



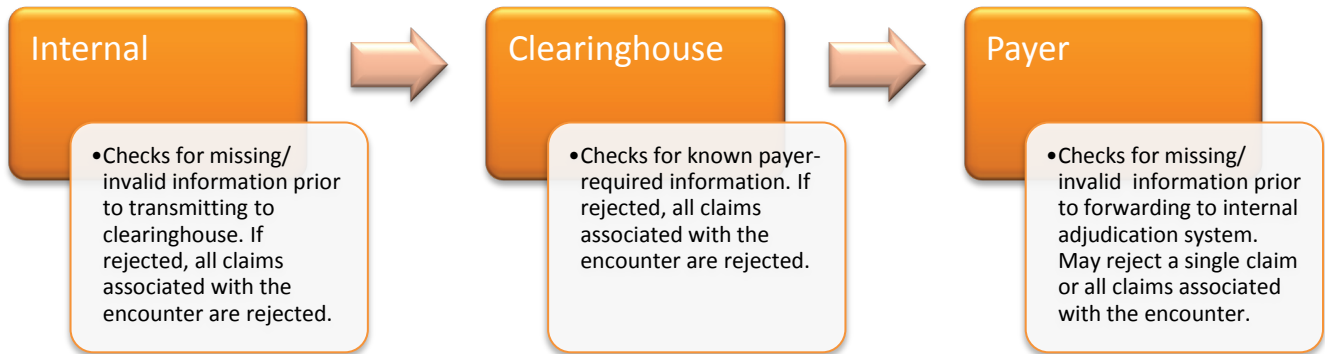
*Kareo Claim Rejection
Troubleshooting Guide
January 2012*

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About Claim Rejections

As part of claim processing, claims go through three separate reviews before reaching a payer's internal adjudication system. You may receive electronic claim rejections from one or more of these reviewers: Internal (Kareo), clearinghouse or the payer.



These reviews check for correct claim formatting rules (i.e.: patient address, service location, diagnosis/procedure codes, payer ID etc). If there is missing or invalid information, your claim is prevented from being forwarded on to the next reviewer. When this occurs, a rejection report is generated and you must review the reason for the rejection, make the correction and resubmit the claim.

Once the claim passes through all three reviews for correct information, your claim will go on to the payer's adjudication system. The payer then reviews the claim based on the patient's insurance plan coverage and the contract it has with the provider; any claim denials at this stage are reported to you via an Electronic Remittance Advice (or Explanation of Benefits). If you are looking for instructions on how to resolve claim denials, please refer to the [Payment Posting](#) guide.

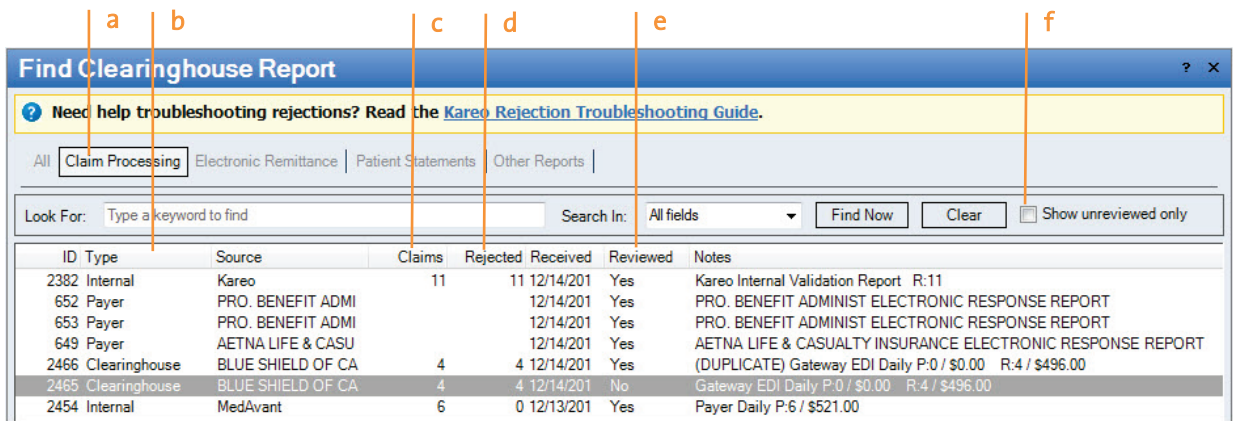
This guide covers how to review the clearinghouse report, correct electronic claim rejections and rebill, including a list of the most common electronic claim rejections.

Correcting Claim Rejections

This section is an overview of how to make corrections. Once corrections have been made to an encounter, you will have the option to rebill all claims or a single claim associated with the encounter record.

► To make corrections and rebill one or more claims

1. Click **Encounters ► Clearinghouse Reports**.
2. Double-click a report.
3. View the rejection description. For the most common claim rejections and corrections see sections [Kareo Internal Validation Report](#), [Clearinghouse Report](#), [Payer Report](#).
 - a. Click to view all claim processing reports.
 - b. Indicates if report is from Kareo (Internal), clearinghouse or payer.
 - c. Number of claims in the report.
 - d. Number of claims rejected in the report.
 - e. Indicates if report has been marked “Reviewed.”
 - f. Check to view only unreviewed reports.



4. Click the Claim ID number to access the encounter record and make corrections. Some corrections are done directly in the encounter record, while other corrections are made to your Kareo settings; please see [Tips](#) below. Always save your corrections.

Claim ID 695214 KITCHEN, MIKE 05/31/2012
 REJECTED AT CLEARINGHOUSE LINE LEVEL - DATE

Note: The Claim ID number is composed of two sets of numbers separated by a Z: In the example below, 695 = encounter record number, 14 = company ID (your individual company ID will always remain the same).

5. After making corrections, you are now ready to rebill. To rebill the entire encounter, click **Save and Rebill** at the bottom of the window.
6. To rebill only a specific claim, click **Show Claims** at the bottom of the window; this opens the *Find Claims* window displaying all claims associated with the encounter.
7. Click **Action** at the bottom and select *Rebill*.

8. Click **Apply** on the right of the window. A message will appear asking if you would like to rebill all claims associated with the encounter:
 - Click **Yes**: All claims are set to rebill.
 - Click **No**: Only selected claim is set to rebill.
9. Return to the report on the Clearinghouse Report window and click **Mark As Reviewed**.
10. Once you are finished setting one or more claims to rebill, you must resubmit them. Click **Submit E-Claims**.

The screenshot shows the 'Find Claim' window with the following data:

Encounter ID	Claim ID	Service Date	Procedure	Modifier	Patient	Billed To	Adj. Charges
801	2135	12/06/2010	98941		Wisholek, Dave	Aetna Southern CA	\$20.00
801	2136	12/06/2010	98943		Wisholek, Dave	Aetna Southern CA	\$600.00
801	2137	12/06/2010	00100		Wisholek, Dave	Aetna Southern CA	\$135.00

The 'Type' dropdown is set to '5 - Rebill'. The 'Apply' button is highlighted in yellow.



Tips

- Kareo Internal Reports are generated within a few hours after submitting electronic claims. A good practice is to check reports regularly; for example, if you submit claims in the afternoon, check the reports as a first task the next day.
- Clearinghouses will reject duplicate claims. It is recommended to wait three (3) business days before resubmitting corrected claims.
- Many corrections can be made directly in the encounter record by clicking active buttons, clicking in the information fields or clicking underlined information (which hyperlinks to where you can make changes).
- Certain rejections will require changes to your Kareo settings such as service locations; click **Settings** in the Navigation menu to make these kinds of corrections.

Kareo Internal Validation Report

Prior to submitting claims to the clearinghouse, the Kareo system does an internal check for missing information or discrepancies. When detected, the claim will be rejected so that you can make the necessary corrections. Because Kareo's report is generated within a few hours after claim submission, corrections can be made in a timely manner. For the most common rejections and resolutions, see the next section [Kareo Rejections](#).

Note: If a claim is rejected from Kareo, all claims associated with the encounter are rejected.

Example of Kareo Checks:

- Patient's full name, date of birth, gender, address and phone number
- Guarantor name and address, when guarantor (other than patient) is checked under the *General* tab
- If insured is other than patient, insured's full name, address, ID, date of birth and gender
- Policy number for both primary and secondary insurance
- When billing secondary payers, adjudication date on payment received from primary payer
- When DME-related procedure codes are used on an encounter record, referring physician's address under the *General* tab of the referring physician's record

- a. Reason for rejection.
- b. Click to access the encounter record.
- c. Click to access the specific claim associated with the encounter record.



Kareo Rejections

This table covers the most common types of Kareo rejections and provides details on how to resolve them.

Error: Description	Further Explanation	Resolution
Referring physician Provider Numbers are missing	Your claims cannot be submitted without appropriate referring provider information.	Open the Edit Referring Physicians task in Kareo and enter valid provider number to identify the doctor to Payer. Typically this would be the referring physician's UPIN number; unless the payer requires a different type of provider number for the referring physician named on a claim.
Your claims cannot be submitted without a valid date of birth for the other payer's subscriber.		Open the Edit Patient task in Kareo, open Case, open Insurance Policy, and enter a valid date of birth for the Insured.
Missing N301 street address for (Provider) (ordering provider for DME procedure code). Missing N401 city in address for (Provider) Missing N402 state in address for (Provider) (Note that the ordering provider is typically the referring physician shown on the encounter record.)	You have used DME-related Procedure Code that requires Ordering Provider. Your claims cannot be submitted without a valid address.	Open the Edit Referring Physician task in Kareo; and under the General tab, enter the full address of the referring physician.
Your claims cannot be submitted without a valid adjudication date from the other payer's payment		Open the Edit Payment task in Kareo and enter a valid adjudication date for the other payer on claim.
Missing subscriber's insurance policy number	Your claims cannot be submitted without a valid insurance Policy Number.	Open Edit Patient task in Kareo, open Case, open Insurance Policy, and enter a valid Policy Number for Insured in the Insured ID field (right side of policy screen).
Your claims cannot be submitted without a valid gender for the other payer's subscriber.		Open the Edit Patient task in Kareo, open Case, open Insurance Policy, and enter a valid gender for the Insured.
Missing Insurance Policy Number for (Patient)	Your claims cannot be submitted without a valid insurance Policy Number.	Open Edit Patient task in Kareo, open Case, open Insurance Policy, and enter a valid policy number in the Policy Number field (left side of policy screen).
Missing N301 street address for (Subscriber). Missing N401 city in address for (Subscriber)	Your claims cannot be submitted without a valid address.	Open Edit Patient task in Kareo, open Case, open Insurance Policy, and enter Insured's address.

Error: Description	Further Explanation	Resolution
Patient DOB missing	Your claims cannot be submitted without a valid date of birth for the patient.	Open the Edit Patient task in Kareo and enter a valid date of birth.
Patient's street address is missing.	Your claims cannot be submitted without a valid patient address.	Open Edit Patient task in Kareo, open Case, open Insurance Policy, and enter a valid policy number in the Policy Number field (left side of policy screen).

Clearinghouse Report

Prior to transmitting claims to the payer, the clearinghouse runs a series of checks for missing or invalid payer-required information. When detected, the claim will be rejected so that you can make the necessary corrections. The clearinghouse report includes both rejections and acknowledgements. For the most common rejections and resolutions, see the next section [Clearinghouse Rejections](#).

Note: If a claim is rejected from the clearinghouse, all claims associated with the encounter are rejected.

Example of Clearinghouse Checks:

- Missing or invalid Practice or Service Location primary and secondary IDs
- Missing or invalid ID qualifiers
- Missing submitter IDs when payer requires a unique submitter ID
- Missing or invalid payer ID
- Missing or invalid procedure, modifier, or diagnosis code
- Missing or invalid adjustment code
- Missing or invalid subscriber's identification number (policy number)
- Missing provider specialty code

- a. Click to access the encounter record.
- b. Reason for rejection.
- c. REJ = claim rejected; make corrections and rebill.
- d. ACK = acknowledged; claim forwarded to payer.

View Clearinghouse Report (2074)

File Name: 09081301_2045.csr.pgp
Received: 11/11/2010 6:08:50 AM

Gateway EDI Daily Claim Processing Report (P:1 / \$200.00 R:4 / \$0.00) 8/13/2009 6:08:39 AM

Provider Tax ID: 455888393 - CARDIOVASCULAR ASSOCIATES (14,1)

Type	Kareo Claim ID	Patient Name	DOS	Charge	Payer	GEDI Claim ID	Ref. Date	Status
OT01	376214	BRINTIS, JULIE	07/08/2009	200.00	AETNA BETTER HEAL	090813205943	08/13/2009	ACK
OT01	552214	JACKSON, PHIL	07/01/2009	0.00	BLUE CROSS OF WAS	090813207024	08/13/2009	REJ

SUBMITTER ID IS REQUIRED FOR THIS PAYER. INVALID SUBMITTER ID FOR THIS CLAIM TYPE. **ERROR: Primary insurance submitter id**

Print Close Mark As Reviewed

Clearinghouse Rejections

This table covers the most common types of clearinghouse rejections and provides details on how to resolve them.

Error: Description	Further Explanation	Resolution
REJECTED AT CLEARINGHOUSE LINE LEVEL - PROCEDURE CODE MODIFIER IS MISSING OR INVALID. (...)	This rejection is caused by the user entering a modifier that is invalid for the procedure being billed - or - the user didn't enter a modifier and the procedure requires one.	On the clearinghouse report click the link that will take you to the original encounter record. Make the necessary changes to the modifier associated with the procedure. Once you make the correction, save the encounter.
ERROR: Primary insurance submitter id	This rejection means the payer has assigned a submitter number to the provider in addition to their individual and/or group number, but the submitter number is missing. Please contact the enrollment department at Kareo if you don't know the submitter number for the payer in question.	<p>There are two steps for setting up a submitter number in Kareo when submitting claims through Capario ; and this is <u>ONLY</u> required when a payer has assigned a unique submitter number in addition to their individual provider number and/or group number. (These steps are also only required when submitting claims to this payer through the Capario clearinghouse. Gateway automatically does this for you.)</p> <p>First, you will need to set up the submitter number: Go to Settings > Group Numbers > New Group Number In the Type field, select "SN - EDI Submitter Number". Click the Insurance Plan button and select the plan that requires the unique submitter number. Enter the submitter number assigned by the payer in the Group Number field. Select "Electronic Claims Only" from the drop-down list in the Attach to field. Click the Save button to save the record.</p> <p>Next, you will need to set up a special group number type in order to link the group number to claims sent through MedAvant. Go to Settings > Group Numbers > New Group Number In the Type field, select "SM - EDI Submitter Name."</p>

Error: Description	Further Explanation	Resolution
		<p>In the Group Number Field, type the word "ProxyMed" (without the quotes).</p> <p>Click the Save button to save the record.</p> <p>When configured this way, the system will know to include the submitter number when electronically transmitting claims through MedAvant (formerly ProxyMed.)</p> <p><u>Additional Note:</u> The above settings need to be configured for each insurance plan where the payer requires a unique submitter number; and, again, is <u>ONLY</u> required for claims sent through the MedAvant clearinghouse.</p>
<p>1 CLAIM LEVEL ADJUSTMENT - OTHER PAYER CLAIM LEVEL ADJUSTMENT IS MISSING OR INVALID. - [] **** REJECTED **** ----- ----- or... REJECTED AT CLEARINGHOUSE CLAIM LEVEL ADJUSTMENT - OTHER PAYER CLAIM LEVEL ADJUSTMENT IS MISSING OR INVALID. (...)</p>	<p>This rejection occurs when you are billing a secondary payer, but the adjustment made by the primary payer is not showing up on the claim.</p>	<p>On the clearinghouse report click the link that will take you to the original encounter and then do the following.</p> <p>Click the link that will take you to the patient's case.</p> <p>Locate the insurance company associated with the claim rejection. Go to the Insurance Company>"Practice Settings" tab Make sure Box 2 & 3 ("Use electronic billing when this payer is secondary") and ("Send COB Information") are checked.</p> <p>Look up the primary payment by going to Encounters > Find payment Select the payment in question and make sure an adjustment was entered on the claim.</p>
<p>REJECTED AT CLEARINGHOUSE BILLING PROVIDER ADDITIONAL NAME IS NOT TO BE USED (...)</p>	<p>The electronic claim format has a limit of 35 characters including spaces and punctuation for the Billing Provider name. This rejection is typically caused by your Billing Provider name exceeding that limit.</p> <p>Note: The Billing Provider name is actually referred to as the "Practice" name in Kareo.</p>	<p>The Billing Provider name can be shortened by clicking Settings > Company > Practice Detail The application administrator or other designated staff member with appropriate permission will need to correct the name of the Practice so that it does not exceed 35 characters.</p>
<p>REJECTED AT CLEARINGHOUSE CLAIM LEVEL - SERVICE FACILITY SECONDARY IDENTIFICATION NUMBER QUALIFIER</p>	<p>This rejection is caused by one of three reasons: 1. No facility ID number was on the</p>	<p>Typically, you will get this message if the payer requires a facility ID number.</p>

Error: Description	Further Explanation	Resolution
IS MISSING OR INVALID (...)	<p>claim, if this is the case at the end of the clearinghouse error message you will see the following: ()</p> <p>2. A facility ID number was on the claim, but it is invalid according to the edits in place at the clearinghouse for the payer in question, if this is the case at the end of the error message you will see the following: (invalid facility ID).</p> <p>3. A facility ID number was included on the claim, but the facility ID type used is invalid. If this is the case at the end of the clearinghouse error message you will see the following: (invalid qualifier).</p>	<p>Go to Settings > Service Location Open Service location record and make sure that you have the Facility ID 2-digit qualifier and description set up correctly (typically “1 – Facility ID Number”). Make sure that the Facility ID number assigned to this facility has been entered in the Facility ID field. If this all appears correct, verify with the payer that you are using the correct Facility ID qualifier and number.</p>
REJECTED AT CLEARINGHOUSE PAYER ID MISSING/INVALID (...)	<p>This rejection is usually a result of the insurance company in question being linked to the wrong electronic payer ID number; or there is a problem at the clearinghouse.</p>	<p>Go to Settings > Insurance > Find Insurance Company record. Once you locate the insurance company, do the following. Select the “Electronic Claims” tab. Make sure that the company is linked to the correct payer ID for the clearinghouse you are signed up with. If the electronic payer connection appears correct, please contact Kareo support for further assistance.</p>
<p>REJECTED AT CLEARINGHOUSE CLAIM LEVEL - PRINCIPAL DIAGNOSIS CODE IS MISSING OR INVALID. (...)</p> <p>or...</p> <p>REJECTED AT CLEARINGHOUSE CLAIM LEVEL - SUPPLEMENTAL DIAGNOSIS CODE IS MISSING OR INVALID. (...)</p>	<p>These rejections are caused by the user entering either a principal or supplemental diagnosis code that is invalid for the procedure being billed, or the principal or supplemental diagnosis code is missing. principal or supplemental</p> <p>Also, in the case of the second error, the user might not have entered a supplemental diagnosis code and the procedure billed requires one.</p> <p>Note: The principal diagnosis code is the first diagnosis code entered on a specific procedure line item. The supplemental diagnosis code is considered any diagnosis code other than the principal (first) diagnosis code entered on the same line item.</p>	<p>On the clearinghouse report, click the link that will take you to the original encounter. Make the necessary changes or additions to the diagnosis code(s) associated with the procedure being billed. Once you make the correction, save the encounter record.</p>
REJECTED AT CLEARINGHOUSE LINE LEVEL - PROCEDURE CODE IS MISSING OR INVALID. (...)	<p>This rejection is either caused by the user entering a procedure code that is invalid for the date of service recorded on the claim; or the procedure code is</p>	<p>On the clearinghouse report, click the link that will take you to the original encounter. Make the necessary changes to the procedure</p>

Error: Description	Further Explanation	Resolution
	missing.	code or procedure date. Once you make the correction, save the encounter record.
<p>1 CLAIM LEVEL DATE IS MISSING OR INVALID. DATE MUST BE IN THE CCYYMMDD FORMAT. - [] **** REJECTED **** ----- ----- or... REJECTED AT CLEARINGHOUSE CLAIM LEVEL DATE IS MISSING OR INVALID. DATE MUST BE IN THE CCYYMMDD FORMAT. (...)</p>	<p>This rejection is most often a result of the user selecting one of the condition types under the “Condition” tab of the patient’s case, but not entering a valid date associated with the condition. If you select any of the condition types, a date (such as the date last seen, date of last injury, etc... is required).</p>	<p>On the clearinghouse report, click the link that will take you to the original encounter. From the Edit Encounter screen, double-click the link that will take you to the patient’s case,, and then do the following: Click on the “Condition” tab. Check to see if any of the options are checked in the “Condition related to” section. If checked, you must select the applicable date type from the “Date Type” drop-down, and then enter the date in the Date field(s). Click the Add button after entering the date.</p>
<p>REJECTED AT CLEARINGHOUSE SUBSCRIBER PRIMARY IDENTIFICATION NUMBER IS MISSING OR INVALID (...)</p>	<p>This rejection is caused by the by the patient’s or insured’s insurance policy number is missing or it doesn’t meet the clearinghouse format edits</p>	<p>On the clearinghouse report, click the link that will take you to the original encounter. From the Edit Encounter screen, double-click the link that will take you to the patient’s case, Open the insurance policy for which the claim was billed. Make sure that the correct policy number was entered in the Policy # field on the left side of the policy screen. Or, if the insured is other than self, make sure that the correct policy number was entered in the Insured ID field on the right side of the screen. The policy number should match the policy number on the insurance card.</p>
<p>1 CLAIM LEVEL - RENDERING PROVIDER SPECIALTY CODE IS MISSING OR INVALID. - [ooooooooo1] **** REJECTED **** ----- ----- or... REJECTED AT CLEARINGHOUSE CLAIM LEVEL - RENDERING PROVIDER SPECIALTY CODE IS MISSING OR INVALID. (...)</p>	<p>The rejection is cause by the user selecting unknown as the specialty type for the provider or not selecting a specialty at all.</p>	<p>Go to Settings > Providers Select the provider in question Click the Specialty button, and then select the provider’s taxonomy code from the master list of taxonomy codes. Once selected, save the Provider record.</p>

Payer Report

Once the payer receives a batch of claims, they review the claims for missing or invalid information before adjudicating them. For the most common rejections and resolutions, see the next section [Payer Rejections](#); however, payer rejections can frequently change and you may need to contact the payer directly for clarification (be prepared to provide information about the type of error message you are receiving).

Note: Depending on the reason for rejection, a payer may reject a single claim and process the remaining claims or reject all claims created from an encounter.

- a. Click to access the encounter record.
- b. Reason for rejection.
- c. Number of claims rejected in the report.

The screenshot shows a software window titled "View Clearinghouse Report (160894)". At the top, it displays "File Name: 02092009-194549-0082911U.INS" and "Received: 11/2/2010 7:36:25 PM". Below this is a summary line: "Payer Daily Claim Verification Report (P:2 / \$350.00 R:7 / \$1,034.00) 11/2/2010 7:36:16 PM". Underneath is "Provider Tax ID: 392166159 - HOLT GRP 122,20)".

Kareo PCN	Patient Name	DOS	Charge	Payer	Payer Reference	MedAvant Trace#
265821Z590	BARINO, GAIL	09/17/2010	119.00	04271		408617662819332
	INVALID MBR/PATIENT BIRTH DATE					
265822Z590	BARINO, GAIL	09/27/2010	151.00	04271		408617662820332
	INVALID MBR/PATIENT BIRTH DATE					
265825Z590	BARINO, GAIL	09/29/2010	151.00	04271		408617662821332
	INVALID MBR/PATIENT BIRTH DATE					

At the bottom of the window are three buttons: "Print", "Close", and "Mark As Reviewed".

Annotations:
- 'a' points to the first PCN link ([265821Z590](#)).
- 'b' points to the rejection reason "INVALID MBR/PATIENT BIRTH DATE" for the first row.
- 'c' points to the "R:7" value in the summary line, representing the number of rejected claims.

Payer Rejections

This table covers the most common types of payer rejections and provides details on how to resolve them.

Error: Description	Further Explanation	Resolution
<p>REJ Submitter ID is required.</p> <p>or...</p> <p>REJ INVALID SUBMITTER NUMBER PLEASE CONTACT ENROLLMENT</p>	<p>This rejection means the payer has assigned a submitter number to the provider in addition to their individual and/or group number, but the submitter number is missing from the claim or the one used is invalid.</p> <p>Please contact the enrollment department at Kareo if you don't know the submitter number for the payer in question.</p> <p>Note: This is the same type of error message that you may receive from the clearinghouse; however, for some reason, certain claims manage to pass through the clearinghouse without being rejected, but then are rejected by the payer in the end when the payer requires a submitter ID in order to process the claim.</p>	<p>There are two steps for setting up a submitter number in Kareo when submitting claims through MedAvant; and this is <u>ONLY</u> required when a payer has assigned a unique submitter number in addition to their individual provider number and/or group number. (These steps are also <u>ONLY</u> required when submitting claims to this payer through the MedAvant clearinghouse. Gateway automatically does this for you.)</p> <p>First, you will need to set up the submitter number:</p> <ul style="list-style-type: none"> • Go to Settings > Group Numbers • In the Type field, select "SN - EDI Submitter Number". • Click the Insurance Plan button and select the plan that requires the unique submitter number. • Enter the submitter number assigned by the payer in the Group Number field. • Select "Electronic Claims Only" from the drop-down list in the Attach to field. • Click the Save button to save the record. <p>Next, you will need to set up a special group number type in order to link the group number to claims sent through MedAvant.</p> <ul style="list-style-type: none"> • Reopen the Group Numbers task and do the following: • In the Type field, select "SM - EDI Submitter Name." • In the Group Number Field, type the word "ProxyMed" (without the quotes). • Click the Save button to save the record. <p>When configured this way, the system will know to include the submitter number when electronically transmitting claims through MedAvant (formerly ProxyMed.)</p>

Error: Description	Further Explanation	Resolution
		<p>Additional Note: The above settings need to be configured for each insurance plan where the payer requires a unique submitter number; and, again, is <u>ONLY</u> required for claims sent through the MedAvant clearinghouse.</p>
<p>REJ Rendering Provider SSN cannot start with 000 or be greater than 733. (...)</p> <p>or...</p> <p>REJ Billing Provider SSN cannot start with 000 or be greater than 733. (...)</p>	<p>Payer is rejecting the claim due to an invalid provider Social Security Number. SSN cannot start with 000 or a number greater than 733.</p>	<p>Go to Settings > Providers</p> <ul style="list-style-type: none"> • Open the provider record • On the General tab make sure the number entered in the SSN field is correct.
<p>REJ Rendering Provider Numbers must begin with an alpha character. (...)</p>	<p>Payer is rejecting the claim due to an invalid provider ID number</p>	<p>Go to Settings > Providers</p> <ul style="list-style-type: none"> • Open the provider record • Click on the “Provider Numbers” tab • Check to see if the provider number set up for this insurance payer Ensure the provider number in question is correct and starts with an alpha character (A-Z)
<p>[CLAIM(...) FOR THE ABOVE MEMBER HAD INFORMATIONAL MSGS: 2010AAREF B P ADTL ID 1234567890 M012 BILLING PROV NOT ON FILE 2010AAREF B P ADTL ID 1234567890 M013 SUBMIT BPRV NOT ON FILE]</p>	<p>Payer is rejecting the claim due to the provider ID number submitted (12345690), not being on file with them. Either the provider is not registered to submit electronic claims with this number or the wrong provider ID number was used.</p>	<p>If billing as a group, Go to Settings > Group Numbers Make sure that the group number linked to the payer in question is the number you received approval for electronic submission.</p> <p>If billing as an individual (no group number), Go to Settings > Provider > Provider Numbers Ensure the provider number linked to the payer in question is the number you received approval for electronic submission.</p>
<p>REJ Supervising Provider Number is required.</p>	<p>Payer is rejecting the claim because either (1), the claim being billed requires a supervising provider; or (2) the supervising provider is missing a payer-required provider ID number.</p>	<p>On the clearinghouse report, click the link that will take you to the original encounter. Make sure that a supervising provider was entered in the “Supervising Provider” field.</p> <p>Next, go to Settings > Provider > Provider Numbers tab Make sure that the provider number has been correctly set up for the payer being billed.</p>

Error: Description	Further Explanation	Resolution
REJ Procedure Code must be a valid code. (...)	Payer is rejecting the claim because one of the procedure codes used is invalid per their edits.	<p>On the clearinghouse report, click the link that will take you to the original encounter.</p> <p>Make the necessary changes to the procedure code. Once you make the correction, save the encounter record.</p> <p>If necessary contact the payer if you are not sure which code to use.</p>