



Top Ten Claim Submission Errors December 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: <ul style="list-style-type: none"> • 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.
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 advance 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 non-covered 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 non-covered days. Correct and resubmit.



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38031	<p>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>	<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>
31259	<p>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.</p>	<p>If value codes A1, A2, A7, B1, B2, B7, C1, C2 and/or C7 are on the claim remove them and store F9.</p>
38118	<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>
30905	<p>No record of processing an original claim for this adjustment.</p>	<p>Verify HIC#, cross reference DCN, dates of service and/or provider number. You will not be able to correct this. You must inactivate your adjustment and resubmit a new adjustment request with the correct DCN number.</p>
32200	<p>Diagnosis 'V048' or 'V0382' present on claim without condition code A6 for the following bill types: 13x, 14x, 22x, 23x, 24x, 34x, 71x, 72x, 74x, 75x, 83x, 85x</p> <p>For dates of service 10/1/03 or after, diagnosis code 'V0481' is present and the claim does not contain condition code A6 for the following bill types: 12x, 13x, 14x, 22x, 23x, 24x, 34x, 71x, 72x, 74x, 75x, 83x, 85x.</p> <p>For claims with dates of service 'from' date on or after 07/01/03, this edit is bypassed for types of bills 14x and 74x.</p>	<p>Please review and verify your claim, correct and resubmit if appropriate.</p>



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<p>31023</p>	<p>The No-Pay claim does not have any of the required criteria.</p>	<p>1. Use a condition code 20 when the beneficiary has requested a demand bill. (SNFs 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:</p> <ul style="list-style-type: none"> ○ "benefits exhau" for benefits exhausted ○ "no qhs" (for no qualifying hospital stay; this applies to SNFs only) ○ "no 30 day tran" (for no 30 day transfer, this applies to SNFs only). <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>