CMS Manual System

Pub 100-20 One-Time Notification Transmittal Sheet

Transmittal 159

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: June 17, 2005

Change Request 3627

***NOTE: Transmittal 149, dated April 29, 2005, was rescinded and is replaced with Transmittal 159, dated June 17, 2005. The following information has changed: CMS has removed the specific waiver allowing Home Health Agencies to go into the shared system and delete claims. Also, reasons in the "Acceptable Claims Deletions" Section and the "Return as Unprocessable Claims" Section have been switched. All other information remains the same*.**

SUBJECT: Requirements for Voided, Canceled, and Deleted Claims.

I. SUMMARY OF CHANGES: This CR describes new CMS procedures for voiding, canceling and deleting claims.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : October 01, 2005
IMPLEMENTATION DATE : October 03, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
N/A	None

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

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SUBJECT: Requirements for Voided, Canceled, and Deleted Claims.

SUMMARY OF CHANGES

This CR describes new CMS procedures for voiding, canceling and deleting claims.

I. GENERAL INFORMATION

A. Background: This One-Time Notification (OTN) implements requirements for affiliated contractors (ACs) to:

Deny or reject (if a full record of the rejection is retained in the shared system) claims that do not meet CMS requirements for payment for unacceptable reasons (see policy section for a list of reasons),

Cancel, void, or delete claims that are unprocessable for acceptable reasons (see policy section for a list of reasons),

Return as unprocessable claims that meet conditions specified below for the return of unprocessable claims (see policy section for a list of reasons), and

For all cancelled, voided, deleted, or returned as unprocessable claims to which the shared processing system assigned a claim control number (CCN) or document control number (DCN), maintain an audit trail.

The reasons we are implementing this requirement are:

The practice by ACs of voiding, canceling, or deleting claims without maintaining an audit trail allows providers to game the processing system by removing the claims from AC scrutiny. CMS knows of cases where a provider's response to an AC request for medical records is to delete the claim from the ACs system. The DHHS Office of the Inspector General has occasionally encountered this practice and has indicated that the practice must stop.

The Comprehensive Error Rate Testing (CERT) program flags claims for review on the day the claim arrives in an AC's claim processing system. The CERT contractor waits 30-60 days for

the claim to complete its processing cycle. The CERT contractor requests specific information from the AC using the claim ID number to identify the claim. On occasion, the AC will not be able to locate the sampled claim. Failure to locate a claim is often due to ACs who void, cancel, and delete claims without maintaining an audit trail. The CERT contractor counts these "missing" claims as an error.

B. Policy:

Acceptable Claims Deletions

Below is a list of conditions under which a contractor may cancel, delete, or void a claim. Currently, if an AC cancels, deletes, or voids a claim, the claim data is not retained in the system and there is no subsequent, permanent audit trail or other record that Medicare received the submission. No permanent record is kept of the submissions because they are not considered claims under Medicare regulations. This OTN requires that ACs keep an audit trail on these claims unless the shared system does not assign a CCN or DCN to the claim. The following are the acceptable reasons for deleting, canceling, or voiding a claim:

1. The current CMS 1500 form and the current CMS 1450 form is not used.
2. The front and back of the CMS 1500 (12/90) claim form are required to be on the same sheet but are not submitted that way (Carrier only).
3. A breakdown of charges is not provided, i.e., an itemized receipt is missing,
4. Only six line items may be submitted on each CMS 1500 claim form (Part B only),
5. The patient's address is missing,
6. An internal clerical error was made,
7. The Certificate of Medical Necessity was not with the claim (Part B only),
8. The CMN form is incomplete or invalid (Part B only), or
9. The name of the store is not on the receipt that includes the price of the item (Part B only).

The AC shall keep an audit trail for all claims in the acceptable claims deletions category and return as unprocessable category except those to which the shared system did not assign a CCN or a DCN.

Return as Unprocessable Claims

Currently, for certain contractors, if an AC returns a claim as unprocessable, the claim data are not retained in the system and there is no subsequent, permanent audit trail or other record of the submission. This OTN requires that ACs keep an audit trail on these claims unless the shared system does not assign a CCN or DCN to the claim. Below is a list of conditions under which a contractor may return a claim as unprocessable. This list is not all-inclusive and refers principally to data elements used in carrier processing. For additional information on handling incomplete or invalid claims, refer to the Medicare Claims Processing Manual, Chapter 1, Section 80.3.2 ff. Valid reasons for returning claims in fiscal intermediary processing are found throughout various chapters of the Medicare Claims Processing Manual.

1. Valid procedure codes were not used and/or services are not described (e.g., block 24D of

the CMS 1500) (Part B only),
2. The patient's HICN is missing, incomplete, or invalid (e.g., block 1A of the CMS 1500),
3. The provider number is missing or incomplete,
4. No services are identified on the bill,
5. Block 11 (insured policy group or FECA Number) of the CMS 1500 is not completed to indicate whether an insurer primary to Medicare exists (Part B only),
6. The beneficiary's signature information is missing (Part B only),
7. The ordering physician's name and/or UPIN is missing/invalid (blocks17 and17A of the CMS 1500),
8. The place of service code is missing or invalid (block 24B of the CMS 1500 -- Part B only),
9. A charge for each listed service is missing (e.g., block 24F of the CMS 1500),
10. The days or units are missing (e.g., block 24G of the CMS 1500),
11. The signature is missing from block 31 of the CMS 1500 (Part B only),
12. Dates of service are missing or incomplete (block 24A of the CMS 1500), or
13. A valid HICN is on the claim; however, the patient name on the form does not match the person to whom the HICN is assigned.

The contractor may return as unprocessable claims that have any of the conditions described in items 1 through 13 above if the contractor keeps an audit trail, except those to which the shared system did not assign a CCN or a DCN. For condition 1, the contractor shall also retain a full record of the rejection in the shared system.

Unacceptable Claims Deletions

The following are unacceptable reasons for ACs to void, cancel, or delete claims:

1. A provider notifies the AC that claim(s) were billed in error and requests the claim be deleted (Carriers only).
2. The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (type of bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review. (Fiscal intermediaries only)
3. The patient's name does not match any Health Insurance Claim Number (HICN), i.e., no HICN is found for the patient’s name.
4. A claim meets the criteria to be returned as unprocessable under the incomplete or invalid claims instructions in the Medicare Claims Processing Manual, Chapter 1, Section 80.3.2 ff.

ACs shall deny or shall reject or return as unprocessable (if a full record of the rejection is retained in the shared system) claims in this category.

The requirements in this OTN do not apply to adjustment claims. If an original claim is cancelled, deleted, or voided because of an adjustment, the AC shall provide an audit trail for the original claim.

If an AC's shared system meets one of these requirements, no system change is needed for the requirements that the shared system meets.

Summary

CMS believes that the problems listed under the acceptable claims deletion heading are valid reasons to void/delete/cancel a claim if the AC maintains an audit trail. The problems listed under the unprocessable claims heading and further discussed in the Medicare Claims Processing Manual are valid reasons to return a claims as unprocessable if the AC maintains an audit trail. The AC should handle problems listed under the unacceptable claims deletions heading by denying, rejecting, or returning as unprocessable. (if a full record of the rejection or return is retained in the shared system) the claims and recording the decision in the AC's claims processing system history file. If an AC determines that they will cancel, delete, or void a claims or return it as unprocessable before it enters the ACs claims processing system (i.e., the claim processing system did not assign a CCN or DCN to the claim), it may be cancelled, deleted, voided, or returned and the AC does not have to keep a record of the claim or the cancellation, deletion, voiding, or return. Otherwise, the AC shall not totally remove a denied or voided/cancelled/deleted/returned claim from the claims processing system and contractor records, i.e., ACs shall maintain an audit trail for all canceled, deleted, voided, or returned claims that have entered the ACs claims processing system (i.e., the system assigned a CCN or DCN to the claim).

Therefore, ACs shall maintain an audit trail of all processable claims received, including claims that are voided, canceled, deleted, returned, etc. If the shared system has not assigned a CCN or DCN to the claim when the AC determines that it should be cancelled, voided, deleted, or returned as unprocessable, CMS does not require that the AC keep an audit trail.

II. BUSINESS REQUIREMENTS

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3627.1	Shared systems and ACs are not required to retain a record of claims the AC determines to be unprocessable and to which the shared system has not assigned a DCN or CCN.	X	X	X	X	X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3627.2	If the shared system voided/cancelled /deleted/returned a claim and has assigned a CCN or DCN to the claim, the shared system and the AC shall track the claim from receipt to final resolution. The tracking system shall retain a record of the claim for the shorter of a) three years from the date that the shared system rejected the claim or b) the period paid claims are retained by the shared system. This CR does not require or preclude that the tracking system be on-line, or that the tracking system is part of the shared system.	X	X	X	X	X	X	X		
3627.3	Shared systems shall retain sufficient information on voided/cancelled/ deleted/returned claims to allow identification of the claim and why the AC voided, cancelled, deleted, or returned the claim. The information is not required to be on line and does not need to be part of the shared system.	X	X	X	X	X	X	X		
3627.4	If the shared system voided/ deleted/returned a claim for one of the reasons listed in the unacceptable claims deletions section above, shared systems and ACs shall deny or reject (if a full record of the rejection is retained in the shared system) the claim.	X	X	X	X	X	X	X		
3627.5	If the AC voided/cancelled/deleted a claim because the HIC number of the beneficiary changed, the AC shall maintain a cross reference between the old and new HIC numbers. The cross reference is not required to be on line and does not need to be part of the shared system.	X	X	X	X	X	X	X		
3627.6	The FISS shall ensure that claims selected for or subject to medical review cannot be cancelled by the submission of a claim with an xx8 type of bill.	X				X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3627.6.1	Fiscal intermediaries shall provide an audit trail for claims that are cancelled by the submission of an xx8 type of bill.	X				X				
3627.7	If an original claim is cancelled, deleted, or voided as a result of an adjustment, the AC shall provide an audit trail for the original claim. This CR does not require or precluded ACs from maintaining an audit trail for any adjustments to the original claims that are cancelled, deleted, or voided. The audit trail is not required to be on line and does not need to be part of the shared system.	X	X	X	X	X	X	X		
3627.8	Contractors shall retain a list of all over activated ICNs and DCNs, over activated ICNs/DCNs are ICNs/DCNs initiated in the system but to which a claim in never assigned. The list just needs to contain the ranges of ICNs/DCNs that the contractor has over activated.	X	X	X	X	X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3627.9	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2005 **Implementation Date:** October 3, 2005 **Pre-Implementation Contact(s):** John Stewart, (410) 786-1189 JStewart@cms.hhs.gov **Post-Implementation Contact(s):** John Stewart, (410) 786-1189 JStewart@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

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