

## Top Ten Claim Submission Errors March 2007

The following is a list of the top 10 claim submission error reason codes (and their resolutions) for March 2007, which generated the largest volume of claims to Return to Provider (RTP). Please share this information with your staff as the submission of accurate claims will result in less rework and improve cash flow.

Reason Code	Narrative	Resolution
<b>30715</b>	The patient last name and/or first initial as submitted on the claim does not match the beneficiary record on file for this HIC number.	<p>Check the beneficiary's Medicare card or the beneficiary information on the Common Working File (CWF) for the correct name and HIC number.</p> <p>The name displayed on page 1 of the returned claim (map1711) is how the name appears on the FISS* beneficiary file:</p> <p>* If the name on page 1 of the returned claim is incorrect or misspelled, contact the correction line for a correction.</p> <p>* If the name on page 1 of the returned claim is correct, PF9 or resubmit a new claim.</p> <p>* If the insured's first and last name is incorrect, submit a new claim if appropriate (EMC)</p> <p>* If the HIC number submitted was incorrect, resubmit a new claim if appropriate</p>
<b>38119</b>	This is a continuing stay SNF or non-PPS claim but there is no record of the prior processed claim.	<p>Verify HIC, admit date, from date and through date.</p> <p>Submit the prior claim(s) and resubmit this claim after you have received the remittance advice for the prior claim(s).</p>
<b>38031</b>	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 &amp; 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 &amp; 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>
<b>38038</b>	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.	<p>Condition codes G0, 20 or 21 may only be used if appropriate.</p> <p>If the services are not separate evaluation and management medical visits on the same day, an adjustment must be submitted.</p> <p>If the services are separate evaluation and management medical visits, the claim may be resubmitted with condition code G0. Correct and resubmit if appropriate.</p> <p>Note:</p> <p>*If the claim is a demand bill, resubmit with condition code 20</p> <p>*If billing for denial notice for other insurance, resubmit with condition code 21.</p>
<b>39012</b>	This reason code replaces 32923. Justification for timeliness reason code 39011 override not formatted correctly or missing.	<p>There should be one of the following:</p> <ul style="list-style-type: none"> <li>- Justify: MSP involvement</li> <li>- Justify: SSA involvement</li> <li>- Justify: PRO review involvement</li> <li>- Justify: Other involvement</li> </ul> <p>**To correct your claim**</p> <p>1. On page 4, in the Remarks section, type in one of the following four 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.</p> <ul style="list-style-type: none"> <li>- Justify: MSP involvement</li> <li>- Justify: SSA involvement</li> </ul>

		<ul style="list-style-type: none"> <li>- Justify: PRO review involved</li> <li>- Justify: Other involvement</li> </ul> <p>2. Store claim</p>
<b>32402</b>	Invalid HCPC code/revenue code combination.	<p>Verify and correct the claim:</p> <ul style="list-style-type: none"> <li>- Lab HCPC must be billed with 030X or 031X</li> <li>- Orthotic / prosthetic's must be billed with revenue code 0274</li> <li>- Surgical dressings (A6000 range) must be billed with revenue code 0623</li> <li>- Effective 6/22/98 all chemotherapy drug HCPCS must be billed with revenue code 636</li> <li>- Effective 7/1/98 all HIPPS codes for SNF PPS must be billed with revenue code 0022</li> <li>- Effective 7/1/02 all HIPPS codes for SNF PPS swing bed claims must be billed with revenue code 0022</li> </ul> <p>Note: Do not use revenue code 274 with HCPCS other than orthotic or prosthetic.</p> <p>DDE providers: Please validate HCPC code/revenue code combination with the HCPC file.</p> <ul style="list-style-type: none"> <li>- Go to menu selection '01' from the main menu and press enter</li> <li>- Go to menu selection '14' from the inquiry menu and press enter</li> <li>- Enter in the locality code and HCPCS code and press enter</li> </ul> <p>Note: For DDE users with providers in multiple states, the carrier will default to the 'MAIN' carrier. Please use CMS's Website for pricing information.</p> <ul style="list-style-type: none"> <li>- The appropriate revenue code and /or range will be listed next to the effective date that matches the dates of service on your claim (you can F6 forward for more entries)</li> <li>- The revenue lines listed with revenue code 096X, 097X and 098X only apply to CAH (method II) providers. All other providers must use the other entries</li> <li>- On HIPPS code, verify alpha digits are not confused with numeric digits and vice versa</li> </ul> <p>For more information, go to:  <a href="http://www.cms.hhs.gov/manuals/iom/list.asp#topofpage">http://www.cms.hhs.gov/manuals/iom/list.asp#topofpage</a> and access Pub. 100-04, Chapter 6, Section 30.</p>
<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 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.
<b>W7062</b>	Code not recognized by OPPS; alternate code for same service may be available.	Correct and resubmit.
<b>38118</b>	This is a continuing stay SNF /non-PPS claim. The prior claim is pending but not yet finalized.	Resubmit/PF9 to store this claim after you have received the remittance advice for the prior claim.
<b>30905</b>	No record of processing an original claim for this adjustment.	You will not be able to correct this adjustment. Verify the HIC#, cross reference DCN, dates of service and/or provider number. You must inactivate your adjustment and resubmit a new adjustment request with the correct DCN.
<b>30949</b>	For a UB92 adjustment the claims frequency code is equal to a '7' or '8' and there is no claim change reason code (condition code).	Correct and resubmit.