

## Top Claim Submission Errors: Rejections—May 2009

In the chart below are the rejection reason code narratives for the top claim submission errors with claim tips, as appropriate. This list contains the top reason codes for hospice claims in the following states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

Reason Code	Reason code descriptive narrative and tips to correct and/or avoid future rejections.	Total Number of Rejections
38032	<p>This outpatient claim is a duplicate of a previously processed outpatient claim. The following situations exist:</p> <ol style="list-style-type: none"> <li>1) The 'statement covers period' is the same on both bills</li> <li>2) Provider numbers are the same</li> <li>3) At least one revenue code or one HCPCS code is the same on both bills</li> <li>4) At least one diagnosis code matches on both claims</li> <li>5) At least one line item date of service for lab charges is the same on both claims.</li> </ol> <p><b>Avoiding/correcting this rejection:</b></p> <ul style="list-style-type: none"> <li>▪ Verify the 'from' and 'through' dates on the bill.</li> <li>▪ Verify provider number, revenue codes, HCPCS codes, diagnosis codes, and line item dates of service.</li> </ul> <p>If all information is correct, add the charges from the incoming claim to those of the paid claim.</p>	124

38031	<p>This outpatient claim is a possible duplicate to a previously submitted outpatient claim and the following conditions exist:</p> <ol style="list-style-type: none"> <li>1) Statement 'from' and 'thru' dates overlap;</li> <li>2) Provider numbers are the same;</li> <li>3) At least one revenue code line matches;</li> <li>4) The diagnosis code(s) on both the history and incoming claim are the same;</li> <li>5) If the history or incoming claim has one of the following HCPCS modifiers - LT, RT, E1-E4, FA, F1-F9, TA or T1-T9 for the same HCPCS, and same date of service, and the incoming or history claim has a blank HCPCS modifier, or the HCPCS modifier isn't equal to the following -LT, RT, E1-E4, FA, F1-F9, TA or T1-T9;</li> <li>6) At least one HCPCS code is the same on both claims</li> <li>7) If HCPCS/modifier (LT, RT, E1-E4, FA, F1-F9, TA or T1-T9) are equal on both the incoming and history claim, the reason code will assign.</li> </ol> <p><b>Avoiding/correcting this rejection:</b></p> <ul style="list-style-type: none"> <li>▪ Verify the 'from' and 'through' dates on the bill.</li> <li>▪ Verify provider number, revenue codes, HCPCS codes, and line item date of service.</li> </ul> <p>If all information is correct, add the charges from the incoming claim to those of the paid claim.</p>	56
U5211	<p>Our records indicate that the services billed on the claim were provided after the beneficiary's date of death.</p> <p><b>Avoiding/correcting this rejection:</b> Verify the HIC number and dates of service.</p> <ol style="list-style-type: none"> <li>1) If appropriate, correct the information and submit a new claim or update returned claim.</li> <li>2) If actual date of death was reported in error to social security office that office must be contacted to correct the date.</li> <li>3) If the beneficiary is still alive, he/she must contact social security office for an interview as these cases cannot be corrected through the intermediary.</li> </ol>	46

39929	<p>Each line of charges on this claim has been rejected and/or rejected and denied.</p> <p><b>Avoiding/correcting this rejection:</b> Verify the line level rejection information to determine the rejection for each of the lines of the claim in question.</p>	30
38200	<p>This claim is an exact duplicate of a previously submitted claim where the following fields on the history and processing claim are the same:</p> <ul style="list-style-type: none"> <li>- HIC number</li> <li>- Type of bill (all three positions of any TOB)</li> <li>- Provider number</li> <li>- Statement 'from' date of service</li> <li>- Statement 'through' date of service</li> <li>- Total charges (0001 revenue line)</li> <li>- Revenue code</li> <li>- HCPCS and modifiers (if required by revenue code file)</li> </ul> <p><b>Avoiding/correcting this rejection:</b></p> <ul style="list-style-type: none"> <li>▪ Check for a previously processed claim.</li> <li>▪ Verify prior records before submitting another adjustment.</li> </ul>	8
E0401	<p>The type of bill (TOB) is invalid, is inconsistent with the provider number, or the type of bill (TOB) code present is not allowed for revenue code 0403.</p> <p><b>Avoiding/Correcting this Rejection:</b> Verify that the appropriate type of bill and provider number combination is being billed.</p>	8
U5600	<p>The dates of service reported on this claim are a duplicate to a claim, with the same dates of service that has previously processed. Therefore, no Medicare payment can be made.</p> <p><b>Avoiding/correcting this rejection:</b> If appropriate submit an adjustment to the previously processed claim.</p>	7

34281	<p>Claim submitted as Medicare primary and a positive working elderly record exists at CWF. The claim should be billed to the primary insurer.</p> <p><b>Avoiding/correcting this rejection:</b></p> <ul style="list-style-type: none"> <li>▪ If this is correct: Follow MSP billing guidelines and submit the claim accordingly.</li> <li>▪ If this is incorrect: As part of a provider’s eligibility verification process for Medicare beneficiaries, which is required to be conducted before claims are submitted to Medicare, providers should be checking for MSP file(s) on CWF. If a provider identifies an MSP file that requires correction because the information within that MSP file is invalid, it should contact the Coordination of Benefits Contractor (COBC) at 1-800-999-1118 so that they can make the correction before the provider submits its claim(s) to Medicare.</li> <li>▪ In addition, providers should utilize all available/applicable condition codes, occurrence codes, and remarks opportunities when submitting Medicare primary claims when there is an active MSP file on CWF.</li> </ul>	7
34002	<p>Claim submitted as Medicare primary and a positive working elderly record exists at CWF. The claim should be billed to the primary insurer.</p> <p><b>Avoiding/correcting this rejection:</b></p> <ul style="list-style-type: none"> <li>▪ If this is correct: Follow MSP billing guidelines and submit the claim accordingly.</li> <li>▪ If this is incorrect: As part of a provider’s eligibility verification process for Medicare beneficiaries, which is required to be conducted before claims are submitted to Medicare, providers should be checking for MSP file(s) on CWF. If a provider identifies an MSP file that requires correction because the information within that MSP file is invalid, it should contact the Coordination of Benefits Contractor (COBC) at 1-800-999-1118 so that they can make the correction before the provider submits its claim(s) to Medicare.</li> <li>▪ In addition, providers should utilize all available/applicable condition codes, occurrence codes, and remarks opportunities when submitting Medicare primary claims when there is an active MSP file on CWF.</li> </ul>	6



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U5200	<p>The Centers for Medicare and Medicaid Services' records indicate that the beneficiary is not entitled to Medicare coverage for the type of services billed on the claim. Therefore, no Medicare payment can be made.</p> <p><b>Avoiding/correcting this rejection:</b></p> <ul style="list-style-type: none"><li>▪ Review the beneficiary's entitlement</li><li>▪ If you are billing for a rejection in order to bill another insurer, you have accomplished what you wished to do.</li></ul>	4
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**NHIC, Corp.**

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