



**Top Ten Claim Submission Errors
January 2008**

Reason Code	Narrative	Resolution
38119	This is a continuing stay 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).
38038	Effective for 8/1/00 dates of service, whether any revenue code lines are equal or not, outpatient PPS bill types cannot have overlapping dates unless condition code 'G0' or '20' or '21' is present on the claim.	Condition codes G0, 20 or 21 may only be used if appropriate. If the services are not separate evaluation and management medical visits on the same day, an adjustment must be submitted. If the services are separate evaluation and management medical visits, the claim may be resubmitted with condition code G0. Correct and resubmit if appropriate. Note: *If the claim is a demand bill, resubmit with condition code 20 *If billing for denial notice for other insurance, resubmit with condition code 21.
32116	The receipt date of the claim is on or after the NPI implementation date (05/23/07) and the billing provider NPI is not present on the claim.	Enter the billing provider NPI and resubmit.
39012	This reason code replaces 32923. Justification for timeliness reason code 39011 override not formatted correctly or missing and should be one of the following: Justify: MSP involvement Justify: SSA involvement Justify: PRO review involvement Justify: Other involvement	To correct your claim: 1. On page 4, in the Remarks section, type in 1 of the following 4 justification reasons on the first line. Any other remarks should start on the next line. There should be no other information on the first line. Justify: MSP involvement Justify: SSA involvement Justify: PRO review involvement Justify: Other involvement 2. Store claim



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31715	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.
W7006	Invalid procedure code (HCPCS).	Correct and resubmit if appropriate.
38031	This outpatient claim is a duplicate to a previously processed outpatient claim. The statement from and thru dates are the same on both claims, the diagnosis codes are the same, the provider numbers are the same, revenue codes match, at least one HCPC code or at least one revenue code service date is the same on both claims.	<p>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, then check the online manual Pub.100-4, Chapter 4, Sections 170 & 180.4 for proper billing instructions. Correct claim and resubmit.</p> <p>If claim is not a distinct and constituted independent visit, then add charge to previously billed claim.</p> <p>If this is the third medical visit that occurred on the same day in the same revenue center that is a distinct & constituted independent visit, the online manual has been checked, and the second and third claims have a G0 condition code on them, contact the correction line to verify that third claim was intentionally billed. If claim is not a distinct and constituted independent visit then add charges to previously billed claim.</p>
N5052	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.



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31715	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.
12206	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 dates are the same the bill must show only 1 day. Or, late charge claim XX5 should not contain covered or noncovered days. Correct and resubmit.
31259	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/or C7 are on the claim remove them and store F9.