May 2021 top claim submission errors - Delaware

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| # | Reason code | Description | Resolution |
| 1 | 30949 | Claims with bill type xx7 or xx8 must contain a claim change reason condition code. Valid codes are D0 thru D9 and E0.  When using condition code D9, the remarks section of the claim must show the reason for the adjustment. | Please verify, correct, and resubmit.  You can find a list of claim change reason/condition codes on the [National Uniform Billing Committee](http://www.nubc.org/) website.  References  [Adjustment condition code clarification](ddocname:00003589)  [Reason code 30949 resolution](ddocname:00142518) |
| 2 | 38038 | This outpatient prospective payment system (OPPS) date of service is overlapping or the same day as another processed OPPS claim for the same provider number. | Verify dates and coding; correct and resubmit.  If the second claim is a separate and distinct visit, identified by a visit revenue code (i.e., 045X, 051X), add condition code G0 (zero).  If the second claim is not a separate and distinct visit, adjust the paid claim and add the late charges if within timely filing limits.  If the second claim is a demand bill, add condition code 20 and F9 back into the system.  If billing for a denial notice for another insurer, add condition code 21 and F9 back into the system.  If reporting condition code 07, only splints, casts, and antigens will be paid under OPPS.  For type of bill 75X, only vaccines and their administration are paid under OPPS. |
| 3 | 38119 | A skilled nursing facility (SNF) claim or a non-prospective payment system (PPS) inpatient claim submitted. However, the statement covers from date is greater than the admission date and there is no claim pending with a through date one day less than this claim from date. | SNF and non-PPS providers are required to bill in sequential order.  This claim cannot process until the prior bill(s) is processed.  Resubmit this claim once the previous month’s claims have processed. |
| 4 | 31743 | Charges for incidental packaged services (1st OCE flag equal to 'N') are not to be allocated/distributed among all submitted 0360 revenue code lines. | Please verify, correct, and resubmit. |
| 5 | 31102 | The following requirements must be met to consider processing as a conditional payment:   * Occurrence code 01, 02, 03, or 04 must be present. * Medicare secondary payer (MSP) value code 12, 13, 14, 15, 16, 41, 42, 43, or 47 must be present. * Associated MSP value code amount must contain all zeros.   Remarks must state why the primary payer has not paid on this claim. | Please verify, correct, and resubmit.  If occurrence code 24 is reported, 'remarks' must be present for justification purposes. The information for 'remarks' can be pulled directly from the primary payer explanation of benefits.  Reference  [Reason codes 31102 and 31361](ddocname:00142520) |
| 6 | 30940 | A provider is not permitted to adjust a partially or fully medically denied claim.  This reason code will edit when medically denied lines are moved into a covered status or medically denied lines are altered. | If you disagree with the medical denial and have records to support the services, submit a [redetermination request](https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00004472) following the established protocol.  Reference  [Reason code 30940 resolution](ddocname:00002737) |
| 7 | W7113 | Supplementary or additional code not allowed as principal diagnosis. | Please verify the diagnosis codes reported; correct and resubmit. |
| 8 | 30960 | A provider is not permitted to adjust charges that were denied by medical review. No Medicare payment will be made. | If you disagree with the medical denial or have changes to the initial claim, and have records to support the services, submit a [redetermination request](https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00004472) following the established protocol. |
| 9 | 37544 | Total covered charges on the adjustment and previously processed claim are the same.  Condition code D1 should only be used when the submitted covered charge on the adjustment is different from the previously processed claim.  Valid condition code for adjustments are:  D0 - Change to service dates  D1 - Change to covered charges  D2 - Change to revenue code or HCPCS code  D4 - Change to diagnosis or procedure  D5 - Cancel (correct health insurance claim number/provider number)  D6 - Cancel (duplicate or OIG)  D7 - Make Medicare secondary  D8 - Make Medicare primary  D9 - Any other change (add remarks)  E0 - Change in patient status | Please verify, correct, and resubmit.  If the adjustment is changing the number of units on a revenue code line, condition code D9 should be used and Remarks should be added to indicate adjustment being done to correct number of units.  Note: When reporting condition code D9, you must include Remarks on page 4 of the claim to explain why the adjustment was necessary. |
| 10 | 39011 | The claim in question was not filed in a timely manner. | Verify the timely filing requirements for Medicare claims and resubmit accordingly.  Failing to file a claim in a timely manner is not grounds for an appeal.  References  CMS IOM Publication [100-04, claims processing manual, chapter 1, section 70.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf)  [MM7270 - Changes to the time limits for filing Medicare fee-for-service claims](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7270.pdf) |