

Top 10 Claim Submission Errors June 2007

The following is a list of the top 10 claim submission error reason codes (and their resolutions) for June 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
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).
30715	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.	Check the beneficiary's Medicare card or the beneficiary information on the Common Working File (CWF) for the correct name and HIC number. The name displayed on page 1 of the returned claim (map1711) is how the name appears on the FISS* beneficiary file: * If the name on page 1 of the returned claim is incorrect or misspelled, contact the correction line for a correction. * If the name on page 1 of the returned claim is correct, PF9 or resubmit a new claim. * If the insured's first and last name is incorrect, submit a new claim if appropriate (EMC) * If the HIC number submitted was incorrect, resubmit a new claim if appropriate
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.
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.	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. If claim is not a distinct and constituted independent visit, then add charge to previously billed claim. 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.
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.
19202	Attending physician UPIN error: format invalid.	1. The first position of the attending physician UPIN is not alphabetic.

		<p>2. The second position of the attending physician UPIN is neither alphabetic nor numeric.</p> <p>3. The third position of the attending physician UPIN is neither alphabetic nor numeric.</p> <p>Correct and resubmit.</p>
38118	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.
16806	The alpha suffix or prefix of the health insurance claim number (HIC) is not valid.	Verify HIC. Correct on page 1 if the HIC number is completely different, or on page 5 make sure the HIC number has the correct letter on the end of it.
30905	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.
77745	The claim submitted is being returned since the Common Working File (CWF) indicates that the patient is Medicare primary.	<p>Please review the Medicare Secondary Payer Questionnaire to verify the primary payer information. If Medicare is the primary payer and a primary payment was received from another insurance, refund the payment and then resubmit the claim as Medicare primary. If a primary payment was not received from another insurance but a denial was received, please remove all other insurance information from the claim and resubmit the claim as Medicare primary.</p> <p>If Medicare is not the primary payer, please contact COB (Coordination of Benefits) at 1-800-999-1118 to have the primary insurance information added to the patient's MSP record. When the Common Working File (CWF) is updated, resubmit the patient's Medicare secondary claim.</p>