



**Top Ten Claim Submission Errors  
March 2008**

Reason Code	Narrative	Resolution
<b>38119</b>	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).
<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>39012</b>	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
<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>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.



Reason Code	Narrative	Resolution
<p><b>38038</b></p>	<p>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>	<p>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.</p>



Reason Code	Narrative	Resolution
<p><b>32402</b></p>	<p>Invalid HCPC code/revenue code combination.</p>	<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 HCPC 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>



Reason Code	Narrative	Resolution
31023	The No-Pay claim does not have any of the required criteria.	<p>1. Use a condition code 20 when the beneficiary has requested a demand bill. (SNF's only)</p> <p>2. Use a condition code 21 when you have determined the patient is no longer receiving a skilled level of care, or the service is excluded from Medicare coverage and you need a denial from Medicare in order to bill.</p> <p>3. If you are submitting the No-Pay bill due to the Medicare benefits exhausted, no qualifying hospital stay or the thirty day transfer requirement was not met, please enter verbatim the following remarks on page 4 of your claim:                      ***"benefits exhau" for benefits exhausted                      ***"no qhs" (for no qualifying hospital stay, this applies to SNF's only)                      ***"no 30 day tran" (for no 30 day transfer, this applies to SNF's only).</p> <p>4. If the claim does not have any of the criteria indicated above, it will be returned to you, (RTP'd).</p> <p>----or----</p> <p>A Medicare secondary claim has been submitted without covered charges and/or contains a condition code 20 or 21. Medicare secondary claims must contain covered charges and must be billed without condition code 20 or 21. Correct and resubmit if appropriate.</p> <p>----or----</p> <p>If you are submitting a claim for an IME reimbursement and the 04/69 condition code is present on claim, charges must be shown as covered.</p> <p>---or---</p> <p>If no entitlement, bill claim as covered and CWF will reject with the correct reason code.</p>



Reason Code	Narrative	Resolution
<p><b>38031</b></p>	<p>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>	<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>
<p><b>38118</b></p>	<p>This is a continuing stay SNF /non-PPS claim. The prior claim is pending but not yet finalized.</p>	<p>Resubmit/PF9 to store this claim after you have received the remittance advice for the prior claim.</p>