



TOP TEN CLAIM SUBMISSION ERRORS
July 2009

Reason Code	Narrative	Resolution
38119	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.
N5052	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.
38118	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.
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 "from" and "through" dates are the same, the bill must show only 1 day. 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 Notice (ABN).	To correct your claim, verify units and resubmit if appropriate.
38038	Effective for 08/1/00 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.	<ul style="list-style-type: none"> • Condition code 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. <p>Notes:</p> <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.
31023	The No-Pay claim does not have any of the required criteria.	<ol style="list-style-type: none"> 1. Use a condition code 20 when the beneficiary has requested a demand bill. 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. 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. <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 CWF will reject with the correct reason code.</p>
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 On-Line Manual, Medicare Claims Processing Manual, Publication 100-04, Chapter 4, Sections 170 & 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>
16806	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.
U5607	The admit date is less than the from date and there is a processed claim within the admit and from dates that has a different admit date, provider number, or status is not 30.	<p>Verify HIC, provider number, admit date, from date, through date and patient status on the claim.</p> <p>If this claim is in error, correct and resubmit.</p> <p>If the processed claim is in error, submit a cancel for the claim(s) in error. Then resubmit claims in sequential order after remittance advice is received.</p>