

## Part A J4 Top Billing Errors

The following are the top errors for February–April 2010:

1. **Reason Code 30940** – The provider is attempting to adjust a partially or fully denied claim. Providers cannot submit adjustments electronically that make changes to the medically reviewed line/service or add, remove or change a diagnosis code(s) that was used when determining payment of services previously.

### Resolution

- A redetermination request should be submitted when the provider is disputing any service that has been medically denied on the claim. This includes any changes to the ICD-9-CM coding on the claim.
- A claims reopening request should be submitted when the provider is **not** disputing any medically denied services on the claim but the claim requires correction of a minor error or omission that falls under the definition of a clerical error.
- Additional information on how to determine if a non-covered claim line was denied due to medical necessity, the definition of a clerical error and instructions on how to request a redetermination/claims reopening is available in the “Correcting Medically Denied Claims” job aid.

<http://www.trailblazerhealth.com/Publications/JobAid/CorrectingMedicallyDeniedClaims.pdf>.

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2. **Reason Code 39012** – The justification for timeliness (reason code 39011) is missing or was not formatted correctly.

### Resolution

The justification statement in the remarks field must be entered exactly as follows:

- Justify: MSP involvement.
- Justify: SSA involvement.
- Justify: PRO review involvement.
- Justify: Other involvement.

**Note:** A detailed explanation is required when the justification statement, “Other involvement,” is used.

3. **Reason Code T5052** – The beneficiary identification submitted on the claim is incorrect. Medicare records do not exist for this beneficiary.

**Resolution**

Ensure the Health Insurance Claim (HIC) number submitted on the claim matches the HIC number on the beneficiary's Medicare card.

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4. **Reason Code N5052** – The Common Working File (CWF) indicates that the beneficiary's name and Health Insurance Claim (HIC) number do not match.

**Resolution**

- Compare the information submitted on the claim to the beneficiary's Medicare card.
  - Ensure the beneficiary's name and HIC number are reported exactly as they appear on the beneficiary's Medicare card.
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5. **Reason Code 19201** – The attending physician's National Provider Identifier (NPI), last name and/or first initial is missing.

**Resolution**

Report the attending physician's NPI, last name and first initial.

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6. **Reason Code 30905** – FISS has no record of processing an original claim for this adjustment.

**Resolution**

To ensure a processed claim exists for this adjustment, verify:

- The patient's Health Insurance Claim (HIC) number.
  - The Document Control Number (DCN).
  - The provider number.
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7. **Reason Code 31102** – The primary payer code is "C," but the required occurrence/value code information is missing.

**Resolution**

The following information is required when requesting conditional payment from Medicare:

- Occurrence code 24 and the date of denial from the primary insurer.
- The appropriate value code and 0000.00 for the dollar amount.
- Remarks to indicate the reason the primary payer did not pay.

Additional information may be found in the “MSP Conditional Payment” job aid.

<http://www.trailblazerhealth.com/Publications/Job Aid/MSPConditionalPayment.pdf>

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- 8. Reason Code 32400** – A HCPCS code is required for one of the line items, and a HCPCS code is not present on the claim.

**Resolution**

- Verify the revenue code billed is correct.
  - Refer to the current CPT and/or HCPCS coding books for a valid CPT/HCPCS code. CPT/HCPCS coding information is available by calling the American Medical Association (AMA) at (800) 621-8335 or visiting the AMA Web site.  
<http://www.ama-assn.org/>
  - Direct Data Entry (DDE) users may reference the “Revenue Code Verification in DDE” job aid for instructions on how to verify if a revenue code requires a HCPCS code.  
<http://www.trailblazerhealth.com/Publications/Job Aid/VerifyRevenueCode.pdf>
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- 9. Reason Code 70359** – The claim was submitted as Medicare Secondary Payer (MSP) but there is no open valid MSP file in the Common Working File (CWF).

**Resolution**

- When a claim is submitted as secondary and the CWF MSP file indicates Medicare is the primary payer for the claim dates of service, contact the Coordination of Benefits (COB) contractor at the following address or telephone number:

**Medicare – Coordination of Benefits Contractor**

MSP Claims Investigation Project

P.O. Box 33847

Detroit, MI 48232

(800) 999-1118

TTY/TDD: (800) 318-8782

Monday – Friday, 8 a.m. to 8 p.m. ET

- If COB indicates that Medicare is primary, adjust the claim to reflect Medicare as the primary payer.

- If COB indicates that Medicare is not the primary payer, adjust the claim after the CWF MSP file has been updated. Use condition code D9 and adjustment reason code OT, and indicate that the MSP record has been updated in the remarks field.
- Information on the claim adjustment process is available in the *DDE Claims Correction Manual*.  
<http://www.trailblazerhealth.com/Publications/TrainingManual/GPNetClaimsCorrection.pdf>