Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

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Requirements for Voided, Canceled, and Deleted Claims

Note: This article was updated on February 16, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

All Medicare physicians, providers, and suppliers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs)

Provider Action Needed

This MLN Matters article is based on information contained in Change Request (CR) 3627, which describes new Centers for Medicare & Medicaid Services (CMS) procedures and specific instructions to Medicare contractors (carriers, intermediaries, and DMERCs) for voiding, canceling, and deleting claims.

As a result of these changes, providers should note that some claims they were able to delete in the past will no longer be deleted from Medicare's systems, but will instead become denied claims.

Background

The Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) has verified instances in which Medicare claims have been voided, canceled, or deleted by Medicare carriers, DMERCs, and FIs. Further, the Medicare contractors have not traditionally maintained an audit trail for the voided, canceled, or deleted claims. The OIG has indicated that Medicare must maintain an audit trail for voided, canceled, and deleted claims.

CMS is therefore implementing requirements for Medicare contractors (carriers/FIs, including DMERCs and regional home health intermediaries (RHHIs)) to:

- Deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons;
- Cancel, void, or delete claims that are unprocessable for acceptable reasons;

- Return as unprocessable claims that meet conditions mentioned below for the return of unprocessable claims; and
- Maintain an audit trail for all canceled, voided, or deleted claims that Medicare systems have processed far enough to have assigned a Claim Control Number (CCN) or Document Control Number (DCN).

Note: CR3627 requires that Medicare carriers, intermediaries, and DMERCs keep an audit trail on these claims once a CCN or DCN has been assigned to the claim.

Acceptable Claims Deletions

Below is a list of acceptable reasons a Medicare contractor may cancel, delete, or void a claim:

1. The current CMS 1500 form or the current CMS 1450 form is not used.
2. The front and back of the CMS 1500 (12/90) claim form are required on the same sheet and are not submitted that way (claims submitted to carriers 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 (CMN) was not with the claim (Part B only).
8. The CMN form is incomplete or invalid (Part B only).
9. The name of the store is not on the receipt that includes the price of the item (Part B only).

Note: The Medicare contractor must keep an audit trail for all claims in the above "Acceptable Claims Deletions" category if a CCN or a DCN was assigned to the claim.

Unacceptable Claims Deletions

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

1. A provider notifies the Medicare contractor that claim(s) were billed in error and requests the claim be deleted (carrier claims 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. (FI claims only)
3. The patient's name does not match any Health Insurance Claim Number (HICN).
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, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdfon the CMS website.

Medicare contractors must deny or reject claims in the above "Unacceptable Claims Deletions" category.

Return as Unprocessable Claims

Medicare contractors may return a claim as unprocessable for the following reasons:

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 claim.
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 are missing/invalid (blocks 17 and 17A 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).
13. A valid HICN is on the claim, but the patient's name does not match the name of the person assigned that HICN.

Summary

In summary, CMS believes the following:

- The problems listed under the "Acceptable Claims Deletions" heading are valid reasons to void/delete/cancel a claim if the Medicare contractor maintains an audit trail; and
- Claims with problems listed under the "Unacceptable Claims Deletions" heading should be denied or rejected by Medicare, and the decision to deny/reject the claim should be recorded in the Medicare contractor's claims processing system history file.

If a Medicare contractor determines that a claim is unprocessable before the claim enters that contractor's claims processing system (i.e., the claim processing system did not assign a CCN or DCN to the claim):

- The claim may be denied; and
- The contractor does not have to keep a record of the claim or the deletion.

If a Medicare contractor determines that a claim is unprocessable after the claim enters their claims processing system (i.e., the claim processing system did assign a CCN or DCN to the claim):

- The denied or rejected claim will not be totally deleted from Medicare's claims processing system. The Medicare contractor must maintain an audit trail for all deleted claims that have entered the claims processing system (i.e., the system assigned a CCN or DCN to the claim).

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R159OTN.pdf on the CMS website.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.