

**Top Ten Claim Submission Errors
October 2007**

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.
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.
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.
31259	Value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 are not allowed on the	If value codes A1, A2, A7, B1, B2, B7, C1, C2 and/or C7 are on the claim remove them and

	entry of direct data entry claims effective with dates on or after July 1, 2007.	store F9.
38031	This outpatient claim is a duplicate to a previously processed outpatient claim. The statement from and through 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>
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 page 5, make sure the HIC number has the correct letter on the end of it.
1461A	A secondary payer value code is present on the claim (value code 12, 13, 14, 15, 16, 41, 42, 43, or 47), however Medicare is identified as the primary payer on the claim.	Correct and resubmit.
32148	<p>“Exception”-If the discharge falls on the first day of one of the following months: 100199, 100100, 100101, 100102, 100103, 010104, 100104, 100105, 010106, 100106, or 10/01/07 submit one bill.</p> <p>If the discharge date does not fall on one of the dates listed above, split bill the claim.</p> <p>If the discharge is on the first of the month and does not meet the “Exception” above, split bill the claim.</p>	<p>For example, claim DOS is 091507 to 100107, bill one claim for 091507 to 100107.</p> <p>For example, claim DOS is 092507 to 100507, bill one claim for 092507 to 09/30/07 as still patient (30) and another claim for 100107 to 100507.</p> <p>For example, claim DOS is 122106 to 010107 do the following:</p> <ol style="list-style-type: none"> 1. Submit the December claim with a patient status of 30 on page 1 and F9. 2. Submit a no-payment (210 bill type) claim for 010107 as noncovered (day on page 1 and charge on page 3 as noncovered), condition

		<p>code 21 on page 2 and the correct discharge code on page 1 and F9.</p> <p>**Note** the day of discharge is not a payable day so the provider will not receive reimbursement. This will allow the provider to receive the old rates for their claim.</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.