUND DETAIL RECORD (1)

If the Compound Code (406-D6) in the Claim Category of the Detail record equals "2", submitters should populate the History Compound Detail Record (1) as defined in the NCPDP Post Adjudication Standard Implementation Guide Version 4.2.

2.4 HISTORY COMPOUND DETAIL RECORD (2)

If the number of compounds exceeds eight (8), submitters should populate the History Compound Detail Record (2) as defined in the NCPDP Post Adjudication Standard Implementation Guide Version 4.2.

2.5 REQUIRED BATCH TRAILER RECORD

The Batch Trailer Record is a fixed length record and occurs once during the transmission. All fields are mandatory.

FIELD	FIELD NAME	FORMAT	SIZE	START	END	VALUE
601-04	Record Type	A/N	2	1	2	"PT"
601-09	Record Count	N	10	3	12	
895	Total Net Amount Due	D	12	13	24	
693	Total Gross Amount Due	D	12	25	36	
694	Total Patient Pay Amount	D	12	37	48	
	Filler	A/N	3652	49	3700	

APPENDIX A – COUNTY ID NUMBERS

Code	County Name	Code	County Name
01	Alameda	30	Orange
02	Alpine	31	Placer
03	Amador	32	Plumas
04	Butte	33	Riverside
05	Calaveras	34	Sacramento
06	Colusa	35	San Benito
07	Contra Costa	36	San Bernardino
08	Del Norte	37	San Diego
09	El Dorado	38	San Francisco
10	Fresno	39	San Joaquin
11	Glenn	40	San Luis Obispo
12	Humboldt	41	San Mateo
13	Imperial	42	Santa Barbara
14	Inyo	43	Santa Clara
15	Kern	44	Santa Cruz
16	Kings	45	Shasta
17	Lake	46	Sierra
18	Lassen	47	Siskiyou
19	Los Angeles	48	Solano
20	Madera	49	Sonoma
21	Marin	50	Stanislaus
22	Mariposa	51	Sutter
23	Mendocino	52	Tehama
24	Merced	53	Trinity
25	Modoc	54	Tulare
26	Mono	55	Tuolumne
27	Monterey	56	Ventura
28	Napa	57	Yolo
29	Nevada	58	Yuba
99	Out of State		

APPENDIX B –CHARACTER SET DESIGNATION

Submitters are reminded to carefully review the Post Adjudication Standard Implementation Guide Version 4.2 to understand the various character set designations used within this transaction.

Particular attention is drawn to the Character Sets Designation section (12.5) within the Implementation Guide.

Appendix C – Void and Replacement Scenarios

C.1 Void of an Accepted Encounter

The value in Transaction ID is used as a short representation – appropriate format requirements are described earlier in this document.

This scenario shows the related fields used to void a previously submitted encounter that was accepted. The first table shows the original encounter submission after processing:

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
03/01	5551234	n/a	n/a	0091234	Accepted	

A void is submitted. The following table shows both encounters after processing of the void on 03/26 has completed:

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
03/26	5551234	n/a	n/a	0091234	Voided	Original encounter has been voided
03/26	5551234	1	0091234	0091245	Void Processed	

An attempt to replace this encounter once it has been voided would result in a denial, as follows:

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
	5551234	n/a	n/a	0091234	Voided	No change
	5551234	1 (void)	0091234	0091245	Void Processed	No change
03/27	5551234	2 (replcmnt)	0091234	0091256	Denied	Once an encounter has been voided no further action can be taken

C.2 Void of a Denied Encounter

This scenario shows the related fields used to void a previously submitted encounter that was initially denied. The first table shows the original encounter submission after processing:

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
04/01	5552234	n/a	n/a	0081234	Denied	Invalid Generic Indicator

The submitted void was incorrectly formatted. The following table shows both encounters after processing of a void on 04/26 has been completed:

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
	5552234	n/a	n/a	0081234	Denied	Unchanged
04/26	5552235	1 (void)	0081234	0081245	Denied	Invalid reference in Transaction ID

Another void is submitted on 04/27.

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
	5552234	n/a	n/a	0081234	Voided	Voided on 4/27
	5552235	1 (void)	0081234	0081245	Denied	Invalid reference in Transaction ID
04/27	5552234	1 (void)	0081234	0081256	Void Processed	

C.3 Replacement of an Encounter

This scenario shows the related fields used to replace a previously submitted encounter that was initially denied. The first table shows the original encounter submission after processing:

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
05/01	5553234	n/a	n/a	0071234	Denied	Invalid Generic Indicator

A replacement transaction is submitted but is also denied for a different reason. The following table shows both encounters after processing of the replacement has been completed:

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
	5552234	n/a	n/a	0071234	Denied	Unchanged
05/16	5552234	2 (replcmnt)	0071234	0071245	Denied	Prescriber NPI invalid

Another replacement is submitted on 05/27.

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
05/27	5552234	n/a	n/a	0071234	Replaced	Original encounter was replaced
	5552234	2 (replcmnt)	0071234	0071245	Denied	Unchanged
05/27	5552234	2 (replcmnt)	0071234	0071256	Accepted	

In the previous table take special note of the fact that since there was no accepted encounter in the history of this submission, the value supplied in Transaction ID Cross Reference was the Encounter-ID for **the earliest denied encounter.**

Another replacement is submitted on 05/29.

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
	5552234	1	n/a	0071234	Replaced	Unchanged
	5552234	2 (replcmnt)	0071234	0071245	Denied	Unchanged
05/29	5552234	2 (replcmnt)	0071234	0071256	Replaced	
05/29	5552234	2 (replcmnt)	0071256	0071267	Accepted	

In the previous table take special note of the fact that the value supplied in Transaction ID Cross Reference was the Encounter-ID for **the latest accepted encounter** “0071256 **NOT** the Encounter-ID for the original submission “0071234”.

C.4 Encounters that can NOT be corrected

This scenario shows an encounter that has been successfully voided.

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
03/01	5552234	n/a	n/a	0081234	Voided	
03/15	5552234	1 (void)	0081234	0081245	Void Processed	Original encounter was voided

A subsequent replacement is submitted. This is denied.

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
03/01	5552234	n/a	n/a	0081234	Voided	
03/15	5552234	1 (void)	0081234	0081245	Void Processed	Original encounter (0081234) was voided
03/18	5552234	2 (replcmnt)	0081234	0081267	Denied	Once an encounter has been voided, no further action can be taken
03/20	5552234	2 (replcmnt)	0081267	0081288	Denied	No action can be taken on denied Replacement
03/25	5552234	1 (void)	0081267	0081299	Denied	No action can be taken on denied Void

Denied Replacement Encounter with encounter ID 0081267 cannot be corrected.

Denied Void and Denied Replacement encounters cannot be acted on.

This scenario shows an encounter that has been submitted and denied, because although it is an original submission to DHCS it is not coded as an original encounter – Adjustment Type and Transaction ID Cross-Reference should be blank on original submissions.

Date	Transaction ID (896)	Adjustment Type (205)	Transaction ID Cross-Reference (897)	DHCS Encounter ID	Internal DHCS Status	Note
03/01	5552245	2 (replcmnt)	0099345	0091234	Denied	Not an original encounter

Encounter ID 0091234 cannot be corrected.