



## Top Claim Submission Errors: Rejections – April 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 Home Health 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
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. Providers can access MAP171D for line item detail information:</p> <ul style="list-style-type: none"> <li>▪ Hit PF2 once or PF11 twice from page 2 of the claim to access MAP171D.</li> <li>▪ Since it is possible for each line item to have a different line item reason code, review the additional lines that were rejected. To perform this function, PF6 to forward to the next claim line and PF5 to go back through previous claim lines.</li> </ul>	485
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 a claim/adjustment.</li> </ul>	391

U5233	<p>The services on this claim fall within or overlap a Medicare Advantage (MA) HMO enrollment period. Verify the admission date, from and through dates on the claim and compare them to the MA entitlement dates.</p> <p>Outpatient facilities and inpatient Non-IPPS, IRF or LTCH hospitals billing services within a MA enrollment period will be rejected to be submitted directly to the Medicare Advantage plan.</p> <p><b>Avoiding/correcting this rejection:</b></p> <ul style="list-style-type: none"> <li>▪ Verify the dates of service on the claim.</li> <li>▪ Check HIQH for MAO plan information.</li> <li>▪ If appropriate, please make corrections and resubmit.</li> </ul>	321
C7080	<p>The dates of service on this outpatient claim fall within or overlap the From and Through dates on an inpatient claim from another provider.</p> <p><b>Avoiding/correcting this rejection:</b></p> <ul style="list-style-type: none"> <li>▪ Verify the dates of service on the claim.</li> <li>▪ Check HIQA for inpatient hospital dates.</li> <li>▪ If appropriate, make corrections and resubmit.</li> </ul>	164
38157	<p>This RAP is a duplicate of a paid RAP or paid, suspended or denied Home Health claim for the same provider, Medicare number and statement from date without a cancel date.</p> <p><b>Avoiding/correcting this rejection:</b></p> <p>This edit is firing due to the RAP and final claim being submitted at the same time; they are editing against each other. To avoid this problem, please wait to submit your final claim until the RAP has been finalized.</p>	146
C7010	<p>An inpatient, outpatient, or Home Health claim has service dates overlapping a Hospice election period and condition code 07 is not present.</p> <p><b>Avoiding/correcting this rejection:</b></p> <p>Verify there is a Hospice period overlapping the dates of service billed on your claim by going to page 2 in HIQA.</p>	73

38050	<p>This claim is a duplicate of a previously submitted Home Health claim. The first two positions of the TOB are 32X, 33X OR 34X and the following fields on the history and processing claim are the same.</p> <ul style="list-style-type: none"> <li>- HIC number</li> <li>- Provider number</li> <li>- Statement 'from' date of service</li> <li>- Statement 'thru' date of service</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 a claim/adjustment.</li> </ul>	34
39011	<p>This claim or adjustment has failed the timeliness submission edit. All claims for services furnished in the 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> quarters (January – September) must be received on or before December 31 of the following year in which the services were furnished. All claims for services in the last quarter (October – December) must be received on or before December 31 of the second year following the service year. Home Health Prospective Payment System (HHPPS) claims can represent extended periods of time between admission and discharge. HHPPS claims with discharge/episode end dates on or after October 1 must be considered timely if received by December 31 of the second year following the service year. The time limit for filing may be extended up to six months following notification to the provider or beneficiary of a Medicare program administrative error. Claim remarks and date of notification are required to request the six month extension.</p> <p><b>Avoiding/correcting this rejection:</b> All claims must follow the timely filing guidelines.</p>	25
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>	24
38054	<p>This Home Health claim was submitted as a Medicare primary claim and contains service dates which overlap a previously submitted claim for the same provider with at least one matching revenue code.</p> <p><b>Avoiding/correcting this rejection:</b> Verify the dates of service and charges on your bill.</p>	23

