

**Top Ten Claim Submission Errors (Part A)  
June 2008**

<b>Reason Code</b>	<b>Narrative</b>	<b>Resolution</b>
<b>38119</b>	This is a continuing stay Skilled Nursing Facility (SNF) or non-PPS claim but there is no record of the prior processed claim.	Verify HIC, admit date, from date and through date. Submit the prior claim(s) and resubmit this claim after you have received the remittance advice for the prior claim(s).
<b>31486</b>	SNF PPS claim (21X) Type of Bill with a from date on or after 7/1/98. The sum of all covered units for revenue codes 0022 does not equal the claim covered days count.	Verify that the covered units for revenue code 0022 match the covered days count. If not, correct and resubmit
<b>31715</b>	Beginning with dates of service on and after 01/01/07, it has been determined the units of service are in excess of the medically reasonable daily allowable frequency. The excess charges due to units of service greater than the maximum allowable may not be billed to the beneficiary, and this provision can neither be waived nor subject to an advanced beneficiary notification (ABN).	To correct your claim, verify units and resubmit.
<b>N5052</b>	Common Working File records indicate the beneficiary's name and health insurance claim number do not match.	Verify the information with his or her Medicare card. Correct and resubmit if appropriate.
<b>12206</b>	Statement covers period: When the from and through dates are not the same on an inpatient or SNF bill types 11X, 18X, 21X, 28X, 41X, or 51X, the number of days represented must equal the sum of the covered days plus the noncovered days; unless the patient status is 30, then 1 additional day is used in the calculation.	If the "from" and "through" dates are the same, the bill must show only 1 day, or if you are billing a late charge claim TOB XX5, it should not contain covered or noncovered days. Correct and resubmit.
<b>31259</b>	Value Codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 are not allowed on the entry of Direct Data Entry Claims Effective with dates on or after July 1, 2007.	If value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 are on the claim, remove them and resubmit.
<b>30949</b>	The adjustment has been submitted by a provider, and there is no adjustment reason code (condition code).	To correct your claim, add adjustment reason code (condition code) and resubmit.
<b>38031</b>	Outpatient claim is a duplicate to a previously submitted outpatient claim and the following conditions exist: - Statement from and thru dates overlap; - At least one revenue code line matches; - The diagnosis code(s) on both the history and incoming claim are the same.	<ul style="list-style-type: none"> <li>• If this is the second medical visit that occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits, the claim may be resubmitted with condition code G0. Refer to CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 4, Section 170 and 180.4 for billing instructions.</li> <li>• If the claim is not a distinct and constituted independent visit then add charges to previously processed claim.</li> </ul>
<b>77745</b>	Claim has been submitted with a Medicare Secondary Payer (MSP) Value Code and amount and CWF indicates that Medicare is primary.	Verify CWF to determine who is primary. If Medicare is primary and you have received payment from the other insurance, refund the payment to that insurer. If primary payment was not received from the other insurance, remove all the other insurance information from the claim and resubmit.
<b>30960</b>	Providers are not permitted to adjust Medically reviewed claims.	Adjustments must be sent in hardcopy.