



**Top Ten Claim Submission Errors  
April 2009**

Reason Code	Narrative	Resolution
<b>38119</b>	This is a continuing stay Skilled Nursing Facility (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.
<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.
<b>39012</b>	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 reason on the first line. Any other remarks should start on the next line. There should be no other information on the first line. 2. Store the claim.
<b>38118</b>	This is a continuing stay Skilled Nursing Facility (SNF) /non- Prospective Payment System (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>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 Notice (ABN).	To correct your claim, verify units and resubmit if appropriate.
<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 non-covered days; unless the patient status is 30, then 1 additional day is used in the calculation.	If the "from" and "through" dates are the same, the bill must show only 1 day. Correct and resubmit.
<b>77745</b>	Claim has been submitted with a Medicare Secondary Payer (MSP) Value Code and amount and Common Working File (CWF) indicates that Medicare is primary.	Verify CWF to determine who is primary. If Medicare is primary and you have received payment from the other insurance, refund the payment to that insurer. If primary payment was not received from the other insurance, remove all other insurance information from the claim and resubmit.



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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 on HCPC code or at least on revenue code service dates are 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, the claim may be resubmitted with condition code G0. Refer to CMS Internet-Only Manual, Medicare Claims Processing Manual, Publication 100-04, Chapter 4, Sections 170 &amp; 180.4 for proper billing instructions. Correct and resubmit claim.</p> <p>If this is not a distinct and constituted independent visit, then add charge to previously billed claim.</p>
31023	The No-Pay claim does not have any of the required criteria.	<ol style="list-style-type: none"> <li>1. Use a condition code 20 when the beneficiary has requested a demand bill.</li> <li>2. Use a condition code 21 when you have determined the patient is no longer receiving a skilled level of care, or the services is excluded from Medicare coverage and you need a denial from Medicare in or to bill other insurers.</li> <li>3. If you are submitting the No-Pay bill due to benefits exhausted, no qualifying hospital stay or thirty day transfer requirement was not met, please submit a payable claim to Medicare and the claim will deny with the appropriate denial reason code.</li> </ol> <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 and 69 condition code is present on the claim. Charges must be shown as covered.</p> <p>----or----</p> <p>If no entitlement, bill claim as covered and</p>



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		CWF will reject with the correct reason code.
<b>16806</b>	The alpha suffix or prefix of the Health Insurance Claim Number (HIC) is not valid.	Verify HIC to make sure the HIC number has the correct letter on the end of it. Correct on page 1 if the HIC number is completely different or on page 5 if you are changing the number at the end.