



Top Hospice Rejection Codes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

The chart below identifies rejection reason codes for the top claim submission errors and tips for avoiding/correcting these rejections.

Reason Code/Narrative	Avoiding/Correcting This Denial
38200 This claim is an exact duplicate of a previously submitted claim where the following fields on the history and processing claim are the same: <ul style="list-style-type: none">- HIC number- Type of bill (all three positions of any TOB)- Provider number- Statement 'from' date of service- Statement 'through' date of service- Total charges (0001 revenue line)- Revenue code- HCPCS and modifiers (if required by revenue code file)	Information on avoiding and/or correcting this reason code can be found in the <i>Avoiding Reason Code 38200</i> Job Aid: http://www.medicarenhic.com/providers/pubs/Avoiding%20Reason%20Code%2038200.pdf

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Reason Code/Narrative	Avoiding/Correcting This Denial
<p>38032</p> <p>This outpatient claim is a duplicate of a previously processed outpatient claim. The following situations exist:</p> <ol style="list-style-type: none"> 1) The 'statement covers period' is the same on both bills; 2) Provider numbers are the same; 3) At least one revenue code or one HCPCS code is the same on both bills; 4) At least one diagnosis code matches on both claims; and 5) At least one line item date of service for lab charges is the same on both claims. 	<p>If the claim is truly a duplicate; no action is necessary. Providers should develop and implement a process to ensure that duplicate claims are not being submitted.</p> <p>If this is not a duplicate and the provider is trying to add information to the original claim, submit an adjustment to the processed claim.</p>
<p>U5211</p> <p>Our records indicate that the services billed on the claim were provided after the beneficiary's date of death.</p>	<p>Verify the HIC number and dates of service.</p> <p>If appropriate, correct the information and submit a new claim or update returned claim.</p> <p>If actual date of death was reported in error to social security office that office must be contacted to correct the date.</p> <p>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.</p>

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Reason Code/Narrative	Avoiding/Correcting This Denial
<p>38031</p> <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"> 1) Statement 'from' and 'through' dates overlap; 2) Provider numbers are the same; 3) At least one revenue code line matches; 4) The diagnosis code(s) on both the history and incoming claim are the same; 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 LT, RT, E1-E4, FA, F1-F9, TA or T1-T9; 6) At least one HCPCS code is the same on both claims; or 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. 	<p>Verify the 'from' and 'through' dates, provider number, revenue codes, HCPCS codes, and line item date of service on the bill.</p> <p>If the claim is truly a duplicate; no action is necessary. Providers should develop and implement a process to ensure that duplicate claims are not being submitted.</p> <p>If all information is correct, add the charges from the incoming claim to those of the paid claim by submit an adjustment to the processed claim.</p>

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Reason Code/Narrative	Avoiding/Correcting This Denial
<p>38033</p> <p>The incoming outpatient claim is a duplicate to a previously processed outpatient claim and the following conditions exist:</p> <ol style="list-style-type: none"> 1) The 'statement covers period' of the incoming claim spans one day; 2) The date on the incoming claim matches either the 'from' or 'through' date of the processed claim; 3) The provider numbers are equal; 4) All the revenue codes on both claims match; 5) At least one HCPCS code is the same on both claims; or 6) At least one line item date of service for lab charges is the same on both claims 	<p>If the claim is truly a duplicate; no action is necessary. Providers should develop and implement a process to ensure that duplicate claims are not being submitted.</p> <p>If this is not a duplicate and the provider is trying to add information to the original claim, submit an adjustment to the processed claim.</p>
<p>39929</p> <p>Each line of charges on this claim has been rejected and/or rejected and denied.</p>	<p>Information on avoiding and/or correcting this reason code can be found in the <i>Reason Code 39929</i> Job Aid: http://www.medicarenhic.com/providers/pubs/Reason%20Code%2039929.pdf</p>

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Reason Code/Narrative	Avoiding/Correcting This Denial
<p>U5600</p> <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>If the claim is truly a duplicate; no action is necessary. Providers should develop and implement a process to ensure that duplicate claims are not being submitted.</p> <p>If this is not a duplicate and the provider is trying to add information to the original claim, submit an adjustment to the processed claim.</p>
<p>U5200</p> <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>Verify that the Health Insurance Claim Number (HICN) on the claim is for the correct beneficiary.</p> <p>If the HICN is correct, verify the beneficiary's entitlement information, correct, and resubmit if appropriate.</p> <p>If the HICN is incorrect, submit a new bill with the correct HICN.</p> <p>If you are billing for a rejection in order to bill another insurer, you have accomplished what you wished to do.</p>

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Reason Code/Narrative	Avoiding/Correcting This Denial
<p>38037</p> <p>This claim is a duplicate to a previously processed outpatient bill and one of the following two situations exist:</p> <p>1) The incoming claim 'from' date is equal to the 'from' date of the previously processed claim; or</p> <p>2) The incoming claim 'from' date falls within the 'from' and 'through' dates of the previously processed claim; and one of the following elements are identical:</p> <ul style="list-style-type: none"> ▪ Provider number is the same and at least one revenue code, HCPCS code, or diagnosis code matches. 	<p>Verify the 'from' and 'through' dates, provider number, revenue codes, HCPCS codes, and diagnosis codes on the bill.</p> <p>If the claim is truly a duplicate; no action is necessary. Providers should develop and implement a process to ensure that duplicate claims are not being submitted.</p> <p>If all information is correct, add the charges from the incoming claim to those of the paid claim by submit an adjustment to the processed claim.</p>
<p>U5220</p> <p>The services billed on the claim were provided prior to the date the beneficiary was entitled to Medicare coverage. Therefore, no Medicare payment can be made.</p>	<p>Verify that the Health Insurance Claim Number (HICN) on the claim is for the correct beneficiary.</p> <p>If the HICN is correct, verify the beneficiary's entitlement information, correct, and resubmit if appropriate.</p> <p>If the HICN is incorrect, submit a new bill with the correct HICN.</p> <p>If you are billing for a rejection in order to bill another insurer, you have accomplished what you wished to do.</p>

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Reason Code/Narrative	Avoiding/Correcting This Denial
<p>34465</p> <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>If this is correct: Follow MSP billing guidelines and submit the claim accordingly.</p> <p>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.</p> <p>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.</p> <p>Additional Information/Job Aids: More information can be found by visiting the Medicare Secondary Payer section on our Web site at www.medicarenhic.com.</p>

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Reason Code/Narrative	Avoiding/Correcting This Denial
<p>34002</p> <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>If this is correct: Follow MSP billing guidelines and submit the claim accordingly.</p> <p>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.</p> <p>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.</p> <p>Additional Information/Job Aids: More information can be found by visiting the Medicare Secondary Payer section on our Web site at www.medicarenhic.com.</p>
<p>E0401</p> <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>Verify that the appropriate type of bill and provider number combination is being billed.</p>
<p>34928</p> <p>For 81X or 82X type of bill, statement 'from' date on or after 01/01/08 and revenue code 055X, 056X, or 057X is present on the claim.</p>	<p>The associated payment for this service(s) is included in the payment or allowance for another service/procedure.</p>

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<p>34540</p> <p>Claim submitted as Medicare primary and a positive disability record exists at CWF. The claim should be billed to the primary insurer.</p>	<ul style="list-style-type: none">▪ If this is correct: Follow MSP billing guidelines and submit the claim accordingly.▪ 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.▪ 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. <p>Additional Information/Job Aids: More information can be found by visiting the Medicare Secondary Payer section on our Web site at www.medicarenhic.com.</p>

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<p>34050</p> <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>	<ul style="list-style-type: none">▪ If this is correct: Follow MSP billing guidelines and submit the claim accordingly.▪ 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.▪ 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. <p>Additional Information/Job Aids: More information can be found by visiting the Medicare Secondary Payer section on our Web site at www.medicarenhic.com.</p>

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Reason Code/Narrative	Avoiding/Correcting This Denial
<p>34471</p> <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>	<ul style="list-style-type: none"> ▪ If this is correct: Follow MSP billing guidelines and submit the claim accordingly. ▪ 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. ▪ 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. <p>Additional Information/Job Aids: More information can be found by visiting the Medicare Secondary Payer section on our Web site at www.medicarenhic.com.</p>

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